Academy of PHYSICAL MEDICINE

Transcript

Rotator Cuff Problems: The Expert View- Jeehan Lynch

Steven Bruce
to one Good evening and welcome. Here we are at the beginning of February and we're on our seventh broadcast already. This evening is all about rotator cuff. And we've covered it before, of course, but no discussion is ever exhaustive especially when it comes to the complex area of the shoulder. So I have a very special guest with me this evening G Lynch. She's an MSK, clinical specialist in the shoulder. She's a physiotherapist and her absolute favourite thing in the world is the shoulder isn't it? It sure is. You made the trip up from Hampshire. Thank you for coming all this distance. It's great to have you in the studio.

Jeehan Lynch
Thank you for having me.

Steven Bruce
We need to need to know a bit about you. Obviously, you're a chartered physiotherapist because you've got your badge on your shirt. I used to work with London Welsh, didn't you? Yes. Under 18? Yes, I'm so good as I used to play for them and Welsh and possibly not when you were working with them? It was a few years before that. But you're also involved. You have been involved as an educational fellow. Yes. Sort of. What does that mean?

Jeehan Lynch
Yes. So I took a year out and worked as an educational fellow in primary care, working with GP, registrar's and just multiprofessional teams such as nurses, advanced practitioners, sharing, not just my love of the shoulder, but really coming together to look at more multi professional way of working. And so it's been it was really fun year and got me to step aside from my normal run of the mill job and do something challenging and fun. So that's

Steven Bruce
even a physio for what just over 25 years now, yes, but specialising the shoulder for the last

Jeehan Lynch
1515 years I've been specialising just in the shoulder. Yep. And based in primary

Steven Bruce
care, yeah, we've built this show as being about rotator cuff and I'll put good money that it will go off piste at some point, because people will just want to know where anything to do

with the shoulder. You've also talked about being interested or particularly keen on treating the complex instable, unstable incident in some way. Yeah,

Jeehan Lynch
so complex children's split is another area that I that I treat, mainly because they have been proven that they need that specialist input. So yeah, so that's, that's also my other love.

Steven Bruce
And as I explained, everybody I've done a couple of times, you're a physiotherapist and the bulk of our audience are osteopaths and chiropractors, and we have got some physios out there. So I suspect they're all eager to know what we can learn from the other side from the dark side as it were. I say that with tongue in cheek, because I hate this conflict that we have between the professional

Jeehan Lynch
degree I mean, I even have a neighbour who's a chiropractor, and we share knowledge all the time. And I think that's what this is what hopefully all about is that hopefully the things I'm going to speak to you today is about the things I've learned not just from my patients over the last 16 years, but also from my peers. And that's not just physios that I've worked with. That's other professionals. And I think we can all learn from one another

Steven Bruce
only. First of all, I want to go completely off piste. First of all because you've worked all of your career in the NHS and New York the Siouxland NHS Trust at the moment. Yes. What's it like working in the NHS as a physio at the moment?

Jeehan Lynch
It's paid obviously. Yes, absolutely. Yes, totally. I think it's very challenging. I think over the last few years, it's been getting more and more challenging. Our demands are obviously quite an issue in the NHS. I think the thing that keeps all routed together as the team that we work with, I work with an amazing team of physiotherapists, and they're all still passionate, but it's been very challenging. Our waiting lists are what challenge us. And also just the general well being of our patients, patients aren't looking after themselves as much as we'd like them to. So there are challenges in that way. Yeah.

Steven Bruce
I suspect that one of the things people will be wondering is and this is please don't misinterpret this is not a criticism of physiotherapy at all, is that NHS physio therapists have a bit of a reputation for just reaching into the box and handing out the exercises and not putting their hands on the patient or anything else like that. And I know you're going to demonstrate the sort of stuff you do later on. But are you seeing that more and more in the NHS that physios are not allowed under their contracts? Are you going to

Jeehan Lynch
put there? Absolutely. If you place that I have heard that I think there's a lot more work that's been going down the route of being less face to face more telephone triage, which certainly happened during COVID. That definitely went that way. But I think hopefully from today, and hopefully I'm going to tell you today that you know i Although I'm a specialist, and I can organise diagnostics, I can inject shoulders, my passion at the end of the day is what brought me shoulders, which is about rehabilitating and making sure at my level, I'm expert in that rehab of my patients. So the passion I have is around treatment and management.

And it can be a bit of both I use hands on when I need to. And I use rehab and exercise when I want to as well. So it all comes together.

Steven Bruce
Well. Yeah. And it'll be interesting to talk to you as we go along through the evening about how much role there is for non hands on treatment, whether that is simply rehab exercises or whether it's laser or Shockwave or ultrasound or injections and so you want to you want to remind us first of all what the hell it is we're talking about. I know that osteopaths, physios, cornrows, we've all done the a&p. We all we all know where the shoulder is on patients and what it's meant to do. Yeah, probably just worth US reminding ourselves. Yeah, what we're talking about in terms of rotator cuff and its problems.

Jeehan Lynch
So I think the first place to start if you look at what we see in the NHS, I mean if you think 90% of patients come spinal pain into our service, we have about 70% of them with shoulder pain. So it's a very common muscular skeletal thing that we See? Not so most of my patients I see probably 72% of those are patients that present with a rotator cuff related problem. And

Steven Bruce
you said nine 90% of spine?

Jeehan Lynch
Yeah. For shoulder No. So so when they come through with so nicely into patients in their life will start struggle with spinal pain, sorry. And 70% of patients struggle. Sorry, I should have clarified that. So when they come through, obviously, the most important thing is to make sure they have a reliable diagnosis. And I think that's where we've changed a little bit about the way that we describe pathology to patients. So they'll come in sometimes with a conception that they have this rotator cuff pain, and is it a tear? Is it just a inflammatory type problem, I think it's about how we reassure our patients on that diagnosis. And that's something we can learn both if you're working privately or in the NHS,

Steven Bruce
the terms can be scary. One of the people who's talked about the shoulder on the show in the past, Simeon the Alicia, who's been asked you a few new Simeon do is a lot of work on frozen shoulder in particular. And now more on trigger points, and needling and so on. But he said that, I think at the age of about 50, there's a huge percentage of people will have a supraspinatus, Benitez tear, possibly a full thickness tear, and they'll be completely asymptomatic, absolutely scared witless. If someone tells them that they've got that full thickness, certainly.

Jeehan Lynch
And I think it's the way we explain to patients because when we're reaching the age, if you look at over 6065, most of us are going to have degenerative change within our tendons. And that's just normal ageing process, I hit the way we describe it to patients is it's just like when we get older, we get wrinkles on our face. These are normal changes that happen to your attendance. And when we start them putting the fear of life into the room, start saying you've got tears and using those words, and appropriately, it can then give patients the idea that oh, well, do I need to have surgery for that? When you hear the word tear? You think there's something wrong? And actually, that's not the case at all? You can't, you could have a generic term your shoulder and be totally asymptomatic and have no pain. And then I see

obviously the ones that do have pain. So it's about really educational pieces around the fact that you can be asymptomatic and still have a tear and manage very well functionally.

Steven Bruce
Yeah, so we'll get on to how we do that later on. But you talked about changes in terminology. And I remember that we stopped talking about shoulder impingement some years ago, and I think it became subacromial pain syndrome. But now it's called something different.

Jeehan Lynch
Yes, well, well, that's good thing to talk about, because we've talked about it as rotator cuff related pain, which goes into that sort of global thing of why we call it that. And I think the reason we've moved away from that impingement or subacromial pain is when we look at research, and this has been looked at quite quite, quite extensively. If you look at patients that have partial tears, most of those tears actually are into substance tears, or they occur around more of the articular surface. They're not actually occurring on the on the top, the tender bursal surface. So in the old in the 70s. When wonderful, NIR came up with the idea of the Chromium shape, where it was curved and impinging on the tendon. What we know now is actually that isn't actually happening. And it's more down to more different factors that can affect tendon, tendon and where

Steven Bruce
and is this a term that's going to change again in a year or two? Is there emerging evidence to support all this rather than just the latest theory,

Jeehan Lynch
I think, but we don't want to go down the route of just saying hello to a patient saying you've got shoulder pain, patients don't want to just be told that they need more understanding. And I think that's on my last slide. When I'm summarising things, it's about explained patients, when I've examined them what I think is the likely cause of their symptoms. But again, we can have scans we can have X rays tell us certain things that are going on in the shoulder. But we do also know that that isn't always the cause of a patient's pain. And you get the real gist from the patient by listening to the patient, getting a really good history, and then putting that together with your examination. The diagnostic bit should only be used really to backup your clinical findings. It's not something that should just be relied upon. Yeah,

Steven Bruce
I'm gonna take you off piste. As I promised, I would very early in the show because I want to bring him a question we brought up by Trevor and we're doing it because I think this is the earliest we've ever had a question on the show. It came out I think seven minutes after we went live. And Trevor says permission to go off piste. What are your thoughts on treating a stubborn sub deltoid bursitis shown on MRI what are the treatment recommendations for that that's his Oh,

Jeehan Lynch
so a subtitle bursitis again you know that that that can take us back down the route of also think about injections and injection management obviously I also do injections that that can sometimes help with we need to be really clear about the benefit of injections injections can only really give and this is proven by good research a good four months relief of pain, if you look at most patients their short term fix of pain. So the idea of an injection in my eyes to calm down and inflamed bursa would be to allow it to settle obviously with the use of for

steroid injection and and and give them that pain relief. But the idea of that is then to work on their rehab. So I look at it and how I advise my patients is this is a pain relief. This is to settle it down. And then the idea that then is to meet to work on your rehab. So it would be then looking at conditioning the cuff but also looking at factors as to why Why did they get this decision?

Steven Bruce
Yeah. And of course it makes this question difficult to answer doesn't use, you've got to have the patient in front of you and find what those underlying factors are. Maybe Trevor will be a bit more forthcoming later on and give you the whole case history and say, Well, what should I do? Yeah, we'll send pictures or whatever else. Do you want to show us the likely problem areas on some of your pictures? Or

Jeehan Lynch
are we Yeah, absolutely. So lovely.

