Academy of PHYSICAL MEDICINE

Transcript

391R- Treating Pelvic and Coccygeal Pain with Stephen Sandler

Steven Bruce 13:22

The And good afternoon and welcome to today's lunchtime learning with others. We're looking today at a particularly interesting aspect of MSK care, at least I think so, something which perhaps divides a P. And particularly when it comes to treatment options. The issue is, of course, coccygeal pain and to help me explore the issues around this, I've got an old friend, Dr Steven sundler, with me in the studio. Actually, Steven's probably best known for his expertise in treating pregnant women, and he's been on the show in that capacity a couple of times before, but he's also one of relatively few osteopaths in the country who is experienced in perectal adjustments of the coccyx. And when I say experienced, he is very, very experienced indeed. Steve, welcome back to APMs. Great to have you. I mentioned, you know, we've had you on the show in the past in your obstetric capacity. I mean, is there a connection between obstetrics and coccyx, or is it just coincidence that you do both?

Stephen Sandler 20:41

No, no, no, it's not coincidence one grew out of the other, because with pregnancy, and more importantly, with a delivery, you can get trauma to the sacral corpus, digital junction. And there are a large number of women who come in, who come in because everything was okay until I had that baby, and he was a bit large or he was the wrong way around in the birth canal, and now I've got coccydernia, and the treatment of that is quite poor.

Steven Bruce 21:14

Well, I suspect all colleges teach internal adjustment of the coccyx. I know they did at my college, but frankly, just call it fairly simple and brutal was would be perhaps understating just how poor the training was in that. Yeah,

Stephen Sandler 21:30

I think you're right in many respects. And in fact, I've refined the technique. Firstly, I make sure that it's a coccyx problem, because differential diagnosis is absolutely essential, as you'll see. But once it is, there has to be a specific test, which I will demonstrate. And if that test is positive, it's an internal technique.

Steven Bruce 21:55

Yeah, you've hit on a real nub there, haven't you? Then your differentials have got to be absolutely spot on, because nobody wants to be doing this or having it done to them if there isn't a good reason for it, as in any other treatment. Yeah, and but I've also opinion is divided about this. I've heard lots of people say that internal techniques are absolutely unnecessary, and clearly that's not your view. No, it isn't my view.

Stephen Sandler 22:19

And the main reason it's not my view, is because I see between 40 and 60 new cases every year referred to me in central London by osteopaths and others who haven't managed to be able to get the problem sorted with an external technique Only, yes, and the difference is, either the differential diagnosis is questionable, maybe it's something else, other than a coccyx problem giving coccyx pain, or it's the technique has to, quote, replace, unquote, A coccyx which is in the wrong position,

Steven Bruce 23:02

right? Okay, so you better talk us through the differentials then at some point, haven't you?

Stephen Sandler 23:05

Yeah, certainly I'm going, I'm going to do that. Is that the No, this is the audit I wanted. The other presentation, which is, I'm just going to come back.

Always the problem with the problem with slides. I'll get there in about five seconds. Okay, here we are. The problem is always going to be the diagnostic process, and we always begin in the same way with the case history, because the case history is absolutely paramount, onset, aggravating, relieving, non affecting factors. It's standard stuff, but a full comprehensive medical history, there are various Garni problems, there are various prostate problems which will give pressure attention in the area related to the coccyx. Vas score is very useful in objective on that pain. But a visual analog score, a visual analog score, but the commonest etiology is trauma and external, or internal, external trauma, the classic, some joker pulls the chair away from you, thump. Or you go down the staircase and you reach it, bang, bang, bang, bang. And that's that's classic, the backwards fall on the tail, bruised, dislocated or fractured in the coccyx in my practice, as he said, See many women who come in after a pregnancy. Now, patients come with scans. Yeah, they come with X rays. The

problem with that is has to be interpretation. What was the radio? Just asked for, right? So if you ask him for a lumbar spine and pelvis, that's what you're going to get. If you ask him for coccyx to identify the position, then you'll get a different thing. And Jean mania in Paris, who's probably the world expert on coccyx pain, does a sitting, standing X ray, and he as as the patient sits and stands, he can then measure the angle that the coccyx is at. What profession is he? He's a consultant to orthopedic surgeon, right? Sorry, rheumatologist, but he uses that test. And in fact, if I was to send a patient for an x ray, I would send them for a sit, stand, X ray, and I use mains protocol, which the patient takes with them, so the radiologist knows what to do,

Steven Bruce 25:50

right? Okay, and is there a specifics in that protocol that we ought to know for our own

Stephen Sandler 25:55

the protocol is in that paper there.

Now, in about three seconds, someone's going to say, we can't read the slides. Are you happy for me to share these slides with people as a PDF after I am totally

happy. Okay, good, totally happy. So the differential diagnosis the scan really is very important, because you can see that fractural dislocation. You can see any analyst chemical changes the bone spurs. That's another one that's blamed for coccygeal pain. It really is really it's been there before. It'll be there afterwards. Why should it become a problem? You know now, she fell down the stairs. So if,

Steven Bruce 26:38

in the conventional world, if someone gets this follows this protocol, they find a bony spur is the likely remedy, right? We're going to go in and saw that off.

