Intervertebral Differential Dynamics – Evidence and Outcomes - Ref254

with Robert Shanks

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TRANSCRIPT

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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 as 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.

Robert Shanks
Thank you, Steven.

Steven Bruce
Now, the plan for this evening is that we hear about what the machine does and who's 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 Ana 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 business, intervertebral differential dynamics doesn't mean anything to anybody.

Robert Shanks
Yeah, no, you're right. And 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 IDD, but you're right. I mean, I personally prefer the term spinal decompression as well, I feel like it gives a slightly better say what it is on the tin. But yeah, essentially, that's right.

Steven Bruce
I think Steven Small, the chap who does a lot of the UK marketing 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'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 it with surgical decompression.

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

Steven Bruce
What makes it the gold standard though?

Robert Shanks
With IDD, we'll see a bit more later, but there's a particular part of the treatment we call oscillation decompression. So roughly speaking, we're going between cycles of high tension and low tension, but when they're on the high tension, so 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 you want the machine to do, but that's the patented part that only this machine does.

Steven Bruce
Are there other machines which target specific levels of the spine?

Robert Shanks
So, not to the extent that IDD therapy will do to, as far as I'm aware, so 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 as we like to call it.

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

Robert Shanks
Well, it is traction with bells and whistles on, so there are traction forces involved, the traction you're talking about on the NHS that would have been around 20, 30 or more years ago, was a linear type of traction, where usually it's just a single angle of very limited variation in the angle, and again, it's normally static as well. So it's a case of putting the person on for 20 minutes, half an hour at a set pressure and leaving them there. With this, 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 two of these machines.

Robert Shanks
We have.

Steven Bruce
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 no, what got me into IDD therapy originally, and this is kind of back in 2011. So I graduated in 2000s. And after a few years, I was kind of struggling with some of my disc 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 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 traction, was using that for a few years. And as you said, Steven Small knocked on my door and said, well, how about this IDD therapy, and I told him to go away, I said I'm not interested. I'm quite happy with my traction. Thanks very much. And I carried on for a couple of years ignoring it. And then it kept my ear to the ground. And I was hearing little stories about well, there's a machine up in Edenborough, there's a machine down in Brighton, and I was hearing anecdotally some positive stories coming from it. So I went down to the Brighton clinic to see Morrison's and to try the machine out for myself.

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

Robert Shanks
So there you go.

Steven Bruce
Not that I don't trust you.

Robert Shanks
And no, that visit sold it for me because 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 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 operators of the machine. And, you know, I just didn't trust those spreadsheets. And frankly, it was only when I started hearing from you about the success you'd had with them. I thought well, maybe we will after all go 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 said selecting patients is important. And you're right. I do wonder sometimes, is it any surgeon

or other medical practitioners to say 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. Well, how do you select them for IDD?

Robert Shanks
So, okay, so, I mean, principally the target tissue and what you're looking for is disc decompression, so 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 disc you're 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 several degenerative discs in their spine, but you gotta know which one you're targeting. And usually there'll be one that's actually one, the most relevant one to target.

Steven Bruce
Interesting, getting insurance for this machine, probably you do the same thing. But two of the people who operate this machine for me are sports therapists. And I'm the only other one in my clinic who is trained to use the machine. It doesn't take long to train to use the machine. But the sports therapists 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 tend to be the insurance criteria and that's got to be kind of, they're the ones who are leading the protocol.

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

Robert Shanks
Yes, I mean, as I said before, if they're suspecting it's discogenic pain, and it's coming from the disc, and that 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 your wits about you and have your awareness about you. Having some 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 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 a face-to-face course on how to interpret MRIs. But frankly, I suspect that a lot of chiros, osteos 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. That's a fair comment. It does take time, like everything, it's something you have to keep practising. Otherwise, you will unlearn.

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 on? Or would you insist on looking at the MRI yourself?

Robert Shanks
I personally always insist on looking at 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 sorts of things that would be acceptable. But in my opinion, having the scan, understanding the scan, is a level above that. But there's scales you see, so there'll be very simple cases for example, as you say, you might have an L5 radiculopathy in clinic and the report says L5 radiculopathy. That's an easy, you know what to do. It's coming from the L5. But there's inevitably like everything, there's grey areas, and I think that's where the difficulties sometimes lie. And that's where the art, if you like, of having that MRI versus the report and looking at it yourself can make a lot of difference for some patients.

Robert Shanks
Is it worth us 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 look at it on our screen here and Justin can bring it up for the audience as well. We can share the information freely. This is one of my long suffering, literally long suffering, patients, this is my father, who is 90 years old, and he has suffered chronic back pain, it's been going on for a good 40 or 50 years probably. And he had a disc decompression at, I think, L4/5, it's hard to find out because I can't find any of his notes, L4/5 in 2003. And it is only since I've had him on the IDD machine that he has been able to get sleep without four Tramadol a night and has been able to walk the short distance to his post office and he's a fit, man. If it weren't for the pain, he'd be climbing mountains.

Robert Shanks
Yeah, as you say, you can see this is an older gentleman, you can see there's several degenerative discs here. They're all dehydrated, they're all flat discs, there's no nucleus preserved in the discs. We can see some lipping of the disc at the back here. But initially, you can think to yourself, well, okay, there's

probably been some surgery down here. If you said L4/5, we can see there's a slight retrolisthesis of the L5, so instantly thinking possibly an L5/S1 issue. I think you were telling me he had some leg symptoms as well, is that correct?

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

Steven Bruce
Which is the canal on this?

Robert Shanks
Yeah. Okay, so let's just look have a look at the screen here. So we're just gonna navigate down to that L5 then. So now axial view of the of the L5/S1 segment. Now, if we just quickly scroll between L4/5 and L5/S1 the canal is actually not terrible. It's actually looking reasonably okay.

Robert Shanks
So the canal is literally this part here. So I'm instantly suspecting possibly something in the L5/S1 foramen, because of that retrolisthesis. 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 sagittal view here where we'll see the SPs, the spinal 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 foramen is on the L5.

Steven Bruce
Can you just with a big stubby finger point where the exit foramen is?

Robert Shanks
Yeah, so we're looking at this area here.

Robert Shanks
Okay. And we're looking and thinking how much daylight have we got there? Now again, because it's an older gentleman it's inevitably going to be a ittle bit stenosed compared with a younger person, but we then compare that with the other side. And we can get the impression that this is tighter here on this side. So this exit, there's not a lot of daylight there for that exiting that L5 nerve root. 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 disc segment, opening up that foramen, and trying to decompress this segment here and potentially even helping a little bit that retrolisthesis.

Steven Bruce
Yeah.

Steven Bruce
Yeah, okay. Spondylolisthesis is that ever a contraindication?

Robert Shanks
It's only a contraindication if it's more than a grade 2 or grade 2 and above. And if there's isthmic spondylolisthesis, so if there's a pars defect 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 osmotically rehydrate some?