Steven Bruce
Looking at work, yeah. All right, we got rotator cuff and we got rotator cuff tear. Yeah, so

Jeehan Lynch
I was just going to talk about obviously, the function of the cuff. So we could just remind ourselves on that. So I think when I first qualified all those many years ago, we were taught specific tests, we were talking about this before we went on air went was talking about tests that we were talked about, they had to contest, the full contest, the login, the bicep speeds, test all these very particular tests that tested specific structures. But what we now know really, is that we can't really do that with the cuff. So the supraspinatus infraspinatus, that and the toes might make up our posterior calf, or external rotators, they tend to blend together obviously, from the back, and then we've got the subscapularis, that's our medial rotator. And what we've proven is that the soup spinning sub scat blend together, and the seats been in for spin also blend together. And they all blend into the capsules, they really work as one unit. That unit is to keep that shoulder stable, keep it centred in the in the glenoid. And hopefully function fully when you have a tear. As I've already said, that was a very different way of managing a traumatic tear, to a non traumatic tear, which is something I wanted to speak about. So when we talk about non traumatic rotator cuff pain or rotator cuff tears, ideally, we should be managing them conservatively. So that doesn't matter whether you're a physio osteopath, hopefully they should do well with conservative management. But the traumatic tears in our younger patients. So if they've had quite significant trauma, they tend to be the ones that we do need to redress a little bit better. And sometimes those patients do require surgical intervention, degenerate cuff tears, obviously, we need to split them into partial thickness and full thickness tears. Again, people say, is there a difference? Does a partial thickness tear become a full thickness tear? Again? We don't have any proof of that. So no. So I see lots of patients who are in their 60s have a partial tear. So do I need to have an operation? Because is it going to become a full tear? And I say no, there is no clinical evidence to suggest that we just need to try and manage you conservatively.

Steven Bruce
Now, I'm seeing my patients and someone's told them, they've got a rotator cuff tear, and I bring up that image there. And what we've got there is a rupture of a very well defined supraspinatus tendon. So that might be a full thickness tear, but it's actually a rupture of the tendon. Yeah. In fact, the full thickness tear is not likely to look like that, is it? No, not necessarily, possibly going to run at right angles to that. So there's still an intact tendon on

either side of the tear? Is this something you find yourself having to explain to patients because that is a scary image, I think that's got to be sewn together or,

Jeehan Lynch
and I brought it up as a fact that actually so many images can also scare people, because obviously I pharmacy that that would be looking at scary. So when I talk to patients, especially when I'm talking about diagnostics, or scans or MRI scans, you have to be very careful about the words that you use the patients do not put the fear into them. And that's where we really need to engage them, but had their level of understanding some patients see you and want to know don't know everything about what's going on. Some patients say would you can you tell me what's your understanding of this, I'll be guided by you. But again, it's the it's that really key thing around shared decision making, is it making sure they're understanding what's going on, but you're absolutely right. So anyone want to fit forgotten to miss that.

Steven Bruce
And I don't know that I've ever seen any recall these nice simple anatomical diagrams to show to patients. But I've ever seen any commercially produced simple diagrams that make a full thickness tear or a partial thickness tear look less scary than there used to be available prep then probably are

Jeehan Lynch
available. Yes, the shoulder doc doc is a great. Shoulder doc doc is a great one, which is obviously written lots of web by the wonderful Miss linen does consult Miss Leonard, Hunk Funke, who does some great work around the imaging stuff. But yeah, there are some out there.

Steven Bruce
Okay. Another couple of questions. We haven't read this one before. So ego says that the system gives them funny names. Or they give themselves funny names. I don't really know. They just get said to me subacromial bursitis versus Supraspinatus tendinopathy. Do they occur simultaneously?

Jeehan Lynch
Absolutely. Absolutely. We know that the bursts obviously being quite an active area of pain as well. Absolutely they can affect can come together. This is where it goes back to the meaning around what we believe tendinopathy and pain some people think is it an inflammatory thing is a degenerative thing. Without that we do know that there is an effect on the space in that subacromial space. So we know there is an inflammatory thing at some stage of this condition. So absolutely. The two could certainly go together.

Steven Bruce
Right. I suspect his next question has been which one do I treat? Or how do I discern what's the most important one? We'll come to that maybe. Imran says what are your recommendations after CSI corticosteroid injection like how long to rest and getting back to activities of daily living in snorting rehab? Yep, that's

Jeehan Lynch
a really good question. So when if I was to inject the subacromial Bursa, I would always recommend a two week period of take relative rest. That means not doing things to aggravate their shoulder. So they would have told me their aggravating factors, I would say,

please try to avoid that. Don't load it too much. I really don't want them lifting too much, again, very good question, because we know that the effects of steroid can obviously affect the tensile strength of tendons. So again, obviously, being a very, you know, mobile structure with lots of tendons. Ideally, I don't really want them doing too much forceful lifting, I certainly don't want them going back to sport. And I personally myself, I also view all my patients postinjection amount about the three week mark, because without a doubt, again, it's that window opportunity. We don't just do it single on its own, we get back in and getting back on with the rehabilitation.

Steven Bruce
You talked earlier on. You said four months, injections will give them four months being removed, remind us how many of those you can have in a year or any given space of time? Good question.

Jeehan Lynch
Ideally, really no more than two or three, where I work at the moment on our on our pathways, we're only really meant to do two within the primary care service. By the time patients getting up to having three, you need to be thinking, is this really working? Again, I certainly wouldn't advocate do any more than really to to Yeah, but again, I want to see them have a good out, output with the injection. The injections again have to be sold to the patient. It's a short term relief of pain, there is no long term benefit for your condition. And again, I go back to the evidence again, you need a good 12 weeks of rehabilitation and proper supervised physiotherapy, not just the exercises out of the bag, like you say, but a really good guidance around that. But objecting,

Steven Bruce
how often are you seeing the condition actually worsen because people have had a steroid injection, I think I'm out of pain. Now. I don't have to worry about using the arm as

Jeehan Lynch
absolutely quite a few times. I think also because they get quite useful. It's a passive type treatment, isn't it? I'm gonna go and see my dog and I was like, given a tablet, you're gonna make it better. I want to be made better on my paint go away. And that's the first thing people say, I'd like an injection. I get that all the time. Hello, I come see you for an injection. But again, it's I said it's a short term problem you have, if it's a generic tear or problem, I say you've got agenda condition. This isn't gonna last forever. There are alternatives to your care. And I then talk about the evidence suggests you're not going to get long term effects this injection, please try some rehabilitation with me from my specialist hat on and they're actually normally pretty willing to give that a go.

Steven Bruce
Now most osteopath, so I'm pretty sure most chiropractors don't do steroid injections, some are able to and but not many. Do you do yours under guided imagery, guided imagery? No,

Jeehan Lynch
I don't I do mine in clinic, and I get good results against good question. At the moment. There is not sound evidence just that guided is much better than blind. But in some conditions it might be but at the moment, no, I do mind blind.

Steven Bruce

Yeah, I'm guessing. I'm guessing here that that possibly depends on the experience of the practitioner. Yeah. And of course, GPS. I'm not saying they've got a bad reputation this but GPS quite often will will inject people, but they might not necessarily be quite so good at finding the right shoulder is. So you would.

Jeehan Lynch
And I think that's probably at no lack of perspective. For my job recordings. I noticed my junior college really well where I work. And sometimes I say We'd rather go and see G foot because she'll show up because I did that's what I do. I just suggest shoulders on. You're not realised I do a lot of it sounds pretty pretty, ya know what I'm doing? But absolutely, again, if I've had a patient, I've injected the first time round, they haven't got a good outcome, that I wouldn't want them to have an injection again. I mean, if you look at the evidence, one out of five patients get a good outcome with an injection. So one out of five, yeah, so it's not many. So you had to injected quite a few to get good outcomes that just shows you not everyone gets good outcome with injection.

Steven Bruce
Now, why is that? Is that just different metabolisms different patients? Or is that bad injections?

Jeehan Lynch
It could be better? It could be is it Absolutely. Is it bad approach? Or is it bad that actually it wasn't going to help them anyway? And is there something else that was going on? Could it have been the fact that they really get the diagnosis right? In the very beginning? Could it be in their neck? Could it be so start? Yeah, there's lots of different reasons. Yeah. Okay.

Steven Bruce
So I don't think we're gonna get off our seats this evening, because I've got so many questions in this list already. And we are here. Great, thank you. Imran says, just ask that once we put someone in boss to says, How do you feel about railroad radio shockwaves for helping with our scientists? I don't know why radio specifically but shockwave therapy.

Jeehan Lynch
At the moment, from what I've been reading. I haven't seen any sound evidence, clinical sound evidence just it works. That's so like I said, most of the evidence I've read, there isn't any clear research and good clinical evidence suggests that that works. However, I do know there are some practices that are doing it. But at the moment, the evidence, just what I've been told, by consultants, there's no sound evidence, just it works that moment.

Steven Bruce
Yeah. It's interesting is the annual and you'll know this. I mean, anecdotally, we're all taught that. There's a clinic somewhere that was using ultrasound, and when it went for servicing, they found it had no crystal in the machine. So it couldn't have been doing anything but people were getting better totally and some and sometimes it's hard to distinguish whether it's just the having treatment that got you better rather than the absence treatment. It's that one word called doesn't help us do very much, but some people are getting results with it. Absolutely. And I do

Jeehan Lynch
know actually, I think it was a while ago. I think one of the consults I went to another conference was going on about shortwave Again, he did say we need more randomised

control trials, more extensive evidence is the same thing good clear out research. But the moment there isn't anything to say that's better to treat that condition at this moment.

Steven Bruce
Yeah. And there'll be a long time coming when the money is not there to do as Jane asks, What about traumatic tears in the older population? Is your management any different to younger people?

Jeehan Lynch
Really good question. So with the patients that I see, so I can think of example, so if I see a traumatic cuff tear in an older person, that they're fit there, well, they've never had previous shoulder pain before, I would always still offer them a good 12 weeks rehabilitation, I wouldn't rush them off to surgery again, we know with good clear sound evidence that as you get a bit older again, and even if you had a trauma, there is on top of that trauma, your tendons are not going to be like they were when you were in your 30s. So again, they're going to be trickier to treat and manage. Again, that does sometimes help when you do get a scan because when you get a scan, it's important to see how decent that tear is. Has that tear also retracted? So I need to know, how's that tender attracted? Can the surgeon even get it to pin it back on? And also is there any fatty infiltration that tendon so the quality of the tendon, the type of tear really authored, it takes us to whether I think that patients going to do well with surgery. So it does depend, but most I would try was given them a good physiotherapy course of physiotherapy. First,

Steven Bruce
what constitutes a good course of physiotherapy question.

