Evening Case-Based Discussion – Ref218

with Pippa Cossens, Rob Shanks & Claire Short

2nd March 2022

TRANSCRIPT

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- *Some elements (repetition or time-sensitive material for example) may have been removed*
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Steven Bruce
A good evening, and welcome to the Academy of Physical Medicine. I've got something slightly different for you this evening. We have done case-based discussions before as one of our evening broadcasts, but normally we do these things as a lunchtime show just 45 minutes. We got some criticism for that because lots of people have busy clinic lists and so on, so they can't make the lunchtime shows. So what we thought we would do is we'd throw on a number of particularly interesting cases over tonight's 90 minute session and see what you think. And the idea of course, is not just that we tell you what's happened with these cases, but the idea is that you tell us what you might have done, where you think we went wrong. This is a groupthink exercise, groupthink is probably the wrong word, but what we want is a group discussion over how we can handle patients better so that when you do your much vaunted reflection, we all go away with something which tells us how we can do better in our own clinic. So let's get on with the CPD: I've got three fantastic guests joining me all by virtual camera. On one hand I've got Claire, who you've probably come across before. Claire is my wife, my follow osteopath, very experienced and has usually got lots to see for herself, as well as things about interesting cases. Good evening, Claire.

Claire Short
Evening.

Steven Bruce
Oh, I'm gonna get it in the neck for that later on. And we've got Pippa Cossens. Pippa, you're also very, very experienced in osteopathy. And I think you've got an interesting case, which isn't about the musculoskeletal aspects this evening. We'll come on to you in just a second. And of course, we have Rob Shanks. Now, Rob has been on the show on a number of occasions before, again, hugely experienced but also very, very expert in how to look at MRIs and imagery of that sort, and there'll be a bit more about that later and he'll be taking us through some images while we're on the show this evening. Anyway, so that's my guests for this evening, between us I think we've got four, possibly five cases, depending on how the time takes us. But let's start with you, Pippa, if we may, what have you brought to the table?

Pippa Cossens
I brought, actually a patient I only saw this week for the first time, who was a lady who is 58 and she came because she's really, really anxious and that was why she came for treatment. In our clinic we tend to treat quite a lot of psychologically biased cases. So actually, it's not unusual for us. But this lady was the most anxious patient I think I've ever seen. So she arrived at the door, and she proceeded to put on her FFP2 mask with a surgical mask over the top. And she stood on the doorstep outside and said that she wasn't sure she could come to her appointment because her daughter was at home because she was sick from school. And I said, that's absolutely fine. If you want to rebook it, we can do that. To be fair, and I'll tell you a little bit more about that in a minute, I had actually had a telephone conversation with her prior to this, but I didn't know how anxious she was. Anyway, so she stood on the doorstep, and I realised that the level of anxiety, it was palpable without touching her, you could just see it coming off her.

Steven Bruce
Can I just ask, Pippa: so this wasn't just anxiety about osteopathic treatment, this is just anxiety about life in general?

Pippa Cossens
Absolutely. And in fact, one of the pieces of information I'd gathered from her in the pre-consultation phone call was that, essentially, she'd suffered anxiety a long time, but the beginning of the pandemic had just ramped it up to a completely different level. So you could see a fizzing. She decided that she'd come, I said, listen, if you want to come in, we can just take a little bit of the history, and we can make a start, and you can see how you're doing. So she came in and she sat down and we opened the window wide, and we did all of that stuff to make her feel as safe as possible. We went over what we'd done to make the space safe. And then we started taking the history and how she has acute anxiety, and she has some depression and it obviously is affecting sort of all aspects of her life. I think she does have health anxiety, but I think it's affecting everything. And literally, I'm just gonna flash the case history. This was as far as I got, halfway down the first page. And then she said, I really can't talk about this anymore, I can't speak anymore, it's making me more anxious. So I ended up really with a kind of a non- case history, if that makes sense. And I suppose that, in some respects, the difficulty of this case is, should I have gone on to treat her without having a full case history. But I'll come back to that in a minute. So she sat there and we talked a little bit about what she wanted to get out of it and she obviously just wants her systems to be calmer, so that she can function in life better. And in the pre-conversation that I'd had with her on the phone, she'd given me several other pieces of information. So she's a single parent, of an adopted child who's 10. She's had obviously a history of the anxiety and depression, insomnia for quite a long time. She, I think, has been on medication in the past to help control that, but I think is not on so much at the moment because it doesn't agree with her. She had had quite a lot of upset over the pandemic with regards to moving to be with family and then moving to be home. And she also mentioned in her history that, as I say on the phone, that she had been in Bosnia as part of the peace process and she had ended up with some PTSD following that. So the other consideration we have to take with a case like hers is, is this osteopathic or not? How far can we take it when we're on the edge of the comfort zone essentially of the psychology of it? So I myself am also a SIRPA trained practitioner, Stress Illness Recovery Practitioner, and in that guise we are very well informed psychologically, but we certainly wouldn't treat psychiatric patients without the say so of their psychiatrist and the support of that. So as long as it's a psychological disorder, then we're somewhat happy, but she was definitely on the edge of my comfort zone with that, and I treat a lot of anxious patients with a lot of psychological stuff going on. Anyway, so we took half the history and I thought, well, realistically, my compassionate osteopath thought, the best thing I can do is to try and start treating her, so that she feels a little bit calmer. Because essentially, we're not going to get anywhere without that. So she took off her coat, and she took her shoes and she lay on the table. And I thought, if I can just start to calm down her nervous system, we might get somewhere, she might feel better. So I did that. And I was as a practitioner really aware that I needed to be really calm. I was super, super slow in my speech, which is not normal, I talk quite quickly. So super, super slow, really thinking about my connection with the ground and my grounding. Anyway, I nearly always start with a contact on the sacrum, just thinking about bringing that nervous system activity down, looking at the parasympathetic outflow in the sacrum, just starting to calm it down. And she was absolutely fine for about three and a half, four minutes and then she said, I think I'm going to have to go now. And she got up off the table, and she put her coat and her shoes on. I said, that's absolutely fine. I'm sitting

