Academy of PHYSICAL MEDICINE

Transcript

IDD Broadcast - ref254

Steven Bruce
Good evening and great to have you with us for another 90 minutes of fascinating CPD. We are looking at IDD therapy this evening intervertebral differential dynamics, or it's quite a few people prefer spinal decompression. And we'll talk a little bit later on about what's actually happening in the spine. But you have possibly seen or heard about these machines before. They've been around since the late 90s, in one form or another. But as always, it's very difficult to separate the marketing from the medicine. So we're going to try and do some of that this evening. To try and make sense of this. I've got Rob Shanks here in the studio with me, and Rob's a very experienced London osteopath, who has helped us out quite low in the past, particularly with MRI analysis. And that itself is a key element in IDD therapy, as we'll hear shortly, and he's also been using IDD himself for several years. And he's now got two of these machines in his London clinics. Rob. Good evening. Great to have you up here. Once again, thank you for making the journey. Thank you. Now, the plan for this evening is that we hear about what the machine does and who suited for this sort of therapy. And then we're going to look at the patient pathway. And we're going to see the machine in action using our model Haley who's over at the far side of the studio waiting patiently for us at the moment, what you should get out of this is a better understanding of how IDD might help your own patients who turn up at your clinic, because you'll have an awareness of the evidence behind it. And of course, all of this is going to help you to communicate better with patients about their treatment options, and so on. I'm sure there's gonna be lots of questions. So don't hesitate to get on the chat lines and fire away. But also we have the option for you to talk to me and Rob live via video link. And it will be great to have you in the room as it were. All you got to do is click that button at the bottom of your screen which says Ask a question live on air and Anna will look after you from there on in. Sadly, that option isn't available if you're watching through Facebook, but your comments will still reach me via the chat line. If you're already a user of IDD, then we'd love to hear about your own experience. Again, don't hesitate to get in via the chat and the video links. Anyway, let's move on. Rob, as I say, it's great to have you with us. I mean, you and I have talked about IDD for a long time long before I actually got my machine which was four or five months ago. What about this terminology, businesses intervertebral differential dynamics doesn't mean anything.

Robert Shanks
Yeah, no, you're right. And what the vaccine that we've been trying to push for a slightly different name change recently. So intervertebral disc decompression is kind of the slightly newer push for the for the IDD, but you're right. I mean, I personally prefer the term smart

decompression as well for like gives it a slightly better say what it is on the tin. But yeah, essentially, that's why

Steven Bruce
I think the Steven smaller chap who does a lot of the UK marketing for the for the machine, when I've said spinal decompression in the past, he's always shied away from it. And I think it's because they are they're conscious of what the evidence proves that it does. And they don't want to give a false impression, or maybe they don't want to confuse the surgical assistants. I

Robert Shanks
think there's that there's that fear that you have our patients going to confuse it with surgical decompression, as you say, but certainly in the states in the USA, where where this stuff has originated that the term spinal decompression seems to be really relatively popular. And there are several types of spinal decompression machine on the market and IDD therapies is one of those arguably the the gold standard, but, but they would come under or

Steven Bruce
come up with incredible what makes it the gold standard. What's

Robert Shanks
with IDD there's we meet better see a bit more later. But there's a particular part of the of the treatment whereas we call isolation decompression. So roughly speaking, we're going between cycles of high tension and low tension, but when they're when they're on the high tension. So the the high pulling force, there's a variable amount of oscillation that you can do. So it can for example, go between 60 and 65 pounds or whatever, whatever you want it to the machine to do, but that's the that's the patented part that only this machine does, right?

Steven Bruce
Are there other machines which targets cific levels of the spine so

Robert Shanks
not not to the extent that IDD therapy will do to, as far as I'm aware, so there is a, there's a big range in, as you say, the angle of pull, and that therefore has a big effect on the segment that you target the anchor point it's like to call it

Steven Bruce
it's, I think one of the criticisms I've heard about this, of course, is that the NHS does not recommend traction for low back payrexx. Yeah, in fact, I think the NHS says that it's been shown not to be effective. Yeah, there you go. As far as that, yeah. This is traction, isn't it? Well, it

Robert Shanks
is traction with with you know, bells and whistles on the so you know that there are traction forces involved that that the the traction, you're talking about the NHS that would have been around 2030 or more years ago, was a linear type attraction, where usually it's just a single angle of very limited variation in the angle, and it's and it gets normally static as well. So it's a case of putting the person on for 20 minutes, half an hour, set pressure and leaving them there. With this. There's there's changes in pressure, there's changes in angles, there's oscillations, there's a lot more to it.

Steven Bruce
So you got to have these machines we have Does that mean you're just a bit of a gadget man?

Robert Shanks
Well, it has been said I do like my gadgets, but But no, what got me into IDD therapy originally, this is kind of back in 2011. I was. So I graduated in 2000s. And after a few years, I was kind of struggling with some of my disease patients. And my mother is a physiotherapist. So I had some awareness of traction. And I first started getting into just basic traction, the type we described before, which personally I would say still has some some merit. But you're right, the evidence for it is weak. Partly, in my opinion, because wrong patients have been selected in the past for it. That's another story. But yeah, I got into the attraction was using that for a few years. And as you said, Steve, Steven small knocked on my door and said, Well, how about this idea of Ethiopian I told him to go away, I said, I'm not interested. I'm quite happy with my attraction. Thanks very much. And I carried on for a couple of years ignoring it. And then it kept me to the ground. And I was hearing little stories about well, there's a machine up in Nigeria, this machine down in Brighton, and I was hearing anecdotally some positive stories coming from it. So I went down to the Brighton clinic to to see Morrison's try the machine after myself easily

Steven Bruce
I'm going down. He doesn't know this yet. But he said we are setting up a visit for me to go down there as well.

Robert Shanks
So there you go. Trust you. And know that that that that visit sold it for me because I could I could feel myself and what the machine was doing and what it was doing something different to what I was doing. So I decided to give it a go and haven't looked back.

Steven Bruce
It's a difficult decision, isn't it because it's a bloody expensive machine. And I think either you're weaker willed than I am, or you just do the the numbers more accurately, because I put Steven small off for a much longer time before I plumped for the machine. Because I'm very aware that a salesman with a spreadsheet can say to you this is all you need to do in order to make back the cost of the machine and make a profit for the clinic and pay the the operators of the machine. And, you know, I just didn't trust those spreadsheets. And and frankly, it was only when I started hearing from you about the success you'd had with them. I thought well, maybe we'll maybe we will after all going for this. And of course it did help that having moved premises recently, we then suddenly had the space where we could put it because you gotta have a room for it. You gotta have a room for it. Yeah, yeah. You said selecting patients is important. And yeah, you're right. I do wonder sometimes is it any surgeon or other medical practitioners? So we'll do the surgery will only work if you put the right patient under the knife or under the machine or under your hands in osteopathy, chiropractic. Yeah. Well, how do you select them for IDD?

Robert Shanks
So, okay, so, I mean, principally that the target tissue that and what you're looking for is, is disc decompression, so it's got it you got to be you got to be pretty confident that the patient's pain is coming either directly or indirectly, from degenerative discs or disc. So You therefore have to have an MRI, because you know what you're gonna know what digital

targeting the clinical findings have got to correlate with that MRI as well. And, you know, you've got to know which because, for example, you could have a patient who's got, you know, several degenerative disc in their spine you got, you know, you're gonna know which one you're targeting. And usually there'll be one that's actually the one most relevant one to target.

Steven Bruce
Interested in getting insurance for this machine. I probably do the same thing. But two of the people who operate this machine for me are sports therapists. And I'm the only one the only other one in my clinic who is trained to use the machine and they don't take long to train to use the machine. But the sports therapists have can only treat patients who have been referred by a qualified practitioner. So I must say I haven't actually looked deeply into what makes you a qualified practitioner. They said, I think in the insurances, it must be referred by an osteopath. But not every osteopath would possibly know what indications are required for this therapy.

Robert Shanks
So well, osteopath, chiropractor physio tends to be Yeah, that's the insurance criteria and that's got to be kind of they're the ones who are leading the protocol. Yeah,

Steven Bruce
sorry, misleading. In my clinic, we don't have any chiropractors or physios at the moment. And so they specified osteopath.

Robert Shanks
Yes. Okay. Yeah, sorry. So the question was sorry.

Steven Bruce
Where we were the first part of it was would would any old chiropractor or osteopath or physio know what patients will be suitable for IDD? I suspect that I've had to run through a little bit of training on that.

Robert Shanks
Yes, I mean, as I said, before, you know, you if they're suspecting it's discogenic pain, and it's coming from the desk, and that could be the same could be back pain due to a disc problem. It could be nerve root pain due to disc protrusion, etc. Then that's the criteria. That's what you're looking for. But you're right, you know, you do need to have, have your wits about you and have your awareness about you. Having some MRI MRI training is really invaluable because yes, you can rely on the reports. But as we've discussed in previous times, sometimes you know the reports can be lacking. So you need to have your actual eyes on the the scan yourself and understand what you're looking at and have that patient scan in front of you,

Steven Bruce
which is why we've had that we've run those courses. We've had you on our show numerous times you and Darren on the show numerous times in the past, talking about how to interpret MRIs. We've had you both in the studio here for face to face course on how to interpret MRIs. But frankly, I suspect that a lot of Cairo's osteopath and physios, you know, they still look at them, like the one we're going to be talking about in a minute. And you know, they think well, I really don't know what all those little white squiggles and blobs are.

Robert Shanks
Yes, true. Yep. That's a fair comment. It is it does take time it takes like everything. It's something you have to keep practising. Otherwise you will leave those.

Steven Bruce
So if you received a report from a radiologist who said, yeah, there's a disc protrusion at L four, five. And in clinic, you say, Well, I'm seeing some neurological symptoms, some signs that suggest that might be the cause of the pain, would that be enough to go? When you insist on looking at the MRI yourself?

Robert Shanks
I personally always insist on looking the MRI. I mean, I think it is acceptable, however, to go just off the report, if you want to do that, in terms of insurance, and all those sort of things that would be acceptable. But in my opinion, you know, having a scan on the standard scan is a level above that. But this the scales you see so that you know the there'll be very simple cases for example, as you say, No, you might have no five radiculopathy in clinic and reports match just says alphabetical people that's that's an easy you know, you know what to do he is coming from the afterlife. But there's there's inevitable everything. There's there's grey areas, and I think that's where that's where the difficulty is sometimes lie. And that's where the art, if you like of having that MRI versus the report and looking at yourself would can make a lot of difference for some patients.