Stephen Sandler 26:47

Well, the likely remedy has been that's been done, and you end up with a patient that's gone. I've got two sorts of pain, yes, no. If it's a bone spur, I tend to leave it alone. I tend to maybe suggest that they need to go and get a corco steroid injection, right, which, which helps, or a ganglion in power injection which helps the coccyx at the SC joint can become arthritic, which has its has its problems. And don't forget, are things like tumors, infections, you know, they're giving pain in the pelvic floor, the center of which is the coccyx. They're quite rare. They're not something you would come across every day. But if you take your case history correctly, the indications will be away from coccyx, as opposed to it's definitely going to be a coccyx, otherwise, central lumbar disc prolapse. This is really very important indeed, but not commonly diagnosed. Now there's a scan, and you can see on that scan, the red arrow is pointing at a central lumbar disc prolapse.

Steven Bruce 27:55

Could you apologies for interrupting your flow here? Many people won't be quite as familiar with Mr. Imagery as perhaps you are. Would you mind just taking us through a few of the structures on there so people can just identify what they're looking at? Yeah, you might be better off using the pointer, because then we can open up a full screen for

Stephen Sandler 28:12

them. Okay, here, whoops, that's it. There. You can see the disc bulging back towards the spinous process. So

Steven Bruce 28:25

the big round circle of dark material that is the intervertebral disc, and there's a little bit poking out from it, which is where the arrow is going the bright signal below that, yeah.

Stephen Sandler 28:33

Well, then you've got facet joints either side, yep.

Steven Bruce 28:37

Those are the dark spaces between the mitosis,

Stephen Sandler 28:40

and you also got the lateral recesses, so that if that disc was prolapsing left or right, you would end up with your sciatica left or right. But here there is no sciatica. There is no major leg pain. There's certainly no differential diagnosis from a neurological testing point of view, reflexes are fine. Power is fine, sensory is fine. But it comes back to all of the possible reasons, which come from your history. It's a weight bearing problem. Disc. There's only two structures in the spine that carry weight, discs and bones. Anything else carries weight, it wears out and then now you got spondyloarthrosis. So that's the problem. It's a weight bearing problem, so therefore it's going to be worse in the morning. Now, standard medical school education says morning pain is inflammatory, for example, acros and spondylitis, but the disc is a sponge. You're horizontal on that disc when you're in bed, and when you become vertical on that disc, you compress it. So therefore 21st 20 minutes disc pain is always going to be very uncomfortable, and then it wears off. Yeah, I tell my disc patients, leave you. Shoes and socks by the front door. Put them on just before you're going to go out, and it's much easier to bend things like coughing, sneezing, which produce provoke that bulge, whereas movement tends to make discs easier. Now, if you've got a coccyx, all those questions will be fairly negative, but if it's a weight bearing problem, can you sit on the coccyx? And most people say, Well, I always sit on one buttock. Okay, that's a clear example of avoiding the coccyx and things like get it rising getting out of a chair. As you rise and get out of a chair with a disc lesion, you've got

to go back into extension trapping the bulging roll ups coccyx not a problem. Things like potholes in the road. A patient once said to me, you should have your telephone number printed backwards over potholes. Once you hit the pothole, look up Sandler or stepper. We didn't bother but the the jolting, the jarring, but very specifically so coccygeal pain. If it's a traumatic coccyx, we'll be looking at that. But as I said before, you've got to take a full medical history, because anything that's gynecological, associated with the colorectal area or with the prostate area. These can all produce Phantom Pains because the nerve supply is common to all of them. While you're

Steven Bruce 31:29

on the subject of nerves, I've had a question from Lawrence. Lawrence is clearly a very clever bugger, because he says, Would pudendal nerve in all Cox canal mimic coccygeal pain?

Stephen Sandler 31:39

It would mimic it. But if you actually had a pure coccyx case, when you put pressure into all Cox canal, it would not respond, right? So that's one of the differential diagnoses. Put pressure

Steven Bruce 31:56

into all Cox canal. Sorry. How do we put pressure into all Cox canal with

Stephen Sandler 32:00

a thumb, so that you're coming off the ischial tuberosity, medial and ascending, right? And they'll rise from that quite quickly. But the the the nerves that we can see here are shared nerves, okay? And they're coming all the way down, yeah, and they're coming into the coccyx, and this is the ganglion impulse, where the two parts of the ventral nervous system are going to be coming together. And we can see, if you look at the simple lumbar plexus, this is shared by everything down here, coccygeal pain, the differential diagnosis is all about that. But there's also, there are various tests that you would use, standard orthopedic tests. But if I'm going to use an internal technique, I've developed something called a coccyx provocation test, and that coccyx provocation test has to be positive, right in order for me to go inside. Now, is

Steven Bruce 33:00

this the technique you're going to demonstrate? It is indeed. Do you want to do that now? Yep, let's go and let's go and have a quick look at that. I'm trying to rush you, but we have time on the lunchtime we've recruited Neil as a willing coccygeal patient. Neil, thank you.

