Academy of PHYSICAL MEDICINE

Case Presentations - Ref 136SNA

with Simeon Niel-Asher, Martin Matthews and Pippa Cossens

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TRANSCRIPT

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Steven Bruce
Let me turn to this evening's guests. I have Simeon Niel-Asher, who will be familiar to most people. I'm sure you've seen him before on some of our previous shows. He's joining us from Tel Aviv where I think he's three hours ahead of us so it's a bit of a late evening for him. I also have Martin Matthews, who's joining us from Bath, where down in the Southwest, I think the time zone is probably a couple 100 years before us. And I have Pippa Cossens, who's joining us from East Sussex where everything is perfectly normal. Simeon, you might know is our world leading expert on frozen shoulder and trigger points and I'm sure that his case discussions this evening will have quite a bit of trigger points involvement. Matthews is an osteopath, like the others massively experienced, everybody on the show this evening has got well over 20 years' experience as an osteopath, and Pippa. I know a bit more about Pippa, Pippa has trained as an equine osteopath, I know this because she trained with my wife, Claire. She's also a SIRPA therapist, which I mention because we had the founder of SIRPA, which is the Stress Injury Recovery Practitioners Association, Georgie Oldfield as one of my guests some time back and I suspect, I think Pippa, you also had quite a few years at the Osteopathic Centre for Children as well, didn't you? So massive experience amongst everybody. But I'm going to start with Martin. So, Martin, let's have a picture of you. Welcome to the show.

Martin Matthews
Thank you.

Steven Bruce
Martin, you're a bit of a stalwart of our case-based discussions, which is nice. And you and I have certainly, we've discussed this particular case before, haven't we, perhaps you'd like to take us through it. And remember that you can ask questions at any point during this or make your own suggestions as we go along. The whole point is for everyone to learn from other people's experience.

Martin Matthews
Okay, thank you, Steven. Now this case goes back a couple of years, but I think it's worth going over again because there were certainly some lessons, I felt that I learned from it. And there were some concerns I had over the way I handled it and the way I thought I might be judged by the GOsC over my handling of it. So, I was certainly concerned about it at the time. Now the patient in question is somebody that I've known for about 30 years. So, I've been in practice about 35 years and she's somebody I knew, as I said for a very long time. So, I knew her before she got married, I knew her when she got married, when she had her kids. And the same for me, our kids were about the same age going through the same things, choosing universities and doing all that kind of stuff. And we used to talk, well, we had a lot in common really and we used to talk about things as osteopaths do with their patients, just talk about everything really. So, I really enjoyed having her as a patient. She's a super person and I used to see her every year, every couple of years or whatever it was over that 30-year timespan when she had a problem with her back or with her knee or hip or whatever, all very run of the mill osteopathic things. So, a couple of years ago, she came along to see me again and at this point in time, she's 52 years old. She had a little bit of sciatica down one leg and what she described as a kind of screw or ringing out type of pain in her hip, which then went down the sciatic nerve, sort of derivation down her leg. And as we all know, a lot of patients use that kind of terminology, so it just

sounded like fairly run of the mill sort of stuff to me. I thought it's possible there might be a disc involvement. So, I started treating her, I'm a very straightforward kind of osteopath, really, I don't really use cranial osteopathy much, I'm very sort of structurally orientated in my approach and started treating her back pain and then her hip pain seemed to not go away and maybe even get a bit worse. So, I just couldn't explain this sort of ringing out pain. I don't know if there's any osteopaths out there watching who are familiar with that sort of presentation from their patients, who think it might lead them down one path or another when it comes to diagnosis, but certainly for myself, I didn't feel able to really put my hand on my heart and tell her what this kind of ringing out pain was being caused by. And it just didn't seem to add up. You know, I've known this girl for a very long time and the picture just wasn't kind of her usual sort of presentation. So, we had a chat about it and although it was pretty expensive, it was 350 pounds, and that was a lot of money for her, someone who doesn't work, who's putting two kids through university, but we decided between ourselves that just, let's get the scan done, and see what's going on. So, the scan was pretty expensive, and it was done at a local Bupa hospital once they accepted my referral. They were pretty stuffy at the Bupa hospital in accepting a referral from an osteopath, and not from her doctor. And in fact, she said, when she went for her scan, the hospital were really offhand with her, which I thought was pretty unfortunate, to be honest. Anyway, she had a scan done. And she asked me as the referring clinician to ring her when I had the results and tell her what was going on. I didn't mind doing that, I've known her for a long time, that's not a problem. So off she went, had her scan done and we were waiting for the results. Now I realised after a couple of days that the Bupa hospital had been trying to contact me frantically and two years ago, we were all getting very sort of stressed about GDPR and breaking these kinds of protocols, making sure we didn't break them. But Bupa were frantically trying to contact me and so I eventually, I mean, why they didn't ring me, I don't know, but they were emailing me, it would have been pretty easy to find my telephone number, to be honest. But so, I contacted them and they said they've got these scan results and they must send them to me now. And so, they actually sent me these scan results that I'm about to show you with no kind of encryption and kind of basically breaking GDPR rules. So, Justin, if you wouldn't mind just putting those scan results.

Steven Bruce
You've got a lot of experience, you're also a qualified proper acupuncturist aren't you, not a dry needler.

Martin Matthews
Yes, I always make a point of being very stuffy about that, Steven, but yes, I am. I received these results, they emailed them to me. And it was then incumbent upon me to ring my patient to tell her what the results were. So, I rang her on her mobile phone, she was driving a car, and I suggested that she ought to pull the car over and listen to these results. And she could tell because she knew me and because of the tone of my voice that the results weren't going to be good. It's probably the hardest, well it's not probably, it is the hardest phone call I've ever had to make to a patient. So, if you can see those results once you have a little read through them, you'll see the kind of enormity of information I had to impart and explain on my patient.

Steven Bruce
I'm being told that we've got problems with sound. Justin, can the audience actually hear Martin while this picture is up on the screen? Okay. Martin just run us through the key points on that image, if you would, on that document and report.

Martin Matthews
Okay, so the key points of the scan were basically destructive bone lesions in the sacrum *audio problems* just reading this multiple metastases really, and they weren't actually able to find a sort of primary lesion. There was a bit of disc bulging going on and a bit of wear and tear, but that's all really insignificant compared to the multiple bone metastases involving the lumbar spine and the sacrum. So, this is what was causing this sort of ringing pain in her hip. And I should have mentioned this at the beginning that she did have a few years earlier, a little brush with breast cancer, which was dealt with very quickly and very well. So, I impart this information onto her and she was extremely brave and really, really compassionate towards me, actually, saying that, it must be very difficult for me to ring her and all that kind of stuff, which just makes me want to cry when I think about it now. But anyway, that was that and I came on this forum and spoke about it at the time, and an osteopath who was watching asked me if her GP had had these results. And I said, well, I kind of assumed the GP had the results. And the osteopath suggested that maybe I should check. So, I contacted the Bupa hospital and the hospital said they'd been completely unable to send the results to their GP, because the GP was using an encryption system called Egress, which they weren't sharing themselves. So, the Bupa hospital were unable to tell the GP these scan results, which I was absolutely dumbfounded by, but thank you to whoever that was at the time, because I would just have assumed the GP would have had that information. And of course, they didn't. So, there we are, that's the situation with the patient. We've got their presentation of pain, and we've got the results of the MRI scan. And this left me with what I thought was a huge kind of dilemma, really, a sort of moral and professional dilemma as to what to do next. I've known this lady for a really long time. I know her kids, treated her kids, husband, I know her husband, her husband's a scientist, he is a guy who doesn't cope with stress at all well, and I didn't really quite know what to do. I wanted to obviously be in a position to lend my patient as much support as I could and lend her a sympathetic ear whenever possible. But the fact is I'm not an expert in oncology and I'm not a counsellor. And I wouldn't know how to approach or address the situation with her husband, who really is somebody who doesn't cope. And frankly, that side of it is none of my business anyway. But I did wonder what would happen if I found myself in front of the GOsC. What I would say, if they questioned me about the way I handled this case. I know it sounds dramatic, but I've never been a great fan of the GOsC, and they may or may not have improved over the years, but I've always kind of, they've always kind of scared me really with this sort of always this kind of possible threat of litigation and you hear of other osteopaths being dragged over the coals, only to be found that there was no case to answer but that they spent a good year suffering while the case was questioned. I don't know anything about, I have no expertise in cancer, as I said, I'm not a counsellor either. And in short, I'm not calling I'm not really qualified to sort of correspond in any way with this patient about the results she's had, because any help I can often really is on a sort of non-osteopathic basis.