Steven Bruce
Is it worth having a look at this particular MRI and you just explaining some of the complications on this one for us? What we can do is we can we can look at it on our screen here and Justin can bring it up for the audience as well. So yeah, sure. We are we can share the information freely. This is one of my long suffering literally long suffering patients is my father, who is 90 years old, and he has suffered chronic back pain is what has been going on for a good 40 or 50 years probably. And he had a disc decompression that I think l four five is hard to find out because I can't find any results. l four, five in 2003. And it is only since I've had him on the IDD machine that he has been able to get sleep without for Tramadol a night and hasn't been able to walk the short distance to his post office and he's not a he's a fit, man. Yeah, if it weren't for the pain, he'd be climbing mountains.

Robert Shanks
Yeah, so and as you say, you can see this as a an older gentleman, you can see the several degenerative disc or dehydrated or black disc has no nucleus are preserved in the discs. We can see some some looking at the disc for the back kit. But initially, you can think to yourself Well, okay, there's probably been some surgery down here. If you said Oh, four, five, we can see there's a slight retrolisthesis Of the five things that we think can possibly now five s one issue. I think you were telling me he had some big symptoms as well.

Steven Bruce
Yeah, he's gonna drop foot on the right and his sciatica is mainly right sided.

Robert Shanks
Yeah. Okay, so that's just gonna look at the screen here. So we're just gonna navigate down to that l five then so now axial view of the of the L five s one segment. Now, if we just quickly to scroll between L four, five and l five s on the canal is actually not terrible. It's actually looking reasonably okay, which is the canal. So the canal is literally this this part here? Yep. So, so we're I'm instantly suspecting possibly something in the L five s one foramen,

because of that retro ice thesis. And if we kind of scroll, so what I'm doing now is I'm going so start off in the middle. So we've got the parrot the sagittal view here where we'll see the s. SP response processes and then we're just going to navigate left and right of that. And if we go to this is the patient's left side, what we're going to see here, we're just looking to see how capacious that exit frame is on the Aisle Five, can

Steven Bruce
you just with a big stubby finger point where you're actually

Robert Shanks
looking at? We're looking at this area here? Yeah. Okay. Well, listen, we think looking at ourselves and thinking how much daylight have we got there? Now again, because it's an older gentleman is inevitably going to be Little bit stenosis compared with a younger person, but we then compare that with the other side. And we can we can get the impression that this is tighter here on this side. Yeah. So this exit, there's not a lot of daylight there for that for that exiting that l five nerve root. So so this is where I would be suspecting that the patient's symptoms were coming from this area. So for me, I would be wanting to think about targeting this next segment opening up that foramen, and trying to decompress this segment here and potentially even helping a little bit that retrolisthesis

Steven Bruce
Yeah, okay. spindling ISIS, is that ever a contraindication? It's

Robert Shanks
only a concrete indication if it's more than a great site or greater and above? And if there's political cholestasis, if there's a pause Path effect as well, then that would be contraindicated

Steven Bruce
all these dehydrated discs? Is this machine going to help those? Do you know if there's any evidence that they will there's particularly rehydrate some

Robert Shanks
of that? So, you know, we're not going to turn these desks into brand spanking new desks. There is there is limited anecdotal evidence to say that there is partial rehydration, or patients have clinicians have sometimes seen that. But it is it is anecdotal. And as I said, you know, I doubt you're gonna get a brand new nucleus back, somebody suddenly formulas for decompression. But it's more to do with, you know, taking the pressure off and taking the pressure off the neurological structures, taking the pressure off pressure off the pain centre structures in the case, if it's the case of the distance, simplify Steven

Steven Bruce
small again. He's a UK representative for the company that makes these things I think gives me he makes a big fuss about the fact that it's more than anything, this is increasing mobility in the spine.

Robert Shanks
It is yeah, I mean, you are absolutely you are literally mobilising the segment, you know, you're you're distracting the segments that you're creating distraction of the targeted device that you want. And I think the studies that have done the cadaver studies show that you got a five to seven millimetre opening of that discouragement during the during the treatment.

And that does have a, as you say, a decompressing effect, a change in the fluid dynamics at that level with the nerve root and the desk as well. So,

Steven Bruce
interesting study or categoric study, because you can't always rely on those to reflect what happens in a human being a human life human being.

Robert Shanks
Yeah, that's true. Yeah. I mean, it's a fair comment. But obviously, it's the next best thing. And it's the least they have seen that you can target the different segments and you can open up presuming the same thing would happen in life.

Steven Bruce
Okay. You talked about some success you've had in your own clinic with with IDD before we came on air. Do you want to run through that for us as well? Yeah, I

Robert Shanks
mean, honestly, for me, it's been it's been revolutionary. I mean, it's really helped um, team up to the VA patients. I've got increasing case at the moment, I'm dealing with a chap who I've been communicating with him actually, for three years. He came through a friend, and we were just talking on the phone three years ago, and I said to him, I suspect you've got some disc pain. He didn't have any particular pain at the time was all just low back. But he, it was his onset was very much where he'd been working, environment flexed, moving, lifting, heavy cables, and twisting and the onset sounded quite discogenic to me.

Steven Bruce
So real nasty, repetitive strain.

Robert Shanks
And he eventually had the MRI and I said, I suspect we're going to see a nasty Angular term we'd and we did and it wasn't it was quite a sizable in your tear that we saw the four five and actually show up on here. So and then your tail would show us a what's called a Hizzoner or high intensity interval a little bit like a big sort of white line up at the back of the disk and was like a little worm at the back of the disk like, like a white line. There's not there's not really too much. I mean, it looks something like see we've got this little white line here. Now this isn't Yes, yes, it but usually they're vertical, okay. And usually towards the back of the disk.

Steven Bruce
This is a T two scan, as you see on the water is

Robert Shanks
bright fat is bright as well. So the subcutaneous fat is bright, but also the water is, is bright. So usually what you're seeing there is separation of the annular fibres, and there's some swelling in water in between. But that's that's usually an indication of that you've got a, you know, an annular tear, you would also would see a huge on the axial view as well. And you've got to correlate you'd see this sort of line coming in in this way if there was an editor. And but again, this is a controversial subject, some some even surgeons, and some authorities will say, well, they're non symptomatic. Others will say are symptomatic. There's this debate. But this particular chapter I'm talking about, I mean, he went through every every single treatment you can imagine over the last three years, he's had the current practice. I asked him osteopathy physiotherapy, he said, facet joint injections. He's had

epidurals. And I think the next one, this was going to be the surgery, and he's now just started his IDD therapy with us. And he's just had the best week he's had for three years. And we're targeting the second with the four five. He's only a few sessions in as well. So he's doing actually really, really well ahead of Par. So yeah, they're the sort of cases that we often deal with. Those were cases we would often put on, on the machines. They usually have to be having symptoms for it. I know that my patients, not like my patients, but I won't usually use it unless they've been suffering for at least you know, usually a few months because a lot of disk problems will as you wouldn't know will clear up with themselves anyway, within a few weeks to months, but when they're getting to that stage where they're not, they're not doing that. That's when it starts to become a serious contention to use the ICD.

Steven Bruce
What's the range of conditions which the manufacturers would say are appropriate for

Robert Shanks
this? Well, so everything from facet joint degeneration to disc degeneration spondylosis disc protrusions. Yeah, they will just they will say just generalised low back pain. But for me, it has to be really a DISC DISC lead,

Steven Bruce
if you like, right? So it was the generalised back pain I wanted to focus on just for a second. Because is this just a cop out for instead of treating with your hand sticking on the IDD machine and try and get rid of their low back?

Robert Shanks
I think I think that's the danger. And that's the thing. And that's that's where, I mean, there was one famous study that was done that that basically excluded it was it was just patients with back pain, and he excluded them if they had any problems with this pathology, which is kind of a an inevitability that was going to turn out to be poor results, because that's the thing of targeting. But you're right, that's the danger. If you're just sticking people on machine, willy nilly without really any due process and thought and knowing what you're doing and know what segments and having justification for targeting that segment. I think that's when you can end up with poor results. And that's not really the way it should be done. In my opinion. Certainly,

Steven Bruce
it sends a few questions from the audience, because Trevor says, I'd be interested to find out how you can market it to patients. He's an osteopath. So his patients are used to hands on treatment. Yep.

Robert Shanks
Well, very simply, as I sort of alluded to earlier, if you have a patient who is not responding, and they are exhibiting signs and symptoms and clinical symptoms, signs of, you know, disc pathology, and they've had it for several weeks, they're not responding to treatment. And you would say to them, well, we have this, we think this is the pain, but the real problem is coming from this particular disc, I would I would show them the MRI, that also helps to get the patient's understanding. And then you explain to them well, this is where your disc problem is, this is where the nerve has been compressed. And this is what the machine is going to be doing. That starts to make sense to patients.

Steven Bruce
It's it's not a cheaper treatment, but it's not least because it's not an instant fix.

Robert Shanks
Yes, that's That's true. I mean, the patients usually need a course of several sessions. I mean, you're looking at at least 20 sessions normally. And you're right, normally, they will be paying more per session they would do for a standard hands on treatment. But where this where this lies and where this, this is the bridge, as I said before, between when mental therapy is not working, and potentially injections and and that's not worked, and then it's the next step before surgery. Yeah. So and that that's that's the that's the gap that this is trying to bridge. So So to put it into context, yes, it is expensive, but so is a private epidural surgery is even more expensive.

Steven Bruce
If you can get it these days. Yeah. Yeah. And and I'm guessing, I know your clinics are in London. So it's probably not a fair comparison with other other areas. But you've got to have these machines. And I'm guessing you wouldn't have to if they weren't kept busy,

Robert Shanks
correct? Yeah. No, we aren't. They are kept busy here.

Steven Bruce
And you wouldn't be the only ones in London either. No, no,

Robert Shanks
that's right. Yeah. Yeah. I mean, it. Ideally, when I started off in 2011, I think I was the third in the UK. There's now now around about 50 clinics, nationwide, they're doing it and there's more that are being added on. As time goes on each month, it seems like it's wearing out.

Steven Bruce
I'm guessing this person knows you. The machine I think has called them ego. Imagine that's not their actual name. But whoever it is, is Hello, Mr. Shanks? Would this ID treatment be appropriate for a patient with a horizontal disc term? Is there a chance that the attraction might cause a muscle or ligaments battle?