there kind of going, Oh, my God. Anyway, so she did that. I said, that's absolutely fine. I said, what we can do is you come back another day, perhaps when your daughter's not at home and when you feel a little bit better about it. And we talked for a few minutes about what we could do and we talked about a grounding technique, you know, we get people to imagine that they're an oak tree and they've got roots growing out of their feet. So we talked about that as a sort of self-care technique for her to take home. And then she said, I think maybe I'll have a little bit more. So she took her shoes back off again, and she took her coat back off again, and she got back on the table. And so we started again, and we just we calmed things down a little bit. And again, she was fine, interestingly enough until she started talking about what was going on. And she was very concerned about me and that I'd take on her stuff, and I was telling them I wouldn't, and it was absolutely fine. So we got a little bit done, but I mean, I don't know 3% of what we needed to do. And then she said, I really think I'd better go now. So she got up again and put her coat on. Anyway, so she then she rebooked, to make another appointment and then she left. And when I'd calmed down from her leaving, I was slightly left with this feeling of, should I have treated her? I didn't have a full case history, I had some of that information but as I say, was it better for her and actually more compassionate, to have treated her a little bit to settle that down. We always say to our patients, all of our patients, if they have any concerns at all, they need to get in touch with us. So we've done that part of the conversation. And to be fair, actually, about 10 minutes after she got home, she'd obviously rung the receptionist and said thank you for the treatment and stuff like that. So I wasn't overly concerned about her. But it is an interesting, as I say, even though we haven't quite psychologically informed practice, she was still kind of right on the edge of that of that comfort zone.

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

Pippa Cossens
I've got my barefoot shoes on.

Steven Bruce
Excellent. Getting back to this patient, what made her come to you rather than go for counselling or other sort of psychological help?

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

Steven Bruce
But you also said you're SIRPA trained, didn't you? Which is Georgie Oldfield is the moving force behind that, I think, and for those who have not seen the broadcasts we've done with Georgie, they're well worth a look. And SIRPA, remind me what the initials stand for?

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

Steven Bruce
So I've had some observations come in from people other than Robin already, but before I go to those observations, one of the criteria which is in our practice standards, whether chiropractic, osteopathic, physiotherapeutic or whatever else, is that we shouldn't act outside our areas of expertise. And clearly this is to some degree, an area of your expertise. So my initial thoughts and I'd love to hear other people's are that what you did was not going to cause harm, but might have enabled your patient to calm down sufficiently to give you the case history that you needed. And one of the things that, of course, we talk a lot about in first aid is that if you're acting in the best interest of the patient, and you're not going to cause harm, then I think you're probably safe. But that's just my view. Let me take these issues here. Claire has just told me that she's got a rather canine emergency going on at the moment, so she'll be back with us in a second. Martin says, what is your osteopathic diagnosis, Pippa? And apologies to the chiropractors, we're not trying to exclude chiropractors, and SIRPA doesn't exclude chiropractors either, as far as I'm aware, but he wants to know what your diagnosis was.

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

Steven Bruce
Okay. And of course, you didn't get the chance to nail down where you thought that was arising, so maybe this is something we'll discuss at a future date. Kerry has asked whether she was more able to talk over the phone, to maybe complete the history over the phone, so she's within her own comfort zone? Is that something you'd thought of?

Pippa Cossens
Yes. And to be honest, actually, then looking back, because I'd already had that. I think I was probably less worried about continuing because I'd already had that pre-existing conversation with her on the phone, which is not something that we do as a regular course in practice, but because she was so anxious, that was something she wanted to do. We offer it, but it's something that she wanted to do before she came. And as I say, I did get more information in that conversation than I did in the case history when

she was when she was present. So I think my understanding because I had that pre-information, I was like, okay, I know where this is, as I say, she told me that she'd had PTSD and she told me sort of when that had come from, so I had got an understanding of that, but then you've got to be super cautious with a nervous system that has got that heightened activity.

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

Pippa Cossens
I think it probably arose from that.

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

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

Steven Bruce
Somebody, I don't have the name of the person who sent this in but this is an interesting idea and I can see pros and cons to this, they've said could she have supplied a history by email or writing? And of course, you can get so much from a written history, don't you? But we get so much more from looking into a patient's eyes while they're talking to us and exploring the answers. So the things that you get on that sort of screening sheet that we hand out these days are only a starting point, I feel. What do you think, Pippa?

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

Steven Bruce
This is another question from me before we turn to other people. Is there a danger, when you give someone a 15-page questionnaire or whatever it is, is there a danger of promoting some sort of

catastrophisation on their part? When they see all the questions, they don't know what they are, but they think, oh, my God, I must have this horrible thing wrong with me.

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

Steven Bruce
Alex asked if you are craniosacral therapist as well?

Pippa Cossens
I'd possibly stick myself in the biodynamic cranial osteopathic gang.

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

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

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

Pippa Cossens
I think in some respects, I think, not just osteopaths, I am an osteopath, I can speak only as an osteopath, I think it's part of that amazing osteopathic health care, I think which actually, I think so much of what osteopaths do is that listening, that is just spending time understanding, hearing patients, actually hearing what they're saying, signposting them if that's necessary. And I think I spend a huge amount of my week, but as I say, that's because we sort of, like a lot of practices you start to attract the same patient, so we

have a lot of a similar group of patients, kind of just making people feel more settled, more in their bodies, less agitated. And this is going to sound completely ridiculous, I do apologise, it's almost like sometimes it feels like they come home, it's like they settle back in themselves. It's like they feel more like themselves when they leave. And part of that is the hands on, part of that is the advice we give them so that they feel empowered to be able to do something themselves, and part of that is just the listening and the being there in combination with the hands on.

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

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

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

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

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

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

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

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

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

Pippa Cossens
In what sense?