Steven Bruce
Martin, can I just ask, some people actually missed the last part of the report, she was diagnosed with metastatic infiltration of basically the whole of the lumbar spine and the top two sacral vertebrae, wasn't she?

Martin Matthews
That's right.

Steven Bruce
Dare I ask what the outcome was for her?

Martin Matthews
Yes, the outcome was that she died about three months later, which is just the worst possible thing, isn't it? And she went into hospital and the cancer went to her brain and she got extremely aggressive and then towards the end, she calmed down, it became very peaceful for her. And her passing was kind of a peaceful event, really. But I look back on my conduct during this period of time and I really find myself quite impotent really in not knowing how, really how to deal with it, how to deal with her, and what was the appropriate way to deal with the situation, what things I maybe could have done better. Now this was all two years ago and I still think about this case quite often now. And after she died, obviously, I went through a phase of thinking, every patient that came to see me has cancer. And it really affected me sort of quite badly, really, and yeah, to this day, I don't know if I could have done things better. I don't know what support I would have had from the GOsC if her husband had made a complaint about me, for instance. His wife, she's been to an osteopath, his wife just died, what's he got to say for himself? So, I just wonder how other people would have responded in my situation and what other people would have found maybe an appropriate thing to do or what the GOsC may have deemed an inappropriate thing to do. I mean, my only regret, really, my only regret, I mean, I don't care what the GOsC think now, to be honest, but my only regret really was that I didn't just put my arms around her more and just say that I was sorry, really. I was just being too much of a professional, stuffed shirt osteopath and keeping my distance. And really, she just wanted somebody to give her a hug and show her that they were human and I regret not doing that more.

Steven Bruce
Anna has asked whether there were any obvious red flags other than the pain not going away? And I guess on top of that, how long were you treating it before you decided that the scan was needed?

Martin Matthews
Yeah. So, there weren't really any red flags other than a brief brush with breast cancer a few years before that.

Steven Bruce
But she'd had the all clear on that?

Martin Matthews
Yeah, yeah, no, absolutely. And so, the time between her seeing me with this ringing pain in her hip and me deciding that I didn't know what it was and that we should think about having a scan and then having a scan. That was two weeks in total?

Steven Bruce
Gosh, I mean, that's, honestly, that's nothing in the development of cancer, is it? So it's, it's not as though there was a significant delay in getting the diagnosis to her from when you saw her.

Martin Matthews
Yeah. But when I think you know somebody for a very long time and something strikes you as just not quite right, you've got to sort of act on your gut instincts, really.

Steven Bruce
Indeed. Barry has asked why the GP wasn't involved at the outset and why he or she didn't refer for the scan?

Martin Matthews
Yeah, I don't think she'd been to a GP. I think it's one of those probably quite risky situations where, if there's a pain in your back, you just go to the person you've always gone to, who normally fixes it. So, she came to me.

Steven Bruce
Yeah. Apparently, there are lots of people saying in the chat lines that you did everything right, which certainly it sounds to me as though you did. In terms of the GOsC, I really sympathise with anybody who is worried about how the GOsC might react and, as you say, I can understand how it would guide people's treatment in terms of being overcautious as a result of that. Because as you say, actually had you put your arms around this lady and given her a hug, that would definitely have been regarded as unacceptable professional conduct if, for whatever reason, she decided that it wasn't welcome. Or if her husband decided it wasn't welcome. But as you say, had they had they accused you of doing something wrong, it's hard to imagine what they could have found at fault, given that there's only two weeks between you starting the treatment and then getting that diagnosis.

Martin Matthews
Yes, yeah, I think at that point in in time, obviously, I wasn't thinking so much along those lines. But it's easy to reflect back on these things and think I should have done better I should have done this or that. But really, I kind of acted a bit on gut instinct, I suppose, and also having known this person for a long time, but I'm just not sure if you stand up in front of the disciplinary committee, the GOsC, and you say that I acted on gut instinct, that they would say, oh, fair enough then, off you go.

Steven Bruce
Lots of people actually on the Vimeo team are saying that they've had similar experiences, which is quite an eye opener, isn't it? Because we think of these things as being very, very rare, which of course, I suppose they are in the population as a whole, but they are not so statistically rare when it comes to people presenting an osteopathic practice or a chiropractic practice.

Martin Matthews
Well, I'm afraid, with the statistics now, it's 50%. One in two of everybody is going to have some brush with cancer in their life. It's absolutely horrifying, really. And I know it sounds overly dramatic at the time, me worrying that every patient that then came to see me probably had cancer. The fact is, probably lots of my patients have cancer, and neither of us know about it.

Steven Bruce
That's a really good point. Because I don't if you remember, I brought up a book, I don't know six months ago about breast cancer screening. The point made by the author, who founded the Nordic Cochrane Centre is that actually, when you get to 50 or 60, most of us have cancer and most of us will die with that cancer, not of it. Because most screenings or many screening tests will pick up even the smallest innocuous invasive form. So, you're probably right, we probably all do have it and distinguishing between what's innocuous and what's not is a very tricky thing.

Martin Matthews
Yeah. It makes you wonder sometimes if, the stakes are really, really high in this job, I think sometimes and it does kind of make me wonder, sometimes on a bad day, if it's worth it.

Steven Bruce
Talking about the MRI scan, Mel has pointed out that a private scan report would probably not go to the GP unless the patient had asked for it to go there, the report would be sent back to the referring practitioner.

Martin Matthews
Yeah, indeed. But I would have thought when you're filling out these forms, you always have to write down the name of your GP.

Steven Bruce
Yeah, I would have thought so too. And you'd kind of like to think, wouldn't you that in the real world, when a radiologist gets a diagnosis like the one here, he would say GDPR be damned, I'm going to call all the relevant people to make sure this patient is dealt with as best possible, as soon as possible.

Martin Matthews
Well, to their credit they did try that, they did their best to contact me. As I said they could have rung, it would have been quicker than emailing me. But once, as the referring clinician, they'd sort of passed the

information on to me, I guess they thought that was their job done and that they didn't share the same sort of encryption system as the GP didn't really matter, because the referring clinician had got the results and that was their job don't really have their hands.

Steven Bruce
And I suppose that GDPR does have an influence here, too, doesn't it? Because people will be worried about the minutiae of the Data Protection Act, rather than handling the patient as best possible. When really, I think we've all found now that GDPR has had very little effect on any of us, because nobody's going to complain about the way we deal with their notes unless we do something grossly stupid.

