404 – Non-Surgical Spinal Decompression

With Steven Bruce and Rob Shanks

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Steven Bruce 00:00
This evening is all about non surgical spinal decompression, otherwise known as IDD therapy. We've got this in my own clinic, but our experience pales into insignificance next to my guest this evening, Rob Shanks.
Rob is not just a hugely experienced osteopath. He's also become something to an expert on MRI interpretation, and he's spoken on the show here on that topic and IDD in the past, as well as providing his own online courses
Before we start, I recognize that there is a mixture of enthusiasm, scepticism and ignorance about IDD therapy, and so what I'm hoping to achieve with this evening show is to shed a bit of light on what it is, but mostly to help all of us understand how we work out who is most likely to benefit. , the process of assessing our patients, as well as determining the treatment protocols that we might use.
Now if you don't have an IDD machine yourself, this is still going to be really useful, because you might well be able to strike up a relationship with an IDD clinic elsewhere, which would not only be mutually beneficial, but of course, it could be enormously helpful for those patients who don't need or don't want surgery.
Rob, welcome back. Great to have you here, and we've probably talked about this in the past, but I just wanted to ask before we get going with the meat of the discussion how long you've been involved in IDD therapy,

Rob Shanks 02:04
approximate 13 years. So , 2011

Steven Bruce 02:08
which explains why you're so much better at this than I am. You've got two machines across two different sites.
You work in London, so a hell of a target audience down there. But it is popular, and we'll hear how effective it is later on. Did your interest in MRIs come before or after the IDD?

Rob Shanks 02:27
Slightly, slightly preceded it, I would say, but around the same time, but , kind of preceded the IDD and then, but then getting into the IDD therapy just enhanced my interest with the mri side?

Steven Bruce 02:39
Well, we, as I said, we've got one in my clinic. that we're going to be using it demonstrate. Using it, demonstrating on it this evening. We've had it for we've actually had it for probably

three or four years. We've only really been using it for two years. And even now, people are going to wonder why I bought the bloody thing if I wasn't using it. Well, I could go into that. It's a different story. Even now, I still feel that I'm not completely sure how we determine who should be put forward for IDD therapy. So should we start with that? What is it good for?

Rob Shanks 03:08
Well, I mean, in essence, it's the main thing you're using it for is discogenic pathology. Let's just say that. So that could be discogenic back pain, or the obvious one could be disc protrusion, slipped disc in layman's terms, that's causing nerve compression, therefore causing sciatic type pain, or femoral distribution, or sciatic distribution. But they're the two main things

Steven Bruce 03:29
but there's also, there are other things, which, I think, if you look through the list of things that Steven Small, sort of the main salesman for this kit in the UK, says, I mean, there are other things that you can regard as being potentially beneficial.

Rob Shanks 03:46
Yes, definitely.You might talk about things like facet joint pain, but that would then be potentially secondary to the to the spondylotic pain. So if the disc is shrunken, you're getting more facet loading, and then that could be the tissue causing symptoms, but it's also coming due to the fact that the disc is affected. My point would be that it's ultimately the disc is the thing that you're targeting in a unique way with IDD therapy.

Steven Bruce 04:07
. Now I've called it non surgical disc decompression therapy, which is not what IDD stands for, clearly. But I just think it's a, it's a simpler to understand abbreviation, yes. Is that fair?

Rob Shanks 04:20
I think that's, I think it's very fair.

Steven Bruce 04:21
Is there any evidence that it does decompress a disc?

Rob Shanks 04:26
Well, depends what you might mean by decompress. There's certainly evidence to show that, in cadaver studies, to show you can get a negative pressure within the disc when you're distracting it, which will then have certain, certain sequence of reactions within the body, physical, some of it physiological. I suppose the underlying bit of your question is can you actually change the morphology of the disc? Can you actually make a difference between, a bulging disc and then sort of retracting it? And I think that's, that's where there's a lot of nuance, a lot of argument and but it will come down to a variety of things. So if you've got a, we talk about. MRI, course, you often talk about wet disc, dry disc. So, a wet disc would be something along the lines of the nucleus is kind of extruding outside of the annulus. So that that type of scenario is much more amenable to change than, let's say, a hard fibrosed, osteophytic type of, disc, which is probably not going to change very much. But it's not all about the morphological changes. It's really, ultimately, it's the symptoms you're trying to

improve, and therefore the physiology behind that. So it's what that disc is doing to the surrounding environment and to the to the nerve and the other tissues that you're trying to change.

Steven Bruce 05:34
Now I don't think we've ever had a question that's come in before I even finished my intro, but we had one here from Aiden, who's asked what you think about flexion distraction, otherwise known as Cox technique. Are you familiar with that? How do the two compare?

Rob Shanks 05:47
So the flexion distraction is as it as it sounds. You're there's a element of distraction - traction, you could say. And then there's also flexion and extension that goes on within that. It's more like a manual type of technique, you can say. So there's the similarities and also differences. With this (IDD), you'll probably go into a bit more detail later, It's purely distraction, so it's purely like opening up and elongating on the actual anatomical plane. But then with that, you're getting very controlled forces, and there's also oscillations involved, so there's more, like a more sort of precise pumping mechanism involved, and also certain angles that you're targeting specific levels with as well.

Steven Bruce 06:30
Traction doesn't have a very good reputation in the NHS. does it? NICE guidelines don't recommend traction for low back pain. So is that simply because they've tried the wrong form of traction, do you think or have they not tried it properly at all?

Rob Shanks 06:45there's lots of things you could kind of say around it. I mean, the strange thing is, I don't know if you get the same I often get patients who, who seek me out, let's say, because I have one of these machines. Because in the past, 20 plus, 30 years ago, they responded very, very well to traction, and they and they say I had traction in 19 so and so, and it absolutely sorted me out. And that's why I'll come to you.
But you're right. If you look at the evidence and the statistics behind it, it's something like a 50-50, and I think the argument goes, well, that's not much better than placebo, and therefore traction doesn't work. And that's that's the traditional stance that within the NHS and a lot of other establishments. But , I think, if you ask me personally, I think even just plain traction can be very useful, but for a certain number of people, the problem is it can also be used just as a blanket treatment, and not with the right selection of patients. And then if you use it on the wrong patient it’s obviously not going to have an effect

Steven Bruce 07:40
I was going to come to that with IDD therapy, because, I suspect, in fact, I'd go so far as to say, I'm sure that there are clinics who are using it as a cash cow - just get everyone on it, charge them for a long series of treatments, which is something that many of us would resist. And one of the reasons for this show is I'm trying not to do that in my clinic. I only want to put people on it if they're going to benefit because i don't know i can look them in the face after I've taken a couple of thousand pounds off them, and the treatment hasn't worked if I didn't do my best to assess them beforehand. Before we get on to all that, Sarah's actually just sending a question about NICE guidelines and traction. She says she's used a teeter table,

an inversion table, to good effect. Have you ever tried those? Do you have the same opinion of them as you do about traction?

Rob Shanks 08:27
Well, as Sarah says it's worked well for her. I think it can work well, it can work in the right circumstances for the right people. So I don't have a negative view of traction, per se. But what I also think, is that this works even better than traction. So o often you'll see the phrase IDD isn't traction, and it's true, it's not traction, but it's a bit like saying, that the first generation of Nokia phones aren't the same as the latest iPhone, that there's some similarities, some baseline similarities, but this has got a lot more sophistication behind it. A lot

Steven Bruce 09:01
I'm with you on this thought that NHS assessment of traction is based on just applying traction as a blanket treatment for people with low back painWhat then is your process for assessing a patient who you might want to put on the IDD?

Rob Shanks 09:18
for me, we'd always assess the patient, assess the individual in front of you, see what stage they're at. To give you an example, if I have a patient who comes in and they're literally just presenting with, let's say, radiculopathy is IDD going to be the very first thing I'm going to say to them that they need to go on? Not necessarily, because we do know that a lot of disc protrusions will resolve themselves within six to eight weeks, quite happily.
Really. What I'm interested in is those people that aren't resolving in those six to eight weeks, they're the ones who are going to maybe push towards IDD, and then my process will be as we'd always do, clinical assessment, MRI analysis, making sure that the clinical symptoms match the MRI scan and making sure there's no contraindications. And if that's the case, then IDD therapy is something that I would often properly.

Steven Bruce 10:08
We're only going to be looking at lumbar problems today. But of course, the IDD machine can be used for cervical problems as well. I don't know what success you've had there. I've heard it said that it's even more successful with cervicals than lumbars.

Rob Shanks 10:19
I think it depends on which clinic you talk to, but , certainly it can be very successful. Very successful. So cervicals as well as lumbars,

Steven Bruce 10:24
. So a patient comes in, they've got low back pain. You've been through your normal assessment, you think that potentially IDD is on the cards. Is your first resort to send them for MRI?

Rob Shanks 10:36
Well,you mentioned low back pain, of course. the radiculopathies may not present with low back pain. It might simply be pain the legs. They may or may not have low back pain, but if I'm suspecting, as I said at the beginning, a discogenic cause for their symptoms, that's,

that's really my start point. So whether that's discogenic Low back pain or whether it's discogenic radiculopathy, that's my that's my entry point. Is to thinking, right? Let's, let's see whether we need to go further with this and assess them. And often the MRI would be the thing to send them for, correct.

