Academy of PHYSICAL MEDICINE

Transcript

Neonatal Feeding Difficulties – Ref 244

Steven Bruce
Good evening and welcome. Great that you're able to join me for another evenings fantastic CPD. My guest this evening is the wonderful Miranda Clayton, one of the most widely respected voices in the osteopathic obstetrics and paediatrics world? Well, at least in this country, I should say. She's teaching and she examines at the LSO, she has been doing that for several years. So there can't be many people who are better placed to answer any of your questions about all things related to the treatment of babies and their moms. So Miranda, welcome. It's great to have you with us. I'm really sorry that it has to be via video link. How are you? When I spoke to you last year, we're suffering from COVID?

Miranda Clayton
Oh, thank you, Steven, thank you so much for having me on. I'm feeling much better. I've got a little bit of COVID brain fog. But apart from that up and running again, thank you for asking.

Steven Bruce
Well, I'm I'm very glad that you're feeling fit to do the show, because I know there's a lot of people eager to hear what you have to say this evening. However, before we get started this evening, do remember that if you are watching through the website, you can now ask your questions by live live video link. All you got to do is press that button on the screen that says ask live on air. And you'll go through to Anna in the gallery, she'll cue you up to come through to me on the screen just here. And we can take it from there. That's not available, I'm afraid through the Facebook link. But you can still ask your questions through the normal chat systems on either of those platforms. So keep the questions coming. Keep it all entertaining, keep it lively. Miranda, can I set the scene a little bit here? Because I don't know I always feel that the treatment of babies is a bit controversial, at least in the conventional medical world. Again, I hate using that term. So what are the what are the challenges and opportunities for osteopaths and chiropractors who want to treat babies and mums these days?

Miranda Clayton
Well, I think that the opportunities very much outweigh the disadvantages. I think the disadvantages are probably more around our continuing lack of good evidence base around our treatments, and also from the fact that, in my opinion, we are a very overregulated profession. So although it's easy for me to get baby patients, etc, because I'd been in practice about 25 years, I do find it very, I feel quite sorry for for new grads, because they're basically not allowed to advertise that they do anything around treating babies or say that they have to do anything around treating babies. And I have actually had new graduates over the last couple of years who's who said to me, Well, I'd love to treat babies. But I just

don't see how I can build a client base given that I can't say what I do. So I sort of appreciate that. But on the the good side for this, I think that other health care professionals are increasingly understanding what we as manual therapists do, and how we can kind of fit into the whole picture. And one of the things that I was intending to talk about tonight, was really the treatment of babies with feeding problems. And what a kind of in a sense, what a growing market this is. So if I can just sort of set the scene a little bit on this over the last kind of, well, I don't know, 3040 years. I know we work in I think you know, you and me and all practitioners, we often work in areas with really not an awful lot of evidence base. But for something like breastfeeding, there is a mountain of evidence base. You know, there's so much of it June as a landslide of evidence base, proving how good breastfeeding is for babies, for all kinds of reasons that we can go on to discuss if if you would like,

Steven Bruce
oh, yeah, well, I think we'll definitely go on to that. Of course, the the the conventional world or the critics of what we do will say it's all very well to say that breastfeeding is good, but there's nothing to say that osteopathy can help with it, or chiropractic can help with it.

Miranda Clayton
Well, no, quite. And I think you know, this is I think that, you know, this is an ongoing, kind of, I think this is an ongoing problem. But I also think that because all these mommies now want to breastfeed, and there's all this kind of information about how good it is in terms of the microbiome and future allergies and all that kind of thing. That you know, we are increasingly getting lots of parents and because patients vote with their feet, don't they really, they don't come and see you. If it doesn't work and and nothing happens. So more and more mum is wanting to breastfeed. Babies themselves are hopeless and don't read any of the evidence base and a no more kind of neurologically mature now than they were 3040 years ago. So we've got this kind of mismatch between what parents want to do based on lots of current evidence base. And what babies are actually able to do. And we're talking a sort of billion multi billion pound industry here in terms of helping babies with breastfeeding. But actually, it's the majority of babies I see at the moment, are struggling with breastfeeding. And it's a massive, great issue. It's something that we can really help with. And I think midwives, lactation specialists, breastfeeding counsellors, paediatricians, GPS, they are, I think, increasingly understanding that, even if they don't quite understand our approaches, I think they're understanding that these things are safe, and that they are generally quite often effective.

Steven Bruce
Can I clarify what you said a minute ago, Miranda, you said that most of most babies are having difficulty feeding. I take it that you mean most of the babies that come through your door are coming because they're having feeding difficulty feeding. Not Most babies generally. Yeah,

Miranda Clayton
no, generally aren't. But more babies are. And they are more babies are because I think the culture has moved from bottle feeding, which is really easy for babies through to breastfeeding, which is much more challenging for babies, and always has been. But we also have two particular issues going on here. One is that tongue tie is on the increase. It's not just being more diagnosed, it actually is being on the increase, as well as

Steven Bruce
a reason for that. Why would that happen?

Miranda Clayton
I think it's, it's actually it's actually genetic. The the gene that carries it is, what's it called? I think it's an autosomal dominant gene, I might have got that ran the wrong way. But what it means is, if your Mommy or your daddy carries that particular gene, as a baby, you will definitely inherit that gene, where you'll go on then to have a tongue tie, and that will be expressed in the baby as a tongue tie. Well, you know, genetics is way beyond me. So I don't know. But actually, in the population, in general, what's happening is that we're getting more tongue ties. And something else that's also happening is that women choose to have babies later. I mean, you know, we don't generally have be our first baby when we're 1718. Lots of women are having babies considerably later. Now, what this means is because there is evidence base out there that if you're over late 30s, early 40s, if you let a baby go beyond term, so longer than its normal 3940 weeks, there are dangers in doing that. So a lot of pregnant women have very much coerced into having a inductions or elective C sections, possibly before babies are ready to come out. And it's, I think, at the moment, lots of babies and not what I would call they're not technically premature. However, they're being born that week, two weeks, three weeks, before they're actually fully cooked. And I think that, you know, that is also something which is increasing this breastfeeding problems that I'm sort of seeing. Generally,

Steven Bruce
when, when people determine what the due date, the fully cooked date is for a baby. How accurate are they? I know, I want to know the answer to this, but it seems to me that there's a lot of fudge factor around the actual date of conception.

Miranda Clayton
Yeah, well, there can be and I mean, you know, some some I you know, I can't answer that question. I'm afraid. I don't know. I've often wondered. And I often ask parents, do you actually think that the dates were right, and some women of course, so Oh, absolutely. Yes. I know exactly when it happened and whatnot. And other women say Well, I haven't got a clue because my cycles terribly erratic and it could have been, you know, so I'm not sure though. Things Are, are actually that accurate. I mean, a lot of it's done though through scans as well. And you know, medical professionals who see 1000s of pregnant women and look at 1000s of scans. So I don't think they're terribly inaccurate. But I do think women are under a lot of pressure, particularly older women to finish a pregnancy and get the baby out, rather than leave it a little bit longer. And some of the kind of oropharyngeal and primitive reflexes perhaps are not fully formed. If you're bringing babies out two or three weeks before they would have chosen to come in so

Steven Bruce
even such a shine before they would normally have been do.

Miranda Clayton
I think so it depends what reflex you're talking about. But if you're talking about something like let's get a slide up here, actually, Justin, can you put up slide number six? And Steven, could you tell me when the slides come up? Or can you not see it anyway?