Robert Shanks
We're not going to turn these discs into brand spanking new discs. There is there is limited anecdotal evidence to say there is partial rehydration, clinicians have sometimes seen that. But it is anecdotal and as I said, I doubt you're gonna get a brand-new nucleus back, suddenly forming after decompression. But it's more to do with taking the pressure off and taking the pressure off the neurological structures, taking the pressure off the pain sensor structures if it's the case of the disc that's...

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

Robert Shanks
It is yeah, I mean, absolutely you are literally mobilising the segment, you're distracting the segments, you're creating distraction at the targeted disc that you want. And I think the studies they've done, the cadaver studies, show that you get a five to seven millimetre opening of that disc element 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 disc as well.

Steven Bruce
Interesting study a cadaveric study, because you can't always rely on those to reflect what happens in a human being, can you? In a live 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 at least they have seen that you can target the different segments and you can open up, presumably the same thing would happen in live patients.

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

Robert Shanks
Yeah, as I said, for me it's been revolutionary. I mean, it's really helped umpteen of our patients. I've got an interesting 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 radicular pain at the time at all, just

low back. But his onset was very much where he'd been working in an environment flexed, moving, lifting, heavy cables, and twisting and the onset sounded quite discogenic to me.

Robert Shanks
And he eventually had the MRI and I said, I suspect we're going to see a nasty annular tear. And we did and it was quite a sizable annular tear that we saw at the L4/5.

Steven Bruce
So real nasty, repetitive strain in an unusual place, yeah.

Steven Bruce
How do they show up on here?

Robert Shanks
So an annular tear would show as what's called a HIZ zone or high intensity zone. It'd be like a big sort of white line usually at the back of the disc, almost looks like a little worm at the back of the disc, like a white line. There's not really too much, I mean, it looks something like, see we've got this little white line here? But usually they're vertical, okay. And usually towards the back of the disk.

Steven Bruce
This is a T2 scan, isn't it? So water is highlighted.

Robert Shanks
Water is bright, fat is bright as well. So the subcutaneous fat is bright, but also the water is bright. So usually what you're seeing there is separation of the annular fibres, and there's some swelling, some water in between. But that's usually an indication of that you've got an annular tear. You also would see it usually on the axial view as well. And you'd be able to correlate, you'd see the line coming in in this way if there was an annular tear. But again, this is a controversial subject, some even surgeons and some authorities will say, well, they're non symptomatic. Others will say they are symptomatic. There's this debate. But this particular chap I'm talking about, I mean, he went through every single treatment you can imagine over the last three years, he's had the chiropractic, osteopathy, physiotherapy. He's had 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 segment with L4/5. 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. They're the sort of cases we would often put on, on the machines. They usually have to be having symptoms for, I normally like my patients, not like my patients, but I won't usually use IDD unless they've been suffering for at least, you know, usually a few months, because a lot of disc problems will, as you would 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 doing that. That's when it starts to become a serious contention to use the IDD.

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

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

Steven Bruce
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, stick them on the IDD machine and try and get rid of their low back pain?

Robert Shanks
I think that's the danger. And that's the thing. And that's where, I mean, there was one famous study that was done that basically it was just patients with back pain, and it excluded them if they had any sort of disc pathology, which is kind of an inevitability that was going to turn out to be poor results, because that's the thing they're targeting. But you're right, that's the danger. If you're just sticking people on the machine willy-nilly, without really any due process and thought and knowing what you're doing and knowing what segment you're targeting 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
Let's turn to 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.

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 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 where the problem is coming from, this particular disc, I would show them the MRI, that also helps to get the patients understanding. And then you explain to them, 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 not a cheaper treatment though, is it? Not least because it's not an instant fix.

Robert Shanks
Yes, 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 lies, this is the bridge, as I said before, between when manual therapy is not working, and potentially injections and that's not worked, and then it's the next step before surgery. So that's the gap that this is trying to bridge. So to put it into context, yes, it is expensive, but a private epidural surgery is even more expensive.

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

Robert Shanks
Correct. Yeah. No, they are kept busy.

Steven Bruce
And you won't be the only ones in London either.

Robert Shanks
No, no, that's right. IDD when I started off in 2011, I think I was the third in the UK. There's now now around about 50 clinics nationwide that are doing it and there's more that are being added on as time goes on, each month, it seems. So it's growing, yeah, certainly.

Steven Bruce
I'm guessing this person knows you. The machine, I think, has called them Ego. I imagine that's not their actual name. But whoever it is says, Hello, Mr. Shanks, would this IDD treatment be appropriate for a patient with a horizontal disc tear? Is there a chance that the traction might cause a muscle or ligament spasm?

Robert Shanks
So horizontal disc tears. As you say, it's more designed- Well, in my experience, we tend to use them more on the, as you say, the kind of circumferential disc tears, whereas you stretch, if you like, it's kind of then almost concertina-ing the disc. You're right, if you have a horizontal disc tear, there is a concern that as you open up, you could be opening up the tear.

Robert Shanks
They're pretty rare, yeah, I was just gonna say. Much more common to have those circumferential disc tears that you see going from north to south rather than east to west. So they tend to be the ones that we would use it on. However, the annular tears are, you do have to be careful, and you have to be careful with the pressures. And this particular chap that I mentioned earlier, he's very, very sensitive to anything you do with him. And with him we have to use lighter pressures, lower oscillations. So again, they're a slightly separate subcategory, if you like, of 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. I would probably try with them some core stabilisation techniques, all that sort of stuff, but it does have a place in those difficult cases.

Steven Bruce
They're pretty rare though, aren't they? I presume, I guess I know actually, IDD is not something you do in isolation, is it? There is still the rehab process to go along with it, once they've stabilised or mobilised enough to be able to cope with the rehab.

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

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

Robert Shanks
Well, Stephen Small's the man 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, they are 50,000 pounds. There's every chance they've gone up quite a lot this year, given that everything's gone up a lot this year. Of course, Stephen will put on a spreadsheet for everyone, with 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 putting this money into something and you, I imagine, 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, you're absolutely right, it does have to be carefully thought about, it is a lot of money.

Steven Bruce
And a lot of what you said will frighten people off as well. Because you've talked about being able to work out what the highest traction level is, what the amount of oscillation is, and all that sort of stuff, and all these things and 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 all 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's a very highly supportive WhatsApp group. I'm very active in that group as well. And 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 patient.

Robert Shanks
That's true. But yeah, there is that support network there too.

Steven Bruce
Yeah, and I can vouch for them. On the one hand, it's a very, very useful group, on the other it's annoying because it goes bing every five seconds, when someone puts in some more information. Remind me the name of the American chiropractor who is very, very active in there.

Robert Shanks
Oh, Dr. Jeff.

Steven Bruce
Dr. Jeff, yes. A fount of knowledge, isn't he?

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

Steven Bruce
He's obviously getting good results with them. Gominda says, this is a very easy question to answer, Gominda says, would you know if the funding for these is available through the NHS?

Robert Shanks
It's not available on from the NHS, no.

Steven Bruce
I'll tell you what This is one of the dreadful things about this, if enough of us get IDD machines and we show the benefits of these, then the NHS will start buying them and everyone will go through the NHS instead of us.

Robert Shanks
I mean, it's a theoretical thing.

Steven Bruce
Given the amount of money they have to spare at the moment, it's not gunna happen for a long time.