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

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

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

Rob Shanks
Yeah, certainly. So the case that I was going to present to you is a chap named Carl, he's given me full consent to share all his information with you as well. And I've got a vague feeling this is a case that I did touch on way back when, I think I may have put up his scan when he first came in. But I've now gone the full way with this chap, he's now been discharged, and he's had his treatment. But I followed him up for several months, I thought it would be an interesting case to share because it actually picks up on some of the points we've have already raised in the sense of, when this chap first came to me I actually remember the receptionist saying to me, I've got this chap on the phone, or he's booked in with you for next week, and he is, I think in her words, I think she may even have used the S word. He was kind of almost suicidal, he was at the end of his tether, and he literally was just kind of pulling his hair out in terms of what to do. So he was a young policeman. He was in his early 30s. And he'd been complaining of many years of left arm pain, shoulder blade arm pain. Now, it wasn't your typical kind of, oh it's into the C6 dermatome, C7 dermatome. It was a little bit more proximal than that, bit more around the shoulder

blade area. And he'd been through a whole remit of seeing different practitioners and doctors and I remember speaking to him first on the phone. I said to him, right, I said, I want you first of all just to send me all your stuff, all the information you've had done and just send it all to me. And when he did, I thought I almost regretted it because it was one of those ones that had pages and pages and pages and pages and pages of stuff. But I spent my time going through all and he actually had done a very nice summary for me, which I'm just going to share. I'm gonna try and share with you now. And this is one of the first things that I put on my notes. Okay, are you seeing are you seeing this, everybody?

Steven Bruce
Yes, we've got that.

Rob Shanks
Great. Okay, so let's just go back to kind of near the beginning, so this was actually his summary. This was part of my notes. This was the summary that he kindly sent in. And he'd had a few things going on, various different injuries, but the one that was really concerning him was his left shoulder area, like I said, and he'd had the shoulder looked at itself, was it a tendinopathy thing? Was it a bursitis? He got referred to the the orthopaedic surgeon. He'd been to the Queen Square neurology place. And again, he'd had various MRIs done and one of the MRIs came back and it said that there was an impingement on the on the C4. But then I believe there was a subsequent one that actually concluded it wasn't any worse on the left than it was on the right. And long story short, I won't go through everything with you, but he ended up seeing I think about three consultants in the end, he saw a spinal surgeon, who basically said there was no surgical target. He'd ended up having some nerve conduction studies, EMG studies done, and they concluded there was nothing wrong. And he was then told he had various different possibilities of things like fibromyalgia and thoracic outlet syndrome, he'd been to see different therapists, and they'd all been treating him and not really getting on too well, and he hadn't really had any sort of long-term relief. As I said, this is the one here: he had the MRI scan 2019, it basically just said, it's kind of causing bilateral nerve root compression. And I think this one, I kind of a conflict, one of them said it was worse than the left, one of them said it was worse on the right, another one said it was equal left and right. And anyway, the conclusion they came to was that it was nothing to treat surgically, he had a cervical epidural injection, which hadn't really worked. He'd had a medial branch block injections, which again, hadn't really worked. And like I said, he kind of came to me and said, well, look, what do I do? And he'd been to the pain management people, the pain management said, well, you're just going to have to live with it. And kind of almost like a chronic pain situation. But literally, he'd been to different therapists, and he wasn't getting there. So the first thing of course, being me, I said to him, well, look, let me have a look at your scan. I want to see your scan. So let me cut to, I've done an extract of one of his slices for his scan and I'll just bring that up now. Okay, so I'll come back to that in a second. So this is one of the first things that *audio problems* Am I back?

Steven Bruce
We can see you.

Rob Shanks
I was just getting a vicious echo of myself, hearing myself talking. But you can hear me talking now? Yeah, okay. So here was his MRI image, or one of the slices that we saw, and I think we can all see there

was something going on here at C3/C4. Now, I just thought myself, hang on, that's got to be relevant, that just looks quite severe to me. And I kind of actually pulled up the scan I showed him at the time and said, look at this, Carl, you can see this doesn't look right, does it? And I said, this is potentially hitting on your C4 nerve on the left side. And I said, if you've got a C4 impingement, then that potentially could explain all your symptoms and it has already been mentioned by some of the previous consultants that you've seen, but it seems to have been dropped. And they're just not going with it. And then he said, yeah, but I've been to see, you know, three consultants recently, and they've all told me, it's nothing to worry about and it's just kind of general wear and tear and actually, you know, I shouldn't be having anything done about it, surgically at least. And he said, they tested my nerves and they said, look, I've got nothing wrong with my nerves. I said, well hang on, let's go through it. And I actually said, well, if we go through your nerve conduction studies, what they've done was they tested from C5 down. so they hadn't actually tested his C4 nerve root. And then I said to him, look, the injections you've had done haven't actually targeted this nerve. So I said, the one thing you haven't had done is a diagnostic C4 nerve root injection. So you haven't actually had the proper diagnostic kind of remit in terms of going through systematically, according to what we're seeing on your scan. And I remember him getting quite not almost like he was on the verge of being angry with me. I think because I was making it sound so simple, I think he was sort of thinking, hang on, you can't be telling me this, I've seen three consultants. And I had to politely stick to my guns and say listen, I know you've seen three consultants, but I honestly do think this is something you need to explore. And, again, this is why I think as osteopaths we've got the time because I think I probably spent more time with him than any other previous consultant had done. And I was just piecing through he'd had done, he hadn't had done. And I think that's one of the benefits we can sometimes have. Anyway, long story short, the first thing we did was we got him to have the C4... Well, the first thing we did actually was have a qualified second opinion on the MRI scan. So I was I was saying to him, this is what I think is going on in your scan. I think this is significant, but I'm not a qualified radiologist, I'm not really in theory qualified to tell you this. But we need to get a second opinion, I want to get an opinion from a radiologist that I trust. And I'd done my little speech about how not all radiologists are as good as some others. So I said, look, we're going to get this done by this other chap and long story short, what came back was that they more or less agreed that this was definitely a potential C4 radiculopathy. And that then led to him having a nerve root injection into the C4 and I think he had something like three days of almost total relief. It was the most significant chunk of pain relief he'd had in many, many years. So for me that sealed the deal, that made me think, right, this is definitely what's now the source of his pain. I even also went one further, I had a meeting over zoom with Bob Chatterjee, who you know, you've had on your shows before, spinal surgeon. And again, Bob's opinion I trust very much. And I remember him actually getting quite annoyed about it, the fact that this guy had been mismanaged, clearly been mismanaged, and they hadn't really taken him through the proper diagnostic steps. And he totally corroborated what I was saying. So then having had the diagnosis, it was then a case of now what do we do? What do we do to treat you? And can we do anything to treat you? And this is where I kind of set out a little plan for him. And I said, Well, this is my proposed treatment, we can tick that off the list, we had that done. And I said to me, if that does work, well, then I'd like you to have one of the treatments we do, the IDD therapy, to try and target that disc level and try and decompress that particular area. So he did do that. And he, again, he had an equivocal response, I would say it wasn't convincing. I was suspicious he probably wouldn't get much relief from it, but it was something to try ahead of further invasive procedures. I did talk to him about possibly having some prolotherapy done for his neck. I don't