Robert Shanks
So horizontal this tears as you say, is it's more designed? Well, in my experience, we tend to use them on the as you say, the kind of circumferential details where you're, you know, you've got as you as you stretch up, like it's kind of then almost closer to the disk You're right. If you have a horizontal detail you're you're there is a concern that as you as you open up your Could you be opening up the tear. So they're pretty rare that they're pretty rare, it's it's gonna say that yeah, they are much more common to have those you know, circumferential distance that you see going from north to south rather than east to west. So they tend to be the ones that we would use on however, the annual at the end of the tears are, you do have to be careful, and you have to be careful with the pressures. And this particular search as I mentioned earlier, he's you know, he's very, very sensitive to anything you do with him. And we have to agree with him we have to use lighter pressures, lower oscillations. So again, that they're they're a slightly sub separate subcategory. If you're like a patient that you decide, either you do or you don't. If I had a patient who had an annular tear, it might not be the first thing I would try with them. You know, I would probably try with them

some core stabilities, stabilisation, techniques, all that sort of stuff, but it's, it does have a place in those. Those those difficult cases,

Steven Bruce
I presume. I guess I know actually. This is not something that you do. IDD is not something you do in isolation is it there is still the rehab process. Once they've stabilised or mobilised in bed To cope with the the rehab.

Robert Shanks
Yep, absolutely. And that's it should be used in conjunction with. Certainly postural reeducation is a core exercise improvements as well. And that kind of is should form part of the protocol.

Steven Bruce
Alex here says, can you tell me the price of the machines please?

Robert Shanks
Well, Steven spells that the man to bet to probably ask that question. But my understanding they're around about 50,000 pounds.

Steven Bruce
Yeah, that's my understanding of this year, there are 50,000 pounds, there's any there's every chance they've gone got going on quite a lot this year, given that everything's gone a lot this year. Of course, Steven will, will put on a spreadsheet for everyone that a wonderful leasing plan and show you the number of appointments that you need to cover the lease and things like that. But it's a leap of faith, isn't it? Because you're gonna you're putting this money into something and you I imagined even you didn't have absolute confidence that it was going to pay for itself.

Robert Shanks
That's absolutely true. I took a deep breath like you did. And I got a bank loan. And I was thinking, Am I going to cut my overheads? And thankfully, I did. But yes, he absolutely right, it does have to be carefully thought about is a

Steven Bruce
lot of money. And a lot of what you said will frighten people off as well. Because you've you've talked about being able to work out what the the highest traction level is, what the amount of oscillation is, and all sorts of, and all these things I'm reading the detail of MRIs, which most of us are not familiar with, I imagine a lot of people are put off by the idea of having to learn or that presumably, a lot of it just has to come with experience.

Robert Shanks
It comes with experience. But what I will say is we in the UK, we do have a WhatsApp group. And it was a very highly supportive Whatsapp group. I'm very active in that group as well. And you know, certainly for the newcomers, we try and hold their hand we try to give them benefit the other practitioners experience.

Steven Bruce
I must admit, I've been very naughty, because I tend to email you directly and say, Tell me what to do with this.

Robert Shanks
Video. But yeah, but there is that support network there to to?

Steven Bruce
Yeah, and I can vouch for them. You see it on the one hand, it's a very, very useful group on the other it's annoying as it goes Bing every five seconds, someone else sent some more information. Remind me the name of the American chiropractor who is very, very active in the old Dr. Jeff. Dr. Jeff. Yes. A fount of knowledge.

Robert Shanks
Yes, he's very expensive. got seven of these machines in his clinic. Yeah,

Steven Bruce
that's going some he's obviously the making good getting good results for them. Good. Minda says would you like this? This is a very easy question to answer give me this is would you know if the funding for these is available through the NHS?

Robert Shanks
It's not available yet? Yes. No.

Steven Bruce
That's really what this is. This is one of the dreadful things about this, if enough, enough of us get IDD machines. And we show the benefits of these and the NHS will start buying them and everyone goes through the NHS and

Robert Shanks
stuff. I mean, it's a theoretical thing. I mean, given the amount of money they have to spare at the moment, it's probably not going to happen for a long time.

Steven Bruce
No, I mean, but if we can show, what I'm finding is that we are we are getting even in the infancy of my IDD therapy. We aren't getting orthopaedic consultants who are saying go and get IDD therapy yesterday, and either they will say there's one in our town or the patient will look up the nearest one. And that's easy to do. And then they'll come and and find us. So there are serious. I don't mean that we're not serious medical practitioners, I mean, people who are very elevated in the NHS and in the private medical spheres who know about and trust these machines. Yes, that's true. Yeah. So we're gonna meander through, there's no good news for you there, the NHS is not going to buy it for you. Classes that lots of people are asking if we're going to have a demo is of course, we're going to have a demo, I said, we're gonna have a demo. But I want to get out of the way, first of all, who we're going to use this machine on and how we're going to use it. And I have got my eye on the time. So don't worry, we will clear get round to the demo. And can I reassure people that we'll come on to that later in the show, thankfully, I've done that now. But thank you for letting me know, Claire, because I do have a tendency to waffle on. Darren says is the decompression only short term. Yeah, this is a key element of it isn't isn't the commercial only short term as surely with weightbearing is going to return to his compressed state. So very regular treatments would be needed.

Robert Shanks

Yes. So as we said at the start, you know, is a course of sessions the patients will need, usually over six to eight weeks. They don't need to be coming in two to four times a week. But you do you do see progressive improvements week to week. And, you know, I would say the success rates depend well, in terms of anecdotal data that the clinics supply, and also that was in the literature are between 70 to 90%. So you're right in the sense that you have a session on machine you come off, then you're subject to gravity again, but it's how it therapy's working. It isn't just the pure kind of okay, let's decompress the data. It's actually if you think about how discs function and how to get the nutrition, it's you know, it's the innovation of fluid and expulsion of fluid during the day. And essentially what you're doing is you're you're speeding up that process so you're you're changing the fluid dynamics on the disk, think of this as as a sponge, and a degenerative disc has become less, you know, that has a lower rate of dialogue, change in pressure with this, you're trying to start to reverse that.

Steven Bruce
I always I can be wrong in this. I've always made the assumption or the assessment that also all those soft tissues around that effective segment. well over the years have got shorter and tighter. And of course, we know that a session of stretching in the clinic or assessment of session of stretching at home is not going to make a long term difference, it'll make a difference for a couple of hours. But because you're doing this, as you said two to four times a week, that very frequent stretching actually does have a long term effect on those tissues. So in a way, you'll let them and would bear me out on the fact that you need to do this a lot and very, very frequently if you want to get them to change.

Robert Shanks
So if you're talking about ligament and muscle stuff, yeah, okay, so so soft tissue mobilisation, so, okay, so this is this is why my slightly, slightly disagree with with the, the general consensus, so, yes, you're right, we did talk about, you know, soft tissue mobilisation, as well as the Rosa desk. But for me, it doesn't quite make a huge amount of sense. Because this is think about, for example, you know, think about a poster longitudal living and think about interspinous ligament, what's the what's the best way of stretching that will probably flexion knee hugs, the amount of stretch you're gonna get with opening, actually opening up a segment five to seven millimetres for less than actually, if you flex a segment. So for me, it doesn't quite add up. For me, what really is happening in the big difference that the ICD therapy is making the end the forces you're using, which you can't use with with other methods is that central actual distraction, and that that, for me is the key. And it's this is the effect it's having on the desk. Okay,

Steven Bruce
I'll run through a couple more questions, and then we'll we'll get on to demonstrating just how we would go about doing this. Bionic dance is this is this machine similar to the orgasmatron machine which was in the Barbarella. movie in 1968? Well, maybe, maybe our patient will be able to tell us later on I'm not sure. Mindy says if you know a patient has a disc protrusion from their symptom picture but don't have an MRI. Could you still use it?

Robert Shanks
Short answer no. Because let's just give you a brief example. So let's say let's say you have a patient who has let's use the long hair before and in Aisle Five radiculopathy. Just based on the fact that an alpha l five radiculopathy. You don't know whether that disparate fusion or that radiculopathy is coming from a lateral recessed protrusion at L four, five, or a femoral protrusion l five is one. And the setup for machine for those two segments is very different or

in terms of ankles. So you got to you got to know what this bill targeting not just what nerves being compressed.

Steven Bruce
Right? And in fact, when you did your course here, you've spent a lot of time saying well, hang on, you know, is this the descending nervous system? Merging? No.

Robert Shanks
Yeah, so the MRI, so it suddenly clicks. And also, you've got to know about the contraindication. So that patient may have, for example, a radiate copy. But they also may have a positive effect, in which case, then you can't put they also, for example, one of the contraindications is osteoporosis, if they've got a crush fracture, you've got to have all these were all of these things out tickle these things off the list before you put the patient on the machine,

Steven Bruce
you could get that information from an x ray, which might be easier to

Robert Shanks
you, we certainly get them we if you suspect a patient of having any any sort of issue with bone density, then you need to get them to have a DEXA scan. So again, you have to have a case history is anything in the case history where you suspect that could be an issue and if so then we will get a DEXA scan done as well.

Steven Bruce
Okay. Jackie says why wait for so long for a nasty disc problems? Why not do it earlier? Why not use it earlier for mechanical pain? You said you're waiting. So

Robert Shanks
the reason why we wait? Well, the reason why I would tend to wait a few weeks is because if you have a patient who's had a recent disparate disc prolapse, for example, a lot of those would would tend to resolve on their own spontaneously within a few weeks within four six weeks. Case in point the chap I mentioned earlier, the the track with the the annular tear, he was discogenic back pain for about two or three years. And then just before he came into me, he did develop radiculopathy and he phoned me one day said, Oh my god, Rob, I've never had an intimate leg pain. I've never had leg pain and now suddenly got loads of leg pain. I said right? What did you do? I bent over and I said right, you have products to deskew that's what's happened. But I said he said what do I need to come in I said, Look, just sit tight for a few weeks it will probably resolve and within four weeks is low, his leg symptoms did resolve. And we then suddenly did bring him back back in for it to start the ICD but that was for his discogenic back pain. So that illustrates the point that not only things these acute disc will will resolve certainly they're wet protrusions anyway, but if they if they're not resolving, then I would then certainly offer them odd.