Robert Shanks
I was gonna say, it's probably not going to happen for a long time.

Steven Bruce
No, but if we can show, what I'm finding is that we are getting even in the infancy of my IDD therapy at my clinic, we are getting orthopaedic consultants who are saying, go and get IDD therapy 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 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.

Robert Shanks
Yes, that's true.

Steven Bruce
So Gominda, I'm afraid there's no good news for you there, the NHS is not going to buy it for you. Claire says that lots of people are asking if we're going to have a demo. Yes, 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, Claire, get round to the demo. And can I reassure people that we'll come on to that later in the show. Hopefully, I've done that now. But thank you for letting me know, Claire, because I do have a tendency to waffle on. Derren says is the decompression only short term... Yeah, this is a key element of it, isn't it: Is the decompression only short term, as surely with weightbearing it's going to return to its compressed state, so very regular treatments would be needed.

Robert Shanks
Yes. So as we said at the start, it is a course of sessions the patients will need, usually over six to eight weeks. They normally need to be coming in two to four times a week. But you do see progressive improvements week to week. And I would say the success rates depend, well, in terms of anecdotal data that the clinics supply and also that what's 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 how IDD therapy's working, it isn't just the pure kind of okay, let's decompress the disc. It's actually, if you think about how discs function and how they get their nutrition, it's the invulvation of fluid and expulsion of fluid during the day. And essentially what you're doing is you're speeding up that process. So you're changing the fluid dynamics on the disc. Think of the disc as a sponge, and a degenerative disc has a lower rate of diurnal change in pressure, with this you're starting to reverse that.

Steven Bruce
I always, I could be wrong in this, I've always made the assumption or the assessment that also all those soft tissues around that affected segment will over the years have got shorter and tighter. And of course, we know that a session of stretching in the clinic or a 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. I know Eyal Lederman would bear me out on the fact that you need to do this a lot and very, very frequently if you want to get long-term change.

Robert Shanks
So are you talking about ligament and muscle stuff? Yeah, okay, so soft tissue mobilisation, this is where I slightly disagree with with the general consensus. Yes, you're right, we do talk about soft tissue mobilisation, as well as the disc, but for me, it doesn't quite make a huge amount of sense. Because let's think about, for example, think about a posterior longitudinal ligament, think about an interspinous ligament, what's the best way of stretching that? Well, probably flexion, knee hugs. The amount of stretch you're gonna get with actually opening up a segment five to seven millimetres is probably less than actually if you flex the segment. So for me, it doesn't quite add up. For me, what really is happening and the big difference that the IDD therapy is making and the forces you're using, which you can't use with

other methods, is that central axial distraction, and that for me is the key. And it's the effect it's having on the disc.

Steven Bruce
We'll run through a couple more questions, and then we'll get on to demonstrating just how we would go about doing this. Bionic Dan says, is this machine similar to the orgasmatron machine which was in the Barbarella movie in 1968? Well, 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 IDD?

Robert Shanks
Short answer no. Because, let's just give you a brief example. So let's say you have a patient who has, let's use the example we had before, an L5 radiculopathy. Just based on the fact that an L5 radiculopathy, you don't know whether that disc protrusion or that radiculopathy is coming from a lateral recessed protrusion at L4/5 or a foraminal protrusion L5/S1. And the setup for machine for those two segments is very different, in terms of angles. So you've got to know what disc you're targeting, not just what nerve's being compressed.

Steven Bruce
And in fact, when you did your course here, you've spent a lot of time saying well, hang on, is this the descending nerve root, is this the emerging nerve root, and it suddenly clicks.

Robert Shanks
Yeah, and also, you've got to know about the contraindications. So that patient may have, for example, a radiculopathy, but they also may have a pars defect, in which case, then you can't put them on the machine. They also, for example, one of the contraindications is osteoporosis, if they've got a crush fracture, you've got to tick all of 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 obtain.

Robert Shanks
We certainly get them but if you suspect a patient of having any sort of issue with bone density, then you need to get them to have a DEXA scan. So again, you have to have the case history, is there 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 nasty disc problems? Why not do it earlier? Why not use it earlier for mechanical pain? You said you were waiting several months before starting.

Robert Shanks
Well, the reason why I would tend to wait a few weeks is because if you have a patient who's had a recent disc prolapse, for example. A lot of those would tend to resolve on their own spontaneously within a few

weeks, within four to six weeks. Case in point, the chap I mentioned earlier, the chap with 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, you keep asking me about leg pain. I've never had leg pain and now I've suddenly got loads of leg pain. I said right? What did you do? I bent over. I said right, you have prolapsed a disc, that's what's happened. He said do I need to come in? I said, Look, just sit tight for a few weeks, it will probably resolve. And within four weeks his leg symptoms did resolve. And we then ultimately did bring him back in to start the IDD, but that was for his discogenic back pain. So that illustrates the point that a lot of these things, these acute discs, will resolve. Certainly, if they're wet protrusions anyway. But if they're not resolving, I would then certainly offer them IDD.

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

Robert Shanks
Osteopenic is okay but you need to have a T score. You need to actually have, if you do have an osteopenic patient or anybody who you suspect of poor bone density, the DEXA scan is important because bone is weaker in distraction than it is in compression, the trabeculae, so what you don't want to be doing is causing obviously a fracture in those bones.

Steven Bruce
We actually had fantastic orthopaedic consultant, a spinal consultant on the show, we've had him on several times, a chap called Nick Birch, and he talked a lot about scanning for osteoporosis. And I'd say to you watching, if you want the detail about scanning for osteoporosis, do dig up that recording from the website because, I can't remember the title of the show, but it was Nick Birch and it was about osteoporosis. And 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. There's some lots and lots of questions coming in. But we need to get over and do some stuff with our patient, don't we, so should we go over and meeet Haley? Haley, good evening.

Haley
Hi, Steven.

Steven Bruce
I'm gonna leave you with Rob. He's going to talk people through what's happening with you at the moment and what he's going to do with you next.

Robert Shanks
Haley's been on the heat belt, we're gonna take that heat belt off. So that's just a little thing we do to help get a little heat into the back.

Steven Bruce
So that's 10 minutes, we put them on for 10 minutes on the infrared belt.

Robert Shanks
That's the same as us. Okay, so Haley's gonna just come stand in front of me here, we're just gonna find the ASIS and then we're gonna pop this in the front, Haley's gonna hold that for me, and then if you turn around for me, Haley.

Steven Bruce
And the thinking behind this, of course, is that you've got to have something to hold the lower half of the body stable while you separate it from the upper half.

Robert Shanks
This is the part that is being pulled, if you like, and this is the harness that goes around there to facilitate that.

Steven Bruce
I know that when we got our training on it, Steve made a big thing about making sure that the ring there, which is going to connect to the machine, is level with the knees and bang in the centre.

Robert Shanks
That's right, the O ring, we want that absolutely dead centre.

Steven Bruce
If it's off centre, what's it going to do? It's going to apply traction to the wrong side, or...? And there are different sizes of these to suit different patients, aren't there?

