Academy of PHYSICAL MEDICINE

Transcript

377R- Niel-Asher Technique (NAT) for Shoulder Pain with Simeon Niel-Asher

Steven Bruce

Good afternoon and welcome to the start of the week, the start of a new month and another great lunchtime learning session. Before we start, I'm going to give a little shout out for mentor rollers. I've been record recommending these for ages. But it was only this weekend when I jolted my own back. You know one of those niggly pains under the ribs, that sort of thing that you could easily find gets much worse overnight. It's the first time I've used the roller on myself. And I have to say the effect was pretty much instantaneous. Virtually all the pain and stiffness gone after just 30 seconds on the mentor. I did use it again before I went to bed just in case and I had absolutely no issues the following morning. So once again, I really recommend the mental roller, a simple, well designed self help device that your patients will love. Anyway, enough of that today is all about shoulders. My guest is Simeon, Neal Asher, and he and I have known each other for well over 20 years, during which time he's established himself as a leading authority on shoulder pain, especially frozen shoulder, as well as an expert on trigger point therapy. He's run numerous courses in both subjects were here for us here at the academy, but he also teaches across the world both the physical therapists and doctors of conventional medicine. Today, we've planned to look at rotator cuff problems. And we have a real patient for Steve Simeon to treat here in the studio. But I know you'll be happy to take questions on anything shoulder or triggerpoint related as long as there's time. So Simeon, welcome back. It's been too long. Good to have you back in the studio again. Thanks, right. We live in a background on rotator cuff but we're going to get across to our patient fairly quickly. Because we don't have much time. Okay, it's 45 minutes this lunchtime. Okay, so talk to me about rotator cuff and how it relates to all the other shoulder things that you deal with. Yeah,

Simeon Niel-Asher

well, you know, 70% of all shoulder problems present to physical therapist hands on people like ourselves, our rotator cuff problem is so it's a huge problem. Something like one in three people will get a shoulder problem at some point in their life. And importantly, the incident increases with age. So what we know about the rotator cuff, it's an age related condition. And also it's related to there's a number of things I don't know if I should go into it now melee. Okay, thank you very much for you

along if we run out of perfect, perfect, so so we know it's age really Eating. So what it appears from all of the clinical data is that there are two main problems. One is posture. Now, you know, as osteopaths, we look at posture and we're very well placed, I think, to, to address rotator cuff problems. So the lot of evidence published, there's a lot of studies published that showed that an upper crossed you know, genders up across pattern relates to absolutely correlates to rotator cuff problems. So, round shoulders up across the slouch posture, we know that there's studies about occupation. So for example, anyone that works in a job, that's overhead, painting ceilings, car mechanics, anyone that works in overhead, 100% will get a rotator cuff problem or a tear,

Steven Bruce

you say that they're also prone to frozen shoulders. And

Simeon Niel-Asher

so you know, the frozen shoulder, as you know, is my passion. So that's kind of how this all started. And the frozen shoulder, I think is teaches us a lot about as an osteopath, about the inner wisdom of the body and how it works. And to a certain extent that the rotator cuff follows that pattern, although there's a slight variation. In fact, we were looking at a patient today and I promise you, I only saw her for like, a few seconds before. But I'm gonna explain to you with her this holding pattern that we see in all shoulder problems, and the patient has that holding pattern. But but but to a certain extent, all shoulder problems follow that that holding pattern, especially the rotator cuff, and, you know, I talked about it with you before a few times, you know, it's this sort of internal rotation flexion. And it's this guarded, if you I call it like a default, it's almost like, well, it's an almost it's like an A D celebration. So so we know that when people are have a stroke, they sort of have tight flexors and internal rotation. So it's there's a shoulder flexion of the elbow. Correct. So it's kind of a default holding pattern for shoulder problems, while the nervous system tries to fix itself. And of course, the two muscles that are involved are biceps, flexion, and subscapularis. Internal Rotation, but of course, with the rotor with the rotator cuff, we have four muscles. Oh, God, can I do it now? Yeah, but um, okay, let's have a look. So let's go back that way. So. So the fact the role of the rotator cuff is to center the ball and socket joint, the glenohumeral joint. And that's why these overhead activities and round shoulder postures, you know, for one of a better phrase, round shoulders, D, they stop this sort of cavitation, this glenohumeral joint efficiency, or kinematics. And we know that there are four rotator cuff muscles, there's the supraspinatus, the infra teres minor, which actually, if you look, it's really one muscle with a fascial sort of septum. And subscapularis. And of course, sub SCAP is, is on the sort of anterior surface of the scapula, difficult to reach. But there's another thing here as well, which is hugely important, which is this one here, which is the long head of bicep, which goes all the way up. And, you know, of course, on the courses, as I've said to you, this technique that I've developed, is it's hugely effective for for a whole range of problems. In fact, I'm going to say Illimani are going out on a limb, I think. I think it's a cure, actually for for certainly for the frozen shoulder because it's about 100% effective in 95% of cases. So, it, I think it is as close to a cure in terms of osteopathy, that there's that there is and again, understanding that the way the shoulder works and understanding the kinematics of it leads us to effective treatment for a whole range of shoulder problems. I hope people aren't gonna pull me down somewhere where it really is. You know, I've been doing it. And I think 1997 is when I started like that's when I