believe he did go through with that and maybe that's something I could have pushed him to do a bit more, but he didn't. Oh, sorry, yeah? I can't hear you very well, actually, Steven.

Steven Bruce
Can I just stop you there, because you just talked about doing 20 sessions of IDD. How many of those sessions did he have before you said this isn't working?

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

Claire Short
I'll take over. What Steven was saying is, Victoria has asked had he had any previous injuries?

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

Steven Bruce
Thank you. Can you hear me now?

Rob Shanks
I can hear you a bit better now. So basically, where we went with this chap is that he went to see Bob, went for an opinion with Bob and Bob did say to him, okay, I actually think you are going to need surgery and you are going to need a cervical fusion operation. And, again, I think there was this question in his mind, well, why haven't I been offered that before? And I actually said, well, the reason you haven't been offered that before, Carl, is because the people you've seen before don't do that surgery. And whilst they perhaps should have been thinking about that, because they don't do it, they're not necessarily going to offer it to you. Anyway, long story short, we ended up getting him referred over to the Royal National Orthopaedic Hospital in Stanmore and he saw one of the surgeons there. And I believe that within something like 10 minutes, the guy just turned around and said to him, 100%, you're going to need this operation. And he said, I'm going to give you an 80% chance that it'll work for you. So, anyway, he was still very concerned about having the surgery and I think he did actually try to put it off for a while. But in the end, he had the surgery and thankfully, he had a fantastic outcome. And it took a while to get rid of his pain, because it been there for so long, but he hit all the goals and all the milestones that they wanted for him. And I can't remember the exact timeframe, but it was a few months down the line, he got back to doing everything he wanted to do. The only sad thing is he had to give up his job within the stables

and the horse riding and he was actually involved with mucking out the horses and looking after the horses and he had to give that up, unfortunately, because he'd had so much time off, they wouldn't keep him on. But he sent me a couple of emails recently and he's so, so grateful that we got to the bottom of it. And I think it was his persistence that paid off really. Now, he would have been definitely one of these people just going around in circles, going from one practitioner to another to another, one kind of consultant to another, not ever really seeing the right one. So come back to your point before about signposting: I wasn't able to get this guy better myself, but I feel confident that I did signpost him in the right direction.

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

Rob Shanks
Obviously, it is tricky. My particular case, as you know, many people know, I've been fortunate enough to work very closely with a leading radiologist and that's how I've kind of got to know my way around MRI scans of the spine. So yeah, my confidence is high. But I've also got him to back me up. So the first thing I did, and this is it, I think you're right, it comes back to the point of the first thing you want to do, if you do strongly suspect that something isn't quite right with the previous reporting, is you want to have some in your team who you actually do trust and who actually trusts you as well and also thinks, I know this guy knows his stuff and if he's suspicious that something's not quite right, it likely isn't, and they're going to take you seriously. And it comes down to just simply asking for a second opinion. Now unfortunately, this is the point, we're living with a situation at the moment where, and in fact I was literally on the phone to Bob Chatterjee the other day we were discussing exactly this point, once upon a time the only person who could really refer to the MRI scan would have been the spinal surgeon and somebody of Bob's stature who really does know his stuff and if he's going to refer to that scan, he can then not only look at the radiologist's opinion but he can also give a qualified opinion as to what's going on that scan. And then obviously we've got into the era where, without being rude and whilst I make use of them, but we've got the budget MRI scans coming out and patients can also self-refer for MRI scans, and the whole thing's got a little bit more cheap in terms of they're going to try and get the cheapest radiologist to do that report, to be frank. And with it comes poor quality reporting. And we in clinic, in our in our clinic at Spine Plus, I would have to say to epidemic proportions, we see stuff coming in on a weekly basis that's missing very, very relevant pathology and very, very relevant stuff. And I've got another classic one to show you in a minute if you want, if we've got time. And we're literally seeing it all the time. And this is the problem. So the patient's had a scan that says it's clear, it's okay, or there's no surgical target or it's no worse on the left than it is on the right. But the subtleties are being missed. Because they've not been read or not been reported on by someone who's really, really looking at it. And even though they've got the qualification of

radiologist, they're perhaps not musculoskeletal specialist radiologist, they're a neuroradiologist or they're not used to looking at they don't see as many spines as Dr. Butt would or Bob would.

Steven Bruce
In their possible defense, is it the case that sometimes they're not asked to look for the right thing as well?

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

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

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

Steven Bruce
And someone Specky, and I suspect I know who Specky is, and if I'm right, hello, Specky, says in terms of the whole-body management of the patient, how about considering dorsal spine and ribcage and she's thinking along the lines of the amount of weight that policemen have to wear, body armour and so on, not to mention riding kit and all the rest of it.