Steven Bruce
No, I'll be able to see it. I think you will as well once I once Justin's dug it out and stuck it up. There we go. So we got the phasic bike reflex.

Miranda Clayton
That's right. So phasic boat reflex. Now this is the belt, this is the reflex, it's primitive reflex. And if you so you what it means is a primitive reflexes that it's a reflex which you grow out of. So it's a sort of building block onto which other reflexes will cut will, will build more, more more sophisticated reflexes will build in time, but you're born with something called the phasic bite reflex. So what that means is that if you press on a baby's bottom or kind of mandible gum, the little jaw will flap up and down. So it will open close, open, close, open close. And this is something which benefits breastfeeding like mad. So it's a sort of like a pattern that the little babies Jaws go like like that. And that's the basic bite reflex. Right now, the thing with this reflex is it doesn't emerge until about 38 weeks in utero. It's a very late reflex to emerge. And so I think here that say you were born by elective C section because you had an older mummy at 39 weeks. You could argue that possibly this primitive reflex won't be there. And it could be a reason why a baby might really struggle you know struggle with its with its breastfeeding.

Steven Bruce
Right. Okay, just before we go on around, I did have a question that came in a little while ago, he peppers asked why tongue ties might reattach after they've been cut. And she'd also like to know whether you think that lip ties are important or not, I don't even know what a lip tight.

Miranda Clayton
Okay, so lip tie is the bit from the top of your lips. So it's like a friend Ulam under the tongue but a lip tie is usually sort of from the from the top lip to the top gum, you can also get Buechel ties. So, anywhere in the mouth, you can actually get little sort of where the where it's almost like a little tie across which which shouldn't, shouldn't be there. Now, I think that in terms of of reattachment, I think it's very important with tongue ties, and it's something that I will spend time doing with with parents, that they are taught to rehabilitate babies, after they've had a tongue tie operation. So what you want to do is you want to immediately try and get the baby latched on feedings so that its tongue will start flapping up and down. And that will sort of stop the reattachment. But some babies, after they've had tongue tie operations, they do take they either don't respond or they take days to respond, because you've got a whole really complicated neurological circuitry here in terms of the tongue. And I think if the tongue isn't encouraged to move well enough, then they can reattach. Now, what used to happen in the past is the sounds rather horrible, but they do a tongue tie, and then they would teach the parents to push where the friend knew Elon was under the tongue to stop it reattaching. Babies hated it for good reason. And also, why would you push a wound I mean, you know, I mean, pushing a wound is not normally the way of actually getting it to to heal. So this is not the current advice. But I think that sometimes parents aren't really given enough advice about how to keep the tongue moving. And there are some lovely videos on YouTube, about how you play with the baby's mouth, go inside the mouth stretch inside and, you know, generally sort of encourage the baby to use its tongue. And I think the more that you do that, the less likely they are to reattach. But it's not an exact.

Steven Bruce
No. Okay. We've had a speaker before that, who suggested on this show that perhaps we're a little bit too keen to snip buttons at tongue ties. Do you think that's the case?

Miranda Clayton
Oh, absolutely. But the problem here is, parents love tongue ties. All right, parents, they love them. Love them love them, you know? Because they make sense to them. Okay? If you

can, yes, baby can't suck. And somebody says yes, there's a piece of string under the tongue. And if you snip it, the baby's tongue will be able to flap up and down again. It totally makes sense, doesn't it? It you just think, yes, that's what it is. So and because it's like a one off kind of thing. Because parents have no idea of the complexity that it actually takes for the mouth and tongue and throat and swallowing and you know, everything else that we can go into later. They haven't got a clue. They just think you slipped through something that ought to be there, and it'll work again. Sadly, not always the case at all. So I quite agree with your other guests. I think they are. I'm not sure that overdiagnosed I think the problem is that often babies have tongue ties. But that's not what's giving them a feeding problem. And so very disappointing for parents, so they get them snipped. Nobody's doing anything illegal here. Nobody's pretending they've got tongue ties when they haven't. It's just that parents also a very, very insistent on having, honestly it, Stephen 50% of babies. I see. I've had tongue tie operations. Okay. Sent cannot have tongue ties. It's genetically it's impossible that that many babies have tongue ties. But they

Steven Bruce
must have snipped something. But they've snipped something.

Miranda Clayton
And they all have this sort of lasers thing at the back. I do think it's a whole industry. And you know, it can be jolly expensive. You can have somebody come around to your house and do it for less than 200 quid, you can go to Harley Street and it can cost you 1500 quid, I could do it. I mean, I was not going to or not trained to do it. It doesn't cost 1500 quid you're not. It's a big industry for some not meaning to sound completely sort of cynical here. But I

Steven Bruce
confess, I had a personal interest in this. And I have a grandson obviously, I look far too young to have a grandchild, but I have a grandson. And he had some feeding difficulties. And the first response was that he had a tongue tie snipped, and I wondered at the time whether it was necessary, but his feeding has improved. So something Something went right at least.

Miranda Clayton
Sure. And I mean, the thing is that age, often feeding can change from day to day anyway. So you know, some baby's tongue tie snips, then miraculous, you know, I mean, the baby is just so much better afterwards. But there are downsides to doing tongue ties, snips as well. And I'm not sure that's ever when I asked parents does anybody, you know, we're constantly as osteopaths being told to ask for informed consent. And we're taught totally Oh, to tell patients about all the horrible things that could happen to them if things go wrong. When I've asked parents has anybody ever explained to you what what could happen with a tongue tie? I mean, nothing cataclysmic but that it might not work and it might make it worse. And when I said that to parents, everybody's like nobody ever said to us that it could have met could make it worse. So someone's not concerned we

Steven Bruce
will get comments about the disparity in claims that can be made in what is regarded as conventional world and what is ours. You said were overregulated earlier on? I suspect that we aren't any more rare. related in doctors or nurses are regulated, it's just that people are more prone to complain about us. Whereas medicine which is provided by the NHS or by established doctors is accepted and is very rarely blamed for things that don't work, unless there's obvious negligence. But anyway, moving on moving along from that, one of our

audience today who I am being told his name is and I know it's a him is MTBS are better than rode bikes. So Robin, good to have you on the show. Thank you for joining us. He says, Can you detect the term sigh In vitro? Now I presume he means in utero, and I can't, from my own my own perspective, see why you would bother to detect it in utero? Because you can't do anything about it, then.

Miranda Clayton
I think in vitro is in the test tube, isn't it? Yes, it is. Yeah. What I would say is, I cannot All right, there is absolutely no way that I would claim to be able to feel that a baby had a tongue tie in utero. But then I am absolutely not that kind of osteopath. All right. So

Steven Bruce
it wasn't what would be the point anyway, could you do about it?