Steven Bruce 11:05
The guidelines for IDD say, I think, that the MRI has to be more recent than nine months.

Rob Shanks 11:11
Something like that.

Steven Bruce 11:13
I mean, that's that for a lot of patients, if they've got a 12 month old MRI, and they'll probably be thinking, I don't want to pay for another one, because, by and large, they're probably going to have to pay for it, unless they want to wait another 12 months.

Rob Shanks 11:23
. So , absolutely, we do get that mentioned a lot of the time. I think it comes down to common sense. So nine months, but if their symptoms have suddenly changed in the last two months, then it makes sense they need a fresh MRI. So things can change and evolve all the time. Things can get worse, things can resolve. But, if you ask me, if I had a patient who had a 12 month old MRI, would I be happy to go with that as the analysis, provided their symptoms hadn't changed during that time, and particularly if they'd had a long history of familiar kind of things going on then, potentially, yes, I would probably start by looking at that MRI, and then, and then I'd make a decision as to whether or not that was good to go on,

Steven Bruce 12:08
you probably know what was going through my mind there. It that if the manufacturers or the people who sell this machine say MRI has got to be within nine months, and we do something, and it goes wrong, and it has the potential for pain to get worse, because any treatment does, would we then be held culpable because we hadn't followed the guidelines? What you're saying is, if you've got a rational clinical assessment, which says, actually, there's no reason for a new MRI, we can run with the old one, then that would we hope be acceptable?

Rob Shanks 12:34
I would hope it would be. Obviously, look into the legals yourself, because, I don't want anybody to take my just to take my word for that. But it comes down to logic, like you say, and equally, the other way around, though, just don't just take a blanket X number of months, because, like I said, you really have to delve and go into detail and ask people, has the symptoms changed? Because why is it if they've had it nine months ago and it's only now that they're coming to see you, why is it taken nine months to come and see you? Has something happened? Has something got worse recently? Have things changed? Again you could be inquisitive about that, because, if something's changed severely, and , significantly in the last month or two, it may well be that they need a fresh MRI, even though they had one, even six months ago. You just have to be sensible

Steven Bruce 13:15
With something changing as rapidly as that, would you be more concerned about sending them off surgery rather than

Rob Shanks 13:20
depends on what the changes are

Steven Bruce 13:24
Let's exclude cauda equinas. And we've done shows on cauda equina in the past, and hopefully everyone would know how to recognize it. If they don't, they should watch the show that I did with James Booth, because there's a great assessment tool for that and a great way of getting it across to the NHS to make sure that people get the right treatment. We had somebody in here on Saturday during the course, and was saying that he'd referred somebody with clear ces symptoms, and they were just sent away. Told that the Osteopath was talking nonsense.
I don't want you to do a full assessment of an MRI, but Should we have a look at your way of running through an MRI and see with the things that you would look like? Now this the one that we've got here, is just a general MRI. It's not specific to IDD

Rob Shanks 14:17
So what we've got on the left hand side of our screen is, it's what called t2 sagittal image. So it's a sideways slice, though, through the middle of the body. So this is the front of the spine. This is the back.

Rob Shanks 14:33
and on the right hand side, obviously we've got a what's called an axial, an axial t2 in this case. So that's like the transverse slice now,

Steven Bruce 14:40
and you're always fond of pointing out to me that with that axial slice, that what is the left hand side to us is the right hand side of the body, because we're looking up the body up,

Rob Shanks 14:53
we're looking from the bottom up was yes, we looking from where that green line is.

Steven Bruce 14:58
We've got two frames up here. That green line is shown on is the exact corresponds to that axial slice.

Rob Shanks 15:05
It does. so I've just briefly chosen this this slice simply just to point out, a relatively normal segment. And what we would like to see here is that sort of kidney bean shaped disc. And then we're just going to scroll down a little bit, so go to bit lower.

Steven Bruce 15:21
Now on the on the left hand panel, you can see that there's a bulge there. So would you be immediately drawn to that or so,

Rob Shanks 15:26
So what we can initially see there is, like, you say there's a forward slip of that, of that, of l4, isn't there? So we're looking like it's probably a spondylolisthesis. First thing we wanting to think about in terms of ID suitability. Could it be an option, actually? Is that a lytic spondylolisthesis, or is it just a degenerative one? So that's going to be a key question. They're quite hard to get your eye on those ones. So I would probably then also want to refer to the radiologist report. So I would always want to see not just the commentary, maybe from the surgeon, or from the GP, but with the actual radiologist report, because that's going to be the definitive have they or haven't they got a lytic?

Steven Bruce 16:06
How easily do you find it to get hold of those, the imagery and the report?

Rob Shanks 16:11
Me personally find it relatively easy, because I know the channels and I have the connections to get to it. It can be it can sometimes be a bit tricky. But my biggest tip for anybody would be ask the patient to try and do the do the pushing, because they've got a right to have a copy of their MRI report. Probably the best thing to do is try and get in touch with the centre where they had the MRI scan done as their first port of call. So get through to the imaging department. So, I had this scan, can I please have a copy of my radiologist report, and then, obviously, then, in terms of getting the images, depends on where they've gone, sometimes a lot of the places now to automatically send online links to the images, which the patients get, less likely to happen in the NHS, but it is still possible, if you keep pushing,

Steven Bruce 16:55
Interestingly, we've managed to achieve that with the NHS. So anything, certainly in this, CCG, we are able to get hold of the images, and they do it within hours. And we have a relationship with VISTA scan as well. So we've got to log in with VISTA scan, so anyone who's been scanned by them, they can send the results directly to us. Most people, most osteopaths, I think, would say, well, sod all this looking at the pictures. I'm going to look at the radiologist report, because I understand that, and I don't understand all this black and white stuff

Rob Shanks 17:25
I think, I think that's definitely very important. I certainly wouldn't be saying, look at the images in the absence of looking at the report. Definitely need the report 100%. It is a special interest of mine, but I would always encourage people, if they can, to try and look at the images themselves, just to build up that library of normal versus abnormal. And it's like anything when you start off as a therapist, you do assessments, you feel patients, backs and spines and bodies, and the more you do it, the more familiar you get with it. And the unusual then stands out more and more so. And then there'll be sort of little things on those scans that may may not have been written down. So things like, how good are the musculatures around the spine? And that's not necessarily of interest or that much interest to the radiologist, but it probably is a lot of interest to us as therapists. So small, little things like that are worth trying to think about. so , so we can look at this - this in our mind. But then as we

scroll down, looking at this section here, this section here, that little slip forward. So this looks like a grade one spondylolisthesis. It's no more than 25% slip. But then we want to see, what's happening at that level? There we go. So what's happening at that level. When we get the images, there we go. So we get that actual slice now in line with that disc. And if you can remember the image I had before we had that kidney bean shaped disc, we now lost that kidney bean shaped so it's now we've got it. We've started to see a little bit of broad based disc protrusion. At the moment, the central canal doesn't look too occluded. But we're not just interested in that. We're interested in the exiting foramen, where the where the nerve roots are emerging.

Steven Bruce 19:06
When I first looked at these, I wasn't aware of this. But here we've got the spinal cord and those little white bits going out to the left there and the right, those are the exiting nerves. Is that right?

Rob Shanks 19:30
Well, not quite so. So what you need to do is look at the foraminal sagittal view. So what you're seeing, I'll just bring that up on screen. Let's go to the left side so we can see that first. So what we're looking for is there. So there we can see the nerve on the patient's left hand side. The dark thing's the nerve, the white thing is cerebrospinal fluid, and the fat around it. So that's all looking for how much occlusion is around that nerve root. And on the left side, it's not, it's not too occluded. And what you're seeing, what you've got to sort of get your eye on here, is that what you're looking at on the axial image is just the front to back dimension, but we're also interested in the sort of north to south dimension, because that's often where the compression happens. So now we can see what's happening on the right side, and hopefully we just come down a little bit. Now we can see there's a difference. So now we can see the nerve, we can't see much of the perineural fat around the nerve. And you can hopefully appreciate there's a lot more occlusion going on that side. So , potentially, we're looking at probably an l4 radiculopathy on the right hand side. So if the patient's coming in with that type of distribution in the right leg, I would be suspicious that, this is now something that might be amenable to IDD.

Steven Bruce 21:18
If you see inflammation of the ligaments, ligamentum flava intervertebral ligaments and so on, is that something which you think will be aggravated by IDD?

Rob Shanks 21:34
it's something we will certainly want to be aware of, and you're right to say that the stir sequence is the one to highlight that. So just for those who don't know, STIR sequence is a fat suppression sequence.
So this is a stir sequence now. So what we can now see is that the subcutaneous fat has been darkened. So anything that's bright now is fluid, it's water. So obviously we can see that highlight the nucleus in the disc, more so than on the t2 and we can see those middle three discs there, so L4-5,3-4, and 2-3, that they're dehydrated. But what you're referring there is if we if we were to see lots of white in the interspinous ligament area, that would indicate potential ligament inflammation, as you say, which then also could make me think this might be an unstable segment. There could be some symptoms coming even from the

ligaments themselves. But also, if there's edema, swelling in the ligaments, it probably means that segment is somewhat unstable. And then you're right, that would be making be that would make me be thinking, we might have to go quite light on that particular patient.