Rob Shanks
Yeah. Absolutely. I mean, it's all relevant, but for me at the time, that would have been a bit like shutting the door after the horse had already bolted. For me, this guy had very clear cut C4 impingement, that was not going to go away. There was a bony osteolytic lipping on that left side and no amount of dorsal springing, and to be honest his thoracics weren't too bad anyway, it wasn't like a kyphotic, hyper lordotic

cervical spine. This was just bony lump sticking in his in his nerve root. And, for me, I just couldn't see that he was ever going to get out of that pain, to be honest.

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

Rob Shanks
Yeah. And also, because he'd been through the wringer, he'd been through so many different therapies working on his thoracic outlet, working his shoulder mechanics, working his scapulothoracic mechanics, he'd been there and done it all, that's the thing. So for me, he was one that I had to find the right practice and the right pathway for.

Claire Short
Steven?

Steven Bruce
Yes, Claire?

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

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

Claire Short
Yeah, and this wasn't, she was working for the NHS, she was being paid by the NHS to do her training. But her supervisor said she was over reporting. Now, she had an interesting background and was very pro-osteopathy. She and I had talked a lot about the kind of information that we like to see on a report. And she said, I'm being told not to put that information in the reports that I'm writing, so how are you guys ever going to get the right information unless you know how to look at the scans yourself? And even if all we learn is a spinal scan, we don't look at the shoulders or the knees, we just learn to look at spinal ones,

I really think that we'll be helping so many people because we can do what Rob did, which is look at the numbers. He just counted 1, 2, 3, 4 and looked at the clinical assessments that had been done. It wasn't like you waved a magic wand or had this incredible five-year course that you had done on reading spinal scans, you just counted and looked at the stuff that you know as an osteopath, and I really think more people should do it.

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

Rob Shanks
Okay, so yeah, absolutely. I think where we stand with this is that we are well within our rights to question and we're well within our rights to say, I'm not sure that report is correct, or I think something has been missed. But from a legal point of view and an insurance point of view, what we're not qualified and covered to do and say is to say right, I think there's this problem going on and because of that problem, we need to do that treatment. Now it's a subtle point, but the best thing to show you is if I show you my next case history, this point will become very obvious and will show us how we need to approach this particular aspect.

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

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

Steven Bruce
He's a 42-year-old man, I think isn't he?

Rob Shanks
Yeah. Now the first thing that I thought wasn't right with this, well, the first thing it says here two months progressively worsening right L5 radiculopathy. So they've instantly gone in and said, they've kind of gone for a diagnosis before they've gone through the scan. So my first question was hang on, it doesn't

sound like he's complaining L5. It sounds like it's L4, not L5. That's my first impression. Just from asking, where's your pain? And so that's the first thing I thought, that doesn't quite tie up for me. Anyway, then look at this one here, L4/5 there was a minor disc dislocation but no significant herniation and no canal or foramenal stenosis. Just read that again, no significant herniation, no canal, and this last bit, or foramenal stenosis. So they're saying categorically, there's no problem at L4/5 to account for his pain on the right side. But it does say is that at L5/S1 there's displacement of the disc and the left S1 nerve root, but the right S1 nerve root is not impinged, okay. However, in the lateral recess, it's compressing the exiting L5 nerve root. So again, that's basically telling us that, okay, they're going with this idea that it's the L5 nerve root, and it's coming from, crucially, it's coming from the L5/S1 disc. Okay. So that's what we would be going on if we just relied on the report. Now, when you go, and you look at his images, it's gonna be quite subtle but let me try and... Why don't we go through this one, first of all. So here we go, this is the L5/S1. So this is what they were kind of picking up and what they were talking about. Now, what we're seeing here, actually, just where my cursor is there, that's actually the left S1 nerve and that's the right S1 nerve. Now, it looks like there's potential for some left S1 nerve contact there. But remember his pains on the right side, he did have some on the left, he did actually complain a little bit of pain on the left, that did correlate with the S1, because he's the got sole of the foot, the fizzing in the foot. But predominantly his pain is on the right-hand side and what they're saying here is that he's got a lateral herniation of the L5 that's affecting the exiting L5 nerve root. We haven't quite got that L5 in view here, but imagine the nerve root's coming out between here. Okay, so fair enough. But as I said, when you really listen to him, and he didn't really have any L5 myotome weakness, and most of his pain was above the knee, kind of into the thigh, coming around a little bit into the front of the thigh. So I thought, that doesn't sound like an L5. So I don't understand that. So then I'm suspicious already that, let's have another look at this L4/5. Okay, now I'll come back to that one in just a second. Here's the L4/5 in sagittal view. So it looks initially that oh, well, there's not much of a problem there. But remember, this is just the midline slice. Now, how do we know there's nothing coming out towards us, like coming out literally towards us here. This is why we need the axial. So you always need an axial scan, you can't just diagnose from a sagittal. So this is the axial. Now if you think of this axial in two halves, which half do we think is slightly more bulbous, if you want to call it that word? Well, I would go with this side, the right side. Okay. Now the other thing we see down here, which is really subtle, see this little faint line just here? That's actually an annular tear. Now we go to the next image, where about is the annular tear in relation to the nerve root? Look, this is what's called a parasagittal slice, that there is the exiting L4 nerve root and that there is the tear. Look where it is, it's sitting right underneath the L4 nerve. And there's a little bit, there's a small little kind of, you know, so this business about the L4/5 foramen being not stenosed, well, that's wrong, it is being stenosed. There is contact there between the disc onto the L4 nerve. And not only that there's a tear right underneath the nerve. And we know that tears potentially can be a source of chemical radiculopathy as well. So for me, that absolutely correlates with where his pain is. So, again, the reason why I'm so keen to know, because we kind of come to the conclusion, well, what does it matter if it's L4 or L5, he's got a disc issue. Well, for me, this guy is going to have, again, coming back to the IDD therapy and I've got to know which disc I'm targeting. Because I've got one angle for this, and I've got a different angle for this. So I've got to know which disc that I'm going to be going for. So that that was our judgement. Now, picking up on the point we were just saying. This hasn't been mentioned on the report. So they're not they've not said there is potential for an L4 radiculopathy. They've not mentioned an annular tear. They've not even made any comment over this little line, this little line here. Now, I'm pretty confident that is what I said it is, it's an annular tear but I'm not qualified. Absolutely. I'm not a radiologist. I've not been