Martin Matthews
Which is what you said at the time. You said that a couple of years ago. But you know, we were all getting into a little bit of a flap of the unknown back then as to what the implications of GDPR were, and I think, well, as it's proven, you were correct. We don't need to get quite stressed about it.

Steven Bruce
Yeah, there's an interesting comment just come in from Anne, who says she genuinely doesn't think the GOsC would have come after you because these metastases had been growing for quite some time. And the reason I bring that up is because I think you're right, there wouldn't have been a case to answer, Anne, but the GOsC does not go after anybody. But if someone complains to them, they have no option but to investigate that complaint. And the screener would have taken this and said, well, there is the potential that the practitioner did something wrong in some way and it needs to be investigated. You'd like to think the investigating committee would say, no, everything's fine. But you can never, you can never be sure of that. And of course, it could then take a year, as you mentioned, Martin, before this whole thing gets to court, during which time not only have you lost a friend, but you're worried about your professional future. And it's a hugely, hugely stressful experience. Lots of people saying you didn't do anything wrong, so even had it gone to the Professional Conduct Committee, they couldn't possibly have found against you. But Elizabeth has brought up an interesting one. She said she had a patient on one occasion who had a square shaped breast, one square shaped breast, who would not go to the GP. And her local GP said, a woman with children who won't get a new square shaped breast looked at is not of sound mind. And it has nothing to do with your particular patient but again, it's another reflection of the types of patients that come through our doors. Martin, I think it's really good of you to share that with us because I think it brings up a lot of points about our concern about the legislative procedure that lies behind a lot of this, about GDPR, but also about perhaps the gaps in our training. We don't expect people to come through our door and die shortly thereafter of cancer and we're not equipped with the tools to counsel them. I suspect that GPs are slightly better at it, because they probably do more of it. But again, it's difficult, isn't it? And it's probably worth us remembering that we might need one day to be able to refer to an appropriate authority to get that counselling done.

Martin Matthews
But it might happen, just on that note, it might happen actually more to osteopaths now, because I mean, who can get an appointment with their GP?

Steven Bruce
Indeed, yeah. Yeah. Good. Well, again, thank you for that. I'm going to turn to Pippa next. Pippa, I know nothing about the case that you're bringing to the table. Would you like to kick us off with this one?

Pippa Cossens
Yes, certainly. So, this patient wasn't originally a patient of mine, it was a patient of my associates and so I came into the case a little bit later. But obviously, she'd written really good notes, so I've got those and you'll understand why I came in later on as we go on. So, the patient was a lady in her mid-30s and she had a 14-year-old daughter, she was married, she was working part time. And she presented with a reasonably straightforward, what appeared to be a reasonably straightforward pain in her sort of thoracolumbar region and around the right sort of quadratus lumborum. So that was where her symptoms, her main symptoms were. And she'd had this pain for about 19 months. So, it had been there for a little while, and it had been there during her first pregnancy. And she felt that it had come on after she'd lifted a box. And this was something that she'd done a lot of, it wasn't an unusual thing, it wasn't a particularly heavy box, but that was the incident that she particularly kind of attributed to the onset of her pain. And that pain then had been kind of fairly persistent, it was maybe a sort of a 5 or 6 out of 10, it varied in its intensity. And she did also have with it a little bit of sort of sciatica, she sometimes had some sciatica and some sciatic radiations. I haven't got a good note of what particularly made it worse, but certainly it was waking the patient at night. She was therefore better sleeping on her left side or sleeping slightly propped up, that seemed to make a difference. And the pain generally was better for warmth, for heat, and it was better for movement. Before coming to the clinic with us, she had seen a sports massage therapist, another osteopath, and she'd also seen the acupuncturist. And that was over those sorts of 19 months or so. There was nothing massively significant in her medical history. She was well, she didn't have any sort of trouble with any of her systems. She had had surgery for a bunion on her left foot, but that was, I think, in her adolescence, actually, or late adolescence, 20s. And she'd had an extraction of her wisdom teeth. And beyond that she had a bit of eczema, that was sort of really the most significant things that came up in her history. The delivery of her first child had been induced and was fairly quick, but there was nothing really more remarkable about it from there. So, my colleague had examined her and on examination, probably the most noticeable thing was a small scoliotic pattern that was concave to the right at her thoracolumbar junction, there was definitely an increased level of tension in the right quadratus lumborum compared to the left, and also there was an element of more tension in the right lumbar erector spinae muscles compared to the left. And there was restriction of rib 9, rib 10 movement inside the concavity of that scoliotic pattern. So, then the other aspect of it was the fact that there didn't feel like there was full expansion of her diaphragm, so that was reasonably straightforward. So, my colleague looked at that very mechanically and worked on those areas and also then looked obviously, beyond that, to make sure that there was nothing else going on at the other pivot, made sure that everything was balance. And she did this using sort of a gentle sort of articulatory approach, some soft tissue, inhibition of the rib heads, sort of direct massage on to the tight muscle tissues and doing side

bending and things like that. And she, basically she felt she got a good change and the patient went away and came back a couple of weeks later. And when the patient came back, she'd had sort of 24 hours that were better, but then it had gone right back into the same pattern. And essentially, the findings were pretty much the same. The pattern was very similar mechanically and the patient reported that the only other thing that had changed was she'd been a little bit emotional after the treatment the first night, but there was nothing else massively significant. So, my colleague, again, treated her a couple more times and essentially exactly the same thing happened. So, she was doing good treatments, she was looking at all the aspects of it, she was working on the diaphragm, she was working on the ribs, on the spine, looking at the other factors, looking at the limbs, looking at any imbalances elsewhere. And eventually, I think after about 4 or 5 treatments, she asked if I'd perhaps come and have a look at this patient, because she wasn't getting the change that she was expecting. There was, as I say, generally a sort of a 24-hour period where the patient was better and then the symptoms would pretty much return. So, I then came in to have a look at the patient and again, examined the same, the same sort of findings. But my background now is that I have had a little bit of extra training with my SIRPA approach and so I'm a little bit like a terrier, with my case history taking. So, I then wanted to expand the questioning of the patient to see what else might have been a factor. And she was very insistent that she'd lifted this box and that it had all come from lifting the box. And I think we find that with quite a number of patients. They're very, there's a very much like, this was the action and the result was the pain that I've suffered afterwards.

Steven Bruce
And it's quite easy, isn't it, Pippa, for us to to make that association rather than establish the causation. We think, the patient says this, then it's likely to be the case.

Pippa Cossens
Absolutely. But obviously with her what was interesting was that we've got this persistence of the pain. The pain had been there for 19 months. Now that's a long time for a fit, young, healthy woman, who's very active, to have had musculoskeletal trouble like that after lifting a box that she had lifted, many, many times, a box she lifted for work, and it was something she lifted many, many times. So, what we then discussed with her, obviously with her consent and very gently, was we wanted to find out a little bit more about what had been going on at the time of her injury. And it was at this point I said to her, so what else might have been happening, had you just moved house, was there anything going on with your family? And the slightly shocking response was that she said, actually, you've just reminded me that I was out walking and I found a man hanging in a tree. And essentially what had happened in that moment was she had gone into this massive sort of shock pattern. And so, we talked a bit about it, she was a little bit upset. But what had happened was that she had dealt with this with the psychotherapy, she'd had quite a lot of treatments. So, we were aware that we were able to treat that in that moment and she was safe and she was okay to do that without further psychological help in that minute. And so, what she had not done was put the fact that that incident had happened at the same time as the fact that she picked up the box. And so, we then went on to treat her with this knowledge. And whilst we treated her, we chatted a bit about it and how she'd felt about it. And a little bit about the sort of biological and neurological response that happens when you've had an incident like that. And she actually, her whole system, I tend to treat, we tend to treat a mixture through the

practice, quite a lot of general osteopathic treatment, articulation, and some cranial treatments. So, what we did that time was we actually treated her body with an idea to settling her system. So very calming, we wanted to establish really good midline movement and really good organisation around it. But all the time talking about the experience that she had had, while she'd been out walking in the woods that day. And she was a little bit as I say, she was a little bit tearful, but I think, because she's done a lot of that work already, actually it wasn't that distressing for her. And we obviously made sure that she knew we were going to be there for her and she could contact us and get in touch with us after the treatment at any time. And what was really interesting was that after that treatment, she had a similar pattern. She had sort of 24-48 hours, but then by the time that we treated her after that she then was pain free.