Steven Bruce 22:43
they can also contribute quite a lot to nerve occlusion. Can't they?

Rob Shanks 22:48
Well, yes. I mean, depending on which ligament is involved, like ligamentum flava, for example. Yes, that can, that can, that can cause nerve root compression and irritation - chemical irritation as well as mechanical irritation.

Steven Bruce 23:01
That's a very quick run through on there. And obviously you're, you're rattling off your expertise as though we all understand it. Is it sufficient for someone who doesn't have your expertise, just look at the report and say, this report doesn't have any of the contraindications on it?

Rob Shanks 23:14
So by and large, yes, the only bit of caution I would say is that, sadly, not all radiologists are the same, and sometimes you do see reports that I've seen reports over years that are missing certain key findings. So I'm not saying don't trust the MRI Report, by any means, but I'm simply saying just have it in the back of the mind that if the patient is presenting with something that doesn't seem like it's mentioned on the MRI Report, have a high index of suspicion, and don't be afraid to ask for a second opinion.

Steven Bruce 23:45
No, they're usually quite responsive if you ask for an explanation.
Very quickly, before we move on and do some practical would you just like to quickly talk about contraindications to IDD?

Rob Shanks 23:57
I've mentioned one already, so, if you had a pars defect, for example, that was a lytic spondylolisthesis similar to that. We think about bone density. So osteoporotic patients, you want to know
a. have they got osteoporosis, but
b. crucially, what their what their T score is, as it mentioned on screen here. So, severe osteoporosis, DEXA scan, it is on the official contraindication list of IDD therapy, if that T score is less than minus 2.5

Steven Bruce 24:27
there's the obvious cancer related things like tumors
Sequestered, I think some people call it sequestrated, a free floating disc. Why is that a problem?

Rob Shanks 24:38

So the reason that's a problem is because if it's separated from the main body of the disc, there's nothing, if you like, to decompress with regards to that actual free floating segment. So you're not going to influence, directly influence that particular free floating fragment and the other worry is where that free floating fragment could end up, getting lodged in a place you don't want it to, and we don't want to get the blame for having having done that.

Steven Bruce 25:07
And another obvious one, perhaps, is if there's surgical hardware in there, we don't want to start messing around with that, with traction.

Rob Shanks 25:15
That's right, especially if it's again, especially if it's recent as wellwhich would mean six months.

Steven Bruce 25:22
Shall we go and have a look at our patient? , we've got Georgie. Georgie is an osteopath and is involved with IDD assessment in my clinic. So, Georgie, thank you for volunteering this evening. Welcome. Show us what you would do in clinic.

Rob Shanks 25:38 so let's have you standing Georgie, so before the patient gets on the bed, we do our observation exams and all that sort of stuff, and look at spine, spinal curves that goes without saying. But with regards to what we're looking for IDD in this position, I want to have a quick little look at what her power is like in her leg. So if we get you to stand on tip toes, Georgie, and then just walk forward and backwards for me, brilliant. great. So we know that S1 is looking like there's no issues with that. And then I should just do the same with you on with your heels, walking on your heels. So again, now we're testing the L5 myotome, brilliant.

Steven Bruce 26:13
What do you do when you think there's a problem with L5 but that didn't show up on the MRI?,

Rob Shanks 26:17
Well exactly. So, so this is what I'm saying. So if you've got that report, if you if you have that report, it doesn't mention the L 5, and we see a finding like this, then we're suspicious. Oh, maybe there's something that's not being mentioned or we're not seeing on the scan. It's quite rare for that to happen, I would say. But , absolutely, that's, this is where you've got to be inquisitive the whole time.

Steven Bruce 26:37
But quite often you might see a problem on the MRI, which isn't reflected in your examination

Rob Shanks 26:42
That's right. It's more likely to be that way around. The next thing I would do is I'd ask you just to do a little bit of squat for me. That's it. And then I just went to try and take the weight on one leg and then the weight on the other . Now the reason why I'm doing that is because,

let's just say we had an L3-4 nerve root, compression. And if we're asking the patient to resist with our hand, our hand is generally a lot weaker than the patient's leg. So again, I've had it in clinics sometimes where you think there's no deficit, no issue, but you get the patient to bear their weight, which is a lot more, power, and then you then you can see something, ah, again, a bit weak on one side and the other, for example. So it's just a bit of a better test, I would say, doing it that way

Steven Bruce 27:23
I've never seen it done that way before.

Rob Shanks 27:27
it's one I invented. But because the issue I had earlier in the year and that was only showing on that particular test. So I ended up with a spinal fusion, I had an L3 compression and if somebody tested my power of my legs, they couldn't notice it, but I couldn't go down the stairs on one leg and I could feel it, and that test was positive. So before my surgery I couldn't take the weight - I'd collapse like that. But if you test me clinically, and you push against my leg extension, it seems strong, as with the other side, but when you did that, it wasn't. So that's why I always include that now with my patients. so we'd probably then just want to look at hip flexion, so just to pull her knee to the chest, nice and strong, brilliant. And then the other side, look at the upper nerve. And then I would also want to look at the reflexes. So we just do L3-4, again, good. And then I would normally come around the other side. But just for the demonstration on the camera, I'd want to do something similar. So we do something like this, good, and then we're going to do just the ankle jerk, and you want to include, whilst we're here, just the Babinski, plantar response. That's perfect. And then I would also just do a quick little light touch sensation. So can you feel that? , all the way down to the same, into the legs as well. Yep, and the toes. Nothing down here.

Steven Bruce 29:16
Do you ever use neurotips, or do you just use soft touch?

Rob Shanks 29:19
I would do, especially if I was a bit suspicious, then I would get the neuro tips out and try and map it out and see does it fit a particular dermatome. And the one I always also do as well down here, we have done it with the heel walking, but just to be a bit more specific to the L5, I'd get her to bring her big toes up. Just hold that here, nice and strong, brilliant. And now pull the toes down. Think about S2-3, that sense, testing that toe flexion. And then we would then do a neural stretch test. We do our straight leg raise? We ask the patient how that feels. Obviously, if they were getting a nerve root compression, we might expect to see some sort of pain around here, which I would then probably check again with lifting the head or pulling the ankle up to see if that's neural tension rather than hamstring, and also the other side as well.
And then what I would also do, I mean, apart from doing the regular mechanical assessment. So we're particularly talking about IDD and neurological I'd lie the patient on her side. I probably want to have a quick look at the femoral nerve stretch as well. So you hold onto your knee, Georgie, and then we're going to bring your top leg just back a little bit. It's almost like a modified quad stretch. But we're pulling down the femoral nerve roots, and if she was getting some sort of radicular pain down here again, I would ask her to drop her

chin to the chest, just to see if that accentuates it or not. So I get an idea of any neural tension signs on there as well. With all that said, even if that was absent, that wouldn't rule it out. Again, coming back to my personal experience, I never had a positive femoral stretch test. Because mine was a foraminal disc protrusion, and evidently they often are negative in your stretch, I learned - amazing what you learn when you're when you're injured.
And then last little thing I would do is just a general, particularly for IDD, if I'm going to start stretching those segments, I want to get an idea as to how mobile or not they are. And let's say I've already got a bit of an idea where I'm going to be targeting, let's say L4-5. I particularly just get a sense of how's the L4-5 moving? How is it relative to L5-S1 all those sort of things, because that's going to possibly have an influence on the pulling force I use. So if I felt a really floppy segment, for want of a better word, I would probably tone down the pulling force, and potentially the opposite if we felt the opposite. And then obviously, from there, you can do all your regular other general assessments in terms of muscles.

Steven Bruce 31:52
What's your thought process? When a patient comes to you, they've got low back pain, they've had manual therapy, and it's not made any difference, they've got an MRI, which is unremarkable. You've got unremarkable tests here. Would you try IDD?

Rob Shanks 32:08
That's a good question. Probably not. But my first instinct, though, would be, when you say unremarkable MRI, is that based on the on the reports? Was that based on my assessment of the images? So the first thing I would personally do in that situation would be, even if the patient was coming in and had an unremarkable report, let's say, but my examination was hinting that something might be going on, I would want to scrutinize that MRI personally. But even if things were absent, even say the clinical signs were absent, and we just weren't getting that patient better. I was still personally go and scrutinise them. Because I'd be thinking, is there something going on like an annular tear that's hanging around that's, doing something that means we're not getting better?

Steven Bruce 32:53
And again, I'm not looking necessarily for reasons to put people on the IDD table. I'm looking for, the those you'd exclude for reasons like that, perhaps. Are we done with Georgie?
So what we're gonna do now is, we've got Rachel on the IDD table already prepared for you. So we'll look at how we set a patient up. Before we go and deal with Rachel, would you like to just explain what we're seeing on the screen here?

Rob Shanks 33:36
indeed. So , so the top figure we've got there, 69 that's our high tension pulling force. That basically means the top tension which the machine is going to pull at. So we look at the graph, you see that the height of that graph, we've got the little wiggly lines. 69 corresponds to those peaks,

Steven Bruce 33:56
And the bog standard setting is half body weight, less 20 pounds.