Steven Bruce

was you were keeping it all very secret when we met randomly

Simeon Niel-Asher

because I did you know, the clinical researcher Addenbrooke's I was the first osteopath to do research at Cambridge in the hospital. And then I published also in the Journal of Osteopathic Medicine, when I just I kind of wanted to keep it you know, just until I had some data, some evidence base

Steven Bruce

for it actually understand that. You mentioned osteopathy a number of times there's obviously nothing which is specifically osteopathic about this, maybe your philosophy but physios chiropractors, this

Simeon Niel-Asher

is a hands on absolutely no. Please don't get me wrong. I this is a technique for manual manipulative many of therapists and We cover a lot of anatomy, you know, obviously, it's anatomically based, you know, let you

Steven Bruce

Yeah. Okay, so should we look at our patient now?

Simeon Niel-Asher

Yeah, we can. Before we do, I'm just gonna do one more slide, just one more slide. So I think what I'm gonna run through these now, I've got, you're gonna send these out. So I just think this is the really key slide here. So a rotator cuff is like a spectrum disorder. So it really depends where someone comes to us on this spectrum, the treatment methodology and approach. So we probably have a case that we're looking at now, which is a reactive tendinopathy, stroke, tendon disrepair involving the bursa. But But again, you know, and bear this in mind, when we're answering questions, it really depends where are patients coming to on this spectrum, the arrows indicating I'm going to leave this slide on, the arrows are indicating that we can bring it back until we get to, you know, sort of degenerative tendon when it's a little bit more of a different approach. But in general, as hands on therapists, we can really have a really excellent effect on people that are coming in, in this area here. And with the degenerative tendons, or the full partial thickness, full thickness, tears, I just go through those really quickly. So when we diagnose a tear, we're either going to go on the depth from top to bottom, and then we're gonna go on the circumference. So you can have partial thickness, full thickness, and massive tears. But once we get to the tears, you get a loss of centering, you get a loss of proprioception, and that's a slightly different treatment protocol exercise based.

Steven Bruce

Only the terminology thing we we've gone into this on previous shows a little bit of detail, because I think the terminology is misleading. A full thickness tear often makes people think it's a rupture correct. It simply means a tear that's gone completely through the tendon. Surrounding intact fibers. That's

Simeon Niel-Asher

incorrect. Yeah, that's right. There's a I know I saw your your coverage, which was excellent of the tears. And that's why there's there's a top to bottom, and then there's the cuff itself. So you know, it's when you get four centimeter, five centimeter full partial thickness. That's how it works.

Steven Bruce

Okay. Right. So bear that in mind, I can go across here, I meet our patients, you go first. Now, as Simeon said, a moment ago, we have only met Lorraine ourselves today for the first time and about 20 minutes before we went on it. Lorraine, you very kindly responded to a Facebook post, I think asking for a volunteer who had a rotator cuff problem, right. So it was up to you to diagnose whether she actually did have one and tell us what to do about it. Okay.

Simeon Niel-Asher

First of all, thank you. Okay, I'm gonna treat you but I'm also going to sort of talk to the people about it as well. Tell us a little bit about yourself and how long you've had this and what how it started what you've had done.

Lorraine (model)

It's been going on for about two months.

Unknown Speaker

Oh, sorry.