Robert Shanks
Yeah, exactly. It forces don't go dead centre, we want them as central as possible and as evenly distributed as possible. Just have a quick look on the front again there, Haley. Okay,just gunna double check she's in the middle of the harness. Ok, that looks fine. We can put the thoracic harness on now.

Steven Bruce
Yeah, there is. That's 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 IDD machine. Now I'm gonna stand this side, because we're in a bit of a tight space here. So Rob, I'll let you go close to the machine.

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

Steven Bruce
Now, what's this little bladder doing?

Robert Shanks
Okay, so this bladder is called the sacral bladder. So once Haley goes into a flat position, I'll be pumping...

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

Robert Shanks
We're just going to tip the machine back now, So Haley, just relax and you'll be nice and flat in a second. But yeah, the bladder, 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 pulling through into the lumbar spine.

Steven Bruce
We should point out as well this thing does do necks, doesn't it?

Robert Shanks
It does, yeah, that's right. Yep, there's a different setup for the neck, there's an extension that comes up and there's a plate you put on here and then there's a harness that would connect into here. Right, Haley, if you could just move up the bed for us a little bit. That's brilliant, oh not that much, come back down. That's it. Okay.

Steven Bruce
So what we're doing now is aligning the pelvis with the split in the upper and lower half of the bench.

Robert Shanks
Yeah, I'm just getting her iliac crest just level with the lower half of the bench. Perfect. And now we're going to connect the thoracic harness and give you a little cushion for your head, Haley, as well. Basically this now straps into the top of the bed, and there's a little buckle where we thread this through. And it basically 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.

Robert Shanks
So that's nice and tight. And then if you just bend your knees for me, Haley. That's great stuff.

Steven Bruce
I lied. The audience can see it, that's good.

Robert Shanks
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 O ring down here. We're going to hook this up to to the cable to the machine. And then we also have some ankle bolsters. We're going to pop those underneath there.

Steven Bruce
Those are primarily for patient comfort, I take it?

Robert Shanks
Absolutely yeah. I have a few patients that don't like to have the ankle bolsters, but the majority of them prefer them there. But it's completely optional. You don't have to have the ankle bolsters. Right, Haley's gonna bring her arms up above her like that. Actually just gonna move this down tiny bit. And we're just going to do our final 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. Is that okay?

Haley
Yeah.

Robert Shanks
Perfect. Okay, so if you put your arms up there. And what we're now going to do is get the thoracic harness just going along the angles of the ribs. Just have little feel where the ribs, and I'm roughly gonna follow the angle of the ribs there. Okay, so if you can take a deep breath for me, Haley, and then out, please. Okay, so we'll lay that down there. And that needs to be again, reasonably tight. I can just about get my finger in. And that will then keep her thoracic area nice and still. And then we can do the bladder as well.

Steven Bruce
When I've done that, I'm brutally tightening that thing up. But actually, it's relatively comfortable for the patient. Ist that okay for you, Haley? You're not choking, strangling?

Robert Shanks
And then the last little thing we're going to put in before we can start the machine, just put these arm bolsters in as well.

Steven Bruce
Could you try and do that with your back up to this end. Just so we can see what you're up to.

Robert Shanks
So that's going to slot into there. And then Haley's gonna bring her arm down there.

Steven Bruce
Now, I 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 the footplate.

Robert Shanks
Yeah. So obviously, the higher the pressure then the more they become important. And then if you want to just move your arms on there, if that's better for you, Haley. That's it. So what I would then do is just have a final check to make sure that she's nice and in the middle, the harnesses are nicely in the middle, and everything's looking symmetrical. We would then want to set the angle here to the relevant disc.

Steven Bruce
Come round this side. I know it's awkward and we wouldn't do it this way. And we've got one of these things as well. So you've set the angles...

Robert Shanks
So we've set the angle accordingly to what disc we wanted to target. So as I say, if it was an L5/S1, we'd be going for a 10 degree angle, L4/5 15 degree and so on.

Steven Bruce
I think we've got to come clean with the audience at this point. 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 traction is invisible, effectively. There's a little bit of movement when one releases the bottom half of the table part of the way through.

Robert Shanks
But yeah, that's basically it. She would be ready now, if you wanted to, to start machine.

Steven Bruce
So we turn the machine on, we set the angle, the block in the middle of the machine here rises to what it thinks is the angle, but we check it with the spirit level to make sure that it's right.

Robert Shanks
That's right, fine tune it.

Steven Bruce
Fine tune it. On the machine, we tell it how heavy we want it to be, the heaviest pull we want.

Robert Shanks
So there's several parameters on the machine. We tell it, as you say, the high tension. We set the oscillation as well. So let's keep the numbers simple, 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, for that minute that it's on the high tension, it was going either between 95 and 100 or 90 and 100, whatever we wanted to set it at. 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.

Steven Bruce
And it goes through 13 of those cycles. So we end up with should be about 26 minutes.

Robert Shanks
26 minutes.

Steven Bruce
It's about 26 minutes in total, isn't it? As I understand it, 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 the standard protocol. Obviously, there's certain circumstances where you may go a little bit lighter than that. Some of the examples I've mentioned before, the annular tears. We found from pooling results and talking to each other in the UK, modic type 1 change, we tend to go a bit lighter, and we'll take about 30 pounds off. But yeah, roughly, the average is 20 pounds under 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 their weight plus 20 pounds.

Steven Bruce
Oops. No, that's about where I am with my father. I can afford to be brutal with my father. He's an ex-Royal Marine, he can take it.

Robert Shanks
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 and what we do with that one.

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

Steven Bruce
Because it is affected by friction up to that point, isn't it?

Robert Shanks
Yeah. The first two cycles tend to be a bit of a warmup, tend to take the slack out of the harness and just get it bedded down in preparation for the release of the bed.

Steven Bruce
But I 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, and just see how they respond.

Robert Shanks
So in the example I gave earlier, the chap with the annular tear, I've not released the bed in four sessions, because I know how sensitive... when you release the bed, there's about a 26% increase in pulling force compared with not releasing it. So you have to decide whether you're happy to do that or not. There's a bit of a swing recently, within the IDD 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. And there sometimes the patients who are highly... again this is why I've made the decision recently with this annular tear chap not to release the bed, because I've seen in the past where you have a patient who's highly sensitised, if you release the bed too early, there's a risk they can go into spasm, and they come off the bed extra sore. So, I've learned from experience how to navigate those waters.

Steven Bruce
Of course, there is a safeguard for the patient, isn't there? Because 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. The annoying thing is that you can't then restart the protocol, you have to start from scratch. And it doesn't stop it, suddenly, it just gradually releases the pressure. So there's no 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 and alarm us. Because quite frankly, it's very boring as a practitioner to sit in here for 26 minutes while your patient is being gently stretched. There is an argument that the patient going to sleep, which so many of them do, is actually beneficial. Presumably there a little bit more relaxed.

Robert Shanks
Actually, the vast majority of... And the goal is that the patient should be having the treatment and it should be very relaxing, as you say, to the point that they could go to sleep should they wish. And the vast majority of patients experience that.