Jeehan Lynch
So again, good evidence, just a good 12 week session of physiotherapy. And that's when you've really got to make sure patients have a clear understanding of that. A week, 12 weeks ago, not even once a week, as long as it's a good graduated, and you're challenging that calf and they're not just having an exercise sheet I get I get quite annoyed about this I what I don't want to see is when a person has an excellent sheet and they're sent away for six weeks, the patient's doing the same exercises, that isn't going to really cut it, they need to be challenged and shoulders a challenging joint, they need that stimulus, they need that proprioceptive input, they need that difference in the way that we have. So I really would say no, they need to come in and see

Steven Bruce
a real set. We also know I think there is reasonable evidence behind this that many patients just won't do their exercises, full stop, and others will try the exercises and find it's uncomfortable and they'll stop but they won't think to go back to the person prescribing the exercise and say, Look, this hurts taking what should I do instead?

Jeehan Lynch
And so I think that's also the first piece of when I say I can I see a lot of patients that have failed primary care physiotherapy or they felt other physiotherapy and they come see me for more of a specialist input. And most of the reasons actually failed is because first of all, they haven't had a clear understanding about their diagnosis. Secondly, they weren't on board with the physio. Third, they thought the exercises making them painful, okay. And fourthly, they couldn't fit it into their life. And I think sometimes we sometimes put unrealistic demands on patients, you know, if they're working, sometimes can't fit in twice a day exercising. And

sometimes when I have an irritable patient or an irritable cough, I would say don't do it every day, do it every other day. And just by modifying that you sometimes can engage better your patients, they're going to be more on board with you. So it's how we relate

Steven Bruce
some of these exercises. But I'm struck by I forget who I was talking to only a few days ago that we were talking about exercises, which actually fit in with your normal activity and how I actually had a patient who said I was given exercises to stand on the bottom of the stairs and stretch my calf muscle. He said, I can't bother doing that. I'm not doing that. But tell him to stand on an incline board while he's cleaning his teeth. And he's doing that totally. It just doesn't detract from anything else. Absolutely.

Jeehan Lynch
And you've put it into something functional they can do, isn't it? And it's like, you know, I had a lady recently and I get back to that question about traumatic cuff tears. I had a lady that was a quite high level tennis player. She was 71. She had a really traumatic fall. Very upset about the management of her shoulder. She did really well because she was very on board with her rehabilitation. She knew she wanted to get to which was a tennis. And I said right, we're going to get you the gym. And we made the exercises, very functional specific to her her sport. So her tennis hand what I could do with that, so made it relatable. So she could see, she has worked for me in a functional position. I'm actually quite enjoying these exercises. It's also how you sell it to your patients, isn't it about how you promote that self management where you're going and also goal setting. So absolutely, I totally agree. Make it very specific to the patient. And hopefully

Steven Bruce
there's a there's a big role for communication isn't absolutely noticed earlier. I know Sally, Ron's the terminology you were using about older people about how they had had a trauma. It's just kind of like how older people have falls rather than fall over if you get traumatic injury when you're younger. And you have a trauma when you get older.

Jeehan Lynch
Yeah. Well, I didn't mean to say that. Because anyone can have a trauma.

Steven Bruce
Right, Doug says, What's your opinion on steroid injections for frozen shoulder?

Jeehan Lynch
Very good question. Absolutely. They certainly have their place. So interesting enough, I've actually been part of the FOSS trial, which is the largest RCT that's happened recently. So I'm part of that stakeholder group, which has been really interesting. And part of our role is to disseminate that information. So hopefully, that's all going to be out there. But what we found we get that Oh, I don't know. Well, we've part of it. It's that that we've all the things to come through. So hopefully, that information is gonna be coming out soon. But the evidence from the frost trial did showed that an early injection, if we can get the injection early intracapsular effectively works very well. So absolutely, it has its place in Frozen shoulders in the earliest stages. But again, as you know, and I know, sometimes it's tricky to pick up a frozen shoulder in the early stage, because they sometimes can mimic rotator cuff pain, they just come in with pain. It's only when they start to notice the loss of external rotation that we send to them. Actually, it is a frozen shoulder. But if you can get them injected sooner rather than later, we know it's better to get them in the earliest stages than later on down the line,

Steven Bruce
which is pretty much the same for every intervention of any sort for any injuries and take that what's that? What are what modalities were considered in the Frosta trial?

Jeehan Lynch
So we were looking at, they were looking at injections, but they were looking at physiotherapy and they split them didn't they into they looked at em UA, they looked at arthroscopic release, and they looked at just plain physiotherapy at the end of all those three groups, they all got better. Okay, but the one that was most cost effective for the NHS was the UAE. But again, patients like you say some patients don't want to go down the route of having a surgical intervention. And if we realised if we could have caught them earlier on in their diagnosis, they would have done better with injection.

Steven Bruce
But here's the thing I remember interviewing Simeon nila, the physio the Osteopath, that I've mentioned already and I hope he's watching today because he'll be offended His method wasn't included in the in the front row. But I interviewed him together with a consultant from the Royal National Orthopaedic Hospital, specialisation the shoulders. And the consultant was absolutely adamant that there is no evidence whatsoever for the success of manipulation under anaesthetic and he said it's dangerous and it shouldn't be done. And simians evidence in his trial on this was me way works. But it only works if you include the same number of physiotherapy sessions that you would have had if you hadn't had any way at all. Yes, absolutely. Probably the physiotherapy that's as effective as the me

Jeehan Lynch
Yeah, yeah. And part of the fascia, we actually felt that it was it was 12 sessions or 12 visits, a physiotherapy. And I said, first of all, that isn't going to be realistic in NHS, we can't provide that. So 12 weeks of stretching regularly, it was a supervised physiotherapy thing isn't something the NHS can offer. So I think also you get to see to face shoulders, it's the is if they've been struggling for such a long time, isn't it, and patients come to see you and they want it to add, they just want their pain to go away. You can't get to that stage and then not refer them on to have a surgical opinion, in my opinion, because if they tried, or the physio they tried an injection, none of that's worked, surgery must be considered. Yep.

Steven Bruce
You talked about picking up frozen shoulders early. And that being a key to the success of injections. I remember when I was attending the CCG near here, when we had a contract with the NHS that essentially everybody went on to watch full weight for at least 12 weeks. So you never picked up anything early in the NHS because you weren't allowed to see them until they were chronic. I know. And they still had an acute pathway even though they weren't seeing.

Jeehan Lynch
And I think that's where I think that's where Steven I think so the first contact practitioner work is trying to embed itself better into the primary count. I think now, with our FCPS, we have a large number of volumes of FCPS, working in clinic with GPS, and they are now seeing a lot of the muscular skeletal patients. And that I hope has meant that we can pick patients up quicker, that have genuine muscular, muscular skeletal issues, and we can get them in a bit quicker. Our weights the moment we're very fortunate, it's about four to six weeks. But I know I know, it saddens me to say this that in a lot of places, our weights are

very long. We just need we just need more therapists, don't we we need more we know we need to get more qualified.

Steven Bruce
Yeah, well, I guess it's good for people in private practice, because patients, genuinely patients are struggling to see anybody in the NHS at the moment. And you

Jeehan Lynch
know, so the nice thing about that, and I get that I work very closely with private practitioners, and there's some wonderful ones out there. But I think when you actually see your patient, they come to the door, they see they actually they were said If only I'd seen you bit earlier on and it's been and they get they get the care, they knew they liked the care, they're happy they care, but they're just saddened by the weight. And that's that's the sad thing about working the NHS and the challenges that we face.

Steven Bruce
Okay, we're gonna get off our offices in a minute, a couple more of these questions before we move on, because otherwise it would have been immense list. But when we finished doing the practical, somebody who's called mega thinker, I like the title says, Why can't you tell a patient they have a tear? If they do? Is it really scary to be told that there does seem to be a move away from being honest with patients? Is that Is that true? Are we not being honest with patients? Or are we just framing our words around? Do you know what something a little bit less scary?

Jeehan Lynch
Absolutely. So I think we're framing around less scary, but I think the first thing I say to my patients when they come into my room, I say do you have a clear understanding about your diagnosis and what is it that you want from me? And I think that's the first place I need to start you to explain to them that in a non scary manner.

Steven Bruce
The first thing you say are you not doing the diagnosis?

Jeehan Lynch
Absolutely. I absolutely will when I say yeah, but when I say to them, I say do have an Well, my they've gone through physiotherapy fast for this evening. So all my patients I should explain that sorry. All my patients come through a physiotherapy first they fell physiotherapy. They're now here to see me. And sometimes patients see me and they Haven't had an understanding about what's going on? And they say, Oh, I've been told, I think I've got a tear. But I don't really know I got a tear on ice. Right? Well, that would be good play Stein. Absolutely. I totally agree. If a patient's got a tear, you should say I, from looking at you today from examining you, my, my, like likely cause of your symptoms are yes, you've most likely got a tear. But what I don't want to then say is, I think you need to then go and have an injection or you need surgery, we then need to educate them around getting them on board that not everyone with a tear, require surgery. That's that's what I'm really going out. So absolutely, we do need to explain to patients but in a manner that's not frightening and realistic and getting the full picture of how to manage that condition.

Steven Bruce
And I think for mega thinkers benefit, earlier on, I was saying that she was the image, which is more scary than necessarily the terminology, especially if you've got an image that can

back up what you're saying, because this doesn't stop you're using your shoulder it'll fix or whatever else. Absolutely. Keith says I thought there was a way around a three month window, but the time a patient has gone to a GP got referred to MSK seen a physio and got referred for an operation. Is it still viable to do? So I this question he thought he's asking whether there is a way around that three month wait that I was talking about? You said he's eight weeks with you. But even so it's still two months, isn't it? Yeah. And is the operation still viable after the week that you're normally going to expect? I guess about him up but he could be talking about?