Stephen Sandler 33:17

So you asked the patient to sit upright in a neutral position, okay? And what's going to happen is that I'm going to use those three fingers. The outside fingers will spread the buttocks, giving access

to the coccyx with my middle finger. So I'll bring him onto the side. That doesn't hurt, I'll literally just lift the coccyx and then drop them into hyperflexion, so drop down, and I'll push the coccyx with my middle finger,

Steven Bruce 33:54

so we're lifting, literally, I'm

Stephen Sandler 33:56

going to be doing that, yep, and if that coccyx is flexed, which means that the junction between the coccyx and the sacrum, that sacral coccygeal junction, I'm doing that to it. Yes, he will rise off the table, okay? And if he, if he says it's bit uncomfortable, it's not a coccyx, okay, it's very painful. If it's positive, there's no argument about it patients, whoa, it has to be that's

Steven Bruce 34:25

wrong. And this is a provocation test, which you can do fully closed. He doesn't absolutely there's

Stephen Sandler 34:30

nothing. You don't undress the patient. You make sure that you say to the patient, this is what I need to do, of course. Okay? And you explain it to the patient. They say, yeah, that's okay. You tell them that it's external. You tell them it's over their clothing. Yeah, that's fine. But I think it's very important, it's not just an internal technique that needs consent,

Steven Bruce 34:51

yeah, oh, of course. You're anywhere around the intimate areas.

Stephen Sandler 34:55

It's anywhere around the areas. Yeah.

Steven Bruce 34:56

Did you feel interfered with? Neil? You felt. Comfortable. We're still friends,

Stephen Sandler 35:02

but that's if we if we go back, sure.

Steven Bruce 35:05

Thank you. Thank you, Neil. I'll

Stephen Sandler 35:07

demonstrate with my hands. What is actually happening? Okay? If we look at my hands, my two little fingers are the coccyx supported by the muscles of the pelvic floor. You fall down the stairs, you're on a horse, and you know, the horse goes one way, and you go the wrong way down the stairs. Bang. So your coccyx is now forward, okay? But unfortunately, we're not horses. We haven't got a tail, so there's no mechanism to pull it back so it goes forward and it can stay there for years. I had a patient who, over 20 years, had made her office on top of filing cabinets, so she stood all day long lady in the back of a Volvo estate to or any other car to facilitate holidays. Yes, two treatments, symptom free after 20 years, after 20 years, because it's been there, stuck in that position. And in fact, the technique that I use actually, which, if they come along to the if people come along to the postgraduate course, will show them how to put that coccyx back into place, and the patient actually replaces her own coccyx. Now, once it's back into place, the muscles will contract and hold it nice and firm. If during that process there's a tear at the sacral cock steel junction. No amount of pulling it back will keep it there. It'll just be doing that, right? So that's when you say, Okay, what are we going to be doing here? What other things are necessary?

Steven Bruce 36:51

So how would you sorry? How would you recognize that mobile

Stephen Sandler 36:55

Okay, so when your fingers inside,

Steven Bruce 36:58

right? So you can't during this provocation test, you won't know at that stage. You simply know that it's not going to work. When you're doing the internal

Stephen Sandler 37:04

the patient is laying on their side. I'm working from behind. My thumb is external at the SC junction, my index finger is inside, yeah. So I will pick up that coccyx and it wobbles around, yeah? And you almost know for sure that one will not respond

Steven Bruce 37:21

that. Well, okay, how long did it take you to develop the expertise, to learn that, to recognize that I should say

Stephen Sandler 37:26

I don't know, is the answer. But one thing that you have to do in your head if I'm going to treat something, what do I do when it fails? If we can go on to the audit results. There's an audit that I did of 400 cases in my own practice, and the audit results show very clearly what's actually going on and what you do when I Okay, so this was 400 patients, and 65% referred either friends, family or an organization called coccyx.org I knew nothing about coccyx.org until people started coming in saying, I've been referred through coccyx.org It was founded by a guy who had chronic cockle pain, and nobody was able to help him. And so he brought together all sorts of people, including patients, 30% refer biosystemic colleagues. That's why I think it's very important, I'm going to be retiring soon, to get as many people as possible. And in fact, I keep a private register of my own of people that I've trained. So that's that's important. If someone says to me, Oh, is there an osteopath that you know in Edinburgh, I can say yes or no, yes, which is important, or referred by other healthcare practitioners, consultants, GPS, those are usually pregnant ones.

Steven Bruce 38:55

This strikes me as being one of those treatments which we osteopathic chiropractors do, which can also almost seem sort of miraculous to the patient. We had a patient on the show the other the other day I told you about him, though Laurie Hartman did a couple of very gentle manipulations, and all of a sudden he had a miraculous increase in mobility and loss of pain and so on. Whereas this one, we've got patients who perhaps have had a very long term pain in the butt, which has been misdiagnosed or undiagnosed by countless other practitioners, and they've just put up with it, and yet, as you say, in a couple of treatments, you can fix

Stephen Sandler 39:33

the problem for them. Maybe you can. The point is, knowing which ones you think you can fix, getting the differential illnesses, right? And then who to refer them to if you can't help them? And I've developed a network of people that do injections, people that do surgeries, etc. But these 400 the mean age was 31 it's not an old person's. Problem. It's a younger person's problem.