examined. I've not done any examinations in reading MRI scans. So who's to say I'm right? What I'm doing is I'm going to be sending this off to Dr. Butt or another radiologist that I trust and I'll say, would you mind giving us a second opinion? Would you just let me know, am I correct in thinking that this is an annular tear and it's a far lateral herniation causing an L4/5 potential radiculopathy of the L4 nerve root? If we get that second opinion coming back and it says, yeah, absolutely, that's what it is. We are 100% then in the clear to then go ahead and do what treatment we want, because we've had that diagnosis confirmed. But what if I'm wrong? What if that is actually some sort of nerve cell tumour or some other sort of pathology that I've missed? Okay, so I've told the patient, oh yes, this is to do with the tear and the disc and then we're going to do this IDD treatment on you. But what if down the line that turns out that actually it's something other than what I think it is? Okay, the radiologist has missed it the first time around, but then I've also just missed it as well, I've misdiagnosed it. I am absolutely carte blanche out to be had in the court, because I've given him an unqualified opinion. So the take home message is we must, must, must, however confident you are, you must get that second opinion in writing from the person who is qualified, ie a second opinion radiologist report to back you up.

Steven Bruce
I hope my sound is manageable at the moment, but playing devil's advocate in the absence of an MRI with L4/5 radiculopathy as an osteopath, you would have treated that L4/5 radiculopathy. And we all know that MRIs show up things which have nothing to do with the injury, they look horrible, but they aren't producing symptoms, and we don't treat them. So you could have proceeded on the basis of a normal standard musculoskeletal analysis said well, this, these are what your symptoms are showing, this is what I'm going to work on. Just because there's an MRI, does that put you in a difficult position, do you think?

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

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

Rob Shanks
I think in terms of was it an irrelevant finding, should I or shouldn't I be treating it? I mean, there's debates, if you go to one therapist, go to another, there's always gonna be a debate as to well I want to treat this, I think it's this, I think it's a cranial rhythm, I think it's your tight pecs. I mean, there's always gonna be academic debate. I'd be surprised if they could sue you for that. But what they could sue you for is if I categorically told him, yeah, that nerve's being impinged because it's got a disc bulge and it's got a disc tear. But if in actual fact, I was wrong, and there was some sort of serious pathology, basically talking about cancer. That's where the real stuff starts to happen. And this is the discussion I had with Bob Chatterjee the other day, and this is a thing he was flagging up to me, because he's actually involved in a couple of court cases that basically involve this scenario, where the person has seen a physio or an osteopath or chiro, I think in his case, it's a couple of physios that his particular case is intervening on, and they told the patient, they had a certain diagnosis based on an imaging scan that they did, but they hadn't actually been qualified to give that opinion. And in this case, the patient unfortunately had some other pathology that wasn't picked up and wasn't therefore acted on soon enough. And unfortunately, the physiotherapist is now facing litigation. Now, as I say, I think it's very important that we're aware of that and we don't allow ourselves to be in that position. And it's very easy to avoid that by simply asking for a second opinion which backs you up anyway, so just confirms, if they agree with you, it confirms what you suspected all along.

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

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

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

Rob Shanks
All I would say is that, from the patient's point of view, I think he was very happy with what I was telling him because I was able to explain to him where his pain was coming from and able to tie up some of the loose ends and explain to him, well, that is actually coming from that and if you think about where that nerve goes to it's on the right side where you're complaining the pain and actually predominantly goes to above the knee, it does go to kind of the distribution in your leg where you're telling me. For him, that was a bit of oh, great, fantastic, that's you sound like you're making a lot of sense. And again, I wish passionately this were taught at undergraduate level, because I just think it's just gonna skyrocket what we can do, because if we can learn this stuff as undergraduates, become really, really familiar with it, honestly, it opens up your eyes so much and it makes the the clinical examination fit the MRI, and absolutely, you're right, the MRIs, they do throw up loads of red herrings, loads and loads of red herrings. I mean, look at that guy. His L5/S1 looks like the worst disc bulge, that's not where the problem's coming from, it's coming from higher up. So if you start to learn all that stuff and you can piece it together and correlate this with that, it means your accuracy in terms of embarking on certain treatment pathways becomes so much better, in my opinion.

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

Pippa Cossens
I don't know. Absolutely, hands up. I don't know.

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

Pippa Cossens
No, I would imagine that she's probably had some treatment, like you said a while ago, but I think it's important in the picture, because it's probably the event that changed the way that her nervous system was functioning in the first place.

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

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

Steven Bruce
Well, others may come in on that, but we haven't got too much time. We've got 15 minutes left. Rob, do you fancy being put on the spot for a minute?

Rob Shanks
Yeah, sure.

Steven Bruce
Right. Oh, Robin's come in with one here, he's going back to radiology. He says, he's often got difficulty getting hold of anything other than the radiologist's report. Any thoughts on that, Rob?

Rob Shanks
As in he had difficulty getting hold of the images, is that what he's saying?

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

Rob Shanks
Yeah. So again, my first thing I'll say, if you get a brief report, one or two liner, instantly have your suspicions raised times 10. Because a good radiologist will go through each segment and they'll make some comment, you know, L3/4 there's no this, there's no that, there's no facet joint hypertrophy, there's no foramenal stenosis. At least then you know they've been thinking about it. So that's the first thing. But basically, most of the MRI centres now, so take InHealth as an example, which is one of the big suppliers in the UK, they will, if you ask them, set you up with a cloud based viewing portal. So the one that they use is called Biotronics, or sometimes referred to as 3Dnet Medical. And they'll give you a login and any patient that you refer to them, they'll be on the portal, the images will be on the portal, the reports will be on the portal, and you can literally look this stuff online.

Steven Bruce
What about the patients you don't refer, that have been sent there by someone else?