Jeehan Lynch
Yeah, so talking about tears. I just want to mention it if you have a traumatic tear in your younger patient and you've had a trauma are decent for Neil Young, we really should be seeing those quite soon. And if you look at the the bessborough guidance, the if you pick up an urgent traumatic cuff tear and young patient, that should be signposted as urgent, and the GP should be able to refer them straight into Orthopaedics. So that's what happens in my place. We shouldn't be sitting on young traumatic cuff tears, messing around with rehabilitation, those patients probably do require some surgical intervention. But absolutely, it's how we manage these patients, isn't it? If they're chronic, they've got a degenerate tear. Ideally, we should be seeing them sooner. But again, it's all about weakness. But

Steven Bruce
well, last question before we ever do some practical is a great question. PK says can arm vaccinations trigger a longer GH problem? glenohumeral breaks, we know, humour or humour or problem. My other teeth and I think we're talking. I think we're talking about COVID here. Maybe it may be a really nasty rabbit hole. We don't want to go down. But are you seeing any complications triggered by vaccinations? Well,

Jeehan Lynch
very interesting. So you would hurt a server, which is some patient described, which is obviously where you can get some shoulder pain following a vaccination injection. And they have asked a good question, because during COVID, we saw a lot more of those patients, funnily enough. And the the evidence suggests that if you were to vaccinate a bit too high, so you hit the subacromial space, then you're more likely to cause irritation to use some kind of space, but also potentially to your capsule. If you inject with a too long needle into the mid deltoid, and you hit the Serena, patients are going to go out, and then they can obviously get them secondary shoulder pain from that. And then obviously, if you hit too low, you could then obviously hit the radial nerve. And again, that's that's not a good sign either. So absolutely. What's

the technique? Or the absolutely, I

Jeehan Lynch
mean, that's what I've seen if you start to really question patients around how they were vaccinated, and during COVID, you know, we had a lot of vaccinations, it was a mass vaccination period. And we had not just clinicians doing it do did we have lots of volunteers that kind of came in and helped and there were some patients that came and said, well, straightaway, they injected me and I felt pain. Obviously, as you say, they all get better, by the way, just to mention that a lot of these patients will get better. But I have seen a few of those. Yes.

Steven Bruce
Good. Well, I hope that's satisfied PK with a question APKs company, we're gonna come over and we're gonna do some examination and diagnosis and treatment and also

Jeehan Lynch
anything on your iPad that any wants me to do, or should I just do what I want to do?

Steven Bruce
We want to see your examination process or how you get your diagnosis. Yeah, lovely. Hi, sir. We have a long suffering model Susie, I hope you're not actually suffering Susie,

Jeehan Lynch
Susie, so first of all, obviously, extensive history, I'd always want to clear the cervical spine with any neck that I see. So I would always assess the neck over press the neck and obviously make sure there were no questions of any neurology and it altered sensation. So the neck magnetics always get rolled out so I won't bore you that obviously looking at the shoulder. Suzy Do you want slipping off your T shirt for resort? Is that okay? I'm just going to show you to the side of the camera. So if you turn to the sides easy like this, I just like to get a variable just observing. I'm looking at muscle wasting. I'm looking angles of her scapular. I'm looking to see if there's any difference in the orientation of the humeral head just to get a general feel about how she's standing. This also gives me a little idea about her thoracic spine. I think Steve and I spoke about before about how the thoracic spine in my opinion plays quite a large Rolling in scapular mobility and certainly has a role to play in the role of the shoulder, especially when you're looking at overhead movements. So this just gives me a rough idea about how what I'm looking for.

Steven Bruce
So you're just observing. Yeah. So let me put some questions. Let's say you've got a tiny little bit of winging. Yeah. One of the scapula. Yep. What's that going to tell you?

Jeehan Lynch
If it's the asymptomatic side, I'm not going to worry about at the moment. It's only when I move it. I want to see dynamically what's going on. Absolutely.

Steven Bruce
And so far, you haven't touched the thoracic spine. So how what what are you learning just from looking at it,

Jeehan Lynch
I'm looking at whether she's got an increased kyphosis. I'm also watching her lumbar lumbar curve, I'm looking to see this equal leg balance, just see she has not shifted against gives me a rough idea about how she's issues level, I'm looking for any scoliosis. So absolutely, it's really important to undress and have a good look at the spine and just see what's going on. It's really interesting, actually, because I see quite a few patients also with shoulder pain, especially when you're looking at rotator cuff pain, who have actually had low limb issue in the past and or spinal issue. And that's really interesting, because I'm going to talk a little bit about the effects of the kinetic chain in a minute. But there's lots of our patients who've had a previous knee up or a hip up who've been using crutches get guarantee, you'd get that from their history, they say actually funny enough, a few months later, I end up getting shoulder pain. So I also need to have a look at say, right, how is your hip, what's going on with your spine. And then when you start to delve into the details, actually, they say actually, my spine

is not great still, or my hips not great. Still, I then might have to have an examination of those two arrows as well. So don't ever forget your spine in any of this. And don't forget your low limb, treat the treat the human in front of you treat the whole person as I say. So looking at examination, obviously, I'll have a look at their flexion. So even free flexion and a nice feel of the range. I'm just observing her range, making sure she moves nice and fluidly. Susie doesn't have any shoulder pain. So obviously, in an acute cuff tear, I'm looking to see if there's any hitching. So when you have a catheter, patients will cut sometimes come in and you'll see this quite elevated humeral head and on on X ray, yeah, and active movement. And actually on X ray, you'll see that the soup, the humeral head has actually superiorly migrated because they've lost that integrity of the calf. So you'll see this sort of upward rotation, and you'll see an abnormal movement of the scapula. So it just gives me as soon as I've done that, what's going on with the shoulder and the cuff, just to see if anything's going on there. With it. Next movement will take you to the front, Susie, and we're looking at abduction. So we're looking at the again looking at the fluidity of the movement. Is there any hitching again, this tends to be more of a provocative position? Actually, if you're thinking more of a posterior crafter,

Steven Bruce
now, again, you're doing this passively. Yep. Oh,

Jeehan Lynch
yeah, absolutely active first, and then opposite, there was always absolutely always active first. And then if I feel like I need to have a feel of it myself, then I'll check passive,

Steven Bruce
as still feel the hitching on passive movement,

Jeehan Lynch
not as not as much yeah. And obviously, this is when you might need to load the patient down and use the couch. Because again, just to offload them, again, we've not considered on who's experiencing pain, if there's a lot of pain, I may need to lay them down Steven doing that position, then we've got obviously our external rotation test, which is obviously very important to test for frozen shoulder, again, in the early frozen shoulders, they won't be stuck, they can still normally get there. But if I'm looking to see if there's a differentiating between a frozen shoulder or cough, they're going to have that passive blocked through to external rotation. And obviously, with a rotator cuff patient, they should still have relatively full passive external rotation. Now, if you turn your cough, or you've got massive tear, though, some patients if they turn the soup spin, and they're interesting, they'll have what we call a lag sign. So I saw a lady lovely lady literally this week, and she can't she has no external rotation. And we know when those massive cuff tears, that you know, they are that that that's quite a tricky movement to get back. So again, challenges around the way that we then manage those patients. And that's a different type of exercise group that I'll talk about if I've got time as well. Internal Rotation, obviously, can be quite useful tests. But again, most shoulder patients find that movement painful. So you just need to bear that in mind when you're doing your testing. Now, one of the reasons

Steven Bruce
I like that into that, yeah, we're back under test. And it's nice. It's easy to compare, isn't it? Steven? Yeah. So they're getting pain in here. Somehow you're working out where that pain is coming from? It's not generally that

Jeehan Lynch
obvious? No, not at all. Absolutely, absolutely. But I would always test it because again, it gives me an idea about their internal rotation, which is getting a good test. So now we look at cuff integrity tests. Again, as I've said, and to California, we cannot be specific about tendons that are irritable. Remember, I'm testing the whole cup. But again, if I'm seeing something significantly weak, and there's been a history of trauma, then these tests can be slightly more reliable. So if I've got a patient, and I'm testing, you just push out into my hands, yes, sorry. If you push into my hands, I'm looking for obviously equal power. I'm looking to see if she can push out again. That's testing more posterior cough. I quite like the belly test, which is testing more of your sub scaps. If you push into my hand here, some patients, yes, some people use the Gerber's test where you lift The lift off test. Again, I tend to find that's quite uncomfortable to test. So I tend to quite like that test just to see what the subscripts doing. And again, you can then take them into these more positions. But again, remember, we are not being specific with these tests. These are not sensitive and not very specific. So they don't always have their value. But resist pap tests should be used just to check for covenant Tegrity.

Steven Bruce
Okay, so the moment you're talking about cuff integrity, we got to rule out other things as well, haven't we? So do you use a scarf test?

Jeehan Lynch
Yep, yep. So Scott. So scarf test is obviously quite useful for acromioclavicular joint, if I tie it to the front that might be easy to see. So Susie, if you can just take the arm across your body. But again, what also are we compressing there, we're compressing, not just the ac joint, we're also stretching out areas of the neck, we're also stretching out the areas around the back of the posterior capsule. So again, not great sensitivity and specificity of AC joint pathology,

Steven Bruce
and you get more specific.

Jeehan Lynch
Absolutely. So if you're looking more of an AC joint pathology, you'll get more load, those tend to come in and say, Gee, I feel the pains more here. Whereas cough patients tend to say they get more epaulette pain. Yeah. Okay. And biceps patients tend to say, Oh, I'm getting pain or going down to my biceps area. But again, not so specific. But absolutely scarfed has has its place.

Steven Bruce
Absolutely. Okay. Okay. Any others that we've included that

Jeehan Lynch
I'm trying to think actually, so 1000 tests so So on that note, to get to the bottom, what I'm trying to do, also, I use my tests and my examination to them base my treatment ideas around and the wonderful Jeremy Lewis, who I've looked up to, and obviously a read lots of his wonderful work, does a lot of really valued work around scapular modification tests. And what they basically mean is if I just turn you around CZ, and I'm just going to lose the left one for for an idea is by changing the orientation of your scapula. So there's various things we can do, we can elevate, we can depress, we can protract, we can retract, and we can anterior and posterior tilt. So my handling, I play around a bit with my handling, and then I

get the patient to move into that provocative position. So for example, Suzy, if I think about doing a posterior tilt, I would post you tilt her shoulder, Suzy, could you just raise your arm forwards for me or Yep, forwards all the way up as far as you can go, and then down again. And I'm looking to see whether there's any change in her pain. And as she says, to me, that definitely feels a lot better than I know that I'm going to want to recruit some scapular work into her programme of exercises. The other one is if you think about external thoracic spines, we know that the classic spine has a little bit of influence in overhead elevation. It also has a role in the rotation of our spine, which also is very important in our sporty patients because no one play sport static. It's a dynamic rotational movement. So I really like to look at the thoracic spine. So I get patients to think right, think about lifting up with your sternum. So you're extending through your spine, and then elevate through and see if that changes the pain. And I may even just try and influence a little bit with my handling. And see again with that has an influence on their pain. Now again, go back to monotherapy. I, again, this is not research base. This is me as a clinician working in my clinics. If I find there's an area of stiffness, and myofascial tightness, I personally do like to work on that area. Because if you engage the patient, they say actually, I can feel freer, I feel I can move better. It brings me on an alignment with them around their exercise programme. I know this is where I need to work. I've had some good effects by working hands on around the plastic spine, and also on the scapula. So just to know

Steven Bruce
this may not be completely correct, yeah, but you as a physio could go to an orthopaedic consultant. So this is what I do, and it makes them better. And they'll say, oh, great, you're a physio you do that. That's fine. If I as an osteopath do that, I would put I'd put some money on a proportion of consultant orthopods would say, Well, I'm sorry, no, you need to work on the specific areas because it's causing the pain, not this general stuff around here. And they seem to not to trust that we know what we're doing as well as physios. It's really disappointing. Isn't it is disappointing? And maybe I'm

Jeehan Lynch
No, I think it's I think, you know, not

Steven Bruce
all allied health care professionals.