Miranda Clayton
Well, nothing really, I suppose that as soon as the baby came out, then you can just snip it. No, no, I suppose what you could it sorry, I'm being very flippant, what you could do is knowing that there was a tongue tie. And also these things can be familial as well. So you know, babies were sort of both the parents had tongue ties, they are likely to have them as well. And actually, what you could do is, well, you could do some very nice osteopathic chiropractic, physio, everything else sort of cranial sacral treatment on that baby, to try and actually treat the floor of the mouth and everything that was sort of surrounding areas, rather than wait and see whether it could get her out breastfeeding, you could treat kind of pretty instantly. That would be

Steven Bruce
but once again, you couldn't you couldn't do that all the baby was born at which points or point there was a much easier way to look for a Tundra 10

Miranda Clayton
Tie. Ups? Absolutely. Also, yeah, I mean, we aren't allowed to do anything to babies in utero, anyway, but I have worked with all sorts of people who claim to, to be able to feel all kinds of things, which are actually out of my palpatory range. But I don't necessarily doubt or, or I have no idea whether they couldn't feel those things, or not. All I'd say is I'm just quite structural. And I'm quite honest. I can't feel those things. Yeah. All right, struck

Steven Bruce
by the slight paradox here that the the critics of cranial sacral therapy sacral occipital therapy would say, well, it just doesn't work. But at the same time, they'll say, Well, you mustn't treat babies in their mums in case it does some damage.

Miranda Clayton
Well, yes, quite. I mean, this doesn't make sense, does it? I think also mean as a practitioner, Stephen, over the years, although I started from a very cranial standpoint, over the years, I do increasingly less kind of cranial sacral biodynamic sort of using the involuntary mechanism, I am getting more and more and more gentle structural with babies, as I've progressed through my career. And

Steven Bruce
interesting, I suspect we'll touch on that in a little while we can reference a couple of questions from the audience to you. Before we move on. Mary has says we're as asked

whether you have an opinion on whether the back to sleep policy has an effect on tongue function, for example, through tensions on the die gastric muscles?

Miranda Clayton
Yes, I think it does. I'm afraid the blacked back to sleep thing. It's not just about pleasure carefully. But I certainly think it affects the whole kind of I think it affects the the whole orofacial kind of region for all sorts of mechanical reasons. And, you know, I actually that's, something's just occurred to me now. I mean, it might be the sort of back to sleep campaign, which I think has been going on since about the mid 80s. Hasn't it?

Steven Bruce
Driven by the sudden infant deaths in rate cop Beth's

Miranda Clayton
current policy is that you sleep babies on the backs for the first for the first six months. Now I'm also wondering if maybe the fact that breastfeeding also does seem to be slightly more difficult than perhaps than it used to be. It may be that all this it's another thing that's the the bat sleep campaign perhaps it's also has a knock on effect on to on to The tongue function and, you know, I don't know, it's not something you can research on because I mean, obviously, it'd be thoroughly unethical to do one thing and not and not do the other. But actually that that's a very interesting question.

Steven Bruce
But do you it's okay to sleep babies on their front?

Miranda Clayton
Yes, I do. But I think that you need to be there to look at them. So what I tend to do is with parents, I tend to encourage them to put babies on the front, but only when they're looking at them. So you know, if you're popping a baby down for a snooze for 14 minutes or something, but you're in the room with them, you can watch what they're doing. You're not going to go to sleep yourself, all that kind of thing. I think it I think it's a really good position for babies to be in. But I do think one has to be careful because you know, it's hard for parents, you know, this is very much drummed into them, not putting babies on their fronts, and you don't want to go against the information. And also thing is where all practitioners were used to placing patients and babies in positions and using towels and making sure they can breathe and the sudden the other, but you don't quite know what a very tired, sleep deprived parent is going to do. So I only say that to a parent if I think that they're reasonably kind of awake, and compass mentors.

Steven Bruce
Yeah. But it's a curious again, a paradox here isn't there and we would as osteopath, chiropractors, we almost certainly advise our adult patients not to sleep on their front. And yet, I know we probably ought to steer clear of advising people to sleep their babies on their front, but we will say it's okay, if you're watching, I'm speaking from my own perspective, as a First Aider. The most dangerous position for an unconscious person, which is, of course, slightly different from sleeping is to be on their back, because the tongue can block the airway. And now babies, I don't know where they would fit in that that little spectrum between unconscious and sleeping not quite as in control of their muscles as an adult would be. But again, it would seem to me that there are risks from being on your back as well.

Miranda Clayton

There are I think, then with babies, I mean, there's a, there's a sort of a risk, or this bit counterintuitive, but if you're on your back and your neck is hyper flexed. That is not, that is not a good position for a baby's airways. But the thing with putting babies on their front is that all their viscera tend to flop forward. And for a number of reasons, for certain things like colic, reflux stuff and the other it's a very nice position for their viscera to be in. And I think as an adult lying on your front is often difficult, because, you know, like, fully rotated is really quite uncomfortable. But babies have a lot of rotation in their necks, and it doesn't seem to do the much sort of harm to actually be in that position. So the sort of oropharyngeal anatomy round here is slightly different when you're a baby to to, to when you're when you're an adult.

Steven Bruce
Yeah, a few more calls for you by PIP says what other sorts of things can give rise to feeding difficulties?

Miranda Clayton
Um, well, I think there's a whole this is okay, this is a totally complex Jigsaw of things, isn't it? Because what we're talking about, we're not talking about 100 piece jigsaw here. We're talking about that horrible 10,000 piece jigsaw. So I mean, we've got all the stuff about, you know, the maternal environment, and the sort of external environment, the mother, her breasts, her nipples, her milk production, all this kind of thing. And then we've got all sorts of issues within the sort of mother baby dyad itself. But certainly, you know, for babies, I would say the main problems here, you know, one is tongue function. One is mandibular, and facial anatomy. We have all sorts of problems that they get around the hyoid bone, the front of the throat, but also we have to think here about what's going on with the sort of two things one more globally, that there are very common global patterns that babies have and actually, the more I treat, the more I'm doing very full or the treatments on babies, rather than constantly be looking at the cranial base, or the sphenoid, or whatever, I very much moved away from that. Because I think the things which I think there are two things that that we can see in babies with feeding problems. One of them is that they often babies have sort of intra uterine compression. So they're shoved in uterus, they're in there for nine months, and they get you know, squished around. I don't think the birth process is such a big deal. But I do think being in inside your mother's womb, is likely to give you compressions which can have mechanical implications. But the other one really is about neurological immaturity and immaturity through the autonomic nervous system, and also through the sort of state regulatory systems. So we're not here talking a mechanical problem. We're talking about neurological immaturity. So we mentioned before the phasic bite reflex, and we're saying, you know that that's a reflex, if it isn't there, that might give kind of that might give you a problems. But there are loads of oropharyngeal reflexes. I mean, you were there, maybe try and learn them all, and you lose the will to live, you know, it's the kind of incredibly complicated, babies don't always have them. For whatever reason they've not emerged in utero, some things happen, they haven't got them. So there are so many different reasons that babies may have feeding problems, both local or global. And neurological, then I mean, I can certainly talk more about that. But I don't know where you'd like the conversation to go, Steven?

Steven Bruce
Oh, no, no, it's, this is where the audience would benefit from it going. And if they understand that sort of thing, that would be good. There is a question which has come in, I'm not sure a name was given to the question. But the question was, if a baby comes to you for a checkup, do you have a starting point for just a general checkup in the absence of any known difficulties? And I suppose my my follow up is okay, you're doing a check up on a

baby, maybe it has got feeding difficulties? Well, how do you determine what are? What is the cause of those difficulties?