Rob Shanks 34:02

That's the default of what, how we would start somebody off the first session. And obviously, then over, usually, over the course of the sessions, you're progressing that tension up upwards.
And then underneath that we've got the treatment time, which is 26 minutes.
The progression time, 120 seconds, basically means, how long are we taking from zero pulling force to get up to our target pulling force. So how long it takes to go from zero to 69 and in this case, we've punched in two minutes, 120 seconds.
The regression time is simply the time it takes to go from that 69 down to roughly half of that, to what we call the resting tension, the low pulling force.

Steven Bruce 34:40
Now, basically we don't adjust those figures. It's always set for 120 progression time in the middle there and 26 minutes total time at the top, which means we get 13 cycles and a fairly gentle , increase to start with. So is there any reason to change those?

Rob Shanks 34:53
Not really, no. And as you say, what you want to do is a very nice, slow, gradual increase in that pulling force, especially at the beginning, where they go from zero pulling force.

And then what you can see underneath there is, we've got oscillate, which has a number five in there. So that just refers to the little wiggly lines - we're going between, 69 and then taking five pounds off those peaks. So going to 64.

Steven Bruce 35:31
I like to think of that, as being a sort of a pumping action,

Rob Shanks 35:35
so that's the patented oscillatory function that we're talking about. So when you about oscillatory distraction, that's what it refers to, and that's actually a patented feature of IDD therapy. So there's, there's several different machines, spinal decompression machines, that are out there, but this particular feature is something that's exclusive

Steven Bruce 35:52
So if we stop you moving on there, because I know you move on to something else in a minute, but let's just have a quick look at what we've done with Rachel. Normally, obviously, we would go through the setup process here in the clinic. What we've done is we've got a lower harness, a pelvic harness and a chest harness on here. This is done up fairly tightly. There's a strap that comes out underneath Rachel's head, and it's going into the top of the machine, where it's cranked down very tight.

Rob Shanks 36:14
That's to stop her from sliding down the machine. Anchored in, is it?

Steven Bruce 36:17
It is. It's all anchored in. What do we do with this bottom harness?

Rob Shanks 36:21 so we have the bottom harness connected to this thing called an O ring, and all we're going to do is simply connect that to the tower. And then that's going to be the thing that actually connects her, and actually pulls her down the bed

Steven Bruce 36:39
From the patient's point of view, they've got the security of having this emergency button on their chest, haven't they, so if the patient at any time is unhappy, they can press that and it will just gently stop from where it is.

Rob Shanks 36:53
Now, before we actually start pulling we've got to set the angle. So what you can see on here is there's a series of numbers from 30 down to five. And if we use one of those, there we go, we get a bit of a movement on the tower. And this now is going to set the angle that we want to pull at. And what this refers to is what, which segment we're going to target. So I always just double check that with the inclinometer to make sure we are ok - 50% of the time I find it's incorrect. It all depends on, where, how high the beds been set on, that sort of thing. But, in this case, we're on the bang on 15 degrees. So in this case, we'd probably be looking at targeting the L4-5, and on 15 degrees. So the higher, the higher you go with the angle, the higher up the spine you'd be targeting.

Steven Bruce 37:39
How precise do you reckon it is?

Rob Shanks 37:43
it's like you say. It depends on the there's always gonna be a slight variation thing on the size of the patient and all those things. But it's a rough, rough estimate of where you're zoning into.

Steven Bruce 37:57
Rachel doesn't actually have a back problem, so we're allowed to practice on her, our guinea pig. So what comes next?

Rob Shanks 38:03
so next, we're happy. We're set up. I just want to always just do a little double check make sure I'm happy with the tensions on the belt. Everything's all secure. Patient's happy. We're happy. We then press next, and then we ask Rachel just to press that stop button to make sure that is connected, which it is, and then we can start our session. And what we'll see after a few seconds is a red line, hopefully emerging on the screen, and this is now showing us what's happening in real time. So the patient is just lying there, passive. The blue line is the course that we're plotting for that particular session. And hopefully, if we can see that, you can see on the screen that red line.

Steven Bruce 38:44
Let's say this is our patients first session. We decided half body weight, less 20 pounds, is about right. We could go more gently if we had some of the things you talked about earlier on. We're going to increase that over the course of treatment. What's the the maximum tension you're likely ever to reach with a patient.

Rob Shanks 39:05
So the maximum advised tension is half body weight, plus 20 pounds, right? Sometimes 25 pounds

Steven Bruce 39:11
But that would be a gentle progression over something like 10-20 treatments.

Rob Shanks 39:15
Absolutely. You'll be able to add a couple of pounds each time. And obviously, we listen to the patient when they come in each time. Is it ok to add that tension, or is it not? Sometimes you have to take the tension off. So it's always a continual kind of review and feedback.

Steven Bruce 39:32
It's actually quite, despite the noise of the tower, it's quite a relaxing process. Do you stay with your patients, or do you leave them here so they go to sleep?

Rob Shanks 39:41
So first session, I tend to stay with them unless they want me to go out the room. But generally speaking, thereafter, once the patient's happy, if they're relaxed, as you say, most patients, most patients, have a little snooze in the relaxing machine, and they find it very gentle. And I'm just literally next door keeping an eye on them. And literally I can hear them if they want me to come in. But generally I just leave the patients to relax once they're happy.

Steven Bruce 40:03
So Rachel's being a good guinea pig, because the light the red line has followed almost exactly the blue line, so it's mapping what it should do, and it will now start to wiggle a little bit. Now we're not going to go through this as we would normally do, but there's an added feature on the side of the table here, where we can release the bottom of the table. Now we were told you do that after the second cycle, but you don't do it until after the fourth treatment. Is that largely up to the operator? Or is there a reason for your cautious approach?

Rob Shanks 40:34
The Reason for my cautious approach is because when you do release the bed, there is about, effectively, a 25% increase in the relative pulling force for the patient. So for some people, that can be quite, quite a lot, particularly if they're, hyper mobile or if they've got anything particularly inflamed around the body. So I like to do a more, slower, more gentle introduction. And then what I usually do is add on a few - one or two - pounds each time they're coming in, but not release that bed until they've had four sessions and they're still happy the machine is reaching the tension you've set.

Steven Bruce 41:11
Why does this make a difference? Doesn't it just take less effort on the part of the tower to get to the same tension?

Steven Bruce 41:20

I mean, this has come up to full tension. It's come up to 69 pounds. if we undo the bottom of the bed so that it can slide, it will still only go to 69 so what's the advantage?

Rob Shanks 41:30
Well, there's yes and no. So at the moment, what's happening is, yes, it says 69 on the screen, but there's a certain amount of resistance within say that the harness and the bed itself, so it's kind of taken all that slack. And certainly when you release the bed, the patient definitely feels an increase in the pulling force

Steven Bruce 41:55
Rachel, your foot is jiggling a bit. Is that just you being fidgety? Or shivering? So long as you're OK.

Rob Shanks 42:02
When we release that bed that literally, as they say, everything's now completely free, not being, not being, resisted by the bed itself. So more creaking as the machine sort of adjusts to catch up. But what will happening now is there will be maximum distraction happening in their spine, so then things will actually be opening up and separating. So the lines always go off a little bit initially when you first do that, because the machine has to sort of work out and catch up with what's going on. But once you get through that next cycle, you normally then see the lines coming back in sync again. But that that feels like more pull, doesn't it?

Rachel Hill
Yeah

Steven Bruce 42:44
still comfortable?

Rachel Hill 42:46
Still comfortable, but stronger.

Rob Shanks 42:49
So for us, that's why we personally like to just leave it until at least a session or two after the first session. Because the thing we worry about is if you, if you added on too much force, too quick, then very, very occasionally you have a patient who comes off, and they're a bit sore they come off. And since we've been doing it in this way, being bit more cautious, a bit slower, we've had much, much less of those scenarios.

Steven Bruce 43:16
it's amazing, actually, that it makes such a difference simply not releasing the bottom on the table. And I think, to be honest, basically, we follow your protocols whatever we can, because if you're doing it and getting good results, then that's what we want to do.

I've got some questions for you. Sue says, What does it feel like from a patient's point of view? So let me come over somewhere where you might actually reach my microphone. But what's it feel like from your point of view?

Rachel Hill 43:39
It's fine. You can feel the tension there. It is quite tight. Especially with the table release. You can sort of feel that difference there. The main thing is just being in the harness and everything that is all quite restrictive.

Steven Bruce 43:52
you've been sitting there for a half an hour. It is quite tight, isn't it?

Rachel Hill 43:57
is quite tight. So I think, really, from that point of view, that's probably more, from my point of view, is the fact that it's just very restrictive around this sort of midline, but the actual stretching side of it

Steven Bruce 44:10
I've. put a few patients through this, but you've put lots more than me, because it's your primary functions here. But have you ever had anyone who's complained about it being uncomfortable?

Rachel Hill 44:17
I've had some patients say, especially if someone's very, very petite, for instance. Then this harness can get sort of stuck around the ribs, and they can find that a little bit uncomfortable.

Steven Bruce 44:27
It's kind of got to get stuck on those ribs, hasn't it? Because that's what's keeping them at the top of the table.

Rachel Hill 44:31
exactly. So, sometimes I can use the towel or something just to pad that out. Still get the tightness there, but it just makes it more comfortable. And then I've had the opposite of patients, where it doesn't grip as well. If they're bit larger.