Steven Bruce
Mindy's asked for clarification about osteoporosis, osteoporosis osteopenic patients

Robert Shanks
osteopenic is okay that you need to know need to have a t score you don't actually have if you do have an osteopenic patient or anybody who's suspected, you know, poor died bone density, the DEXA scan is is important because bone is weaker in distraction than it is in

compression. The trabeculae so you don't be doing is causing obviously a fracture in those in those bones.

Steven Bruce
We actually had fantastic orthopaedic consultant, a spinal consultant on the show. We had him on several times some called Nick Burch, and he talked a lot about scanning for osteoporosis and then I'd say to you watching if you want to know about the detail about scanning for osteoporosis and do dig up that recording from the website because I can't remember the title of the show. But it was Nick Burch and it was about osteoporosis. And he the equipment that he's using, which is available elsewhere in the country, goes beyond what the DEXA machine can do and is a much more accurate assessment of the strength of the bone. So it's a good one to watch. Yeah. Right. Okay. Well, there's some lots and lots of questions coming in. But we need to get over and do some stuff with our patient, then we say, should we go over me, Haley? Yep. All right. Let's do that. Haley, good evening. I'm gonna leave you with Rob. He's going to talk people through what's happening with you at the moment. He's going to do with you next, so

Robert Shanks
he's been on the heat, but we're gonna take the heat off. So that's just a little thing we do to help the glitter heat in

Steven Bruce
the back. So that's 10 minutes, we put him on for 10 minutes on the infrared belt, and that's the same as us. Yep. Okay,

Robert Shanks
so he's gonna just come stand in front of you here, we're just gonna find the asis. And then we're gonna pop this in the front is gonna hold that, and it makes you turn around behind.

Steven Bruce
And the thinking behind this, of course, is that you're gonna have something over the lower half of the body stable, stable while you

Robert Shanks
separate it from the other. This is where this is the part that you know, he's been pulled if you like, yeah, and this is the harness that goes around there to facilitate that

Steven Bruce
I know that so when we got our training on the Steve made a big thing about making sure that the ring there which is going to connect to the machine is depth level with the knees and bang in the centre. That's about the only thing that we want that actually, if it's off centre, what's it going to do? It's going to apply traction to the wrong side. Well,

Robert Shanks
yeah, exactly. It just doesn't doesn't go 40 Don't go dead centre, we want them as central as possible and easy. This isn't possible with a quick look on the front again. Okay, double check she's in the middle of on by thinking about the practicality now.

Steven Bruce

And there are different sizes of these to suit different patients. Yeah, there is. Always interesting, we're going to strap you down over your microphone, we might have to move that in a minute. Okay, let's go through and meet the odd machine. Yeah. Now I'm gonna stand this side, because we're in a bit of a tight space here. So Rama let you go close to the machine. Okay,

Robert Shanks
so how you're going to just come and stand on machine here. And you're gonna stand in the middle on this little plate here. And you can position yourself right in the middle. And you're gonna lay lay back on the on the couch.

Steven Bruce
Now, what's his little bladder do?

Robert Shanks
So this Okay, so this bladder is called the sacral. Bladder. So once once it goes into a flat position, are we pumpkin,

Steven Bruce
and I suggest if you grab that and come over here, because that way the camera can see what you see you rather than just look at the back of the

Robert Shanks
machine back now say, hey, just relax. And you'll be nice and flat in a second. But yeah, the bladder will basically what that does is it inflates underneath the sacrum and helps us to lock out the sacroiliac joints a bit more, just to keep forces optimally putting on to throught into the lumbar spine.

Steven Bruce
We should point out as well this thing does do an X, doesn't it? It does.

Robert Shanks
Yeah, that's right. Yep, the different setups the neck is the extension that comes up in his plate, we put him here and then has a harness that would connect into here. Right, anything could just move up the bed for a little bit. That's brilliant that all that not that much. Come back down. That's it. Okay.

Steven Bruce
So what we're doing now is aligning the pelvis. The split is

Robert Shanks
just getting early at crest, just level with the lower part of the bed. Perfect. And now we're going to connect the geometry here. It's going to connect the thoracic artery and give a little cushion for your head as well. Kristen, so we're just going to place this this now strapped into the top of the bed, there's a little buckle where there we thread this through. And it completely needs to have that nice and tight.

Steven Bruce
So the audience can't see that but it's a simple metal snap hitch, which holds the holds the thoracic harness in place. Yes,

Robert Shanks
that's nice. And then fix bend your knees. That's great stuff. I'm gonna

Steven Bruce
lay that I lied. They can't make the audience can see it and that's good either. That's right, just a

Robert Shanks
second. So now we've got the knee bolster. So again, this helps us to flatten the lower back and makes things more comfortable for the patient. And then we're going to connect up the yo ring down here. We're going to hook this up to the harness to the to the cable to the machine and then we also have some ankle bolsters. We're going to pop those on this grip style.

Steven Bruce
Those are primarily for patient comfort. I take it

Robert Shanks
absolutely yeah I mean, a few. Sometimes, I have a few patients that don't like to have the ankle bolted majority of them prefer them there. But it's completely optional. You don't have to have ankle monitors. Right, he's gonna bring her arms up above her like that. And ask Haley, she was gonna move this down tiny bit. And we're just going to find a little fix for the pelvic harness. So these straps need to go quite tight, because if they're too loose, they'll just slide down, but they need to be gripping her without causing too much pain. Zelicah Perfect. Okay, so we put your arms up there. And now what we now can do is we're gonna get the thoracic harness just going along the angles of the ribs, which have little fear with it, where the ribs are roughly gonna be falling the angle of the ribs there. Okay, so if you can take a deep breath, and then out, please, stretch. Okay, so we'll lay that down there. And that needs to be again, reasonably tight. Just about get my finger in. And that will then keep the thoracic area nice and still. And then we can do the bladder as well.

Steven Bruce
Yeah. When I've done that, I mean, I'm brutally tightening that thing up. But actually, it's relatively comfortable for the patient doesn't Yeah, yeah, it was okay for you, Haley. You're joking, strangling.

Robert Shanks
And then the last little thing we're going to put in before we can start machines, just put these on both of them as well. So this is this another layer if

Steven Bruce
you try and do that with your backups of this. And

Robert Shanks
so that's going to slot into there. And then it's just unless he's gonna bring around down there.

Steven Bruce

The only thought I've put patients on here in particular, my father and I have a heavy traction on him. And I thought these things were largely unimportant, but actually, they are really useful in stopping him from sliding down the table. Because even with all these straps tied on the force was so great that he ended up with his feet on

Robert Shanks
the footplate. Yeah. So obviously, the higher the pressure the that goes, then the more the becomes important, yeah, yes, right. And then if you want to just move your arms on there, that's better for you. That's it. There we go. Okay. So what I would then do is just have a final check to make sure that she's nice and in the middle of the harnesses, and nicely in the middle, and everything's looking symmetrical, we would then want to set the angle here to the relevant desk that

Steven Bruce
we want to run with this. So we wouldn't do it this way. So we've got, we've got one of these things as well. So you've set the angles. So we've set

Robert Shanks
the angle accordingly to what this we wanted to target. So as I say, if it if it was an L five s, one, we'd be going for a 10 degree angle, L for 515 degree and so on.

Steven Bruce
And then we've got to complete with the audience at this point. We are not we are not going to turn this machine on. We don't want to apply traction to Haley when she doesn't actually need it. But actually with the machine turned on and doing its stuff. There's nothing that you could see anyway, because the the traction is invisible effectively. Yeah, there's a little bit of movement when one releases the bottom half of the table halfway through, or part of the way through.

Robert Shanks
But yeah, that's that's that's basically it. Yeah, sure. We'll be ready now if he wanted to, to start machine. So we

Steven Bruce
turn the machine on, we set the angle the block in the middle of the machine here, right right as to what it thinks is the angle, but we check it with the spirit level to make sure that we fine tune it fine tuning on the machine, we tell it how heavy we want it to be the heaviest pool we want to so

Robert Shanks
the several several for Amazon machine, we tell it as you say that the high tension, we set the oscillation as well. So let's say this is not as simple as let's say, for example, we had 100 pounds of high tension, we could then set the oscillation to five pounds or 10 pounds, meaning that on for that minute that is on the high tension, it was going either between 95 and 100 or 90 and 100, whatever we wanted to set it up. We've then got the progression time as well. So how quickly we go from zero pressure to 100. We tend to recommend 120 seconds for the first full release. And then obviously the the overall treatment length as well. And it

Steven Bruce

goes through 13 news cycles. Yep. So we end up with should be about 26 minutes, six minutes. It's about 26 minutes in total. As I understand it, the the bog standard setting when you put someone in here is you start off with half body weight less 20 pounds.

Robert Shanks
Yep, that's that's the standard, the standard protocol. Obviously, the certain circumstances where you may go a little bit lighter than that. Some of the examples I've mentioned before the end of the tears, somebody who's who's got multiple we work with we found from pulling results and talking to each other in the UK mode, it's one change, we tend to go a bit lighter, and we'll take about 30 pounds off. But yeah, roughly, the average is 20 pounds on the half body weight. And then what we tend to do is we'll progress the pressures through the sessions. And the maximum we'll go to would be half the weight plus 20 pounds.

Steven Bruce
Oops. Sorry about where I am with my father. So I can afford to be brutal with my phone. Yeah, no, He's extraordinary. You can take

Robert Shanks
there's definitely that's just the standard. There are outliers. We go outside of those parameters sometimes. Yeah.

Steven Bruce
Tell me about that little handle down there. What we do with that one,

Robert Shanks
so Okay, so what tends to happen is we let the first two cycles at least go without releasing a handle. But what happens when that handle is released, the lower half of bed would then start to pull away from the top half. Okay? And, and that's when you like the patients then can experience the full distraction, because hurt because her pelvis will be starting to move and drift down.

Steven Bruce
Because it is affected by friction up to that point is Yeah,

Robert Shanks
yeah. So the first two cycles tend to be a bit of a warm up, tend to take the slack out of the harness, and just to get it bedded down in preparation for the release of the bed. But I

Steven Bruce
know that we've got several controls over how forceful you can be on this. And I know that when I've asked your advice in the past, you've said Well, with this patient, lower high tension, don't release the bed for the first three or four sessions, if at all. That's just see how they respond.