Miranda Clayton
I think it's good question that over the years, I think that I have realised how important structural examination of a baby actually is. And it's not actually particularly easy to do it. Because they're not terribly old, very compliant, always. They don't, you know, they're all come in all bundled up, we can't really see them, you need to get them undressed, which they don't always like you need to take the nappies off to have a sort of look at what's going on in there. And I think the point with doing a general checkup is and it's why I think I probably say I've very much moved away from all the sort of cranial sacral were treating and the models, I do tend to really look at Babies globally, and from the feet up and check every joint, you know, what are its feet do what are its ankles doing or to its needs doing. But I do know, what a baby's structure should be doing at any particular time. So I've got something to I've got a norm to compare it with. So I'm generally looking at scanning the whole body, having a look to see, you know, whether this baby matches up to the sort of perfect baby for that age range. So if it's a checkup, and in fact, with most babies, I will I'm not I mean, if I can't find anything, I can't find anything. I don't really sort of make things up. There are some areas that I think are very important for babies. I mean, I think the diaphragm and the ribcage and the whole thoracic or lumbar area. I think babies are, by definition, actually quite breathing. It's hard for them. It's very difficult for them. It's another source of of feeding problems. And I think that's an area that you will find lots of osteopaths and practitioners, making sure that the baby can actually breathe. Because if you can't eat right From the top of your respiratory tract, sort of down to your diaphragm, actually, you can't do anything. So there's certain main things like that, that I would be looking at. And I think another region that's very important that osteopaths look at a lot is the cranial cervical junction. And certainly, we could maybe have a talk about this as a particular area. And I'm really sorry, I forgotten what the question is. I forgot what the question

Steven Bruce
is start with, with a general assessment. Where do you start? Is there a point in weight? Do you have a routine? And I followed it up with if say, if a baby comes in, and they do have feeding difficulties, then how do you assess the cause of those feeding difficulties?

Miranda Clayton
I mean, I think quite a lot of it, I will spend time. I mean, I do, you know, take a full case history. And we try and work out what's happened so far. And try and I think the main thing is to try and work out, does this sound like it's a problem with the baby? Or does this quite frankly, sound like it's a problem? Sort of, you know, with the with the mother or the environment?

Steven Bruce
Runaway? Sorry? What would give that away? How would you how would you make the difference?

Miranda Clayton
Well, I think, I think that some women, you know, women who I really suspect have got postnatal depression, or they're really struggling, they found the whole birth process or having a baby very, very difficult and very traumatising. And particularly kind of women who've been all over the place. They've had every lactation specialist in seeing their GP had the midwife they've had this, and everybody's telling them that there aren't any problems, but

they absolutely think they are I mean, I certainly would, I don't. It's not that I don't believe them. It's just that I realised there's an awful lot of emotional and possibly traumatic input there. And I think as practitioners, we've all had that experience of having a perfectly healthy baby brought in for us for a birth check. And taking one look at the mother and thinking, Oh, my God, do you know her man and thinking, see, the baby does not, you know, and actually, it's the mother that's suffering to these would be the kind of things that I'd think not actually quite sure here that this is a baby problem, if the baby appeared to be very happy, and healthy, kind of baby.

Steven Bruce
So the problems largely occur in time mothers, then who really don't know what to expect from their babies?

Miranda Clayton
Um, yes, I think so. I think it's much easier, the much easier the second time. But I also think if you've had I mean, there's an awful lot of research now on the effect of stress during pregnancy, and how that affects babies and their, the sort of pituitary axis their way of dealing with stress. And some babies where there has been a very traumatic pregnancy, they are really difficult babies, they're really unsettled. And there is nothing worse than being with a baby that screams all day. I mean, that's incredibly difficult. Now, when I talk about stress, I'm talking about kind of middle class stress that you know, you may have not got this, that and the other that you want, I don't really mean that. I'm talking about mothers who have awful things happen during the pregnancy. Maybe they've miscarried multiple times. You know, it's been an IVF pregnancy and very, very stressful. Their partner has left at eight months, do you not? I mean, people do have horrible things happen to them. And I think the problem with this is, I think it actually affects the baby's neurologically. And you're very likely to get one of these really kind of high maintenance babies, rather than getting a sort of lovely placid kind of baby who just eats goes back to bed eats goes back to bed and all the time you don't you get these babies that are challenging. So yes, somebody agree with you. I think first time parents struggle, struggle more, but I guess it's all unique. What people Hello are experiencing. You know, sometimes they just knackered because they've already got another one. And it's just one, you know that I think you have to read you have to read the family.

Steven Bruce
Yeah, I guess it's making me think that there's this huge scope here for treating the mother protecting pregnancy rather than just afterwards to try to make sure that the baby is getting the right signals from the mother because she isn't feeling so stressed. And that treatment might not be osteopathy, chiropractic, it might be sort of talking therapies or whatever else it is to try to overcome issues in her mind. But moving on to that. I think somebody in the audience has learned how to change the name which the system gives him because this one appears to be someone who calls himself barefoot rocks, which boggles my mind slightly, I'm not sure how they can be barefoot. But anyway, he says, he says, Are there any feeding positions that you would advise people to avoid?

Miranda Clayton
No, there really aren't actually. And I try not to go down there. I'll tell you why. The reason is, women get so much advice about feeding positions. And the only feeding positions that I think the only time I've ever told a woman not to do a feeding position that she was told to do was someone I saw and she had been told to do and if I can, let me see if I can demonstrate this with a with a with a with a doll. Alright, she'd been told to have the baby like this lying flat

on a bed and dangle her breast and nipple over the baby's mouth and allow the baby to feed that way. And then she came to see me because you had the most awful back and neck pain while you would, wouldn't you? I mean, what a ridiculous way of trying to kind of feeder, feed a baby. But no, I mean, I don't think I think babies, I think babies need to feed in the way that they can feed. The only thing I'd say about that is it's quite interesting the way babies because babies with mechanical problems around the mouth and the neck, they often adopt a completely different breastfeeding posture on one side than the other. So one side, they're fine with a sort of nice little kind of cradle hold the other side, they can only do it when it's sort of rugby ball. Now that might be to do with a mother's breast size, nipple shape, etc. But often, it's actually a clue to the fact that there are mechanical problems going on around the cranial base, the neck, the throat, and the and the jaw and that you know, at the front of the thorax, itself, but I try not to intervene too much on on feeding, feeding positions, just because it adds one more piece of complexity to to the jigsaw. Really,

Steven Bruce
yes. That feeding position that you did describe was was that recommended by a healthcare practitioner or is this some woolly hippy theory that had come out of

Miranda Clayton
it was a healthcare it was by a healthcare practitioner. I was absolutely gobsmacked actually and me, Bobby, for me to criticise another healthcare professional. But I really think that that was what I mean you do. Most people very occasionally hid most peculiar, peculiar things. I mean, somebody told me the other day that they there, they're winning their baby about seven months or something. And there were a health care practitioner, tell them to get the baby. If the baby didn't want to wait to get chips with salt on it. I mean, a seven month old, it's dangerous to give salt but I will be giving chips just seven month old I mean, I was just

Steven Bruce
reasonably dangerous to advise feeding any child on chip, as you say.

Miranda Clayton
But you know, anyway, one does hear some peculiar things, but not very often.

Steven Bruce
Okay. Kim says that her son had a very difficult forceps birth, and as a result had cranial nerve damage. And he never had the sucking reflex. And as a result, she thinks that all babies should get some sort of cranial treatment at birth. What do you think?