Steven Bruce
Haley wouldn't do this, but I've had patients who snore their heads off while they're on the machine. 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 they can feel the pulling force, but they often say I'm not feeling a huge amount of pulling, and then you have to gently explain to them, wait until you come off the bed. And then you'll realise that you have had a big pull, because when they come off of it, then they start to feel oh, yeah, my back has changed quite a bit, I can feel the change in the tissues.

Steven Bruce
Apparently, my father, and my father is a lovely guy, but don't get him started on some topics. He's a lovely guy but he kept saying to me, look, I can feel it pulling here, but how is that affecting my back? I'm trying to explain to him, it's pulling at both ends, somewhere in the middle, something has to give. But, 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 had 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, we get him on once a week now, which obviouly I can do that with my father, which perhaps other patients might say they can't afford to do that. But yeah, 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, with no guarantee that that's going to have any beneficial effects. So you're comfortable there, I hope, Haley. We're not gonna be able to demonstrate this partly because in order to do so we would have to tilt the table up, but how does it get rigged for neck traction? We're obviously not gonna turn it around.

Robert Shanks
Okay, so for a neck traction, what I would do, I don't know if the cameras can see, there's a little plate here, this would slide out. And then what we would be doing is sliding this cervical harness into there instead. So this part 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 come out at the top here. And there's actually, you might not see off camera, but there's what's called a cervical boom, 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, depending on what we want to do, the relevant disc in the neck. So this would be the higher the angle, the lower in the spine it's going to go.

Steven Bruce
It's interesting with that though, do you ever measure the angle with the spirit level, the inclinometer, when you do that?

Robert Shanks
For the cervical? Yes, I do. Yeah, I would always measure here.

Steven Bruce
Because I remember Stephen saying, make sure that the cable's in a straight line when you do this.

Robert Shanks
That's right. So the cable that comes up has to be in line with the angle here so that you get an unrestricted pull. But absolutely, yeah, you want to make sure that the angle at you think you've got, you have got.

Steven Bruce
And these things here just grip around the mastoid process, don't they?

Robert Shanks
Yes, the patient's head would be here, this would be around the mastoid process.

Steven Bruce
Relatively comfortable?

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

Steven Bruce
That's a handy tip because I have had patients complain that they're uncomfortable.

Robert Shanks
Yeah, they are quite hard.

Steven Bruce
Because you're still doing 26 minutes of this thing, aren't you.

Robert Shanks
Yeah. And it does dig into the mastoids a bit, but that's why I will sometimes even put some towels on here, if I can, but we tend to use the sweatbands.

Steven Bruce
And people are now immediately thinking, Well, if you do that the gaps narrower, so we're going to start strangling them. But, of course, you adjust the straps with these little...

Robert Shanks
Absolutely these stirrups can widen or narrow.

Steven Bruce
We're not gonna strangle our patients. 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?

Robert Shanks
Yeah, certainly. Okay, so if we imagine we've stopped the treatment, it's kind of just everything in reverse order, really. But I would disconnect the cable.

Steven Bruce
I'm gonna stop you just there, 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 quite close

to the groin and you need to make sure that patients, particularly female patients, know that you've got to rummage around in there sometimes to get it to open.

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

Steven Bruce
It's definitely not a machine for wearing a skirt, is it, or a kilt, if you're a bloke.

Robert Shanks
Definitely not a kilt time, no. So in reverse order, what I would do though, before I did that...

Steven Bruce
Can I get you to come around here and try to do that from that angle as well?

Robert Shanks
Just going to disconnect the the O ring first. That's one little tip I always to get people to do. So if we disconnect those clips, then when we stand Haley up, it's not a trip hazard, basically. So we do that.

Steven Bruce
Also I always forget to undo it when they're standing.

Robert Shanks
So and then we're going to take the ankle bolsters off. And again, one other little tip would be when we're going to get Haley to move her leg, or legs, I would always try and assist the patient because often, if it's a radicular patient, if you just lift the leg too quick, or they lift the leg, that can be quite quite sore for them, so I'd always assist the patient. Say right let's lift together, brace your spine, great, bring the other one up, if you can, there we go. And I would then take the knee bolster out. And then we can do same same sort of thing reversed, legs come down. Good. And then we're gunna 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 cause like a reactive spasm. So we did it really slow, we brace it, we come up nice and slow. Just keep a little bit of tension with this other hand, I'm holding that there, and then I'm going to release. And that's usually the comfortable way of doing it. I would then just take a little bit of pressure off the pelvic harness, not completely disconnecting it just yet, just to release a bit of pressure, and then we're ready to stand Haley up. So I might just take that away from there, Haley. Thank you.

Steven Bruce
We need to take the arm bolsters out as well, don't we? Go to the bottom switch on this particular one, P1. Otherwise, it'll dig in somewhere.

Robert Shanks
Well, I actually tend to keep them in until the patient's upright. Again, it's not wrong to take them out. But with Haley, I would take them out, you're right, because her feet aren't on the plate. But if at all possible, I like to try and keep them in simply because as the patient comes up, it gives them another little bit support as they come off the bed, but you're right in Haley's case we are going to take those off. Okay, so then we've got a couple choices, we can either ask you to slide down the bed, Haley, or if you're happy to, as the bed comes up, you'll inevitably to start to slide down and the feet will then hit the plate. Happy to do that? You ready, Haley? Start sliding. So we're going to come up, I'm going to pause it halfway, so roughly there. What tends to happen is, when the patient's been tractioned for 26 minutes, when they get past the halfway point the legs can seem quite heavy. So I'm just gonna warn you, so that you're ready for the weight to come back onto your legs. Okay. And then the machine comes to a nice stop there. And I go, Haley, are you ready to come off? I'd always just assist the patient coming off. And that's it. And they can sometimes feel a little bit stiff coming off. Obviously we didn't have the traction force on with Haley, but had you had that on, the patient can sometimes feel a bit stuck to the bed sometimes. The core muscles don't quite know what to do. Imagine you've just been stretching your hamstring for 20 minutes, your leg could be a bit stiff, but same sort of thing can happen for the back.

Steven Bruce
Are they going to get that sort of stiffness anyway after treatment, perhaps later in the day?

Robert Shanks
So possibly they can feel a little bit stiff for a day or two. What we say actually is we like the patients to feel we've had an effect, but we don't want to increase their pain. But if we have a reaction in the back where it's a little bit stiff, possibly a little bit sore, not excruciatingly so, that's actually normal and almost desirable. It will almost inevitably come down within 24 to 48 hours, but we try to aim for some effect. But the key component though, after having done this, is we would put them on an ice pack. So we'd have Haley sit down with an ice pack on her back for five or ten minutes. And talking to Dr. Jeff, as you mentioned earlier, he's found that that particular component is a very is a key component of the protocol. Yeah, he's found that the results he gets when he does the ice versus non-ice is far superior. So if you can just come stand here, Haley. So now we've released the O ring, what I'm gonna do, it's really easy to take the belt off, we just unclip one side and then we can just take that away.

Steven Bruce
We hang these up nice and tidy for normal treatments in here. But for now, for speed, we'll just do that. Haley, I'm sorry, you didn't get the full traction effect on there, but I explained the reasons for that. And thank you for doing that. Of course, we would now lower the bed and have it ready for the next patient. And I think we'd better go back and start taking questions again. Thank you again.

