Transcript

Evening CBD - Ref 218

Steven Bruce
Well hello and welcome once again to the Academy of physical medicine for some more fantastic CPD. Now as you can see, it's a hive of activity here in the studio as we prepare to go live in just over a minute's time. However, there's a few housekeeping points that I would like to cover. Thanks, Jay. First of all, we're delivering this to you live through the internet. And there are some things which are outside our control. Even though our system is very robust. It's very important that you get the right browser. And Google Chrome we found in our experience is the most reliable, he doesn't suffer from the sort of glitches that others particularly Safari do, it's still possible. Of course, if your internet goes wobbly that your picture might freeze. If that happens, hit the refresh button at the top of the screen, and do that a couple of times it hasn't worked, then go to the little Settings icon, the cogwheel at the bottom right, the video pane. If you click that, pick the lowest number 360. And that will just reduce the resolution of our picture and smooth everything else on your internet for you at camera three. Steven what of course makes this brilliant CPD is your participation is what we wanted. We want your observations, we want your questions, your own experiences about anything that's relevant to what we're talking about this evening. Thanks very much. Do that using the chat button awesome, right to our website, or using the normal comments system in Facebook. We don't know who you are unless you give us your name. But it's really nice if you do that, because I like to acknowledge people who are contributing to the show. The one I'm on the subject of Facebook, please do register, registries got two advantages. First, it means we have a record of your attendance, which is useful if you're ever audited by the General Counsel. It also helps us to send out a reminder email at the end to make sure you claim your certificate, which is dead easy to forget otherwise. On the subject of the certificates, there's a button at the bottom of the website, which you click at the end of the broadcast and your certificate, and a link will appear on Facebook. They've got all the details that you could need for your CPD record. But there'll be updated over the next 24 hours, magically and seamlessly in your profile where we store all your secrets. Right. That's the housekeeping oh boy, let's get on with the CPD. Hey, good evening, and welcome to the Academy of Physical Medicine. I've got something slightly different for you this evening. We have done case based discussions before as one of our evening broadcasts. But normally we do these things as a lunchtime show just 45 minutes. We got some criticism for that because lots of people busy clinic lists and so on, so they can't make the lunchtime shows. So what we thought we would do is we'd throw on a number of particularly interesting cases over tonight's 90 minute session and see what you think. And the idea of course, is that not just that we tell you what's happened with these cases. But the idea is that you tell us what you might have done where you think we went wrong. And this is a group think exercise group thinks probably the wrong word. But what we want is a group discussion over how we can handle patients better so that when you do you're much vaunted reflection, we all go away with something which tells us you know how we can do better around in our own clinic. So let's go and see me CPD I've got three fantastic guests joining me all by virtual camera. On one hand I've got Claire who

you've probably come across before Claire is my wife I follow osteopath very experienced and has usually got lots to see for herself as well as things about interesting cases evening, Claire, II think, Oh, I'm gonna get it in the neck for that later on. We've got pepper, customs, pepper, you're also very, very experienced in this in osteopathy. And I think you've got a an interesting case, which isn't about the muscular skeletal aspects this evening. We'll come on to you in just a second. And of course, we have Rob shanks. Now, Rob has been on the show on a number of occasions before again, hugely experienced but also very, very expert in how to look at MRIs and imagery of that sort. And there'll be a bit more about that later. And he'll be taking us through some images while we're on the show this evening. Anyway, so that's my guest for this evening between us. I think we have got about we've got four possibly five cases depending on how the time takes us. But let's start with you pepper, if we may, what have you brought to the table.

Pippa Cossens
I bought actually a patient I only saw this week for the first time who was a lady who is 58 and she is she came because she's really really anxious and that was why she came for treatment. In our clinic we tend to treat quite a lot of stuff logically biassed cases. So actually, it's not unusual for us. But this lady was the most anxious patient I think I've ever seen. So she, she arrived at the door, and she proceeded to put on her FFP to mask with a surgical mask over the top. And she stood on the doorstep outside and said that she wasn't sure she could come to her appointment because her daughter was at home because she wasn't she was sick from school. And I thought, that's absolutely fine. If you want to rebook it, we can we can do that. i To be fair, and I'll tell you a little bit more about that in a minute. I had actually had a pre telephone conversation with her prior to this, so I didn't know how anxious she was. Anyway, so she stood on the doorstep, and I realised that you know, the level of anxiety you could, it was palpable without touching her, you could just see it coming off. So yeah,

Steven Bruce
this wasn't just anxiety about osteopathic treatment. This is just anxiety about life in general.

Pippa Cossens
Absolutely. And in fact, one of the pieces of information I'd gathered from her in the, in the pre consultation phone call was that, essentially, she'd suffered anxiety a long time, but the pandemic, the beginning of the pandemic, and just, you know, ramped it up to a completely different level. So she then was, well, you could you could see a fizzing you know, and so she, she decided that she'd castable. Listen, you know, if you want to come in, and we can just take a little bit of the history, and we can make a start, and you can see how you're doing. So she came in and she sat down and she, we open the window wide, and we you know, did all of that stuff to make her feel as safe as possible. We went over what we've done to make the space, you know, safe. And then we started taking the history and I and she she was saying, you know, she was saying how she has acute anxiety, and she has some depression. And it obviously, is affecting sort of all aspects of her life. I think she does have health anxiety, but I think it's affecting everything. And she, she then we I mean, literally, I was just gonna flash the case history. This was as far as I got halfway down the first page. And then she said, I really can't talk about this anymore. I can't, I can't speak anymore. It's making me more anxious. So I ended up really with a kind of a non case history, if that makes sense. And I suppose that in some respects, the difficulty in this case is, should I have gone on to treat her without having a full case history. But I'll come back to that in a minute. So she, she, she said she stopped there. And we talked a little bit about what she wanted to get out of it. And she obviously just wants her systems to be calmer so that she can function in life better. And I in the pre the pre conversation that I'd had with her on the phone, she'd given me several other pieces of information. So she's

a single parent, of an adopted child who's 10. And she's had obviously a history of sort of the anxiety and depression insomnia for quite a long time. She I think has been on medication in the past to help control that. But I think there's not on so much at the moment because it doesn't agree with her. She had had quite a lot of upset over the pandemic with regards to moving to be with family and then moving to be home. And she also mentioned in her history that as I say on the phone, that she she had been in Bosnia as part of the peace process. And she had ended up with some PTSD following that. So the other consideration we have to take with a case like hers is is this osteopathic or not? How, how far can we take it when we have got that, you know, we're on the edge of the comfort zone essentially of hers, you know, the psychology of it. So I myself am also a certified trained practitioner stress on this recovery practitioner. And in that guys, we are, you know, very well informed psychologically, but we certainly wouldn't treat psychiatric patients without the sort of say serve their psychiatrist and the support of that. So as long as it's a psychological disorder, then we're somewhat happy, but she was definitely on the edge of my comfort zone with that. And I mean, I treat a lot of anxious patients with a lot of psychological, psychological stuff going on. Anyway, so she, she, we took off the history and I thought Well, realistically, my my Compassionate osteopath thought the best thing I can do is to try and start treating her so that she feels a little bit calmer because essentially, we're not going to get anywhere without that. So she, she took off her coat, and she took her shoes and she lay on the table. And on trigger table, a nice thought my my thing was, like, if I can just start to calm down her nervous system, we might get so much you might feel better. So I did that. And I was taking as a practitioner really aware that I needed to be really calm. I was super super slow in my speech, which is not normal at all quickly. So super, super slow. really thinking about my connection with the ground and my grounding anyway, I nearly always start with a contact on the sacrum, just thinking about bringing that nervous system activity down. Looking at the sort of parasite, parasympathetic outflow in the second just kind of started to calm it down. And she was absolutely fine for about three and a half, four minutes. And then she said, I think I'm going to have to go now. And she got up off the table, and she put a coat no shoes on. I said, that's absolutely fine. I'm sitting there kind of go, Oh, my God, you know, anyway, so she, she did that. I said, that's absolutely fine. I said, what we can do is we can cut you come back another day, perhaps when your daughter's not at home. And when you feel a little bit, you know better about it. And we talked for a few minutes about what we could do when we talked about a grounding technique, you know, we get people to imagine that they've got, you know that they're an obituary, and they've got roots growing out of their feet. So we talked about that as a sort of self care technique for her to take home. And then, and then she said, I think maybe I'll have a little bit more. So she took her shoes back off again, and she took a coat back off again, and she got back on the table. And so we started again, and we just we calm things down a little bit. And again, she was fine. Interesting enough until she started talking about what was going on. And she was very concerned about me, and I'd take on her staff, and I was telling them I wouldn't and it was absolutely fine. So we got a little bit done. But I mean, I don't know 3% Of what we needed to do. And then she said, I really think I'd better go now. So she got up again and put a coat on. Anyway, so she then she she she she rebooked to make another appointment. And then and then she left. And when I'd come down from from her leaving, I was slightly left with this feeling of should I have treated her I didn't have a full case history. I had some of that information. But as I say, was it better for her and actually more compassionate to have treated her a little bit to settle that down. We always say to our patients, all of our patients, if they have any concerns at all, they need to get in touch with us. So we've done that part of the conversation. And to be fair, actually, about 10 minutes after she got home, she'd obviously rung the receptionist and just you know, saying thank you for the treatment and stuff like that. So she was obviously I wasn't overly concerned about her. But it is an interesting, as I say, even though we haven't quite psychologically informed practice, she was still kind of right on the edge of that of that comfort zone.