Miranda Clayton
I agree, and I actually think if they, if they did, Kim, I think that I mean, there are certain things like say you've had forceps both and you actually have cranial nerve damage. I mean, it will get better, or it won't and, you know, our sort of hands on treatment may may be really relieving, but maybe it will take time. Maybe it will never 100% Come back. But one of the things I do think is that if all babies I had a proper structural checkup by one of us very early on, I don't think we'd be seeing so many tongue tie operations, because I think if we could treat all around the floor of the mouth, and the jaw and the front of the throat, I think a lot of that would sort out a lot of feeding problems early on. And you wouldn't end up having to go down the route of, of, of tongue ties. And it's something that really annoys me because I always see babies after they've had tongue ties. And it hasn't been any difference. And I think, Well, I do, we should come before you'd heard it. But this is this is a culture that, as I

said, parents love tongue tie operations. If they don't work, then they tend to kind of fetch up with the cranial osteopath, don't they? That's how it's working.

Steven Bruce
I just can't help thinking and is inflicting an awful lot of pain on a baby that can't really tell you what's going on, in some cases, for no benefit, and I guess you really answered one of the questions here, which is, do you believe that when a tongue tie is identified in the absence of feeding difficulties, should it be cut?

Miranda Clayton
I think no, I don't. I absolutely don't. I don't think there is any evidence at all that children with if it's not, so I mean, if it's good enough, if it's functioning all enough, well to breastfeed, I cannot see that that will lead to speech and language problems later on. And if it does, what, okay, you can have a tongue snip later on, but I think best left alone. And I worry a bit about babies, you know, because there's there's only evidence seems to point to the fact that actually, they feel more pain in the first eight weeks of life than later on. There's when babies are born, they're very poor pain gating. But they also the vagus nerve, which usually moderates and modulates the way that you as an adult would feel pain. It's it doesn't happen with babies. So babies actually have the capacity, I think, to feel more pain and distress than you do when you get older. So the eye on the idea of snipping through the frenulum. And certainly poking away at it afterwards. I mean, I don't think that many No, I don't think there's nerves there that actually cross the midline. So maybe it's not actually that painful. You know, you don't want to have do operative procedures on babies unless you unless you have to.

Steven Bruce
We've had somebody come back to us about the feeding position that you talked about. Elaine has said that dangle feeding, we have a name, dangle feeding is usually recommended for mastitis and blocked ducts. Does that sound reasonable?

Miranda Clayton
Yes, thank you very much for that I didn't realise and maybe that is why my patient was told to do it. I can't remember it's a long time ago. And I suppose that it and maybe for something like mastitis, maybe it perhaps it does help. And perhaps I was being kind of judgmental and scathing there, it just looked really odd to me. Because she'd been feeling like that for quite a while. I mean, presumably, if you're going to feed like that, you're going to feed like that for a fairly sort of short time, until you you know, really to sort of drain the breast and have gravity help and all this this kind of thing. But thank you very much for that, because I didn't know about dangle feeding. But certainly it had given my patient, an acute neck.

Steven Bruce
Yes. And so your patient ought to have known that. That's why she was being advised to feed that way and perhaps should have passed that on as well.

Miranda Clayton
Yeah, maybe. But I think you know, the thing is sometimes, you know, mums and babies, they're so tired and they're given so much information. Perhaps she just missed that that point of it. Also, maybe she'd only been told to do it for like a couple of days, not three weeks or something, you know, something like that.

Steven Bruce

Yes. Carrie has whether you find a correlation between very unsettled babies and poor sleeping babies with mums who've required steroid medication during pregnancy.

Miranda Clayton
I haven't seen enough to know. But interestingly, I think that there is some eye feeding there might be some research on that. Really sorry. Okay, I've read something about that. But I'm afraid the old COVID brain is it's kind of it's kind of gone. I haven't seen enough women who have been prescribed significant amounts of steroids in pregnancy to make the link. Have you it? Could you sort of tell us if that's something that you've noticed or read about or know about?

Steven Bruce
If you come back to us, then that'll be useful.

Miranda Clayton
I mean, it might be a nice thing to kind of share if it's something that you know you you know about, do tell us because it's not something I know about.

Steven Bruce
What about says Aryan babies? So I've been asked whether you find those particular princes Aryan babies.

Miranda Clayton
Yes, I mean, I think that the the classic pattern with says Aryan babies is that they are generally unexpanded. So when I say that knives, sort of saying, Oh, I work on a more structural basis, but actually, what I'm saying here is probably more energetic. I feel that the whole of their body and their mechanism, it might be a sort of delayed first breath or whatever, but they feel compressed. And they don't feel like they've kind of inflated like a balloon that they ought to have done at birth, that you take your first breath, and it's almost like, everything kicks in, you inflate, like a balloon, the whole sort of neurology is, is kicked on and, and everything. And I often feel they don't feel like that they often feel to me, like they've got loads of AP compression, so anterior posterior, either compression, or disparity between Sorry, I'm just moving, because my necks gonna go otherwise, between the sort of front and back of the front and back of the body. So the whole chest often feels the back and front of the body don't feel like they're sort of moving very well. And you'll often have something like that the front will move, but the back won't move, or vice versa. And they often feel like their heads, almost feel like cannonballs, your your hands just sit there and then slowly go in and in and in and in. And then you don't seem to feel that nice, energetic kind of flow. So earlier

Steven Bruce
on Miranda, you said that subscribe, necessarily to the benefits of the birth process. I remember I don't remember very much from what my cranial sacral teacher told me at college. But I do remember particularly him saying, and many people since that that whole compression and release of the birth process is very, very important. And yeah, that sounds as though you're saying that's what was missing?

Miranda Clayton
Yes, I mean, I think that the way I was taught paediatrics was probably that the birth process almost took pride of place, you know, the birth process was incredibly important. And probably a lot of people would disagree with the fact that I personally think that intra uterine

compression is more important. And that also, I mean, say around where I work, and where I live, says Aryan section is running at about 40%. So about 40% of babies that never go through the birth process, because they're born by emergency or elective caesarean section. Anyway, then I think babies are built to be born. So the ones that are born through vaginal births, I think they have all sorts of structural things that make it you know, the birth is reasonably quick. Being in utero for six for for nine months, takes a lot longer. So I'm not maybe quite so convinced that there will always be problems around the cranium. Or that the Spino Basil of symphysis might be the maybe a sort of somatic dysfunction around the screen of asanas synthesis or, you know, the bones of the head and made to overlap. And then hopefully, they will kind of they will decompress afterwards. They don't always, but usually, usually they do. So I know that lots of people that really, really believe in that sort of thing. The cranial sacral mechanism the head as being the thing that they look at first really concentrate on they're probably been taught that. I just, as I said earlier on, I think I treat a lot more, a lot more globally now than I than I used to, and I sort of move away from from that a little bit. But you know, some people might completely disagree with me.

Steven Bruce
Yeah, well, I've been sent the completely outrageous observation from Claire who says that some of the viewers are speechless that I remember anything from my cranial lectures at college, I think it's dreadful, a slur on my character. Probably well justified, that's not the point. Carrie says that she totally agrees that many Tongue Tied divisions are unnecessary and osteopathic treatment could relieve much of the problem. However, I've seen a few toddlers, she says where tongue wasn't tongue tie wasn't diagnosed until they've had a very poor speech. And then dealing with the tongue tie was more complicated. Any thoughts on parameters of when to snip to prevent later complications? Or just wait and see?

