

## Shockwave Therapy - Ref 314

Robin Lansman 16:08

Hello, and welcome to this evening show. It really is great to have you with us. I'm Robin Landsman back for an unexpected second appearance in the house chair and tonight, it's the topic of shockwave therapy. That's the centre of attention. I have James college in the studio with me to tell us about it. And we have some state of the art kit that he'll be using to demonstrate on our model a little bit later on. James himself is also an osteopath. And he's been lecturing and clinical mentoring in shockwave therapy, and has been doing that for about the last five years. James, welcome.

James Woledge 17:08

Thanks for having me. Thanks very much. Yeah, I mean, just a little bit more about me. I am an osteopath of 20 years and I got into shockwave therapy. About 10 years ago, I have been teaching about seven years now. And started out teaching at Leeds Met on a Sports Med MSC course and my my background was always wanting to get into sports injuries more than and soft tissue disorders. And ultimately, that led me about 10 years to go to investigate what seemed to be this new thing that was coming out. I'd never got into machines before. I was a traditional osteopath. And so I looked into shockwave therapy and embarked on that journey to

Robin Lansman 17:51

slow you down just a little. Yeah, what kind of motivated you to go from what you were doing into looking at new options, because I think that's always interesting to know a little bit about your background story. What do I do? Well,

James Woledge 18:02

that traditional practice, the traditional way that I used to treat was great. And that was my background as being a purist osteopath, so to speak. But in the practice, I was in a very big practice, I tend I tended to you know, I like treating foot disorders I seem to get interested in plantar fasciitis tendon problems and it seemed to be that the other guys in the clinic weren't interested. So I take these on like, Right Okay, let's try and throw everything at it and realised that even though my background was in sports type stuff, my knowledge was poor one. The knowledge I think I got from the British gloss over that time wasn't great on those things. And and so I just started investigating other ways in which I could help these patients particularly you know, the chronic stuff we've got a soft tissue disorders we

Robin Lansman 18:49

will come on and do a lot of talking about that but going back to the whole thing about I guess feet, particularly I mean, you mentioned that was a key area of interest or key thing that drew you so what was it about feet and

James Woledge 19:01

no idea No, I mean, I think that they they just presented plantar fasciitis if anyone sees those conditions that I just you know, the top of the body migraines and headaches are really hard to treat the challenge. I like a challenge and plantar fasciitis you know they'd come in and and you'd give them a week or two of respite and, and they still keep coming back and dreading getting out of bed in the morning. It's a really wearing horrible condition. And everything I threw at it just seemed to be really resistant.

Robin Lansman 19:25

When you say everything you through what do you mean by everything? Were the usual hands on stuff

James Woledge 19:29

I tried acupuncture I did all sorts of various taping courses which work but it's the short term isn't big enough taping works for the two days and then patients slowly started to realise that you know as soon as they don't take and it becomes quite arduous or Phottix I make my own orthotics I still do I hate those he moulded them tried that of course the stretching makes sure the cast loose I mean everything you know you care to name it I went on course about it. And and then actually an old colleague who's not an osteopath anymore, he worked for one of the big companies and I was still chatting to him as friends and he said you got to get on board with this new thing. This was 1112 years ago. And I was a bit resistant to it because you know, I was at an osteopathic age where, you know, we could do everything with the hands and to plug a machine in was a little bit bit too much of a challenge. You know, it was sort of some suggestion that you weren't being a very good osteopath, if you plugged the machine in, you must be good with your hands. But I went and met him and I got one on trial. And the rest is history, really, because I had had this group of patients that I wasn't getting anything with. And then I tried it. And because I'm about long term change, I pretty much did three treatments in the fall a month later. And that's the long term change the shockwave brings about that's the bit that got me. It's not just giving a quick fix for a week getting back in. I wasn't interested in that. And I still am not in practice. I don't see maintenance patients. I have my own beliefs about that. And I don't I don't like doing it. What else give me your beliefs,

Robin Lansman 20:49

it's good to know you believe.

James Woledge 20:51

I'd like to find it, fix it and leave it alone. Very osteopathic, doesn't it weirdly, but osteopathic practices and you know are sometimes in geared up to get people to come in for checkups and maintenance stuff. And I just don't believe that. I think that with with these conditions, particularly that I deal with, I quite like to gain do the treatment set them up for the fact that I'll take them say 75% better because tendons still take nine months to get better. Plantar Fasciitis does. Give them a realistic prognosis, give them empower them to look after themselves. But I'm there to make sure I kick them out of that chronic phase. And this is what shockwave

Robin Lansman 21:24

can have you suffered yourself from any injuries, ironically, or otherwise.

James Woledge 21:27

Now I've got a really grumpy old knee, right. But apart from that Touchwood I've always been Okay, thank you, I'm getting grumpy thumbs down. I do less less with my hands. Now to be honest, I give them a rest. Because my various shockwave machines kind of step in where my thumbs would usually have been,

Robin Lansman 21:43

what percentage of the time would you say split between hands on, we'll call it traditional, whatever that means Strv actually using the shortwave to

James Woledge 21:50

some extent, you know, from a power patient point of view. And still that sort of connection you get with your patients, I still touch every patient regardless with original machine or not, whether it be to find out where I'm going with a machine or some traditional soft tissue stuff. But I'd say that, you know, say this week 75% of my patients now are chronic tendinopathy chronic joint stuff, plantar fasciitis that I would use my shockwave machine with, that'd be 25% of patients that I would my traditional osteopathic stuff that you know, neck neck stuff. Well, Shockwave has no place. I still do hands on stuff for about 25% or so.

Robin Lansman 22:22

Okay, so you're kind of niching a little bit, I guess.

James Woledge 22:25

Yeah, niche specialist stuff. And when I when I teach this, I make sure that people would, you know, you set yourself up as a specialist tendinopathy. Chronic tendinopathies are probably more prevalent in primary practice than osteoarthritis. Now we've got the data to say that that's probably your number one thing you're seeing, it might be that we're now understanding the tenant off, these are more commonplace, and we're probably misdiagnosed with the past. But tendinopathies is probably the more common than see general osteoporotic more common? No, it's always been more common. Our understanding of what is a tendon problem. For instance, the lateral hip, the outer hip, that forever would have been referred pain from the back, or arthritis of the hip, or in some cases a bit of sciatica because it travels down the leg a little bit. Now we understand that gtps, as we now should call it, which is your gluteus medius tendinopathy is probably the most common of all tendinopathy problems or the most common tendon problem. And I think historically, when I left college that wasn't even on the radar. It was tracking, Tarik besides us? Yes. But actually, we now know it's hardly ever slight. It's it's tendon. And so you know, all of those patients with pain on the outside of the hip pretty much are attendant problem. But actually, that might be news to some people tonight, then they're always it's referred pain from the SRJ or whatever else. Sometimes it can be but the number one thing around the areas is tendon problem.

Robin Lansman 23:40

But still differential diagnosis is rather impairment. Absolutely, yeah. And

James Woledge 23:43

so when you you know, when we teach this and we're saying, Look, if you get into Shockwave, what you're really doing is setting yourself up to say, I'm attend an expert, I specialise in tendons stuff

niche, or specialism and the shockwave is the thing that allows you to break through that chronic picture, to get them better amongst your other skills. It's still embedded in a whole network of treatments that we would otherwise do anyway, hands on included. So it's not excluding osteoporosis or excluding hands on. But it's bringing in a skill set that is, you know, mostly borrowed from physiotherapist for rehab and loading programmes and so forth.

Robin Lansman 24:18

Right. And people getting this in the NHS. I mean, it's available understanding the NHS.

James Woledge 24:23

Yeah, so yeah, we've had NICE guidelines dating back. This is 20 year anniversary of the first nice guideline, which was calcific tendonitis of the shoulder. And you know, there are four others that have this five that are nice guidelines for and that's plantar fasciitis, Achilles tendinitis, the calcific tendonitis, the shoulder, tennis elbow, I mentioned five,

Robin Lansman 24:42

not quite, I

James Woledge 24:43

think even three and a half, four, four, the other one that comes to me tennis elbow, calcific, tendonitis, shoulder, Achilles, plantar fasciitis and gtps. So lateral hip, there's your five okay, and so yeah, 20 years of that and so if you go to the Royal National in Birmingham, the Royal National Hospital they Got shockwave so Thomas's have been doing it for at least 10 years. So if you're in the right postcode shockwave will be available, whether it be focused or radio, which we might talk about later.

Robin Lansman 25:10

But within the physio context it's it's not being looked at in an osteopathic way. If one can say that does that how does that sit with you that kind of statement that question about how it's contextualised within the care plan?

James Woledge 25:24

I see. It's historically the number one thing which everyone talks about with plantar fasciitis is with with shockwave is plantar fasciitis. So it's quite a lot with podiatrists and treating heel pain. But I'd say that when when we're, you know, doing courses and teaching it's a fair mix of osteopath, physios, podiatrists and chiropractors across all four. They sit in the room, there's 20 people, there'll be a fair mix of all of those. But really, what it's saying is go back to the start is if you're an osteopath, and you want to treat these conditions. It's the number one evidence based modality that you can use alongside your graded loading programmes and so forth. And I think from when your graduate a little bit before me, but 20 years ago, there was still this sort of, you know, you're you're in that bracket that does this, and you were in that bracket that does that. And I think now, my colleagues a physiotherapist and we share ideas all the time, and we're pretty similar. Very, very, very, you'd be hard pushed to see the difference between he does more hands on work in private practice, I'd be more loaded programme rehab stuff, and patients don't care, in my view. They just want answers and they want guidance and a plan. And they really know that I'm an osteopath call me a physio half the time so I remember that used to be annoying

Robin Lansman 26:32

to me, but not now. Why? Because they didn't know the difference, or they didn't see. Yeah, they

James Woledge 26:36

sort of didn't know the difference, but I also used to probably be quite snobby about me being an osteopath. And I was really proud of what I did. And that's the way and I just realised you're no longer proud to be an osteopath. No, I'm not. I think I was. I was I was so proud that I thought I was a little bit more significant in the world of musculoskeletal health care. But now that I've learned so much from other professions, I realised that was that was nonsense. We've all got plenty to offer. doctors, chiropractors, physios, whatever else. We've all got our skates so it's really about the skill set that you do your Postgraduate if I'm going to be a good tendon person. Doesn't matter whether your osteopath physio, podiatrists don't do the tendons stuff. And then, you know, as I say, the shockwave is a part of that.