Steven Bruce 40:02

Do you have a female to male? 70% I think five to one. Sorry, you said, yeah. So is that because of pregnancy and childbirth?

Stephen Sandler 40:11

It's partly because of pregnancy and childbirth. But it goes back to my PhD research, which was the effect of circulating female hormones on collagen,

Steven Bruce 40:20

the longest PhD title she's ever come across, according to the Princess

Stephen Sandler 40:25

Royal this, this literally shows that in a 28 day menstrual cycle, round about ovulation, day 12 to 14, you've got an 80% chance of hurting yourself, right? Because estrogen is a muscle sorry. Eastern promotes muscle strength. And day 12, it drops hero to zero. So if you carry on training, you're going to hurt yourself. You haven't got enough soldiers in the guardhouse to protect

Steven Bruce 40:52

you. Okay, maybe you want to do this first of all, but then perhaps you could talk us through the non traumatic possible causes. You mentioned exercise there. Now, what sort of exercise, for example, is going to promote this?

Stephen Sandler 41:07

Exercise is not common. The most traumatic, the most common traumatic problem is a fall. Yes, a fall on it. You can get problems with scar tissue. People that have had pelvic floor surgery, for example, episiotomy, which will pull the pelvic floor towards one side, deviating the coccyx. But the the actual reason why this happens is usually traumatic and as such. But the youngest person was an eight year old girl. The oldest was a 76 year old man, but I think it's very important that when we look at that five to one, you know you're thinking. So my question would always be, at some point in your menstrual cycle, is this worse? Oh, yeah, just before my periods do my coccyx is really throbbing and hurting. Okay, that's the effect of relaxing. Yes, relaxing is not just the pregnancy or hormone. It's every woman, every month, just before, before menstruation. Oh, is it worse in the mid cycle? Oh, it can be because she hasn't got estrogen, protecting those strengthening those muscles. The scans, as I say, 42% come in with scans or X rays. Are they helpful? Depending on where they've been done, previous treatments, we're not the first people to see these. Yeah.

Steven Bruce 42:31

Just talk us through the whole business of the scans. Then do we need to if I'm suspicious, if you are suspicious of a coccygeal problem, you possibly wouldn't bother to refer for a scan. You'd do your provocation test. Yes, if someone else who might not feel competent or confident about that test would were seeking confirmation, what do they need to ask for?

Stephen Sandler 42:55

Okay, if in doubt, shout you need someone else's opinion. So you would say, I'd like a scan please. Of this. CT scans are X ray scans. We don't use those. MRI scans are magnetic resonance. We use those. We do use it. Oh, yeah, yeah. But even easier than that is an x ray now, Professor Manu in Paris, who's the world expert on coccyx dual pain, he's described a protocol, okay? And part of that protocol for diagnosis is a sitting, standing X ray. So the patient sits and then stands, and he measures the angle change. And that's where his diagnosis is particularly important. And

Steven Bruce 43:37

is that is, I was going to ask this earlier, wrongly. Is it easy to recognize there must be a degree of anatomical variation. There's

Stephen Sandler 43:44

very much a degree. And in fact, there are six different types of coccygeal, quote morphologies, unquote. But this is, according to Maine's protocol, the angle has to change dramatically between flexion and extension. So I actually send the patient to an x ray unit with a copy of mains paper, okay, telling them how to do it, because it would normally be X ray lambda spine patients laying down

Steven Bruce 44:15

this might, this question might relate to this. I haven't had a chance to read it all, but Alexia says I find a lot of problem with imaging as often they would scan the lumbar spine and sacrum, but not the coccyx. Do you then ask them to rescan? And you mentioned X ray, but would an MRI not be better to have more of the surrounding soft tissues, potential issues, any particular views we should request? You mentioned sitting and standing for X ray, anything for MRIs, and that noise was exactly what we talked about before the show when we said we had told DHL not to come while we were on air. And we have a sign outside which says, On Air, don't ring the bloody Bell. But now we have DHL who have come to create a collector parcel right in the middle of a broadcast.

Stephen Sandler 44:54

Okay, getting back to her question, I. If you're going to do this, you need an X ray, because it's cheap, okay, and it's accurate. And I work in a particular hospital in central London, and the radiographers there know what I want, yeah, but I still send the patient along. And he says, Oh, Dr Sandler said, Can you do that for me, please? And I said, we don't normally do that. Yeah, we can do that. And then that has to go to the radiologist. Yes, who knows. Why I asked, does it help

Steven Bruce 45:37

that you can stick doctor in front of your name because you have a PhD?