Steven Bruce
Well, actually, first of all, would you mind if I don't go down a very brief rabbit hole? Yeah, because for if the people watching this evening have not been on our case based discussion before then they won't be familiar with the characters who are out there in the audience. And one of our regular attendees, Robin has a pet theory about fixing virtually everything. And before any of us said anything this evening, he'd already said, Have we tried barefoot shoes for all our patients? So we'll just throw that one in at this stage. But getting back to more specific Thank you, Robin for that very helpful. And getting back to the specifics on your

Pippa Cossens
I've got my barefoot shoes on. Excellent,

Steven Bruce
good. Getting back to this question. What made her come to you rather than go for counselling or other sort of psychological help?

Pippa Cossens
Do you know that? I? That's a really good question. I'm just I can't it doesn't say where her recommendation was. So I'm not sure if it was another patient. I think I'm 99% Sure. It was a chronic pain patient that we had before. Who had seen us and I think their friends, and she the anxiety and chronic pain just completely go hand in hand. Nearly every single one of our chronic pain patients has some degree of anxiety or other and essentially, I think so the angle, she'd obviously talked about the anxiety and I think this is why she'd been referred to us. But to be fair, we have built a practice. Because we have we we say we're specialising in chronic pain. As I said, we end up with the anxiety patients as well.

Steven Bruce
But you also said your Serpo trained, didn't you which is Georgie Oldfield is the moving force behind that. I think, for those others, those who have not seen the broadcasts we've done with Georgie they're well worth a look. And sirpur Remind me what the initial Stanford

Pippa Cossens
surfers the stress illness recovery practitioners Association. And essentially, what it is, is a it's really, it's really formed out of looking at different perspective of treatment of chronic pain. It isn't a physical therapy based thing. It is very much about bringing the psychological therapy to that. And so it's all about kind of the neurobiology of the brain and all about helping people to reframe their pain, educating them about not being so fearful about the thing. Fear is such a huge, again, a huge part of the pain story. And so it's about integrating we integrate that with a hands on approach in the clinic here.

Steven Bruce
So I've had some observations come in from people other than Robin already. But before I go to those observations, one of the criteria which is in our practice standards, whether chiropractic osteopathic physio therapeutic or whatever else, is that we shouldn't act outside our experts in our areas of expertise. And clearly this is to some degree, an area of your expertise. So my initial thoughts and I'd love to hear other people's other what you did was not going to cause harm, but might have enabled your patient to calm down sufficiently to give you the case history that you needed. Yeah. And one of the things that, of course, we talk a lot about in first aid is that if you're acting in the best interest of the patient, and you're not going to cause harm, then I think you're probably safe. But that's just my view. Let me take these issues here. Claire has

just told me that she's got a rather canine emergency going on at the moment. So she'll be back with us in a second. Martin says, What is your osteopathic diagnosis paper and apologies to the chiropractor's I mean, we we're not trying to exclude chiropractors, and sirpur doesn't exclude chiropractors either, as far as I'm aware, but he wants to know what your diagnosis was.

Pippa Cossens
When essentially the diagnosis was anxiety. That you know, she that's very much what she presented with, from a from a osteopathic perspective, from a tissue feel. You've got a an overactivity within the nervous system, but the diagnosis would have been anxiety.

Steven Bruce
Okay. And of course, you didn't get the chance to nail down where you thought that was arising. So maybe this is something we'll discuss in the future, they carry his asked whether she was more able to talk over the phone to maybe complete the history over the phone. So she's within her own comfort zone? Is that something you've thought of?

Pippa Cossens
Yes. And to be honest, actually, then looking back, because I'd already had that. I think I was probably less worried about continuing because I'd already had that pre existing conversation with her on the phone, which is not something that we do as a regular course of in practice, but she was because she was so anxious. That was something she wanted to do we offer it, but it's something that she wanted to do before she came. And as I say, I did get more information in that conversation than I did in the case history. And when she was when she was present. Um, so I think my understanding was I had that pre information. I was like, Okay, I know where this is, you know, we, as I say, she told me that she'd had PTSD. And she told me that she'd you know, sort of when that had come from, so I had got an understanding of that, but then you've got to be super cautious with a nervous system that is got that heightened activity.

Steven Bruce
I'd say when you mentioned she'd been involved in peacekeeping activity in Bosnia, I was thinking to myself, why on earth would someone so anxious go there? Did the anxiety arise as a result of that PTSD where she already anxious beforehand?

Pippa Cossens
I think it probably arose from that.

Steven Bruce
Right. Simon's Simon's asked a question which actually flashed through my mind as well. Which did you say she came to you with pain as well? Or was it purely anxiety?

Pippa Cossens
No, she actually, she came purely with anxiety. Now we are on the, you know, the things we're allowed to say we treat with regards to the Advertising Standards Agency. So she does have an inability to relax. So you know, we're sort of, you know, but I'm, we're not necessarily. That's not not the point. But no, that's why she came, she came with anxiety, I don't actually let me just have a look and see, I can't know she doesn't she didn't describe the painting picture at all.

Steven Bruce
He says somebody I don't have the name of the person who sent this in. But this is an interesting idea. And I can see pros and cons to this. They've said Koshi have supplied a history by email or writing. And of course, you can get so much from a written history, don't you? We

get so much more from looking into a patient's eyes while they're talking to us and exploring the answers. So the things that you get on that sort of screening sheet that we heard that these days are only a starting, I feel that when you think

Pippa Cossens
we're interesting enough as part of the circle process, when we have our kind of patients that we know a chronic pain patients, and that's why they booked and that's a specific type of appointment that we offer. We actually will have the server questionnaire is about 15 pages long, and actually would cover all of that, but she hadn't kind of quite come through that route she'd put to standard osteopathic treatment. And so I hadn't, hadn't actually she hadn't. I hadn't got that information, if that makes sense. But it might be something from this point, depending on how I almost want to see how she is next time and before I suddenly bombard her I don't want to overwhelm her even more. It's quite a big document. So it's, that's the beauty of the face to face as you can kind of judge and go out Hang on a minute, when you know we're going too far with these questions, we need to back up a bit.

Steven Bruce
This is a another question from me before we talk to other people to interview. Is there a danger when you when you give someone a 15 page questionnaire or whatever is, is there a danger of promoting some sort of catastrophize ation on their part? And when they see all the questions, I don't know what they are, but they think, Oh, my God, I must have this horrible thing wrong with me.

Pippa Cossens
Interesting enough. I'm there. And this is a really big generalisation. So I apologise to anybody who's out there struggling with with chronic pain, and I am a, I did have chronic pain myself, and I've recovered. So I do know the whole of the process. Interesting of the catastrophize ation may already be there. So it's it's normally that's that's already, that's very often present, pre we've even got to the point of the questionnaire, the questionnaire very much covers kind of current history. It covers, obviously, previous history, but it also starts to link together. Things that have happened that are not necessarily I lifted, that box or eyes fell over, they're starting. So what else was going on in your life at that time, you know, but then actually, because history is so important in a chronic pain pattern that goes all the way back to childhood. We're also looking at what it asks for sort of timeline and even goes back and looks at, as I say, what possibly can constitute adverse childhood experiences. Hope goes right back to the beginning. But it's always we always say that people only fill in what you want to fill in because it can be a little bit overwhelming.

Steven Bruce
Alex, if you are craniosacral therapist as well.

Pippa Cossens
I treat i i possibly stick myself in the biodynamic cranial osteopathic gang.

Steven Bruce
Right. Okay. Martin sent in a follow up to his earlier point, he says he thinks the essence of what you're doing is providing excellent support to a very needy patient. He's just worried how you justify this approach as an osteopath, if you were ever called to. Rob, what do you what do you think about that, about the sort of the ethics of treating something, which is not what we traditionally think of as an osteopathic chiropractic problem?

Rob Shanks
I mean, I think if the patient's there in front of you, and they're requesting your input, you know, okay, it might not be the textbook kind of, you know, classic sort of case, but I kind of tend to find the accountable if you feel like you can be a service to them, then you probably should. That's, that's, and also

Steven Bruce
and also in terms of care for the patient, what could be worse, and they turn up and you say, I'm sorry, I can't treat you go away. And so

Pippa Cossens
in some respects, it's the I think, not just me, I'm Alaska can speak only as an osteopath. I think it's part of that amazing osteopathic health care, I think which actually, I think so much of what osteopaths do is that listening, that is just, you know, spending time understanding hearing patients, you know, actually hearing what they're saying, signposting them if that's necessary. And I think I mean, I, I spend a huge amount of my week. But as I say, that's because we sort of like a lot of practices, you start to attract the same patient. So you know, we have a lot of a similar group of patients, you know, kind of just making people feel more settled more in their bodies less agitated. And this is going to sound completely ridiculous about politics, it's almost like sometimes it feels like they come home, it's like, they settle back in themselves. It's like they feel more like themselves when they leave. And part of that is the hands on. Part of that is the advice we give them so that they feel empowered, to be able to do something themselves. And part of that is just the listening and the being there. And, you know, in combination with the hands on

Steven Bruce
wouldn't be much of psycho therapists or people involved in that sort of area of practice. Would they not argue that if people try to listen, and they don't do it properly, they could aggravate the problem? When I say listen, I mean, effectively try to take on a role that we're not skilled in performing.