Lorraine (model)

How old? Am I? I'm 70 years old. Okay. 70. I do a lot of sport. Racquet Sports, particularly. And I have two very mad Springer Spaniels that need a lot of exercise every day. But I do walk them in my other arm. Are you right handed? I'm right handed with the dogs walk on my left hand. And so how long have you been suffering with shoulder pain? Oh, I would say two months, at least

Simeon Niel-Asher

a month. Okay. Are you getting any pain at night? Just? Yes, I

Lorraine (model)

do. I can't get comfortable. Can you lie on that side at night? Well, I can. But it's not very long. I have to turn over. And that's my favorite side. Okay,

Simeon Niel-Asher

so let's just have a little examined together. So we've had got 70, we've had this for a couple of months. Obviously, she's in a correlate significant amount of pain. So I'm going to ask you, I think we're going this way, right? Okay. So the first thing to say is that we've got this slight up across posture. So we can see that but I just want you to observe this. So this is what I would call and now we brought attention to it, it will change but can you see she's holding her arm flexed and internally rotated. So this is what I'm talking about this default posture. This default I call it a holding pattern of the nervous system. Now one of the things I'm going to do is just examine her briefly. I idle try to keep things very simple with examination. So I either diagnosed anterior, lateral or posterior, depending where I feel the restriction. So I'm going to start here at a long head of bicep. Now, how's that there? You feel that one? I can feel it. Yeah, so that's the long head of bicep. Now. Importantly, the bicep often gets involved in the whole range of shoulder problems, and I'll explain that why on the course but this is really a key area for her. Of course, longhaired bicep, that shorthead bicep Karaca Brekky Ailis and pec minor they will come from this coracoid process. And then as we work around, we can feel here. So here's her supraspinatus tendon. Now, you said to me before you fit it down to the elbow as well, I do. Yeah, and lower and lower down. It's really one of the key things that I've kind of stumbled on have discovered is that actually, the rotator cuff starts at the elbow, not at the shoulder. And what we can do is, and I'll show you on the course, hopefully, when you see me is that if someone has a supraspinatus tendon, what we can do is we can actually tell cap palpate a taut band, well below the deltoid.

Steven Bruce

So if they have a supersuit, so notice tendon problem

Simeon Niel-Asher

tendinopathy. The rotator cuff, yeah, generally is the Supra. That's usually the main rotator cuff problem, we know that. So when we palpate here, this sort of lateral, that's the supraspinatus insertion. But what we can do is often find a taut band and it goes all the way to the elbow. Infraspinatus This is the insertion is here. And she's really definitely got infra here. And we can palpate again, a taut band all the way down to the elbow. subscapularis is slightly different. So. So when we're going to treat her, we're going to actually look at the elbow. And I'll discuss that when I when I do the treatment. But pick me up on that if I don't, now we're just gonna look at her range of motion. So often I tap the ac joint area just to sort of counter. Yeah, we're getting there now. So she's got what's called a subacromial pain, or painful arc, she's definitely got restricted now come down on your own. Now, because she hasn't got this is what's called a negative drop arm test. In

fact, we'll do it here. So she's got a painful arc as we go through sort of, sorry, see if you can just gently bring your arm down to your side. So because she can do that she has not got a thickness full thickness tear. Because she's able to do that if if you have a tear, the the arm just collapses. Okay. So we know she's got an intact cuff. But she's inconsiderable out of pain. I wouldn't do too many tests. But really nice test just to look at, obviously, we could do some strength and power. So we can look at Super infrared subscapular, we can do that. With just a nice one here, look at the subscapularis. Put both hands on your tummy. And then push your hands to your tummy. And push back as hard as you can on your tummy. And what we're looking for here, this is the belly press test is weakness in subscapularis, and she's got a little weakness, this arm comes a little bit backwards that that relax, come and sit down for me again. Again, we're going to go through some of these clinical tests together when we see each other, the scarf test where we have 9090. And we're going to ask you just to resist me here. So this is looking at the ac joint, little bit AC a little bit subacromial impingement as well.

Steven Bruce

So again, 9090, meaning 90 degrees flexion,

Simeon Niel-Asher

90 adduction. So adduction adduction. So and the other one is the hornblower's test where we get her to push me this way testing weakness of infraspinatus, which is weak, I can tell you pretty much in my opinion that she has a Supra and infringement artists problem here. I can see it pretty much immediately.

Steven Bruce

Okay. Now you didn't compare with the other side, would you normally compare you said this is weak? I would

Simeon Niel-Asher

compare with the other side. But remember, this is the potential is symptomatic. So you know, that's what I would? Yeah. Okay. Should we get on with a little bit of treatment then. So again, what we saw was she had a very limited painful range of motion can lie on to your left side. So technique, again, is based on this frozen shoulder technique. And it's a kind of algorithm. Bend your knees a little planks,

Steven Bruce

while you're setting arena. This question from Vince, he's talking about diagnosis and the role of imagery and saying, you know, without an MRI scan, how do you know whether it's full thickness rupture or whatever else? Yeah.

