How Does Hysterectomy Change Things - Ref 279

with Kelston Chorley

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TRANSCRIPT

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Steven Bruce
Good evening and welcome to another of our evening CPD sessions. We've been trying to set this up for ages. But at last, I'm actually in the studio with Kelston Chorley to talk about visceral issues. Now, this was prompted by a question from one of our members about how treatment is effective when a patient's had a hysterectomy. And at the time, I thought, well, that meant about treatment outcomes. But I've realised, of course, that this could also and should also include delivery of treatment to those patients. So we'll hear about that in a short while. The show is also very timely, at least I thought so because our case-based discussion last week focused on a patient with chronic lymphedema. And we had all sorts of suggestions from among the 400 or so people who took part in that. But it did strike me that maybe a visceral practitioner such as Kelson would have a very informed view on the topic. So I'll be asking Kelston about that later on and we'll see what he has to say. Obviously, visceral treatment has a much wider role than these matters. And so you know, it'd be grateful if you send in any of your own questions as soon as you have them. Share your experience as usual but make use of the fact that we have a real expert at your disposal here. Who is the expert? Well, Kelston qualified as an osteopath some 30 odd years ago, but specialised for much, if not all of his career in visceral treatment. He has now retired from teaching and from practice, so technically, we can't say he's an osteopath. But that's his background. He's been on the show once before, I think it was about eight years ago, we went down to his clinic, and we talked about visceral osteopathy in general. But it's a real treat to get him in the studio here and retired or not, he's still one of the country's leading lights on this topic. So great to have you here, Kelston.

Kelston Chorley
Thank you for that.

Steven Bruce
Thank you for making the trip up here. Sad, it couldn't have been on a motorbike in better weather because then we could have had an entertaining day tomorrow.

Kelston Chorley
The weather's good. It's just the temperature.

Steven Bruce
Well, I didn't mention, before we get onto this evening's topic, when I email you, when you email back, it comes from fit bones. You don't practice as an osteopath anymore. So what's fit bones about?

Kelston Chorley
Fit bones is a project I set up when I retired. It's basically an idea for enthusing and inspiring people over the age of 50 to think about getting fit, too many people leave it too late. So they get to 50. They get to 60. And they're looking forward to their retirement, but they've got to the age of 60 without doing anything about it and a bit like a pension, they hadn't put the investment in and all of a sudden they want to do things or they think to themselves I'd like to retire maybe a few years earlier, do some skiing, do some outdoor activities, but they haven't got the fitness or something happens and they don't recover as well from an injury. So it's about encouraging people to think at the age of 50 at least to start putting that investment in, which means going to the gym, it means managing themselves, planning effectively.

Steven Bruce
So how do they hear about it, how do they get involved?

Kelston Chorley
There's a website fit bones, fitbones.co.uk, you can find all the information about me on there. And there's a YouTube channel that goes with it. And I'm developing some podcasts with all kinds of people who hopefully will inspire others.

Steven Bruce
So actually, I mean, this is not for the practitioners who are watching this evening, but it's for their patients, and it will be very helpful for them to send their patients.

Kelston Chorley
One of the things I noticed, you know, you would notice the same as most osteopaths, chiropractors and physios in practice, private practice, will see those clients of theirs coming through at a certain age and you get chatting to them, don't you? And they've all got their ideas of what they'd like to do. But you look at them sometimes and think you know what, you're not going to make that unless you do something about it now. So it's about that sort of encouragement.

Steven Bruce
We offered up our clinic here in Higham Ferrers to the NHS on Sunday to run COVID vaccinations and flu vaccinations for the public. And three of my staff there, and I were in the clinic for the whole day. While, and I want to be polite about the NHS, because I love the NHS, but it was very badly organised this thing. So we only actually jabbed 55 People in the space of eight hours. And I think they could do better. But I was struck at one point because some people came in and they were hugely overweight. They were I think mid-60s, and they were hugely overweight, husband and wife. And I was just thinking to myself, you would help yourself so much if you did something to get fit. But I just suspect that people at that age who have reached, they were both, I think certainly one of them was type two diabetic. And of course, I think sometimes that's a diagnosis. But also, sometimes it's used as an excuse for being overweight or, and maybe people will resign themselves to being overweight, because they're diabetic, even if that might have been the thing that caused it in the first place, ist that something that rings a bell with you?

Kelston Chorley
Yeah, it does. But it's not just about those kinds of people, it's about often just your average person. As you know, once you get to the age of 50, you start losing muscle tone, it's gradual. It's not an immediate effect, but it's a gradual process. And then if you get into your late 50s and early 60s, it's a much more rapid decline in muscle tone. So unless you built that level up, it's going to be hard at the age of 65, coming up to the 70s it's almost impossible to start gaining muscle tone. So you've got to have it in place initially, just to maintain things, let alone increase it. So it's about just your average person who doesn't understand these things. You can't go into your mid 60s without putting that preparation in, you're gonna have lost a lot of muscle tone. And if you want to have an active, I mean, we all live much longer now, don't we? And I mean, and if you want to have an active lifestyle, you got to be fit to do it.

Steven Bruce
So fitbones.co.uk?

Kelston Chorley
fitbones.co.uk.

Steven Bruce
All right. We're here to talk about visceral osteopathy. So I suppose a lot of the audience are not osteopaths, they're chiropractors and obviously we don't want to exclude them. I'm one of these people whose, I'm slightly heretical in that I don't actually think that osteopathy fixes people, it's a person who might have trained as an osteopath applying certain techniques, and they can be all sorts of different techniques. Do you know what the chiropractic equivalent of visceral osteopathy is?

Kelston Chorley
I'm not sure if there is one in the sense that we understand it in Europe. I know in the States, I visited some chiropractic training colleges out in the States. And their approach is spinal manipulation, that tends to be the the way they work.

Steven Bruce
It would be very profitable for chiropractors watching, you can enlighten us on that because there's obviously there is a direct correspondence with cranio sacral with their sacral occipital techniques. And maybe there is something that some of them, they do, which is similar to what you do.

Kelston Chorley
The understanding is, I mean, in uni we have this understanding of visceral somatic reflex and the somatic visceral reflex, the somatic of visceral reflex, in other words, you know, something that occurs in the spine will generate a reaction somewhere in the visceral. Now we know that occurs through muscle guarding and spasm and various other things. But there's no evidence that I've ever seen that suggests that triggering a reflex from the spine following manipulation will have any effects in the viscera.

Steven Bruce
You did say when I came down to talk to you eight years ago, and I asked you about the evidence for visceral osteopathy, you said it's awful.

Kelston Chorley
It's appalling in all directions. But I have to say, we were talking earlier on about this, I mean, I'm retired now, so I don't use the title osteopath. So I would use the generic term MSK. So the application of what we understand in Europe as the sort of osteopathy is applicable to all people who work in MSK. It's a hands-on approach.

Steven Bruce
Yeah. When would you choose to use a visceral approach as opposed to what I'll call a structural approach, sort of manipulation?

Kelston Chorley
Well, generally speaking, having worked in private practice, and worked in visceral for quite some time, you kind of learn over the years, what is effective and what isn't. There's the theory about if you treat the liver and you do A, B, and C and you mobilise the liver, you're going to get this reaction. And that's a nice theoretical model, but I'm not gonna be treating anyone with liver disease, I'm not going to treat anyone with spleen ache or pancreatic disease. So I'm going to be treating more mundane problems if you like. So a lot of those might be pelvic related pain. Those are very common, testicular pain amongst men, pretty common.

Steven Bruce
That's an interesting one, isn't it? Because I don't think I've ever had a patient come through my clinic, saying, I've got testicular pain, can you fix me?

Kelston Chorley
Well, they'll usually come in with something else. And it'll be a by the way during the conversation that he crops up. So there's your opening, and you have a discussion about it, and discuss how it might be helped. And it is a relatively common thing amongst men, not generally spoken about, of course, I mean, people don't usually ring up their MSK therapist and say, well, I have a pain in my testicles, what can you do about it?

Steven Bruce
Probably a bit nervous about going to the GP surgery as well, because I'd have to say this in front of the waiting room. When I came to see you, I want to get on to what we are supposed to be talking about in a second. And we talked about evidence, and you said it was very hard to convince GPs and the conventional world about the benefits of visceral treatment. But you said there was a research doctor who was doing research into infertility. And she had been convinced, I think what you had done, possibly for her, but at the time she was in the middle of the research, did that go anywhere?