Pippa Cossens
Yeah, no, and that's when that's where we, when we get to the edge of that sort of sense of our comfort of that, then quite often what we would do is refer the patient on to perhaps a certain practitioner, who is a psychotherapist, that's their, that's their professional thing. So we there is a sort of a border of that. What we're not trying to do is necessarily talk it's more about understanding and putting the clues together rather than psychoanalysing and actually counselling the patient if that makes sense. So it's about listening and make and helping them to understand that events, perhaps in their history are important as to how their nervous system is functioning. So So We're not providing counselling as such, we're providing understanding and then advice of how to start to, you know, reframe that within the body.

Steven Bruce
Yeah. And one of the things that we're planning to do on one of our shows in the in the not too distant future, is we're going to we're going to run a show on how to do that listening empathetically without trying to pretend we're a psychotherapist or anything like that. But while I've been listening to you, I've been think well, what would I do if a patient came through my door with sight sign symptom behaviour, such as you've described, but of course, I suspect it's very unlikely that they would come to you because someone knows you and knows what you're capable of, so that they've come to you because you're who you are not simply because you're an osteopath. Claire, have you got any thoughts on treating anxious patients?

Jack March
I thought that what people were saying about it being I know you don't like this word, but being very much a holistic approach is really important. And the fact that she's done the surfer training means that she's got understanding and boundaries in place that those of us who haven't done any training, don't have. And I think that's always my biggest worry. And many years ago, Stephen, and I met somebody who did massage. And it wasn't wasn't anything to do with our clinic, we were on a course. And she was there as well. And she just happened to mention in in conversation, that she did counselling, during her massage sessions. And it really hit the two of us or struck the two of us that there wasn't an understanding of the boundaries and the limitations of her profession. But I think I think the majority of us have much clearer boundaries. It's just, we don't have we don't have the training.

Steven Bruce
Yes, we have clear boundaries. And also, as a massage therapist, she's not responsible to a governing body, which can impose sanctions even strike you off the register, if you're found to be acting beyond your capabilities for the patient, possibly to their detriment. And you might be doing the best that you think you can for the patient. But if they subsequently have a turn for the worse, have an adverse reaction, or whatever it is, and they decide to blame you, it's going to be very hard to show without a reasonable amount of relevant training, that it wasn't your fault. Dave has said he would definitely have done the same as you pepper. But we thinking always about aiming to convince the patient that psychotherapy would be considered alongside physical therapy. Do you think your patient would have been responsive to that?

Pippa Cossens
I don't think in that first appointment with the way that it went that I could have even mentioned that. But I think it would be certainly something that I would be considering. I don't to be honest, I don't think I don't think I don't think she mentioned whether she had or not. And it's interesting, because I think for her talking about it is actually quite agitating. So I think it's almost that that delving into it might be worse. Now, I facilitated a course last summer, which Michael Harris taught, and Annie Greenacre his wife on discovering the health and trauma. And they worked. So Mike was obviously an osteopath and Annie as well as being accredited. That therapist is a psychotherapist. And they work together. And one of the things they say very often is actually the patient often requires maybe six osteopathic treatments before to sort of stabilise the nervous system to calm the nervous system to make the patient feel safe enough to be able to do the psychotherapy. So it's almost like the hands on stuff comes first. And the just as I say to make the body feel safe, that then the psychotherapy can happen because there's not they're not dissociating and they're not you know, is it safer for them.

Steven Bruce
I think the the Mental Health Foundation, I think it's cool because it's made great strides recently, but there are still there is still a huge stigma isn't there in admitting to confessing to considering that you might have a mental health problem and anxiety could be a mental health problem as well as just a nervous system problem. And I think actually we're going to run we're actually going to run a show on mental health first aid as well because part of the battle is getting people to realise that mental health first aid is no different to looking after your structural illnesses and problems. It's just another part of the body that sometimes misfires for as you say we have this particular patient thinking it might need counselling or she might need therapy with that so it might have made her feel even more anxious and work.

Pippa Cossens

I think interesting enough to we find with quite a lot of patients because they come because they've got chronic pain. But we screened for we screened for anxiety we ask about anxiety we ask about sleep we ask about fatigue we're looking for we're almost looking for these patients, if that makes sense. But it's interesting with the anxiety when you get people talk And then you just say to them, you know, might there be something further back in your history, you know, from when you're a child that might have been, you know, significant and, you know, almost everybody's got a story. And, and I think it's the firm people often say to me, because I'm a physical therapist, and they sit like that they go, hang on a minute, I've just told you more than I told my counsellor in 10 years, because I think they're slightly disarmed by the fact that you're not there to kind of delve into their head. And so they, they just open up and tell their story. And that's so important.

Steven Bruce
Well, perhaps the last one before we move on from this particular patients come in from one of our viewers who was very appropriately called helpful person, I think, by the system. He or she says, actually, they think you're doing an amazing job. Plus pain is sometimes not what we can see it's a crutch. And sometimes we can work wonders, and PIPA, they say that you are spot on. So thank you for that helpful person. However, where do you think this is going to go? Just briefly, before we move on to rob?

Pippa Cossens
What sense what do you think is the

Steven Bruce
next stage for this particular patient? What do you think you'll be able to offer her or how do you think you'll be able to signpost her now,

Pippa Cossens
I think interesting enough, it'll be very much depend on how she comes in the next time, I'm encouraged by the fact that when she got home, she rang to say, actually, thank you for the treatment. So that makes me feel that she had almost done her exploration to make sure that we were safe, and that she liked us and that she could manage to come. So I think we might get further when we see her next time. But we'll always keep in, as I say in mind, whether this gets, you know, over the edge of our comfort zone of treating her.

Steven Bruce
And apologies, I said we were going to move on, but actually Robin sent in probably one of the critical questions, which is kind of refers back to what we said at the outset. Are we in a position here to take informed consent? Or valid consent? Are these a better term from from a patient? If we've explained that it's not our primary role, but the patient still wants treatment? And we're not doing any harm? And I can see his point of view? Do we have valid consent? I think we probably do, as long as you've got some expertise as you have pepper in dealing with psychological issues. Right? We might we may end up getting dragged back to that because some patients or some questions come in a little bit after the discussion. But Rob, can we move on to one of your cases, please?

Rob Shanks
Yeah, certainly. So the the case that I was going to present to you as a tapper named call, he's giving me full consensus shows information with you as well. And I've got a vague fee. And this is a case that I did touch on way back when I think I may have put up his scan when he first came in. But I've now gotten the full the full way with this chapel is now being discharged. And

he's kind of had his his treatment, but I followed him up for several months, I thought would be an interesting case to share. Because it actually picks up on some of the points have already raised in the sense of when this chat first came to me. I actually remember the receptionist saying to me, I've got this chap on the phone, or he's booked in with you for next week. And he is I mean, I think in her way, I think she may even you may even use the S word. He was kind of almost suicidal he was he was at the end of his tether, and he literally was, you know, just kind of putting it out in terms of what to do. So he was a young policeman. He was in his early 30s. And he'd been complaining of many years of left arm pain, shoulder blade arm pain. Now, it wasn't your I'd say typical kind of, you know, I was into the C six dermatome C seven downtime, he was a little bit more. So you know, proximal than that bit more around the shoulder blade area. And he, well, he been he'd been through a whole remit of seeing different practitioners and doctors. And I think I'm promoting them I actually remember speaking to him first on the phone. I said some right, I said I want you to first of all just to send me all your all the stuff, all the information you've had done and just send it all to me. And I kind of when he when he did I thought I always regretted because he was one of those ones that had pages and pages and pages and pages and pages of stuff. But I know I spent my time going through all and he actually had done a very nice summary for me, which I'm just going to share. I'm gonna try and share with you now. And this is one of the first things that I put on on my notes. Is everything right? Get this right Okay, are you seeing are you seeing this, everybody? Yes. Great. Okay, so this is go back to kind of near the beginning. So this was actually his summary. This wasn't just this was part of my notes. This was a summit that he kindly sent in and he had a few things going on. Various different different injuries, but the one that was really was concerning him was this was his left shoulder area, like I've said, and they it had the shoulder Was it a tendinopathy thing? Was it a bursitis he got referred to the the orthopaedic surgeon. He'd been to the Queen Square neurology place. And again, you had various MRIs done and one of the MRIs came back and it said that, you know, there was an impingement on the on the C four. But then I believe there was a subsequent one that actually concluded Actually, it wasn't any worse on the left than it was on the right. And long story short, I won't go through everything with you. But he ended up seeing I think about three consultants. In the end, he saw us and spine is sort of surge, surgical spinal surgeon surgeon, who basically said there was no surgical target. He ended up having some nerve conduction studies, EMG studies done, and they concluded there was nothing wrong. And he was then told he had various different possibilities of things like fibromyalgia and thoracic outlet syndrome, he'd been to see different therapists, and it all kind of, you know, been treating him and not really getting on to well, and he hadn't really had any sort of long term relief. As I said, this was this is the one I think here we had the MRI scan 2019 It basically just said, you know, it's kind of causing bilateral, you know, nerve root compression. And I think this one, I think it kind of a conflict is one of them said it was worse than the left one of themselves worse than the right another one. So it was it was equal, left and right. And anyway, the conclusion I came to was that it was nothing to treat surgically, he had a cervical epidural injection, which hadn't really worked. He'd had a medial branch block injections, which again, hadn't really worked. And like I said, he he kind of came to me and to say, Well, look, what what do I do you know, anything to the pain management people, the pain management said, Well, you're just going to have to live with it. And kind of almost like a chronic pain situation. But literally, he'd been to different therapists and just and he wasn't getting there. So the first thing caught being me I said to him, Well, look, let me have a look at your scan. I want to see your scan. So let me cut to I've done a done an extract of one of his slices free scan. And I'll just bring that up now. Okay, so I'll come back. So this is this is one of the this is one of the first things that striping, striping, striping, striping, striping, striping. Oh, right. Are you my back? No, we can see you. I'm just getting a vicious echo of myself. hear myself talking. But you can hear me talking now. Yeah. Yeah. Okay. Okay. So he was he was his, he was his MRI image. Or one of the one of the slices that we saw. And, you know, I think we can all see there was