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

Claire Short
Steven, with the NHS ones, with all of my patients, I ask them, any test they're having, any scans they're having, I ask them to get a copy of it for themselves. Partly because we all know that things can get lost. And partly because I think we owe it to ourselves to take responsibility for our own test results and scans

and not to say, oh, the NHS is in charge of that. And what I tell them to do is to go to the front desk of the hospital and ask for a copy of a scan, it normally costs between five and 15 pounds. I very specifically tell them not to ask the MRI team, my experience has been with two hospitals, that the MRI team think that they own the scans and they're not aware that actually it's the patient's property. And obviously I don't want the patient to have to get into a row, whereas the people at the front desk are used to having that request. Some hospitals, they even allow you to make the request online. And I think it's really important, even if you aren't going to look at them yourself, to encourage your patients to get the copies for themselves.

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

Rob Shanks
Just to chip in there, Steven. I'll be honest, I tend to find the opposite experience. So I tend to say to patients, again, you're absolutely right, I always try to encourage patients to have a copy of the CD themselves, just because if it's not for me, it might be a future consultant or whoever see down the line. And I say to them, you're unlikely now to get the CD sent to you automatically, but please make sure you ask and request a copy for your own records. But I sometimes if they come away from the hospital, and they're no longer at the front desk, I just say to them, listen, just ring up the X-ray department or ring up the imaging department and literally just say to them, oh, can I please have a copy of the CD, I'm going to see a private consultant next week. And nine times out of 10, almost 10 times out of 10, they'll do it no problem.

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

Rob Shanks
The one for PCs is a really good one. It's called RadiAnt. Now it costs, there's a free, I think it's a 30 day free trial. And I think the yearly subscription is 30 to 40 pounds. And that's well worth it, in my opinion.

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

Rob Shanks
You've got to know what you're looking at and you got to know the different types of scans and sequences that they do. So the common ones are a T1 and T2, okay? So I can tell you for a fact that this is what's called a T2. T2 weighted image. And what that means is that the, you see the fluid around the spinal cord is white. So you instantly know, with a T2... That's it, yeah, so you've got the core, which is the dark bit and front and back of that you've got the cerebral spinal fluid, that's in white. Now, the other thing you have there, is you have the subcutaneous fat is also white. So that's what you get on a T2. So on a T2 water and fat both show up as white or bright signal, high signal.

Steven Bruce
I tell you what else, Rob, in addition to that, the highlighted image up here says that it's a T2 TSE SAG11 image.

Rob Shanks
Exactly. But the important thing to understand is, yeah, you can pick up the T2, but you've got to understand what the T2 does. So the T2 is highlighting water, basically, water and fat. So then you get that in your head, then you're kind of off to a winner. Because if you go for a T1, what will happen is... Perhaps you could try and do it there, Steven. If you try and bring up the T1, you got the T2, if you can try and bring up the two slices together. So you bring up the T1 and T2 together. Are you able to do that?

Rob Shanks
Click on one of them first, usually, and then what you can well, okay, so you might not be able to do it. What you can do on a Mac, you can hold down the command key and click on the other one.

Steven Bruce
If I go for that one. I've got to look for two images, haven't I? So if I open a window up here. I'd like to do that, I've just buggered it up again.

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

Rob Shanks
That's the one. There we go. Right. So now what you want to do, you want to have the T1 in one of the windows and the T2 in the other window. That's not a bad one. That's an axial image next to it, which is actually also very important to go for as well. But just to try and show you what I'm talking about in terms of the contrast between the water on a T1 and T2, if you could maybe just bring up the T1 for me on the left side.

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

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

Steven Bruce
Now let's see what I can do with this.

Rob Shanks
You can easily see the brain's a different colour. If you look at the top, the top down, you can easily see you've got something different going on, even though this is looking at the same anatomy. Okay, again, see if we can go for where you can see the spinal cord, right in the middle of the spinal cord. Okay, we're getting there, a little bit further. Keep going. One more. There we go that'll do. So can you see now, what we're looking at on the left-hand side, the cerebrospinal fluid is showing up as bright and white. But on the right-hand image, it's dark. That's it, but then look at the subcutaneous fat. Now the subcutaneous fat is the same colour in both scans. So the fat is showing up bright on both images. So the only thing that's changed is the water. So the water is showing up as dark on the right hand side, which is the T1. Okay? Now a T1 image is pretty good at showing up or better, let's say, for showing up bony contours. Whereas the T2, okay, I always remember it thinking of the formula water, h2o has got a two in it. So a T2, two in it, that's the one that shows up the water. Right? Remember that. That's a helpful hint. So the reason why I want to show up water, why is water important? Well, water is swelling, isn't it? So if you have oedema, that's going to show up as being bright.

Steven Bruce
Is that what all this is around here?

Rob Shanks
Where are you referring to? Well, now that's probably ligament tissue you're looking at there. So you've got subcutaneous fat, you've got ligaments as well. So that's probably not. You normally would see, where you see, I actually have got an image where I could show you that, I've got one of my other cases if you have got time.

Steven Bruce
Literally we've got about two minutes left.

Rob Shanks
Problem one is what you'll see in reports referred to as modic type 1. Okay, so modic type 1 which is basically bone oedema. These patients are often going to have, it's more common in the lower back but they're going to have like real deep gnawing kind of pain, deep in the spine. And when you see the image and you see a patient, usually in the lumbar spine, who's got significant modic type 1, you can really instantly get a sense of their pain. Because you see all this swelling in the vertebral body and think, goodness me, that must be painful. How could it not be? So yeah, that just illustrates a T1 versus a T2. The other very important thing you need to do is bring up the axial images. So if you maybe go on to the right hand side, so the right hand window, okay that'll do for starters. Okay, so you've got on the right-hand side the sagittal T1. And we've got probably an axial T2, I would believe, yeah, looks like an axial T2. Okay, so now what we can do, we can scroll through the levels, we can see now in cross section, what's going on at each level.