Kelston Chorley
Don't know, didn't follow it up, got distracted by other things in life and got forgotten about. But yes, that was an interesting one. And that came about kind of by accident, I was treating a lady for pelvic pain of unknown origin, one of those functional kinds of scenarios if you like, anyhow, she became pregnant. And it surprised her because they'd been trying for approximately two years to get pregnant. And so this took them by surprise. And I wondered whether anything I'd worked on had had an effect. And that got me thinking. So I put my thinking hat on and explored some ideas and got a few willing clients for me to practice on, practice my technique, honed the technique if you like. And then one or two clients recommended their friends who were at the point of considering having drug therapy. And I said, well, let's give this a go. And we did, and we got some results. And it was surprising. And out of the blue, I got a phone call from actually it was a senior gynae consultant at the John Radcliff hospital who'd heard what I was doing. And I recall the conversation because it scared the pants off me. I thought she was going to come down and give me a real earful. You know.

Steven Bruce
So we all expect that. You can't be doing this.

Kelston Chorley
Yeah, she didn't want to discuss it on the phone, you see. So anyway, so she came to see me and was quizzing me what I did and wanted me to show on her what I was doing. So that was interesting. And then it turns out that what they were doing at the John Radcliffe at that time was an experiment on giving a range of their clients, half an aspirin a day. The thinking behind it was not dissimilar if in fact, it was more or less exactly what my thinking was. The half an aspirin a day was designed to increase the circulation to the ovaries, the fallopian tubes in the womb generally that region of the of the body. My technique was a very hands-on, very specific, with the same principle trying to stimulate circulation in the area. So we had a kind of meeting of minds over a theoretical idea if you like.

Steven Bruce
And again, I suspect that evidence is going to be hard to come by for what actually happened as a result of your treatmeant.

Kelston Chorley
Yes, of course.

Steven Bruce
The outcomes you think were, were they statistically significant?

Kelston Chorley
No, obviously, I didn't have enough clients to do that. So one doesn't know.

Steven Bruce
Is anyone carrying on this work? Could you pass it on to anyone?

Kelston Chorley
Taught a lot of students. Whether they're carrying it on or not I don't know. But what was most interesting was the understanding that this consultant gynae had about the rationale.

Steven Bruce
I'm surprised about the aspirin thing because I've always thought of, you know, aspirin amongst other things as an anticoagulant, but I didn't think that it would improve the circulation.

Kelston Chorley
Low grade it within the blood paths, and that was the idea. Just that little bit of difference might be enough to cause a higher level of permutation.

Steven Bruce
Interesting. John has just sent him an observation saying chiropractic manipulative reflex technique is used by SOT chiropractors. sacro occipital therapists, I guess, and is widely taught at their seminars worldwide. So there appears to be an equivalent there. I don't think I've ever had questions coming in this quickly on one of our shows.

Kelston Chorley
It's a hot topic.

Steven Bruce
Normally they rush in at the end when there's no time to ask them. So I'm very grateful. Thank you to John and to Cat who sent this in. Cat says I have a patient who has recently had a hernia repair, since this, and it's been about six months now he's had testicular pain. Is this something you can help to explain?

Kelston Chorley
He's had a hernia; I presume it'll be an inguinal hernia?

Steven Bruce
Yeah. We don't know what the repair was whether it's mesh or not.

Kelston Chorley
Yes. One can only assume that there's been some irritation to the pudendal nerve, maybe. Always the problem with surgery. You never know what position people are being put in. You don't know what the depth of the surgery was, as you say, whether they put mesh in, could be any of those possibilities, right?

Steven Bruce
Any suggestions how she might approach this?

Kelston Chorley
The technique unfortunately is definitely classified as an intimate area. And it does involve stretching the testicle and with a gentle unwinding technique, you would need to go back to your anatomy book, look at the testicle and the tethering and the vascular supply to it. But it's hands-on.

Steven Bruce
Do you know right now I'm thinking that this evening's model is probably very grateful that she's not eligible to have this demonstrated. That's a shame her husband is not in, you could have demonstrated on him.

Kelston Chorley
But it's interesting, yeah, it's not something you'd normally think of as visceral work. But it is.

Steven Bruce
Yeah. Okay. We set this up because somebody asked about treating patients who've had a hysterectomy. And well, I mean, where do we go with this? And where do we start with how you might adapt treatment or use treatment to help the patient?

Kelston Chorley
Well, the first thing when I'm teaching students about treating anyone, or any area around the abdominal cavity is if we can bring up the slide of the abdominal pelvic regions.

Steven Bruce
As if by magic.

Kelston Chorley
As if by magic. What I've noticed is, particularly when you get your students for the first time doing a visceral course with you is they have got no idea about how to approach the front of the body. They're very used to feeling the spine they know exactly where T4 is, T7, T12. LS, they know where these regions are. When you turn the body around the other way, they're kind of lost, and they fumble about all over the place. And when you're doing post hysterectomy work, you really are looking at this little section here, which is if you drew a line across the ASIS and drew another line across the top of the pubic area, and then do two lines straight down from the mid clavicular line. That little section at the bottom is the tiny little area you're working in. So it's a very small contained little area. And one of the first problems is stopping people from rummaging around. You have to be very focused. It's a very precise area. Treatment approaches, well, it all depends on the type of hysterectomies, they've had. Of course, if they've had a full hysterectomy, where it's an abdominal incision, it's going to be quite deep through multiple layers of muscle. And you're not going to be going anywhere near that for two or three months. You're really not, they wouldn't want you near it anyway. But it needs time to recover, the deeper layers of muscle need time to recover.

Steven Bruce
How does the body react and adapt to the sudden loss of some fairly major bits of equipment?

Kelston Chorley
Well, like anything, if you take something out, something or fill its space. So other parts of the visceral will just move on down and take up and occupy that space. Although it's not such a large amount of material, if you if it's a full hysterectomy, we're talking about ovaries, fallopian tubes. Maybe the top section of the uterus, it's not a massive amount of tissue that's going to be removed. But there'll be some bowel incursion or intestinal incursion into that space.

Steven Bruce
Is that likely to be a problem? Does it cause issues?

Kelston Chorley
I haven't found that it has with people. Although of course, it depends on the reason for the hysterectomy. If it's been done because they've had growths or other kinds of problems, then they're most likely going to be in a younger age group. If they're in the older age group, then you've got the risk of I guess, yeah, things are going to move down.

Steven Bruce
As they are saying everything moves south as you get older. Women do say that a lot, yeah. Okay, so we've got some big glaring gaps in the structure down below that line. What's your aim in treating it? What is it you think you're doing or are doing?

Kelston Chorley
The only reason I'm going to be treating someone post hysterectomy is if they've got pain. I mean, that's the thing that's going to bring him into the clinic, that's the thing that they're going to be worried about.

Steven Bruce
Is there a characteristic pain of different types of hysterectomy or hysterectomy, in general?

Kelston Chorley
Characteristic pains will often be sharp, stabbing pains, those you're gonna find earlier on in the recovery in the healing phase, post three months, there might just be lingering, knawing pains, sometimes people get a slight, they get pain and a slight pressure, sensitivity of a pressure of something pushing down slightly. But it's usually a dull, persistent, or stabbing pains that they get.

Steven Bruce
And I imagine they're told to anticipate that by the surgeon before they have the operation.

Kelston Chorley
Yeah, of course.

Steven Bruce
What will the surgeon say you should do about it when it happens?

Kelston Chorley
Well, in the first three months, there isn't a lot apart from taking painkillers, the majority people are going to recover and have fairly minor issues, fairly minor pain, and that will dissipate as the weeks and months go by. But there are those that it doesn't, for whatever reason. Maybe some adhesions develop. Whatever the reason, their pain persists, and becomes a persistent nagging, interfering, affecting their life. So those are the ones we're going to be treating.

Steven Bruce
And have you, I imagine you must have had good outcomes in treating people in that situation in the past, you've been doing it for a very long time. You wouldn't be here this evening, if you weren't very successful at it.

Kelston Chorley
No. And those, as I say, one of the things if you're in private practice is you're going to tend to treat those conditions you know that you're going to get a high outcome result with because there's no point in treating weird and wonderful conditions where you're going to have someone coming back and back and back with very little outcome, if any outcome at all.

Steven Bruce
It takes a long time to know what you're going to be effective at treating doesn't it?

Kelston Chorley
It does.

Steven Bruce
Of course you can learn from your peers.

Kelston Chorley
I was just gonna say, you can usually learn from your peers, from them, the types of patients they have coming in, what they're successful with and what they're not successful with and so on.