Simeon Niel-Asher

Yeah. Well, I think that in terms of which camera, in terms of in terms of in terms of tears, you would know if there's a drop positive drop arm? Yes. So but that would be a rupture. That'd be a rupture. Okay. So we know her calf is intact. Okay. Beyond that, I would say the use of imagery is problematic, okay? Because you have so many asymptomatic rotator cuff tears,

Steven Bruce

you know, most people over the age of 60, I think you told us, I've got a tear to

Simeon Niel-Asher

some degree that like 25 to 30% over the age of 70 have a full thickness or some kind of martial rupture. So I think that imagery is like, all these things, you know, is important and definitely important, but I think you've got two things, you've got the function of the person as well. And I think that's where it brings me in here, which is it's really important. So,

Steven Bruce

yes, but the clinical test is designed to tell you with a function of functionality, but of course there are only reliable,

Simeon Niel-Asher

reliable. We talk now about clusters when you're testing in clusters, and there's a real three clusters really, for the for the shoulder are the drop arm, the hornblower's and basically, you can do some active resisted passive, but again, you can see she's in so much pain. What good testing gonna do you know, the drop arm is the main test and painful arc and the history you know, yes over 40 night pain, weakness, no weakness. The difference between a frozen shoulder is that you have restricted range of motion active and passive. Whereas here we have restricted passive. So I can, I can lift her up if I help her, whereas with a frozen shoulder, they're, they're just stuck. But you also

Steven Bruce

you did tapping while you're wandering. So, there was blood on the list? Well,

Simeon Niel-Asher

it's a good question. It's just something that I, I do, it's sort of like takes the brain's sort of concentration away from the shoulder itself. I use a lot of typing I can't really answer it's just something I do that I should enveloped, like all these things as an osteopath. So the last thing just to say is that again, super spin artist takes its origin, obviously, from the super sinus fossa comes under the chromium, and inserts here, really into this sort of lateral part of the arm. Now, if we palpate here, we can see that she's got a freshman. You can do this with me just say that I'm not. Yeah.

Steven Bruce

That's how it feels. To me, let alone do

Simeon Niel-Asher

it. Right. How far does that come down? Will you just trace it down, and you'll see that it comes well below the deltoid. So we're not talking about the deltoid. So in fact, I'm gonna get started. Right. So it actually comes with her here that come through this one here, between my fingers. She's still got a band there. So when we're going to start treatment, we're going to start at the elbow. nivia

Steven Bruce

my favorite real fan of Navy army fan Olivia.

Simeon Niel-Asher

I was just, I was just teaching in, in Hamburg, and there's a big factory there. You must be in your element was that I asked them Can you do a bucket? But they didn't. Okay, so what? So the technique deliberately uses trigger points in an algorithm. And the first thing we're going to look at is something called the Konstam reflex. Okay? So the Konstam reflex is when, when you when you're a kid, our what we've done is that you put your hands in a doorframe and you push for about 30 seconds, just submaximal 70 80% And you let go in the arms float up on their own. Okay. So that is what's called a tuner genic reflex. And then we have one in the ankle, we have one in the in the Super in the in the shoulder. And what's happening there is that you're loading the Golgi tendon, and the muscle spindle, and the brain is expecting your shoulder to be at a certain height. But because you're restricting it in the door, you're not achieving that height. And then what happens when you let go is that in order to even out the body, the brain automatically elevates the shoulder. So we saw with her that she can't lift the shoulder, you saw how it was restricted. So effectively, I am the door I'm holding here, and I'm going to come up here now I'm going to trace that tight band that I felt all the way to the elbow all the way up. Okay. We can keep talking while I'm doing that. Yeah.

Steven Bruce

Drummers asked why you commented on active range of motion, but you didn't appear to test active range of motion.