Robert Shanks
Thanks, Haley.

Steven Bruce
Right, so it looks simple, but of course you have explained all the little niceties of treatment that mean it requires some experience and certainly some anatomical knowledge, isn't there? 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. 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. How much more would this machine do for him? We've replied that it will give him or her orgasms make tea and hand out popcorn, ice cream and revels. 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. Well, there's several differences. Firstly, it's how long can you stay upside down for? I challenge anybody to be happy hanging 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 discs. There's no oscillation traction either.

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

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

Steven Bruce
So I hope that satisfies Mischief Maker. Someone in the chat calling himself or herself Green Grass Makes Sheep Healthy is helping to answer some of the questions. So we don't know who you are, Green Grass 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, cutting to the chase, that's fine. I mean, we charge 80 pounds per session in our clinics. 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 at least have to be prepared for a 1,600 pound course of treatment. And possibly longer than that. 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 probably six treatments means that they are committed. So there is less of an issue with the money because they know what they're in for when they arrive.

Robert Shanks
Absolutely. 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 within six sessions, most patients are only going

to be minutely better. The real turning point we look for is around session 12. We expect them to be 20 to 40% improved after session 12. If they hit that milestone, then we're usually confident that they're 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 tension pattern on the machine. And I wonder if Justin can put that up so the audience can see it, maybe so that we can see it as well. It will illustrate the high tension, the oscillation, low tensions and so on.

Robert Shanks
Yeah, that would be useful. 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 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 to look for is that towards the end of the session, the lines are converging 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 pressures you're using throughout the treatment.

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

Robert Shanks
Great question. They used to and the tendency is that they're increasingly not doing now. They even used to have their own separate code for it. But I think they're becoming increasingly more difficult to get that funding through. So I would say don't rely on the insurance companies.

Steven Bruce
It is bizarre, really, isn't it? Because the evidence, I know the clinical evidence from your own practice is that, as you said, between 80 to 90% of people are going to benefit from this. 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. And their alternative is the knife.

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

Steven Bruce
With no great guarantee of success for those either. Certainly in the long term.

Robert Shanks
You're right. If I was an insurance company, I would be paying for it, but there you go.

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

Robert Shanks
So again, spinal stenosis depends on the severity of the spinal stenosis. So severe spinal stenosis where the canal is pretty, completely occluded, there's hardly any cerebrospinal fluid in that canal, I would, poor prognosis and I probably wouldn't even put a patient on who's at that stage of the game. But mild to moderate cases, I would be happy to try it. and often the patients will get better. I would say the success rate with spinal stenosis isn't quite as good as with the classic radiculopathy, kind of lateral recess, 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 just saw a question, here we are: Bone setter 66, this person is called, says, How does adjusting the angle of traction specifically target a given level? Has this been shown in the real world?

Robert Shanks
Yes, it has.

Steven Bruce
It's vectors, isn't it?

Robert Shanks
It's vectors, yeah. So basically, what you're looking at is, if you're going up, the higher the angle on the y axis, the further along the x axis, the angle of pulling. And that's just physics. And it's actually one of the questions that I did ask myself at the beginning and I actually got my brother-in-law, who's got an engineering degree from Cambridge, I did get him to check 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 cadaveric studies they've shown how it is affecting the gap between specific spinal segments.

Robert Shanks
That's right, they did. And come back to what I told you at the beginning, when I went down to see Steve Morris in Brighton. Actually, what convinced me to get the machine myself, I'll be honest, was the fact that I said to the guys, right, target my L5. They did that for 10 minutes. I said, right now target my L1/2 and let me see if I can feel it. And 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 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 haven't 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 will 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 can understand people worry about that. All the clinics that I'm aware of, including ours, if that was to happen, we would always encourage that patient to go back to that clinic afterwards.

Steven Bruce
And a great way to do that really is to say, Okay, we'll do the IDD, but you've got to go back to your sports therapist, physiotherapist, whoever, because you still need rehab at the end of it, you still need to strengthen.

Robert Shanks
It's a key component, absolutely. We now encourage patients to have at least a few sessions of manual therapy alongside the IDD 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 IDD.

Steven Bruce
Victoria has 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. If you set it with the wrong pressure at the wrong segment. Let's say for example, this is the beauty of why sometimes you want to target one segment and leave another segment completely alone, because, let's say you've got hypermobility, let's say you've got a disc protrusion at L5, but you've got an unstable, dynamic spondylolisthesis at L3/4. You want to avoid pressure going through L3/4, we don't want to make that L3/4 even more unstable by putting even more ligament stretches and vectors through that. You want to target the L5. So yes, in that scenario, if you did target the wrong angle, you could potentially make the patient worse. But that comes down to your clinical judgement and working out what you're doing and what angles you're using and all those things.

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

Robert Shanks
So rough rule of thumb is the goals we're looking for usually are session 12, or there abouts, 12 to 15, you want to be seeing, at least 20 to 40% improvement, I would say. And if you get that you usually would

then expect to then get the full improvement within the set protocol. So again, the criteria, there's been a recent advice come in from America that there's kind of three categories, if you like, that we aim at. So a simple category one would be like a broad based disc protrusion, approximately 24 sessions. If it's a focal single level disc protrusion with a nerve root entrapment, 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, so you might have facet joint hypertrophy, might have disc degeneration, we're looking towards the 40 session 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, two, three category, our results have skyrocketed. We're getting 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 it, we were told 20 sessions is the rule of thumb. And certainly there are people who benefit before they reach 20 sessions.

Robert Shanks
Yes. That's what we explain to patients in the beginning, this is what you need to expect, they need to be prepared for that. Now inevitably, some people will do, it's like a bell curve, some people do better than you predict, but that's the majority under the bell curve. Some people have a better result than you expect and potentially you can then actually stop them before that.

Steven Bruce
One thing, I find slightly mystifying about the machine and I know yours are a slightly different model to mine, but I 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, it asks me for their pain level. And I just think it's totally irrelevant, I'm interested in what happens between this 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, is the patient coming off the bed, with less pain than they came off in the previous session. And it just does sometimes give you a little bit of an idea. Again, giving you an example, the chap I mentioned earlier with the annular tear, interestingly, the session that preceded his really good week, he came off the bed feeling quite stiff, feeling quite store. So 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 data collection really, that then might have an influence in my decision on the future sessions and what pressure to use with this particular chap. But I agree really it's kind of a little bit surplus requirement sometimes.

Steven Bruce
Well you have to do it on the machine, don't you, whatever you put in you have to input something or it doesn't let you do it. Mayory's come up with what I call an old chestnut really, does the patient have to have their MRI scan standing? Because so often...

Robert Shanks
Okay, so the differences between an MRI standing and MRI lying down are usually MRI quality. So the upright MRIs are less pixelated if you like, so the image quality is not generally as good as the supine scans. However, the statistics are approximately that you'll see pathology on an upright scan that you won't see on a supine scan 30% of the time. But also they are a lot more expensive as well we should say, usually at least double the price for the uprights. So usually what we would do is supine MRI scan will give you what you need to see 70% of the time. If you have suspicion that 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 an upright scan. We certainly have had cases where that has been the case.