Steven Bruce
Cat came back to say that her patient had an inguinal hernia, and it was a mesh repair. So to answer that question. And Sarah says that she remembers in your first broadcast with us, she has a very good memory.

Kelston Chorley
Yeah she does.

Steven Bruce
You talked about sticky people, people who were more prone to adhesions and others. Can you talk a bit about adhesions and whether we can or can't have any effect on them? She hasn't said can we break them down.

Kelston Chorley
Thankfully.

Steven Bruce
And I say that because...

Kelston Chorley
Yeah, let's just clear that matter up once and for all, adhesions we cannot break them down, no matter how hard, no matter how deep, no matter how vigorous you work, you're not going to break down adhesions. They are what they are, very fibrous tissue, when you open an abdomen up under surgery and have a look at them, you know, the surgeon is there with a knife, cutting them, they are pretty tough stuff.

Steven Bruce
And I know as I was saying to you earlier that people who've done some dissection courses with us, because we're using, by and large, our courses have been with animals, and so the material has been either fresh or fresh frozen. So there's been no interference with formaldehyde or anything. People have seen adhesions, and they can feel for themselves that these things are not going to break down.

Kelston Chorley
No, they're not. But in relation to her query about sticky people. I mean, those are actually I got that term from an abdominal surgeon. And there are those people that they get very fearful of opening up because they have a very a high likelihood of developing adhesions from the surgery itself.

Steven Bruce
How do they know?

Kelston Chorley
I guess they've had surgery before, they've had a reaction. Their repair to tissue has been well outside the norm, over healed if you like, you know how some people scar easily and generate quite thick scars on the outside, you get people like that who develop similar responses internally. And once the surgeon's opened somebody up for something and realises that they've got the type of tissue that's going to be highly responsive, they often get very scared of opening them up again. And they're classed as sticky people because they know that the minute, they go near those tissues they are gonna congeal and just form.

Steven Bruce
So these people you would have avoided as a practitioner as well.

Kelston Chorley
Well, I'm not gonna get anywhere with them, really, to be honest.

Steven Bruce
Okay. Interesting, Joe, we were talking about aspirin, I was asking about aspirin earlier on. Joe says that she was advised after blood testing to take aspirin on her third course of IVF. And the IVF was successful. That was 10 years ago soon, around about the time we did our broadcast.

Kelston Chorley
Yes, yes. And just to come back to that point, obviously, the work I was doing with infertility, all those clients I saw, had gone through a gamut of tests. They were at the point of having IVF. I would never have taken anyone on unless they've had the full gamut of tests beforehand to say, we don't know why you can't get pregnant. Nothing obvious. You know, it's one of those things.

Steven Bruce
Is there a test to assess the blood perfusion of the ovaries or other related tissue?

Kelston Chorley
There may well be, wouldn't surprise me.

Steven Bruce
Wouldn't know how they do it, but clearly it was what the NHS were working on, wasn't it, with their aspirin. And now I've got somebody who has sent in, Moor Health Pain Relief Clinic, APS, aka Hughes

syndrome, only labelled in 2008 is one of the main causes of miscarriage and stillbirth due to abnormal clotting. Were they given aspirin for that? Do you know anything of that?

Kelston Chorley
I know nothing about that. But it's a possibility, isn't it, if they've had abnormal clotting. That's quite a big problem for some I would have thought.

Steven Bruce
Yeah. Well, maybe somebody else can help with that. Alex says, under what circumstances would you be treating this area? He says hysterectomies, direct pain as a result of surgery or other reasons. You kind of answered that having people have come in with pain.

Kelston Chorley
They've had a hysterectomy, were well past the three-month point, they've usually been to their GP, because they're on follow up care. They've done the painkiller route. And it's not working, or they can't reduce their painkillers. They're stuck because they have to keep taking them. And things aren't clearing up. And as far as the surgeon is concerned, everything's gone according to plan. There's no obvious reason for it, yet the patient still has the pain. So those are the ones that I would take off.

Steven Bruce
And the only result that the NHS has is drugs.

Kelston Chorley
Normally, yeah.

Steven Bruce
It's a curious thing, isn't it that we, it's perhaps a popularly held belief, even among surgeons that an operation is measured in terms of its success by whether what you intended to take out is now taken out, not by whether the patient feels better.

Kelston Chorley
Yes, yes, that's true. That conversation just sparked a memory for me on treating an abdominal pain client. Here's an interesting one. There was a patient who rang me up from London. She was an Indian lady and she just returned from India where she'd been having some visceral treatment from an expat osteopath. That was a London trained osteopath, who was out living in India, treating expats. And she complained of this right lower abdominal pain, and it had gone on for 18 months, two years. And she saw this visceral osteopath. And there was a little bit of progress, but it really wasn't making any fundamental difference, came back to the UK and saw another local osteopath. And that didn't make a lot of benefit for her. So she rang me up on a whim, I think, really, to be honest, just seeking an alternative view I suppose. So she came up to see me. And this is one of the issues I have with people who work solely in this role, or solely in cranial as we were talking about, before the show started, is if you're not careful, you can have that hat and just go down that little rabbit hole. And everybody who comes in has got this or that, and you forget to look outside the box. So this lady came up with a bunch of files, you know, and all the treatments that she'd had in India and the investigations and dot dot dot. And I examined her, and

there was nothing obvious. And I asked if I could do one more examination procedure on her which was an intimate area. So I had to get her to sign a form and do all that. And basically, I went up into the obturator muscle. And lo and behold, painful as hell, right up towards the edge of the hip. Other side, perfectly fine. So immediately, I'm thinking to myself, this is not a visceral problem. This is a hip problem manifesting itself as lower abdominal pain, and sure enough, sent her off to an MRI, she had a labral tear, which wasn't an obvious one in the sense that she could move around and do things with her hip without inducing the pain. But that's what was causing the pain, had the surgery, problem was gone.

Steven Bruce
We had a chap called Simon Marsh on the show a couple of times, I think, he's a hip consultant in London. And he was very good at saying hip pain is not where people quite often expect it to be. It isn't out here on the edge of the hip. It's often very deep in the groin. Because of course the socket itself is quite a long way inside, isn't it?

Kelston Chorley
Yeah, it is.

Steven Bruce
And yeah, so it's interesting, you should say that, in fact, Christina Anne here has said that Simon Marsh did her husband's non-mesh hernia repair in August. He's had excruciating pain in the lower leg on that side since, she says L4, 5, S1. I presume she means dermatome. Simon says that he doesn't cut through nerves but moves them aside, I assume that this can impinge on the nerve or damage it. Any thoughts on that?

Kelston Chorley
Yeah, again, I will come back to the potential of the pudental nerve and its associated minors nerves. I have to admit my anatomy is a little bit adrift, having not taught these areas for quite some time now. But I would come back to that. And this is potentially a good case for working on the pelvic floor muscles from the front and the back as a way of releasing pressure off some of those muscular systems around it. She may well find some benefit from that.

Steven Bruce
Well, Christina, if you're up for doing that, it'd be fascinating to hear how you get on.

Kelston Chorley
Bring up a slide. Let's see if this thing works.

Steven Bruce
Sometimes if it's not been used for a while you have to buzz it for a while.

Kelston Chorley
Okay, let's move on. It's a little slow. That's all, it's going there. So we got pelvic floor muscles here from the front. And if you were going to be approaching this. Let me just show one more slide here. There we are. So again, like I was discussing, in the abdomen, the area and region you're going to be working in

is very small, very narrow and tight and compact. Again, these are intimate areas. You have to do the correct protocol before you approach any of this. But the area that you're going to be working is very defined. So it's important that you get your anatomy refreshed. But wonderful things, I mean, I think of all the areas I've worked on in the body the pelvic floor muscles are the ones where you get the most dramatic effects.

Steven Bruce
I've been told that that clicker's being erratic at the moment, but Justin will move the slides on to wherever you need them if it's not where you want.

Kelston Chorley
We can go back to the abdomen, I think.

Steven Bruce
I said we would talk about this, again, before we came on air, because, of course, a lot of what you have talked about so far, and a lot of the work that you've done in the past has been intimate areas. That being the case and given that there was a whole day spent on communication and consent on the visceral training course that you used to run, what procedure do you go through, if you are having to do an intimate examination or internal technique of some sort?