Stephen Sandler 45:40

It's the one place where I don't use it, because I don't want people thinking that I'm a medical doctor. Actually, I'm just Mr. Sadler. But that's got an interesting point. But I would say to the radiologist, this is the history, there's trauma, there's this, that, and the rest of it. There may be a fracture. I've asked for sit, stand, X ray, and everyone knows what you want. Now, if that's inconclusive, which it can be MRI scans, but it's often common that patients will arrive with their scan, yeah, because the standard pathway in orthopedics is not X ray, it's scan. But if the patient's

paying 300 quid for himself, that's one fee. If he pays 110 for an x ray, that's another fee. So I'm always wary of too much. But if it is a scan, I'll say query, central lumber disc prolapse, okay, and then we can see that picture that we saw. Yeah. And everybody knows what we need. So my advice,

Steven Bruce 46:44

so the source of pain in that image that we saw was, No, you said that was a lumbar prolapse that was causing, yeah, the

Stephen Sandler 46:51

lumbar prolapse was a prolapse pushing back on the posterior longitudinal ligament, which shares the same nerve supplies to coccyx, but the coccyx was Ouch. I'm hurting in the coccyx. The actual site of the origin of the pain was higher

Steven Bruce 47:07

up, right? So it was, it was the longitudinal ligament which was the issue,

Stephen Sandler 47:11

yeah, for micro dyskectomy, and had fabulous result, literally just in with the crab claw. Tweezers, pull it out and it's done.

Steven Bruce 47:22

Can I ask a few more questions before we go on? And I want to get on to the issue of consent, particularly before we go because a very, very important one. But Bertrand asks, why the coccyx changes its angle if it's stuck in inverted commas?

Stephen Sandler 47:35

Well, it changes from what you would expect to be

Steven Bruce 47:39

normal, stuck. But

Stephen Sandler 47:41

then so coccyx is normally, normal. Something comes along and knocks it forward. Where's the mechanism to pull it back? Doesn't exist,

Steven Bruce 47:49

right? Exactly. That's why it's stuck, because there's nothing to pull it back.

Stephen Sandler 47:52

Yeah, there was one slide that I found from, I think, 1860 edition of Grey's Anatomy, which described a slip of muscle called extensor coccygeus. Never seen it anywhere else, right?

Steven Bruce 48:03

Okay? And if it's that much of a slip, it's not going to have much power over a bend like that. Kim wants to know if the treatment is okay, and I presume she's talking about a perectal treatment, if the patient has a pessary in due to prolapse.

Stephen Sandler 48:19

If it's a uterine prolapse, I'm not worried about it, because the pessary will just hold that in place. I'm often asked, What do you do if a patient's menstruating? And my answer is, a tampon is not going to interfere with what I'm doing, but always aware of sensibilities. Yes. And I would say to her, if you're menstruating, come in next week. It's easier, you're more comfortable. Oh, don't worry about that. Okay, fine. Then I won't, but I think it's, you know, a patient's got piles, a patient's got fissures, you know, you're just going to have to say, well, maybe I can't do it. Or if I'm going to do it, I'm going to be so gentle as they go past them. But it's not a contraindication, per se,

Steven Bruce 49:02

I'm not wishing to be too graphic. I imagine that hemorrhoids are quite a problem with women postpartum, aren't

Stephen Sandler 49:08

they? They are immediately postpartum, but they shrink back up inside the annual canal and hey ho, yeah,

Steven Bruce 49:15

okay. Sue wants clarification about the the protocols you talked about is it Professor Merin or main let me find it will be on the slides that we hand over on

Stephen Sandler 49:26

the slides, yeah, M, A, R, G, N, E. His name is Jean Yves mania, and is from the hotel du Hospital in Paris, right? And his, if you do a Google search, not a Google search, PubMed search, it'll be there. It's a standard piece of information.

Steven Bruce 49:45

There is an interesting one. Christina Ann wants to know, would the presence of migraines indicate a coccyx problem? It's

Stephen Sandler 49:52

very good question, especially if you use a lot of Quino sacral a. Approaches to problems because of the long connections right the way through the Jura up to the top, I haven't found particularly there's a major connection as such, and that might be because patients aren't educated when they come in with migraines to tell me they've got a coccyx problem. Or if they come in with a coccyx problem, some of the got migraines. I would always say, if they came in with a coccyx problem, as part of my general routine, Do you suffer from any other problems? Headaches, for example, and then say, Oh, it is headache. What sort of headache is it? Oh, well, it's migraine. And I take such and such. Or you go through a differential diagnostic protocol for migraine. So you do see there's an anatomical connection, but I wouldn't say it was common.

Steven Bruce 50:46

So there's a coincidence there of headache and coccygeal problem. Does that mean that when you've remedied the coccygeal problem, the migraines go away?