Rachel Hill 44:49
it's the opposite way then, because then this top harness is struggling to grip

Rob Shanks 44:54
remind me to show you later this alternative way, how you can put the harnesses on inverted. To create, like, a funnel shape, and that way, then you can, even if the patient pulls down the bed, it catches them, that can often be a bit more comfortable as well.

Steven Bruce 45:09
So what other questions? It seems you annoyed somebody earlier on! Tish says, slipped disc. In her opinion, you should never say a word like that.

Rob Shanks 45:25
I did say layman's terms!

Steven Bruce 45:28

We actually put out a brochure from my clinic saying you do not have a slipped disc. Because, actually, I think patients are frightened by that expression sometimes, but it was layman's terms.
Simon wants to know if you've ever come across a McManus table for traction and he says his family practice has used McManus tables for over 40 years with great success.

Rob Shanks 45:49
I mean, that's reflects very much my experiences in the early days. I mean, I was, before I got into IDD, I was using those type of traction tables, similar to the flexion distraction table, but it's a bit like a treatment couch that separates and can have that traction type function, without having hands on the patient, but it's like I said earlier, for the right patient, traction techniques are really good. We were using them for a couple of years before we got into the IDD, but I was inquisitive, and I thought, well, we'll try it and see if it's any better than what we're doing before. And I found that it was better. So that's why I started.

Steven Bruce 46:27
I'm not using McManus table, but I've seen some of the alternatives for just plain straight old traction. And of course, they're possibly quite good. They don't do the oscillation. They can only be a general traction force, can't they? Because there is no variation in angle.

Rob Shanks 46:41
some of them can have a slight variation angle, but not, not in the same way this does.

Steven Bruce 46:45
And to keep, keep it up for the length of time this machine does, and apply that traction, I think, is possibly its selling point. And the oscillation, as you say.
So what other considerations have we got here? I was going to ask about what you do with obese patients, because it is hard to get a grip with them. But we haven't got time to demonstrate how you might fit that top.

Rob Shanks 47:09
So we have a well, perhaps off camera is there's a range of different harness sizes. So that's the first thing. So there's like a small, medium and large. So some of the larger patients would need that larger harness. But the other one, other thing you can do for particularly large is, what we just started using recently, is you can get, like a like a seat belt, which you can then wrap around them and that can add some extra if you can't quite get the grip you need. You can then put these straps around them and grip them as well.

Georgie McGahey 47:39
Actually, I was gonna ask about treatment time. we speak a lot about kind of, how many treatments and just kind of managing patients expectations, how would you go about that? Is it as long as it takes, or is there a kind of required number of sessions?

Rob Shanks 47:53
So, we get asked this quite often, and the original protocols were based around a 20 session treatment program. And what I start off by telling my patients is to say, Listen, if you want to get, the best result from it, that's where, if you look all the patients and think of a bell curve,

that's where the majority of them would fall. That would require that type of number to get the maximum or optimize the outcome. With that said, you will have some patients who are better than that, and some patients are slightly worse than the outliers, let's say. And the best example I had of that was a gentleman who sticks in my mind well. I actually turned him away. I said to him, I wouldn't even bother. He came to me wanting IDD. I looked at the scan and I said to them, this is so bad, you need surgery. Please don't waste your money with me. Just go have a surgery. And he insisted, and he was actually symptom free within seven sessions.

Rob Shanks 48:56
It's not a crystal ball. You can only give them your best theory of what you think is going to happen. But reality can be different sometimes, and you can have the opposite result. You can have somebody who thinks a textbook case, and whatever reason, they don't have the outcome that they want. So do explain to people, it's about two out of three people will respond very well, and the majority of them are going to need around 20 sessions. Some a little bit more, some a bit less. But , the minimum that I've ever seen somebody literally turned around in is about six or seven. So I personally say, unless you're going to be in it for six or seven, don't bother. think of six or seven as a minimum. But don't expect it to be because that's only for probably 5% of the cases. if you're going to try it, you really got to be prepared to give it a good 20-odd sessions.

Steven Bruce 49:55
On the subject of treatment protocols, if you like. I mean, we've actually read. We started, almost from the outset, saying, Well, if you're not going to commit to 20 sessions, we're not going to see you. Because there is a there is a history, isn't it? That some people get better, and they'll think, I don't need any more IDD. They'll go away. They'll then deteriorate again, and then they'll say, IDD doesn't work, which isn't the case, because they needed that extra sessions. Or equally, there's those who get worse and think IDD is not working, but if they go the distance, they get the results they want.

Rob Shanks 50:24
That's a very, very valid point.

Steven Bruce 51:15
Rachel, we're gonna leave this. We would never leave a patient to unhook themselves from the machine, but you're happy for us to leave here while we go and chat more about the process, Rachel, thanks for being a Guinea Pig. That's been great, and I'm sure you're much better after that very short, single session.
Now, obviously I have a different policy to you. I don't say six or seven sessions

Rob Shanks 52:01
And that's the only way doing it absolutely. That's what's what I do. But, but you're right. The expectation should be that it, the should be trying to commit to those 20 odd sessions. We've actually started to evolve that even further. We've we did a category one, Category Two, category three. So category one, being broad based, disc bulge, probably going to need 20 to 24 sessions. If it's a category two, which is a focal disc protrusion hitting on the nerve root, it could often be a bit more than 20, near it towards 30. And if they've got severe problems,

they've got, say, a double level, or there's multiple pathologies going on the same segment, they're probably going to need more than, even more than 30 sometimes. So, I've learned over the years, there's some patients who we get gave up a little bit, little bit too early, and some of the ones that we've now started to do the 30 sessions with actually, actually, then only get that improvement happening between the 20 and 30.

Steven Bruce 52:51
So we've,we've noticed with some patients that the improvement happens quite suddenly. At the end of that protocol, there's not much difference, and then suddenly they start to feel it.

Rob Shanks 53:03
That's a very common experience around the country.

Steven Bruce 53:07
CB says, Is there any recent research to show how that IDD works? When I last looked says CB, they couldn't find any.

Rob Shanks 53:15
So, there are studies that are out there that have investigated it, but there probably isn't the volume and the quantity that we would like, but there's various reasons for that. But there are. I mean, if you go into the I think it's IDD therapy.co.uk, there should be some articles there, and some studies that have been done, one in particular was done with patients with non-specific low back pain, and that didn't have a great result, understandably, because they hadn't selected the right patients. But there's certainly some others on there which have shown good outcomes as well.

Steven Bruce 53:48
I think I might have mentioned you already. I'm trying to set up a trial myself, with the help of Jerry Draper-Rhodi, who's been on the show and he's coming back on again next year. Great guy to talk to about research. You must know him, I'm sure. And I'll certainly look to you for advice on how we run that trial, if not involve you in it, with your own clinic. Of course, funding will be the key issue there. But I am surprised that, given that this has been around for quite a long time, principally in the States, and there are clinics over there making quite a lot of money, taking quite a lot of money from their patients that somebody hasn't funded a decent trial to prove that it works? ?
Well, tell me what's your success rate? How many patients go away unhappy after their 20 sessions, 25 session

Rob Shanks 54:33
I would say Good. 70% of people have a kind of a good result. So again, I always say to people, listen, this isn't a crystal ball. We can't guarantee it, nobody can, but if you want me to give it in terms of numbers, it's, let's say, three out of 10 that might not be getting the result they would ideally hope for.

Steven Bruce 54:51
But the big selling point, though, is that it's not a knife,

Rob Shanks 54:52
it's not a knife, and all the other options are still on the table. So it's not like, it's not a point of no return.

Steven Bruce 55:00
But then, of course, the patient is saying, Well, if I do this and it doesn't work and I have to go for surgery, then I'm paying much more again,

Rob Shanks 55:06
of course, and that's why you have to be honest and upfront with them about it.

Steven Bruce 55:09
Darcy says patients with acute disc disease would hardly be able to move as they've been agony. Is IDD for more chronic disease?

Rob Shanks 55:19
not necessarily. even patients with acute presentations can respond, in my experience, can actually benefit quite a lot from it. With that said, coming down the question of is it necessary, and given what I said at the beginning, we know that a good percentage of people with acute disc proplapse, if they're wet, nuclear extrusions and stuff, they will improve on their own anywayover a month or two. So it's certainly, I don't want to say more geared towards chronic cases, because that's wrong. Because if you have a patient who says, Look, I want to get better as quick as I can, what can you do for me? Am I prepared to wait six to eight weeks? No, I've got a flight that I've got, whatever it would be, what you do for me to get me better in record time? Well, then that will be something always to offer an acute disc protrusion, but like I said, they may well get there anyway, on their own eventually. So I often try and be bit like your point before, just try and be as honest as you can with the patients and let them know what the likelihood is,

Steven Bruce 56:15
Even so we're not gonna fix them in one week are you so how many weeks does it take to finish the protocol.

Rob Shanks 56:19
Well, like you said, does take time to get through those 20 sessions. They can have it up to four times a week, even something that will even do five a week. So you can go through them relatively quick, but so it still might take that six week period, but it can be a much easier journey. It's not uncommon to find patients, whilst, like you said, they do need that 20 sessions to fill get the full benefit, it's not uncommon, even though they don't expect that, it isn't uncommon for them to feel quite significantly better, even within a few sessions. Or at least, they're not cured, but their symptoms are significantly alleviated, and they're having a much easier time on it.