there was something going on here. Let's see, three, four. Now, I just thought myself, Oh, hang on. That's that's got to be, you know, that's got to be relevant. And that's got to be that that just looks quite severe to me. And I kind of actually pulled up the scan I showed him at the time. So look at this, look at this car, you know, you can see this doesn't look right, doesn't it? And I said that this is this is potentially hitting on your C for nerve on the left side. And I said, you know, if you've got a C for impingement, then that potentially could explain all your symptoms. And it has already been mentioned in by some of the previous consultants that you've seen, but it seems to have been dropped. And they're just not going with it. And then And then he said, Yeah, but I've been to see, you know, three consultants recently, and they've all told me, it's nothing to worry about. And you know, it's just kind of general wear and tear. And actually, you know, I shouldn't be having anything done about it surgically at least. So then I said nothing. So we both they tested my nerves and they said, look, I've got no nothing wrong with my nerves. I said, well hang on, but let's go through it and actually say well, if we go through your nerve conduction studies, what they've done was that the test is from see five downs I haven't actually tested to see for nerve root. And then I said to him, Look, the injections you've had done, haven't actually targeted this nerve. So I said the one thing you haven't had done is a diagnostic see for nerve root injection. So we haven't you know, you haven't been part of me but you haven't actually had the proper diagnosed diagnostic kind of remit in terms of going through systematically, according to what we're seeing on your scan. And I remember him I remember him getting quite not almost like he was almost on the verge of being angry with me. I think because I was because I've making it sound so simple. I think he was so well hang on what you know you're not you can't be telling me this. I've seen three consultants, and I've had to had to sort of politely stick to my guns and say listen, I know You'll notice things for consultants. But I honestly do think this is something you need to explore. And, again, this is why I think, you know, as osteopaths where we've got the time because I mean, I had spent a lot of time going, I think I probably spent more time with him than any other previous consulting had done. And I was just piecing through we had done we hadn't had done. And I think that's one of the benefits we can sometimes have. Anyway, long story short, I, the first thing we did was we got him to have the CIF, what first thing I did actually was have a qualified opinion on his second opinion on the MRI scan. So I was I was saying to him like, this is what I think is going on in your on your scan. I think this is significant. But, you know, I'm not a qualified radiologist is not I'm not really in theory qualified to tell you this. But we need to get a second opinion, I need to get I want to get an opinion from a radiologist that I trust. And I was kind of done a little speech about, you know, how not all, not all radiologists are as good as some are some others. So I said, Look, we're going to get this done by other chat. And what long story short what cat what came back was that, more or less agreed that this was definitely a potential see for radiculopathy. And that then led to him having an injection and nerve root injection into the sea for and I think he had something like three days of almost total relief, it was it was the most significant chunk of pain relief he'd had, in many, many years. So for me that that sealed the deal that that made me think, right, this is definitely what's now the source of his pain. I even also went one further, I had a shattered meeting over zoom with, with Bob Chatterjee, who you know, you've had on on your shows before spinal surgeon. And again, Bob, Bob's opinion, I trust very much. And I remember him actually getting quite quite annoyed about it in the fact that this guy had been mismanaged, clearly being mismanaged. And not, you know, they hadn't really taken him through the proper diagnostic steps. And he, you know, he totally was incorporated what I was saying. And so then having had the diagnosis of like, it was then a case of war. Now, what do we do? You know, what do we what do we do to treat you? And can we do anything to treat you? And, and this is where I kind of set out a little plan for him. And I said, Well, this is this is this is my proposed treatment, we had we we take that off the list, we had that done. And I said to me, if that does work, well, then I'd like you to, you know, have some one of the treatments, we do the odd therapy to try and target that disc level and try and decompress that that

particular area. So he did he did he did do that. And he, again, he had a equivocal response, I would say it wasn't wasn't convincing. I wasn't I was suspicious, he probably wouldn't get much relief from it. But it was something to try ahead of, you know, further in invasive procedures. We did. I did talk to him about possibly having some prolotherapy done for his for his neck. I don't believe he did go through with that. And maybe that's something I could have pushed him to do a bit more. But he didn't. Oh, sorry. Yeah, I can't hear you very well, actually steam,

Steven Bruce
because you just talked about doing 20 sessions. How many of those sessions did you have before you said this isn't?

Rob Shanks
He had about memory, he had about six sessions. Now he, you know, potentially could have had more, but I was might I was expecting to see some degree of relief within six to give me the confidence that he would then benefit from more. And he you know, I mean, he had the hardly any relief to be honest. So for me that I felt I was barking up the wrong tree at that point. And so I can you say that again? Same. I'm really struggling to hear your mind. Sorry.

Jack March
I'll take over and what Stephen was saying is Victoria has asked had you had any previous injuries?

Rob Shanks
Right. Okay. So, so he was a an avid horse rider. And in fact, that was he he was actually a mounted police officer. So he was, you know, used to running horses. And in also in his home, one of his hobbies was golf. And he was his, he remember him saying to me, I don't just practice golf, like most people golf is I'll be I'll be out potentially some some days, or have done in my, in my past 12 hours a day. Like he was obsessive. He was he was, you know, twisting and turning and rotating. And so yeah, he had a lot of wear and tear, let's say coming through his neck. And and I don't think there was any direct injury as such in terms of remember, there was no like head trauma or anything of that nature, but it was more, you know, perhaps from the horse riding but also, I remember him saying to me, I think it's the golf that's done it to me.

Steven Bruce
Thank you. Thank you. Can you hear me please?

Rob Shanks
So I can hear a bit better now. Yeah, yeah. So basically, I mean, what where we, where we went with with with this chap is that he, he, he went to see Bob, and went for an opinion with Bob and Bob did say to him, you know, okay, I actually think you are going to need surgery and you are going to need a cervical fusion operation. And, again, I think there was this question in his mind, well, why haven't I been offered that before? And, you know, I actually said, Well, the reason we haven't offered that before, Carl, is because the people you've seen before, don't do that surgery. And whilst they perhaps should have been thinking about that, because because they don't do it, they're not necessarily going to offer it to you. And we long story short, we ended up getting him referred over to the Royal National Theatre hospital and Stanmore. And I, he saw one of the surgeons there, and I believe that within something like 10 minutes, the guy does turn around, said to him, you know, 100%, you're going to need this, this operation. And he said, I'm going to give you, you know, an eight, he saw I 80% chance that work for you. So, anyway, he was still very concerned about having the surgery. And he, he, I think he did actually try to put it off for a while. But in the end, he had the surgery. And thankfully, he had a fantastic

outcome. And it got it got it took a while to get what he was paying, because it been for so long. But he hit all the goals and all the milestones like but they they wanted for him. And I can't remember the exact timeframe. But you know, it was a few months down the line. But he was he got back to doing everything he wanted to do. The SEC, the only sad thing is he had to give up his job. Within, you know, within the stables and the and the horse riding and he was actually involved with mucking out the horses and looking after the horses. And he was hey, you have to give that up, unfortunately, because you've had so much time off, they would they wouldn't keep him on. But, you know, he sent me a couple of emails recently. And, you know, he's so he's so so grateful that we got to the bottom of it. And I think it was just the you know, it was his persistence that paid off really. Now, and he would have been definitely one of these people when he was you know, going around, just going around in circles going from one practitioner to another to another one kind of consultant to another, not ever really seeing the right one. So come back to your point before that's signed by I wasn't able to get this guy better myself. But I feel confident that I did signpost him in the right direction.

Steven Bruce
You want to stop sharing your screen for a while Rob? Yeah, not sure. I'm not sure if that's affecting what the audience see. But we've got some questions that have come in about this. Because yes, it's a fascinating one. And I'm going to lead off because I'm in charge saying that these you've muted it. My point here is, as you said, right at the outset, because you know your stuff, when it comes to looking at the imagery and so on. You are pretty confident in what you get. Now, I suspect strongly suspect that most of us osteopaths, chiropractors and physios and so on, although we do occasionally see the MRIs and stuff like that, we'd be a lot less confident in contradicting not just the appoint the opinion of one consultant, but three consultants. You got any sort of advice? And how do you get first of all, how do you go about doing that without offending the whole medical world?