Miranda Clayton
I mean, that's really, really difficult. I mean, I think, you know, I don't consider myself as enough of a tongue tie expert. I mean, I guess, if you were a tongue tie assessor. And you saw a tongue tie, which was really significant, but for whatever reason that baby was, you see, sometimes there are significant tongue ties the knot causing a feeding problem, because the baby's bottle feeding, and so they don't get picked up on till later on. Whereas if that baby had been breastfed, maybe it would have been picked up on because it would have found it very difficult to breastfeed. But there also may be a scenario that, you know, you have a baby who manages to find its way around breastfeeding, but it does have a significant tongue tie. So I think I'm sort of making the assumption that if babies can breastfeed, the tongue tie can't be that significant. But I don't think that would necessarily go for a baby who would walk over? And it is difficult. I mean, there aren't any sort of set parameters around that. And I think you'd have to have a very good and also very honest, tongue tie assessor, who would actually say, No, there's no problems here. And the tongue tie is just moderate. So we'll leave it, or maybe no problems here. But actually, that is significant time tie. And it's sort of an IT and IT needs doing. That's not as

Steven Bruce
possibly a this is this is possibly a stupid question on my part. But why does a tongue tie operation become more complicated? And an older child? I would have thought with a larger mouth, it will be easier?

Miranda Clayton
Yes. I don't know. I don't know. Actually, that's a really good question, Stephen. I can't really answer I know that they're more, they're more complicated. Perhaps it's because of, you

know, children. And then sort of the I mean, I suppose the problem with toddlers are, that they do endlessly stick their fingers and dirty things in their mouth, which babies are not able to do. I mean, when babies having tongue tight snips, they're not really up to anything else. I mean, all they've got in the gap coming in the mouth is milk. So the the possibility of infection is obviously going to be less, whereas you can imagine with a toddler or an older child, you know, they're going to be they're going to constantly be fiddling around, they're shoving horrible things in and, and also that, you know, they're they're also, I mean, neurologically as well, you know, you tongue is very complicated. Muscle wise, neurologically wise. And it's also linked up to all sorts of central central sort of neurological central pattern generators. Now, I guess the point is that if you have snips in early life, then yes, a baby has to relearn to use its tongue. But if you already learned to suck, and you've learned to eat, and chew, and you've started to kind of speak, the neurological net connections are way, way, way more complicated. And so if you cut through the tongue at that point, you cut through the frenulum. It may well be there's an awful lot more retraining, and you may get a lot of sort of behavioural regression going on there. Well, the tongue is learning you know, too. To be a tongue again, also, the way that the tongue move shapes the oral cavity. So I guess as well, if you do have a bad tongue tie, and it isn't kind of fixed, then it could be the kind of thing that might give a child a developing high arch palates, and maybe they would be mouth breathing, not nasal breathing. So our sound here, like I'm completely contradicting what I said before, I think, probably more what I meant before was trivial, or thick tongue ties that don't look too bad. And there's no and there's no feeding difficulties. No, I don't think it should be snipped. But as your as your view of ancient This is not doesn't you know, sometimes things are more complicated than that. Yeah,

Steven Bruce
you did a few minutes ago, you mentioned the tongues role in central pattern generation. Can you elaborate a bit on that? What do you mean by that?

Miranda Clayton
Okay, so you have, obviously, you have all sorts of bits of the central nervous system, and peripheral nervous system. And to what extent these things are working, when babies are born, they're just working, they just about work. What's central pattern generators are there parts of the nervous system that are able to generate patterns. So like, for instance, with breathing, you don't have to think and take and take every breath. Neurologically, there are pattern generators, whereby unless something else intervenes, this pattern of breathing in and out will keep happening. And some of the oropharyngeal reflexes and things to do with sucking, swallowing, breathing, all these things, they're actually based on the need neurological central pattern generators to help this pattern. So when a baby starts sucking, it doesn't just suck once, and then have to think and suck again and suck again, once the once the thing is actually started to suck, it will have a central pattern generator that will keep that neurological circuitry going and going and going. Now, we don't really know when babies particularly like premature babies and things, maybe some of those central pattern generators. They're not even ready yet, you know, they're not even working yet. And that's why a lot of preemie babies, you know, they can't feed or they have very early nasal gastric feeding, and they never can get the hang of, they're never really can get the hang of, of breastfeeding. There's a fairly short window of of opportunity there. But that's basically what in a very laypersons terms, what a central pattern generator is.

Steven Bruce
Interesting, we've had some feedback about the problems with older children and tongue ties, it's coming. Several people, I imagine at least some have told us that tongue tie snip is

more traumatic and requires analgesia in an older child, but none is required with a baby. I'm just wondering how people know that it's not traumatic in a baby, I thought it was extremely traumatic. They just not able to tell us quite as clearly as an older child would. But I accept that I accept that that might be the case. Yeah. Carry has come.

Miranda Clayton
Yes, I think the fact is that it's supposed to be that because they're cutting sort of in the midline. And certainly with anterior tongue ties, they're just cutting through the frenulum that there isn't really supposed to be much innovation there. So it shouldn't hurt that much. However, the posterior tongue does and when you're actually cutting through little bits of muscle and things such as imagine that's pretty painful. I can't see how it how it wouldn't be. You're right though, maybe but also, I suppose babies just forget. Whereas when you're when you're an older child, you can register pain.

Steven Bruce
Carrie has come back in with a follow up on the steroid thing she says she saw three or four babies in a short period of time. And they all seem to present with a very similar pattern of symptoms or unsettle unsettled Poor Sleepers. And all had mums who'd been on significant dose of steroids during their pregnancy for various reasons. She noticed the similarities at the time, but it was only a few so wondering if anyone else has seen the pattern. So it's not the basis of a research paper that she's thought of this from.

Miranda Clayton
And it's come back to me now there is some research on steroid use in pregnancy and the effects on the the adrenal axis So your stress recognitions later on in life, and I can't remember the study of your own, but thanks very much, because I remember that now. And they had looked at women who had taken steroids for all sorts of reasons and did seem to think that it gave children they they will, they found it harder to deal with stress, and it seemed to be d having some problem with this pituitary adrenal axis that it had they thought maybe it had some effects on it. In the same way that chronic pain in babies and small children can really can really affect the adrenal axis. So if that's something that you notice, carry, no, I don't think that's a sort of just a random thing. I think that there is a little bit of, there is a little bit of research on on that.

Steven Bruce
Okay. So, a couple of questions to take us away from the topic of tongue ties, Miranda. Emma has asked what you would look at for constipation in a four month old predominantly breastfed baby.

Miranda Clayton
Oh, okay. Well, I'm greatly constipation. In fact, one I do quite like home visits. And I used to go to one home visit and they called me the poor doctor there, because apparently, just sort of, you know, what

Steven Bruce
was better than being caught? It's better than being called a ship doctor isn't really.