Steven Bruce
Astonishing. It's actually quite hard to imagine that that psychological aspect of pain can have such an impact that you could fix something so quickly that couldn't be dealt with structurally over such a long period of time, that period of time. Tell me what the, we've had Georgie Oldfield, the founder on the show, tell me what's the SIRPA thinking when you went through this diagnostic process?

Pippa Cossens
One of the big things with the SIRPA process is actually taking people, rather than just doing kind of like a case history, you would do a whole timeline. So, you actually send the patient away with it. So that you ask them when they had their pain and what else was going on at the same time. So, as you just mentioned earlier, people really want to attribute their pain to injury or incident, rather than emotional events. And very often it can be a combination, you don't necessarily have, you can have injury with emotion or you can have trauma without, but what the timeline does is it makes people really look back at their history and then start to go oh, do you know, actually when I got divorced, I had a lot of pain in my 30s when actually my husband moved out or my partner left or whatever. So, the big thing really, in some respects with the SIRPA approach is to look at the other factors that are contributing to the point of onset really, and I have to say this patient probably is the most dramatic and also they don't all get better that quickly. You know, often there's an awful lot of unpicking to do, with this one it's just the one in that moment where the significant, you just saw the penny drop in her eyes. And she went, oh my god, I saw this man in a tree. And it was like at that moment, her whole system went, okay, and it was like she exhaled. She took a breath. We then supported her through that realisation by releasing the tissues, making sure she felt safe and relaxed within her body. And that then is what made the difference. But often, it is much more complex than that, particularly with a long term chronic persistent pain.

Steven Bruce
Yeah. Billy has asked them what it was you said you'd had training in. And I mentioned it at the beginning of the show, SIRPA, which is the Stress Injury Recovery Practitioners Association. I think I'm right there, am I not, Pippa?

Pippa Cossens
Stress Illness Recovery Practitioners Association, yeah. It's a training for a professional. So essentially, you have to be a professional in another, you have to have another professional qualification to be able to add the SIRPA training, but it's a mind body approach to pain, recovery, stress, illness, and sort of quite a lot of patients who've got medically unexplained symptoms. So, we now in our case history taking will always ask about, people ask about general health, but we'll always ask about sort of sleep and anxiety and work scenario and family. Which I know is not unusual, we're asking it with that, where are the cues? And the beauty of it is, is it often puts together all those symptoms in those patients who've got multiple conditions, if that makes sense? You know, they've got low back pain, they've got plantar fasciitis, they get a bit of acid reflux, they get migraines, they've got TMJ pain, and suddenly you can start to go, do you know, we know that often all of those come from the same cause.

Steven Bruce
Okay, if you want to know more, as I said, we did interview Georgie Oldfield, who founded SIRPA, some months ago. If you go onto our website and put into the search bar either SIRPA or Georgie Oldfield, then the recording will come up and you'll be able to look through that one. So, does your case history taking process now take you twice as long as a result of that SIRPA training?

Pippa Cossens
What we tend to find, we do have some patients who will book in specifically for that. But very often, what we're finding now, even patients without long term persistent pain, we're kind of starting to see the cues much earlier. I had a lady who came in with, she's got an OA hip and it does need replacing, but she came in and she said, well, the pain came on suddenly in September. This must have been sort of October, no, it' was spring. So, she said, the pain came on in October very suddenly. And to me, that wasn't terribly an osteoarthritic pattern, I would have expected a slightly more gradual onset. And so, she was incredibly tight, the muscles she was holding on incredibly tight to that hip, partly as a response to the discomfort that she had. But I said to her, I said, anything else happened last year, there's nothing stressful that happened last year, anything that worried you? And she kept saying no and she kept saying no and we got 25 minutes into the consultation, and I'm trying to get this hip to relax off and she said, actually, she said, my daughter nearly died last year. And it again, it was that moment where you kind of go, okay, what happened in September? She said that was when she came out of hospital and everything was going to be alright. And interesting enough, it sometimes happens that way around, almost when the stress has gone actually, that's when the pain starts. And she walked out far better than when she came in, because we'd acknowledged to her that the stress, the effect it had had on her system and it meant that her whole system was able to relax, and then the muscles weren't so tight and so her hip wasn't being held in such approximations.

Steven Bruce
This isn't so vastly different from the bio psychosocial approach that we were all told to take many years ago, but which many people, myself included, probably paid lip service to.

Pippa Cossens
Absolutely, it is really an issue. I think with the SIRPA and the mind body approach it is, the biopsychosocial is really important. We also include in practice some of the Neuro-Orthopaedic Institute's, the NOI, Lorimer Moseley sort of work. Greg Lehman, we sort of look at that sort of work. So, I think all these ways, sometimes I think we don't stick necessarily just to one theory. I think sometimes you've got to kind of have an awareness that, when there's a persistent pain, there's something slightly different going on. And actually, sometimes you've got to explain it in different ways to different patients, some probably want a quite a biological, neurological approach, and some people are really happy to go straight into the emotional stuff.

Steven Bruce
So, given those experiences you've described there, I mean, what would be your advice to people who are not SIRPA or NOI or Greg Lehman trained, other than go and get training with them?

Pippa Cossens
Of course. I think the big thing too, you don't want to delve into the emotional stuff without some backup. Because I'm sure many people have had patients where they've perhaps done a release technique, could be an HVT, it could be a diaphragm release, it could be anything, and actually, suddenly, the patient has become incredibly emotional and you don't really know why. And I think, when you're starting to then look for these clues and look for these patterns, you need to have that kind of backup, to make sure that you're able to support the patient through that. But I think being aware of it is really important. And I think sometimes it's that thing of, I mean, I wrote an article last year about it, that I think we're gonna see quite a lot of chronic pain on the back of the pandemic, because I think the stress that hit people through the last 10 months is actually possibly going to then manifest later on as a persistent pain situation.

Steven Bruce
The pandemic aside, would you care to stick a finger in the wind and say, what proportion of your patients you felt had a significant psychological stress component to their injury?

Pippa Cossens
Significant, I don't know maybe 30%. But as a contributing factor, probably nearer 60%. But then also we have to be a little careful of bias, because essentially, we're looking for it. So, we're aware of our bias and we have to be, you know, sometimes it is just a knee. And it's been twisted or it's been strained or you've got to look at that just from that perspective. Often, there's, however small it is, there's something else in there.

Steven Bruce
Somebody after Martin had finished giving his presentation there, was saying that they'd been reminded of the need to have some sort of resource to fall back on if there is a stress component, a psychological component. And of course, it's very difficult to do, isn't it, when that comes out in a treatment session, if you're not qualified in counselling or anything else, I mean, it could come as much of a shock to the practitioners as to the patient perhaps.