Robin Lansman 27:12

And the people who come on the course is mentioned them being all different professionals. What do you think draws them to come? I mean, I presume you ask them, but what do you think's going to drive these guys

James Woledge 27:20

nothing more is nothing more obvious than just they know the evidence base. They know that the evidence base for plugging a machine in back in the day would have been ultrasound if one had ultrasound machines. And you know, and now that the nice nice guys actively dissuade you from using it for loads of conditioning, dissuading you not telling you to use ultrasound as a modality. But the evidence and the amount of level one research and so forth for shockwave is just better than anything else, you can plug in the wall. So going

Robin Lansman 27:46

back maybe to ask the question, since you've mentioned ultrasound, it was on my mind to bring it up. Yeah. I mean, traditionally, I know when I mean, I've actually been in practice 35 years for quite a while. physios used to say sometimes the crystal or whatever it is, the cool thing inside the shell isn't even in the machine. And we're using it. Now. Would you perhaps just explore a bit about you know, ultrasound was certainly a very popular modality was using something that you put jello on, and you kind of like train through it that way. And that was done for tendons for years, and years and years, as far as I know. And laser therapy as well. There's two different things there. But laser therapy has also been used or reported to be useful, tendon related issues. So what's happened to them? And what what how do you sort of help with that

James Woledge 28:27

ultrasound is still has a place, it has mostly a place in acute injuries. So if you can get ultrasound, the only evidence that really exists if you can get hold of someone in the acute phase, within two or three days, this Sunday to say that she needs to be on the day. So football clubs still use them, you know, quick turnaround coming, you've had a knock on the ankle, it may well enhance healing by using ultrasound on that acute injury. But for chronic stuff. As far as I'm aware, I'm someone that comes and corrects me at some point, there's hardly anything at all. So most most physios now that I know do not have an ultrasound machine, it's definitely become a bit passe. Laser, on the other hand is on the app, I would say. And the only thing with laser is that there isn't any good quality studies. There are lots of studies on rat hind limbs, the only thing that I know of that exists, which is for NICE guidelines is recovering from mucosal cancer of the mouth. So it's a good tissue healer in

some circumstances. But that's the only nice guideline it does have. It doesn't have any guidelines for musculoskeletal pain. And I get this sometimes on Facebook or whatever other forum I'm on where people have got a certain amount of money to spend. And should I be laser should I be shockwave and I'm a little astonished at that because it didn't take too much time on Google to look at the research for shockwave for our stuff, which is musculoskeletal pain, and for laser, but lasers got from how it works. It's got some real really good potential with some reason there isn't any great quality studies out there yet to say it does some fantastic stuff probably has a place to work alongside so a few people doing a bit of both. But if you had an answer, you know tissue healing lasers or He's quite good at that stuff, but not for muscular skeletal. It's not, not great. Yep.

Robin Lansman 30:03

Okay. And what about I mean, in terms of the placebo effect, because I read, you mentioned somewhere 60 to 90% success rate? Well, yes. And that with shock wave. Yeah. So what I mean that that kind of presents a bit of a conundrum in terms of how, how definitely effective things are? And how did you catch that

James Woledge 30:22

those numbers were probably on the fact that when you look at that, look at all of the conditions that it's got guidelines for whether they'd be nice, or whether they just be good level one trials, we know that the lower extremity, the weight, the weight bearing tendons do particularly well with Shockwave, whether it's whether it's radial or focus, Shockwave, we can

Robin Lansman 30:39

come on to that. There's a difference. I've got a question, actually, that's come up from a gentleman called Steve bass. What evidence is there on heel spurs in symptoms of plantar fasciitis, or the connection, I presume?

James Woledge 30:53

So I'm lucky enough to be in my clinic, I've got a foot surgeon. And so I learned lots from him. And there are some times where the nomenclature around heel pain has moved on a lot. So for so heel spurs are not not correlated with heel pain. So it's a bit difficult to say, what it does

Robin Lansman 31:12

not correlated. I mean, clearly, people come in and say, I've been told I gotta Hills bear, they have

James Woledge 31:15

radio, my GP Yeah, right. Yeah. Yeah. radiographically. It may be the case they have a heel spur, but it's thought to be that heel spur as a consequence of traction on the plantar fascia, which creates a bony growth like it does your tibial tuberosity. Yep. It's a consequence of time in ageing. It's not the causative factor in their pain. In all, but point 1% of cases. So it's not something we talk about really, the modern way we should discuss it actually, is that it's plantar heel pain, right? That's not that's now the new term. Plantar Fasciitis is possibly on the way out, right? So plantar heel pain is what they have, but the plantar fascia is the most, the most deceptive item and that's what shockwave treats is the most of the soft tissues. So in effect, if I think what he might be asking, does it have an effect on the spur? Would it break it down? That's what a lot of people ask us. Probably not at all. If it's a bony spur, the shockwave energy is not enough to break that but people get better and I've had plenty of them. They've got heel spur, all their pain goes away after treatment until they're gonna hit as well. They can have my ultrasound monography as well. So I scan these and they've got

a whacking great heel spur. Right. And you know, I don't make much mention of it because I know that clinically it's not relevant most cases, but patients get better in the heel spurs to their it's just a fascia that you're treating. Not not the heel.

Robin Lansman 32:26

Okay, I've got another question from Lisa op. Who says does James know much about T car ticker?

James Woledge 32:33

ticker ticker? ETS. That's that's, that's, you know, the sort of conferences I go to T car is also on the up a little bit. It was a long time ago. Explain what it is? Because I don't really know that much. So I'm going to be what it stands for.

Robin Lansman 32:45

Maybe Lisa could does it message back in and explain what it's a

James Woledge 32:49

very, it's a very Yeah, I don't know that much to make a comment. But there's not there's not much on it. It's got a lot of press at the moment, but I don't know of any evidence.

Robin Lansman 32:56

So maybe Lisa sent us in a revision of your question. Yeah. Great. That will be great and helpful. So going back to the placebo business. Yeah. Yeah. What What's the because obviously, you know, like going back to the ultrasound idea that was often used and kind of, you know, some of the benefits like with lots of therapies, yeah, the placebo effect is in there as well.

James Woledge 33:13

So yeah, so this is the bit So going back to that lower extremity really good for for Shockwave, the upper extremity, not so much. So if I were going to pick my perfect patient, it would be someone plantar fasciitis or lateral hip pain, they worked really, really well. So as you go to tennis elbow golfer's elbow, not so good. Still better than most things. So it still is there. Well,

Robin Lansman 33:32

how do you explain the difference that we don't know.

James Woledge 33:35

I don't know why one is more effective than the other I lower extremities and upper extremities, we simply don't know the lower extremities seem to come out better they do is what so that so that so there's some of those studies, and plantar fasciitis, 80%, and some of the studies on tennis elbow 5050. And that is literally how I say that to patients. It's about 5050 for anything in the upper extremity. It's about 7560 75%, depending on their comorbidities, all the other things that we usually tell patients, you're not going to do that well, because unfortunately, you smoke, you're overweight, and there's all that sort of thing in it as well. But most of the studies support that sort of region of improvement over a three month course, the placebo bit I love placebo like everyone else, we should embrace that. And it's just a part of what we do, right? I don't know, we'll have to, well, we don't you can't not You can't not be part of the perceiving. Can you I mean, as soon as you therapeutically have an alliance with the patient, you know that placebo to some extent, their belief in you is going to have an impact on their outcomes. There's no doubt about that. But the short that only usually lasts in the short term. I think there's some studies that say about about three to four

weeks, and if you don't see them for three or four weeks that that placebo effect drops off. But the key point was Shockwave, which I was really liked is long term follow up studies. Most of the good quality studies, long term follow ups to a year. It beats steroid, it beats almost everything else which is usually measured over three months long term stuff where placebo has gone out the window. Shockwave continues to improve this.

Robin Lansman 34:54

So would you say I mean, again a rough guess but how many of the people who come in and see you have already had some sort of heel, steroid injection, or some other kind of invasive, slightly invasive treatment.

James Woledge 35:04

Yeah, so plantar fasciitis and lateral hip, for instance, are very people are very keen to steroid those GPS because it's an easy injection that needs you don't need ultrasound guidance. I probably say about one in 10 have failed steroid before they see us or failed interventions of other sorts.

Robin Lansman 35:20

Well, the only thing the people who are coming because they haven't succeeded, I guess. Measure it exactly. But quite a lot. I've had the the injection

James Woledge 35:27

Yes, yeah. Yeah, lots. Yeah. I mean, I mean, almost, I mean, half of my shockwave stuff is lateral hip, and plantar fasciitis. I'm gonna guess that probably 30-40% a month easily. And you know, you're talking about five or six of those would have been stimulated before fail. Steroid tends to go to Shockwave, and failed. Shockwave tends to go to storage, because they're really the only two things outside of our hands that are really going to change these patients, particularly with plantar fasciitis. But most people know that that it's a 50-50 hit for a steroid. It's about 60-70% for an ultrasound guided steroid, getting it right into the right bit. But a good portion of those people after three months returned to baseline, and when that's where shockwave continues to improve, but the steroid drops back to where they were. So I've seen hit patients where they've had literally seven steroid injections over two or three years, because they just go back every three months and have another steroid for a tendon disorder, ultimately, because they were diagnosed with bursitis. And it's not besides hisses, but you inject steroid into a grumpy tendon, it gets better, short term. So

Robin Lansman 36:27

okay, let me just come back to here for a sec. Because diathermy better known as T car tech, our therapy got an acronym for capacitive and resistance energy transfer. That's what I've been told here. And it's a therapeutic technique that uses an electric current with frequencies in the medium frequencies of the radio band. That's di for me, and also someone from Google. I'm not sure who provided this. But Google have said shortwave is used to break down adhesions and calcified tissue as well as stimulate blood flow. So whereas the T car electric magnetic waves are aimed at the target tissues to produce heat, and drainage and stimulate cells involved with inflammation and healing, so there's some crossover in effect, it seems

James Woledge 37:10

possibly, I have no idea. Right at all, they've got to be like the laser, they just, you know, do the research prove it actually happens, as opposed to right on a rat hind limb, or in a petri dish? Right? I don't know. I mean, if someone wants to come and tell me the T cars got that evidence, great. We're

gonna look at it. I'm not I don't I'm not, you know, biased against anything else. If it's proven to work, it's just that those things interesting and not that well proven yet.