Kelston Chorley
I don't, very rarely do an internal, I kind of gave that up. I mean, I taught it in the postgraduate course, early on, for coccyx release, and so on. But actually, over the years, I discovered that you didn't need to do that at all, if you just worked around the pelvic floor muscles, you can eradicate it. If it was going to be one that responded well, it would respond without doing an internal. Internals, largely for me, I don't need to do but the intimate areas are close to those regions. So the usual protocol as you discussed beforehand, the rationale for what you want to do, I usually get up a little picture of what I'm going to do, the area I'm going to be involved in, demonstrate on a, you know, a little model, my little anatomy model, pelvis, show them what I'm going to do, explain the pros and cons and then say, go and think about it. Come back next week. And if you're happy, we'll go ahead and I kind of leave it with them for a week to think about it.

Steven Bruce
What are the current guidelines about this? I know, for internal work, you have to give them a 24-hour cooling off period, I believe before you're allowed under the GOsC regulations to do an internal procedure. Is that just your commonsense rule for that or is it laid down somewhere?

Kelston Chorley
I don't know if it's laid down somewhere. I mean, I remember I wrote a booklet on it, which the GOsC largely took on board word for word, verbatim as I recall. But I was thinking a week is a good time, they get a chance to go home, chat with their friends, chat with their husband, boyfriend, partner, whatever it might be. I like to give them a bit of time.

Steven Bruce
Do you get written consent?

Kelston Chorley
Always, always. So I have a standard form, explains what I'm going to do, why I'm doing it. They sign it, I sign it. That goes on the notes. It's copied onto the electronic notes, or it used to be.

Steven Bruce
Yeah. And it's probably worth emphasising the point, isn't it because we're constantly being told that the biggest cause of complaints against practitioners is failure to communicate properly. And of course, as soon as there is a complaint, one of the first things that they will look for in your demand every time is whether a, you've got good notes, and b, whether you have recorded that you've got consent, and mostly oral consent is acceptable. You don't have to have written consent. But for something like this, it's probably very sensible. Of course, in this day and age, we don't want to do that, because we've got all our notes on computer, and we don't want a box full of bloody consent forms.

Kelston Chorley
Yeah, I mean, when I worked at the, what was the BOA, now the Institute of Osteopathy, so I spent seven years with them as head of professional development. And that was a big area for me was improving those standards, improving the written work, setting up standardised forms for communicating what you're going to do. Yeah, it's a must, whether or not you have an electronic way of getting that permission. But definitely a written form, for any area of intimate work to me is just you've got to do it, it just make sense. It just saves any hassle. Thinking back to the you know, the phone calls we get at the office, from people who had been complained about and GOsC were following up, it's a nightmare for them.

Steven Bruce
Yes. And the same here, because lots of people will talk to us about complaints, and we here will try to help them out as much as we can. And it always strikes me that for so many people, you have no idea just how unpleasant it is, being the subject of a complaint until it happens. And it's very easy to think well, I've always done my notes this way. I always just scribble a few lines and you know, and all the things they will look for is, you know, have you recorded your examination. Have you recorded your working diagnosis and what you treated and have you recorded consent in every case, and it's just, people might regard it as tedious but come the day of the complaint you'll be grateful if your notes are accurate.

Kelston Chorley
Absolutely. Because until it happens, you don't know at all what you're going to experience but the people I've dealt with where they have been complained about. And then it's been taken up by GOsC. I mean, it's not like it just goes on for a couple of months. I mean, these things can drone on for a year, two years. And all that time it's sitting on that therapist's back in the back of their minds all the time. And I've even come across those cases where, right at the last minute, the protagonist is pulled out and said, well, actually, maybe I've made too much of it.

Steven Bruce
I sympathise enormously with anyone who's had to go through that procedure, particularly if they're innocent of whatever they're accused, of course. But I also have, and this won't go down well, with many practitioners, I have some sympathy with the general counsel's because once a complaint is made, they have no option, but to investigate it completely. And the registrant, the osteopath, or the chiropractor feels hard done by because the person who made the complaint doesn't have to have any involvement in that procedure at all. Once they've complained, it's handed over to the barrister, who's representing the general counsel. And so it's all on the shoulders of the osteopath or chiropractor, which is horrible.

Kelston Chorley
It is. And you're absolutely right. When the complaint's been made, they're an official regulatory body and they have a body that sits above them who monitors and assesses them annually, so their hands are tied.

Steven Bruce
And it's why they get the reputation of persecuting practitioners, of course, because they have no option it is their job, they have to do it. I have taken it up with one on these shows. I know in other occasions, the length of time is sometimes extraordinary, two years to resolve a case, particularly when that case then goes to appeal and it's found in favour of the registrant, seems an awful long time to me, but the law is the law, I guess.

Kelston Chorley
The law is the law, but sometimes it's an arse.

Steven Bruce
Christina Anne has said she's gonna see what she can do about the problem she reported earlier on. Elspeth has asked about, what about the prolapse of the bowel into the space left by the absence of the uterus?

Kelston Chorley
Well, as I say, the uterus is a fairly small structure. And there may be a bit of this sigmoid section of the lower bowel that moves in there and a bit of intestinal structure that moves in there.

Steven Bruce
Would you actually call that a prolapse, it's not really going...

Kelston Chorley
It's gonna prolapse unless it prolapses, if it starts coming out through the vagina, hopefully, that's not going to occur. They usually leave the top section of the vagina and the wall layer in place.

Steven Bruce
Okay, so it shouldn't be a problem.

Kelston Chorley
And that's obviously again, only with a full hysterectomy. Some people have partial, sometimes if it's a partial hysterectomy, they'll do it per vagina anyway, so they don't do an abdominal inseam.

Steven Bruce
She also, Elspeth also raises an interesting point because a hysterectomy is a really, really significant procedure for a woman, isn't it? So many women are devastated that they have to have this and there must be a consequent mental health effect. She's asked whether you've noticed if your work on post hysterectomy, women has helped with the depression. But if not, I'm interested to know what advice you gave them and how you were able to help them.

Kelston Chorley
Yeah, I mean, that's a complicated one. I mean, humans are humans, we all have mixed reactions to things. For some women, it's a devastating process, because it's like the whole end of their reproductive life. And it brings with it all those emotions and not being able to have kids and a whole raft of stuff that comes with that.

Steven Bruce
Isn't there an association with it, that is what makes you female as well?

Kelston Chorley
There is all of that, especially if you have your ovaries removed as well. And then you have to have drugs to replace them. But for others, it's an absolute blessing. So I mean, some patients would say, best thing they'd ever had done, they don't have periods anymore, their moods are more stable. So you get mixed reactions.

Steven Bruce
With those who do suffer from some sort of mental health struggle afterwards, some stress afterwards, does your work help with that?

Kelston Chorley
Not really, I wouldn't say it has. I mean, obviously, as a therapist, you've got to do a bit of bedside counselling, what have you, but usually, if they've got big issues, I would always recommend them go and see a therapist.

Steven Bruce
I imagine they're quite amenable to us as well. I always thought it's quite difficult in many cases to raise the issue of mental health in a physical therapy treatment room, but there are some occasions like that when you say, this could be worthwhile.

Kelston Chorley
Yeah, I mean, it's first and foremost in their mind usually, or they've had a lot of time to think about it because they're in the recovery phase.

Steven Bruce
Yes.

Kelston Chorley
Talking about mental health issues, there was a case, here's another interesting case, as a full warning, for those that start rummaging around on people's abdomens, it can set off, I think all therapies can, in fact, but there's something about the abdomen that is more sensitive, if you like it, people feel more exposed when you're working on the front of them than they do when you're working on the back of them. And that very exposure can lead to different responses. And I had a case that really took me by surprise, a lady who'd come in with chronic back pain, wasn't responding particularly well to normal procedures. And I just thought I'll have a, I'll just examine her abdomen, just to make sure she hasn't got any large growths in there, cysts, or whatever. And I did a very basic abdominal examination, wasn't deep, it wasn't particularly painful. It was a fairly standard approach. I thought nothing more of it, said that I couldn't find anything. And left it at that. I got a phone call the next day. In fact, it was the next evening, about 10 o'clock at night with this woman at absolute tears. Desperate, had to come and see me first thing in the morning in a heck of the state. And I'm thinking, what have I done? What did I do? And it turns out that having my hands on her abdomen and exploring it in that way, triggered an event that she kept quiet for 25, 28 years, she'd been raped by her uncle and his brother, when her parents went out one evening, and she didn't want to tell her parents. She didn't want to tell her husband, who she married about eight years later, she'd had two kids, she kept this buttoned down for all that time. And for whatever reason, maybe it was just right to come out. But that process was the trigger for it. And that took a bit of handling.