Pippa Cossens
Very, very definitely. And actually, I'm running a course hopefully in the summer, taught by Michael Harris, an osteopath, and his wife, Annie Greenacre, who is a psychotherapist, and it's called Finding the Health in Trauma. And it's all about the osteopathic approach to patients with trauma. And one of the simplest things that he talks about doing when you're in that scenario, is to really contact with the patient, you need to kind of try and get eye contact with them, you might want to sit them up so that you're actually looking them in the face, because otherwise they're lying there, looking at the ceiling, and that can be a bit frightening. If you need to do it and just engage them and just very simply, you don't have to go, oh my gosh, why are you feeling like that. No, just checking in that you're okay, let me know that you're feeling alright. And if they need a little bit more than that, sometimes what we then recommend is a very simple exercise where we say, okay, what I want you to do is I just want you to let me know, 5 things that you can see, 4 things that you can hear, 3 things that you can, you know, you're aware of, I can't think what the other 3 are, but it's that bringing people's awareness back to their body because they've gone into that slightly shock pattern. So, like having a simple strategy to kind of bring people's awareness back is sort of almost essential.

Steven Bruce
Yeah. One final question for you, somebody has asked whether you have a place where you start when you're treating trauma like this, diaphragm, sacrum, or...

Pippa Cossens
Personally, myself, I tend to start at the sacrum. Because I'm often, I mostly will start cranially, but I will then if I feel I need to do some sort of very gentle articulation but I'll do that with a really calming intention myself. But I tend to start away not right on the diaphragm, possibly on the back of the diaphragm or the sacrum from a sort of a grounding point of view.

Steven Bruce
Susan has just asked, I said, that was the last question, but Susan sent one in just now saying, do you ever find patients who are reluctant to acknowledge a stress or emotional factor and insist that it's purely mechanical? Which I think you did say earlier on.

Pippa Cossens
Very, very, very, very definitely. And I think that then you have to, I think sometimes as the practitioner, it's slightly frustrating, because you know you could make more difference if they were able to acknowledge that, but actually, you've got to meet people exactly where they're at. And that might be that we go back to talking about things very mechanically, we might then say that anything in your life that makes you a bit tense is gonna make your joints a bit more tense, but we'll go right back to that sort of language. And then we've got other patients who are really happy to embrace it and go fully into the sort of the emotional aspect of that.

Steven Bruce
And would it be fair to say that statistically, more blokey blokes are likely to refuse to make that acknowledgement or could it be either sex? I don't want to go see my practitioner and be told it's just because you're under stress, because I don't suffer stress, you know.

Pippa Cossens
Of course, you don't. Which is why the latter end of this year, we're seeing more men with persistent pain than they'd normally have, because they don't want to talk about it. Which is fair enough. But we're finding that patients, rather than we maybe fixing something in sort of 2 to 3 sessions, it might take 5 to 6 before we can we can get there.

Steven Bruce
Well, Claire's been telling me I'm a persistent pain in the neck for many years, but that's her neck, I think. Tisha has just said that many of her patients are actually very grateful when they realise that their emotional state is having a huge impact on their symptoms. And so, yeah, it probably comes as a big revelation to some of them, doesn't it? That's all the questions that I have at the moment. So, thank you for that, Pippa, that's very helpful. And I think I will now turn to Mr. Simeon Niel-Asher to wind us up the last part of the show. Simeon, are you there? I think Simeon's falling asleep.

Simeon Niel-Asher
Hi there, sorry, I was on mute. I've not fallen asleep, that's for sure. Thank you, both of you for your excellent shares, really. Yeah, I felt a lot of compassion about this cancer patient. Actually, I've sort of put together like a little PowerPoint presentation. But I'm now thinking that basically-

Simeon Niel-Asher
I like the content, but people just triggered this unbelievable case that I had, which I kind of feel obliged to say it, I feel that people come to us with a sanitised version of their pain. I think we are mechanical, let's say, priests, if you like, of touch, and they see us as sort of, and sometimes when you move beyond into that kind of other realm, you can open up a can of worms. And I had a case fairly early on, I got into this kind of hole kind of thing early on, where I could definitely see that some patients were holding on to the emotional component around their physical pain. And it was quite kind of heady to release some of that stuff, because you were getting some real significant, like, catharsis, and really amazing kind of stuff. And then it scared me, so I kind of moved away from it into the sort of more structural way, which is kind of when the frozen shoulder thing started, actually, that whole thing, but can I just, I'll try and do a brief story. It's an amazing case and really, you just triggered it for me. Is that all right, can I go off piste?

Steven Bruce
Oh, I like the presentation.

Steven Bruce
Yeah, please, no.

Simeon Niel-Asher

I hope the GOsC aren't watching because it was a bit of an odd, well it was about 25 years ago. So, it was a really interesting case. It was a woman that had come in. And she was recommended by her best friend, no, her sister-in-law, her sister-in-law, there'd been a lot of trauma in her family. She was quite dour, she was quite kind of sour, and never smiled. And she came in with this sort of upper lumbar pain, L1/2 area. And she gave me the story that she had a crush fracture of L1/2 and that a metal bedframe had fallen on her back when she was 18 years old and she'd suffered with back pain ever since and no one was able to help her. And like she came in, you know, you're not gonna help me and, young whippersnapper as I was and kind of into this sort of psychological thing, I just kind of thought okay. So again, her tissues were really guarded around that L1/2 zone and you could see that there'd been some trauma there. I had her on her back and I wasn't kind of feeling the sacrum, in that moment when I was doing that kind of work, I would actually put my hand on the area that people were complaining with. And I actually was calming her down and I was getting the breathing and I was feeling into the tissues. I said to her, is there anything else that happened when you were 18, around about that time when this occurred. And she said no. Well, she said, there's something. And then she mentioned her mother. And as she mentioned, Mum, all the tissues went like this in her erector spinae. I thought heyho, we might have something here. And anyway, so then I said to her, look, do you want to talk a little bit more about this, your mom and then wow, man, it was such a story. So, her mother had basically, she had a terrible relationship with her mother, she told me, when she was about 17 her mother had had this terrible OCD and she would have to pull everything away and clean everything nonstop. And there was a metal bed frame behind a cupboard. And she moved the cupboard with her mom, and that fell on her back and fractured her L1/2. And she never forgave her mom for that and she left him as soon as she could and then she grew up herself. Her mother was about 51 when she was 18, or something like that, 47, something around that. Anyway, when she hit 47, she started to get an obsession for cleaning. And it turned out that she had, it was a menopausal kind of symptom that was in her family. And she felt this unbelievable conflict. She told me that she hated her mother so much but as she looked in the mirror, she saw her mom because she was starting to look like her mom and act like her mom. And she was in this incredible conflict of wanting to forgive her mom because she realised that her mom had a problem, but still wanting to hold on to the anger of a child. And it was all around this L1/2. Anyway, as she was processing it and talking it through while I was holding it, she had an enormous catharsis and she walked out and both of us felt something really healing had taken place and it was really powerful and that was it. She never had any more pain after that in her L1/2. And she even sent me a postcard saying she'd been waterskiing. So anyway, you just triggered that memory for me, thank you. Probably felt that I was out of my depth to be honest and had I have had a course, I think your words are incredibly wise, which is to have some resources behind you if you're gonna start doing this stuff, because it can be quite powerful. But nevertheless, I think, as I said, there's this kind of sanitised way that people come with, what I did find when I was doing that kind of work was that not everyone wanted to do it. And actually, some people felt really, I would use the word, a bit violated almost like we were kind of forcing them in there. They just didn't want to do it. But some people were very open to it. But anyway, that's the end of that, we can go back on piste now.