Steven Bruce 56:58
Not surprisingly, someone Hannah, has asked, how much you charge per session. Well, I don't necessarily want to put you on the spot. In my clinic, we priced up IDD at £78 per session, but we sell it as a 20 session package, which also includes, I'm going to say, six

remedial therapy sessions as well, because that is part of the whole process, isn't it? So the package itself for us cost about 2200 quid. Is that similar to your London rates?

Rob Shanks 57:29
I think it's around about similar rate. I mean, most of the clinics in the UK are charging those sorts of prices.

Steven Bruce 57:37
Mindy says, Why is a pacemaker a contra indication.

Rob Shanks 57:42
So the pacemaker a contraindication because of where the pace pacemaker is placed, usually around the thoracic area. And then the worry is that sometimes it might be slightly off center where that thoracic harness comes through. We don't want any risk of that harness interfering with the wires. That's essentially why.

Steven Bruce 57:59 I reckon the chances are, I think mostly zero, but I suspect that's just one of those “We're not going to even go near this”.

Rob Shanks 58:06
It's on the list that's been given us, to us by the IDD manufacturers. That's right, and I think it's simply because they haven't proven the safety of it. As you said the chances are very unlikely, but they haven't actually tested on patients with pacemakers, and therefore we can't officially say

Steven Bruce 58:24
on the subject of contraindications, Bob has said, Could you use this on someone with, someone with scoliosis?

Rob Shanks 58:31
I would say depends on how severe the scoliosis is. if you're asking me, how I use it on patients with somewhat of a scoliosis curve, yes, I have, if it was a severe, scoliotic curve of the magnitude that would potentially need be needing surgery. I probably wouldn't.

Steven Bruce 58:46
I think, I think it was on the slide that we put up earlier on, but I'm pretty sure, when I questioned them about this, it was a cob angle of 45 degrees, that sounds a lot, though, but maybe they can put the slide back up, because it's up on here somewhere. It says 45 degrees. There's a decimal point in there which is in the wrong place, but I didn't spot that when we put slide together. So it's 45 degrees. So, scoliosis is not necessarily a contraindication,

Steven Bruce 59:19
JS says, Would you know in the first session if IDD is beneficial? Or can it take a few sessions? And I think they're not asking whether they're going to be better, but just whether you're going to get an indication

Rob Shanks 59:30
I don't think within the first session, though. Put it this way, if the patient is coming off the table, even after their first session and their radiculopathy, and this can quite often happen, they feel it easing whilst on the bed, and then they come in for next session they say, actually, I've had a 5-10% improvement. That's probably a good sign. But the absence of that doesn't necessarily mean they're not going to get the result either. So it's a very rough indication,

Steven Bruce 59:58
is that reduction in pain the result of the disc being reabsorbed into the intervertebral space, or is it the fact that there is greater movement achieved which allows the disc not to irritate the nerve

Rob Shanks 1:00:15
I think if you're talking about the early stages, after one session, two sessions, it's almost certainly not enough for the disc to have changed very much at all. I think much more likely what you're doing is relieving pressure. You're opening up that neural foramen. You're changing the pressures and the inflammation around the nerve and related structures. And like you said, it's that oscillatory, that pumping action. You're reducing pressures.

Steven Bruce 1:00:39
Somebody unknown here says was that 20 sessions we talked about over a period of a month. Now, you answered that question by saying they can have up to five per week. Is there? Is there a minimum number that's going to achieve success

Rob Shanks 1:00:54
I'd say the minimum number would probably want to be about two sessions a week. that's what we tell our patients. And we have done the odd one for whatever reason where it's only done once a week, and they have still got on well, but generally speaking, we would say twice a week would be the minimum.

Steven Bruce 1:01:10
So you've, you've talked about one fellow improved after seven sessions, and one here has not gone on quite as well. Who's got worse? And could you blame the IDD machine for that worsening?

Rob Shanks 1:01:27
I would honestly say I don't think we've had, I can't think of any patients that necessarily got worse, grossly got worse, and that we've attributed to the IDD, but we've certainly had patients who hadn't progressed. I mean, I'm a case in point. It didn't work for me. I had a spinal fusion.
I can't think of any where they've actually got worse as a result of the machine, or, they certainly they were in a bad place and just on that trajectory, it would have been,

Steven Bruce 1:01:58
that's the tough one, isn't it. We had a lady on our machine here, who she had a pretty nasty disc bulge, and we had her on the machine, and I forget how many sessions we'd given her,

but she'd made some slight improvements. And then she got a little bit worse, when we adjusted the tension, the traction, and then suddenly she called up and said, No, I had to go in for surgery, because then it got so dramatically worse, she didn't blame us for it, and I don't think there's any way that the machine could have caused that worsening, but it's horrible to have been treating a patient and given them that sort of encouragement and created that false hope, if you like, and then they go to surgery, which, of course, was 100% successful, which is great, but it's not always the case, neither is it. No, that's right. Dave says, Does Rob try a standard course of manual osteopathic treatment with IDD candidates before offering IDD to see if there's possibility of good outcome without the need for it?

Rob Shanks 1:02:49
Yes, this is what we found earlier with regards to the six to eight weeks type of window. So if you have, like I said, in patients that often are coming, especially if it's early stages, we often wouldn't be offering the IDD straight away, lots of times there's a lot of bigger things you can do.
Is often the reassurance and explaining what the what the dos and don'ts are. I think that's very valuable. So again, depends on the patient, depends on the budget, depends on… sometimes we'll do a combination.
Sometimes we'll do the manual therapy before we've tried the IDD. Are they getting there? If they're not, right now, that's another thing we can offer them, if the question round the other way, though, if it's a chronic problem what we often see is most of our patients who are having IDD are chronic cases, who have had problems for months or even sometimes years, and have often done they've often gone round the houses. So they've tried osteopathy, chiropractic, physiotherapy, they've maybe tried epidurals, nerve injections, denervations, and literally, we're the last stop before they tried the surgery. So in those situations, then, that probably, ideally would be the thing that I'm going to offer them, right? ,

Steven Bruce 1:03:56
you've talked about the success rate, but 70% I think you said Carrie's asked about the rate of recurrence after people have completed a course.

Rob Shanks 1:04:05
it's a very good question. So what we've what we tend to encourage people to do? And again, this is coming through just liaising with lots of clinics throughout the country and even abroad, if patients finish a successful course of sessions, I think the first year is the critical time period to get them through, and we encourage them, they don't all have it, but we encourage them to do like a infrequent top up . It starts off with once a month, and then maybe stretches out to once every two months. I try and encourage all the patients to do that for the first 12 months. If they get through that 12 months, they usually want to carry on doing that. And the frequency, again, I'm normally suggesting, is every two or three months of the patients we have done that with, I can honestly say we haven't had any that have relapsed. Now, the patients that don't have that, that had the course then go away, There's a percentage of them who we do see again, and it often is around the 12 months mark that they will tend to relapse. That's not to say that if they don't have the top ups, they will definitely relapse, because that's equally not the case. I've had patients who I haven't seen for a few years, and I catch up with them, and they haven't done my recommendations, they haven't had the top ups, but they're still fine.

Steven Bruce 1:05:28
So those ones who relapsed after a year, did they then have to go through the full course of 20 sessions?

Rob Shanks 1:05:33
Well, ones I can recall, generally not. No, you tend to find a stunted course of sessions would then usually get them back to where they were, thankfully. But , I mean, for that reason, I just try and encourage them to do it, just to try and stay as good as they can be, really.

Steven Bruce 1:05:52
we have had two people ask with regard to the angle of the traction, which we are saying targets a specific level of spine. How much do you have to take into account the angle of the pelvis, or, I guess, the lordosis of your spine? Because obviously that differs, that the angle will presumably target a different area,

Rob Shanks 1:06:11
So the goal, what you're trying to do, and this is part of the reason for the knee bolster, you're trying to basically neutralize that curve as much you can, try and get them so the spine is relatively flat, but it is right to say, yes, if you've got a particularly hyperlordotic patient, even with their knees up, that that, that the angle you think you're coming in at is if the spine is like that, it's different than if they're like that. So you can have you sometimes do have to modify a little bit. We in our clinic, we've actually had a modified knee bolster made. The knees actually right up.

Steven Bruce 1:06:42
So would you do that straight away? Or would you do some sessions and then when I think this isn't working because of the lordosis, let's increase the bolster?

Rob Shanks 1:06:51
yes and no. So, if we had a patient whom, let's just say we were seeing lack of progress at a certain, certain number of sessions, we generally look for about 20 to 40% improvement in symptoms by about session 12 to 15. If we're not getting that, then I'm starting to question things, have I got the right angle, all those things? But even sometimes before that, so that might make me think, right? Do I need to change the angle? Do I need to re-look at the patient. Is something going on there? But even right at the beginning, if I've got a patient who's got an unusually hyper lordosis, or even the opposite, that might make me change the angle slightly from the outset.

Steven Bruce 1:07:35
it's not about you this show, Rob, but Bone Setter says, In your case, what was the reason for IDD’s failure, and was that something that you might have predicted from the start?