Robin Lansman 37:31

Well, it'd be interesting. Anyone listening who wants to mention what they use? Because probably there will be people that in practice, be interesting just to hear and contrast and go compare and contrast? Yeah,

James Woledge 37:41

there's no doubt there's anecdotal, like, I've got some good colleagues that I've, you know, gotten to know over the years of doing this. And they use laser, and they are absolutely convinced it's brilliant. So you know, it probably is, but you know, if I was going to spend 20,000 pounds on a machine, or even 30,000 pounds on machine, I just would just go with my sensibilities, which will be I've looked at the research, I can genuinely say to this patient, there's a good 70% chance I'm going to get you better based on all these studies. But like, I liked that about Shockwave, because he's got some definitives around the science was the other stuff that hasn't yet got that. So if you have equal budget to spend on one versus those other things, that's just where I would go,

Robin Lansman 38:20

and that's what you've invested in. That's it. Yeah. So but you said about 75% of your practice is now treating the plantar problem and the hip

James Woledge 38:28

and the hip. But because I scan as well, I see lots of shoulders, calcific tendonitis, tendonitis the shoulder, so yeah, 75% of my working days scanning and using shockwave as as part of that process. Yeah, for all the tendons or there's lots of Achilles as well. Okay. patellar tendons, not so much. We just don't have many footballers in hockey players in our practice, right? They tend to be the patellar tendons. But yeah, golfers and tennis elbow this time of the year, that's a that's probably that's becoming more common as well from

Robin Lansman 38:54

biomechanically assess people then apart from actually doing treatment, because the issue? Well, one of the things I'm seeing is that obviously, there's a pain related drive for people to come and get fixed, which often is in lots of in lots of practices that treat all sorts of musculoskeletal problems. And so then how do you contextualise the heal or other part that's inflamed or sore or foot or hip within the framework of them as a, as a patient as a whole whole entity holistically might say yeah,

James Woledge 39:21

so if we if we go back to let's just pick on Achilles and plantar fascia again, because that's probably the most interesting biomechanical area where the where the research has really changed over the last 510 years. So we got about 15 years, it was all about the pronating too much they need the shoes this orthotic data and that that data, and then we realised that that that that wasn't a simple bit like you know, core stability for low back pain, we realise that wasn't as simple as that either. And so, if you if you looked at the research for whether a tendon is grumpy or the plantar fascia is grumpy or not, compare those two groups. There will be very little to back up a biomechanical process or biomechanical predisposition to that coming from it's really just load It's just you've loaded the tissue too quickly by too much. That is much more the evidence, rather than they've got too much pronation here or their knees in valgus too much or whatever else. Or, for instance, pelvis

is doing something you shouldn't, okay? But it's really about they've loaded it too much. When you go through the case history and you start to learn about tendons, you pick out those parts, where they've just suddenly dumped a couch to 5k. But they've raced through the last stage. And their Achilles is

Robin Lansman 40:24

just so their training programme is suspect. Yeah, there,

James Woledge 40:27

they vote, they've done too much in too short a time. Or they're doing the same amount, but their health has deteriorated. Either way, it's overload to the holistic context, in terms of that whole, because it's still a good portion of my brain, that's, you know, going back to those physiology days at university that says, you know, your tissues are just, I say tissues several times in the room, I try and take them out of the idea that this a tendon, this is your tissues are just being overloaded.

Robin Lansman 40:49

So how would the state of health of someone, let's talk about that from an effect the outcome or the likelihood of the improvement from having shockwave therapy? I mean, is there a, is there a type of patient I mean, to choose your type of patient? Yeah, what would be? Yeah,

James Woledge 41:03

we're getting over that simply because, you know, we see, I see them as a tendon disorder problem. And now the evidence is that if they've got some underlying metabolic disease, diabetes, thyroid, that's one thing that's a big predisposition for these diseases, and not allowing them to get better in a normal timeframe. We've got data on smoking, data and obesity, now we're starting to get data and data on, you know, where the fat is on the abdomen. So you know, we're carrying more white fat here, that's more inflammatory, they're not gonna allow tendons to get better very, very well. In lots of tendinopathies, it's female, slightly more than male and the big one with females. Now, there's lots more evidence about about perimenopause and oestrogen 's effect on collagen. And whether you turn over the tendon, get it healing in appropriate way, lay down the right collagen, is somewhat dependent on your hormonal balance, which is why we think women's women getting more

Robin Lansman 41:51

than men. Right. So they're going back to shortwave, for those cases where there's a metabolic issue. Yep. Rather than a biomechanical issue, perhaps. Yeah, too. Yeah. So what's the sort of the way of approaching that we shot waving? Well, it was

James Woledge 42:04

always just sort of caveat that it's always shockwave within. Right. So, so my, my, I spent a long time on a whiteboard in my room talking about all of those health issues. Yeah, when they can change and they should change. And I will often say, Look, you know, if you don't change these things, it's gonna be might be six eight treatments, and it's going to cost you this much. If you could do these changes, get take these changes in your life and you know, lose a bit of weight here, do this with your blood sugar's you know, and perhaps have a chat with your GP about your Hormonal Health, because you've, you've told me that you're getting hot flushes, and your memories a little lost at the moment, and, you know, so on and so forth. You know, perhaps you need to touch base with your doctor about your HRT, or whether you're having any or not, because all of that will support the

outcomes for my intervention, which will be graded loading programmes getting you back exercising, and shockwave because I'd rather shockwave a nice healthy bit of tissue. Sure, because part of what it does is this regenerative effect, it's giving everything a stimulation and go right come on.

Robin Lansman 42:58

So is it less likely to be effective on a on a call it degenerative, but on tissues that are not running as sounds on my lips, same with our hands, you know,

James Woledge 43:06

I'd rather tackle some tissues that get a good read response. And I've you know, they're healthy. And I know, that's embedded within someone with a good cardiovascular system, good lymphatic drainage, all that sort of stuff. That's the same as Shockwave. I use shockwave as an extension of my fingers. It does a few funky things. But it's the Macondo transductive input into the body that says to the body's tissues, would you mind just crack on? You know, and I use my hands for that, but I usually do. But shockwave is just a little bit more impactful, and has a few extras on top.

Robin Lansman 43:33

Okay, we'll come on to some of the things that I've got a couple more things here. From marketing point of view, how did you start with Shockwave? Do you use Google ads?

James Woledge 43:42

Well, no, I don't. I've never used Google ads. I did I start back in the day, I had a fair reputation for dealing with these sorts of problems. And a few of the osteopaths that I used to work with other clinics knew that I liked them. And I just you know, so I've got this machine seems to do wonders for this and the other. So they sent me a few of those. And then I suppose in a 20 mile radius, I've now become, you know, the go to clinic for that sort of stuff. But you know, been a Facebook ad stuff, occasionally, really optimising your website. And ultimately, it's it's in room, getting it across to the patient that if they if you've got a chronic problem lasting more than three months, and you've tried them now, so now I have the advantage of seeing lots of patients with failed other interventions. And they come to me with expectation that I'm the person to deal with these difficult problems. And then it's up to me to educate them to say, look, this is a decision that you I think you should make based on the evidence, your choices. Now you've done the physio you've done the exercises, there's not much left. Yes, there's a steroid injection, but most people don't want to do those anymore. risk of rupture. There's a shockwave machine that that can help you do pain relief, and start to supercharge your tissues a little bit. There isn't much else. So you have to do the job in the room and educate patients that are about to make a decision about the cost of the treatment, which is a bit more, but actually, it's more expensive. Yeah, but yeah, yeah.

Robin Lansman 44:55

They're having less sessions and other things. Why What proportion more of interest, that's

James Woledge 45:00

a difficult thing because I'm not in the classic mould of seeing patients I you know, if I see a patient more than three or four times, it's unusual, because I am tend to be in and out and give them to do the shockwaves, three to six sessions, and I double my charge in effect, my fee is 58 pounds and slightly less now 58 pounds, see me and 95 for the shockwave the additional. So I have, I do scans as

well. And I just up lift and say to patients, look, I think this would benefit you, we can charge a bit more because the machines are costly, and I have to service them and patients understand

Robin Lansman 45:30

that they will customers session of shockwave therapy as an end of the actual mechanics of it. Yeah. Five minutes. Just five minutes. Yeah, well, yeah. I didn't get on the treatment at that same time. Yeah,

James Woledge 45:40

as I said that the whole point would be that I was have half an hour, right that it will last usually half an hour, I'd say, right, because it's the whiteboard, the education, how the exercise is going this week, touching base with maybe the diets change. Have you seen your doctor? It's all of that around the five minutes. There are some cases where I've, you know, four sessions in, we've done most of that. And it might be a 15 minute treatment. I was ticked off now there are lots of people that chop the sessions down by half and charge the same amount, right? I don't really get that. I don't think that's good value care. But anyway, that's up to them.

Robin Lansman 46:11

Okay, and I've got a question from a sound actually, I've got one from Louise white actually says if you were spending up to 30,000 pounds on a machine? Well, actually, it actually goes to what I've just said, actually about what you're charging for treatment. I mean, you've got to work that out if you're investing 30,000 pounds.

James Woledge 46:29

Yeah, I get asked that a lot. And as far as a lot of money, that's that's the expensive one. So focus. Shockwave is proper lithotripsy or proper shockwave as we would say, that's the expensive stuff. Hardly anyone has got that that's a bit a bit extra. Most people have got radial pressure wave, right still called shock wave. But it's not quite Shockwave. But that's somewhere between I don't get into prices. But let's say somewhere between seven and 10 11,000 pounds. That's usually a quite an easy bind for most clinics starting out on this journey.

Robin Lansman 46:55

But going back to what we said earlier about Google searches or putting on your website, do you think it's What can I say? I mean, the branding, the shockwave name, do you think that pulls people in any way just because of having something

James Woledge 47:06

a little bit of USP and and now I would say because we do some Google stuff sometimes to see what's going and it's a searchable term, it's way more popular. It was 10 years ago, when I started this, it was very fringe. Now patients are aware they get online and you know, there'll be all sorts things about shockwave treating your tendons. So patients come now much more to us and go I understand you do this, and I want this. So they're pretty sold on it before there are absolutely yeah, the marketplace is now awash with clinics with it. So there's just more out there on Google, right? And pay for going back to that question, because that's important is that when we when we teach this, we really important to say this base, like you've got to be a tendon base clinic set yourself up as a tendon specialist. And so my physio and other people that work with me in clinic, they I see them three to six times, but then they might see my colleague physio, three or four times on the back of that, that specialist rehab, who've got a treadmill, we do gait analysis, you know, so it builds not just

the people you see with the machine at the end of the machine, it builds a whole network of patients that come to see you as a specialism. That's where it really gets paid. How

Robin Lansman 48:05

do you deal with the feedback? Can't say the feedback, but you've got a patient coming in, you ask them how they're doing, I guess, is that the normal way? How would you kind of measure improvement? How do you actually gauge whether it's working and it's it's hitting us, but there are some

James Woledge 48:17

some well researched aids to measurement like the foot function index. So there are some things you know, literally, how many steps a day. So for instance, a patient I saw today with tibialis, posterior tendinopathy. So I treat her three times. And you know, you make in my clinical notes for those, you know, you would say that what's your walking distance, 250 Steps roughly, and standing time because it's a real Biggie with that condition, I can only stand for literally a minute or two. And she's coming today. And she's now standing for over 15 minutes, and Ashley will cause her to sit down and her back not her ankle. And she's now walking. I remember up to a mile. She's five. Okay, so there are those general metrics we should use? Would anyone

Robin Lansman 48:56

shift them? So it's interesting what you said about it going from, you know, what was a tendinitis to her back? I mean, is that does that how does that connect with you in terms of one thing shifting onto another?

James Woledge 49:06

Well, that would be part of my normal, you know, that's always there in the background, I think gotta get with that. But one of the things that I think when you become confident in dealing with tendon problems, is saying to patients look, your pain, rather low back pain is not at all correlated with the chances of you doing damage. It just isn't. So giving patients the confidence that says they're in scanning helps you scan so they're no tears here is just a grumpy, sensitive tendon. And actually, if we compare you with somebody who avoids all exercise that causes discomfort, so this person just waits for it to go away. And the person that exercises with tendons, this person come back in a year doesn't way better than the person that avoids all pain. And you give them that confidence. And you know, that's probably more useful intervention to stop them getting knock on effects elsewhere.