Rob Shanks
And, obviously, it is tricky. And obviously you you have I mean, you know, my particular case, as you know, many people know, I've been fortunate enough to work very closely with a leading radiologist. And that's how I've kind of got to know my way around MRI scans of the spine. So yeah, my confidence is high. But I also want him to back me up. So so the first thing I did, and this is it, I think you're right, it comes back to the point of the first thing you want to do, if you do strongly suspect that something isn't quite right with the previous reporting is you, you, you want to have some in your Power team, you know, who you actually do trust and who actually trusts you as well and also thinks that Yep, you know, I know this guy knows his type and kind of if, if he's suspicious that something's not quite right, like he is and they're going to take you seriously. And it comes down to just simply asking for a second opinion. Now unfortunately, this is this is the point now we are we're living with a situation at the moment where in fact I was literally on the phone to Bob chatting the other day we were discussing this point exactly this point. Once upon a time the only person who could really refer to the MRI scan would have been the spinal surgeon and some of Bob's stature who who knows it really does know his stuff and he's going to be if he's going to be perfect scan he can then not only look at the radiologist opinion but he can also give a qualified opinion as to what's going on on that scan. And then obviously we've got into the the era where we've we've got the you know the that being rude and whilst I might use them, but we've got the budget MRI scans coming out and patients can also self refer MRI scans, and the whole thing's got a little bit more cheap in terms of, you know, that they're going to try and get the cheapest radiologist to do that report is to be frank. and with it comes poor quality reporting. And we we in clinic in our in our clinic at spine plus we I would have to say epidemic proportions we we see stuff coming in on a weekly basis that's missing. Very, very relevant pathology and very very relevant stuff. And I've gotten I've gotten I've got

another classic one to show you in a minute if you want to if we've got time. And we're literally sing it all the time. So and then and this is the problem. So the patients have a scan that it's that says it's clear, it's okay, or there's no surgical target. Oh, it's no worse than the left than it is on the right. But the subtleties are being missed. Because they've not been read or not been reported on by someone who's really really looking at it. And even though they've got the qualification of radiologists, they're perhaps not muscular skeletal specialist radiologists, they're a neuro radiologists or they're, you know, they're not used to looking at they don't see as many spines as a doctor but word or, or sad. Or Bob would say these

Steven Bruce
things in their possible defence. Is it the case that sometimes they're not asked to look for the right thing as well?

Rob Shanks
Well, I think I think that's also the case because because, again, especially if you think about a patient who's self referring, that that practitioner that radiologists use reporting on that scan has never met the patient. And as you say, it comes back to all those things, all those clues you can pick up when you're you know, you sit down, you have a consultation with a patient and examine them, and you only have a few suspicions and you're able to write on the referral formula, you know, can you pay particular attention to this particular patient to that cluster? It sounds like this to me. And that's all missing when when they go through that kind of specialist self referral pathway, but also, even when they go to the get the scans referred by the likes of myself and other practitioners, unless you know, the radar to referring to or the radiology is you actually going to do that report. And this is why we're so encouraging people to get to know the person or at least know their reputation. And who's actually supplied that report because they believe you, me, you know, the variate there's there's such a big variation out there and the quality of reporting. And that's just being honest. And so that's such a capacity to it for these things to be missed.

Steven Bruce
But two things, obviously, we'd be nice to move on and do your other case as well. But Carrie asked what it was he had six treatments of which was spinal decompression therapy, which we've talked about more than other on another occasion, perhaps. Yeah, but I think as a guideline, what they would expect to have six treatments before you could reliably say there's going to be no improvement that might not be definitive, but to cut it off any shorter wouldn't be definitive, would it?

Rob Shanks
That's right. Yeah. I mean, six would be the minimum I would expect for that particular tweak modality to to do anything. Yeah, yeah.

Steven Bruce
And someone called someone called specky. And I suspect I know who spec he is, and if I'm right, hello, specie says in terms of the whole body management of the patient, how about considering dorsal spine and ribcage and she's thinking along the lines of the amount of weights that policemen have to wear body armour and so on. Not to mention riding kit and all the

Rob Shanks
rest of it. Yeah. I mean, I mean, yeah, absolutely. I mean, it's all it's all relevant. But for me at the time, it was at that would have been a bit like you know, shutting the door the whole sort of bolted for me, this guy had very clear cut. See, see? See for impingement, that was not going to

go away. There was a bony osteolytic lipping on that left side. And, you know, no amount of dorsal springing and getting and if you want to see he's actually he's three, six weren't too bad anyway, he wasn't, it wasn't like a chi failure.it kind of in a hyper, hyper, hyper lordotic cervical spine. This was just, you know, bony lump sticking in his in his nerve root. And, for me, I just couldn't see that he was ever going to get out of that pain, to be honest.

Steven Bruce
And that, of course, is the first priority for him, presumably, is to get the pain to go away before you start worrying about flexibility, mobility elsewhere.

Rob Shanks
Yeah. And also because you've been through the wringer he's been through so many different therapies working on these Thoracic Outlet work units. He's told mechanics work and he's scapular thoracic, but you know, the kind of he'd been there and done it all, you know, that's the thing. So you know, when you listen to him, so for me, that was just, you know, he was one that I had to find the right so right practice and the right pathway for

Steven Bruce
David. Yes, clear.

Jack March
And I think you went a bit fuzzy when you are answering Karis questions. So just just to clarify, Carrie, they're talking about IDD treatments. The machine that does traction with oscillation and that's where he had six treatments of I think even the second time that you talked about it the the answer was actually was missed. I also wanted to save it's a right that as most people know what Rob does, and training osteopath to look at MRI scans is one of my real Passion passions if you want, I find it so upsetting that so many things are missed. I do think that a lot of people worry that if they start learning how to read MRI scans that we're going into an area that comes back to what we were talking about with Pippa, an area where we're not qualified. But Rob, I think you really hit the nail on the head when you said that. People, radiologists are trained to read scans for the whole body, they might specialise in one area, they might not have huge amounts of experience of musculoskeletal or specifically spinal, spinal MRIs. Plus, and I know I've mentioned this to you before, I know somebody who was training to be a radiologist and she was criticised for over reporting. This is in within the NHS.

Steven Bruce
If you're working for one of those budget MRI companies, they want you to churn out X number of reports per hour. So they don't want you over reporting Do you? Do they not that was the case with her?

Jack March
Yeah, and this wasn't she was she was working for the NHS, she was being paid by the NHS to do her training. But her supervisor said she was over reporting now, she she had an interesting background and was very pro osteopathy. She and I had talked a lot about the kind of information that we like to see on a report. And she said, I'm being told not to put that information in the reports that I'm writing. So how are you guys ever going to get the right information unless you know how to look at the scans yourself. And even if all we learn is a spinal scan, we don't look at the shoulders or the knees, we just learned to look at spinal ones. I really think that we'll be helping so many people because we can do what Rob did, which is look at the numbers. He just counted 1234 and looked at the clinical assessments that had been done. It wasn't like you waved a magic wand or had this incredible five year course that you

were done on on reading spinal scans, you just counted and looked at the stuff that you know, as an osteopath, and I really think more people should do it now.

Steven Bruce
And I just know I can I just take Robert, back to something that he just he mentioned to me in an email a few days ago. Rob, I think you said that you had just been thinking more closely about our role in using MRI scans to refer people for treatment given that we are not trained as radiologists where do we stand?

Rob Shanks
Okay, so yeah, absolutely. No, I think where we stand with this is that we are we are well within our rights to to question and we're well within our rights to say, I'm not sure that report is correct, or I think something has been missed. But what we're not from a legal point of view, what we're not cutting an assurance point of view, what we're not qualified and covered to do and say is to say right, I think there's this problem going on, and because of that problem, we need to do that treatment. Now it's a subtle point, but I'll give you the best thing though, to show you if I show you the my next case history. This point will become very obvious and will show us how we need to approach this this particular aspect.

Steven Bruce
And we'll go through two observations before we move on. But Phil and Alex, Phillip and Alex have segments into similar things. Philip says their local scan clinic allows them to ask to look for certain things but also to raise questions after the scan has been produced before the report has been produced. And Alex says that all of the speakers at the spinal Symposium of the Royal College of Surgeons at the weekend said they welcome queries about diagnosis from other therapists Not least because it shares the burden of responsibility. Yeah, Amanda's and this is something perhaps you maybe we'll have time to consider Amanda says could there be a network group set up for the professions? I'm gonna say professional she said profession not sure which one to get second opinions on scans and images maybe that's something to think about later. But Robert, we want your patient

Rob Shanks
Yeah, okay. So let me show you the this other ones this is one that's come in just very recently and it's really really interesting all it was for me anyway. So okay, so first of all, I'm going to show his report so this this track was coming in complaining of right sided basic right sided leg pain let's let's just let's just say that for a moment, but predominantly in the above the knee, okay.

Steven Bruce
4242 year old man I think his knee Yeah, yeah, yeah, yeah.