Jeehan Lynch
Absolutely. And I'm a passionate AHP as you well know, and I'm passionate about working alongside my colleagues and and that also comes down to an educational thing doesn't and I think nicest possible way around that is probably consulted Orthopaedic Surgeons know physios better because we work. And I think that's, you know, I think it's building trust isn't an alignment and I know that Oh, when I first started as shoulder specialist, I first walked into clinic, they thought who's this you know who you are, but actually, they look at me, they respect me. They know that I'm doing a good job. And I think it's because they've got to know me better. And I think that's part of our name, isn't it? But I agree with you. I think it's an educational thing, actually, you know,

Steven Bruce
and it's it's ingrained in me and I'm sure in chiropractic that you treat that All patient, you don't just treat this because it's so totally I got a question for you here. I just came in some time ago. Lawrence has asked if there's a diet if there are diagnostic criteria to separate a posterior cuff tear from a bank card lesion.

Jeehan Lynch
Poster cuff tear for Bankart lesion is that they're quite different things. So there isn't that I wouldn't I wouldn't I just diagnose them differently. So yeah, there isn't.

Steven Bruce
Right. Okay. Yeah. Do you want to tell us how you would, how you'd make that

Jeehan Lynch
your label tear? I'm looking at history. It's a different type. If you look at the history of a label to label pathologies, are much more commonly seen my younger patients, yes, you think your posterior dislocation, they've had a trauma, you're more likely to see a posterior SLAP tear, okay. Now, sometimes what can go along with those, if it's a significant trauma, you can sometimes miss a tear. And that's why those patients do require an MRI arthrogram Because sometimes you need an arthrogram, not just an MRI scan to look at the label with ology, as well as the cuff. So they do require normally imaging because you don't want to get it wrong, and then miss that. But again, it labelled tears. If it's a significant tear, absolutely young patient, we'd want to repair them. But if we're looking at a very small label tear, again, evidence suggests they can do very well with conservative management.

Steven Bruce
Okay. And I've got, you've talked about SLAP lesions, yes. Someone says, Come on, show us how do you test for a slap lesion?

Jeehan Lynch
Really good question. So a lot of the tests around slap tears do not have a lot of reliability or validity. So I find the tests actually goes back to my clinical reasoning. So I'm asking more about the deep catching pain, okay. You can do a crank test where you lie them and you take like, listen to demonstrate, I don't mind that at all. Absolutely. You go tell

Steven Bruce
Susie, what I slapped her is testing to see whether she's a slapper

Jeehan Lynch
bless you. So you can take the arm overhead, and you're actually putting a force through the shoulder, and you then rotate the shoulder and you're looking to see whether there's any click, or pain elicited from that text. Again, though, you can see that we're winding up lots of different structures. So again, labelled tests have poor sensitivity and specificity.

Steven Bruce
Could you do that one again, but that's not lean over it.

Jeehan Lynch
Sorry, I'm so sorry. So as you say, get right to the end range, you push through the humeral head, and you can rotate the shoulder and you're looking to see whether there's that catching deep rooted pain, they tend to say it's deep in the shoulder labour for allergies, right inside, like a deep rooted pain, and they will talk about this feeling of instability. So that's where you got to question it more around, does your joint feel loose? Do you feel your joint feels like it's coming out of out the joint? And that's the questioning that I would really like to

know for my younger patients, because we Jeff definitely see that more on our younger patients than my patients over 6070.

Steven Bruce
Do use apprehension tests? Yes, yes. We

Jeehan Lynch
can use those. Yeah, for testing is 30 year apprehension. relocation? Yep, they definitely have their purpose. Absolutely.

Steven Bruce
Okay, so we've now diagnosed some form of rotator cuff in Suzy, what are you gonna do about it? Yeah,

Jeehan Lynch
what we can do for treatment. So again, if you come sit up for me, it's lovely to talk about this whole kinetic chain again. But again, what I'm going to start by doing is I'll start by bringing just to see by recruiting the posterior cuff, do they start to move a bit better. So what I'm trying to do is everything I can give that that humeral head has that feeling of stability. So if I get you to come stand up, so as you stand to the side, my better. So see if you could just pull the band thumbs leading, and I want you to take your arms through that range. And I'm going to help a little bit around the back as well. So say it's the left shoulder for purposes of the camera. As she ranges goes through, she's going to tell me what she's finished out to say, actually, gee, am I fit that feels better? And then I might come in here and do a little bit that scapular facilitation, and she's moving nice. And she'll say, actually, the two together have made it even better. Long time ago, we started looking, obviously, the research is do you start with scapular retraining? Or do you start getting the cuff more active, and if I'm being honest, it's what the patient tells me is going to feel more comfortable with them. If I start by playing around the scapula, I'll work more on the scapula. If I start working more the cuff, I'll go more the cuff but absolutely that doubt, the rotator cuff. Originally off the scapular insert into your head, it's all a combined thing for me. So that's the first thing I'll start. Now if that doesn't seem to work, I'll then start to work a little bit on this kinetic chain. And Joe Gibson, wonderful J Gibson, who's Wonderful, wonderful. Consult Vizio, very respected in her field. Brooke talks a lot about the kinetic chain and how nociceptor brings in that lovely input to the shoulder and again, it's about bringing in your slings and how we work at that call and bringing in a lower kind of chain to give the power to the shoulder because we know we don't stand static do we when we're reaching to get the kettle we step forwards we move our body so it's a functional thing to do. So I would get the patient even just doing and pull out with maybe a lunge so I'm bring And again, that nice control. So Suzy, if I can get you to step back with me, as we pull, we're going to lunge through, I'm going to keep that nice course switched on, as we learned, and we pull a left. So just watching Susie pull through. And again, you're asking your patient, what did that feel did that feel better than when you did that without moving your body most pacer actually, it felt felt more stronger. And this is a way also to engage with what I call my the young gentleman that loved the gym. Because young gentleman that love the gym and love their weights, they find it very difficult to to slow them down. And they're still trying to lift heavy squat, I still want to work my legs, do I can I still go to the gym? And absolutely, it's a way to get them on board saying, right, we need to maybe digress a bit of loading your shoulder. But we can do some really nice work on we're working a low limb into your shoulder rehab, and then they get right, that's great. So getting them on board is also quite good. I just lost my mic. Excuse me,

Steven Bruce
that working in is still good. You said that when you were doing the extension exercises, if that didn't work. So when you say didn't work, you're taking it, you're doing it a few times and see whether it uses the same hasn't used the shoulder pain. Now we're going on to this exercise. Yeah. And that would be your standard progression.

Jeehan Lynch
Yes, such progression. Absolutely. And then I might bring it in doing some, some squats. So they're pulling us they're squatting. So again, it's bringing in different components of her chain to see if anything changes with working her shoulder,

Steven Bruce
how much pulling is going on here. Because at the moment, it's roughly shoulder width apart,

Jeehan Lynch
I think that's about right, I said I get them maximum stretch, I'd say just gently pull on the third round. And third and third rounds had a really bad name for itself. For quite a few years, we all are. But it's quite a nice thing to use through range when you're working some resistance. So as soon as they've confident with this, and they say, Gee, actually, I want to get back onto my weights, I listened to my patient, I certainly don't send them off with this for like a whole 12 1314 weeks, they need to be challenged. So then I'd be saying, right, let's get you in the gym. And we're going to start working on doing a little bit more into that external rotation position. Because we know that's where most people don't like take their shoulder when they're when they're uncomfortable with rotator cuff problems. So again, I started to build a more functional movements.

Steven Bruce
And then I want to ask you about communication as well with the patient. Because earlier on you said, we're gonna say we're going to do a nice lunge. And you're going to keep that that core beautifully engaged in which a lot of but I wouldn't understand what you're talking about. Yeah, yeah, absolutely. So what would you what would you attribute? How would you explain?

Jeehan Lynch
Absolutely. So if I was to explain that, first thing I need to explain to the patient is why we're working the lower chain. And I need to explain what I will start by saying as some of the power and the control on your shoulder comes from the effort of your spinal structures, your trunk, your hip, your lower chain, this power is going to help you get better stability around your shoulder blade, and help you move your shoulder better. So by strengthening all of this will get better functioning your shoulder. When I talk about core, what I don't want to see is a wobbly, a wobbly lunge. So when when I look at patients, I sometimes just watch what they do. Normally, I just say just do a lunge and see their control. It gives me a lot of idea about their body awareness and their proprioceptive awareness because again, we know in shoulders have a lot of proprioceptive inputs. And actually, we need to be doing a lot more of that really, when you look at rehab. So absolutely. If I was to talk about saying I want a nice controlled or look at me, I'm normally a nice controlled lunch. And I don't want I don't want it to be fast, just nice and controlled. Probably get and doing 1010 to 15 see their controls. Here they go. We haven't talked about reps either. I'll have

Steven Bruce

to ask you. Yeah, and what we were talking about over there. Yeah. How are you? I mean, Susie's gonna be board witness during this after one day. So make it do this five days, seven days a week. Yep. So

Jeehan Lynch
again, depending on how eligible they are depends why we get them. Susie is usually very irritable. The cuff, Sarah, oh, sorry, that was really bad. So if the cup is really irritable, they're quite painful. I tend to like to do a day on a day off actually in a day on day off. And I found that actually, that gets me better, better affects my patients. So the whole, you know, three sets of 10. It's really not like that your gauge, you're engaged by what your your fifth your patients are doing. So I would tend to say to the patient, right, let's try two sets of 10. How did that feel? Actually, that felt really easy. I think I could do a bit more. Okay, let's do a bit more. So you load them, but you don't load them into an unconscious position. Because again, we know that the benefit of exercise, there has been really nice studies say that actually, when you get paid with exercise, it can still work really well and strengthening and making better crusty

Steven Bruce
old buggers like me will say, Yeah, this three sets of 10 today, why set so why not just do it till you're totally up and stop

Jeehan Lynch
them? Absolutely. So exactly. So that's that's exactly right. So you just need to be engaged with what your patient is telling you. Because if a patient does, this is why this whole two sets of 10 thing really needs to go away. You're guided by your your patient. If they say actually I'm not I can do it or I can load it bit more than right Let's load a bit more. And let's look work on challenging yourself because again, I don't send patients off at the same exercise for six weeks show Just need change. And the other thing I need to say is don't give your patients too many exercises. That's another bit of G. I think I think even like two to three exercises, I know that's two to three exercises of good, focused amount of exercise where they really understand what they're doing is much better. Then given a patient a sheet of 15 exercises, and they do it all wrong seven because patients can get confused. I wouldn't do 15 exercises on the sheet.