Robin Lansman 49:50

So how much pain relief going on to how it works. We're going to talk about the different types of shock wave and but But what in terms of pain relief directly? Yeah, well But what sort of effect and how quickly are people likely to feel a change that is measurable and useful and so on? Well,

James Woledge 50:06

what's really nice is that, you know, if we use sort of high frequencies so that in within a treatment, they will get off the couch and think you're a genius. And, you know, you're not, it's just that it's rhythmical bashing of the tissues if you like, and that creates a big pain gate, not receptive, your antinociceptive Respond to they get off and they walk away, they can't believe it, I can't wait to pay you. But then you have to coach them. That's a short term, you know, perhaps 234 hours, and it will come back and settle into what it normally does, you do get and we still don't, why don't why you

still get within one or two treatments, people that have had something a year and they come in and they haven't got any heel pain in the morning. We truly don't know why that happens. But it does happen. But what we usually say to patients is that the outcome really needs to be measured about a month after your last session. It's the tissue regenerative process knocking them out of an inflammatory chronic inflammatory phase.

Robin Lansman 50:58

So you're saying some people might get up and say well, well well, they will do right they will do they will do but what happens then in the interim, but or how far apart are your treatment sessions a week usually,

James Woledge 51:07

sometimes twice a week, but you have to coach them that this is only three to four hours otherwise they get bit spoiled, send you an email, right so you say look, this is only short term, this is you know, a joke and so it's just so you can go and pay me on the car machine or whatever. But it's just that's it for hours, but I'm not concerned about it and I say to patients next week, I will ask you how you've been but I won't really care what you tell me and that gets a little laugh as well because I do care but actual between treatments up and downs it's not relevant for tendon problems. It's where they are a month afterwards and

Robin Lansman 51:35

so we're How does Okay, but how does it change from being so variable to stabilising?

James Woledge 51:39

We think it's due to the fact that you know, these chronic conditions have got some degree of this is still theorised peripheral sensitization, some element of central sensitization, they're getting not classic inflammation in the tissues, because this idea that we don't call the tendinitis anymore, we call it tendinopathy. And there's no inflammation, we sort of come halfway back from that and say there is inflammation is just sort of grotty chronic inflammation, which is not going to allow the tissues to heal when we think the shockwave have some impact on trying to drive some of that out substance P calcitonin. Gene really all for the nerdy stuff, not not for me, but it helps to clear the tissues out if you like, clean the tissues up. And then and then allow the tissues to move forwards. That seems to take 234 weeks, perhaps quite a few weeks. Yeah, in between. But a tendon, if you look at any data on tendon healing is nine months is the hardest thing to get better. It really is just about you, I found them so challenging. You know, muscles have got great blood supply for six weeks, bones, great blood supply, two months, three months in, and then you enter cartilage ligaments for five, six months, and then nine months for tendons. I think people just a bit afraid to tell patients this is going to be nine months. So I say to them, look within a couple of months, I'd like to get you 75% Better, but the remaining 25% That's Mother Nature, that's not my job. That's just you getting better over the next five, six months after that. Okay.

Robin Lansman 52:57

Well, I guess research is always an interesting one to find out some absolute. So I've got a question here. What I was gonna ask this actually, thank you for Chubs for saying what are the contraindications for Shockwave? Yeah. Shall be someone you know. Yeah.

James Woledge 53:11

What are the what the contraindicated contraindications is? The question was on my mind as well. Gotcha. So the I SMS T they're sort of the world governing body of all things to do with this and they tell us what we should be saying and doing and contraindications. They are very small to 10 years ago, there was lots for instance, the one that we get all this you allowed to treat it over the thorax. You know, is it Soundwave gonna give you a pneumothorax at normal energy levels, you're fine. So that's a normal energy level, you know, is something that most people can tolerate on the ribcage anyway, so even that's now not worried about is not the cause of pneumothorax. Okay? But the only ones that are over over the foetus in a pregnant lady, so actually, someone with me get this, like someone's pregnant, they can have treatment on the plantar fascia. The Soundwave is not gonna go anywhere near there's only on the foetal area, and then it's someone with no malignancy. You don't treat those. And that seems rather obvious. And then if they're coagulate, anticoagulation is pretty high there on warfarin, quite high level stuff. Probably best not to do that. But some of the other ones, you know, I've treated with consent, with doctors advice, saying yes, probably, okay, just warn the patient, the more bruise on the new new ones, Revox and all the other ones, but heavy dose warfarin, let's say, heavy dose warfarin, someone's 75. And their tissues are, you know, not great. I wouldn't use it. I mean, because you're getting into that realm that we talked about earlier. Their tissues haven't got enough in them to respond well to the treatment. So the concentration is just foetal area, malignant cancer and heavy dose of warfarin, that's the only three really, right otherwise it's super safe.

Robin Lansman 54:40

Okay. And I've got a question here, which actually, someone missed earlier on. What does shockwave actually do? I mean, I think if you want to say it again, but is it feel like I think we're going to do that in the demonstration? Yeah. Should we feel the differences? Should we save it for them?

James Woledge 54:54

No, we just touched on it there. The pain relief is supposed to do with C fibres. You know, there's some evidence to say that we can break those C fibres that have grown into the tendon, which we knew and got the word now. So basically, with a chronic tendon problem, you can create nerve earnings that grow into the tissue with little blood vessels, and there's some potential breaking of those strands of nerves, you can do a shockwave, mostly high energy stuff, but it's just anti inflammatory. We think now it's not it's not got that sort of pro inflammatory thing. We're changing the words on this now. So it's not like it's creating a new, amazing inflammatory episode, we think mostly is anti inflammatory, clearing out the gunk. So it's, that's the pain relief aspect. And then the other aspect, which is the regenerative stuff, really giving a boost to things like Tina sights, we know that they flood into the area, and you're getting appropriate collagen laid down after shock wave as opposed to inappropriate collagen. So it changes the fundamentals of how the cells work. Apparently,

Robin Lansman 55:48

there's some apparently some theoretical,

James Woledge 55:51

a lot of there's a lot of theoretical because you know, you're when you start talking about cells in humans, indeed, it's almost impossible to say exactly what's happened, right. So you do we have got also rat hind limb studies showing you this, that and the other helps. But there are also some good Doppler studies after treatment, that sort of stuff that so blood flow increases, there's a number of mechanisms, they get a bit nerdy, but if you google and they're there, but pain relief, and

regeneration, both together, that's kind of what it does. Yeah. And mostly for chronic stuff is really when someone's had it for one, three months, more than three months. Yeah, that's the real, that's the real thing. Okay. And

Robin Lansman 56:22

would that weigh in? If it was six months? Six years?

James Woledge 56:25

Seemingly not? Right. I've had some people that have had, you know, for instance, I can remember clergyman had it for 10 years, Ron fasciitis, in the three months point after his last session. Done, nothing else had done it in 10 years. So you can get some really, really ingrained chronic stuff, and it changes them out of that. chronicity.

Robin Lansman 56:42

Yeah, okay. We've had a few people asking just in terms of brands of machine RPZ, how many different makes are the this kind of product

James Woledge 56:48

A few. I can only speak of mine, I've had mine 10 years, and it still starts every morning. It's great. So stocks is the biggest company. It's a German Swiss company, they've been going for probably 1516 years, they actually make the big lithotripter is for kidney stones. And for cardiology, which is used for as well for treating the vessels in the heart, and ultimately, a focus. Shockwave is a small lithotripter small version of the ones that use on kidney stones. Right. That's where it came from originally. And those thoughts are the big ones. There are other companies. But you know, that's the one you've

Robin Lansman 57:20

had problems. I mean, yeah, I can only speak of mine. Yeah. Okay. And then someone has asked again, and we mentioned Healdsburg, but in terms of reducing heel spurs. And we've sort of talked about it, I think we are so it may

James Woledge 57:30

take take, take the infants away from the bony spur. And it's really important to get patients off that idea. Yes, if they know they've got a bony lump on the bottom of the hill. That's not a great long term feeling in their brain, right? Bony lumps never going to get better, and they've become fixated on it. They want you to break it up. I do get that.

Robin Lansman 57:47

So there was a bit of kind of, say NLP a little bit of an OP while using using words in particular ways?

James Woledge 57:53

Well, I think that's important, isn't it? I think they're using words. You know, there's what we do, we should be we should be embracing it all the time. We know full well that we shouldn't say that someone's got spinal pain because they got a disc out of place, and I'm gonna put it back in. It's the same with those conditions. We shouldn't be saying damaging words to people. Right.

Robin Lansman 58:08

Okay. Okay. And we've got another question. Well, again, we've sort of mentioned a bit contraindications to implanted cardiac devices. I presume that's not obviously working on the heart. But you're right vicinity?

James Woledge 58:19

No, it's fine. And it's not an electrical device. I mean, to people get in, it's a soundwave. It's of high energy sound wave. So it's not it's not electrical, even though it's called Shockwave. It's the shock wave as in, you know, jet flying overhead bang breaks the speed of sound in your greenhouse, back in Concorde days, your greenhouse would go, right. That's, that's the shockwave impact. And so it's not electrical, not to have any impact on hearing aids on your heart.

Robin Lansman 58:42

pacemaker. Okay. And probably, is it worth mentioning the different two types? You alluded to earlier? There's the more focused cheaper

James Woledge 58:49

machine. Yes, standard, sort of you started off on your Shopware journey, just a radial pressure wave. So that's, that's, well, that's probably where we should go over and talk about it was, you know, because talking about it and make sense. Yeah. So one's expensive ones not so much. And they do slightly different things, but there's a big overlap. Okay. It's only when you really get into it that

Robin Lansman 59:09

you we asked Matt to come across Yeah, yeah. Module. Yeah. Just a second year. So. So we're gonna have Matt in as our as our model. Yeah, to talk about a couple of these things and answer questions. Well, I'm gonna carefully detach this to take over in case you get the questions while we're over there. So if you want to pop over, yeah. And, and keep bringing the questions in as we go.

James Woledge 59:31

So the buy in one would be the one underneath. So this is a radial pressure wave device here. This is basically in the gun. Let's call it a gun. We have a projectile bit of metal ultimately inside the tube. So if I take that off, that little hole there, it slightly pops out beyond the hole okay and hits. Okay, back of that bit of metal there.

Robin Lansman 59:56

Is that like mctimoney Chiropractic, how dare you not let it out? A

James Woledge 1:00:02

little bit different. So what that creates is this pressure wave, okay? A shock wave by a physicist standard would require a lot more energy. So strictly speaking by a nerdy physicist, this is a pressure wave device, okay, not a shock wave device, so but he doesn't really matter. So that creates the pressure wave that comes off the end of there so that that in their cameras might not pick it up. That's a pneumatic device with air being sucked in the back of it, which creates pneumatic pressure for the bullet in the gun to hit the back of that, that creates the bag. So it makes a loud noise. Some patients get a bit concerned by that. And you start off nice and low, and then you get the patient used to the feeling of it. So it's a bit like being Jack hammered. It's a bit of a like, a bit a bit abrasive, you definitely know is going on. And the thing about this is that all the energy that this delivers is

delivered at the skin surface and then penetrates slowly into the tissue. But as it goes into the tissue, the energy gets really depleted.