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

Rob Shanks
Yeah, yeah, that's right. That's one of the great things of OsiriX, it does do that syncing up. So now this is a really useful view, because now you can literally see lengthway slices, but also cross-sectional slices as well. And this is where now we would be looking for the exiting nerve roots, the facet joints, seeing what they're like. But yeah, it's like everything, it's like when you first feel a lower back, you don't know what you're feeling. But when you've done it 100 times, instantly your library just opens up, you instantly start to spot things that aren't right. And it's the same for MRI scans, it's no different. Things just start jumping out at you when you start.

Steven Bruce
What I really wanted to do there, Rob, was to put you on the spot and say, what should I be doing with this poor bloody patient? Because I think you don't have to be a practitioner of any skill whatsoever to say that cervical scan there looks bloody horrible. And this was a full spinal MRI. So we could get into his lumbars and see equally horrific things going on there, but maybe we can get around to that some other time. What we have got actually is Victoria has said, I've just realised I need a crash course in reading images HELP, in capital letters. Rob, what do you think she should do?

Rob Shanks
I think you should come along, Victoria, on Sunday morning. Sunday morning, isn't it, Steven?

Steven Bruce
It can't be a Sunday morning, it's a whole day course.

Rob Shanks
Doing a whole day course this Sunday with you guys. And yeah, it's gonna be a really intense day. It's a bargain price, in my opinion, what is it? 78 pounds, I think.

Steven Bruce
78 pounds, including VAT. We even throw in free glasses of water and tea.

Rob Shanks
So we're going to take you through everything from the T1 to T2s, how you put the images in, how you navigate all the different slices, go through what is pathological and what isn't. And we're hopefully at the end of the day, your confidence with looking at MRI scans will be right up there.

Steven Bruce
I made a complete fool of myself the other day, I feel, Rob, because I sent an image to Darren to have a look at, your colleague in your business down there. And I said, well, what are these horrible white things in the spinal bodies. And he said, don't worry they're just blood vessels, they're meant to be there, Steven.

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

Steven Bruce
And so, to put all that into context, it's going to be held right here in the APM studio. Our studio is in Northamptonshire, we are halfway between Northampton and Peterborough, or Bedford, and Kettering, whichever way you look at it. The junction of the A6 and the A45. We've got loads of parking, we're not paying for lunch, but we're taking orders for lunch and we kind of need those tomorrow. It's dead easy to get on the course, but you just have to go to our website and under the thing that says All Things CPD, there's a thing that says Courses, press that and you'll see two different badges on there at the moment, one of them is the MRI course. And I know it might well be too far for you to travel. But we'll try and do something else, which is more helpful for you later in the year. But if you can get here, it's going to be a great day. And if you haven't seen Rob and Darren in action in analysing these things, as is if you haven't seen enough already this evening, they really, really, really know their stuff and you can only go away being much, much better at reading these things as a result of the course. That makes it sound as though you know I'm just desperately trying to sell the course. I don't think I need to sell the course but, like Claire I just feel, and Rob, you must agree with me on this, I'm sure, we come out of college and we're just crap analysing these things and we really ought to be better because people regard us as spinal consultants.

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

Steven Bruce
Well, thank you for that. Pippa, thank you for sharing your case with us, another fascinating one. And Claire, thank you for helping out, particularly helping out because my sound has gone fuzzy for some strange reason. To put that into context, what we've actually been doing here this evening is phenomenally complicated. We've got so many different sound sources in order to be able to share this and get the sound from the people through Microsoft Teams and so on. Justin's done a great job in making it happen at all, since we've never done this before. But I do apologise that something strange has happened to my sound. Just a quick look ahead, we've already talked about Sunday's course, if you can still spare the time, there is still space to come on the course, not a huge amount of space, but there is space. So let us know. Website, All Things CPD, Courses, again, our MRI course. Next week, we're having a lunchtime case-based discussion, a week from today. And then on the 15th of March, we've got consultant Mr. Simon Marsh coming back to see us. Virtually, unfortunately, I'd love to get him in the studio. He talked to us before about Gilmore's Groin, which is an area of his particular expertise. And in

fact, he invited me to bring a whole lot of people down to a presentation in the Royal Society of Medicine after that. Claire gave me no end of stick afterwards because she wanted to talk about hernias, and we just went down this Gilmore's Groin rabbit hole. And so she didn't get all the hernias that she wanted. So he's coming back in to talk about hernias this time. And he's a lovely man, very, very knowledgeable. And yeah, it'll be a treat, listening to him. That's the evening of Tuesday the 15th. Again, a week after that, we've got a lunchtime CPD session. Lunchtime Thursday, the 17th of March, strangely, it's a Thursday I'm not sure why, Ali Noorani, who we had on the show before, he's going to be talking about acromioclavicular joint case histories. And just looking a little bit further ahead, if I can mention it once again, 13th of April, we've got the APM housewarming party, when we get a live audience in the studio. We've got a live band. We've got two brilliant osteopaths coming in to assess that live band and talk about how we use our skills, osteopaths, chiropractors, physiotherapists, to deal with the sorts of injuries that performing artists suffer. And we're going to run it on after the show finishes, we'll keep the live stream going so you can still enjoy it. Because we're going to get the band to play some cool music. We're going to get some drinks going up here as well. And basically, it's gonna be a damn good show. Because as you know, we like to do things a little bit differently in the Academy of Physical Medicine. Anyway, that's it for this evening. Time for you to get back to your gins and tonics. Again, thank you to everybody who's taken part this evening. There are over 400 people watching the show, which is a pretty good number. And thank you to all the ladies behind the scenes who've been fielding the questions, that's Ellie and Becky and Ana, possibly Ruth as well, I'm not sure if Ruth's on the the team this evening, and poor old Justin, who's in the gallery behind me trying to sort out the sound and the cameras and everything else that goes on in here. Because he was left single handed this evening, because Jay was taken away to sort out his elderly father, who's been taken ill. But there we are. That's how it all runs in the studio. It's been great from my perspective. Hope you've enjoyed it, and I'll see you again soon. Good night.