Robert Shanks
So So in the example I gave earlier, the chapter, the only attack, I've not released that then four sessions, because I know how sensitive when he released the bed, there's about 26% increase in pulling force, even like compared with not releasing it. So you have to decide whether you want you can be happy to do that or not. But there's a bit of a swing recently, within the ITV community that we don't release the bed within the first four sessions.

Steven Bruce
Have you seen any adverse reactions to treatment?

Robert Shanks
One or two? Yeah, yeah. So and they, they there's sometimes the patients who are height this is going why I've made the decision recently with this Angleterre chap not really so bad, because I've seen in the past where you have a patient who's you know, highly sensitised. If you lose a bit too early, they are there's a risk, they can go to spasm, and they come to the bed. So, so I've learned from experience that you know how to navigate those waters.

Steven Bruce
There is I mean, of course, there is a safeguard for the patient isn't ever again, all the machines have got one of these things here, which we would clip to Haley. And if she wants to stop the machine, she presses the button and the machine will stop. But the annoying thing is that you can't then restart the protocol, you have to start from scratch and start from scratch. And it doesn't stop it, suddenly, it just it gradually releases the pressure jolt on the patient or anything like that. And in my treatment room here, we've put an intercom on the wall. So if a patient wants to call the practitioner, they can press a button on alarms, because quite frankly, it's very boring as a practitioner to sit in here for 26 minutes when your patient is being gently stretch. Yeah. There was an argument that the patient going to sleep which Lumineer them do is actually beneficial. Because

Robert Shanks
actually, the vast majority of the goal is that the patients should be having the treatment, and she should be very relaxing. And you say to the point that they could go to sleep should they wish. Yeah. And the vast majority of patients experienced that Haley wouldn't do this. But I've had patients who snore.

Steven Bruce
She gets nauseous. Yeah, yeah, when you come back in for the final two minutes, while you're waiting to make sure you can turn the machine off in time,

Robert Shanks
the deceptive thing is, and this is often what happens patients will be on machine and that they can feel the pulling force, but they often say I'm not feeling a huge amount of pulling, and then you don't explain to me how, wait until you come off the bed. And then you'll realise that you've had a big port because when they come off of it, then they start to feel oh, yeah, my bag, my bag has changed quite a bit. I can feel the, you know, the change, if you like in the tissues,

Steven Bruce
often they were my father and my father is a lovely guy, but didn't get him started on some topics. He's loving it, he kept saying to me, Oh, look, I can feel it pulling here. But how is that affecting my back, I'm trying to explain something, it's pulling at both ends, it has to be somewhere in the middle, something has to give. But you know, genuinely I mean, this poor guy had not been able to sleep through the night for many, many years. And I think he had two sessions with this. And he had his first full night's sleep, he has a few bad nights after that, not as a result of the treatment just back to normal. And since we've been getting on machine minimum once a week now, which is obvious, I can do that with my father, which perhaps other patients might be might say, can't afford to do that. But yeah, he's got he gets

good sleep every night, which is a major quality of life change for him, it really is. And his alternative would be the scalpel. Of course, we've no guarantee that that's going to have any beneficial effects. So you're comfortable there, I hope Paley we're not gonna be able to demonstrate this partly because in order to do so we would have to tilt the the bed up the table up. But how does it get rigged for neck traction, we're also not gonna turn it around

Robert Shanks
for Okay, so for a neck traction, well, I will do this during the cameras and see there's a little plate here, this would slide out. And then what we'll be doing is sliding this supports a vital harness into the into them instead. So this this spot would sit at the top of the bed, there'd be an extension cable to the cable which would run underneath the bed, and then would would come out at the top here. And it's actually what you're getting might not see off camera. But there's a what's called survival boomers, there's kind of an arm that swings up and the cable come up, loop through the arm. And then this will connect to here and then we would set the angle to depending on what we want to do the relevant disc in the neck. So this this would be a you know, the higher the angle, the lower in the spine. It's going to go it's interesting

Steven Bruce
with that. Do you ever measure the angle with the spirit level of inclinometers? Can you do that? So

Robert Shanks
there's a Michael Yes. Yeah, always I would always matter here.

Steven Bruce
Yeah. Right. Because I remember Stephen saying, well make sure that the cables in the straight line when you do this,

Robert Shanks
yeah, yes. Right. So the cable that comes up has to be in line with the angle here so that you get an unrestricted palsy like that. Absolutely, yeah, you want to make sure that you've got the angle at your think you've got you have got

Steven Bruce
that makes sense. Now these these things here just grip around the Master. Yeah, so these

Robert Shanks
mats are the patient's head would be here actually, this would be around the mastoid process,

Steven Bruce
relatively comfortable.

Robert Shanks
Honestly, these are quite quite hard. Yeah. So what we tend to do in our clinic, we have a little sweatbands that we put over the top to make it more cushioned. So it makes it a bit more comfortable. But yeah, I

Steven Bruce

also have a patient's complaint that they're uncomfortable. Yeah, they are quite hard to do 26 minutes of this thing on you.

Robert Shanks
Yeah. Does dig in the vessels a bit, but that's why I will sometimes you can put some towels on here I can, but we tend to recently abuse these weapons. Yeah.

Steven Bruce
And people know, immediately thinking, Well, if you do that, that gaps narrow, so we're going to start strangling them. Well, of course, you you're just out yet with the steroids can combine them and I'm gonna strangle our patients. Yeah. We're gonna, we're gonna move on. I've got a lot of questions coming in. But just if you wouldn't mind, can you demonstrate getting Haley off the machine? Yeah,

Robert Shanks
certainly. Yes. Yeah. Okay, so we imagined we'd stop the treatment is probably just everything in reverse order, really. But I would disconnect the cable.

Steven Bruce
I'm gonna stop you just because there was just one issue that occurs to me that there is a communication consent, decency, dignity issue here isn't there because that ring there is, is quite close to the groyne. And yet, you need to make sure that patients, particularly female patients, know that you've got to rummage around in there sometimes.

Robert Shanks
Yeah. So there's a little bit of the technique of how we would do that. So let me sort of beginning I sort of brought it up over here, flopped out the way that I've listed the LI bolster in and I was able to grab it and bring it back down. It saves me leaving it then having to,

Steven Bruce
it's definitely not a machine for wearing a skirt, or a kilt. If you're

Robert Shanks
definitely not skilled kilt time they do. I mean, they enter them in reverse order. What I would do though, before I did that,

Steven Bruce
I don't get you to come around here and trying to do that from that angle is

Robert Shanks
just going to disconnect the the opening first. That's one little tip I was trying to get people to do. So we just discussed those clips that when we stand Hey up. That thing doesn't, it's not a trip hazard, basically. So we do that.

Steven Bruce
We also I always forget to undo it when there's no, yeah, yeah.

Robert Shanks
So and then we're going to take the ankle bosses off. And again, one other little tip would be when we're going to get hate to move her leg, or legs, let's say I would always try and assist

the patient because often, it's ridiculous patient. If you then if you just lift the leg too quick, or they lift the leg up, that can be quite quite sore from so I'd always assess the patient's overall let's lift, lift together, raise your spine, great, bring the other one up, if you can, there we go. And I would then take the knee both out. And then we can do same same sort of thing reversed, legs come down. Good. And then we got a slide as well. Good, slide down. Lovely. Okay, so that's that, and then we're gonna release the thoracic harness, what we do here, we don't just rip it off, because that can get in cause like a reactive spasm. So we did it really slow, we don't embrace it become nice and slow. Just paid a little bit of tension with this with this other hand, I'm holding that there, and then I'm going to release. And that's usually the consequence of doing it, I would then just take a little bit of pressure off the pelvic highs, not completely disconnecting it just yet, just to release a bit of pressure, and then we're ready to stand it up. So I might just take that away from there.

Steven Bruce
And bolsters out as well, don't

Robert Shanks
we? Well, I actually tend to keep them in until the patient's upright. Again, it's not wrong to take them out. But I will see Richard Haley, I would take them out you're right because on the pledge, but if at all possible, I like to try and keep them in simply because as a patient comes out and gives them another little bit support that you're right in how he's going to be able to take that okay, so then Well, we've got we've got a couple choices, we can either either ask you to slide on the bat, or if you're happy to, as a bit comes up, you're never happy to start slide down the feet will then hit the

Steven Bruce
character to the both of these, which on this particular one is p one p one. Otherwise, it'll dig in somewhere.

Robert Shanks
Nice. You're gonna hate the slot sliding. Alright, so we're going to come up, I'm going to pause it halfway. So roughly there, what tends to happen is where the patient's been, like traction for 26 minutes when they when they get past the halfway point the legs can seem quite heavy. And so I'm just gonna warn you that that's a pretty for the weight come back onto your legs. Okay. And then we're going to machine comes to a nice stop there. And I go, Hey, are you ready to come off? I'd always just assist the patient coming off. And that's it. And they can they can sometimes feel a little bit stiff coming off. Obviously we didn't have attraction for someone with Teddy Bear had you had you had that on, the patient can sometimes feel a bit stuck to the bed sometimes I think the call master don't quite know what to do imagine the snoring explain to imagine you've just been stretching hamstring for 20 minutes, your leg could be a bit stiff, but same sort of thing can happen for that? Are they

Steven Bruce
going to get that sort of stiffness anyway after treatment and impress later in the day? Well,

Robert Shanks
so possibly they can feel a little bit stiff for a day or two. You know what, what we what we say actually is we like the patients to feel having either we've had an effect, but we don't want to increase their pain if you like. But if we have a reaction that backwards, a little bit stiff, possibly a little bit sore, not excruciating ly. So that's actually normal in almost dishonourable, it will almost inevitably come down within 24 to 48 hours, that we try to aim

for some some effect. Right. But the key component though, after after having done this is we would put them on an ice pack. Right? Yeah. So we'd have a sit down with an ice pack on the back for five minutes. And talking to Dr. Jeff, as you mentioned earlier, he's found that that that particular component is a very is a key component. Or the critical. Yeah, yeah, he's found that the results he gets when he does the eyes person, normally it is particular. So if you can just come down here and so right now we've released the opening, what I'm gonna do is really easy to take the belt off, we just unclip one side. And then we can just take their way.