Robin Lansman 1:00:58

And it gets dispersed. So how long? Yeah, we're gonna demonstrate Yeah.

James Woledge 1:01:02

And with all things that are based on sound you need, you need a gel interface like you would with sonography, doing scans and so forth. So to give you an idea of one versus the other. And I'll do this on you in a minute. If you ask me nicely, thank you very much. So for treating plantar fasciitis, you know, it's a very simplistic title at all. And we use the the patient's feedback to say, oh, that's where my pain is. And one of the good things about Shockwave, as opposed to you're saving your thumbs, the plantar fascia, when you start scanning these is fairly thick, and it's fairly deep. You can't really get there with your thumb. So a lot of the lot of the times I use shockwave to also identify where the problem is exactly. And we know that the outcomes for shockwave therapy are better if the patient's involved in that. They said, well, that's my pain, all the time having a conversation all the time with the patient saying, where's that your pain is? I think going back to therapeutic alliance, it's quite nice to get involved and take the fear out of it. Because everyone does thing was submachine, you've plugged in electrical notes just the same way.

Robin Lansman 1:02:01

So if you're hurting, you're in the wrong place. Pretty much is more

James Woledge 1:02:05

about the pertinence of their pain. So I could put this on his shin. Now, he wouldn't like me for doing it. But that's not relevant to his maybe symptoms. If he had plantar fasciitis, I want to reproduce his heel pain. And shockwave therapy, particularly focused is really good at reproducing the pain of the patient. And they think that's, I think, therapeutic that's really important. You know, we deal with the hands that we feel that bit and the patient says, Oh, that's my pain, that's probably a good thing for them to feel that you've empathise with their pain. And shockwave is brilliant for that they get oh, that's exactly what I feel like it needs. I often say that, you know, we're like we do when we do a strong treat with the hands or a strong message or whatever. They feel like that's what it needs, you know, as an instinct, I think that's that's therapeutically quite helpful. So that's a that's a low energy sound wave that comes off the end. But it's quite a lot of noise. But it is also quite painful to have done. The wet focus shock wave comes in

Robin Lansman 1:02:55

just couple questions on that sort of frequency. I mean, obviously, it has a certain rhythm to it. How would you choose that? Or how would you decide it's a bad

James Woledge 1:03:01

we're trying if we're trying to get depth into the tissue, so the plantar fascia on him. It's quite a large chap who's got a bit of tissue but have found and eith, we might say, if the lower the frequency, or the lower the hurts, the deeper it goes into the tissue. So if I dropped it down to bum bum, bum, bum bum, it's sort of that's gonna get deeper into the tissue. Because your Is there anything

Robin Lansman 1:03:23

to do with the tolerance of the patient? Is it less painful and more painful, depending on more

James Woledge 1:03:27

valuable to have lower frequency, right? So we always say that you want to start off high, that numbs the area a little bit, and then you drop it down to what you think the depth you need. So if I was treating his proximal hamstring, which deep in there now, I would start off, you know, at 12 to 15 hertz, which is what is that now? Then I'll drop it right back to with him. Big old hamstrings. You drop it down to you know, right? And then it takes longer than five minutes do the treatment? Yeah, but so you can play around with that variable, and just simply how much the air compressor is pushing through. So now I've worked up the

Robin Lansman 1:04:02

he wouldn't like me doing it and frequency can both be modified. Yeah.

James Woledge 1:04:05

Like it's like, if anyone's into scanning since monography. ultrasound scans are the same frequency as depth, but just has that effect. Yeah. So you can play around those things. The fun of

Robin Lansman 1:04:14

that field, can I just because I have another go yet? Yeah. Yeah, you're miked. But you say you could feel it in what kind of way

James Woledge 1:04:23

but a very slight not pain, but I can almost make this engage you in the mini experience. So I wouldn't choose to use this on your elbow. Okay. And I'll drop the bar back a bit, but you will just get the sense of it being quite a bit. It sort of feels superficial when a bit Ouchy. Describe it as Yeah, yeah. And that that energy level is significantly less than the focus Shockwave. But it's much less painful to

Robin Lansman 1:04:53

have come and come on site and say I've got questions rolling in. Bridgette asked, should you wear ear protectors?

James Woledge 1:04:59

We don't think So

Robin Lansman 1:05:00

now it wasn't that noisy. No,

James Woledge 1:05:01

it's not that noisy. No, you don't need that to vibrate week after lot and you're gonna get white finger anything else? These stocks in particular they've done more research than any other company by a long way. And it's all C approved vibration damage on your hat, None None of that. None. Okay,

Robin Lansman 1:05:15

I've got another question from someone called dramatic mind. What can go wrong with shock wave machines? I went on a shortwave course and they said they'd had a colleague who'd had overtreated heel spur to a level that had never come down again. Does this sound right? If so, how do you ensure that you don't do that? Me off getting one

James Woledge 1:05:34

obviously, that's what they call the reason overtreated, Hillsborough, Hillsborough coming up a lot on a I don't know, don't know what to say about that. Okay, now, an individual case. It's very rare that you do shockwave and there any side effects, side effects are well known to be almost zero. Like it bruising literally is about it. Apart from the fact that like anything else, when you're putting a lot of energy in, it can flare you out for two or three days and be a little bit sore for two or three days. It could last two or three days, the saw the soreness as a response can write not often, but can so you would tell patients that it might happen. But we should do with hands on treatment that this could bruise a bit. And because I've worked quite hard with you, and it could be sore for a couple of

Robin Lansman 1:06:12

days off. And someone's ask Jane has asked can you treat it through treat

James Woledge 1:06:15

through clothing? No. Gotta be against the skin. Again. It's got it's got to have ultrasound gel with conductive gel. And it's got to get on skin. Yeah, otherwise, nothing works. Yeah.

Robin Lansman 1:06:23

Okay. And so moving on. Yeah, do you want to tell us about the

James Woledge 1:06:27

one on top is the focus device, which is a true Shockwave. So the energy levels are in terms of touching on the skin, about 10 times more. But by the time the point with this is that the energy will come out of the end here. And we have these little adapters that change the debt. So 10 times more energy of the mechanism that 110 times. Yeah, well, in fact, significantly more than that, actually. So what happens with this one, the radial device will send his energy out and then it disperses like that. So by the time you've gone to three centimetres zitten. For the energy where you want it loss of it's gone over there and over there. So the amount of energy in the tissue breaks down quite a lot, right? This one is a constant beam of soundwave. Right? But most of the energy will then we can cause a cavitation. So the sound wave, like a bubble bursting is about a centimetre off the end of here. Right? So the question was good, No, you wouldn't see that because it happens inside, right? Okay. The whole point of this is that you don't if you could, if you can imagine designing one of these, you'd say, well, I don't want to waste any energy on the skin or the fat. That's where I needed money, the energy inside where the tissue is, yeah, right. And this one does that. This one does not give you any energy at the skin surface, it gives you all the energy inside, right, and you can calibrate it to go as deep as up to 12 centimetres. So wow, a lot deeper and no loss of energy, you will have an adequate loss of energy. It's like it's like a Dyson. Okay.

Robin Lansman 1:07:44

Yeah, sorry. 12 centimetre. 12 centimetres, is Yeah, I mean,

James Woledge 1:07:48

I treat the posterior hip, behind the hip, right. So for instance, the posterior capsule may be piriformis. Right? Excuse me, inside line, that's a long way in some people with depending on their habitus, completely say that, you know, you need six, seven centimetres, eight centimetres in through fat to get to where you need to get right. And if I took that off, right, and put that against the skin, now we're talking out here is depth, right? And no loss of energy on the way in and these

like a hamstring tendon is a big old tendon. And if they're really crying, they're really horrible conditions of proximal hamstring tendinopathy. And you can get in there with this.

Robin Lansman 1:08:21

Okay, and so actually, someone's asked this question, right? My Ori has said, Are there any type of insertions contrary indicated

James Woledge 1:08:28

insertions of tendons? I assume she means presume so. Yeah. No, not contraindicated. The only contraindications, those three things I said earlier?

Robin Lansman 1:08:35

Right. Yeah, I mean, okay, so the risk factor, going back to contraindications, something deeper than you can palpate. See? Yeah, absolutely. But then. So the risk there is that little risk factor, if you haven't spotted, let's say, someone had multiple myeloma and didn't know it. Oh, blimey. Well, I'm just saying they that could be the case.

James Woledge 1:08:51

It happens. They can happen. Yes. Okay.

Robin Lansman 1:08:55

So let's just broaden the rest one has to look at the downside as well as the up and obviously that would be would be a factor. So certainly, you know, seeing people in practice, those things do come up. So Anthony asks, Is it okay to treat a round a troll can Tarik bursitis

James Woledge 1:09:13

I've run away Okay, so we're in the realms of heel spurs again. So we think that only about somewhere in in single figures of lateral hip pain would have any bursary involved at all. And the really good study done by the the Society for orthopaedic surgeons that just deal with hips 2019 And I spoke to those guys that did the study, and that, you know, we know that we treat versus all the time with Shockwave, and they seemingly don't react badly at all. I think most most gtps is just a 10 We need to move away from talking to Eric besides us. It's still used in GP practices. Okay, but a truck and Terry precise when you see one, you literally see it, it's literally that big. So it's a tiny bit of fluid that you see on an ultrasound scan. We think it's not clinically relevant.

Robin Lansman 1:09:58

What about infant developers like this simple, sorry, talking about gtps. Well, we work

James Woledge 1:10:04

around other societies as well, just around the knee. Yeah, they're obvious. But they can happen independently of the tendon problem. There are some joints like shoulders, it's very difficult to get a subacromial bursitis. Without a Supraspinatus tendinopathy, it's almost impossible they go together. So we've sort of lumped those together as subacromial pain syndrome. Now gtps is called that because it's likely to be the tendon plus a little bit, the bursa plus the periosteum. We're not, you know, but mostly, it's the tendon, but it doesn't dissuade you from using shockwave on it.