Steven Bruce
Yeah, and I've seen some sheets, which they have. But do you use something like we have my patient or some other software?

Jeehan Lynch
physio tools, we tend to use it just yet, because we tend to send them off on a nice programme exercises. Yep. Does that include videos to show him how to do it properly? Yeah. video links and pictures and imaging? Absolutely. Yep.

Steven Bruce
And what's the gap between sets.

Jeehan Lynch
So if you do like a set, C haven't do set, have a minute break. Do it again, in a break again, right. So I'm a little rest in between. And you might combine that again, with obviously, if it was something I thought, actually thoracic spine is bit of stretching, she may want to just work a bit more on plastic Spine Stretch and that within the gym programme, and then get

back into doing some strengthening. Just mix it up. And if I've got patients that are on board with the rehab, and they're already going to the gym, then I love that because it's like, right, tell me what you're doing at the gym. Because that's a great place to start. And I don't even need to get my kit out of the bag, because I'm already engaged with them. Show me what you're doing. I had a gym guide, literally two weeks ago, he came to see me saying I think I need to scan my shoulder. I failed with physiotherapy, I want to scarf my shoulder. And after I chatted to him, he said, Well, actually, I don't really want to have surgery. And I don't think I need a scar. Now I said I think I just need to do some physio. And I'd like to do with you. And actually, because I got him in the gym, so I didn't treat him my cubicle. We took him into a gym environment, straightaway, something changed the way he engaged with me.

Steven Bruce
And that's also true, a lot of people don't have,

Jeehan Lynch
I get that, I get that. That's why I'm so passionate about maintaining rehabilitation space. And I put that on my Twitter all the time, we are losing rehabilitation space and health service. And we can't let that happen. Because we need that we

Steven Bruce
could you just give your microphone a space as well. So I'm very passionate about it. Yeah, yeah. And I get we all get that. So what else we're going to do with this patient? You're gonna give these exercises tell her to go away for six weeks and not gonna do that? Because you said you're not gonna say, Yeah, I'm back in six weeks, and we'll see what happens.

Jeehan Lynch
Yeah, I think I'll say it again, it's about how often we see the patients was a good question you asked me, I mean, patients like this, if they're engaged, they're onboard. And they understand what we're doing don't need to be seen every week. But you might want to telephone and say check in how you getting on. We do a lot of telephone consultations now. But again, I work in an era where we have also patients that can't speak English as their first language. And so again, if we had to bring an interpreter in, I would also say they do need a little bit more help to guide with it, especially if you're trying to push them a bit. So it's all dependent on the patient.

Steven Bruce
A question for you from ego who says, Would you not start with isometric exercises? First?

Jeehan Lynch
It's a very good question. So there's been a bit of mixed reviews about isometrics and isometrics definitely have their place and

Steven Bruce
explaining for us all when isometric isometric calls. Yeah,

Jeehan Lynch
so so if you do an isometric test, if you do an isometric exercises around the shoulder, it's literally going to be you push. So if I just demonstrate to Susie, you just push into my hand here, we're going to count to 54321, relax. And you might do that 510 times. But remember when you're doing this is the evidence has really only been shown to be fairly helpful in that

painful irritable cuff and what you got two members, this is all very well, but it's not very functional. Is it? So it's, it's a good question a bit depends on how much I can do with my patients. So if I can get a patient to move into that external rotation position, that's where I need to go because this is this isn't very functional for us. As for our shoulders, our shoulders don't really do a lot here. This is where we function, which is in that 90 degree position. So that's really where we need to go. But they've had a bit of bad press. And they used to be used, but the research. mixed evidence suggests he gave a bit of mixed evidence, but it has its place and I will say if you cannot do anything else, this irritable shoulder, and you want to engage some calf that absolutely isometrics can be used.

Steven Bruce
You demonstrated one presumably we could do isometric. Sorry, Steven, tension or anything? Well, yeah. Okay. But the evidence is mixed, as you said, right. Carry on, please.

Jeehan Lynch
Yep. So, so we've talked about scapula, we talked about the thoracic spine, and then obviously talked a little about treatment. So again, we bring in the strengthening. I'm just thinking, what else do we do? We can do some stuff in lying. So I was going to talk about anterior delt programme for the massive cuff tears. Would you like me to talk about that? Yes, definitely. So Suzy, if I could get you to lie down for now. So some of us out there would have heard about the wonderful work that Bobby Ainsworth did around anterior delt programme. So, when we have got a massive cuff tear that's involving Supraspinatus Infraspinatus To us, and subscapularis. We are in tricky situations. So we know that this exercise, which is called the anti adult programme has been shown to be more useful for patients that have Infraspinatus soup status, but still have subscapularis intact, right. So again, mixed research going on, there's still a lot more we need to do around how we manage those lovely patients that can't be repaired. And they've had a massive catheter, so that tendon has retracted, the surgeon can't find it, it's got fatty infiltration, we won't be able to pin it back. So again, these are the exercise that I would use. So I tend to start ideally supine, that's the way that Bobby Ainsworth who started this whole programme said to lay them down, so they're relaxed, this is good position to start. And I would then get the patient to just bring starting position is to help assist it with this one. And you present your choice. Yes, this is the story, this is the injured one. And you're going to passively help the shoulder up to that position. And then you're going to extend your elbow working the anterior deltoid, and then bring it back down centre, and then slowing it down. And the idea of this, this is, what you got to remember is we haven't got that force capillary more working. So what the anterior deltoid is trying to do is to provide any form of elevation to the shoulder, because these are the patients that come in classically with very little movement. So we're going to try and engage those muscles and see if we can help by doing that. Now, if they can do it in that position, then they don't need to use that arm, then they can just do it on their own, eventually hold the arm there. Susie said, extend it up, keep it there, bring it down, and lowering it down again. The next progression, as we all say, Steven, we've tried to progress the patient, you're gonna hold the arm there, you're going to work at holding it there, counting it to 10 circling it one way, keep your shoulder centred, again, patients with this cuff T, you'll start to see that they start to drop, they start to maybe grimace a little bit, and they get tired. So again, it's all about watching your patient, watching how they're focusing. But what I'm looking for here is a nice centred humeral head and not this classic hitching of the shoulder. So again, you do need to watch how they're moving. Now, the evidence suggests with this programme, though, and this is where you need to engage your patients. The research suggests they had to do this exercise every day, about three times a day. So it was a really

extensive exercise that you've just done. Yeah,

Jeehan Lynch
yeah, well, you would progress them. So you start with the one then you go to the two. So again, it's demanding on patients that are probably in their 80s, and have got other things going on alive. So again, it's challenging to bring that in to their routine. But again, they have to be advised that if you're going to try with physiotherapy, it can take a good eight months, and sometimes up to a year. So this is a long term programme. It really needs a lot of patience. And I'm going to be honest, I see a lot of these patients and however wonderful they all are, they are quite challenging still tricks they need that that lot of that input, lots of real encouragement, because it can be quite defeated.

Steven Bruce
So how often are you making contact with them in person? Yeah.

Jeehan Lynch
So I tend to see them monthly, because again, we're not, we're not seeing quick changes.

Steven Bruce
So they need some sort of contact reassurance.

Jeehan Lynch
Exactly against him. It's very much guided again by the patient, but they those sorts of patients, when they know there's nothing surgically that been done for them. They have no other no other options. We certain don't do any injections, because that's no no for pain relief, because again, they've already wrapped the cuff don't cause any more trouble. So again, it's more about really engaging them again, they need a lot of support.

Steven Bruce
When you're when you're doing this exercise the thing that's going to encourage this 80 year old lady here when she comes in for her second, third, fourth appointment. What improvement so how are you measuring?

Jeehan Lynch
So I'd measure absolutely her range. So range of movements, that would be one thing. I also look at patient outcome score, so I might do an actual score or a dat score. So absolutely this these patients is really question do need an outcome score because otherwise they don't see the progress. We're using the MS MSK HQ, which is a generalised good scoring, outcome score. So they get absolutely so they got an idea where they going. I also always make sure patients set a diary. They set their own patient during so you go away write a diary, what are the things you're doing every month happy? Have you started to move on to that next level? And they might say, actually, you know, I can now reach across to pick up a cup of tea. It could be something just like that. That means that well to them, especially when they have a show like I saw last week where she has a she can't function at all. So they're slow to treat. And they're challenging. Yeah.

Steven Bruce

Right. And one more about communication. When I'm this elderly gentleman on the table and you're telling me you've got a massive tear and you have a massive tear. It's not how is this going to help it because if it's torn surely it's not going to repair by doing exercise,

Jeehan Lynch
right. So what we do what you got to say to the patient is once we've got a massive tear, we know we've lost a few those tendons They're not going to be coming back. So what my job is as a physiotherapist is to change the way that force couple now works. And that's by strengthening your anterior delt muscle. And those the muscles external exercise we've just seen now some patients have said have got some sub scat. So if I've got any calf that's active, I'm going to fire it up. And again, these sorts of patients, they also need what I call proprioceptive input. So again, you know, I also if they can manage it, I quite like doing a bit more like weight bearing work. So table slides are quite a nice place to start. So, you know, just with a towel, just starting and just sliding forwards because again, any flexion that I get, I'm going to get some initiation of any coffee that's active. And again, it's quite an easy exercise to do, it's functional. So anything I can do to get that cup moving, I'm going to do it.

Steven Bruce
We're gonna go sit down, do some more talking.

Jeehan Lynch
As you go, gonna have been so kind. Thank you so

Steven Bruce
much. Megan thing has asked us another question. You said you haven't talked about any resistance tests yet? Did you use them? Is there a role for those evidence?