Steven Bruce
I guess Mayory and a lot of other people will be thinking, well we're trying to save the patient money here, not send them off for another even more expensive MRI.

Robert Shanks
That's right. The vast majority of people we would start off with a standard supine scan.

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, in comparison to rehab or surgery in any of the other recent studies?

Robert Shanks
So there have been studies that have been written up in the literature in the journals. I'll be honest, it's not all the magnitude of The Lancet and those sort of things and stuff that would get NICE guidelines approval, but there certainly have been trials have been done. There's been mostly positive ones, there have been one or two not negative, well there has been one negative one, the one I mentioned earlier, that was a bit nonsensical because it excluded patients with this disc 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 get better.

Robert Shanks
Yeah, we could have told them that at the beginning. But yeah, there was another study that was done that, I think, again, just off top my head, it was comparing a physiotherapy rehab programme versus the IDD. And I think 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 data out there, there is evidence out there.

Steven Bruce
Okay. And I guess people shouldn't be surprised that we don't have the massive quantity of evidence that the pharmaceuticals typically will. Because someone's got to pay for it.

Robert Shanks
What I would also say though is that when, coming 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 interesting, okay, it'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 gave in previous year. So it's from my point of view, the confidence is there anyway.

Steven Bruce
Yeah. Robin has asked, I don't know 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 it is, 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 it does ask you for a VAS score and a pain score. There's also the software has an Oswestry software built into it as well, so you can input that data if you want to. And that will go through to the data collection. But principally and maybe 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 there symptoms improving?

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

Robert Shanks
Objectively, you're looking at straight leg raises, neural tension signs, if they've got myotome weakness, you're looking at improvements in that, but obviously pain, subjectively pain levels as well. Reflex changes. But it's important to review your patients obviously throughout the course.

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

Robert Shanks
Yeah, if they reduce their pain meds, certainly.

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

Robert Shanks
So Shealy, I think was the guy. So it's been around since the 1990s in America. It's an American machine, so the machines are made by a company called North American Medical. They're pretty big in the States, came to the UK about 2009, I think. But yes, American by design,

Steven Bruce
Which isn't necessarily a bad thing at all, is it? I always sense there's a little bit of scepticism in the audience, they say, oh Americans, they're all good at the marketing. Buite often they do produce some good kit.

Robert Shanks
Yeah, it is good kit. And as I said, it is arguably the gold standard in spinal decompression.

Steven Bruce
What was what Shealy's profession? Did you say?

Robert Shanks
I'm not sure.

Steven Bruce
I think he was a surgeon, wasn't he?

Robert Shanks
I think he was a medic, yeah.

Steven Bruce
Justin, do you have pre versus post treatment MRI scans? Justin asked the question, I'm not calling you Justin.

Robert Shanks
Yes, we do. We don't scan every single patient after the treatment, I'll be honest, partly that's to do with money. Patients are now feeling better, they don't want to have to pay another you know, 300 or 400 pounds just to prove they're better. But where it has been done, we don't always see, like, massive change, but we do normally see some change in the disc. Like I said before, you're not going to be expecting to take a degenerative disc back to the state of a brand-new spanking disc. But even small changes is a massive change for the patient. So, the way I explain to patients is imagine if you squeezed your finger, and you squeezed so hard that your finger turned red and was getting painful. If you then just released the pressure slightly and you took a picture, it would look very similar to when you were squeezing it. But the feeling in the finger is very different. And that's kind of the situation you often will get with a disc, 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, as far as I know, yeah.

Robert Shanks
The only thing I know of is the one where they've said that traction is not recommended for low back pain. And of course, they would probably say, well, this is just traction. But of course, it's not just traction.

Robert Shanks
That's right, it's not just traction. I think the stats that often get quoted are that the studies have shown that traditional linear traction, not IDD as you 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. I get that reasonably frequently. And the patients are very convincing,

Steven Bruce
Well, Laurie Hartman, 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. Derren 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 the loan.

Robert Shanks
Yes, I suppose. 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 I refer all the patients to the guidelines that were given as the IDD community and say, Well, this is what's the evidence and the data seems to be suggesting is better.

Steven Bruce
Which actually is one positive difference in this from any other treatment is at least there are some guidelines there. Because you could argue that as an osteopath or chiropractor, well, I'll oversell my treatments because 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. Hopefully we're too ethical and professional to do that. Megan asks, did she 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 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 S1 symptoms, no surgery was performed. 20 years on, I still have symptoms aggravated when lifting and being physically active. Would this treatment help me now?

Robert Shanks
Yes.

Steven Bruce
There you go. And if you're anywhere near my clinic, 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.

Robert Shanks
Just on that point, that for me is the ideal IDD patient, because we often will get patients in who have suffered 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 would 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 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. They're not perhaps as positive as some might like and rather as fibromyalgia patients can be quite down, quite negative, quite draining. We found that with some of our patients, as well.

Robert Shanks
I think that's fair to say, yeah.

Steven Bruce
Vlad, good evening Vlad, nice to hear from you again: I think it's difficult to understand innately what IDD does, unless you have it yourself and/or have administered to a patient and seeing the changes through the course of treatment. Vlad says he's been fortunate enough to work in a clinic where he's done both and he can say that the results are very apparent to see. There was a clinic who used 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, I know the clinic he's talking about.

Steven Bruce
Again, it's just a little bit sad, isn't it, that so much of this is very anecdotal and that doesn't sell to the wider medical professions unless we can...

Robert Shanks
Get some hard data.

Steven Bruce
I don't know if I put this the same way, but did I ask, Curren says Have you actually had a case where this has exacerbated symptoms? We asked about it not making people better.

Robert Shanks
I'm struggling to recall. 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've got kind of vaguely at the back of my head were borderline cases, were kind of moderate to severe stenosis patients, who we explained to them, you're right on the borderline of will this or won't this work. And I can recall one or two patients who we did abort the treatment because it was making their stenosic symptoms worse. But as I said, 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 that that could happen. Normally, though, we wouldn't do it in a severe case, definitely a contraindication, but you're going to get inevitably those borderline cases. Is it contraindicated, is it not? So they're few and far between. Usually, it either works, or it doesn't. So again, roughly speaking, 70% will work and 30% it won't.

Steven Bruce
Igor's asked whether there are training courses for osteopaths, chiropractors, and others to learn about this machine, learn about the treatments?

Robert Shanks
Does he mean in terms of when you buy a machine?

Steven Bruce
I'm inferring from this, that he or she wants to know when they might refer patients, what they should do. Obviously, if you buy the machine, you're going to be taught how to use it.

Robert Shanks
You get training if you buy a machine obviously. It's a good point, there's not actually, as far as I know. There's not actual kind of IDD awareness courses where you can come along.

Steven Bruce
But we've gone through a fair amount of it this evening. I don't know if you were running a course, if you had to put a course together for 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've done this evening?

Robert Shanks
Not really a lot more than we've done. I mean, other than perhaps showing before and afters, and MRIs, and case studies.