Robin Lansman 1:10:33

And what about using the shortwave directly on muscular tissue that's contracted,

James Woledge 1:10:37

that's actually the radio will be good for that. That's where you, you know, in an advanced setting, like you know, mine where I treat it a lot and see lots of those conditions. You treat the you do the radio with the muscular stuff, because it's a broad area. And then you get this out and you use it on the tendon like the insertion of the Achilles either using a bit of a combination of the two, and then I'll use it and then I'll use the grid loading programme is not a standalone, or it's not just you know, I'm a shockwave guru. It's I'm No, I'm just attending guy that uses these tools to get where I need to get with chronic stuff. Okay, and

Robin Lansman 1:11:06

he was saying jiwa I think that's how you pronounce the name with shockwave aggravate hairline fractures. Let's say you've all that there's a little hairline thing or even even a shock, you know, even what's the word of the word. So one of those hidden fractures, you don't know you've even got, yeah, like a stress fracture

James Woledge 1:11:21

stress back back back in the day where we used to use a tuning fork to vibrate the bony and you would get that with that. Yeah, you'd get immediate pain response, quite good diagnostic tool. There are actually some as a couple of Orthopaedic Surgeons I know in Germany wants me on my podcast that uses it as a bit of a diagnostic tool for so would that be something to avoid? No, no is actually more the mote is really compelling evidence for non union fractures, treating stress fractures, and treating non union fractures with Shockwave, brilliant evidence, high level level one stuff. And the reason for that is the mechanic transduction. So if you if you're not able to wade through your tibia, because you've got this non union fracture, you're not creating osteogenesis, you're not creating those pieces of electric forces for the leg. You're literally using sound waves to put in what you're missing. So I've treated three or four non union TVs, and they were all timetable to go into revision surgery. And all of them didn't. Okay, I got the surgeons permission, and always got that but

Robin Lansman 1:12:15

how do I need to obviously need permission but how did he connect to the process and what you didn't really

James Woledge 1:12:20

there there is a device called an Exogen device, which is the wearable ultrasound device. Bupa approved nice approved as long as you got non union after nine months. And I just said to him, Look, it's soundwaves. It's all the same, but a mine is really high energy can really help bring this along anyway, I find it but I thought it was ethical to ask his permission. And the patient obviously, and they all didn't have to go into surgery. It's brilliant for that.

Robin Lansman 1:12:40

Okay, got another question from Kathy me. Do you perform a diagnostic ultrasound prior to shock wave or work on clinical judgement alone? And apologising? If this is already covered, but not? Yeah, I don't think quite that way. So

James Woledge 1:12:53

I have the luxury of now being qualified in that. I do use it a lot.

Robin Lansman 1:12:57

Did you qualify in that first? No.

James Woledge 1:12:59

I've only qualified in that last in this last year. So that was a long haul. We've got a postgraduate in that. So it's it's difficult, but it's well worth doing. It's because it fits with what I do as a practice. But yeah, the clinical judgement for nearly all cases absolutely fine. The occasions where I do see a bursa in the absence of any tendon. So the retro calcaneal bursa of the heel. It's that's quite common, and you damn well think it's an Achilles tendonitis or Achilles tendon problem isn't tennis fine. So the

Robin Lansman 1:13:23

diagnostics coming in to diagnostics. If you're not evaluating it, I'll say osteopathic but if you're not evaluating it fully, adequately, with hands on with evaluations of other sorts, yeah, that the ultrasound is key.

James Woledge 1:13:36

Yeah, well, not No, I wouldn't say it's key. It's just you, if you see as many as I do, if you see not as many, it's just numbers, I'm gonna pick out one or two a month where I scan it and go, Oh, that's not what I thought, then shockwaves, therefore a waste of the patient's money, but it's never it's never, I'm never I'm never getting them out of it. It's not gonna cause any problems, even if it was just a person, just be a waste of my time and their money, and I don't want to do it

Robin Lansman 1:13:56

and make it worse wouldn't make it better. And I just wouldn't do anything. Someone else here. Are there any novel uses? I think we've covered a few novel uses of shockwave therapy

James Woledge 1:14:05

novel would be now so novel would still be probably non union fractures, even though the evidence pretty good, but we don't see enough of them in practice in the world

Robin Lansman 1:14:15

in which the advertising come in with no non union flag. Sorted No, no,

James Woledge 1:14:19

no, no, no, that would be that would be a bit ridiculous in a way. That's why I partnered up with a surgeon to agree you know, because they was they were the primary care isn't that there is lots of work going on. Now with chronic pelvic pain. Prostatitis is a massive study at London Bridge on post prostatectomy. So it's one of his things is angiogenesis with focus on promoting blood flow into the penis. So

Robin Lansman 1:14:40

we're going to come on today sit down again, I think we'll leave that yeah, just for a minute. But erectile dysfunction, I know is something we might check one of the novel ones that would be one of the novel ones. So we'll talk about that in a little bit. But going to this sort of boosting blood flow is also about boosting blood vessel proliferation, new blood

James Woledge 1:14:57

vessels. Yeah, that would be it. So angiogenesis, new blood vessels growing into the tissues or around the tissues in the case of tendon disorders, right? So it's the we think it probably has some elementary effects on stem cells and proliferating the right kind of tissues. So, stem cell will become a tendon, if you put shockwave over the tendon, it will become bone if you put it over the bone. So it seems to just promote wherever you put it done. So in cardiology, they put it over, they put it over the vessels of the heart, but they also use it to its high energy, they use it to distract the calcium layers within the arteries, before you go in and stent and the outcomes are brilliant for stencilling. With the surgeon on hand, it will search and stuff. Yeah, million, million pound version of this. Yeah, is used to soften up the vessel walls to make the stent going better. Right. So in cardiology, it's a big new thing for that, but much higher energy, even higher energy. Okay. Okay. And more targeted, as you'd imagine you want it to be?

Robin Lansman 1:15:49

I think you do. Yeah. So do you want to demonstrate it? Yeah. So with the other head, the other the other version?

James Woledge 1:15:55

So this, this is the one. This focus, this is proper Shockwave? Much higher energy. So if you think about what that felt like on your arm, yes, we're sorry.

Robin Lansman 1:16:05

I'm getting a little nervous, you got to watch

James Woledge 1:16:06

this, this is you'll feel it, but not, not nearly in the same way. So if we put that all and just sit it there for a while, and move it up. So this is this would be where you'd you'd be triggered tennis elbow at the top. And it takes a bit of time to build almost, you'll start to get a sense of what most people would describe the sort of, like a teeth achy, in the out of it, the

Robin Lansman 1:16:29

elbow feels like you're pressing harder. That's right. Yeah,

James Woledge 1:16:32

it's a precious sensation. I'm not pressing at all. And you know that that there, the energy that I've just put into your elbow would be magnificently more than the radial pressure wave that we did put on there that feels like it's, well, that felt a lot more uncomfortable. Yeah, so insertional Achilles tendon problems, which are the tour riously, painful, they wouldn't like you much for treating them with a radial device. So it's a nice way of getting energy in deeper and making the treatment more comfortable for the patient. And I get lots of lots of patients having had radial before two years ago, so what do you need a shockwave? And this sort of bracing themselves? Like I know, I haven't got that type of machine for this condition would be more comfortable. Much nicer.

Robin Lansman 1:17:13

I had someone earlier actually, slightly upset, I think, but I've mentioned mctimoney. In relation. I think you were a bit as well, I don't really know anything about No, but this sort of idea of pressure. But I've got another question from Antony mctimoney. He actually is just come online with a question. So how is this internet surname is metonymy? Well, I don't think so. Oh, well, that would

be interesting. How is this intervention different to an M L S? Laser treatment? I mean, that was one of my questions earlier, laser treatment versus versus what we're offering here,

James Woledge 1:17:44

Heike, no, I don't I don't really know that much about laser. I don't know. He's just imparting again, it imparts a lot of energy into the tissue. So you could they've got those things in common. There's some mechanical transductive thing where you're putting energy in, and your body transforms that into a cellular process, because that's all mechanic transduction is my masseuse does the same. Your treatment doesn't say hands on stuff, it all does the same, which is energy in gets converted to cellular mechanisms and in your body cracks on and does it right. Okay. So we're just printing promoter and a pusher and the body? Does the work right? So osteopathic, isn't it? It is laser. I truly don't know. All I know is that the evidence isn't great. Okay.

Robin Lansman 1:18:21

And I got another question. So good. We're getting so many questions. My Ori again comes in said sorry if it's covered, but can we work with hypertensive patients using this modality? Yeah,

James Woledge 1:18:30

no problem shouldn't be a problem. As long as they're not high warfarin, high level, what about

Robin Lansman 1:18:34

what about anywhere near, for example, a DVT?

James Woledge 1:18:37

You would want to scope that out? Right? That part of your mechanism of saying, Look, you know, I think this calf is not a calf problem, per se, they got DVT. But yeah, I wouldn't treat anywhere near a DVT. If I thought I had a sneaky suspicion of it. They need to go for all sorts of other reasons. Right? I wouldn't be great.

Robin Lansman 1:18:51

No, it wouldn't be wrapped zero. So I've got another question here from Vladimir leverage off. Let it off. Yeah. So sorry. Here's the collocation in what I couldn't hear at the beginning of the broadcast. What's your qualification?

James Woledge 1:19:05

osteopath? Right. So no prefer? Right? It's about it. So I've got a PG cert in ultrasound, diagnostic ultrasound, so famous Kayo,

Robin Lansman 1:19:13

who I'll say is allowed but I mean, you're registered. I'm registered it. Yeah. So in terms of using this type of equipment, could someone set themselves up as a shockwave therapist, by the machine if

James Woledge 1:19:23

they get if they get a distributor or manufacturer to agree that would well I know that the vendor, the UK distributors for Stuart's they would have some rulings on that. So we would probably argue that and don't get quote me on this necessarily, but sports therapists degree qualified, that sort of thing. They tend to be absolutely fine with radial devices. As soon as you get into focused, we'd probably want them to be an HP or clinician. So I have surgeons come to my talks and sports Doc's

use this a lot, but they mostly go with a focus device. And in Germany in Europe, you have to be a medical doctor to use the focus device because of the energy levels in this country. We don't have that. So you can be an osteopath, physio. You can use both but you do need to be registered in it. One of those professional you will be asked by the manufacturer before they sold it to you are this on you, you are this. Because we ultimately, you know, we teach for them as well. And we would say to them, Look, we don't want people just using this per se and not really being safe with it not know what to do. So we've

Robin Lansman 1:20:14

seen differential diagnosis is still key. Yeah,

James Woledge 1:20:16

absolutely. Yeah. At the very least you're wasting their money you shouldn't be doing that should be often the best evidence care. This is what we're doing it.

Robin Lansman 1:20:23

Okay. And we've got another question from chubs. Where can we find your podcasts and further information? I think Stephen said he's sending out listening today, the shockwave email,

James Woledge 1:20:33

shockwave therapy podcast is on all platforms go to go to Apple podcasts wherever. Yeah, and it'll come up. Yeah, I haven't done one in a while. But the you know, some of the early ones were all about the mechanisms and how it works. Interviewing people that are experts in that, you know, exactly want to drill down podcast does. Yeah, well,

Robin Lansman 1:20:48

I think there's nothing like getting lots of questions, no matter what you do. A good test puts you on the spot, but it's useful to explore the topic,

James Woledge 1:20:55

shall we can Shall we could just message me.

Robin Lansman 1:20:56

Well, yeah, that's true. But there. Is there anything else you want to demonstrate or discuss?