Jeehan Lynch
Absolutely. So we looked at the jointer set up for me, Susie, just so we can look them. So resist a cuff test. I'm like, what, like the empty cam fork and all those sorts of things? Or he hasn't specified? No, um, so So absolutely. I showed it. And I use the resistance here, testing sub SCAP here, you can do your own to can. But again, they don't have great sensitivity and specificity, but they definitely have their part to play. So for those,

Steven Bruce
I'm pretty sure most people will know what those tests aren't my interpretation of empty can is your turn your hand over your empty beans. You'll press down on the arm, the patient loses their control, then that's a positive test. Absolutely. That's a resistance.

Jeehan Lynch
And you remember, I remember my days when I used when I first qualified, we had this empty contest. And we were so like push push up to say, Yes, this is super respirators pathology, I absolutely cannot say that anymore. We're testing integral part of the cuff. But obviously, if you're if you're looking for pain provocation, they will say yes, actually, that is quite painful. So it is a way to detect pain. But it's not don't don't make it specific about certain tender structures that you're testing. But it can be absolutely is important part of your assessment.

Steven Bruce
Susie, thank you, Susie,

Jeehan Lynch
thank you so much.

Steven Bruce
For talking to each other. We'll get you back over here again. Thank you very much as always, gee, let's go sit down. I seem to have brought your little plastic dog bone

Jeehan Lynch
away in case I need that. Yeah.

Steven Bruce
You talked, we've talked quite a bit about scans. While we've been here. And I think one of your one of the bees in your bonnet is whether scans are absolutely necessary for these conditions. Talk to us a bit about that. When When would you seeing a patient? If you received a patient on first contact as it were, which you've done to the member? When would you say I've got to send you off a scam? Yeah.

Jeehan Lynch
So Steve, I think thing is it's about education to the patients. And I think a lot of our patients, it's a great thing, isn't it when you can Google everything nowadays, and I think they come in with a preconceived idea that an MRI or a scan is going to change their management, I would only use an MRI or an ultrasound scan, really, if I think the patient's going to require surgical intervention. And if I don't have to have that, that I can use my clinical assessment and my reasoning skills and my assessment of the patient to guide me about what I think is going on with that patient. So again, the other thing to bear in mind is you can get findings for an ultrasound and MRI, that actually isn't the cause of their pain. So me for example, I saw a lovely lady. She had had an ultrasound scan about six months prior I was told she had a partial tear of her her her Supraspinatus she came to see me he'd been referred to see I've been told I've got a partial thickness tear, I think I need surgery. But when we actually looked at her and I assessed her, her symptoms were actually cervical related. And as soon as I started treating her neck, can you see she all her pain went? So it's again, going back to that sometimes we see these things, but it's not the cause of your pain. I think sometimes that can give patients the wrong information. So scanning can be useful in the presence of trauma, if I think that patient's going to require surgery. Yeah. Okay, that's my tend to use it.

Steven Bruce
What about eccentric exercises? Lawrence's asked whether you recommend those who rotate?

Jeehan Lynch
So essentially, exercises definitely also have their place? Yeah, I think essential exercises have been shown, especially when you look at some of the research to be quite effective in more of the chronic rotator cuff patients. So I'm thinking of the patients that 18 months or two years down the line with that adapt eccentric work can be really effective.

Steven Bruce
What sort of thing would you use, some people might be struggling to come up with ideas for e centracare.

Jeehan Lynch
So essentially excises. J gives us a really lovely one actually where she has her band on her lovely Looper band around her foot and she has her sheet she has a knee up so you're lying like this, that the arm is up and then as you extend your foot, you allow your arms come down so she pulls down so you could do some really nice eccentric work like that. So you get some control. Again, make it quite functional. limps, you know, functional position positions. So I definitely think in some adduction Yeah, absolutely has its place. Yeah. There's,

Steven Bruce
there's a wonderful chap in London al Letterman. He's a physiotherapist and an osteopath. And he's done a lot of work on shoulders apartment in the US. But he is one of his big focuses is on exercise. And I can remember attending one of his courses when he talked about getting patients to do exercise by doing things, which were actually what they would do in their daily life. And we mentioned that in passing, but he would say, Well, you know, reach into the cupboard for a tin of beans and pull it out. And you know, next time use it, either use a heavier kind of beans or use a higher shelf, and do that for your repetitions rather than using Yeah, he wouldn't say rather than using exercise, but as an alternative, yet,

Jeehan Lynch
it's lovely idea. I absolutely believe in that. And I think that's what I was saying about the the guy in the gym, you know, as soon as I can engage in something that's interesting to them. And that's when you've got to get to know your patient, you have to find out what engages them. Because that's part of all our jobs. It's the hardest bit of our job, isn't it? It's getting patients to do exercise. We're not, that's why it's so easy, isn't it, I'll give them an injection or give you your pill. Those are actually probably easy things to do, but actually engaging with the patient. And we need to really look at it a biopsychosocial factor, we need to look at all their stresses and elements of their life to make it sustainable. Because the biggest reason why people don't get better is they just they just don't. They just don't believe in the exercise. And they just stopped doing it. And that's where we've got to educate them around what what's important, but I obviously agree functional is always the best.

Steven Bruce
Yes, absolutely. And we've had a number of people asking about where they can find a, an example of a 12 week rehab programme. I love

Jeehan Lynch
that if only there was something so if only there was something so like that. And I think this is where shoulders have been challenging, haven't they over the last. And I think the research has been tenfold we've had lots of great research is going on the last 10 years. But we're still to get a randomised control trial to look at the best form of a 12 week programme in a rotator cuff when we're looking at so many differential type patients. So what do you where do you start? Do you put partial thickness tears into it? Do you just put the irritable Supraspinatus pathology Do you it's that isn't it do to try so hard. But one thing I will say that we really need to be better at doing is really educating our patients around, you know, managing their health bit better. So you know, I always talk to my patients about smoking, drinking, taking regular exercise, limiting your stress levels, getting good sleep, all those things we know has an effect on tender structures. So again, I really feel that's also something we need, we need to look at within how we come up with that sort of way of managing our patients. But I wish there was a 12 is

Steven Bruce
straightforward. And I suspect everybody hopes that but on the other hand, it does fly in the face of what we say in our own our own criticism of standard NHS protocols. Here's the standard list of exercise. And we will say well, you shouldn't be doing this. And we'd like to teach them to treat this particular patient not.

Jeehan Lynch
And that's how I treat my students was just kind of wash your work, I say treat the patient that's in front of you don't just treat it as a book. Because that's really important. I mean, it's like I saw a lady you know that I go to I go back to the same thing. I have a 75 year old that's quite sedentary diabetic, not really that healthy, who may have other issues I need to deal with. But then I've got a 75 year old tennis player who's done a shot in tennis and stirred up her shoulder. I'm not going to be giving them the same sorts of exercises at the beginning, I'm going to give them something different. So they need different things from me. So absolutely. I wish there was something but it's not that easy.

Steven Bruce
A part of that same question was a query about and I'm gonna preface this my own way booth burger rotator cuff rehab exercises. I've never I've never come across it myself. It could be Bush burger be uch Biagio Oh, I'm so sorry. Well, whoever sent whoever sent in that comment about beef burger exercises, perhaps you could enlighten us as to what that protocol regime is and He gives us with ultrasound will be safe to use on an acute nontraumatic shoulder pain.

Jeehan Lynch
Right? If you look, I'm going to go clinical evidence. So clinical research evidence suggests ultrasound doesn't really do much for rotator cuff pathology. It doesn't have long term outcomes. So personally, I don't really use ultrasound. So my provider advocate advocate, you know, there are different things we could be using that would give a better outcome. Interesting. question.

Steven Bruce
The question was, is it safe to use and I'd like to think that there's there are virtually no circumstances where ultrasound isn't safe, really absurd situations. But effective is a

Jeehan Lynch
effective is one question but sorry, go safe. It will be safe. Yes.

Steven Bruce
Yep. Fringe clear here says what's your view of plasma injections, PRP for shoulder impingement. We're not allowed to call it children.

Jeehan Lynch
Again, again, really good question. The research again at the moment suggests there is no difference from other injections. So again, lack of research in that

Steven Bruce
field at the moment, but presumably somebody must be getting some results someone

Jeehan Lynch
must absolutely and it's actually interesting there is that I think consultant when I went to a last conference got got said they do work they do work but again, there's not been enough RCTs and not enough trials around So at the moment we don't know enough about it but at the moment, there isn't a suggested that it's, it's beneficial.

Steven Bruce
Gwyneth Paltrow was asked what your thoughts are on cupping and well he wasn't good at Pelto but she's the one who appeared on the red carpet or marks on the marks. Yeah, so cupping and I didn't want difference in cupping and wet cupping is but

Jeehan Lynch
I've got some icy I acupuncture but I don't know anything much about cupping. So some would have to educate me around that. So I'm so sorry, I won't want to answer. Okay,

Steven Bruce
so what's your acupuncture? Do you do? Are you are you looking for trigger points?

Jeehan Lynch
Yes, I am. I'm trained, probably more the western side of acupuncture sides tend to use more trigger points. Yeah.

Steven Bruce
Right. Okay. Well, it'd be interesting if the fingers around when we run our course with Simeon and Bob going because we're doing a course, which is all about needling trigger points. Oh, my God, it's, it's so much better than any other needling course. I've

seen that fast.

Steven Bruce
It's a three day course. It's phenomenal. It's just phenomenal. So much more specific. Anyway, I'll shut up about that. I love it. Tony has asked for any tips on rotator cuff post op rehab.

Jeehan Lynch
Yep. So is he asking about sort of repair after post repair or

Steven Bruce
I'm presuming post repair? Yes, they've been in they've had the surgery. We have actually

Jeehan Lynch
great orthopaedic protocols, which we worked with, with our consultants. So again, I definitely advocate they feel physio they get some of your consultants have a really good conversation with the consultants. What we do know and again, there's been some good trials is that when we used to sling our patients for six weeks, we know that actually is that beneficial to keep a patient quite still for six weeks. Lots of visitors disagree with the whole sling for six weeks, we really want to get them moving. And so in our hospital, we have what we call a standard, slow and accelerated repair. And that was something we've just worked on over the last three years that was put together with our consultants working alongside us.

So our accelerator programme are those cough patients that they think we've got a good fix. It's a nice young cough, I'm happy with the repair. They're in a sling for three weeks, and then we can progress them as such standard is our six for four to six weeks in a sling. And our SLO is those patients that are slightly, probably more attendance not quite so fixed as well. And they need a little bit longer for mobilisation. So those are six weeks plus. So absolutely, if you want to share, I'm happy to share those if anyone's

Yes. And if you say we'll send them out. Yes, absolutely. Or email me or whatever.