Simeon Niel-Asher

Okay. For the purposes, I should, probably I should probably should have done okay, so I apologize. However, because she's in a significant amount of pain. I just tried to minimize the amount of trauma that I'm doing. And so what I'm doing now, as I'm tracing this pan all the way up and coming to the subacromial space, I'm on the Supra, and I'm going to do a little just to kind of almost surgical cut here just to open it up. And again, I'm going to come here, so

Steven Bruce

feel the room

Lorraine (model)

feels a bit sore, actually, the first hour or

Simeon Niel-Asher

so the depth and the speed and the everything is really important. And it's almost like I'm squeezing toothpaste from a tube. I'm not, I'm not going too deep, because I'm really trying to get that Konstam reflex stimulated. So I'm fixing here now important Only the next step is teres major. So what we're going to do is just have you hold your hand here now with a frozen shoulder we look at teres minor, but with a rotator we look at teres major. So teres major is not one of the cuff muscles. But through a lot of trial error and experience. We're going to come now to a trigger point and teres major around about

Steven Bruce

there. As the expression on the writing space suggest you visit,

Simeon Niel-Asher

I think we might have no need to thank me, Laurie. Moving on,

Steven Bruce

you've done long courses on trigger points to dry needling courses. Concentrate on trigger points. How easy is it for you to find that with that blunt object that you're digging into Lorraine at

Simeon Niel-Asher

the moment? Well, so. Okay. I've used elbows pretty much since the second year of university, I was taught to use elbows to the palpation is excellent with an elbow, it saves your thumbs. You know, over the years, I'm 32 years doing this stuff. Now, you can because it's a short lever, you can generate much more force than with your thumb. And I can palpate I would say for the fiber, materials or the fiber. So here we've got exactly a problem. Keep breathing for me smile for the camera. I'm gonna let go. Step three, let me have the weight. Passive circumduction. Nice and heavy. Let me do the work. And we're just going to repeat that a couple of times. How are we doing for time? Yeah. Okay. So, again, tendency to roll the arm forward, I'm gonna just, that's it. So yeah, so centering of that, so it already feels a bit better, or the way we're going to do that three times. Now, obviously, I've taken a full history, I've looked at, I've done a lot more, but we have, you know,

certain amount of time. Now, I'm going to come a little bit anterior to the midline. Actually, I'm not going to come post here, there. So this is really, in front of you. So when I was gonna tell you was that I had the great privilege of presenting in Padwa. To the fashion Congress, and to the trigger points that of Congress. And I was speaking to call a stalker, you know, she was great, by the way. And I was telling her my ideas about the fascia. And she actually agree with me completely. And I think what it is, is this, and I think this is if there's one key message that I want to get across here with the rotator cuff is as the cuff starts to lose, its its momentum, its force at the glenohumeral joint, it recruits fascia further down the arm to do those jobs. Yeah. So it doesn't necessarily with age, because I've seen young people that are like athletes and baseball players, things like that, that also have tears. But the further down the fascia you come the the more the body is trying to recruit the fascia and the side of the arm to get to achieve the kinematics. So, and again, that's just one of those things that I've kind of fallen upon. So now we're coming on infra. So slightly posterior to the midline? Yes. Lovely.

Steven Bruce

We might have to do a special session on communication with patients after this. When you say, Oh, lovely, and the rain is clearly not enjoying the process.

Simeon Niel-Asher

I wouldn't say she's not enjoying my experience talking to you before. There's something very magical about touching the pain. In fact, even though it's horrible pain, it's almost like the patient wants it. It's like they the paint yesterday, she's helping me now to find the trigger point. It's like what I call therapeutic pain. And I think everyone understands that concept. It's reproducing the patient's pain. Because pain really is the guide, isn't it? It's the nervous systems way of guiding us to where the problem is right? There. It is just that beautiful, keep breathing.

Okay, last one. So because we're a little bit short of time, we're going to do that, come around to your back now. I should have asked for a chair. You can get your chair to get a little ship. Now, you know, on your amazing courses. We have. We have like cameras from the top and things like that. But today I'm going to camera both. So I'm going to look now at the long head of bicep. Ideally, I would probably okay, so I'm going to show you a couple of things. So we're going to actually come in to the bicep. So, actually, what we're going to do first is we're going to look at the another muscle called correct For Brekky less, and then we're going to look at the brachialis muscle as well. So we're going to start with brachialis here. And it's just under the bicep. Fill this time for me. Yeah. Okay. Just come on to here. Look.

Steven Bruce

Yeah. Okay,

Simeon Niel-Asher

can you feel it's not the bicep

Steven Bruce

rolling that way? I was rolling in that way, but I watched the winters as well. So

Simeon Niel-Asher

we're gonna start with that. It's a very interesting, it's slightly precarious. It's not a muscle that we treat very often. We're going to start here. Oh, that one. Let's breathe again, if it's too much, Tammy. Okay. All right.