Steven Bruce
Now, just before we do, when you say some people didn't want to do it, you mean patients not wanting to go down that emotional route?

Simeon Niel-Asher
Yeah. Because it was so powerful. In fact, it was so powerful that I kind of wanted to do it with everyone and it was a bit of a mistake. Although that's kind of what happens when you get into things right. And I realised that actually, sometimes it was prying and they sort of felt it was a little bit too invasive, if you like.

Steven Bruce
I was slightly distracted there, Simeon, because I just saw a message had come in from Simon, who told me to stop talking about men being blokes because we have feelings too. You're absolutely right. Yeah, we do. Some of us are less willing to acknowledge them. Anyway, Simeon, on piste as you said.

Simeon Niel-Asher
Yes, back to the PowerPoint. So, I just put a few cases together. I don't know how long we've got.

Steven Bruce
We've got another half an hour.

Simeon Niel-Asher
Okay, so we don't have to do them all. Right, there it is. Okay, so I thought what I'd talk about are some kind of atypical cases that have been to me. My cat is meowing.

Steven Bruce
That's alright, we can live with that. It's the world of Microsoft Teams.

Simeon Niel-Asher
All right. Look, this is not actually a treatment room. So, if you see the cat on the bed, this is where I made videos from my software. So please don't get a shock. Okay, so, where are we? So, let's go to that those slides. Yeah. So, I thought we'd talk about some atypical cases. So where are we up to? Let's start. So, this was a really interesting question. It was about three years post qualification and it was a kind of a nice English, jolly English gentleman, a bit like you, Steven, he'd been in the military.

Steven Bruce
Apart from the jolly.

Simeon Niel-Asher
Yeah, but you know, obviously liked to cross dress and things like that. Anyway, moving on. And he was like, 71 years old and he'd come in with this really odd thing, which was he was getting back pain and headaches at the same time. And the back pain and headache would come on together, always, kind of

comorbid. How can I say, he was quite, um, I think he was an alcoholic? He kind of smelled of alcohol. And I think he had alcohol abuse syndrome. And his general health was fairly poor, I remember he had diabetes. He had some, I think, cirrhosis of the liver or some kind of liver stuff going on. But obviously being an osteopath and being keen and having done all the clinical method, I thought, okay, well, this is unusual, because why would he get a headache and a back pain at the same time? It just didn't really make sense to me. So I looked at the range of motion, and he had poor range of motion, poor lumbar range, and poor cervical range, didn't really help me very much. Okay, we're going to come back. I might just put these slides up for me actually, on my screen as well. You can't see that, can you?

Steven Bruce
No.

Simeon Niel-Asher
Give me a second. Where are we? Good. So, okay. So, he had poor range of motion, cervical spine, poor range motion, but especially had reduced extension of the lumbar spine. I did some testing on him. And then I thought to myself, maybe it's blood pressure. Maybe he's got a blood pressure issue and that's what his headache's from. And I took his blood pressure, and it was 270 over 180. I did it like three times. I was like, oh my God. All right. And now at the time, I was working in the surgery next door to this GP. This GP didn't like me because I was an osteopath, and he would never refer anyone to me, and this was his patient, and anyone that I would try and refer to say, I think there might be something going on, he just was not interested. Not interested. So, I wrote this letter saying, listen, this guy is come in with headaches and I think he's got something, pretty serious going on, blood pressure's 270 over 180. I remember I said to the guy, this is really not good. You've got to get to your GP right away. So, he went to the GP, the GP got back to me three days later, with a real apology, oh, I'm so sorry and I was very busy, because he'd obviously seen the guy and realised that there was something pretty serious going on. So anyway, it turned out he had a massive aortic aneurysm. And it was a dissecting aortic aneurysm, it ended up being 12 centimetres, and his blood pressure was so high that it was causing sort of headaches and the back pain at the same time, so that the back pain was from the aneurysm. And really nice chap again, I'd seen him a few times, briefly, I didn't treat him that many times, because I could feel that something was wrong. And turned out that he actually did die in surgery. They tried to sort of patch it up and do something with it and it ruptured during his surgery. So that was one case that really, I remember, stood out. Okay, so let's look at the next one.

Steven Bruce
Before we move on, Simeon, was there anything you thought were unusual, in terms of your palpation of the patient, were you able to feel that sort of pulsatile mass that people often talk about.

Simeon Niel-Asher
That's a good question, I did actually have it as one of my differential diagnoses, that it was some, I thought it might be spinal stenosis, stroke, intermittent claudication, some kind of spinal degeneration. It was certainly interesting to me to think that there was this comorbid thing between a headache and a sort of back pain. He was basically quite rigid. There was no, I do think I did do an abdominal, it's a long time ago,

I think I might have done an abdominal and I might have felt some kind of something wasn't quite right. But to be honest, two, three years into, and again, this is something that was shared with the first patient, which was that, and again, I wrote it down here in some notes, which is intuition. It's really odd. And again, with all these cases, I want to share that something kind of kicked in with all these cases, which was this weird thing. You know, you do this clinical method stuff at college, and you learn all this stuff and very rarely do you have to bring it in. But for some reason, in all of these cases, there was just something intuitive that kicked in, and I just knew that this was wrong. I just knew something was wrong. I just knew it. So, I don't know if that answers your question. It wouldn't answer the GOsC would it? But I guess I just knew it.

Steven Bruce
Yeah, I don't know if the GOsC would be satisfied immediately if you were taken to court for it. But you know, at the end of the day, we've discussed many times in the past, how untrustworthy most special tests are for all sorts of things. And sometimes you just have to say this doesn't feel like something I can treat and let's just get it checked out.

Simeon Niel-Asher
Yeah, and I think that's absolutely right. I didn't feel it was something that I could treat. And I felt that I would be disingenuous to the patient, without at least, well certainly once I'd seen that blood pressure, I thought, send him to the GP, because this is, we need to get this checked out. I mean, it was really frightening. I kept doing it and I was thinking, oh my god, how's he even alive this guy? Anyway, so that was one, should we do another one? So not long after actually, was another one that came into that clinic. He came in with left shoulder pain. Now I've already sort of have a special interest in shoulder pain. And this was really atypical because it was diagnosed as atypical shoulder pain and the reason was when they were standing and you did a shoulder examination, they had full range of motion. But when they weren't lying on their back, they were kind of semi supine, so they were like not quite lying back but somewhere a little bit, you would check the range of motion, the shoulder was, they couldn't move their shoulder properly, it was a decreased range of motion. So, what was happening was when they were going to sleep and when they were sitting up in bed, they were getting this weird shoulder pain. Been to their GP, GP had said, this is atypical shoulder pain, neurofen, anti-inflammatories, etc. In terms of the case history, they'd had oesophagitis and looking back, it may have been varices. So, I did think about the diaphragm. Because what I was thinking was, maybe there was some pressure on the diaphragm, as they were going up and down. And left shoulder, stomach, that's kind of what I was thinking, because we'd had it drilled into us in college. And so, I felt the abdomen, and indeed there was a bit of a mass around the left sort of sub-, what's it called? Not subchondral. Actually, I think it's called the hypochondriac region, right? And then I decided that maybe it wasn't for me, and I sent, with a letter to the doctor, which came back as a positive stomach cancer. And again, the patient died fairly soon afterwards. So, I'm not being, you know, it's very difficult, I think, again, with the first share, breaking bad news is not something we're really trained to, not something we do. A lot of us are very compassionate and intuitive and it's quite hard for us to do it. You know, it's just quite hard. So, they were two that stuck out and I know I should, these are all kind of a bit nasty, aren't they? Anyway, I'm going to talk about-

Steven Bruce
I think, Simeon, it's kind of what we need to hear, just to remind us that there is a side to what we do which can be extremely serious and demands skills that we don't necessarily have.