Steven Bruce
Over here. We hang these up nice and tidy for normal treatments in here. But for now for speed. We're just Haley, I'm sorry, you didn't get the full traction effect on there. But it's explained the reasons for that. And thank you for doing that. Of course, we've now lower the bed and we're ready for the next next patient. And I think we better go back and start taking questions again. We thank you again. Right, so it looks simple. But of course you have explained all the little niceties of treatment that make that mean it requires some experience and some and certainly some anatomical knowledge and there isn't a Yeah. Oh, yeah. You've got to know what it is you're trying to treat. It's not just throw them on there and forget about them. Yeah. Although I am aware of practitioners who've managed to work out a system getting themselves on the machine just to get some relief end of the day. mischief maker apparently has asked. He's hanging himself upside down with varying degrees of verticality several times a day. Yeah, how much? How much more would this machine do for him? We've replied that it will give him him or her orgasms make tea and hand out popcorn ice cream and revelled. Are we correct? Or is there a more scientific answer to the difference between inversion and IDD? Well, yes, there, isn't it?

Robert Shanks
Yeah. Okay. So Well, there's several differences. Well, firstly, it's how long can you can you say upside down for I tend anyway to be happy, just upside down for 26 minutes. Secondly, there's no training pressure when you're upside down, although you can perhaps vary the tilt. But you can't be specific to certain disk. There's no oscillation track, there's no oscillation traction either.

Steven Bruce
Because it's what's key in there isn't it is that it's not the whole body is tilting is that there's a different angle of pull on the body? Yes. If you're on a, an inversion table, the pole is always in the same direction because you're not you're sliding down.

Robert Shanks
So yes, it's like a horizontal pool essentially. Yeah, when we this as you say we're we're, we're very the angle and creates an anchor point on the x axis where we can target those individual segments. So we're

Steven Bruce
hoping that satisfies mischief maker. Someone in the chat calling himself or herself Greengrass makes sheep healthy is helping to answer some of the questions. So we don't know who you are. Greengrass makes sheep healthy. But thank you for helping out with answering some of the questions in the chat line. Ian says Rob, how much do you charge per session? cutting to the chase?

Robert Shanks

Yeah, kind of. It's fine. I mean, we we charge 80 pounds per session, and Autistics this is I mean, that this the spread seems to be I think roundabout. Anything from 70 to 90 From what I'm aware of,

Steven Bruce
which means from what you said earlier on, that patients are at least have to be prepared for a 1600 pound course of rehab. Yeah. And possibly longer than that. Yes, yes. My experience of this, and I think I've mentioned this before, is actually that, in some ways, the fact that they know they're going to need that number of treatments. And you can say to them, you're not going to know whether this is working or not. Before you've had it probably for prostate, probably six treatments means that they are committed. So yes, there is less of an issue with the money because you they know what they're in for when they arrive. Yeah,

Robert Shanks
yeah. I mean, so yeah, absolutely. I mean, what the rough rule of thumb that we say to patients is, as you said, don't expect really any change inside of six sessions. If you do that's a bonus. But even even within within six sessions, most patients are only going to be manually better. The real turning point we look forward around session. 12 Yes, we expect them to be 20 to 40% Improve auto session 12. If they hit that milestone, then we usually constantly going to go on to have a successful outcome.

Steven Bruce
Just thinking going back to what is different about this particular machine from standard traction or inversion tables, Justin has got an image of the graph, which shows the the tension pattern on the machine. And I wonder if Justin can put that up so the audience can see it, maybe we can see it as well. Yeah, it will illustrate the high tension, the oscillation, useful, low tension. Yeah.

Robert Shanks
So I mean, it's another useful feature of the machine in the sense that you have an objective measure as to what's going on with the patient. So roughly speaking, what will happen is that we, we set the tensions and the parameters on the machine. And that plots are essentially a blue line, which is the treatment protocol for that session. And then in real time, as the patient is being treated as they're being distracted, there's a red line that is plotted over the blue line and how well that red line overlaps the blue is giving you information as to how much resistance there is from the patient's tissues. And generally speaking, what you want you want it will look for is that towards the end of the session, the lines are converting cleaner than they did at the beginning. And then that data is all saved on the computer, you can compare one session to another and it helps you to decide which presses you're using throughout the

Steven Bruce
treatment. So while you were talking there, our audience were able to see that slide of the of the pressure patterns, which I think goes some way to explaining what the machine is doing doesn't show the angle, but it does the oscillation, which is so characteristic. do insurance companies pay for treatments?

Robert Shanks
Great question they used to and the tendency is that the increasing not doing now even used to have their own separate code for it. But they're because as far as I think they're

becoming increasingly more difficult to get that funding through. So I would say don't rely on the insurance companies to

Steven Bruce
It is bizarre, really, isn't it? Because I'm the evidence. I know the evidence from your the clinical evidence from your own practice is that, as you said between 80 90% of people are going to benefit from Yes. And yes, they might have had 20 sessions, but they might then go for a very long period of time before they need a single top up session or a few top up sessions. Yeah. And their alternative is the knife.

Robert Shanks
That's right. Yeah. I mean, the alternatives that you say are usually epidurals or or surgeon, yeah,

Steven Bruce
with no great guarantee of success for those. Certainly the long term. Yeah,

Robert Shanks
I mean, you're right. I mean, if I was in shorting the insurance company, I wouldn't be paying for it. But

Steven Bruce
yeah, you answered this earlier on, but lots of people have asked whether IDD helps with spinal stenosis and associated radiculopathy

Robert Shanks
Yep. Okay. So again, spinal stenosis is depends on severity response Gnosis so severe spinal stenosis was literally you know, the, the canal is pretty, completely occluded. There's hardly any cerebrospinal fluid in that canal, I would, I would say, poor poor prognosis. And I probably wouldn't even put a patient on who's at that stage of the game. But you know, mild to moderate cases, I would be happy to try it. And often the patients will will get better, I would say the success rate responses isn't quite isn't quite as good as with the classic radiculopathy, kind of, you know, unilateral recessing, or compression of the descending nerve root. But it's not bad. And it's certainly an alternative to surgery.

Steven Bruce
And many, many people would rather avoid surgery with good reason. I've just saw a question. Here we are boom, set to 66. This person has called How does adjusting the angle attraction specifically target a given level? Has this been shown in the real world?

Robert Shanks
Yes, it has. And so it's vectors isn't these vectors? Yeah. So basically, what you're looking at is if you're going up that the higher the angle on the y axis, the further along the x axis, the angle of colleagues. And that's, that's just your physics. And it's, it's actually one of the questions that I did ask myself at the beginning. And I actually got my brother in law. He's got an Indian engineering degree from Cambridge, I did to get into check all the tech all that and just make sure that I wasn't being sold a whole load of baloney. And he completely confirmed to me that no, it's actually sound physics.

Steven Bruce

And in terms of it being proven in the real world, you mentioned in categoric studies, they've shown how it is affecting the gap is specific.

Robert Shanks
Yeah, that's what they do. And come back towards the beginning when I went down to see Steve Morrison in Brighton. Actually, what convinced me to get mushy myself, I'll be honest, was the fact that I said to the guys, right, talk my oh five. Did that for tenants. Right now talking about one, two. And then let me see if I can fit it in. I did. So that for me sold it to me, because I could feel the change in where it was pulling from.

Steven Bruce
Yeah, that's it's a good test, isn't it? Certainly, if anybody wants to come to the studio here, I'm very happy to stick them on the machine and they can experience it for themselves. As long as we got patients booked in for that time, just as I'm very happy if people want to send patients to me, if they're in my local vicinity, we won't try and steal your patients. But we're happy to see them here at the academy and see what we can do for them. And any clinical take referrals from other people, but I suspect that a lot of practitioners are worried that they'll end up losing their patients to other clinics.

Robert Shanks
I mean, I'm not gonna send people worry about that. All the clinics are unaware of and including ours. You know, if that was to happen, we would always encourage that patient to go back to that clinic after afterwards. Yeah.

Steven Bruce
And a great way to do that really is to say, Okay, well we'll do the IDD You've got to go back to your sport service, physiotherapist, whoever, because you still need rehab at the end of it, you still need the service is

Robert Shanks
a key component you absolutely you need you need you need the Well, I mean, we now encourage patients to have at least a few sessions of manual therapy alongside the IDD and and also have the core stability programme as well. And to be honest, it makes our life easier if they have that at another clinic, actually, because we can just concentrate on the odd. So yeah,

Steven Bruce
Victoria said, I was asked whether if you set that machine up wrongly, could it be damaging? Or will it just not do any good?

Robert Shanks
Well, in certain circumstances, it could be Yeah, if you said it was the wrong pressure's the wrong segment. Of us. Let's say for example, this is the beauty of why you know, sometimes you want to target one segment and leave another segment completely alone, because, let's say got hypermobility to see that so you've got to know a disc, the disc protrusion l five. But you've got a you know, an unstable, dynamic spondylitis ceases at L three, four, you want to you want to vote for us going through everything, we do want to make that healthy for you more unstable by putting in some more ligament stretches and vectors through that you want to target the oh five. So yes, in that scenario, if you did talk at the wrong angle, you could potentially make the patient's worse. But that comes down to your clinical judgement and working out what you're doing and what angles using and all those things.

Steven Bruce
And what about that that awful decision we have to make with every patient no matter what we're doing to call centre as asked, How do you know when to stop? If it's not working? How many sessions do you give them?

Robert Shanks
So so getting ruffled of thumb is the goals, we're looking for usually our session 12, or they're about 12 to 15, you want to be seeing, at least, you know, 20 to 40% improvement, I would say. And if you get that you usually would then expect to then get the full improvement within you know, within the set protocol. So again, the criteria, there's been a recent advice coming from Erica that there's kind of three categories if you like that we we aim at so a simple category one would be like a broad based disc protrusion, proximate 24 sessions, if you're going to be having a if it's a focal single level disc protrusion with a nerve racking treatment, you're looking at around about 30 sessions, if you've got a multiple level, so more than one disc affected, or the same disc segment that's got multiple issues who might have facet on virtually might have disc degeneration. And we're looking towards the 42nd. Mark. And I would say that is pretty accurate. We used to only offer patients 20 sessions originally. And I know for a fact that we've under catered for some patients in the past because we accidentally found out that some patients were needing more than 20. And since we started to shift to this one to three category, our results have skyrocketed. We're getting much more we get even more improvement than we used to have.

Steven Bruce
That I find intriguing because certainly when we were being sold the machine over the many years that we were considering, we were told 20 sessions is the rule of thumb. Yeah. And certainly there are people who benefit before they reach 20 session.