Steven Bruce
Yeah, I can imagine it did. And it's not an experience I've had in clinic, but I've had people on the show who have had similar revelations during the course of treatment. And it's right, I think I likened it to first aid, these things come out of the blue, and you're just not ready for it. And in fact, I am guilty of this. We had a show where we were talking about dealing with emotional crises. And the speaker was demonstrating something. And I said to the lady concerned, do you mind me asking? I'd asked her in advance whether we could ask her on air, but I didn't know the answer. You mind me asking what the trauma was? And she said, yes, I was raped. And she went into a bit more detail. And I honestly didn't know what to say, because I thought, I don't know how to handle a woman who had admits to something like that. Because obviously your instinct is you want to be consoling, comforting, on the other hand I don't want to do anything which might exacerbate the problem. It's very difficult, isn't it? And I don't know how you prepare as a practitioner for that sort of sudden emotional problem, which we're not trained to deal with.

Kelston Chorley
I handle that side of it well, just because I'm lucky in my prior life before training, as an osteopath I worked in forensic psychiatry, so I had an overexposure of stuff like that anyway. But again, my first reaction was I'd done something wrong. That was my first reaction. What have I done wrong? And what's gonna happen?

Steven Bruce
What will the General Counsel say?

Kelston Chorley
Coming back to that, yeah. So I mean, I think I handled the general emotional situation all right. But for other practitioners, that might be much more of a problem.

Steven Bruce
Yeah. I wonder if there should be some elements in our training, which, even if it's just a half a day, which prepares us for that sort of thing, and this is how you address those sorts of issues. Do you have patients undressed when you treat them? Or do you treat through clothes?

Kelston Chorley
Never treat through clothes, I like to have my hands on the tissues. I like to feel what those tissues are like. In fact, we have a model on there, I can show a little basic technique around working on the lower abdominal area. And you can see in a way, I can't obviously go through all the different techniques and you won't get the exact sense of how it is. But if you're working through tissues, tissues are going to slip and slide and move. And what you want to be able to do is to take the top layer of tissues and lock them, so you move down and penetrate the lower tissues, because that's where you want to be working. So it just wouldn't work through them, through clothing.

Steven Bruce
Should we go and do that.

Kelston Chorley
Yeah.

Steven Bruce
Okay, I'll take my little iPad with me, in case any more questions come in. We'll see what we can do with Susie.

Kelston Chorley
We have a model. Hi Susie.

Susie
Hiya.

Kelston Chorley
So what I'm going to do here, I have discussed with Susie beforehand what will be involved.

Steven Bruce
Have you got written consent?

Kelston Chorley
I'm not going to do an intimate area. So I'm just gonna bring these trousers, just down to about this point here. So we've got the top of the pelvis here. So imagine we're going to be working on this little area here. So I draw a line. Sorry, am I tickling you, if I draw a line across the ASIS, draw a line across the top

of the pubic area, draw two lines a bit sternal down here, you can now see, it's a little area, isn't it, it's very confined. And one of the first things I would teach on my course, is how to find the landmark of where the uterus will lie, where the ovaries will lie and where the fallopian tube will lie, and you can feel the ovaries, but you don't really feel the fallopian tubes. The uterus is quite low. But one of the biggest landmarks which will tell you whether you're on the right area or not, is the sacral promontory. So you can feel that once you hit the spine through here, you'll run off, imagine the spine comes down, you've got the sacral, the sulcus, sulcus of the sacrum and the sacral promontory here. So you've got a big bony landmark and that disappears into a little gully, which is the sulcus of the sacrum. So that's where your landmark will be. The tissues, obviously, if you're working, a lot of the techniques, they're going to be extremely deep. They're going to involve some traction notions, they're going to involve torsional movements, they might involve some torsion and traction, they might involve some vibration, all those methods are going to be really deep. So if you have clothing, you're going to lose some of that, you're not going to get the same feedback from the tissue. That's the thing.

Steven Bruce
But again, all the more important again, as you said, we feel much more vulnerable this way up, don't we, than with somebody working on spinal muscles?

Kelston Chorley
It's just something about approaching, I guess it's a basic animal instinct, isn't it, you're lying on your back, exposed, it always feels more sensitive. And if I'm working on somebody, I'd always throw a towel on the top, even if they've got a t shirt on, I'm gonna throw a towel, or just anything you can do to make them feel more relaxed, the better for you. Because obviously, the more relaxed they're gonna be on the couch.

Steven Bruce
Susie, are you feeling relaxed under the lights and the cameras and 500 people watching.

Kelston Chorley
But just to relay, to come back to that, the area is going to be very confined. So you're not poking about out here, prodding about out there, it's a little confined area.

Steven Bruce
And what can you reliably feel in terms of the internal organs?

Kelston Chorley
You can reliably find the ovaries, you can reliably, if you sneak down low enough, just behind the pubic bone, you can feel the bladder. And then the uterus is a bit more difficult. In fact, it doesn't matter whether I find the uterus or not, so long as I can work on those tissues close enough to it and get high level of stimulation. That's good enough. And what most people I mean, a technique like that's going to be 15 minutes, much longer than people think. So it will be 15 minutes' worth of hands-on treatment. And what most people will feel after that is an intense heat. And it's a very localised intensity.

Steven Bruce
Which is presumably improved circulation.

Kelston Chorley
Yeah, it's a very intense, and it's very focal.

Steven Bruce
Yeah, and at the risk of sort of taking us back to undergraduate basics. How do you know whether you need to do traction or torsion or traction and torsion?

Kelston Chorley
I mean, that just comes from practice and experience of what the tissues feel like underneath to be honest.

Steven Bruce
Okay, so we've now covered the whole of your visceral osteopathy course, it's just basically practice it.

Kelston Chorley
Yeah, I mean, the techniques to anywhere that's soft and squishy.

Steven Bruce
So, most of me.

Kelston Chorley
Is going to involve those sorts of approaches. It's traction of the tissues underneath the musculature, traction, torsion, vibration, combination of all of those. So you're working down through the deep levels of fascia.

Steven Bruce
What's the vibration achieving?

Kelston Chorley
Who knows?

Steven Bruce
You said that you can be slightly controversial and of course, I can remember at college people will be saying, I can feel the tissues want me to go in this direction, want me to do that. And of course, yeah, under your hands, you can feel that things want to do this. You might not want to do this, but you're a bit more blunt. But it works.

Kelston Chorley
Well, it's more the fact, what you're trying, you go in and you feel the structure, initially it'll be your client is tense, it takes a little bit of time for them to relax and trust your hands and feel safe with you. Once you've got that, then you can go a bit deeper. And then you start to feel when you start tensioning tissues

in one direction, tensioning tissues in a different direction. Once you explore those different directions, you suddenly find well, one area definitely feels more tight when I put it this way than it does the other. And you'll experience, you know, that shouldn't be the case, you could do it on the alternative side if you want to be sure. And then you'll work on that. The vibration, again, it's just a way of stimulating relaxation, circulation. Just like we know that vibration does that on any part of the body, doesn't it?

Steven Bruce
I remember we were taught during my course to do lymphatic drainage techniques which involved vibration over the sternum. Did you or do you do lymphatic drainage?

Kelston Chorley
Don't do too much, I didn't really do any lymphatic drainage apart from someone who's had an injury. I tend not to get involved with lymphatic drainage on the whole. But if someone's had pleurisy, they've had chronic chest infections and that sort of thing, I'll apply the same idea on to the chest as I would on the abdomen only in terms of visceral work, you've got direct application. So I'm gonna go through these tissues, I'm going to make as close to contact as I can with the structure and do something with it. That's a direct technique. If you're working on the mediastinal area, you haven't got direct contact. So it's an indirect technique. So you're going to use your hands to twist and torsion the sternum, mobilise the ribcage, some of it will be basic osteopathy, but others will be quite forceful, torsional movements on the sternum which has an indirect on the tissue underneath. You could apply vibration, absolutely no reason you couldn't.

Steven Bruce
So I suspect I'm gonna get a pretty short answer on this. So let's suppose for a second, that our model here has chronic lymphedema and one of her legs is twice the size of the other one, what are you going to do about it?

Kelston Chorley
I'm going to send her to the GP and get her on drugs. I'm gonna do nothing with it.

Steven Bruce
Is that because you don't know how, or don't believe there is anything you can do?

Kelston Chorley
I don't believe there's anything you can do as a MSK specialist, frankly.