Rob Shanks
Now Now the first thing that I thought that wasn't right with this with this Well, the first thing it says here like he said two months progressively worsening right? ridic l five radiculopathy. So they've instantly gone into said that kind of gone for diagnosis before that you've gone through the scan. So my first question was Hang on. He's It doesn't sound like he's complaining avail five. It sounds like it's L four and l five. That's my first impression. Just asking Where's where's your pain? No. And so that's the first thing I thought that doesn't exam doesn't quite tie up for me. Anyway then look at that. Look at this. Look at this one here oh four, five, there was a minor disc dislocation but no significant, no significant herniation and no canal. And not all frameless noses just read that again, no. synchronisation is no canal and this last bit or frown or stenosis,

so they're saying categorically, there's no problem at all for five to account for his pain on the right side. But it does, so to say is that L L five s one, there's this placement on the desk and the left s s s one nerve root, but the right s one nerve root is not impinged, okay. However, in the lateral recess, it's compressing the exiting l five nerve root. So again, that's basically telling us that, okay, they're going this idea that is the L five nerve root, and it's coming from Cruzi. It's coming from the L five s, one disc. Okay. So that's, that's, that's what they would be going on if we just relied on the report. Now, when you go, and you look at his, when we looked at his images, it's gonna be quite subtle. But let me try and let me go to this one, first of all. So here we go. This is the old five s one. So this is what they were kind of picking up and what they were talking about. Okay. Now, what we're seeing here, actually, not just where my cursor is there, that's actually the left s one earth and that's the right s one nerve. Now, it looks like there's potential for some left s one nerve contact there. But remember his pains on the right side, he did have some on the left, he did actually can play a little bit of pain on the left, that did correlate with the S one, because he's the sole of the third bit of fizzing in the foot. But they're predominantly his pain is on the right hand side. And what they're saying here is that he's got a far lateral herniation of the L five that's affecting the exiting l five nerve roots. We haven't haven't quite got that l five in view here. But it's mentioned the nerve roots coming out between here. Okay, so fair enough. But as I said, when you really listen to him, and and he, you know, he didn't really have any ll five, my time weakness, and all of his most of his pain was above the knee, kind of into the thigh coming around a little bit into the front of the thigh. So I thought that doesn't sound like an L five. So don't don't understand that. So then, then you look at that I'm suspicious already that let's have another look at yourself for five. Okay, now I'll come back to that one in just a second. Here's the URL for for ACL, four, five in sagittal view. So it looks initially that oh, well, there's not much of a problem there. But remember, this is just the midline slice. Now, how do we know there's nothing coming out towards us, like coming out literally towards us in here, this is why we need the axial so you always need an axial scan, you can't just diagnose from a sagittal. So this is this is the axle. Now if you think of this axle in two halves. Look, which which which half do we think is you know, slightly more bold with if you want to call it that word? Well, I would go with this side, the right side. Okay. Now the other thing we see down here, which is really subtle, that see this little faint line just here, that's actually an annular tear. Right, now we go to the next image we're about is the angular T in relation to the nerve root look, this is what's called a parasagittal slice, that's that there is the exiting L for nerve root. And that there is the tear liquid layer is it sitting right underneath the L four nerve. And there's a little bit there's a small little kind of, you know, in this business about the L, the L four five foramen been not stenosed Well, that's that's wrong, it is being snowed, there is a there is contact there between the disk onto the L four nerve, and only that there's a tear right underneath the nerve. And we know that tears potentially can be a source of chemical radiculopathy as well. So for me, that absolutely correlates with his where his pain is. So, again, the reason why I'm so keen to know because we can't come to the conclusion, well, what does it matter if it's four or five, he's got a disc issue. Well, for me, this guy is going to have again, coming back to the IDD therapy. And I've got to know which disc I'm targeting. Because I've got I've got one angle for this, and I've got a different angle for this. So I've got to know which disc that I'm going to be going for. So that that that was our that was our judgement. Now, picking up on the point we're just saying. This hasn't been mentioned on the report. Okay, so they're not they're not said there is potential for an L for radiculopathy. They're not mentioned in any of the tear. They've not even made any comment over this little line, this little, this little line here. Now, I'm pretty confident that is what I said it is. It's only a tip but I'm not. I'm not qualified. Absolutely. I'm not a radiologist. I've not been examined. I've not done any, any any examinations in reading MRI scans. So who's to say I'm right, what I what I'm, what I'm doing is I'm going to be sending this off to Dr. Bart or another right and other radiologists that I trust and I say Would you mind give us a second opinion? Would you just let me know am I correct in thinking that this is

an annular tear and it's a fine lateral herniation causing an L four five Potential radiculopathy VL for nerve root, if we get that second opinion coming back and it says, yeah, absolutely, that's what it is. We are 100% then in the clear to then go ahead and do what treatment we want because you had that diagnosis confirmed, but what if I'm wrong? What if that is actually some sort of nerve cell tumour or that some others will pathology that, you know, I've missed? Okay, so I've told the patient Oh yes, this is to do with the 10. That desk and this is the and then we're going to do this IDD treatment on you. But what if down the line that turns out that actually it's something other than that? I think what I think it is okay, the radiologist has missed it the first time around, but then I've also just missed it as well, I've misdiagnosed it. I am absolutely carte blanche out out to be had in the court if I forgot, and because I've given him an unqualified opinion. So the take home message is we must must must wear the however confident you are you must get that second opinion arising from the person who here who he's qualified IE, a second opinion radiologists report to vacuum up

Steven Bruce
playing, I hope my sound is manageable at the moment, but playing devil's advocate in the absence of an MRI with L four, five radiculopathy as an osteopath, you would have treated that l four, five radiculopathy. And we all know that MRIs show up things which have nothing to do with the injury though they look horrible, but they aren't producing symptoms, and we don't treat them. So you could have proceeded on the basis of a normal standard musculoskeletal analysis said well, this, these are what your symptoms are showing. This is what I'm going to work on. Yes, just because there's an MRI, does that put you in difficult in a difficult position? You think?

Rob Shanks
Well, yeah, but it's I would say if you didn't have the MRI, and you hadn't if I hadn't looked at the MRI, and I just got on clinical set what I'm sticking to my my remit of my training as an osteopath, a working examined on, you know, and what I've done qualifications on I not reading MRI scans. So yeah, I'm in the clear, then, you know, I'm going on a radiologist report, okay, and I'm going on my clinical examination and not stepping outside of that. Now the problem is, for me, that's not good enough, because I know that these patients out there who are getting misdiagnosed, so I can't help myself, I have to look at MRI scans because I want to know what's going on with them. But then in order to then cover myself, I've got to get that second opinion to cover me.

Steven Bruce
And I guess if we boil it down for finances as well, if you end up embarking on a course of treatment, which costs the patient money. And it is discovered subsequently that what you were working on was irrelevant, it was the wrong thing to do. And you had had that evidence, they've got a very strong case to first of all take you to the Professional Conduct Committee for nothing to find out whether you were right or wrong. And having proven that you perhaps in error, they can then take you to the civil court and seek damages, which is often

Rob Shanks
I mean, I think I think it's I think in terms of you know, was it an irrelevant finding should I shouldn't be treating it? I mean, you know, there's there's debates, if you're going to want to focus go to there's always gonna be a debate as to what I want to treat this, I think it's the best they can I think it's a trainer with them. I think it's your, you know, your type to try to type pecs. I mean, there's always gonna be academic debate. I don't be surprised if they could sue you for that. But what they could sue you for is if I category told him, yeah, that nerves being impinged because it's got a disc bulge, and it's got a disc tear. But if in actual fact, I was wrong, and there was some sort of serious pathology that's based on the base, we talked about cancer. That's

what that's where the real stuff starts to happen. And, and this is the discussion I had with Bob chatted the other day, and this is this is a thing he was flagging up to me, because he's actually involved in a couple of court cases that basically involve this scenario. Okay, where the person has seen a physio or naturopath or Cairo? I think in his case, that is a couple of physios that his his particular case is intervening on. And, and they told the patient, they have a certain diagnosis based on an imaging scan that they did, but they hadn't actually been qualified to give that opinion. And in this case, the patient unfortunately had some other pathology that wasn't picked up and wasn't therefore acted on soon enough. And I've walked into Physiotherapy is now facing litigation. Now, as I say so I think it's very important that we're aware of that and we don't allow ourselves to be in that position. And it is very easy the said, it's very easy to avoid that by simply asking for a second opinion which back back back to you anyway, so just confirms you know, what, if I agree with you, it confirms what you suspect all along.

Steven Bruce
Well, do you look at these scans? Are you presented with them for the first time when the patient comes to you for an opinion? Or are you in do you have the option to get them ahead of time because for me to have to look through those those images? I'd be struggling to work out what was going on and to struggle in front of a patient is embarrassing and doesn't do anything for your own credibility? Obviously you're better at this than I am but

Rob Shanks
well, it varies. So so some patients will bring their scans in and bring them in They're CDN. And they're expecting me to look at it there. And then I suppose I mean, I'd be honest, I tend to encourage that, because I like to, I like to see the scans with it wherever I can. But sometimes you can see ahead of ahead of time. So let's just say for example, you have a patient who comes in, and you you end up referring him for a scan. And then rather than you going, you also you're going to get the report that comes back. And if you want to look at the images, they don't, you don't have to wait for them to come back and give you the CD. And then that's the first time you see it. Now, most of the centres are now offering cloud based images. So you can log online, and you can just, you know, in a few days before the patients do, you can log in the portal, before we've got any CDs in front of you, in fact that they're tending to shy away from the CDs now anyway. And you can look and look at those images at your leisure. And you can get fully prepared and prepped when the patient comes into the next appointment.

Steven Bruce
So what What lessons do we learn from this? Obviously, you said, it's okay to ask for a second opinion, don't treat on the basis of your own assessment of the scans. Anything else in terms of the communication with this patient that you'd you'd want to raise? Or pepper or Claire obviously? Yeah.

Rob Shanks
I mean, I mean, all I would say is that, from the patient's point of view, I think he was very happy with what I was telling because I was able to explain to him where his pain was coming from and able to tie up some of the loose ends and explained to him Well, you know, that is actually coming from that and if you think about where that nerve goes to is on the right side where you're complaining the pain and actually predominant goes to above the knee does go to the kind of the distribution in your lake where you're telling me you know, for him, that was a bit of a great, you know, great, fantastic, that's you sound like you're making a lot of sense. And again, this is where I think it's so I just think we're, you know, we're sitting on such a big bow, I wish passionately this are taught at undergraduate level, because I just think it's gonna, it's just gonna, it's just gonna skyrocket what we can do, because if we can learn this stuff, as

undergraduates become really, really familiar with it, honestly, opens up your eyes so much, and it makes the the clinical examination, you know, fit the MRI, and absolutely, you're right, you know, the MRIs. They do throw up loads of red herrings, loads and loads of red herrings. I mean, look at that guy. He's awful. It's all five, this one looks like the worst, the worst this bolt, that's not when problems coming from, it's coming from higher up. So if you start to learn all that stuff, and you can piece it together and correlate this with that, it just it means your, your accuracy in terms of embarking on certain treatment pathways becomes so much better, I might think.