Steven Bruce

Do you imagine that this is a worse pain than it would have been the other arm? If you do think that?

Simeon Niel-Asher

You're no question? No question. Look, the other thing that's important about shoulder problems is they have a significantly bad impact on quality of life. You know, there's something called an EQ five A, which was a European quality of life assessment, which showed that, you know, show complex shoulder problems have the same impact as cancer, you know, as diabetes, people heart disease, you know, they really affect people's quality of life, can't sleep, can't brush your hair can't on your bra up, you know, all these things, but it's true. Right? And wiping yourself after the toilet. You know, that's another difficult position, what we call the the athlete scratch test, you know, try and bring up that so, you know, without wanting to. Okay, yes.

Steven Bruce

That's a different topic. Yes.

Beautiful. And I say that because you have brought up the fact that you've noticed this to happen when you're treating this particular.

Speaker 1

Yeah, area. So it's, yeah, yeah.

Steven Bruce

So people can't really see what you're doing at the moment, regardless of

Simeon Niel-Asher

inhibition and conversion, inhibition, compression on the trigger point in Brachionus. At the moment, it's going really well, it's going really well. Okay, we're gonna come up now is cracking. brachialis? pec minor shorthead. bicep. Okay. So each one of these problems has a slightly different algorithm. So here is this. Yes. And it's because we've got this sort of anterior rotated shoulder, how are we doing for time? I'll keep you on track. All right. Any question? Do you tell us what you like? So inhibition compression, I'm finding the trigger point here is the short head of bicep just here. Breathe and relax. Read them relax, and then surely cater biceps short hereby. So yeah, yeah, I know, I covered a long head in frozen shoulder a lot. But, you know, the biceps is, I could spend two hours just talking about the bicep as you know, hugely important muscle. The long hair is intracapsular is one of the few muscles in the body, that's intracapsular shorthead, inserts into the coracoid process, next to pec minor Karaca brachialis. And it provides eight 70% of the power of the bicep. So most of the power, in fact, more of the bicep comes from the short head. And so so with a with a rotator cuff, we're going to look at shorthead. We're also going to look at long hair, short hair first. Okay. Okay, so let's just release that together. It's focused on the breath. doing really, really well, I'm sorry, perhaps going a little harder than I normally would. Because I want to try and get a dramatic result for you.

Steven Bruce

We have been asked how many treatments you would expect to fix your patients. So yeah,

Simeon Niel-Asher

once a week for about seven weeks, and there'll be some exercise and again, the the key is understanding where the patient is coming on that spectrum. So what the other thing about the rotator cuff now this is a really, really key. This is it now so I'm coming right onto it now. This is subacromial space, I'm rolling back this her pain. So she'll tell us that that's pretty much exactly a pain, breathe it through. So, really important. trigger point. Nice smile. Thank you. Okay, we've

Steven Bruce

given this trigger points. Could you do this with needling?

Simeon Niel-Asher

Okay, so I, I wouldn't. I think there's something about manual therapy that has a much more global neurological effect that again, we've talked about this before. For me, it's all about the neurology. I'm looking at these reflexes I'm looking at changing the you know, the pain gates. So So there's something about you know, physically stretching out the fascia which you don't get with the needles and you know, I love needles. When Anytime we nearly done a few more minutes,

Steven Bruce

you've referred to the course as though, right? Something's already said with me today, we've agreed that you'll come back in September and run a course to do this because, of course are shorter with you for you know, you have enough for a couple of years.

Simeon Niel-Asher

Thank you. I need to thank me. Long head bicep. Sorry. So if you slip over the bicep, that's probably good. Someone's distracting you by talking to It's okay. Don't worry, I'm going to come a little bit away. You're doing so well. Sorry. You're right. I

Lorraine (model)

accept your apology.

Steven Bruce

So we're gonna run a two day course two day course yet? Yeah. Which is sufficient provider, you've got the anatomy already busy. Yeah, yeah, we're

Simeon Niel-Asher

going to cover the first day, we're focusing on the frozen shoulder because that really, you can understand the shoulder in a much deeper, profound way. And then we go to the chronic vikita subacromial pain, which used to be called impingement, bursitis. And then we're going to cover the rotator cuff and all of the things around that. And some more, we might do complex regional pain syndrome.