Steven Bruce
And we did have an osteopath, on the case-based discussion who specialised in this, you said that he does do some techniques, which helps the patients but he also said it works in conjunction with whatever conventional medicine has to offer them.

Kelston Chorley
Yeah, and I would think that's a fair answer. I mean, conventional medicine is gonna have the biggest answer whether that person gets a little bit of short-term temporary relief. That's fine. But you have to be a well-off client, I think to keep coming back for that.

Steven Bruce
Yes. And I suspect some people with chronic lymphedema are quite distressed and anxious about having, this lady had it, I think she was in her 40s. And she had it since her late teens, you know, must be soul destroying,

Kelston Chorley
It must be. I just wouldn't. I wouldn't feel comfortable taking on a case like that, because I don't think I'd be offering, well, I know I wouldn't be offering value for money. And in my practice has to be value for money. Someone comes in with something, I feel comfortable treating it, I know they're going to get value for money. They're not going to be repeatedly coming back. I'm happy with that.

Steven Bruce
So there are a couple of other aspects about post hysterectomy patient, which you did mention earlier, on in terms of, let's move away from the visceral stuff, let's say that she's coming in with some sort of low back pain and I'm a structural osteopath, and I waggle the joints around a little bit and they'll go satisfyingly clunk when I do that. Are those treatment outcomes going to be any different in a patient who's had a hysterectomy, do you think?

Kelston Chorley
Know, why? I can't see why they should be.

Steven Bruce
I wondered whether I should modify my techniques. I'm not gonna treat them in the first three months. But

Kelston Chorley
No, you wouldn't be, I wouldn't be because you're rummaging and you're twisting them around, they're not gonna feel comfortable, there is always a risk of a tear or something. Or a hernia. The biggest risk is a hernia in that first two, three months, so you're going to kind of keep away from it. But after that, no, have no influence one way or the other.

Steven Bruce
Well, that should be setting at rest the member who asked about treating after hysterectomy. In terms of what you know, before we release Susie back into the wild, in all your experience, what's the obvious sort of things that a structure osteopath like myself might miss that you would pick up? Or any interesting cases you can share with us.

Kelston Chorley
Well, there was a case, well, when you've been in practice for a long time, there's a bunch of interesting cases, aren't there. This is an interesting one, there was a guy, German lad, he was 20, 21, brought in by his dad. The story was, they got on holiday, and his dad was driving, they got a puncture, dad forgot to put on the handbrake, rolled over the top of the son, straight across his pelvis, fractured pelvis, you can imagine it was a mess. So he had surgery and he was about eight months after the event when he came in to see me. Another case of testicular problems and pain in the penis, and problems with getting erections and all that stuff. And chronic pain. They kind of written a hands off at eight months and said, well, look, it'll all hopefully come back in the future. But we can't offer you anymore. So I did all my, he was a classic case where you do all your general MSK mobilisation of the pelvis, getting the guy as mobile as you can. But there was a lot more to it. Because the trauma to the tissues and the trauma to the pelvic floor muscles. That was the key to getting this guy right. And without that he'd have struggled. And I think that was, I mentioned earlier about the pelvic floor, that is an area where you can do so much. And the results are so great. It just speeded his case up dramatically. So if you're a standard MSK therapist, you'd have done all the things that I would do, I'm sure and the guy would have felt generally more comfortable. But there's a bunch of problems in there that wouldn't have resolved without that extra bit of knowledge.

Steven Bruce
And I suspect that no GP would refer him to you for problems like that.

Kelston Chorley
No, not at all. And he did very well. Went back to Germany. I think the worst of it all was his dad never forgave himself.

Steven Bruce
Obviously, I was gonna say there must be extraordinary mental health issues for his father.

Kelston Chorley
I think it was his father who probably suffered more mentally than the son did. Yeah. That was an interesting one. So that's an example perhaps.

Steven Bruce
Okay, Susie, thank you very much. We're gonna go back to our seats.

Kelston Chorley
Thank you very much.

Steven Bruce
The questions are coming, I haven't even looked at my list here when we were standing there. Joe has said, I've recently been treating a 51-year-old lady for general stiffness. Prior to seeing me she'd been having periods every three to four months. Heavy, but not painful for six days. And after a couple of treatments, I started treating her psoas and now following treatment within 24 to 48 hours. Every four weeks, she's having a heavy bleed for three or four days. Or psoas I think needs releasing that should

say, but I don't know if I'm okay to continue, as her GP suggested, without hormone testing that she'd started her menopause. Should I continue? I'm only an MSK osteopath, not visceral.

Kelston Chorley
Again, if you're working on the psoas, you could get your anatomy book out and explore a little bit more of the pelvic floor muscles. I mean, it's perfectly legitimate MSK stuff, you know, they're a whole big bunch of muscles. Just because they're there doesn't mean that you shouldn't treat them.

Steven Bruce
But neither should it because she might be perimenopausal either.

Kelston Chorley
She might be. If he's got some kind of result initially, explore it, but at the same time, send her off to have hormone tests, blood tests. I mean, these are the sort of cases always working tandem, because that might well be what's going on. You might be having a good phase. It's not related to what you're doing. It's not fair to them to say that you're going to fix it if it is.

Steven Bruce
We just ticked another useful box in the osteopathic practice standards and the chiropractic code because one of it is to work in conjunction with colleagues across the other healthcare professions, isn't it and some things we can't do entirely by ourself, does seem strange that the GP has made a diagnosis like this and made an assumption if you like that this 51 year old lady is starting her menopause, it seems possible unlikely.

Kelston Chorley
Well, they're in a different position to us. We have patients who come in with the after problems that they come in with. The GP will see a range of women at a certain age displaying and talking about those kinds of symptoms, and they'll probably just, you know, think the likelihood is, and frankly, the first thing you would do is take a blood test. It's an easy test, isn't it?

Steven Bruce
Yes. But of course, it's yet another test that has to be paid for and it's time and all the rest of it.

Kelston Chorley
It's time and there's not a lot of patients in GP clinics for perimenopausal women, unfortunately. That's the bottom line.

Steven Bruce
Jonathan has said you mentioned vaginal hysterectomy, when treating your clients, was there a difference in pain patterns and sensory loss with a normal hysterectomy as opposed to vaginal.

Kelston Chorley
And all hysterectomy always more. I would always see more patients with problems when they'd had abdominal surgery. That's a given.

Steven Bruce
And Pip says, do women who've had an endometrial ablation as opposed to a hysterectomy have any issues you find yourself looking out for afterwards?

Kelston Chorley
Sorry, just repeat.

Steven Bruce
Do women who've had endometrial ablation rather than hysterectomy, are there specific issues you'd look out for there?

Kelston Chorley
Ah, generally not. But if it was, if the endometriosis was just confined to the womb, then I probably wouldn't be that involved with it because they probably wouldn't have too many issues. If they had endometriosis where it had spread outside, then perhaps I'd be involved. But usually that's quite a good successful treatment, ablation.

Steven Bruce
Yes. Katie, Katie, nice to have you on the question list. Yeah, I'm haven't seen Katie for ages. Katie says, interested in what your experience is in patients who come in with symptoms other than directly linked to a hysterectomy, for example, incontinence, lower back pain, not pain from the surgery. Have you found patterns or similar findings?

Kelston Chorley
No, it's a complicated area because the thing with general, lower abdominal pelvic pain is, a lot of it is mysterious, in a sense, because it's functional. There's no obvious cause for it sometimes. And it does take a bit of exploring. It's not always easy to root out exactly what the problem is. Constipation, chronic constipation could obviously lead to problems. Yeah.

Steven Bruce
Okay. And Carrie says that she appreciates that this is subjective, but if there is something a patient has buried, and doesn't want to discuss, do you think this would contribute to prolonged pain or recovery?

Kelston Chorley
Put on my ex-psychiatry hat for that one.

Steven Bruce
Good opportunity to make use of your expertise as a psychiatrist. What does a forensic psychiatrist do? Forensic means court related, doesn't it?

Kelston Chorley
Forensic psychiatry is related to the treatment, management and assessment of the criminally insane, murderous, paedophiles, rapists. Nice little bunch of people.

Steven Bruce
I was gonna say, a fun bunch of people.

Kelston Chorley
Yeah. And some of them would be on Her Majesty's pleasure. And we would be assessing them to see whether it was safe to let them out or not.

Steven Bruce
God, that's a hell of a responsibility.

Kelston Chorley
I was young in those days, you just breathe through it.