Stephen Sandler 50:54

Unfortunately, no, because migraines always have a trigger, and I have failed spectacularly, and this is said on camera, okay, over the last 50 years, in practice, to treat migraine and get rid of it completely, right? So I'll take on cases, and I would always be honest enough to say to them, I can probably affect the number of migraines you're going to get in a month, in a year, and hopefully space them out so you're only getting two or three instead of every week, if that's the way, then, then what we're doing is indicated. But if, if you expect me to treat your migraine and solve your migraine, there's too many other triggers involved, and from dietary to emotional to hormonal. There's many, many, many reasons why migraine, and that's that's why there are so many clinics for migraine, the migraine trust, you know, because nobody's got every answer right?

Steven Bruce 51:55

Okay, that's disappointing for all those migraine sufferers. There we are. Laura wants to know your opinion on the effect of cesarean sections on coccyx

Stephen Sandler 52:05

problems, again, much less because the baby isn't passing down through the birth canal. That's if it's an elective section. So the woman knows that she's not going to have a vaginal delivery. She's going in for a section so there's no trauma to the pelvic floor. If it's an emergency section where the child's passing down through the birth garland gets stuck, okay. And neither Avantis nor Aquila forceps will be able to turn the head and allow it to pass down through the canal that can produce severe trauma to the pelvic floor. Yeah, and diabetic mothers always give birth to bigger babies, and so those bigger babies will provide trauma into the pelvic floor. And in fact, if the baby is more than a certain size, most obstetricians would say elective section.

Steven Bruce 52:57

Okay, I'm going to come back to Christina Ann's question. You had a feeling, didn't you, when she asked about migraines, that there was some hidden agenda in this, and she has now said, Yes, migraines can go away after coccygeal pain is treated. So this person experienced that. That's great, but again, so there's a world apart from saying yes, I can cure your migraines to a yes, isn't it? Right? Let's get on to the what is going to be one of the issues at the heart of this, which is communication and consent. This is an intimate procedure. It's a difficult one to discuss. Maybe it's fairly apparent to a patient why it should work, but what is the proper, the correct approach to getting to communicating and getting consent for internal examination and treatment?

Stephen Sandler 53:41

As I say, the majority of patients that I'm treating are coming to me specifically because they've been sent. You had treatment from him, you've had that, you've had this. So they're being pushed into that. So the if you like, it will be very foolish to take that consent as implied. There is no such thing as implied consent. Implied Consent really is the sort of thing that you want to avoid even thinking about. Consent is consent. You either consent to something or you don't, and yes, it's an intimate area, but putting your hand on somebody's shoulders could be an intimate area. So I'm making even the

Steven Bruce 54:28

person who thinks that's intimate is going to think there's a world of difference between that and sticking your

Stephen Sandler 54:32

finger up their bottom absolutely so if you like the more intimate the area, the more I'm going to be saying. But consent is consent. Now, when a patient comes in to see me, I have my own protocol, which is, take the history, do the examination, standing examination, do all the active movements, etc, indicating a lumbar disc problem or otherwise, with various different tests that I use, and then the coccyx. Provocation test, that coccyx provocation test requires verbal consent because the patient's fully clothed. They're sitting on the table. You explain to them, I use my hands in the way that I used them before to show what needs to be done. How do you feel about that? Is it going to hurt, yes, because the test has to be positive in order for me to put my finger in your bottom.

Steven Bruce 55:26

Well, more to the point, if it hurts, then it's a positive test, exactly. And if

Stephen Sandler 55:30

it doesn't hurt, then it's then, then it's something else. Oh, oh, well, okay, yeah, fine, yeah, you carry on and do that. But patience under understand what osteopathy can do if they've been referred, oh, go and see Dr Sandler. He does these internal techniques, and you know, he's the expert, so they've already been pre warned, and it will be very rare, and if that test is positive, okay, at that point we break I have a consent form. And by the way, if anybody wants a copy of my consent forms, then look me up in the register sound last year@gmail.com free, gratis. I'll send you a copy, if you wouldn't

Steven Bruce 56:18

mind showing it with me. I can send out to everyone who's attended this absolutely, that's that's

Stephen Sandler 56:22

that easy. I'll send it to you by email, and then you just put your own name and address on the top of the paper. But that says quite clearly that I've had the problem explained to me, yes, and I am happy to proceed. It then says, Do you want to chaperone? If you don't want to chaperone, you sign to the fact that you don't want to chaperone. And I know the GLC has said in the past that the consent form doesn't necessarily always have to be used, because people can be intimidated. In my practice, it's always used

Steven Bruce 56:58

well, I'm pretty confident, and I looked this up not very long ago, that I'm sure they have said that there has to be recorded consent for intimate procedures now, because everyone's on electronic notes these days, that is a slightly more difficult thing to achieve. On the spot in the clinic, where you can get someone to sign a piece of paper, it's harder for them to go into their own email system and respond to say, Yes, I agree, but I do remember some time back that you said that you give them a 24 hour cooling off period after they've consented. No, no,

Stephen Sandler 57:33

that's not the case. What we do is they sign the consent form. That consent form is part of their notes, so I scan it in, right? Just literally, I scan it straight in. It's there. It's part of their patient record, and consent is only for that moment. You know, if they come back in two weeks time, we go through a procedure again. I don't require them to sign a form a second time, but I always go through that verbal consent procedure, because it's essential, you know, having been called as an expert witness

in a couple of cases where people have done the wrong thing and there's been malicious intent. Well, I was going

Steven Bruce 58:14

to ask you about occasions when it's gone wrong. What malicious intent? I think we probably don't need to talk about that, because that's a case in its own right, isn't it? But what about where are the occasions when it's gone wrong unintentionally, where it's a person's acting in perfectly good faith, offering good treatment? But perhaps it hasn't been perceived that way by the patient?