James Woledge 1:21:00

No, I don't think so. I think it's it's as obvious as one feels like out and one's like, not so bad, and just has a lot more energy. And strictly speaking, that shockwave and the other one is a pressure wave, but it doesn't.

Robin Lansman 1:21:11

So going into it. Just maybe we could just talk about going back to the placebo. Yeah. Do you think there's more value in what they're feeling when it actually feels more uncomfortable than when they don't know?

James Woledge 1:21:23

I think there is that slightly odd thing in us humans that says, yes, you're giving me you're reproducing my pain. And that really hurts. Therefore, it must be doing good, right? I've got a sports

massage person in my practice. And you know, she's really strong and patients, they will say that they're there. So I used to see this other sports massage therapists it didn't didn't hurt nearly so much. I must be doing me good. I've no, I don't want to make comment on that. I had no idea what's going on there. But there is something therapeutic to that as a perceiver isn't there. But I think the key point from the therapeutic alliance was Shockwave. It's such a winner for reproducing their pay. It really does do all sorts of things that you can't do with your thumbs. Right.

Robin Lansman 1:21:57

And there's a lot of stuff. Sorry, just before we go over and sit down again. Yeah. stuff in the box. Yeah, they look like those things from a Nespresso. So you

James Woledge 1:22:04

talked about the muscles. Yeah, right. So that starts to put a lot of money into r&d Over the last sort of several years. And so it's a way of, there's all sorts of things here to change the way the beam of sound comes out. And there's, there's, I don't know whether the camera can pick out these sorts of things on here. So it distributes the energy differently in the tissue. So if I was treating a great big calf, like it is, this is a bigger surface area, and it has a bit more punch, right. So you can change that depending on what condition and how chronic it is. A big B calf is right. They've done a lot of work on trying to give you many options for different things. That would be a general soft tissue approach for your glutes and hamstrings. You've covered all the area and under a couple of minutes. It's done more superficial, but in a much lower frequency low intense you can change this to Yeah, but that's just surface area. A lot more myofascial work. So there's some good stuff on myofascial treatments with Shockwave, you're good evidence as well. So there is that muscle component you talked about? Yeah. And use different heads for different heads. So the focus is just what size, you know, you have a spacer, then give you the depth, because the energy always comes out the membrane there a set distance, right. But if you put something in between, it's making it so that's more superficial. It's a bit like your focal length with the lens. Exactly, sort of thing. Yeah, yeah. Is that just like just on this display at the back, because maybe just want to explain what that is. So this is how you this is this is in charge at the moment, this is linked to the focus device, so I can change the energy levels, and I focused, it's really joules per millimetre squared. That's quite important. So when you're looking at the research, if people do want to look at this, if you see bar, that's a pressure measurement, which is always associated with bar pressure of this in the same way you play as cartera. But it was focused, it's Millie joules per millimetre squared is a measurement of energy. So if you see research, it says MJ millimetres squared, you notice a focus shockwave they use for the research, which mostly is done on focused L bar, it's radio. So you can fiddle around with these. And the amount of shocks and hertz, if you like, well tells you about shocks. And the built in with the stores is this rather useful thing where you can actually put it in a presets, evidence based guidelines for those conditions. So it's all pre loaded into you don't have to oversee it. But the nice thing as well is that ultimately, you still are in charge with the finger. So I don't tend to experience users tend to use this less. It gives me a rough framework, but it's here I can change everything depending on your feedback. I'd only give you too much pain. Yeah,

Robin Lansman 1:24:17

no, fair enough. Thank you for it. You didn't get too involved. You've got a bit of gel on your ankle, but apart from that, is there anything you want to ask? You doesn't go to Michael. I'll try and translate here. Okay. Okay. Well, thank you. Anyway, yeah. Could you be going back across

James Woledge 1:24:33

your heel to feel those Belladonna?

Robin Lansman 1:24:36

So yeah, I mean, a couple of weeks we've got a question that says what's an HP?

James Woledge 1:24:42

Oh, allied health professional which we are along with physios and podiatrists? I'm not sure about car prices.

Robin Lansman 1:24:48

I believe not. At this stage that clinical professing they're wanting to be Yeah, yeah. So

James Woledge 1:24:54

let's include them with that. Yeah, let's include them with my concept of using focus chiropractors are neither brilliant. Yeah, you can be a brilliant osteopath and chiropractors for as long as.

Robin Lansman 1:25:04

Okay, and so should we have a little chat? If there's anything else you want to bring up specifically? I know you brought some slides, we've probably covered a lot we've gotten. So

James Woledge 1:25:10

if I have a quick shuffle, if this is that one goes forwards. Yeah, just about the NICE guidelines are put in there before the clinical trials, which is there again, energy levels gets a bit boring, just the energy levels are loads more with a focus device, and that's a shockwave lithotripter. The other one radio, we used to be called a litho. Class. That's just the tip

Robin Lansman 1:25:31

of a difference. So that was a brief breakdown. As in as in for kidneys, kidney

James Woledge 1:25:34

stones. Yeah, that's right. So listening, extra call is all known as extracorporeal, shock, wave theory, II Swat. And that just means outside the skin and in, but litho class originally, which is the development of the radio interesting was where they actually went off to the urethra into the ureter, and had little bang, bang. And that's the radial devices that literally a metal bump, and it goes up against the crystal, you know, and smashes it that way. But it's quite fun and nice to come from the outside in, which is what a normal lithotripter does, right?

Robin Lansman 1:26:01

What you mentioned funny, I was talking the other week to cancer specialist who deals with head and neck cancer. And I think she was talking about manual therapies. And she was talking about distributing cancer cells through through disturbing the tissues. Yeah. And apparently, that, well, that was obviously a big concern of hers, working in the hospital where she works. And I was just kind of wondering, you mentioned that earlier. But obviously, if there's something undiscovered, like with lots of things, there's a risk factor in distributing cancers shores?

James Woledge 1:26:29

I mean, I don't know. But it makes biological sense that he would, right, yeah. And it probably would have more of an impact with a shockwave I'd imagine then with your hand. But we were all under

that threat every day. And we if we're all honest, I've been out 20 years, I probably treated people with cancer, not knowing it. You can't always know it, but we have good guidelines on red flags now. And you know, your red flag system should be in place, whether you're using your hands or a shockwave device, I've got a suspicion of something going on here. You need to go off and get x rayed. And make sure that you haven't. So I you know, otherwise we wouldn't treat anything with anything ever.

Robin Lansman 1:27:00

So therefore, we're in the unit that we've been talking about in the hands of a professional in the hands of someone who's got that skill, differential diagnosis experience. I mean, it's critical, like it is in lots of things. Yeah, it's more when it goes wrong. And when it goes, right, but it's definitely yeah, an issue. The other

James Woledge 1:27:13

thing, sorry, I just remind myself, there is my podcast, of course, which I'm shamelessly, you know, talking about, but I put a link on which I think the link goes on from this my PowerPoint, does it go on after this? Yeah, this link goes on. There's a there's a great podcast on by an American doc, who's done a good overview of all the research I did last year. And underneath that is the actual link in his open access. So if you want to look at what it does, in a very short timeframe, listen to him for 10 to 20 minutes. He's really erudite on the subject better than me. And then he's written that paper. Okay, so that gets you everything you need to know pretty okay, I've

Robin Lansman 1:27:47

got two or three questions just coming in now. Darcy Jones says can focus short way be used for treating chronic facet joint irritation due to degenerative disc disease?

James Woledge 1:27:57

Oh, well, nevermind that genitive this disease but not one of those things I like using but I'm facet joints. Yeah, there's good evidence, good evidence, small trials, but good quality, small trials. So there was a check. Neurologists that did a good trial called and a delkor. And he's on one of my podcasts as a guest talking about unilateral facet pain. And he compared that shockwave with steroid injections and radiofrequency which is still the world's gold standard. If you've got a chronic facet problem, radiofrequency still number one, right? Sterile just a little bit behind that. Anyway, he compared 20 people that had shockwave 20 People that have steroid 20 people, you see long term follow ups, which is the thing that's key here a year later, and it be steroids and just going behind radiofrequency. So if people are, you know, about to spend three and a half 1000 pounds on a facet joint steroid injection, which is roughly what it is privately had one today, you can say, look, I can do four sessions of this and 95 pound ago, it's not far off the evidence, even if that one trial needs to be, you know, it's only one trial, but it's got good evidence, and it's no reason why it shouldn't we think through bony Adeem around the facet joints, clearing out inflammation. I do it a lot. And I think I get reasonable results in those really hard to get better patients. Yeah. Okay. And

Robin Lansman 1:29:11

Val says, How careful do you have to be when using shortwave on torn tendons where they're actually torn supraspinatus or Achilles tendon that's been ripped.

James Woledge 1:29:21

Again, it would be, you know, has your has without without ultrasound, has your examination sort of thought, you know, if you're if you've got a suspicion of it being told, there was no evidence the shockwave is gonna do anything for it. It would hurt more, probably. So I you know, I think your examination again, same as anything else, would you really load it up and do shoulder presses or someone who you think that goes suspicion of Supraspinatus tear or half tear? You know, so it's, it's just going back to those basics of, you know, there's no The answer is there's no benefit and I would probably not do it. If I knew that there was a secret to pick your

Robin Lansman 1:29:52

case. You do. And also I've got command command milkhouse I think it is. asks, can you treat decawave veins Tina synovitis.

James Woledge 1:30:01

Sounds real. Yeah, some people do. But I think the key point for shockwave is that it, you can truly say in those chronic cases where they failed other interventions, including steroid or otherwise, that it's that it's niche is brilliant for that. But now you can absolutely say that. So in acute decurrens, there's a better option. If there's always a better option go for the better option, or the better option is a well placed ultrasound guided sterilisation gone. So I wouldn't be faffing around with that

Robin Lansman 1:30:26

angle. It's to ask you, how close do you go between where the tendon attaches to the muscle? Or where the tenant attaches to the bone when it comes to the therapy? Because like periostitis, yeah,

James Woledge 1:30:36

right. Yeah. So in Achilles tendon disorders, the insertional tendon disorders are the harder ones to get better shockwave or otherwise, they're just much harder. So intended insertion, insertion, tendinopathy, insertional. tendinopathy, is particularly Achilles. They're real. They're really hard work. But you treat the area, you just have to play around with your hurts to make it more superficial, because it's really superficial. And you lower the energy because it's really painful. But you drink you're treating them where the symptoms are. That's it. And again, symptom lead each time didn't imagine is as good as good at evidence basis. We've got for outcomes for shockwave alone. Yeah, yeah, that's, that's their feedback, they will tell you when you're on it. Okay. That's, that's the way you need to put mostly ng back it up with a with a with a scan. But sometimes the scan is not as good as the patient feedback. It just gives me a rough idea that haven't damaged it at all it that's what I scan for.

Robin Lansman 1:31:23

Okay. And Robert Peter, Robert Smith says, does it benefit frozen shoulder?