Miranda Clayton
Immediately I looked at the baby shoot itself. Just one look at me, and they just go, you know, so there's something but that's obviously very biodynamic, because I haven't even kind of touched them and touch them yet. Are you talking about true constipation? Or are

you talking about infant disk easier? I mean, there's a big difference here. You know, true. Constipation is unusual for babies. So true. Constipation is defined by hard stool. And it's often to do with allergies, intolerances or kinds of gut biome problems. Disc easier, is that thing that babies do between when they're born and six months of looking like that? They're doing a poo, and it looks like they are being tortured by devils. You know, I mean, there's counting and groaning and farting and writhing around. But what comes out is nice and soft. And you think why was that such an effort? You know, what could have been so difficult about, about doing that? And there's so many babies who do this, have this behaviour that they now call it infant disk easier? And it's sort of healthy babies who struggled to poo for no particular kind of known reason. But true constipation, you really need to keep your eye on it. I mean, I don't know if you can remember caused yourself back to pathology days. And there are certain things like, Do you remember Hirsch brings disease where you have sort of a ganglionic segment so in the colon, whereby bits of the colon don't actually work properly, so they're not really pushing there. They're not pushing the faecal faecal matter through. And you've also got a lot of reef flexes going on, when babies start to feed. There's a sort of, I think it's called the ALRO colic reflex or something like that, that as soon as they feed, the colon starts to push for faecal material towards the rectum. And so, you know, sometimes that then gives them pain and people think, Oh, they've got a feeding problem. But actually, they haven't. It's just that they this reflex has been started off and then of course the baby feels it kind of you know, everything chugging on down the down the colon to eventually evacuate, and that makes it cry for other sorts of reasons. So I think it depends which thing you're which thing you're you're talking about. I think like everybody else I would look at sort of pelvic and I've had lots of success often looking at hip joints, hip joints. And so us, it's the sort of the lower sort of sigmoid colon is the sort of favourite areas of, of mine, that often I find that if you sort of unwind baby, from the hip joints, you managed to kind of perhaps bashley, my family on wine, the whole of the pelvis. And this seems to have a very good effect on the viscera. itself. I'm actually wondering if Justin could get up my final slide, which is slide 13. Lovely. So just something that I want to have a look at it, because we're talking about kind of full body, sort of, if you're talking about things like lower gut problems, whatever they might be, this little, this picture of this little baby, this is an incredibly common pattern that babies lie in. Whether it's to do with you try and lie or the way they've been born, or whatever, but they often lie like this, with the head, neck rotated round to the right and a bit extended, and the trunk is side bend to the left, the pelvis is sort of hitched up on the left and rotated to the left with the left sacroiliac joint dysfunction. And if you don't have a look, there, you can see that there is a whole body torsion going on there, from the top of the body, right through to the baby's bottom, you know, and the bottom bit of the body. And it's such a common pattern, there's obviously some really common compensatory pattern. And eventually, there's no adult, it looks like that. So you know, eventually, we obviously, we work these kinds of patterns out, don't we and but in early life, I think and sometimes you see exactly the reverse, so it's like flopped the other way, the head to look into the left pelvis is going to the right. But I often with babies start with really simple things and look at an overall kind of posture. And particularly with things like pulling problems in dyskinesia, there's two things I want to know one of them is if there's a static posture, like this. And the second thing is, is the baby able to rotate random midline axis, through its spine, and through its pelvis, and through its hips. Because those functional movements are really, really important for every movement we do in life. But I think they're very important for one's digestive function. And if babies are in this funny old position, they get in, or their, their pelvis has completely rotated around to the left. And when you try and rotate it around to the right, they can do it. But they're immediately flopped back to the left again, then I would spend a lot of time in the treatment. And it seems a very simple thing. And it's very simple. But just rotating them around the other way do Knight's exercises, moving their hips, unwinding their

hips, and that often has a really, really good effect on the whole of the pelvic bowl, without having to go into any very tissue or neurologically specific kind of diagnosis, which I think is quite challenging to do with babies. I know people do it that come up with oh, you know, it's the bright posterior dye gastric is not doing that. I personally think it's quite difficult to make these kind of diagnoses with babies, they're so mobile, they move around all the time. You don't know what the underlying neurology is doing. So I think I tend to assess and treat in chunks and groups and actually treat quite globally and quite simply first, and then move on to specifics a little bit later on, or if the larger global things haven't worked so well. Sorry, I've lost track the question I hope I've answered the question.

Steven Bruce
What was fascinating and I was intrigued to say that that person that you showed have a right rotated head and the left side, bent trunk and so on. You said that was more common than the other side, you said it does happen the other way around.

Miranda Clayton
It just happened the other way around. But it's way way more common that babies look over their right shoulder, and then their pelvis goes the other way. It's not, it's not a mechanical problem, Steven, because if you pick the heads up and put them either do it, it's not them got like, it's not a facet joint restriction. It's not like that in babies. It's probably a vestibular problem. It's probably to do with the development of the vestibular system. And there is some really interesting research out there, which is about babies who are breech for long periods of pregnancy. So, you know, they're bottom down through through much of the pregnancy. And they stay that way, sort of throughout the, you know, virtually the whole pregnancy, they are much more likely to have the stimulant problems, which will manifest as sort of balance problems or perhaps slight motor skill problems, proprioceptive problems, that kind of thing as tots, and they think that it's to do with the fact that if when you're because obviously most babies spend a lot of time in utero move around and then their head down. And it's different for the vestibular system, which is which is actually kind of developing here through the, through the ears and through the cerebellum. And that they these babies have a different experience to ones that are head down throughout the pregnancy. And so this thing about head turned over to the right is probably not a mechanical problem, it's probably just like have either a vestibular sort of slightly slightly hypersensitivity, or just the fact that they've they've been in utero in a certain position. And so their vestibular system, it feels much more comfortable and natural and normal for them to be, it'll be something to do with the position of this all the semicircular canals that there be are that way. And when you put them the other way, they cry, and immediately put their head back to the right again, they often have feeding problems as well, because they can feed well on one breast and not on the other because they've got this head term preference.

Steven Bruce
injury that we had a comment from Xena who says she says it's a common pattern in adults. I'm assuming she means the side bending, not the sucking on a dummy and wearing a nappy that's a different business altogether. But you you said the pattern doesn't continue into into adult life? I thought

Miranda Clayton
that might be I mean, you might be right. zener it's not something that I suppose in babies, it's so extreme, you know, this kind of head turn and the extension and then you know, everything going the other way. But you know, no, I mean, I mean, maybe you're right, and it is a more it is a more kind of um, it's certainly more common to get restrictions sort of

through the right away in the right cranial base. So, so actually, you may be you may be you may be right, I've probably just been seeing too many babies and pregnant women over the years and and I've lost I've lost the plot with with with sort of ordinary adult patients. I don't know.

Steven Bruce
Well, we've probably got a little time just to discuss something else other than tongue ties and constipation. So someone who the system is calling grateful being says, Is it just me or is there an increase in reflex cases say recent years? And if so, why? And what do we do about it?

Miranda Clayton
Yes, I think I'm not sure there's a I think there's a big problem with them. There's a big problem with gastro esophageal reflux at the moment. I think one of the things with babies sleeping on their backs. Again, the back to sleep campaign has definitely made reflux worse. Reflux, the baby's often easier lying on the line on the difference. Um, I think one of the problems with there's been sort of new research on reflux, and I mean, the way I was taught about reflux was that it was acid reflux. So what was happening is babies would swallow the milk and then it would mix with the stomach acid, and they would regurgitate some of the stomach acid would come up and irritate the oesophagus. But now they realise that because they have something called in different tests that's been around for a good or to 1020 years but nobody's ever offered it but it's called something like it's called something out impedance monitoring, I think. And they've realised now that a lot of the reflect say that comes up in babies is not acid at all, then actually the non acid reflux is in fact more irritating to the oesophagus, or causes more problems in the oesophagus than the acid reflux. Now, the only medications they have for this are either sickness so that the milk stays in the stomach to start off with, or there'd be things like acid antacids and acid suppressants. But they don't really work for babies in about they've sort of they're about 5050 successful. And the trouble with antacids is in babies that they give but gut, but dysbiosis and gut dysbiosis after a week of using them, so that you can use antacids, on babies, you got a 50 50% chance of them working. But in the meantime, they're going to destroy your gut biome. So none of this is good. So there really aren't at the moment, any medications, which are good babies who have reflux. So parents are very hot on diagnosing and self diagnosing and diagnosing reflux and also silent reflux. So all the symptoms of reflux, but without the regurgitation. And, you know, whether there's more reflux, or whether it's just that parents are more concerned about it, and want something done about it. I don't know. I mean, increasingly, they've been directed to medics to not prescribe antacids for babies, because the evidence of whether they work is so poor, but they're still being prescribed like mad.