Stephen Sandler 58:35

Well, I think as long as you think it through yourself beforehand. What do I need to say to obtain consent? I need to explain. How do I explain? Do I use my hands? Do I use an anatomical model? But taking the time, taking that three or four minutes? You know, it's always better to take three minutes to explain than 10 minutes to apologize, you know. And I've held that a sacrosanct in my practice life, that you take the time you explain, and you hear patients in the waiting room talking to each other. Oh, he's really good, and he explains everything, you know. And on my iPad, I've got anatomy program which shows the structures you take that time, and it says to the patient, this is a serious practitioner, and before he does an intimate procedure, he's going to make sure that I understand. Now the whole thing about this, is it going to hurt? Is the rectal technique going to hurt? The answer is invariably No, because I use a functional technique to unwind the coccyx back into place, to release the tension in the paracoc Digital muscles. Yes, it feels like you're on the loo, but nobody passes anything because my hands in the way, and when you come out, you clean the glass. Of as you come out. So it's, it's actually quite a clean procedure. It's not a painful procedure, even if there's a hero rod or something, you've gone past it. And I think that patient, oh, oh, I can feel, I can feel the coccyx moving, is a common thing that they say,

Steven Bruce 1:00:17

and that is relates to some of the questions I've got in here. So Alexia, for example, says, How do you know you've corrected the cortex? Does the pain go away straight away?

Stephen Sandler 1:00:24

I asked the patient to sit on the table and to rock backwards and forwards, okay? And they say, I can't do that. It will hurt. Okay, fine. After I've done the correction, sit on the edge of my table. Give me a hands rock and roll, and you get this. Oh, look, I can sit on both sides. Now, that's important. And if we actually look at the the slide that talks about the the results 54% 54% are completely since and free off to just one treatment

Steven Bruce 1:01:03

that in itself, and only 5% need more than two, which is exactly, and only 2%

Stephen Sandler 1:01:08

are made worse, right? You know, this is an indication, if we add these up, you know, you're getting over 80% Yeah. And if it's a hypermobile one, you'll know by the second treatment send them off for a steroid injection. So

Steven Bruce 1:01:24

what's happened when somebody gets worse? Then what's what mechanism might provoke? It might

Stephen Sandler 1:01:30

be psychological. It might be because they are hypersensitive. It might be because the diagnosis is wrong, right? Um, you know, nobody gets it right, 100% but that figure of 2% comparing it to the 80% it is, to me, an indication that says, given the protocols, using coccyx provocation test and getting a response, that says, That's painful. With the provocation, there's the response. There's

Steven Bruce 1:01:59

an interesting comparison there to be made as well that we've now got 84% who got better after one or two treatments, but we've got a total of 46% who had good relief, but the pain came back or no difference was made. So of the bigger number is how many got relief but the pain came back. Well, that's

Stephen Sandler 1:02:16

not uncommon. No, that's not uncommon. And I think you have to explain to the patient, and I actually show my patient that slide, and I say, you know, if you're in this group, okay, or this group, maybe what we can do is to release the symptoms, especially if it's spasm around the paracoxogeneal muscles, but if It's hypermobile, or if there's been a tear, you know, that will come back. So what I would suggest is a corticosteroid injection. Oh, no, I don't want any injections. I had injections before I came to you and they didn't work. Okay, fair enough. Then all I can say is that, let's see how far we can get into here. But certainly, if you're one of the 2% we only do one treatment, and that's it,

Steven Bruce 1:03:02

right? Okay, but if you're one of the 36 you get good, get good relief, and the pain has come back. Would you then say, well, let's do some more and see if we can. I would

Stephen Sandler 1:03:08

say, Okay, let's, let's do the technique, one, maybe two treatments. How do you feel much more comfortable six months later? Oh, hi. It's come back again. Or, Oh, I was in the gym corner and I was riding badly, or I had a fall or whatever, and, okay, fine, come back in the end, repeat your protocol, repeat your differential diagnosis, and hopefully try and get into this 80% after just a couple

Steven Bruce 1:03:38

six months. Is, let's say, a typical time for the pain to return. I would imagine that people would be probably grateful for six months relief, even if they had to have the procedure repeated. That's what they tell me, yeah. And the fact that they've come back again, knowing what it was they had done last time, suggests that it's not that unpleasant to protect. And

Stephen Sandler 1:03:54

they go back to coccyx.org, and write a review, and other people know, and they tell their friends. And it's strange how people have, oh, I've had that as well. You know, I was sold after I had my baby. That was just part of it. Well, it isn't women

Steven Bruce 1:04:11

get this a lot, don't they, it's just part

Stephen Sandler 1:04:15

of being a woman. I think that certainly, as far as I'm concerned, if you look back at those that data that I suggested about mid cycle pain and premenstrual pain, that's why women are high amongst this list of people aged approximately 31 years of age. They're in their childbearing years.