Robert Shanks
Yes. So obviously, that's what we explained to patients begin, this is what you need to expect that they need to be prepared for that. Now inevitably, some people will do like a bell COVID that some people do better than you predict. But that's the majority of the bell curve some people get you have a better result than expect. And potentially you can then actually stop

Steven Bruce
before one thing, I find a slightly mystifying about the machine. And I know yours are a slightly different model to mine. But imagine the software's pretty much the same. Whenever I put a patient on it, it asks me for their pain level. And when I take them off their pain level, I just think it's totally irrelevant. I'm interested in what happens between the session and the last one over the course of a week or whatever, rather than right now at this moment.

Robert Shanks
Yeah, I think though, where that's coming from is, you sometimes want to know, for example, we know is the patient coming off the bed, less pain, and they came off the previous session. And it just does sometimes give you a little bit of an idea. Again, giving example that the trap I saw earlier with the mentioned with the angular tear, interestingly, that the session that preceded his really good week, he came off the bed feeling quite stiff, couldn't quite store. So his his post treatment score was higher than the previous post treatment scores. But then he went on to have a very good week. So it's just is this data collection really, then then might have an influence in my decision on the future sessions and

what pressure to use with this particular chapter. So blog really it's kind of a little bit surface requirement sometimes

Steven Bruce
minor is where you have to do it on the machine learning whatever you put into something, it doesn't let you do it without doing my always come up with what I call an old chestnut really, does the patient have to have their own voice MRI scan standing? Because so often

Robert Shanks
right? Okay, so the differences between an MRI standing and MRI lying down are usually MRI quality, so the upright MRIs are less, you have less pixelated if you like so the image quality is not generally as good as a supine scans. However, there's the statistics are approximately that you'll see pathology on an upright scan that you won't see on a Superman scan 30% of the time. So the rough rule of thumb is you but also there are a lot more expensive as well we should say. So, usually at least double the price the uprights so usually what would we would do is supine MRI scan will give you what you need to see and 70% of the time. If you have suspicion Shouldn't that you're there's something you're not seeing on that supine scan, that you're convinced is there from the clinical examination. That's when I would then say, then you're looking at trying to push for that price scan. Yeah. We certainly had cases where that has been the case. I guess

Steven Bruce
my, my already a lot of other people we think of we're trying to save the patient money here, not send them off for another year more expensive. That's

Robert Shanks
right. Yes, there's lots of drugs, people will start off with a supine, standard supine.

Steven Bruce
We mentioned the evidence earlier on, and I'm told that a lot of people are asking about the research base for this. Is there any research that isn't anecdotal comparison to rehab or surgery and of the other research that so there

Robert Shanks
have been studies that have been written up in the, you know, the literature in the journals? I mean, I'll be honest, it's not all the magnitude of like, you know, the lancets. And those sort of things and stuff got a pretty good, nice guidelines approval, but there certainly has been there's something happening, trials have been done. There's been mostly positive ones that have been wanted to know what has been one negative one, the one I mentioned earlier, that was a bit nonsensical because it excluded patients with this disease pathology. So what's the point?

Steven Bruce
Well, it nicely shows that it's true. If you put people who aren't suited to the treatment on it, they won't

Robert Shanks
get well. Yeah, we could have talked about the beginning. But yeah, there was another study that was done that, I think, again, just off top my head, it was comparing, like a physiotherapy rehab programme versus the IDD. And I think the the results were similar. But

then other studies have been shown that when you combine the two, they're even more superior. So there is there is there is data out there, there is evidence out there.

Steven Bruce
Okay. And I guess people shouldn't be surprised that we don't have those massive quality of evidence that more quantity of evidence, I should say that the pharmaceuticals typically will house right? Because you know, someone's got to pay for

Robert Shanks
it. Correct? Yeah. Well, I would also say those that when, in the end, come back to the community aspect of it. So within the IDD therapy community, we do tend to meet up or try to meet up once a year for an annual conference hasn't happened the last couple of years because of COVID. But usually at that conference every year, there's at least one or two clinics who are then presenting their data from the previous year. And that's always an interesting, okay, there's not as you said, Lancet type data, but it is very interesting data and all the clinics generally present the same kind of results as other clinics getting previous year. So it's from my point of view, the confidence is there anyway.

Steven Bruce
Yeah. Robin has asked him Which Robin, this is, and I'm very disappointed. We haven't had anybody come in with a video call yet. And if it's the robin, I'm thinking there's I'm surprised that he hasn't videoed himself in here. But he wants to know what metrics you use to measure progress.

Robert Shanks
Well, we mentioned ones already earlier that he does ask you for a basketball and a pain score. There's also the software has an office three software built into it. So as well, so you can you can input that data if you want to. And that will go through to the data collection. But principally in an MIT, obviously, you're interacting with patients each time you're monitoring their progress, you're keeping the clinical notes, you're seeing how well they're doing. Are they similar is improving?

Steven Bruce
And frankly, it's no different to any other patient. Yeah. You wouldn't keep them coming back for osteopathy, your chiropractic, if they weren't getting better, unless you saw that they had to come back more often before that.

Robert Shanks
Objectively, you're looking at straight leg raises and your tension signs. I've got my time weakness, you're looking at improvements in that, that obviously pain, subjectively pain levels as well. Reflex changes, but you know, we it's important to review your patients obviously through throughout the course.

Steven Bruce
Yeah. Like I said, when I'm with my father, it was the fact that he could sleep overnight. He reduced the Tramadol. Yeah. And I wasn't bothered about him taking for Tramadol because he'd been doing it for years. And it. It's not that he was addicted to him. He was happy to give them up or anything like that. And yet his age, it didn't really matter if he was addicted to them. But he was a very good marker about how much better he was doing. Yes, right.

Robert Shanks

Yeah. They reduced their pain meds. Certainly. Yeah. Yeah.

Steven Bruce
Karen's current says, who invented this device? And how long has it been in use? I can't remember his name.

Robert Shanks
So sharing, I think we should invent it. So it's been around since the 1990s. In America, is that it's American machines are the machines are made by chemical North American medical. They're pretty big in the States as I came to the UK, about 2009, I think. But yes, Americans American by design,

Steven Bruce
which isn't necessarily a bad thing at all. It was. Well, no, no. I always I always sensed there's a little bit of scepticism in the audience and say all Americans, they're all good at the marketing. And quite often they do produce some good kid.

Robert Shanks
Yeah, no, it is. Yeah. And as I said, you know, it is arguably the gold standard in

Steven Bruce
spite of the profession. What was what she leads profession. Did you say? Um,

Robert Shanks
I'm not sure. I think it was.

Steven Bruce
I think he's a surgeon.

Robert Shanks
I think it was, yeah, I think it was a medic. Yeah.

Steven Bruce
Okay. Justin, do you have a pre versus post treatment MRI scans? Oh, sorry. Yes, that was the question.

Robert Shanks
I was thinking you're Justin I'm aware of. Yes, we do. Kate Yes. We I mean, we don't we don't scan every single patient after the treatment, I'll be honest, but partly has to do with money. Patients want to do that now for the better. They don't have to pay another you know, three or 400 pounds. Just but where it has been done. We do know we We don't always see, like, massive change. But we do know we see some change in the disk. Like I said before, you're not, you're not going to be expecting to take a gender disk back to the state of a brand new spanking disk. But even small changes is a massive change for the patient. So I mean, the way I explained to patients, if imagine if you squeezed squeezed your finger, and you squeezed so hard that you could turn red, it was getting painful. If you then just release the pressure slightly, and you took a picture, it looked very similar when he just was squeezing it. But the feeling and the thing is very different. And that's kind of the situation you often will get with a desk, it might not look a huge amount of difference. But if

you've released that pressure in the nerve root, you've got a huge amount of symptom change. But with that said, quite often, you will see the change in the disc as well.

Steven Bruce
Jackie has rather optimistically asked whether there have been any comments from Nice,

Robert Shanks
zero signs or no. Yeah.

Steven Bruce
The only thing I know of is the is the one where they've said that traction is not recommended for pain. And of course, they would probably say, Well, this is just traction. But of course, it's not just a

Robert Shanks
stress, right. It's not distraction. I think, I think the study the stats that often get quoted are that the studies have shown that traditional linear traction 90 days we say, is about 50% effective, and that's no better than placebo, and therefore the inference is that it doesn't do anything. I think what belies that, though, is partly the fact that when they did some of those, even the traditional traction stuff, the patient selection wasn't ideal. Because I certainly have spoken to patients who have sought us out for IDD therapy because they've had traction 30 years ago, and it worked wonders for them. I don't know whether you've had that experience, though. You know, I get that reason, the reason frequently. And the patients are very convincing,

Steven Bruce
well, Laurie Heartland for the benefit of anybody out there who hasn't heard Laurie Hartman, one of the most famous osteopaths in the world. He said on numerous occasions that particularly with what he calls cocktail party, back traction is the only thing that works for them. And he's talking about pure linear traction for that. Darren has asked an interesting one. Is there a risk of overselling the treatment because of the outlay? Because we'll all be conscious willing to pay back?

Robert Shanks
Yes, I suppose Yes. I mean that but that comes down to your own individual set of morals and circumstances. I mean, I'm very conscious of that, that we don't do that. And I'm honest and open. And, you know, I refer the patients to the guidelines that were given as a community and say, Well, this is what's the evidence and the the the data seems to be suggesting is better,

Steven Bruce
which actually is one positive difference in this familiar the treatment is at least there are some guidelines though, because you could argue that as an osteopathic chiropractor, well, I'll oversell my treatments. I've got to pay the rent on my building, and I've got to put food on the table, and I want to get as much money in to do that as possible. We can oversell for all sorts of reasons. Yeah. Honestly, I mean, hopefully we're too ethical and professional to do that. Yeah. Megan, Megan, did she miss miss the relative and absolute contraindications? Megan? Yes, is the short answer, but I will send those out in a follow up email, possibly not tomorrow, possibly the day after. But there is a there is a list of contraindications for this as well as there is a list of indications as well. PK says, Hi, I'm an osteopath had an MRI diagnosis of lumbo sacral. PID with classic s when symptoms no surgery was performed 20

years on, I still have symptoms aggravated when lifting and being physically active. Would this treatment helped me now? Yes. And if you're anywhere near my clinic, where I'd be delighted to take a fellow practitioner on and I'm sure you would as well. So PK, I don't know where you are. But there'll be plenty of people keen to help you I'm sure. research you've done there on current. So I'll start when giving us just on that

Robert Shanks
point. I mean, that's that, for me is the ideal ideal ideal patient, because we often will get patients in who have have suffered for you know, for years with these sorts of things. And I know then well, okay, they're not in that kind of acute window where they might get better in six weeks anyway. So yeah, definitely we try that with IDD.