Steven Bruce
Well, of course, we've done 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, I guess the only answer is you've just got to look at lots of them.

Robert Shanks
It's like everything, you've got to practice 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 lumbars. We do use it for cervicals as well. But whether it's just the patients that are coming through to clinic, I would say they outnumber probably 3 to 1 lumbar to cervical.

Steven Bruce
And does it perform well, do you know, in contrast with the little inflatable collars or the over-the-door weighted traction devices? One would expect it to, for the same reasons.

Robert Shanks
I mean, 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 form of home based traction, as you say, and wasn't improving. And I had about four sessions on the IDD and then was fixed.

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

Robert Shanks
Yeah, I was getting radicular tingling in my hand. Had the MRI, it was showing I had a bit of a broad based disc bulge and it definitely helped within four sessions, yeah.

Steven Bruce
Did you carry on? O was that four sessions, done and dusted.

Robert Shanks
I should have carried on. Like all of us, I probably didn't do as much as I should have done. And I will try and remember to do some top ups but, definitely it was a very interesting contrast. I could feel how much better it was than the home stuff.

Steven Bruce
Are there, I'm assuming there are some more significant dangers with treating the cervical spine than perhaps there are with the lumbar spine?

Robert Shanks
The contraindications are the same, as far as I'm aware. But as you say, it's a smaller area of the body obviously, the machine won't let you go to as high pressure, I should hasten to add, it won't let you go above 30 pounds of traction force, whereas in the lumbar spine it will go up to 200. So there are inbuilt safety mechanisms within the machine.

Steven Bruce
Yes, there's been nasty reports in the last few weeks about when cervical treatment goes wrong. Not IDD treatment, I would add, but we do need to be careful about that. Mike's says, how do you feel about the Y strap or ring dinger treatment with the fast neck pulls to decompress the spine? I think I've seen this, I've seen a video on YouTube. Shocking, horrifying and eyewatering.

Robert Shanks
Yeah, I know what he's talking about. How do I feel about it? I couldn't really pass comment. I don't have any experience of it, so I couldn't really say one way or the other.

Steven Bruce
Pretty sure it's not recommended by NICE. 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 should they do?

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

Steven Bruce
And in terms of management of the machine, do you do all the treatments yourself or do you farm that out to somebody else?

Robert Shanks
So I do the treats myself, as well as my associates in the clinic as well. So we kind of share out. But different clinics operate in slightly different ways. Normally, you would have an osteopath, chiropractor or physio, they're kind of the case lead, if you like, and some clinics will have the sports therapists in who do the actual on the day treatment.

Steven Bruce
I mean, there's no reason why any sensible person can't administer the treatment. Insurance will demand that they have some sort of physical therapy qualification, I imagine. But I have to imagine that nurses

would be allowed to do it, if they're looking for this sort of employment. The key thing is that we get the diagnosis right, so we put the right people on the machine.

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

Steven Bruce
And I take it, it has paid for itself in your clinic?

Robert Shanks
Yes, it has.

Steven Bruce
It's gonna be the big worry for everybody, isn't it? 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, it's making them aware of what you do, which is... Do you know what's the ASA guidelines or are there any? What can we say about what we do with this machine?

Robert Shanks
I haven't specifically looked into that entirety. But I would imagine they, as long as you're sticking to the guidelines that are given to you by North American Medical, what the evidence suggests is you're not gonna fall foul of that.

Steven Bruce
You probably know, and most of the audience know, I'm a big sceptic about the ASA 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, well say it, 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. 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, who 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, had 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, or we wouldn't be able to put this up running right now, but Derren has asked about the course details for MRI training. So if I put those out in my follow up email as well.

Robert Shanks
Yeah, well go2imaging.com is the is the website that we have for all that.

Steven Bruce
And on there just sign up for a course.

Robert Shanks
Yeah, there's a video course on there. We'll also, when we do the in-house courses, they'll be posted on there as well.

Steven Bruce
Are you doing many of those?

Robert Shanks
We haven't got any dates set yet, but we are trying to organise some.

Steven Bruce
Happy to do another one up here sometime. If we can get enough bums on seats.

Robert Shanks
We'd be very happy to come back.

Steven Bruce
Because we can fit quite a few people into the studio here and you can stand on a nice little stage. Well, 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 far as you can in your busy clinic. We at APM 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 in Stephen Small, who can give you a lot more of the background information, possibly even than 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 for you, was it?

Robert Shanks
It was about two. No he's a really nice chap.

Steven Bruce
Either, as I say, you give too easily, or you just make your decisions more crisply than I do. Yeah, but I'm very happy that we've got it. I'm glad you. Rob, 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 is because you're such a mine of information.

Robert Shanks
Thank you.

Steven Bruce
Well, I hope you enjoyed this evening show. And I hope you got some real clinical benefit from it. If you need to know more, let me know as I've said, and I'll make sure we find someone with the answers if we can't do ourselves. Our next show is lunchtime on Monday the fifth when I've got Gilly Woodhouse in the studio to talk about how you can recession-proof your business. And I'm sure as you know, Gilly, she's a passionate woman, she's very, very fond of businesses like ours, and she's a mine of wonderful advice,

stuff that you can put into practice straightaway. And I know a lot of us are worried these days about the effects of inflation and recession and so on. So two days after that, Wednesday the seventh, I've got an evening show with orthopaedic consultant Ian McDermott about articular grafting. Now he tells me this is a total mess in the UK at the moment, but we'll get the full picture on the seventh, that's another evening broadcasts 7:30 to 9:00. And then the week after that on the Wednesday, we've got a lunchtime case based discussion sheduled. And then we move on to the 14th of September, for an evening broadcast with Dr. Gillian Vanhegen. That's the 27th. She is going to be joining me in the studio to talk about psychosexual behaviour. She's also promised that we'll be doing some practical demonstrations, which is, at the same time very intriguing, but also quite terrifying. So that's an evening of psychosexual behaviour on Tuesday the 27th with Gillian Vanhegen. We'll keep you posted about all our broadcasts, of course, but don't forget to download the academy app if you haven't done so already. It's great for reminders and for all sorts of other things, including the programme of all the shows we've got programmed, as far as we know, at present. And one final thing, if you're interested, as you might have seen from this morning's email, I am booking one or two boxes at the Royal Albert Hall for the annual Royal Marines band concert in March next year. Tickets are 57 quid each. And I'd love it if you could join me. It's not just military music, this lot are brilliant musicians. And you'd expect me to say that. But the show is a fantastic spectacle. It's the evening of Saturday the 11th of March, if you'd like to join me, just go to this web page. www.bit.ly/bootneck and you can see that on the screen at the moment. Bootneck of course is military slang for a Marine. So I hope that might stick in your mind. I can't promise I'll be able to get enough seats, but it will be a mixture of members, speakers, friends and family. And I'm sure we'll find a restaurant somewhere nearby to eat before the show and get a few warmers into the butts, if you'll excuse my additional military slang. There you are, thank you for joining us this evening. Hope you enjoyed the show. Hope to see you again soon. That's it for today. Goodnight.