Steven Bruce

Nearly there. At the end of two days, people are gonna go away competent and confident in finding all these trigger

Simeon Niel-Asher

points. It definitely is a hands on course, it's practical, I'd say 70% of it is practical. I, you know, with my courses I want the same with the with the needling courses, I want people to the whole idea for me to go on a course where you walk away with a skill set that you can then turn to your clinic. That's hugely important for me, because not I'm gonna put any other courses down. But the theoretical courses are great. But I think if there's something you can take back to your clinic, you can then pass it on to your patients who's great. Infraspinatus. So we're coming in, there's a what I call a super trigger point here. That's the one. That's

Steven Bruce

that's nothing like the noise I make when he does that on me.

Simeon Niel-Asher

So sorry, last one, that it relax. Yes. So what we're going to do now is ask her just to sink into that with the breathing. This is the last one really the last one, we're finishing off with him for poor thing, which is crying, you're Nearly there, nearly there. So it's so importantly, advice for you what's called relative rest, which means no carrying bags in this arm, no lifting shopping. No pull it no dog walking with this hand. When you're in bed at night, you can sleep on that side, use a pillow or a couple of pillows under the arm here, just to elevate it and lift it like hug a pillow basically, an ice you can use an ice pack here at night as well just to help reduce the inflammation around the cough. You're looking probably at about four to six weeks with some treatment to get this better. But importantly, when you understand the fact that the rotator cuff is type one collagen, that what we're dealing with is a a hypertrophy of the the the collagen structure itself and basically, it can be thought of as a kind of fracture in the cuff. So we need to have what's called relative risk, which means we need to unload it. One of the things we know about rotator cuffs is sudden eccentric overload can cause tears on ruptured. So calm everything down. No sleeping on this side. No lifting, no carrying Neurofen is a great drug for this. So depending on if your stomach can take it depending on obviously I'm not a doctor. So you'll have to get advice but some anti inflammatories just for a week or two just to bring down the swelling. And but what's really important it for you is in your mind to think would you walk on a broken ankle? You know you wouldn't you take it rest, right? So no tennis, you know, really bring it all down for three or four weeks. And then we can start introducing it again. After six weeks, it will be completely better. And we can start you know, rehabbing and getting the strength back and get back to tennis again, should

Lorraine (model)

I wear a sling at all?

Simeon Niel-Asher

I'm not a fan of slings. If you look at that position. Remember we said at the beginning when you came in, you were holding your arm in a kind of sling position. So your body automatically is doing that. But I would advise against it because this can turn into a frozen shoulder what's called a secondary frozen shoulder and that we wouldn't want so I'd take your shoulder gently in circles I can I'm going to talk to you afterwards about some exercises that you can do. But relative rest but not assuming any other questions you've got We're just about finished, we're just about finished. Now, I just want to explain treating the major trigger point of interest in artists to release subscapular. So what we just got there was her arm just fell out. So I'm using the pain reflex in infra, to unlock subscapularis. Because sub SCAP is quite hard to treat. And again, this is one of those part of the theory of this technique is that I'm using sometimes what we think we're treating isn't actually what we're treating, finished. Now, you will have a stand up. Take your time, when your legs over there, I help you. Okay, so take your time, take your time, just sit there for a second. So I'm gonna have you standing up again, we're gonna examine you again, I'm gonna ask you to do a few shrugs. So come and stand again. So let's have you shrugging a little bit, what we should find is that her glenohumeral

joint is centered better. So shoulders have come back. So actually, you can't really see it. I don't know if you can see it here, but I can see it. The whole shoulders come back with an outside if you compare it one to the other, you can see and you see that one's forward? Yes. So what we've done is we've used the neurology of trigger points in a specific sequence to change the way her brain and shoulder are related. Also, she's dropped the holding pattern now. So that it's already I can see it's already much better. So again, I'm going to have a look at with you now. We're going to take the arm up. How's that feel? Feels a little bit better. A bit of a tweet, girl. And this one?

Lorraine (model)

Oh, wow. Yeah, yeah, well, we get in that.

Simeon Niel-Asher

Okay, well, let's not over push it. That was beautiful.