Steven Bruce
Thank you. Victoria, you asked about IDD therapy and we don't have time to go into that here. But we are planning to run a session a full 90 minute session on IDD therapy. You're absolutely right in what you said Rob is an expert on that as well as on reading MRIs. We've just had an IDD machine installed directly behind the camera. And that will make it easy for us to run that session from here. But yes, it is an interesting therapy and we will be bringing not just the salesman in but we'll be getting Robin to talk about that. And right one of its practitioners from elsewhere, Gillian Brown. Hopefully I don't know Julian's watching this evening. But she's already agreed to come in. So no backing out. Jimmy a couple of things. Pippa, can we get back to your case just for a second? Somebody's calling themselves GP says has your patient been fully diagnosed and treated for the PTSD?

Pippa Cossens
I don't know. Absolutely. Hands up. I don't know.

Steven Bruce
It's interesting. I mean, Bosnia was quite a long time ago. She's been diagnosed with PTSD, you wouldn't have thought that any any therapist, any diagnostician would say, oh, yeah, you've got PTSD from from the war, and it's fairly serious and go on your way and transport yourself. Would they?

Pippa Cossens
Know, I would imagine that she's probably had some treatment, like you said a while ago, but I wonder what I think it's important in the picture, because it it's, it's it's the probably the event that changed the way that her nervous system was functioning in the first place.

Steven Bruce
Right. Okay. Thanks to this. John has asked you a particular question on that patient as well saying might there have been a place without specifically testing for emotion through a gently tried the likes of Bach flower remedies? For example, Rescue Remedy.

Pippa Cossens
That's not within. That's not something I would feel comfortable doing. It's not something I do, if that makes sense. It does. There's a possibility of that, but not something that's within my sphere. Really. Okay.

Steven Bruce
Well, I mean, others may come in on it. But we haven't even got too much time. We got 15 minutes left. Rob defensive being put on the spot for a minute. Yeah, sure. Yeah. Right. So what we're going to Robins come in with one here. Robin says he's he's going back to radiology. He says he's often got difficulty getting hold of anything other than the radiologists report. Any thoughts on that

Rob Shanks
Rob? As he had difficulty getting home To the images is that is that we

Steven Bruce
can get the report. And of course, the reports are very brief, very often to brief.

Rob Shanks
Yeah. What is it? So again, my first thing was if you get if you get a brief report one or two liner instantly have your suspicions raised 10 times 10. Because, you know, a good radiologist will go through each segment and say, you know, they'll come they'll make some comments, you know, L three, four, there's no this there's no that there's no facet, John hypertrophy, there's no framework, Gnosis is the issue, then, you know, they've been thinking about it. So that's the first thing. But um, yeah, I mean, you should basically most of the MRI centres now. So take in health as an example, which was one of the big suppliers in the UK, they will if you ask them, and they will set you up with a cloud based viewing portal. So the one that they use is called Bio tronics, or sometimes referred to as 3d net medical. And they'll give you a login. And you can any patient that you refer to them, they'll be on the portal, the images will be on the report, or the reports will be on the portal, when you can literally look

Steven Bruce
at the faces, you don't refer that they've been sent there by someone else

Rob Shanks
yet, you can ask for them to be if the patient gives you gives you permission and tells them I would like my scans and my images to be put on to Rob thanks is, you know, by atronics portal, please, then then they'll oblige. And they'll do it. And I can look them online. Yeah.

Jack March
Stephen with them, with the NHS, ones. With all of my patients, I ask them any, any test that having any scans that have been, I asked them to get a copy of it for themselves, partly because we all know that things can get lost. And, and partly because I think we we owe it to ourselves to take responsibility for our own test results and scans. And not to say all the NHS is in charge of that. And what I tell them to do is to go to the front desk of the hospital and ask for a copy of a scan, it normally costs between five and 15 pounds. I very specifically tell them not to ask the MRI team, my experience has been to hospitals, that the MRI team thinks that they own the scans. And they're not aware that actually it's the patient's property, and obviously don't want the patient to have to get into a Rao, whereas the people at the front desk are used to having that request. Some hospitals, they even allow you to make the request online. And I think it's really important, even if you aren't going to look at them yourself, to encourage your patients to get the copies for themselves.

Steven Bruce
I imagine with the MRI team, there's a certain amount of defensive behaviour going on there, isn't they? Why do you want the scan? We are the experts in reading there's not us, what are you going to do with it

Rob Shanks
is just a chip in their steam? So I'll be honest, I tend to find the opposite experience. So I tend to say to patients, again, you're absolutely right, you should always I always try to encourage patients to to have a copy of the CD themselves just because if he's not for me, it might be a

future consultant or see down the line. So I always and I say to him, you know, you're unlikely now to get the CD sent to you automatically. But please make sure you ask and request a copy for your own records. But I sometimes if they're come away from the hospital, and they you know, they're no longer at the front desk. So I just say to him, Listen, just ring up the X ray department or ring up the imaging department. And did she just say to them, oh, can I have? Can I please have a copy of the CD, I'm going to see a private consultant in next week. And nine times out of 10. Most always 10 times out of 10 They'll do it no problem.

Steven Bruce
We're going to move on now because we've literally got about five minutes for me to put Rob on the spot, which I've quite liked to do not least because Amanda has just asked the question she has said she has great difficulty accessing images and so on. And can you recommend which software to use? So moving smoothly? On to answer your question, Amanda wrong. This is an MRI of a gentleman who was 88 at the time of the scam. Yep, I'm showing this on software called OsiriX. Light, which is the software which is specific for Macs. I think on their website. It says it works on PCs, but it doesn't. So there were there are other software that works on PCs. I think this is free, completely free.

Rob Shanks
So yeah, so we're the ones that pick the PCS is a really critical, radiant. Now it costs there's a free I think it's a 30 day free trial. And I think the yearly subscription is 30 to 40 pounds. And that's that's well worth well worth it in my opinion. Okay,

Steven Bruce
so radiant, you so radiant. Yeah. Okay, we'll put that in the next. Now anything I would say is that, you know, without some sort of DICOM viewer, I think these things are cool, because that's the nature of imaging. You can't make much sense of the of the MRI scans. But when you look at this spread of stuff on here, it's hard for the amateur to know exactly how to use it effectively. Any thoughts from you then Rob? Well, we're not we're not talking about diagnosis here. We're just talking about how do you use the bloody stuff. Okay,

Rob Shanks
so how are you? Okay, all right. So what we're looking at Okay, so first of all, what you're what you're looking at, you got to know what this is, you got to know what you're looking at. And you got to know the different types of scans and sequences that they do. So the common ones are have a T one and T two, okay? So I can tell you for a fact that this is what's called a T two T two weighted image. And what that means is that the, you see around the fluid around the spinal cord is white. Okay, so you know, with a T two, that's it, yeah, so you've got that you've got the core, which is the dark bit and an either either front and back of that you've got the cerebral spinal fluid next in white. Now, the other thing you have there is you have the subcutaneous fat is also white. So that's what that's what you get on a T two, okay, so on a on a T two water and fat, both sharp is white and or bright signal high signal,

Steven Bruce
I tell you what to do. What else Rob, in addition to that, the highlighted image up here says that it's a T two T IC sag 11 image exactly.

Rob Shanks
So long as you but the important thing to understand is you can pick up the T T, you got to understand what the T two does, okay, so the T two is highlighting water, basically water and fat. So then you get that in your head, then you kind of you got to have the winner. Because if

you go for a T one, what will happen is the fact that you could try and do it this way. If you try and bring up the T, you got the T two if you can try and bring up the two slices together. So you bring up the T one and T two together be able to do

Steven Bruce
that. I'm fine. Go for that one. Yeah, my brother for two images having a window up here. Yeah, that's it. I'd like to do that. I'll just forget it up again. No, no. So so just

Rob Shanks
click on one of them first, usually, and then what you can well, okay, so you might have to do it, we can do on the Mac, you can go command, you can hold down the command key and click on the other one. But you might need to be

Steven Bruce
trying to do this with the mouse so people can see what I'm doing. There's a thing that says windows,

Rob Shanks
like I said, That's it. That's the one. So there we go. There we go. Right. So now what you want to do, you want to have the T one in one of the windows and the T two in the other window. Okay, so Okay, well, I see that's not a bad one. That's not, that's an axial image next to it. But which is actually also very important to go for as well. But just just to try and show you what I'm talking about in terms of the contrast between the water on a T one T two, if you could maybe just bring up the T one for me on the left side.

Steven Bruce
Yeah, sorry, I was picking on the wrong one there. I knew what you were saying and doing completely the opposite thing. So that one there.

Rob Shanks
There we go. Right. So now if you can kind of scroll to a mid a midsagittal position.

Steven Bruce
Now you'll begin to see why I can do it this

Rob Shanks
way, you can easily see the brains of different colour. Yes, you look at the top, the top down, you can even see see you've got something different going on, even though this is looking at the same anatomy. Okay, that's again, see if we can go for a week and see the spinal cord right in the middle of the spinal cord. Okay, we're getting there a little bit further.