Rob Shanks 1:07:48

so in my case, I had an L3-4 foraminal disc protrusion, which are always the more stubborn ones to treat. They're the most difficult to treat and get better, coupled with a rotatory listhesis as well. So I have a particularly difficult set of circumstances to get right.

Steven Bruce 1:08:08
What gave rise to that

Rob Shanks 1:08:11
Basically probably it's related to the fact that when I was 18, had a very bad fall on my back, and I've got a sort of tropic facet on my right hand side. So, my rotations are happening at different angles. I think there's L4, L5-S1 doesn't really rotate, and it was over rotated higher up.

Steven Bruce 1:08:30
We're glad the surgery seems to have been successful.
However, Beck says, Have you had any success using IDD on patients with failed spinal surgery?

Rob Shanks 1:08:39
Yes, we have

Steven Bruce 1:08:41
So obviously, obviously, they can't have had any metal work implanted, because you can't do IDD on those,

Rob Shanks 1:08:46
no, but things like decompressions, laminectomies, those sorts of things, microdiscectomies, for example, as well. Yes, we've done several patients like in those presentations, and often they do go quite well.

Steven Bruce 1:08:56
So they've had a laminectomy, and they're coming to you, they've got their MRI, and there isn't anything to compress the nerve because the lamina has been removed. So what's the principle now?

Rob Shanks 1:09:05
Well,the lamina’s being removed, but often there's what there is also still left, is a broad based disc protrusion, sometimes a central disc protrusion. And although they've removed the lamina in theory, opening up some more space, there's still some compression going on, there's still some irritation going on, there's still swelling in the area, perhaps, and that segment's not happy, so that was still something to try.

Steven Bruce 1:09:31
Mayoori is asked about contraindications. So Mayoori, we did put up a slide earlier on with a full list of contraindications, but you specifically asked about hip replacements being a contraindication?

Rob Shanks 1:09:43
Do I think a hip replacement would be a contraindication? It's not on the list and I wouldn't see any reason why it would be, because the pelvic harness hooks around the iliac crest and not really as much around the hips.

Steven Bruce 1:09:54
Robin says you see any difference on MRI, particularly STIR Sequences before and after,

Rob Shanks 1:10:02
Yes, but not always. So obviously, that's, that's the icing on the cake. And some of the early patients that I did do the IDD with, I actually paid them to have MRI scans afterwards, just as I could check all those things. And in those early cases, yes, we did see it. I'm thinking of one guy who had a dramatic improvement in his disc morphology, and he'd had it for 18 months. But you don't always see it, and that sometimes comes down to that the amount of hydration, or wet versus dry disc protrusion, as I mentioned earlier. So , it's the symptoms we're trying to change, not the MRI scan. But same thing can be said for surgery. Sometimes even when patients have had the surgery, there still looks to be some sort of contact with the nerve, even though the patient's feeling better. So it's not about getting pretty images. It's about getting patients better.

Steven Bruce 1:10:50
Hannah's asked a very interesting question, what do you do with the three out of 10 who don't respond?

Rob Shanks 1:10:57
Then I advise them about the other options. So I'll often try and put them in touch with a surgeon that I would trust, or talk to them about other options like, usually they've tried it already, but potentially nerve root injections, caudal epidurals, those sorts of things. I'm also quite a big fan of prolotherapy as well.

Steven Bruce 1:11:16
Nerve blocks can be useful, surely as a diagnostic procedure. If someone's had one of those. Does that give you some clues about whether IDD is going to work?

Rob Shanks 1:11:25
Yes and no. I mean, it confirms that they've got the diagnostic of a radiculopathy. But usually I think we would know that anyway. So sometimes it's an option if the patient's in a really, really bad way. It's something else that can be added in the mix. But, as you probably know as well, they don't always last all that long. Sometimes, the steroid will wear off after a certain length of time, and it's more about calming down the nerve inflammation, rather than fixing the underlying mechanics of the spine. That's, of course, in the first place,

Steven Bruce 1:12:00
Cost is rearing its ugly head here. Nobody has yet asked how much the machine costs. But JS says, Do you think the price of treatment is reflective of the maintenance of the machine? Do they need to be partly replaced or just maintained? So what is the ongoing cost of running one of these things?

Rob Shanks 1:12:23
I haven't got the figures exactly off the top of my head, but there's various things that have to be done. So every year you have to have a service, you have to have it checked,

Steven Bruce 1:12:31
I think we pay 250 quid as a rolling contract. But that doesn't include anything that needs to be replaced? So

Rob Shanks 1:12:37
every few years you'd have to have the load cell replaced, and that's, that's a significant amount of money.

Steven Bruce 1:12:42
That came as a surprise. They didn't tell us about that when we bought our machine. It happened only a couple of months ago. They said, Oh, you've gotta have this replaced.

Rob Shanks 1:12:50
exactly. And then, and then sometimes other extras that can, something have to be replaced along the way as well. So , there is, there is a certain amount of maintenance that has to be done. Does the price reflect it? I mean, the price reflects the initial outlay.

Steven Bruce 1:13:03
And the initial outlay now is roughly what , roughly £50,000. Including VAT?

Rob Shanks 1:13:09
I believe that does include VAT. I think,

Steven Bruce 1:13:32
So this isn't a sales pitch or any anything like that. It's just you don't regret, I imagine, getting the machines or you wouldn't have bought two, would you.

Rob Shanks 1:13:40
Not at all.

Steven Bruce 1:13:45
Claire, my wife, has said that I should point out, if we do talk about cost, that there are occasionally second hand machines available. Ours was a second hand machine. It was virtually new, but we got it slightly cheaper. But there are also probably grants available to help with the cost. Now she's great at finding grants, better than most people I've ever met, but it's always something to consider when you're buying capital equipment like this. I suppose one of the issues, of course, if you buy one of these machines, you've got to have somewhere to put it. Oh, and, and it does take up a substantial amount of space, which you're not really going to use as a treatment room for anything else, because otherwise it would be a waste of the machine

Rob Shanks 1:14:22

Hopefully you've seen on camera they're big machines

Steven Bruce 1:14:25
And actually, in the clinic, in my actual clinic, because the machine lives here at APM, I think we'd have trouble getting it into the clinic, because it's a grade two listed building with narrow doors and things. So that's another thing to be taken into account, I suppose.

Georgie McGahey 1:14:44
So if you don't own a machine, and obviously you're a practitioner, and you think you've got the ideal candidate. Where could you find out if there are other places where you can refer to in your area

Rob Shanks 1:14:59
On the IDD therapy website. So IDDtherapy.co.uk, there's a, there's a tab on there, I think it's called clinic finder, or find the clinic or something. And you can just literally type in a post code, and you'll come up with all the clinics in the UK.

Georgie McGahey 1:15:11
That makes sense. Because obviously it's a huge outlay initially, isn't it, but if you did think that was going to be good for your patient, then actually trying to find kind of like local practices [is a good idea]

Steven Bruce 1:15:20
And that is a really important factor, because for most clinics, spending 50 grand up front is going to be quite scary, and you've got to have some confidence that you're going to fill the books with the machine to make sure you're actually going to make back that money. And I don't know how you run yours, but I've been to the clinic in Brighton, and the way we run ours is that the osteopaths don't run the machine. Rachel, in fact, runs our machine most of the time. We've got a couple of other people. She's a sports therapist, which means that, she has to be paid to run that machine. So we don't get all of the fees for that. We are covering the annual maintenance and so on. And we are also paying quite a lot of money for Google ads to try and get patients in to fill the books, we're not getting any referrals from spinal consultants or anybody like that. Now, I know you've got some very, very nice tme spinal consultants in London who I've spoken to myself. Do you get all the referrals from them?

Rob Shanks 1:16:18
We get some. We don't get a lot, perhaps, in the volume you might think, despite my close relationship with them, but we do get some, but that has taken several years of getting to know them and developing those relationships. So I think the expectation should be, don't expect to get, get that many from professionals.

Steven Bruce 1:16:40
Darcy's actually asked, it's quite a valuable, valid question. If someone's got an acute disc presentation, and we've stuck them on a table, lying on their back, they're there for 26 minutes. Is that going to be feasible for a lot of acute patients?

Rob Shanks 1:16:56

Funnily enough, it is for most of them. Because normally, if they're lying down and the knees are up, you're opening up the foramen and they're off weight bearing. That's probably gonna be the most comfortable position. Not like sitting, not like standing for too long. And

Steven Bruce 1:17:12
what we didn't demonstrate in there is actually getting on and off the machine - it's relatively easy, because it tips completely vertically, so they step onto it. It then goes flat. They get their treatment. It tilts up again, and they just step off. They don't have to climb up,

Rob Shanks 1:17:24
that's right. And, talking from having been a patient with a very nasty radiculopathy, I was, despite having been in absolute agony with my leg, I was still able to tolerate being on the machine. So most of the time they should be able to tolerate it.

Steven Bruce 1:17:40
Sasha wants to know if you need special training to use the machine.