James Woledge 1:31:27

Yeah, there is some good data on that. And that's actually, you know, equally for radial or focused, you know, much more about the second phase of frozen shoulder, so they're stiff and not so painful. They're out of that acute nightmare stage. And they're either looking at a really long haul rehab programme, which they probably do anyway, or they're looking at Hydra distension. But I tend to favour hydrodistillation, we've got someone that comes into clinic and does that and the outcomes relating the

Robin Lansman 1:31:51

rotator cuff really

James Woledge 1:31:52

good, really fast. The shockwave is a very useful four to five sessions, the trials are done for that improving range of motion in a frozen shoulder. But I do anything for pain. I don't I don't know, right? Why not. I just think it's too complex and condition to do with your immune system and a few other things that we think are going on. But in the acute stage, I think again, it goes back to the the curve. And in acute stage, the evidence is overwhelmingly Hammerstone injection, get it into the capsule, calm it down. Once it's calmed down, you can insert the patient that we've got shockwave is an alternative here to then get your range back. We've got distension. And some people just go I'm not sticking another needle in my shoulder. And so they go for Shockwave, but there's a good clinician, you should be out to offer all the best options, even though they might not be done in your clinic. We should still be saying patients, this is still best option at the curve and injection or first stage in Japan,

Robin Lansman 1:32:40

still lifting I mean, shin splints, and for example, yeah, tendon insertion in tennis elbow. That's quite a lot to do with osteitis. That's bleeding, perhaps under the periosteum.

James Woledge 1:32:50

Possibly, yeah, possibly all of those things. But then it goes back to what I just said. Is that the options for those when they're chronic, there are there aren't. There's nothing amazing out there. No one wants to inject them with anything. There's nothing special out there. It's hands on stuff and rehab, and shockwaves got a nice place for trying to reduce the pain of those conditions. But

Robin Lansman 1:33:07

visually point of impact of your wave shock wave yet wouldn't be on the bit that most painful. Would it be? Yeah, absolutely. You would put it on the periosteal lift. Yes, point. Yep.

James Woledge 1:33:16

Okay, well, medial tibial stress syndrome. There's some good studies on that. Right. Yeah. Yeah. Right on that really? ouchy bit. Yeah. Very, very painful. Well, you reduce the energy, right? And you increase the hurts, okay? That it numbs a little bit, and it's very tolerable. I've seen a lot of shin splints and they respond really well.

Robin Lansman 1:33:31

Okay. Yeah. Well, we've got a little bit of time left. I mean, I think if we haven't, we haven't really covered the erectile dysfunction topic. No. And I thought novel approaches to things are left at the end of the programme, so to speak, so to speak. Do you want to talk us through you talked about, you know, blood flow. That's all important. Do you want to talk us through prostatitis you mentioned a little bit as well

James Woledge 1:33:52

so it I in my clinic in Suffolk because in the other one, not so much in my face, I've got a good physio that's that's qualified northern men's health approaches. So that would be anything from post prostatitis pelvic floor rehab. So I'm repeating myself a lot, isn't it? So the shock wave aspect to things like erectile dysfunction, or chronic pelvic pain syndrome, which is the new term for non infective or nonbacterial prostatitis, which is really horrible, painful condition, shockwave therapy on

the pelvic floor as a muscle, and with hands on work as well, and with stretching and rehab and so forth, as a modality. And amongst that has got some fair evidence for these desperate patients. Because it's a really hard to treat condition the CPPs. Erectile dysfunction, there is some reasonably good evidence that the angiogenesis factor comes in and it has also an impact on the same mechanisms by which the PDI fives work which which are the Viagra and Cialis so they basically keep an enzyme floating around in the system, nitric oxide as well which which basically keeps the vessels paitent which allows blood to keep flowing in it seems to optimise those things in the same way the drugs do, but it seems to have a lot longer lasting effect. So if you take someone that started to lose the impact of those drugs after five years, which is not uncommon five years is about when they started tail off. And these patients are now seeking help from Shockwave. So how can I boost the actual health of the tissues, but it would be us giving them advice on their diet that's giving them advice on exercise, losing weight, is a hugely complex condition. So yes, but as soon as you mentioned, Shockwave sound waves on the penis, it becomes this sort of half jokey thing, which is, oh, you just put it on the penis and charge a lot of money? No, they have way more complex than that. My physio seems

Robin Lansman 1:35:33

complex, but I presume people who are drawn to what I know you've got mentioned that on your website, I presume you get some interesting inquiries.

James Woledge 1:35:40

We do. And, you know, some people do like a quick fix, and we just don't We don't take them on. Basically, right. We filter out patients that understand what their condition is, we only take patients that have seen a GP or urologist for proper diagnosis for CPPs. Or for a task function. They've been through the game, we've got a private GP that works in our clinic that also sees them for a screening of things like testosterone cholesterol, if you're going to go down that route, which is a novel for a reason, because it's incredibly hard and complex. And these patients are fairly desperate, for obvious reasons. So the psychological aspects involved in that we've also got two clinical psychologists that work remotely. So I surround myself with people that know a lot more than me. But I deal with some of those initial conversations, and they can be quite difficult and challenging.

Robin Lansman 1:36:22

So I've got a couple more questions. Amanda Knight says, How much do you charge for hydro distension apparently, is a very long waiting list. Presently in the NHS,

James Woledge 1:36:30

I think I think the guy that comes in does it for us, it's about 250. It's it's, it's not that expensive. Yeah, there are other things he charges way more than that. Well, they can't do PRP anymore. physios can't do PRP. But

Robin Lansman 1:36:42

okay, and Rebecca Cole says My dad has had five sessions of shockwave therapy on an OA knee. So far, it hasn't made any difference. What are they hoping to achieve by treating, you know, a museum shop? I

James Woledge 1:36:54

don't know. But I do. So anecdotally, some stuff maybe happens with knees. But you've got you've got to be pretty experienced to treat a knee and I scan those as well. If there's if it's a really stiff

arthritic knee, you'll understand this early stage of OA and the becomes unstable, flopping around all over the place. Ouchie, horrible, nasty, they've got to know at this unstable in a way that shockwave never does anything for them. If they've got a really stiff, achy knee there beyond that phase, they get a bit of night pain, they've got quite localised medial knee pain, which is tends to be where it is. And they've got some bony edoema on an MRI. That's where the anecdotal and some case studies have shown that it reduces bony edoema, you've really got to be good at picking your patient really good. And I suggest that that patient wasn't picked very well. But it's not a classic one foot away need to be honest, you kind of understand, like, you need to really know what you're doing to and then still take the patient. I'll try three sessions. And if he doesn't do anything off three or five off the bat, that sounds a bit well,

Robin Lansman 1:37:54

so I guess it comes down to transparency and honesty and openness and communication and all those

James Woledge 1:37:58

things. It depends. It depends, you know, that patient might have been really desperate, the patient was really desperate to help them and they didn't charge any extra for it or whatever. I can see that. But you know, my experience would tell me that I wouldn't gleefully take those on. I'll be like making sure they definitely have an MRI probably is their bony edoema. That's how stiff it is. And really making sure the patient knew this was still novel. That's a novel thing and only Yeah,

Robin Lansman 1:38:19

okay. Okay, so we've covered a lot of ground. We have we have got a little more time just a few more minutes left. Is there anything? Well, I'm gonna invite any of the viewers if they got any last questions to pick them in as anything else you want to cover you think we haven't, we haven't discussed or

James Woledge 1:38:33

explored that you'd like to know. It's just, you know, what he gave me after many years of just doing osteopathy and I'm done. Shouldn't say that any denigrating way towards osteopathy. It was a real boost and a pick me up to start to learn about completely something different. And to get your teeth stuck in something that isn't also totally exhausting on your hands. There's no doubt my life is a lot easier now. And I get to take on really challenging difficult patients like that. But without killing my thumb's doing it. That's, you know, that's worth the investment itself, I think.

Robin Lansman 1:39:02

Okay, I got Kathy's come up with another question. I think just one earlier, have you had much success treating chronic lumbar disc? herniation.

James Woledge 1:39:11

Don't use it for them. Ideally, you're never gonna get a sound wave anywhere near the disk. Right. Don't do it both ways.

Robin Lansman 1:39:18

Yeah, I guess it depends how you approach things. But no,

James Woledge 1:39:21

unless you report you NT really? Indeed. No, no, no, it was the ASA. Okay, because I don't read them.

Robin Lansman 1:39:26

But fair enough. No, no, no, that's fair enough. Okay. And so, yeah, any any last comments? We've got a few minutes left before we

James Woledge 1:39:32

I can't imagine so I think we have covered loads of stuff and we really

Robin Lansman 1:39:37

have been useful. Yeah, there are

James Woledge 1:39:39

different man, you know, yeah, different energy levels focus shortwave radio pressure wave was asking both asking the patient you know, didn't make a bang bang noise or, you know, there's certainly other most of the people that focus shockwave devices of the more experienced practitioners. Sometimes that's quite useful to know your son has asthma patients. What did it sound like? Was it a tap tap or was it a bang, bang, the tap tap you probably know that they had good quality treatment from somebody experience, I suppose that's useful to us. But does that mean experience totally different than what I do with my machine now that the courses we run the educational programme that we run through Ven, there's a there's a thing that's going to be on here as well, where they're running some free courses at the the head offices in Liverpool. So as part of me coming on here, I think it'd be very hard to put a code on the one of the things here for free started courses one day course, you get to learn all about radial pressure wave, and about how to start off doing Shockwave. They're good courses that we run, the educational side of things is massive now compared to how it used to be. Okay, we've

Robin Lansman 1:40:33

got two more questions. They're coming up the converse, how long is the training when you kind of mentioned that how long it is and how much they cost? You said there's a free option. It's a free option.

James Woledge 1:40:39

Now normally, if you put a pm code, but it's a one day course that gets you started, right? Yes, you started. And then what usually people do is either contact me we do it some one to one mentoring now and then, and I go to clinic, sometimes it's you know, if they've got five or six people, then they can get me come down, because clinics work in different ways and see different conditions like I do not see lots of patellar tendonitis and have no anyway, but I see a shitload of Achilles. And so for practices that were inclined, that asked me to go see them. You've also said

Robin Lansman 1:41:05

the results for lower limb seem generally generally slightly better than anything else. And Vicki Brooks has just asked a random one, and she says My daughter has enjoyed listening, as her dance group is called shortwave. Nice. Well, there you go. That's good. That is a. That's perfect. Well, listen, I'm sorry. Another question. may as well do it just we've got had a focus machine for 18 months. Brilliant for gtps, and pF, and tendon issues. That's Matt. Well, Matt, clearly clearly a happy happy customer there. Which is, which is great news, just checking videos come in. I think that's pretty well

getting near the end. So James, thank you very, very much. So just going to do our what's called  
outro. Okay. So Well, listen, you know, it is that time, we're running out of time. And I hope that you  
found this an interesting and useful and relevant topic, and helping you sort of understand  
shockwave and see how it might fit for your patients, perhaps. So if you'd like more information, I'm  
sure James will be happy to help you help you with that. Well, I guess that's me done for today. And  
thank you for coming and joining us.

DRAFT TRANSCRIPT