Steven Bruce

Now, if we run if we run the video of you doing that at the beginning, and now the look on your face is completely different. It's

Simeon Niel-Asher

already much, much better. And what I probably would do, which I forgot to tell you is to strap it. Right, then we've got any strapping here, I didn't bring

Steven Bruce

some in. Okay, but if we do the course, yeah, absolutely,

Simeon Niel-Asher

what we would do is we would take her into a position of comfort, and then we'd strap it there. Okay. Well, I'll show you how it's called stacking strap. But I can tell you now, that already, it's a significant improvement. What we're going to do now is I'm going to get her dressed like this, and then we're just going to check it one more time. So I'm going to help you don't look at this guy's, close your eyes, okay? So I want you just to straighten yourself up, straighten your trousers and just move the shoulder around a little bit. So when we test it again, after she's got dressed, as I had to help her there, a few more shrugs. And now we're gonna have one more look. So what's happened is now her nervous system has had a chance to adapt to the treatment. When you sing on the way down on the way down, no, no, it's not. Listen, it's not going to be 100%. Perfect. But look, she's almost got a full range of motion now. So because, you know, all we've done is we spent 25 minutes, 20 minutes just working on these trigger points. And we've done it in that algorithm, I can guarantee that seven sessions with that, with the treatment with some rehab, she will be beautiful.

Steven Bruce

The rain Seminole have a quick chat with you after we finish. But for now, you know, you're gonna go to sit down over there and wind up the show. But thank you very much for putting up with

Simeon Niel-Asher

me, it will be much more. Thank you. You're right. Yes,

Lorraine (model)

I'll be fine. Thank you.

Simeon Niel-Asher

Thank you. No, thank you. And thank you, Lorraine.

Steven Bruce

Well, a lot of people apparently still asking about the diagnosis and query whether it should be made by imaging before the treatment. And also pointing out that shoulder pain can come from the neck and you didn't you didn't examine the neck, but we were here to talk about rotator cuff

Simeon Niel-Asher

surgery. I examined her to be examined her a little bit before. Okay, so I did look at her neck before I looked at her a little bit of her back before. Obviously, the confines of the recording. I can't do everything. However, you're absolutely correct. We're looking at the neck. We're looking at the posture, we're looking at the thoracic the role of the thoracic spine. But I think what was interesting for her is when she came in that you could see she was holding in that holding pattern. So that immediately tells me that there's an

Steven Bruce

interesting thing too, as well. We were talking before we when we first started the show, I of course can see Lorraine over your shoulder and I can see her doing this the whole time. I can see her now and she's not No no, it's gone.

Simeon Niel-Asher

It's gone. So so so that's that's really important. Imaging look I would prefer it if someone comes in with imaging but you have to understand the cuff is a very complex structure. It's multi layered. I can

try and just see if we got time I'll just stick this up here. Look. The cuff is a I think I didn't put it here we go. Type one collagen. It's there are fun. It's a five layered structure. And it's interwoven with Karaca humeral ligament. It's got connective tissue inside it, it's got the Bersih that goes through it. And there's a lot. So, so the imaging isn't always massively helpful. I'm not suggesting in any way that it's not good to have imaging. But I think that the imaging doesn't always correlate to the symptoms. I think that we can palpate I use a lot of palpation, you can see she was in significant pain. So I'm not going to put her through these huge sort of range of motions. We've

Steven Bruce

got some other questions which we really not going to have time for. But I'll get some answers from you after the show. When I send out the slides, but empty, you asked about hydro delimitation, you will have a look at that. And also looking about whether acupuncture is a suitable adjunctive therapy to this, we will look at the answer to those questions or at least simians opinion. We talked about the course do you and I have agreed that we'll run here in September, two day course seventh and eighth of September. You want to charge people 450 quid for the two days which frankly I think is a bit of a bargain. However, fly, come on, come on. We got to fly you in to get it more or less. But we got to offer them something for having taken the trouble to watch the show today. So what can we drop it down a bit? Can we use squeezing

Simeon Niel-Asher

me? I look for me. I'm open to suggestions. Look, I think I think for me, it's about you know, I just want to spread this technique 70 label really? From 453 70? Sure.

Steven Bruce

What are we done with pleasure who've agreed? Now, Justin has got five minutes to set something up, which will reflect that so that people can Okay, hopefully. Yeah, but thank you. That's good. So we'll have a two day course Yeah, normally, there are 24 places on that personal attention from you. So

Simeon Niel-Asher

you know, I often ask this question at the beginning, you know how many of you are scared of shoulders when people come in, and I guarantee his money. Now, I guarantee that all of you will walk out of that course with a confidence about treating shoulders. And if you can't treat them what you can do. And I've

Steven Bruce

seen many of those courses, even though we haven't run one for a while and your other courses in they are all they are first day they don't see me and thank you very much pleasure.