Rob Shanks 1:17:45
You certainly do need to be trained to use machines. It's not the case of the machine turns up, and that's it. But that will come with the machine - you would get training

Steven Bruce 1:17:55
And actually, we've found that as we've added people who needed training, then Steve's been happy to come down here and do that training. And it's not difficult. But like any piece of machinery, if you're insurers are going to cover you, they need to know that you know what you're doing. And there are some things you could potentially do in there, I guess, which would be potentially contraindicated.

Rob Shanks 1:18:19
it's more or less about knowing your routine, what goes where, know the sequence, and then knowing what angles, what pressures to plot

Georgie McGahey 1:18:29
Did you find it easy to learn how to use it? I mean, obviously, coming from, as an osteopath, using a bit of kit,

Rob Shanks 1:18:37
The training course we did was a two day training course, and then, like everything that gets you to the point where you know what you're doing, and then the more times you do it, the more sort of the habitual it becomes, and just easier you can do it. And you can almost do it with your eyes shut. So it gets the point where it's very, very instinctive. Initially, in the early days, you just happen to go through the steps, check this, do this, and I connect this bit and that bit, and press this number and that number. But, those two days would get you there.

Steven Bruce 1:19:14
Could ask you about the things that you've done wrong on it. In the early days, there was one patient came in and I kitted her up completely for this, and then realized I got the pelvic

harness on the wrong way around completely and I felt a bit silly, and she'd had a couple of sessions with Rachel beforehand, so she knew very well I got the wrong way around so I couldn't blag.
Darcy says, I'd love to have this machine, but would need to be convinced about acute patients compliance.
I don't think patient compliance is generally an issue, is it? Once you've proved, shown to them, convinced them that this is potentially a beneficial thing to do, their compliance is fine

Rob Shanks 1:19:56
Normally the patients can't wait to get on the machine, because they think it's going to help them. I think maybe with that, when that question is coming from, is that perhaps, at first sight, the machine looks a little bit daunting. It looks like it's going to maybe cause you pain, it's pulling you. But like I said, usually the opposite is happening once the patients get on the bed. It's normally a compression that's caused their problem. The disc is under pressure, the disc is bulging and it's pressing on the nerve root. Normally, once they start to experience that opening up and that relief, then…

Steven Bruce 1:20:32
those mechanics are easy to explain in layman's terms - this is what's happening in your back. We need to pull it apart. And the reason it takes so long is because these tissues are not going to change their structure overnight. It's going to take a while to get that extra space between the discs.
Claire's just come back in about grants for the machines, and says that often the grants will fund match. So if you cough up half of the price of the machine, they'll pay the other half. Again, you've got to find the grants, but they definitely are available.
However, Kim has said, Can patients get this on the NHS? And what about insurance? Now, I don't know of any insurers that cover it, and the NHS currently still says traction doesn't work, and it regards this as traction.

Rob Shanks 1:21:17
That's totally true of the NHS. The insurers, some of them used to cover it. And we do get the odd patient that still does get covered with insurance. It's increasingly becoming a case by case basis.

Steven Bruce 1:21:32
Do you know which insurance companies are likely to cover?

Rob Shanks 1:21:36
Unfortunately, not the regular ones. Are not the AXAs, the BUPA. I'm just trying to remember what Aviva's position is. I know they used to do. I'm not sure they still do or not, but it's going to be the slightly less well-known ones

Steven Bruce 1:21:48
I'm not surprised to find that Bupa doesn't cover it. Or if they did, they'd want to pay five pounds a session or something.

Rob Shanks 1:21:54

I think we had a few WPA patients have come through on it as well.

Steven Bruce 1:22:01
So Mayoori says could you elaborate on any specific insurance cover that may be necessary for the practitioner. She's asked about BGi. Do you use BGi?

Rob Shanks 1:22:10
We just actually started – one of our associates has gone over to BGi.

Steven Bruce 1:22:15
Ican answer for BGi. I know that BGi will cover you as a practitioner to use IDD therapy, provided you've done the training. And they won't ask you for any proof of that, but you aren't insured if you haven't done it obviously.

Rob Shanks 1:22:29
So , obviously, yes, you do have to be insured. You have to have it on your insurance certificate. So we, I mean, I'm currently insured with Balens, and they insure me. They do ask a few questions, and they have to satisfy their responses, but it is possible, certainly.

Steven Bruce 1:22:45
And Hallams are the iO insurers, and I'm not sure who does the the BCA is insurance, but I'm pretty confident that they would all cover a practitioner to use the machine. It's not high risk, is it?
Sue's asking about studies comparing IDD therapy's beneficial results with manual techniques. So manual techniques, not involving machines, but at the same frequency, for example four or five times a week for 20 sessions with top-ups, which is a very interesting question, because when people ask me, How to you compare manual therapy with this? Well, you physically cannot do traction for that length of time successfully, no

Rob Shanks 1:23:24
In that controlled precise way, correct.

Steven Bruce 1:23:28
But you could do manual therapy four times a week for 20 sessions, and it would be slightly cheaper than doing this. I'm not sure I would be able to justify that. Whereas I can visualize the reasons why this might take that long.

Rob Shanks 1:23:47
I mean, I think it's a good question. It's very good question. Have the studies been done? I must confess, I can't remember, not sure. I've got a slight feeling in the back of my head that there has been something similar to that, but not, not of that number of sessions, though. Or was that the exercise one?
But, I'm like you, what got me into doing IDD therapy in the first place, well firstly it was traction and then IDD, was the fact that I was finding, as a practitioner, I wasn't getting enough of my disc patients better, and that was a simple reason why I was then looking for other methods. So anecdotally, I feel that it works better than the manual therapy on its own.

Steven Bruce 1:24:32
Are you convinced, Georgie?

Georgie McGahey 1:24:34
100% but I think it's all about having options, isn't it? It's about giving your patient options. And actually, that's an amazing thing to be able to deliver. It's, maybe this isn't working, but maybe you might want to consider this.

Steven Bruce 1:24:46
I also think, I don't know if you agree, but Rob's been doing this for 13 years. He's got a really good feel, given the number of patients and the volume of patients that he's seeing on a daily basis going through this, he's got a good feel for when it's going to work and when it's not going to work.
A lot of people who haven't been exposed to it or are just starting with it, will be thinking, well, I'm not confident in recommending this treatment yet. But provided you put the right patients on it, you're going to get good outcomes. I think, which is what we want?

Rob Shanks 1:25:12
No, absolutely. It comes down to the prep of the patient first. But I completely understand that sentiment. I promise, Steve Small was knocking on my door for two years before actually got my first machine. And I was very skeptical initially, and it's a bit like some of the questions we had before about McManus tables and the flexion distraction - I was using those type of techniques quite happily and getting what I thought were good results. And I kept telling Steven to go away, I'm not interested in this £50,000 machine that you're trying to sell me. And it was only when I started to hear little snippets of conversations and then went down to see what was at that stage the second clinic in the UK, Brighton, and tried the machine for myself. I then could feel what it was doing that nothing else could do, no other candidates could do. And that's what's convinced me. I thought, OK, I've never felt that feeling before from any other manual therapy technique.

Steven Bruce 1:26:00
Steve is a great example to probably all osteopaths and chiropractors watching today, in that it's not enough to get one hit with your marketing. I think we were longer than two years before we eventually bit the bullet and bought our machine. But so often people will send out one message saying, I can help fix your back. And if no one responds, then they just think they don't want me. But it takes that length of time to convince people, for them to notice you, doesn't it? And I like Steve, yes, he's a salesman for IDD, but I think he's selling a good product.
Darcy says, how does it work in part, by physically stimulating vertical body end plates? You're allowed to say, you don't know!

Rob Shanks 1:26:45
If you're talking about end plate disease and end plate degeneration, that's a subset of patients you'll see. In terms of things like Schmorl's nodes and Modic change, where you've actually got the disk vertebral interface that's lost its cartilage. That would only be one set of criteria, where you might have a patient that's got discogenic symptoms. Does it stimulate that in any way? I again, don't know. I don't know whether it does stimulate any sort of

cartridge regrowth? Can it take the pressure off and take the pain off? Yes, I would say it can.

Steven Bruce 1:27:20
So, regardless of what it does to the end plates, it's still worth a try.

Rob Shanks 1:27:23
In terms of relieving symptoms. But will it actually stimulate things, in terms of regrowth of anything, I'd be a bit skeptical, but Idon't know the answer.

Steven Bruce 1:27:33
Jamie says, How do patients feel immediately when they get off the machine? Does their pain come back straight away.

Rob Shanks 1:27:43
So common experience is when they immediately come off the machine, the immediate feeling is often one of slight stiffness in the lower back. It's a bit like if you said, I'm just going to hold a hamstring stretch for 25 minutes, you'd come off with the leg feeling a little bit stiff. So it's a similar sort of feeling in the back that only usually lasts for a few minutes. We tend to either put an ice pack on the straightaway, or sometimes the ice pack on whilst on the bed. And that that tends to, for whatever reason, whatever mechanism, quite rapidly resolve that feeling. Once the patient has a little walk around for a minute or two, they usually feel back to normal, if you like.
Does their pain come on straight away in the leg again? It depends on the stage. Usually, though, like you said, we're not expecting them to come off the bed and suddenly the radicular pain is gone. It takes a course of sessions in order to get a sustained and significant improvement. So we're usually expecting the pain to come back quite quick, but it's not a one hit fix, it's a course.