Steven Bruce 1:04:38

Okay, few other questions for you. Anita says, in a rectal prolapse with coccyx pain in women, can we still use your technique? I would say that we're contraindicated, right? Okay, so what do you do? Then,

Stephen Sandler 1:04:49

what do you do? Send them to a physiotherapist who specializes in women's health. Maybe she can give some very specific either exercises or treatments to that. Or, if needs be, recommend them through the GP to an anorectal surgeon who can correct the prolapse. Yeah,

Steven Bruce 1:05:06

okay, you, I must say, you've talked a lot about osteopaths and the gosc on this show, and you are running a course in how to perform this assessment diagnosis and take a one day course in November. Can I assume that chiropractors are welcome? Yes, they are, yeah, sorry.

Stephen Sandler 1:05:21

And what's more, I'm happy to put them on my own personal register. There's about 65 people on that register at the moment, and that means that patient, for example, from Glasgow, I'll get the train down, but sometimes I've done the correction, he gets on the train and goes back up again, he's going to be, you know, traumatized. So I'm much happier referring them to people who have either attended one of my courses or who say, Yes, I treat coccyx, internal, external, craniosacral, whatever, so that they don't have to have these, these, these journeys. The Longest Journey is a gentleman that came from Kuwait, but he was able to lie down in his own private airplanes. Well, I have to

Steven Bruce 1:06:09

say you're a bit like your old friend and my old friend, Laurie Hartman. You keep threatening to retire, but you telling me now you're going to retire next year, which means there'll be a lot more coccyx pain sufferers who will need treatment and won't be able to go to you yourself. So now's the time to get qualified.

Stephen Sandler 1:06:24

Yeah, I mean, I am going to retire next year fully, yeah, right, but fully small f, I will probably not take any more new patient referrals as of next year and just treat those patients that I've been treating for a long time,

Steven Bruce 1:06:43

and I think it should just this. Should just be you and Laurie doing the never ending farewell tour, really, yeah.

Stephen Sandler 1:06:47

And you know, we'll still be teaching. I'm quite sure as long as I'm as long as the audience think I'm compos mentis,

Steven Bruce 1:06:54

yeah, let me see if I got a few more questions here. Lawrence says, if the prolapse is posterior, would that precede Cauda Equina Syndrome.

Stephen Sandler 1:07:03

It's a very good question, isn't it, because you know, the caudal Equina Syndrome is usually due to either spinal stenosis. Never forget spinal stenosis in older people, the canal is so narrow with the overgrowth of bone with degenerative arthritis within the central joints,

Steven Bruce 1:07:23

and some people have anatomically have a small canal anyway, so 5060,

Stephen Sandler 1:07:27

years on top of that, yes, and you've got even more. But I think you know your regular standard routine examination in in clinic should include it takes less than half a minute reflexes and power. Yeah, questions about sphincter disturbance. Now, clearly, if that's happening with coccygeal pain, you're going to treat the stuff that's going to kill them

Steven Bruce 1:07:52

first, absolutely, yeah, yeah. And we have done, we've done a superb Show with James Booth about caudal Equina Syndrome, syndrome, which is well worth anybody watching who didn't see it. Quick question from Luke, apparently, you talked about a tear, and he wants to know whether that was ligamentous or muscular ligament, I will say ligaments so ligaments of the capsule around the sacral, coxa durns, right? Okay. Well, considering that we're talking about oxygenal adjustments, perhaps we should be blowing some smoke up your fundament. And Vince. Vince says such a fascinating presentation, exquisitely thorough, clear and deeply edifying. Thank you very much. And I'm sure he echoes, thank you very much. He must echo the view. There's been 510 people watching. So I'm sure they'd all agree with that. You've got a course here on the ninth of November, one day course. What will people who come on that get?

Stephen Sandler 1:08:43

Okay, well, that's going to be a course with a lot more information, a lot more information about the references and the scientific evidence, but with the practical technique, with practical techniques, yeah, absolutely. But the practical techniques, the internal techniques, I just want to underline, okay, no, course that I've ever given anywhere are practical internal techniques, mandatory. You can go along. You can see the course. You can do the course. You can do some of the external work, okay, but if you don't want somebody else's finger in your bottom, that's not an excuse for not coming to the course. Okay? You're entitled to say, thank you. But no, we've had students before who arrive at a course and they say, Oh, my period started this morning. Is it still okay? You would say, How do you feel about that? If you feel uncomfortable, the answer's no, we're gonna

Steven Bruce 1:09:44

stop it there, Steve, we run out of time. Thank you very much. It has been edifying and very clear as Thank you very much. Well, I hope that's given you food for thought if you'd like to become more expert yourself in coccygeal techniques.