Simeon Niel-Asher
Yeah, yeah. Again, you're right. And I think what was interesting with that case was really, and I just want to say again, as she was sort of half supine, the shoulder was really completely stiff, like it really couldn't move it. But standing and lying, it was mobile. So, I don't even understand what that is. I mean, I'm guessing it's just sort of diaphragm sort of induced sort of referred pain. It was a strange case though, strange case. It'll stick with me, I'll remember that.

Steven Bruce
Tamara has sent in a very useful observation. She said that she recommends the book, Blink, which goes into the instinctive knowing that professionals have in detail with an explanation that makes so much sense. I'm not sure I read that very well. But yeah, I've had that book recommended to me in the past as well.

Simeon Niel-Asher
She's right. Absolutely. Right. The blink, it was my blink. Yeah, it's true actually, I didn't really, yeah.

Steven Bruce
Well, somebody's concerned a little bit about your empathy and your consideration of emotional states, Simeon. They've asked whether you've locked your cat in the cupboard and have you listened to it? Is it in need of releasing?

Simeon Niel-Asher
You know, I don't even want to think about it. I'm in love with my cat.

Steven Bruce
Matthew, who spoke earlier is, sorry, not Matthew who spoke earlier, different Matthew, has come in to say that he had a patient similar to your first one, who the doctor said he's so thin, he could see the heartbeat. But there was a visible pulsatile abdomen, when supine. The clue for urgent referral was the laterally expansile abdominal pulse. Unfortunately, the patient died not long after surgery. It's never a good, good sign, is it, aneurysm?

Simeon Niel-Asher
No, I mean, again, there's one thing about learning about it and another thing actually sort of seeing it clinically. The next one I just want to look at was a lumbar disc. And again, if this is being recorded, this was this wasn't me that did it. It was another colleague. But anyway, so this was a patient that had come in and they'd had about 10 years of chronic low back pain. And this is about 10 years after graduating, so already I'd had some clinical experience and I'd seen a few lumbar discs, alright. A lot of back pain. And this was a really nice guy and the shame of this actually is it had quite a good outcome in the end. I'll tell you the story,

it's quite funny but, god, he was terrible. Basically, he was 34 years old and he worked on films, film and TV. In fact, he'd been working on Star Wars and I was so interested in like, I was like so blown away that he was on Star Wars and he was a sparky, but he would go and he would do the electrics and getting in and wiring up the starships and all of these things, so it's really interesting, at Leavesden Studio. And he came in with this kind of acute episode on a chronic low back pain, it was back rather than lower extremity pain. So, I remember that he hadn't eaten all day and I remember his breath smelled a bit kind of keto-y. And I did a straight leg raise on him and some reflexes and it was all fine. Absolutely fine. And I was like, he was a really nice guy, really nice guy actually ended up being friends. Friendly, you know, friendly after, but it was a terrible thing. Anyway, I had him prone, and I lifted his leg into extension and man something just, I just knew something had happened. It was really shocking. It was horrible. And he just let out this enormous scream. And then he literally had to wriggle off the bed onto the floor. And his disc prolapsed on the clinic bed. It was awful. It was awful. And he was on the floor for about 40 minutes. I didn't know what to do, I didn't know, I was thinking, should I call an ambulance? And he was sort of saying to me, oh, no, no, it's not you, it's not you. And I was thinking, oh my god, what have I done? And, in retrospect, I'm really careful now, by the way, with extension with discs. I mean, I'm not sure I did anything more than he would have done leaning backwards trying to get a bit of wiring done on the set. But having said that, it was very dramatic. And he went white, he went sweaty, he had panic and it was really it was really quite dramatic. In the end what I did was I asked to call an ambulance, but his leg pain was searing leg pain, I actually got him into my car and I drove him home. And he stayed in bed, we put them on ambulatory bed rest, I got the GP involved. They did an MRI, and it was a big prolapse L4/5. And I learned a lot of lessons about hot discs. What happened after that was, I went to visit him every day in his house, as a home visit. I felt so guilty I just had to go do a home visit just to see how he was. I had time in those days to do that sort of thing. And in the end, in the end, it was quite a happy ending, like six weeks bedrest and a little bit of anti-inflammatories and he was much, much better. And so that was just a case that jumps out at me. And that was a lot of conflicting emotions, because I really felt that I had done something wrong, you know that horrible feeling when you go like, oh, god, I've done something wrong? And of course, it isn't what we want to do, is it, in our daily life? It's not why we get into this.

Steven Bruce
We're not prepared well for it in our training colleges, are we? Because unless that happens in college, and somebody in the college knows what to do, the first time a patient does something lying in the treatment room, you're thinking, what do I do? Do I call an ambulance? Do I leave him on the floor? Should I try and move this patient? You know, you are a bit of a loss, I think, certainly in your early days as an osteopath or a chiropractor. What would you do differently?

Simeon Niel-Asher
Yeah, I think the big thing was that he hadn't eaten all day and he was stressed out. I think I should have acknowledged that more and not being, I think I was a bit aggressive. I think I was a bit aggressive in retrospect, I mean, I just was a bit jolly. It was a long day and I was a bit overconfident with him, really. And we were having a nice chat and then it was just I wasn't really listening to, but having said that, the reflexes

were fine, straight leg raise was fine. I suspected it was a disc. You know, it wasn't like I didn't think it was a disc. I just didn't expect it to pop, like during the treatment, you know, sequestrate as they say.

Steven Bruce
Why was the lack of eating an issue for you?

Simeon Niel-Asher
I think that's why he went into this huge shock. I think that was part of it. The reaction was really stronger because he had sort of a blood sugar levels drop.

Steven Bruce
Yeah. Interesting, as soon as I saw in your notes that he had sort of a keto breath, I was thinking, is there gonna be a diabetic component to this.

Simeon Niel-Asher
It wasn't diabetes.

Steven Bruce
No, clearly not. Yeah, just going back to your previous one. Maras has sent in his own observations of a patient that he had some ten plus years ago, he says. Classic abdominal aortic aneurysm, pain in the legs and fatigue, lightheaded when walking, was a 70-year-old male, delayed pulse between arms and leg, broad abdominal pulse. And he sent him with his daughter, who had brought him in, to A&E with a handwritten note about the findings and concerns. They sent him away and the consultant on duty rang to complain about the referral. It's not uncommon is it? And Maras told the daughter to take him on an emergency appointment to the GP. The GP sent him back to hospital and this time they took him into surgery and although it ruptured, they did manage to save him during surgery. Which is, yeah. People will know I don't like to criticise our conventional medical counterparts but there are some out there who just don't take us seriously because they have no idea what training we have.

Simeon Niel-Asher
Yeah, I was just saying, because Israel's in the news at the moment because we are number one in the world for COVID vaccination, is that actually, there's a huge amount of collaboration between doctors and osteopath and surgeons over here, much more. It's really lovely. It's really lovely. And they value us as colleagues and they support us. It's great. So, it's a whole different vibe here. But yeah, I totally, I often felt that there was a bit of a glass ceiling, you know, we were treading on their territory and they didn't like it. Can we talk about the next one, because it was quite interesting?