Steven Bruce
Yes. But, in terms of affecting pain and recovery, buried issues.

Kelston Chorley
Buried issues. I think my instinct, I've got no evidence for this at all. But my experience and instinct tell me if you bury something emotional, it's always there. And it's a form of internalised stress. Stress is something that the human body doesn't like. And it'll find a way of shedding it, getting rid of it. So it'll either express it emotionally, or it'll express it physically, it'll find a way out somehow or other. That sounds a bit kind of wacky.

Steven Bruce
I have an example of that, and this has nothing to do with my work in clinic, but I was in jury service last year, late last year and there was a young woman who was the plaintiff, who was complaining that effectively, she had been improperly touched by her grandfather, when she was, I think 10 years old. And she's now 16 or 17 years old. But she had locked this away completely until six or seven years later, and she'd been a perfectly normal child until six or seven years later, a friend was talking about something similar having happened to her and all of a sudden, it kept coming back and broke her up. It was was painful watching her in the witness box, I have to say, it's extraordinary how the human brain can lock away.

Kelston Chorley
It can lock it away and pigeonhole it. A lot of criminal psychiatric cases are people like that. I mean, they're very good at compartmentalising things which allows them to get on in their normal life when they've done something pretty horrible. And in the same way, people who suffer those kinds of events or war events or whatever it might be, like PTSD, those sorts of situations. It comes out, it has to find a way of expressing itself, no matter what. And it's often just a random thing that is the button that triggers it.

Steven Bruce
Some people write a bestselling ghostwritten autobiography and make hundreds of 1000s, that must help with the mental stress. Linda says, would you advise patients with a mild prolapse to go ahead with a

hysterectomy or persevere without one, GP seem keen to do hysterectomy is without exploring alternatives.

Kelston Chorley
A minor prolapse, it depends how much of a problem it's causing, it depends on the age of the patient, it depends on their physical structure, their level of obesity, their bowel movements, are they regular or have they got a tendency to constipation. If you factor in all those things...

Steven Bruce
How would the obesity affect your decision making?

Kelston Chorley
Depending on the level of obesity, if they were fairly obese, my decision would be, go along the lines of the hysterectomy. So if you factor in obesity, age, general physical tone of musculature and their quality of bowel activity, I would look at all of those things and have a discussion and give them my view on it. Whether I think it's a good idea to have it or not. Quite a few factors we need to think about.

Steven Bruce
And Silvia says she just got an email from a new patient that she hasn't seen yet saying that she had surgery for endometriosis resection and has some ongoing discomfort in her lower abdomen and groin area. She's also struggling with bladder pain and constipation. And she says that's rather a lot. Any ideas as to what might be causing those symptoms? And is it a case of working on the different organs affected? Surgery was at the end of November last year.

Kelston Chorley
Yes, so she's at a point where you could happily explore her pelvic area and abdomen without any consequences. And it would be worth exploring.

Steven Bruce
Eight weeks down the line?

Kelston Chorley
Yeah, eight weeks down the line is fine.

Steven Bruce
Okay. What would you expect to be the culprit? And I know we can't go into an examination and know what the culprit is going to be.

Kelston Chorley
It's difficult. But there could be adhesions.

Steven Bruce
And in the presence of adhesions, what are you going to do, you can't break down the adhesions, so?

Steven Bruce
You can't break down the adhesions. All you can do in all these cases really is, it's just, if you like, it's no different to your traditional MSK and that's one of the things I tried to put across to my students all the time. Visceral work is no different to MSK work. What are you trying to do if you've got a stiff shoulder, you wang it around, you're doing some soft tissue work, you're trying to get some circulation in the area, trying to move it and stretch it and get it more mobilised. You are doing exactly the same in these structures in here.

Steven Bruce
I didn't see your clinical notes I wanged his shoulder around.

Kelston Chorley
Waggle, waggle. But the essence of it you can grasp. You want to stretch, mobilise and tease those tissues around which enable everything around it, all the fasciae all the other connective tissue to make way for and accommodate for any restrictions and tensions in one direction.

Steven Bruce
Okay, well, hopefully that will help.

Kelston Chorley
This'll work in a nutshell really.

Steven Bruce
Well. Yeah. And I guess it brings us back to again, it's a thing we discussed in the last show that we did with you, but just, what can you say to patients about something where there is so little evidence? And you at least on one occasion here said, well, I don't know what I'm doing. I know that on other occasions, I've done this, good things have happened. So you can't actually put that on your website, can you? You're not gonna say come here for your post hysterectomy treatment, because I'll waggle you around, and you'll feel better?

Kelston Chorley
No,absolutely, perfectly good. And I never did put anything like that. In fact, I don't think I ever really made a big issue on my website about treating visceral work, it was always through word of mouth, patients who'd see me recommended a friend. And it all really came through that direction.

Steven Bruce
What led you down the visceral route in the first place?

Kelston Chorley
A thesis I did. When I gave up psychiatry, I studied remedial massage, travelled around the world, and went to different schools and went to Asia, India, America. And I finished with all of that, and I did a little thesis if you like on abdominal treatments, because that's quite common in the Asian cultures, Japan and Thailand and lots of Asian countries, they do a fair bit of work on the abdominal area, which we didn't

seem to do in the UK. Got me thinking and I did a little bit of a study on it. And once I trained as an osteopath, that sort of came back to me, and then decided to explore it more.

Steven Bruce
So where did you do your training?

Kelston Chorley
I trained myself.

Steven Bruce
Right, okay. I expected you to come up with, I was trained under Barral or something like that.

Kelston Chorley
No, it was quite interesting. I was working in the area of visceral, I did my master's degree and that was part of my master's. I had lots of ideas, and I was experimenting with them. And I met Caroline Stone. She was experimenting in similar areas. We got together, we discussed ideas, bandied ideas around and formed a little group together called the Visceral Obstetric Society, gosh, we're going back a bunch of years now. So we formed that together, and started to train one or two people in the things that we'd learned ourselves. And then I guess the more you get into it, then you start discovering there are other people doing things which are similar. Barral was one in France, completely different techniques to anything that Caroline or I ever did. Worked in a very different way.

Kelston Chorley
Interesting, it's lovely to hear it, isn't it? Because I suppose most of us now think we've got to go on a course for someone who knows to learn something, but it actually, it's the fundamental basis of medicine, of osteopathy, of chiropractic, it's the look at the anatomy and think about what could we achieve and then go and find out how you can use it to advantage for the patient.

Kelston Chorley
In fact, I had a very, very in-depth long meeting with GOsC about this. There was myself, there was Renzo, there was a couple of other visceral osteopaths. We had this big long discussion about, there are no set down rules for how this works. There are no books written on it. And we had to try and explain what it was we were doing and somehow justify it and GOsC, I have to say, they were pretty open minded about the whole thing and providing that there was nothing that we were doing that would impact the patient in a negative way and that we were all broadly in agreement with an approach. They didn't have a problem with us exploring ideas. In fact, they felt it was a good thing that we explored different approaches, providing there was a kind of a framework that we were consensual with.

Steven Bruce
Yeah. And I think it's nice to hear that because again, so many people are worried about the what they see as persecution by the general counsel's but of course, as you're not promising patients things that you can't justify by some form of research or evidence, you're explaining to them what you're going to do, you're getting consent for what you're trying to do. And you're measuring the effect of that and continuing it if it works or stopping it if it doesn't.

Kelston Chorley
I think the bottom line is, you're right. The bottom line is you have a conversation with your client and you, I mean, I always said every time I did any visceral work, I said this, I have to be clear, this is all very experimental. So I would start the conversation with, this is experimental, but I've done this with X, Y, and Z and had these kinds of results. If you want to go along with that and take that punt, then I'm fine with it. And, but I can promise you, it's not going to make you worse. It's not gonna cause you any problems. But I would always reiterate that it is experimental. And most people you know, when you're, the funniest thing is, just like consent. The more open you are, the more you discuss consent, the more you explain the experimental aspect to it, or the fact that nothing's guaranteed, the more actually that people see you as honest and trustworthy, because you've been completely upfront with them.

Steven Bruce
Yeah. Jason wants to know whether you found that post hysterectomy or that a hysterectomy has destroyed the transverse abdominus function in core stability, says he's seen some patients with excessive external obliques and no transverse abdominal function.