Steven Bruce
Right, we're getting there. Now when we see

Rob Shanks
it going a bit. One more. There we go that day, right. So it can it can you see now what we're looking at on the left hand side, the cerebrospinal fluid is showing up as bright and white. But on the right hand image, it's dark. Okay. Yeah, there they go. So that's that. That's it, but then look at the subcutaneous fat. Now the subcutaneous fat is the same colour in both in both scans. Here, yep, so the fat is showing up right on both images. So the only thing that's changed is the

water. So the water is showing up as dark on the right hand side, which is the T one. Okay? Now that's a T one image is pretty good at showing up or better that they for showing up bony contours. Whereas the T two, okay, I always remember it's thinking that the formula water, h2o has got two in it. So a T two, two in it. That's the West, the one that shows up the water. Right? Remember that? That's the helpful hint. So the reason why I want to show up water why what why is water important? Well, water is swelling, isn't it? So if you have a Deema, that's going to show up as being bright?

Steven Bruce
Is that what all this is around here?

Rob Shanks
Where are you referring to? Well, now that's probably that's probably ligament tissue you're looking at there. So you've got you've got subcutaneous fat, you've got ligaments as well. So that's, that's probably not you'd normally would see where you see again, I should have got an image so I can show you that I've got one of my other cases if you have got time. But we literally we've got about two minutes left on one is where you're sitting in reports referred to as Modak type one Okay, so my next one which is basically bone edoema. Okay, these patients are often going to have with more common the lower back but they're going to have you know, like real deep gnawing kind of pain deep in the spine. And when you look at when you see the image and you see a patient it's usually the lumbar spine has got significant moments like one you can really instantly get a sense of their pain. Because you see this swelling in the vertebral body thing goodness me that must be painful. Yeah. How could it not be? So yeah, that just illustrates a T one versus a T two. The other very important thing you need to do is bring up the actual images Okay, so if you baby go on to the right hand side, so the right hand window, okay that do that do for starters. Okay, so you've got Have you got on the right hand side? We've got the sagittal T one. And we've got probably an axial T two, I would believe that Yeah, looks like an axial T two. So it's an actual row. Yeah. Okay, so now we'll look now what we can do, we can scroll through the levels, we can see now in cross section, what's going on at each level. So this, this is where

Steven Bruce
what really impressed me about this is that without me having to do very much, it automatically synchronises the two images, which is just brilliant.

Rob Shanks
Yeah, yeah, that's right. That's, that's one of the great things of ours RX, it does, it does do that, you know, syncing up. And so now this is a really useful view, because now you can literally see, you know, kind of from linkway slices, but also cross sectional slices as well. And this is where we know we will be looking, you know, for the exiting nerve roots, the facet joints, seeing how what they're like. But yeah, I mean, what it's like everything, you know, it's like when you first feel a lower back, you don't know what you're feeling. But when he when he you know, when you've done it 100 times in your library just opens up, the entity start to spot things that aren't right. And this the same for MRI scans, it's no different, you know, we things just going to start jumping out at you when you start. Now.

Steven Bruce
What I really wanted to do there, Rob, was to put you on the spot and say, What should I be doing with this poor bloody patient? Because I think I think you don't have to be a practitioner of any skill whatsoever to say that cervical scan there looks bloody horrible. And this was a full spinal MRI. So when we get into his lumbers and see equally horrific things going on there, but

maybe we can get around to that some other time. What we have got actually is Victoria has said, I've just realised I need a crash course in reading images help in capital letters. Rob, what do you think she should do?

Rob Shanks
I think you should come along. Vittori on Sunday, Sunday morning, Sunday morning, isn't it? Seven? Yeah, we don't do Sunday morning. It's a whole day course during the whole day course this Sunday. with you guys. And yeah, it's gonna be a really intense day. It's I mean, it's a bargain price, in my opinion, what is it? 78 pounds, I think

Steven Bruce
70 pounds, including VAT? Yeah, these are in free glasses of water. And

Rob Shanks
so we're going to take you through forever from everything from the T one to t twos, how you put the images in how you navigate all the different slices go through what what is pathological. What isn't. And we're hopefully at the end of the day, your confidence with looking at MRI scans will be you know,

Steven Bruce
I, I made a complete fool of myself the other day, I feel robbed, because my sense an image to Darrin to have a look at your colleague in in your business down there. And I said, well, well, these horrible white things in the spinal bodies. And he said, they're just meant to be they're meant to be there. Even

Rob Shanks
though there's no such thing as a stupid question. That's the thing. Obviously, this is this is new to anybody. Of course, there's no such thing as a stupid question. And this is what this is, what's there to be learned. And so get anybody interested, get ourselves, you know, come down on Sunday, it's gonna be a fun day. You know, we're gonna make it fun and make it enjoyable, interactive, and don't be embarrassed doesn't matter how much experience or little or how much, you know, you got, just just get yourself down there. And we'll we'll make it worthwhile.

Steven Bruce
And so, to put all that into context, it's going to be held right here in the APM studio. Our studio is in Northampton share, we are halfway between Northampton and Peterborough, or Bedford, and Kettering, which are we're looking at the junction of the 6845. We've got loads of parking, we're not paying for lunch, but we're taking orders for lunch. And we kind of need those tomorrow. It's dead easy to get on the course. But you just have to go to our website and under the thing that says all things CPD, there's a thing that says courses, press that and you'll see two different edges on there at the moment. One of them is the MRI course. And I know it might well be too far for you to travel. But we'll try and do something else, which is more helpful for you later in the year. But if you can get here, it's going to be a great day. And if you haven't seen Robin Darrin in action in analysing these things, is if you haven't seen enough already this evening, you know that they really really really know their stuff and you can only go away being much much better at reading using drove with the course. It makes it sound as though you know I'm just desperately trying to sell the course I don't think I need to sell the course but I'd be like Claire I just feel I feel I'm Rob You must agree with me on this. I'm sure if we're just we come out of college and we're just crap analysing these things and we really want to be better because people so spinal consultants.

Rob Shanks
Absolutely. And the other thing is it's not just I think the it'll you'll find that your patients will love you for it. I mean, you know, they'll just they'll just hold in such high esteem but not just the patients also the spinal surgeons you start then you know referring these things and questioning so actually I think this person is a second opinion on all Mr. chatted would you like would you mind just reviewing this for me? He's never gonna stop referring your patients because he's gonna think Oh, this guy knows his stuff and this guy is on the right wavelength and it will it will be a you know, win win win and so many levels definitely.

Steven Bruce
Well, thank you for that paper. Thank you for sharing your case with us another another fascinating and Claire, thank you helping out particularly helping out because my sound has gone fuzzy for some strange reason. To put that into context, what we've actually been doing here this evening is phenomenally complicated. We've got so many different sound sources in order to be able to share this and get the sound from the people through ms, Microsoft Teams and so on. Justin's done a great job in making it happen at all since we've never done this before. But I do apologise that something strange has happened to my sound. Just a quick look ahead. We've already talked about Sunday's course, if you can still spare the time, there is still space to come on the course not a huge amount of space, but there is space. So let us know website. Anything see all things CPD courses, again, our MRI course. Next week, we're having a lunchtime case based discussion week from today. And then on the 15th of March, we've got consultants to Simon Marsh coming back to see us virtually unfortunately, I'd love to get him in the studio. He talked to us before about Gilmore's groyne, which is an area of his particular expertise. And in fact, he invited me to bring a whole lot of people down to a presentation in the Royal Society of medicine after that. Claire gave me no inner stick around afterwards because she wanted to talk about hernias. And we just went down this Gilmore's growing rabbit hole. And so she didn't get all the hernias that she wanted. So coming back in to talk about hernias this time, and he's a lovely man. Very, very knowledgeable. And yeah, it'll be a treat, listen to him. That's the evening of Tuesday the 15th. Again, a week after that, so we've got a lunchtime CPD session. Lunchtime Thursday, the 17th of March. Strangely, it's a Thursday I'm not sure why Allina Ronnie who we had on the show before he's going to be talking about the Chromeo clavicular joint case histories. And just looking a little bit further ahead if I can mention it once again. 13th of April, we've got the APM housewarming party when we get a live audience in the studio. We've got a live band. We've got two brilliant osteopaths coming in to assess that live band and talk about how we use our skills osteopaths, chiropractors, physiotherapists to deal with the sorts of injuries that performing artists suffer. And we're going to run it on after the show finishes, we'll keep the live stream going so you can still enjoy it. Because we're going to get the band to play some cool music. We're going to get some drinks going up here as well. And basically, it's gonna be a damn good show. Because as you know, we like to do things a little bit differently in the Academy of Physical Medicine. Anyway, that's it for this evening. Time for you to get back to your gin and tonics. Again, thank you to everybody who's taken part this evening. There are over 400 people watching the show, which is a pretty good number. And thank you to all the ladies behind the scenes who've been fielding the questions as Ellie and Becky and Anna, possibly Ruth as well. I'm not sure if Bruce on the the team assuming and poro Justin is in the gallery behind me trying to sort out the sound and the cameras and everything else that goes on in here. Because he was left single handed this evening because Jay was taken away to sort out his elderly father who's been taken out. But there we are. That's how it all runs in the studio. It's been great from my perspective. Hope you've enjoyed it, and I'll see you again soon. Good night.