Steven Bruce
Well, a couple of comments and then we will. Matthew says, CPD at Vista Imaging years ago, a medical legal expert, orthopaedic consultant, said, don't worry, osteopaths, etc, you can't cause a disc, that wouldn't have happened anyway. I remember hearing that in college, to be honest. All the same you don't want to be

the person who's asking a patient to do the movements when it happens, because they might reasonably think you're to blame.

Simeon Niel-Asher
Right? And that was definitely a fear I had as well that he was gonna sue me or I was gonna get struck off. It was horrible, horrible. As it happens, he was enormously gracious and that wasn't a concern at all. But you know, you go into panic and catastrophe mode. I held it together actually quite well. Unlike the next patient. Segue. Now, this was a crazy case, crazy. Let me get my notes on this one. Here it is. Okay, this was a really interesting case. This wasn't that long ago, it's three years ago. So, I'm already qualified in 92, you can work it out. This was a guy, a young boy that had pain, he had pain on ejaculation. 23 year old male. And he came in with his dad. And basically, it was a bit of a sad story really, because he'd attempted suicide, he'd thrown himself out of a window and it didn't work, but what did happen was he'd had massive spinal injuries and multiple spinal fractures. He'd had three surgeries by the time he'd come to me, laminectomy, decompression and he had sciatica. Sorry, he had sciatic pain. But that wasn't what bothered him. He was bothered because he was recovering and he was getting pain in his groin when he was ejaculating. It was a bit odd, you know, it was kind of odd because his dad was in the room, it's an intimate thing, but you know, I just thought whatever. The dad was a patient of mine and the dad was lovely, lovely guy. And I felt really a lot of compassion for the situation because it wasn't easy for anyone. And so, I thought, you know what, I'll think about it. And I remember learning and actually practising proper needling. In other words, IMS. I'm joking, that's a joke. I have enormous respect for acupuncture, okay. I woke you up though. So, I remember looking at the adductors and sometimes the adductors can refer testicular pain. And the other one that can refer trigger pain-wise is the internal oblique. And what I thought was happening was that we were getting something called the cremaster muscle, which is part of the internal oblique, it's the lower fibres, were being, this is terrible, I can't believe I'm going to how this, anyway, they were being sort of pulled on when he was an ejaculating and we're getting this kind of autonomic and sort of mechanical component to it. So, I decided that I would do an IMS dry needling session into the cremaster muscle and the lower part of the internal oblique. I can see, Pippa, I can see you wincing. Well, it was a bit. I don't know. Anyway, the good news is that it cured his ejaculation pain. That's the good news.

Steven Bruce
The bad news is he's never been able to ejaculate since?

Simeon Niel-Asher
Apparently, it's all working fine. And the bad news wasn't that it happened at a clinic. The bad news was that it was such a strong twitch needle effect that he literally vomited all over my room. He just jumped up and he just vomited everywhere, all over the floor. Oh, my God, it was just shocking. And I didn't know what to do, I just didn't know what to do. I mean, I'm pretty experienced, I've seen a lot of stuff. That was crazy. And I think the takeaway from that is don't do IMS, into the cremaster muscle, even if you think there might be better ways of doing it. That was a case that I thought, to be fair, it's late at night here so I just thought it'll wake everyone up. Should we do the next one?

Steven Bruce
We've got just a few minutes left.

Simeon Niel-Asher
So, let's finish with the last one. So, this was a really, really interesting case. Now this was again, about 15 years into practice. Now this guy came in with bilateral calf pain. He was about 46 years old, he was a lawyer, he loved playing tennis, okay. The history was a couple of days earlier, he'd played tennis, he'd borrowed someone's shoes, they weren't his tennis shoes. And he usually played on hard surfaces and this was on a grass court. And he came in with bilateral calf pain. So, I did my examination, no swelling, no redness, no tenderness, negative Kernig's sign. I thought maybe it was DVT maybe, I was trying to be sort of think it through clinically. And, again, this is one of those cases where I just knew something was wrong. Like there was nothing, everything about it screamed mechanical, borrowing someone's shoes, playing tennis, no swelling, nothing, no reddening, nothing like that. But something about it just screamed to me, do not touch this patient. My blink was do not do it. And I remember having this conversation with him. I said, Listen, I could treat you now but I think you might have a deep vein thrombosis. I said, I can't see any signs. I said, look, if I'm wrong, then the worst is that we've wasted a session and I'm wrong. I said, if I'm right, you will really thank me because I don't want to do any massage on this because it might be bad. And then I didn't hear from him for 10 days and I thought, you know what, maybe just thinks I'm an idiot. Anyway, 10 days later, I got a call from him in hospital. He'd had an 18 centimetre blood clot in his left leg and a 12 centimetre blood clot in his right leg. And he said to me, he said, the doctor said, if you'd done massage on my legs, I would have embolized and thank you for not doing it. So, I'm going to end on that one. Strange, strange, because I really just knew something was wrong and I can't even explain it. Because everything about it screamed, do some deep trigger point soft tissue work on me. So anyway, that's it. That's me done. He's ran out.

Steven Bruce
Simeon, you have an amazing amount of experience behind you. And it's not surprising to me that you've seen some really unusual cases like this. Very helpful to share it as well. Just going back to the DVT. I remember we were taught in college, what the signs of the DVT might be, I think clonus and things like that were amongst them, all of which I'm told are very unreliable. What do you understand to be the most reliable test for DVT?

Simeon Niel-Asher
Yeah, I have seen DVT since then. And it's usually is a little bit more obvious. I think the Kernig's sign is useful. I usually get them to sort of stand on their tiptoes and have a look at the calves that way. But I think and again, we've had this conversation, as you said, many, many clinical tests that we learn are not very specific at best. And usually it's like a cluster, if you're really going to rely on it you need a cluster of positives from several tests at once. Yeah, again, I'm just thinking of my last DVT, it was someone that had been flying. They've been flying or pregnancy, those are the two, it's usually the case history that is a strong factor. This wasn't, everything about this was mechanical, apart from the fact that it wasn't.

Steven Bruce
Okay. Simeon, we've come to the end of our time and it would have been nice to get everybody together to get some final comments but we're right up against the clock. Thank you to all of you for giving up your time this evening, because I think this sort of thing is really, really useful because as you said, quite often we feel very alone in practice and when we hear other people's stories of, not necessarily what can go wrong, but actually how we deal with the unexpected and learn to anticipate certain eventualities, it's very, very useful. Jules has said that your honesty is always very appreciated Simeon and particularly the stories about when your friend did things, they might not be proud of in subsequent hearing. And obviously, we've heard about the book Blink, which is recommended somebody else's pointed out that, I think Lawrence Butler teaches that although instinct is never a good reason to carry out a treatment, instinct can be a very good reason not to treat people, which again, another very experienced teacher. And final one Carrie Sharad says I noticed a bit simplistic, but she takes the view that sending someone to be checked out may give them a chance of better health or saving their life. And she tends to minimise why and say that I'm probably being overcautious, but let's just make sure, and actually finds most of our patients are actually worrying more about something terrible being wrong and feel validated by having it checked out. Yeah, it's one side of the coin isn't it? The other is trying not to waste the time of the teams in the MRI suites and so on. But anyway, that's all we have time for. I really hope you found that useful this evening. Oh, yeah, I've lost my sound, I'm told. Can you hear me, Simeon?

Simeon Niel-Asher
You're a bit muffly.

Steven Bruce
Okay. Fortunately, my sound is muffled right at the end.