Steven Bruce
And I think there's there a nice guideline to that effect.

Miranda Clayton
Yes, there is. There absolutely is. But I think what it is, is that I feel sorry for GPS. I think they're coerced into I think they're just I think most GPS won't prescribe antacids. But people go to see private paediatricians, and honestly, I think parents coerce paediatricians into prescribing antacids and I think babies are prescribed them, because medic medics gets so there really isn't much they can can give. And parents want something and are often really quite coercive about it. But yes, the NICE guidelines and international guidelines now actually are saying that unless you've got acid reflux, you know, the actual acid component has been diagnosed, which you can only do by putting a sensor down and doing a proper

test for it, which hardly ever happens. You should not be giving antacids, but they're still really shocked about the amount of antacids that are being prescribed for babies, but I do think that's parents being coercive, and also GPS and not and paediatricians probably just thinking like, the baby will grow out of this, you know, and just not not to worry about it. But that's no, I

Steven Bruce
remember when I was talking to Clive hade, about cranial treatments, a cranial sacral treatment on babies. He was in his case, he was saying there are different types of reflex, but he was saying that in certain cases, manual therapy, cranial sacral therapy can be very effective in overcoming the problem.

Miranda Clayton
Oh, absolutely. Because I think one of the problems you know, the main problem with reflux is that you've got a very weak lower gastroesophageal junction. So where the oesophagus ends and goes into the stomach, the little sphincter around that it's very weak doesn't get stronger until you're about eight weeks to three months to six months. And in the meantime, the diaphragm and the cruise diaphragm and the old diaphragmatic sling bit acts as a kind of a sphincter and it's one of the reasons that osteopaths are on a manual therapists are always looking at the diaphragm because we see a lot of reflux and often if we can rebalance the diaphragm and get it to function as it should, it will take the it will take the strain off the sphincter in the lower oesophagus and do its job for it until that sphincter gets mature enough to be able to sort of stop refluxing itself. But I would also say if you're a practitioner and you treat a lot of reflux, if you do find Sometimes that you find it difficult to treat, don't beat yourself up about it. Honestly, does sqillzer and constipation dead easy to treat reflux, in my opinion? I don't think it's actually that easy to treat. I think it's very challenging.

Steven Bruce
Well, I suppose that leads me neatly on to a question from Simon and takes us back to where we started this conversation. Simon says, Are we any nearer to being able to advertise our services? No. That's a nice simple answer, isn't it? Yeah. I mean, who is who is who is who is doing some research who is trying to get the evidence together for us to be able to do this? Because it seems a shame to me that tongue ties may be carried out unnecessarily people babies may be given antacids when they don't need them. And yet innocuous treatment innocuous, I am not aware of any serious side effects from cranial sacral therapy with babies, perhaps I'm wrong. But where this? Is it clinically? We've seen it's effective. Surely somebody must be trying to make this known to the conventional world so that they can accept it as an intervention?

Miranda Clayton
Well, you would have thought so I mean, I have actually had a long conversation with God about this about three years ago. And I said, Well, who's actually responsible, in a sense for doing the research? What what, who in a way is? How are we feeding research through to the Advertising Standards, authority, and all this kind of thing? What should we do about this? And the answer I got was, well, it's the profession as a whole. And I said, Well, yes, but who is that? Who is the profession as a whole? Given that we're all self employed practitioners? And I got the and I got the answer. Well, it's the profession as a whole. And I would kept asking, way, didn't get an answer. So I would say that there's probably very little, uh, you know, there's small scale studies being done more far more in Europe than than in this country? And I think it's always a problem, isn't it? Because, you know, research is

expensive and difficult. And unless Pete, people are going to make some money out of it, i Big Pharma or whatever, why would anybody actually put themselves in a position to do it. So I'm not really very confident that we are building the evidence that we are really building the evidence base. And I think, you know, the evidence base, I mean, I because I teach quite a lot. And often looking up evidence base, and all the evidence base I look up always is from somewhere else, you know, it's from somewhere else in science. And I will extrapolate that thing that's been found in this particular codon, genetics or this, that and the other two, possibly what I do as an osteopath, but there's no, but there isn't actually an awful lot of, of osteopath, you know, research within the within the profession. So we are in a little bit of a weird position at the moment. But I mean, gr SC, obviously are going and we'll go over the next few years. But I'm not at all sure what the kind of State of Play will be when they've gotten. And I don't think anybody knows that, whether it will be easier or harder or totally different.

Steven Bruce
And make it sound as though we know they will go of course, that's that's still not decided, and will take several years to come to some sort of resolution, and was part of the conversation we had the other night. And although I know that there are some some watching who will accuse me of being a GEOSS lackey, I know that they do put money into the n corp. And maybe in core could be doing something to promote the evidence behind cranial therapy.

Miranda Clayton
Sure, I mean, I yeah, I mean, I might be doing somebody a disservice here because it may be that in court totally on to this and, and all sorts of things that go going on within that, but and I'm sorry, what I said about God, I, you know, I My understanding was that they were going but obviously my my, my knowledge of this is out of date. I mean, I realised it wasn't probably for a couple of years, but I thought it would that was a done deal. I didn't really realise that.

Steven Bruce
It's definitely not a done deal. It's not a done deal.

Miranda Clayton
Okay. But I do think it's very, very difficult for even for, you know, over for ankle or whatever I mean, you need, where does the money come from for for this research. If they're going to be if they're going to be valid, they need to be big enough. And for all sorts of ethical and practical reasons doing anything on an under six month olds are really really difficult. You know, most of the medication that's given to babies, it's not it's just a guesstimate on what to give them because you can't do Don't research, you can't research medication on sort of two month olds, I mean, what terrorists are going to give their babies over to be researched on. It's problematic.

Steven Bruce
Miranda, we help we've come, we've come to the end of our time, I'm afraid. But a few things before we go. Carry says that there's a cute use trial going on and what Qt stands for. But people always find wonderful acronyms for their trials. This is for osteopathic treatment for babies, but it's for general unsettledness rather than anything specific. And one of the things that somebody sends, you know, again, I don't know who sent this in. But right, somewhere in the middle of the show, you said babies are built to be born. And whoever said Who sent this come in and says You think that's just brilliant. It's such a good thing for all of us to

remember. And I was struck too by the fact that you said that sometimes a baby comes in and you think it's the mother that needs the treatment. It reminded me of when Claire took our dog to be trained. And the trainer realised it was clear that needed training. And I remember thinking good luck with that. I've been trying it for 20 years. It hasn't worked out very well for me so far.

Miranda Clayton
Yeah, but I bet she's jolly good at training you isn't she?

Steven Bruce
That's what she likes to think. Yes. Miranda, thank you. Thank you so much. Thank you so much for your time. It's been very kind of you to join us. I'm glad to hear that the COVID has got better.

Miranda Clayton
Thank you so much, Steven. It was a pleasure.

Steven Bruce
It's been our privilege. Well, that's all we got time for. Thank you for your attendance.