Steven Bruce
Well, I mean, it's better if they tell us because then we can send it to everybody. Yes, the one person who else which is helpful. How do you want to know how posture affects rehab on rotator cuff problems?

Jeehan Lynch
It's really good question. So again, posture. So Jamie Lewis has put some beautiful papers out there bad posture. And again, you know, lots of things be said about posture. But if you look at clinical research and evidence, there is no relationship that posture causes rotator cuff issues. So

Steven Bruce
used to be a great thing in physical therapy. So your posture is wrong. And you're so

Jeehan Lynch
right. You're so right, you've got to look like the textbook totally. But we know that different postures, you could have a lovely ballerina posture because they get shoulder pain. And you could be the person sit at the desk instead of shoulder pain. So again, it's not proven. Yeah.

Steven Bruce
Now here's one is a lengthy one here, Gary says, Have you got any thoughts on the works of John Hirsch MD orthopaedic surgeon, his book, shoulder pain, the solution and prevention? I'm reading this as it's sent through to me, he advocates hanging not from the neck. But to reshape the acromial arch. But well, if you come across

Jeehan Lynch
No, I haven't. But I'm going to probably answer that. And if they think hanging sort of if it's distracting it, it's looking more of a stretch on that couch because it doesn't change the acromial shape. I would I doubt that though much. But again, again, we're going back to maybe he means chromium, chromium space to stretch it. I'm wondering that but I wouldn't I wouldn't like to comment too much. I don't know much about that work. So thank you for sharing.

Steven Bruce
And Alexei says his hydro dilation going to be done on the NHS for capsulitis.

Jeehan Lynch
Very good question. So, again, the hydrogel rotation wasn't we weren't talking about capsules. No, we weren't. But we've moved on to that. But hydro annotation actually wasn't part of the frost trial. We actually put that in it's but what is happening, Manchester is being

utilised more more wildly. But if you look at again, from the frost child, the research, we don't have enough good randomised control trials when the killer perfect was so high dilatation. Now I know that one of my consultants thinks it works really well. The other three, don't think it does work. They'd rather go in and do an arthroscopic release. So it's a good question at the moment, lack of research, but I have to say I'm in touch with a few people that are looking at doing a bit of research. And the idea is to get it actually, as you say in primary care, because actually what we don't want to do, we don't really want them to be waiting that long for that. If it did work. It's an early injection is where we're going one of the consultants

Steven Bruce
we had on the show, I'm sure he said that it's just not feasible that you can dilate the capsule correct. It's just it's just not it's not flexible.

Jeehan Lynch
And when we were actually a part of this first trial stakeholder meeting was is really interesting because within that group, we had orthopaedic consultants with physios with radiologist talking. And obviously everyone has their own opinions around how it works. radiologists, we think it works really well and they get good outcomes. But actually surgeons, I, we had one side to say exactly that same as that, can you actually can you actually stretch break that capsule? Difficult to say, but I know that some patients have had some good relief. And there's really good trials suggest that it can really work. So I hope there'll be small studies and watch this space.

Steven Bruce
It's so often the case on this show that we talk about evidence, and then it's either ambiguous or it's not there at all, because there just isn't the volume of studies of this user. I got a long one here from meow. Meow says she's just started seeing a patient who's a 56 year old lady. You had a fall in July. So you can run about 50 You have falls you don't follow again. Yep. She's had COVID and she was very unwell for a couple of weeks didn't move from bed for that time, manageable shoulder pain and range of motion was limited because still manage normal daily tasks. She had a subsequent fall, she fell over again in October, tripped over her dog apparently I'm not sure if that's crucial to the evidence here. But she saved herself using her left arm and has since developed significant pain around the deltoid and pain into the forearm through the extensors and posterior shoulder. I thought slap region slap lesion says Mia and sub deltoid bursitis. She's had an MRI and this has been confirmed any suggestions for treatment rehab options, as we're limited by significant pain in multiple ranges?

Jeehan Lynch
Yeah, she's really struggling. Is she quite limited with her range of movement as well. So yeah, I mean, again, you know, you could certainly try some some gentle physio with her but she she may be if she's in a lot of pain, an injection may help calm her down a bit. And that may then give me the window to rehab her. Again, if it was a small SLAP tear and a 54 year old patient. We'd like to try manage that conservatively if we could. I tried some calming her down, do some pain control and see how she goes. But absolutely, she's going to need some graded exercise. And also with again, go back to the labour pathology, they do need proprioceptive input so she'll probably feel a little bit unstable in her shoulder. So I'd bring in a bit of proprioceptive input bit of weight bearing some nice scapular work calf activation, and see how she goes. But if she's had to falls, that's very unfortunate. There was no content. Just the labour.

Steven Bruce
The sub deltoid wasn't there on here. So yeah.

Jeehan Lynch
So and again, if she's not progressing, though, she may require surgical opinion.

Steven Bruce
Okay. Well, a couple more before we wind up I think Imran says thank you for answering his earlier question, but he now wants to know whether you think ultrasound can improve the recovery for a reverse total shoulder replacement? And what do you usually recommend patients in terms of ice or heat during their rehab?

Jeehan Lynch
Yeah, so reverse and reverse prosthesis. We haven't talked about them they are again, that's moving on to different topic, but it does go along with you know, an arthritic show that has very little cuff integrity. Again, we have our own protocols, it's very much guided by your surgeon. Every surgeon probably feels differently about how they engage. But again, they are going to be slightly slower. I will say for some of our patients around the six to eight week mark when they can start moving. If they are struggling with pain, they can be quite sore after that, we actually have the lovely fortunate thing of having a hydrotherapy pool, we love a hydrate and those patients they can really get in the pool do some lovely work. So again, they have their place but again, it will be the same thing. Starting with passive exercises first, and then working on to active assisted and then working on to active and then later resisted.

Steven Bruce
Specifically he wants to know about ultrasounds rolling this anything many evidence they're wrong. So ultrasound for rehabbing post.

Jeehan Lynch
Again, I wouldn't use ultrasound for any form of post op physical rehabilitation.

Steven Bruce
Okay. And I don't know how to pronounce his name is DUI. So it could be guy or GUI or graphic user interface. I'm not sure how fast you need to get to surgery before a ligament might shorten too much in a healthy young patient after a trauma.

Jeehan Lynch
So we're talking are we talking about the fact that tendons tendons shortening. Now I'm guessing that's what you mean? So, so again, it's the traumatic cuff tear, a young traumatic cuff tear who's fallen over? I ideally want to be seen within a couple of weeks and the ideal if you talk to surgeons or surgeons say ideally we should be we're operating on those within three months. Three to four longer

Steven Bruce
than I would expect. Yeah. They just seen that because that's the earliest they can expect again,

Jeehan Lynch
it could be it could be but all I'm saying is that ideally within a few months and and that's why if you look at the urgent criteria in the best bow a guidance, a GP should reaffirm this patient

saying they should bypass us and send straight into fracture clinic where they get seen by shot a consultant so that the that just speeds up that it's the bit where they have to wait isn't it to come through physio and then they wait that long trial to get into physio into Orthopaedics?

Steven Bruce
Yeah. And Bo says it's so good to see this clinical approach which aligns with Amber ozone reinforces what we do as osteopaths. And I'm guessing, as as I say, rightly pointed out, he said, but I don't I don't, I don't reserve the Osteoporosis as the only people who do this over the Kairos do as well. Yeah. The only difference he would say is the outcome score recording system, which could assist us to be a professor profession to become more widely recognised. Yeah. And I think I can't speak for everybody, but I know a lot of osteopaths who will treat and they'll observe and they'll, they'll make assumptions about progress. But they might not have an objective scoring system whereby they can say to people I've treated older people with, let's see rotator cuff problems. And here is the progress. And of course, they won't all be the same rotator cuff problems. Problem, but they will still be Yeah, some indication of progress.

Jeehan Lynch
And I think also using outcome measures is really important. I mean, we're at the stage where we have to prove our worth in HS because we're working at commissioning differently. And there's more stress and as Charles and as I think if if we can start to all users as a profession, it would also be able to also sell what you do better to other people, isn't it and share your knowledge. So although you know what you do is effective. Absolutely. Getting an outcome score shows your patients but also shows others that actually what I've done for that patient works really well. So you raise a really good point there.

Steven Bruce
We've got a lot of thank yous coming in, because they know we're getting towards the end of the show. And lots of compute. I'm seeing some of them on here. But I know I get a sense of what's coming in from the background. And we've had over 600 people watching. So clearly, it's a popular topic. We'll see what they say tomorrow and see what we want to get you back.

Jeehan Lynch
Oh, well, thank you. So I'm guessing.

Steven Bruce
But this is this is I think this question is almost meant as a compliment rather than a question, but it is a genuine issue. Stock says Can we refer patients to you but of course, you're not a primary physio, your secondary does that mean that osteopaths and chiropractors could refer directly to you? Do you have any private practice?

Jeehan Lynch
I don't I don't run my own private practice. I see a couple of I do see a few private patients on my own and I initially it but it's I only see a very small number because I'm so busy. I'm so busy being in the NHS, but I do see a few privately so a bit but my brain my main role is in the NHS and that's where my passion has always been is

Steven Bruce
actually a broader question for those people who don't live down near the Solon is how do they identify the right person to refer to rather than just say go to your GP and get a standard

referral to the person down the road he gives you a sheet of exercises and says come back in three

Jeehan Lynch
I hope what I've done today is hopefully make it more aware the fact that I mean obviously there are specialist physios obviously near you work hopefully, seek them out, find out if there is a shoulder physio like myself who works in primary care. I have I get loads of referrals from private physios that either bypass the physio they come straight to me because they think they tried some physiotherapy. I think that's the really disheartening thing isn't if a patient's tried osteopath treatment, chiropractic treatment, and they've they've done okay or they've not got where they want I have no problems getting a letter from my colleagues like that. So seek seek someone out that can help you and who's passionate about shoulder rehab and because there are lots of shoulder physios around. But absolutely,

Steven Bruce
we've got your patient for tomorrow as well, because Bekki ,Bekki, who's one of my team, online helping us online fielding the questions, she wants to know if you can see her somewhere, okay, she says you're amazing. Oh,

Jeehan Lynch
Bekki, I've got to come back. And I'd love to see Bekki, Bekki, you can come back on the show and be more patient.

Steven Bruce
That's been brilliant. I mean, 600 people watching is a very good number shoulders was always gonna be a popular topic, but you've delivered in brilliant.

Jeehan Lynch
That's been great. Thank you very much for having me.