Kelston Chorley
In my experience, that may have been the case years and years ago when they made massive incisions. But most of the cases I've seen, the incisions have been fairly, fairly tidy. And providing that there's a programme stage recovery, shouldn't be a problem. But of course, there are those people who have weak abdominal muscles, for whatever reason, sometimes it's genetics, sometimes it's obesity. Those are always factors, you know, that come into play. There's no absolute on these things, I think.

Steven Bruce
Jay says, is it possible to strengthen internal organs?

Kelston Chorley
No, not that I'm aware of, strengthen internal organs?

Steven Bruce
Yes, I'm not sure why, or maybe the supporting structures I don't know.

Kelston Chorley
Not that I'm aware of. I mean, the fasciae is the biggest abdominal organ, I don't know any way of strengthening that. But I guess strengthen the external structure around it, the back muscles, your obliques, your abdominals, the more that you can use those to contain the structures behind in an organised way, the better.

Steven Bruce
When you advise people to do that, strengthening those muscles, you do that in a functional way as in saying, go and do these activities and they will strengthen or are you somebody says go to the gym and work on your TA and your obliques?

Kelston Chorley
I judge my patients very carefully. Because as we all know, all you lot out there know, you can give a bunch of exercises to people and they'll go away and they'll do them for 10 days. And then yeah, it goes. So you've got to find a practical approach that you know that there's a high likelihood they're going to continue them. So things that you can build into everyday life always work better. I mean, the best intentions even me.

Steven Bruce
Of course, I like to refer to the things I've done with Eyal Lederman in that regard, because he talks about strength, stretching muscles and says the effect doesn't last and most people are doing it a lot. So you have to build it into their daily exercise. And so he talks about giving people an incline board to use when they're cleaning their teeth to stretch their calves because it means they're going to do it twice a day for at least two minutes, which is more than any will ever do any other exercises for probably but they've got the trigger to do it every time. He tells me it's really effective. Probably our last question, I think and Elspeth has preempted me on this because she's asked whether you found hypo pressive exercises help or hinder visceral problems.

Kelston Chorley
Hypo pressive?

Steven Bruce
I had a feeling that you might not know about this.

Steven Bruce
I don't know what that is. Yeah, sorry.

Steven Bruce
I had some lovely people on the show some time ago who talked about hypo pressive training. They were talking particularly about what they called leaky ladies, and I've been told off for using it what sounds like a facetious term, but it was what this lady called her main client base, which is people, usually after they've had children, women struggle sometimes with incontinence and things like that, and also prolapses.

Kelston Chorley
So having a good laugh can cause embarrassment.

Steven Bruce
Her argument was that the conventional attitude is just go away, strengthen your pelvic floor and she said that very often doesn't succeed where she's got this structured exercise programme, which she calls hypo pressive training, which, if you believe her and I think I do is much more effective at improving those problems.

Kelston Chorley
I'd like to know what that is.

Steven Bruce
I shall let you watch the programme and you can see it.

Kelston Chorley
I will mention this because it's slightly controversial what I'm going to say. But in some of these cases, when you get your fingers deep into the pelvic floor muscles, there are some cases where you just go straight through, the muscle just feels completely wimpy and loose. You go through the different layers and have going through the layers so easily. But in others, there's a weakness, but I get the sense, sometimes it's due to it almost like a spasticity in the muscle, rather than a weakness. It's weak, because it's in a spastic state. And actually, sometimes by taking the tension off those, you can get a good result. So that's worth exploring sometimes. This is something I would have done a lot of yeah. Especially when people have been told they need to go and do all these pelvic floor exercises.

Kelston Chorley
So it's not always strengthening that's the issue.

Kelston Chorley
No. And actually, it's quite a hard thing to treat that, especially if it's quite bad.

Steven Bruce
Yeah. And I would love to hear feedback from people who have done the hypo pressive course because I think it just sounded so encouraging. I'll let you say what they said because I mean, it was the lady concerned is, she's not a healthcare professional, such as an osteopath or a chiropractor. And she's a woman, I think he's been through this herself. And I think she was a Pilates instructor before, I'll let you see, because it was fascinating.

Kelston Chorley
Well, when we're just kind of touching on that business, there is a bit of an obsession around the world of exercise and so on, which is about building up the core. I have a bit of an issue with that to be honest. I think a lot of the time, it needs the opposite. There's a lot of work on strengthening piriformis and glutes and psoas and what have you. And a large number of people I've seen they've got very tight strong psoas muscles, too much sitting around, too much sat like this, the muscle shortens, it tenses and actually what you need is a lot more stretching, and a lot less of the obsession about strengthening.

Steven Bruce
I think Eyal Lederman spends a lot of time thinking about it. He's a physiotherapist as well as an osteopath.

Kelston Chorley
Well, maybe we agree on some of that.

Steven Bruce
Well, I've been on his because I think he had a paper called The Myth of Core Stability, countered by Matt Walden, who wrote the Math of Core Stability, but Eyal's approached was that if you're doing

functional exercise, you will strengthen the core appropriately, instead of trying to fire muscles in a different sequence and train them individually. One last question. One very last question. Jen says, have you got an opinion on abdominal or anterior pelvis acupuncture. And I've got a little puzzled emoji face that goes with that.

Kelston Chorley
Abdominal?

Steven Bruce
Abdominal oblique anterior pelvis acupuncture. You don't do acupuncture yourself, do you?

Kelston Chorley
I do, I'm trained in acupuncture. It's not something I tended ever to use for this. So I'm not sure that I'd be able to offer anything.

Steven Bruce
But would you needle the abdomen or the anterior pelvis for various things?

Kelston Chorley
I can't see there'd be an issue with it. So long as you understand your anatomy, I can't see there'd be a problem with it.

Steven Bruce
Again, it's not a high-risk area for acupuncture, is it? I mean, around the ribcage is a high-risk area and I don't know of problems there in the past.

Kelston Chorley
Actually no, I'll stop myself there, I have done a little bit of acupuncture for the posterior pelvis around the coccyx, for those small muscles around there and the coccygeal muscles, where you have to get in a little bit deeper. And I couldn't for whatever reason with my thumb, and I think I have used an acupuncture needle but not on the anterior side. 7

Steven Bruce
To what effect, to what end?

Kelston Chorley
To the end of getting the muscle to relax.

Steven Bruce
Is that as an alternative to internal coccygeal release?

Kelston Chorley
Yes. As I say I stopped doing that years ago. Never found them that successful.

Steven Bruce
We're out of time.

Kelston Chorley
Oh, right.

Steven Bruce
We've had two shy of 450 people watching us. So a lot of people interested in what you had to say as they were last time if I recall but we weren't able to measure accurately back then, we had lots of feedback. So thank you very much.

Kelston Chorley
It's a pleasure.

Steven Bruce
As I say we are out of time. So I'd love to hear from you. Especially if you do visceral work yourself about how you found this evening's discussion. Was it useful? Will it help you in practice? You can just drop me an email and let me know. But looking ahead very quickly, in two days' time Thursday, I'm going to be talking to the marvelous Gilly Woodhouse, again. What's prompted this is that we've had Gilly doing an audit of my own clinics practices, looking at how we find and how we keep patients. So if you want to see how we're doing and find out if you're doing better, then join us on Thursday, lunchtime. Same as usual 10 past one for 45 minutes, and listen to a real expert on getting your practice moving. Always good fun with Gilly. Next week, Tuesday, we have another case based discussion scheduled for lunchtime. If you've got something interesting yourself that you want to share, or challenging that you'd like help with, then please let us know. Like I said, we get three, four, 500 people on some of these discussions. So there's lots of advice and experience that pours into help people out. And on the 30th, which is a Monday again at lunchtime, I have got a session on mindfulness and how you can use that in your practice. That takes us to February. So the first Wednesday is the first of February, and I got Jeehan Lynch in the studio with me to talk about shoulder problems. She is a consultant MSK physiotherapist, and I have absolutely no doubt there's a massive amount that we can learn from her. Final thing is, we got a face to face first aid course running in here in the studio on the fourth of February, which is a Saturday. We set it up specifically for the McTimoney Chiropractic Association, but they told me today that there are a few spaces left. So whether or not you're a chiropractor, if you want to attend what is one of the best first aid courses around and I say that quite shamelessly because it is, now's the time to book. We haven't set up a booking page yet because we only learned today that we can add people to the course but it will fill up quickly. So all you got to do is drop us a quick email and grab yourself a place. The address is on the screen. And it is elaine@apmcpd.co.uk And Elaine sorts out all the courses. She will get your place on that course. Well, that's it from me and Kelston, hope you've enjoyed the show. See you soon. Goodnight.