Steven Bruce
We have found in the relatively small number of patients that we've seen in my clinic bearing in mind, we've not had the machine that long. That we use, you get a particular type of patient very often because they are chronic pain sufferers, they often have a very different approach to being treated then perhaps as positive as some might like and rather than rather, as fibromyalgia patients can be quite, quite down quite negative. Draining. We found that with some of our patients,

Robert Shanks
I think it's fair to say

Steven Bruce
FLUDD Good evening blood. Nice to hear from you. Again. I think it's difficult to understand innately what ideally does unless you have it yourself and or have administered to a patient and seeing the changes through the course of treatment. Francis has been fortunate enough to work in a clinic where he's done both and he can see that the results are very apparent to see there was a clinic who use CCTV footage to show a patient walking into receptions have IDD? And that footage also speaks volumes for what it's worth.

Robert Shanks
Yeah, the clinic is talking about that. Yeah. So you're never

Steven Bruce
Yeah, again, it's just it's a little bit sad, isn't it that so much of this is is very anecdotal. And that doesn't sell to the wider medical professionals and let so we can

Robert Shanks
get some hard data.

Steven Bruce
I don't know if I didn't if I put this the same way. But did I also occurrences? Have you actually had the case where this has exacerbated symptoms we had we asked about it not making people better. And

Robert Shanks
I'm struggling to recall. Not certainly not many.

Steven Bruce

And in those cases, would you simply modify the protocol slightly so that it's less forceful?

Robert Shanks
So the only one or two that I'm kind of vague on the back of my head were borderline cases were kind of moderate to severe stenosis patients who were explained to them. You know, you're right on the borderline of will this awareness work. And I can recall one or two patients who we did abort the treatment because it was making their somatic symptoms worse. But as I said, that's that's kind of literally they would have then had to go into surgery. And they they were well aware that there was a risk of that could happen. Normally, though, we wouldn't do it in a severe case, though. Definitely a contraindication. But you're going to get the nobody's gonna get those borderline cases. Is it? Is it contemplated? Is it not? So they're few and far between? Usually, it either works, or it doesn't. So again, roughly speaking, similar to the case will work and they'd have sent your way.

Steven Bruce
ecozones, whether there are training, training courses for osteopaths, chiropractors, and others to learn about this machine, learn about

Robert Shanks
the treatments. Does he mean in terms of when you buy a machine? I mean, if while I'm

Steven Bruce
inferring from this, that he wants to know he or she wants to know when they might refer patients what they should do. And obviously, if you buy the machine, you're going to be taught how to get training

Robert Shanks
to buy a machine obviously. Yeah, no, it's a very, it's a good point that there's not actually as far as I know, there's not there's not actual kind of, you know, MRI awareness. i Sorry, I see awareness courses where you can come along, and but

Steven Bruce
we've gone through a fair amount of it this evening. Here we have Yeah, I don't know. I don't know if you were running a course, if you were to put a course together with people to say, right, you're all practitioners, you don't have your own machines. These are the things to look out for. Is there much more that we would cover than we did not not

Robert Shanks
somebody a lot more than we've done? I mean, other than perhaps showing before and afters and MRIs and case studies? Yeah.

Steven Bruce
Yeah. Well, of course, you know, we've done the MRIs with you before, and you've got your own online course that people can sign up to for MRIs. And they are a challenge. Yes, I guess the only answer is you just got to look at lots of Yes, like

Robert Shanks
everything. You got to practice what you what you what you are, what you what you learn, and that's the way to keep it.

Steven Bruce
We're nearly out of time. Can we run into a little bit on the cervical protocols? Do you use it a lot for cervical spine?

Robert Shanks
We use it far more for the numbers. We do use it for sabbaticals as well. But whether it's just the patients that are coming through to clinic, we say our number probably 3321 Number two cycle.

Steven Bruce
And does it perform? Well? Do you know in contrast with the little inflatable collars, or the over the door waited attraction devices? One would expect it to be the same. Yeah,

Robert Shanks
I mean, the only the only thing I can say there is from personal experience. So I did have a bit of a disc issue in my neck. And I was I was using an alternative from a home based traction, as you say, and wasn't improving. And I had about four sessions on the ICD and then was fixed.

Steven Bruce
Really? Yeah. And when you say fixed, you're talking about relief of symptoms. I tell you rather than getting

Robert Shanks
ridiculous, ridiculous or thinking houses in my hand, and how the MRI was shown I had a bit of a weird base this bulge and it definitely helped within four sessions. Yeah.

Steven Bruce
Did you carry on with designing for sessions

Robert Shanks
should have carried on? Yeah. I probably didn't do as much as I should have done. And I will try and remember to do some top outs but ya know, definitely. It was it was it was a very interesting contrast. I could feel how much better it was than the home stuff.

Steven Bruce
Although I'm assuming there are some more significant dangers with 3d and cervical spine and perhaps the role with the lumbar spine.

Robert Shanks
The quantification is not the same, as far as I'm aware. But as you say, you are your look yes, wherever the body obviously that the machine won't let you go to as high pressures or to switch over to should hasten to add he won't let you go above 30 pounds of traction force was in the lumbar spine it will go up to 200. So there are inbuilt safety mechanisms within within the within within machine.

Steven Bruce
Yes, MP some has been nasty reports in the last few weeks about when Sir Michael treatment goes wrong. Yeah. Not not IDD treatment. We do need to be careful about mycoses How do you feel about the warning strap or ringing a treatment with a fast neck

pulls to decompress the spine? I think I've seen this video on YouTube. Shocking, horrifying and eyewatering.

Robert Shanks
Always talking about how do I feel about it? I couldn't really pass comment. I don't have any experience of it. So I can I couldn't really say one way or the other.

Steven Bruce
It's pretty sure it's not recommended by Nice. Yes, and I suspect there's an even more limited evidence base for that than there is for any other of our manual therapies. So what would be your advice to anybody in the audience who has actually watched what we've done this evening and is intrigued not necessarily to buy or what would they?

Robert Shanks
You know, honestly do think that for the for the patient if you have those pay So in that category of, you know, chronic disc sufferers, and they're not responding to other treatments, and they're kind of in that No Man's Land, if you'd like of, what do they do next? Do they go for an epidural? Do they go to surgery? This is 100% a definite alternative. Those practitioners should try and see how a clinic that offers that refer to those those those clinics before they're referred for surgery? Or absolutely no look into getting machines themselves and join the community.

Steven Bruce
I mean, in terms of management of the machine, do you do all the treatments yourself? Or do you farm that out to somebody?

Robert Shanks
So I do the treats myself, as well as you know, my associates in the in the clinic as well. So we kind of share out? Yeah, but there's some but definitely, it's operate in slightly different ways. But yeah, normally, you know, normally, you would have asked about our practice or physios that kind of the case lead if you like, and some clinics will have like, say the sports therapists in who do the actual treatment isn't actually on the day treatment.

Steven Bruce
I mean, there's no reason why any sensible person can't administer the treatment, insurance or demand that they have some sort of physical therapy qualification, I imagine. But oh, you I have to imagine that nurses would be allowed to do this sort of employment. The key thing is that we get the diagnosis. Right. So put the right people on the machine.

Robert Shanks
Yeah, the right pressures and the right levels. Yeah.

Steven Bruce
Yeah. And I take it I mean, it has, it has paid for itself in your clinic? Yes. Yes, it is. Yeah. It's gonna be the it's gonna be the big worry for everybody, isn't it? Yeah. If I get one and the bloke down the road gets one, will there be enough patients to go around? There are, of course, lots of patients to go around is making them aware of what you do, which Yeah, it's also what's the IDSA guidelines? Are there any Well, what can we say about what we do with this machine?

Robert Shanks
Yeah, I haven't specifically looked into that entire entirety. But I would say I would imagine they, you know, as long as you're taken to the guidelines that are given to you by net, North American medical, when the, what the evidence suggests is you're not gonna you're not gonna fall farther than you probably

Steven Bruce
know. And most of the audience know, I'm a big sceptic about the HSA guidelines, if you say what you believe to be true. And it's not expressly against their policies, and they say what you're not allowed to say, we'll say, and if someone objects and they say you can't say that, all they'll say is take it off your website. That's fine. Yeah. And I'm not saying I'm not for a second suggesting people should lie, but I'm just saying where you can say what you believe. Because you're getting your message out to patients, you can benefit. Sally says, we got our machine 13 years ago, because I had a treatment in the first clinic in the UK in Glasgow, a disc bulges in my neck and lumbar spine, IDD sorted me out, and I've been using it ever since and treated hundreds of patients. Yeah, fascinating. Thank you, Sally for that. And we probably don't have time to, we wouldn't get to put this up and running right now. But Darren has asked about the course details for MRI training. So if I put those out in my follow up email as well. Off the top

Robert Shanks
of your head? Well, yeah, we'll go to imaging.com. Is the is the website that we have all that?

Steven Bruce
Geo LED number two imaging? yes.com? Correct. Yeah. And on the just sign up for

Robert Shanks
this video course on there. We'll also when we do the in house courses, they'll be posted on there as well. Okay, yeah.

Steven Bruce
Are you doing many of those?

Robert Shanks
We haven't got any date set yet. But we are trying to organise some

Steven Bruce
happy to do another one up here sometime. If you want. It would be very happy to come back because we can fit quite a few people into the studio here. And you can stand on stage. Yeah. Good. Well, I we are almost at the end of the show. We've had 430 people watching. So hopefully, that's got the word out to a few more people about this. I'm sure you're happy to answer questions about it as long as you can, in your busy clinic. We at 8pm are certainly happy to answer questions about it if we can. And we can certainly put you in touch with a very persistent salesman and a very effective salesman and a very nice guy and Steven small, who can give you a lot more of the background information possibly even than then rob can. But he's a nice guy. And he's not a pushy salesman at all. It took him probably 10 years to convince us to buy the machine and six viewers.

Robert Shanks
It was about two to two or three but ya know, it's a really nice chat,

Steven Bruce
Well, thank you for coming up. As I said before, it's been a pleasure, as always, and I'm looking forward to the next time we get you in here for whatever it