

339 - Vestibular Rehabilitation Therapy with Alan Sealy

Steven Bruce 10:38

Good afternoon. Great to have you with us for another 45 minutes of lunchtime learning. I hope you're warm where you are because it's bloody cold in the studio here at the moment, we've somehow the fuses tripped on the heaters, and nobody noticed until five minutes before we went live. Anyway, we are here now, we're down to just two more shows after this before our Christmas shutdown. We're looking at neurological testing on Wednesday evening in a couple of days time. And then we've got a lunchtime case based discussion at lunchtime on Wednesday the following week. So hopefully you'll be able to join me for both of those. That will take us to 63 hours of learning with others delivered by the Academy this year, not including our face to face courses. Do you know I'm quite proud of that. Anyway, today I've got a very popular topic for you vestibular rehabilitation. My guest is Alan Seeley, a specialist physiotherapist who has over 20 years experience in dealing with the problem. Good afternoon, and welcome to you, Alan.

Alan Sealy 11:30

Good afternoon, Steven. Nice to be here.

Steven Bruce 11:32

Yeah, I think it's a bit colder where you are, isn't it? You're up in Aberdeenshire at the moment. So you've even got snow, which we haven't where I am.

Alan Sealy 11:39

We have an inch or two of snow and it was about minus 10. A couple of nights ago.

Steven Bruce 11:43

Yeah. Anyway, let's get on to the topic in questions like you're an expert in vestibular rehab, how comes even 20 years ago? I think.

Alan Sealy 11:54

Yeah, I'm a manual therapist in background and trained in Sheffield in late 90s. And just like many things, by chance, ended up working with an ideological physician at the time in Sheffield and through him, developed an interest in the field and ended up taking that abroad. Worked in Oslo for a while I was invited to start a balanced clinic in Oslo in the early 2000s. And so moved over there. And really through my time there, I was able to work with a lot of the most of the leading clinicians in the field probably through the early 2000s and developed a lot of experience a lot of interest. And to learn from that.

Steven Bruce 12:35

We have done a little bit about well, BPPV mainly on the show in the past. And you know, we've had people on to demonstrate the Epley manoeuvre and so on. I think what you do what you do goes beyond that, doesn't it?

Alan Sealy 12:51

Well remember BPPV is just one trigger one of the many triggers for dizziness. And so yeah, the AquaLine and other manoeuvres are very, very effective at treating benign positional vertigo, but they won't have any effect on anything else. Any of the other triggers that dizziness. So that's just one of the tools that you would use,

Steven Bruce 13:07

didn't you? I think I saw in your slides Didn't you have an interesting quote from a doctor in the 1960s about disease?

Alan Sealy 13:16

Yes, simply that Dizzy patients get a bad dude, if you put the slide up, I can't remember the code off the top of my head. But you have to put the slide up. Slide One, number one one before that. It's a lovely old quote, it dates from the 60s before I was born. And if there can be few physicians so dedicated to their art that they do not experience a slight decline in spirit when they learn that their patient's complaint is dizziness. And the reason I kind of highlight that that as a quote is because nothing's changed. You know, that's sort of 60 years ago, and nothing's really changed. And continued patients get a bad do you know that they generally don't get well treated, and they don't get the effective treatment they need, which is a crying shame. Because there is a natural recovery. For most dizziness, there is a natural recovery process. And the reason some people don't get better is not because they can't. It's just because they haven't been doing the right things, respectively. People often put barriers to recovery in the way and as a therapist, often all we're really doing is removing obstacles to recovery. Well,

Steven Bruce 14:26

yeah, you're right. You're definitely preaching to the converted with that line for the osteopaths and chiropractors in the audience. Because, you know, we're all I remember hammered into us. I think during training that we're just putting the body in a position where it can heal itself rather than actively doing something to it to make that healing happen. You said you went to Oslo and worked there. Is that a big did you find that their approach to treating dizziness was better in Scandinavia.

Alan Sealy 14:52

Back then it probably was. I think at the time a lot of good research was coming out of Sweden and Norway. I was fortunate in that I was working in a in a very exclusive sort of private clinic at the time there was a chiropractic clinic. And that I was fortunate because we were able to get clients very early. So I was able to see clients, you know, within the first week of onset of dizziness, which is pretty unusual in the UK. And then because of that, they were getting the right intervention at the right time good combination of sort of medical intervention with appropriate medications, audiological assessment and myself doing the rehab. So it was just a convenient way of seeing people.

Steven Bruce 15:32

Yeah, obviously, early intervention is good for any problem. Is it detrimental in other ways to delay the intervention to delay your rehabilitation? Does it make it more difficult or impossible to recover? Some

Alan Sealy 15:45

degree, it doesn't make it impossible, but it does tend to lead to more of compensation. So you get more inappropriate compensations, or altered motor motor strategies, altered behavioural patterns will start to kick in, the longer something goes on. But ultimately, no, it doesn't stop people recovering, it just delays things and people become rather disabled in that period of time. So

Steven Bruce 16:06

what now is the course of treatment in the UK, I mean, what would be the patient journey to use that oral expression, they go to their GP, they say, I'm feeling dizzy, what happens on?

Alan Sealy 16:19

Well, probably the GP will, most importantly, make sure it's nothing serious. And that's that's the fundamental rule doesn't rule out the red flags. But assuming it's nothing serious, and they may we'll give them some medication. Typically, sort of propped up errors in scenarios, liens or common names stomatal. And this is really just to stop them being sick, because there isn't a medical, drug, pharmaceutical treatment for dizziness. Although most do get drugs, they don't really work long

term, they just gonna stop you being horribly ill to start off with. So you'll probably be given a medication and hopefully told that it will get better by itself. And it should, the vast majority of people, that's not true 50% of people will get better by themselves, will will cause a time over a relatively quick period of like, you know, a few weeks, a couple of weeks or so something like that. And that's what we'd expect. But half the population probably don't. And the reason they don't is generally because they start to do the right thing that the wrong things. And you know, recovery depends upon the brain getting a lot of feedback. And the feedback means really signals from the eyes, the ears, and the vestibular and the neck and proprioception from the rest of the body, and particularly the eyes, neck. And in practice, that means movement, movement of these bits of the body. And if you move, you're generating a feedback for the brain, the brain will work out, it's getting it wrong, and it can solve the problem. But that means doing things which make you feel dizzy. And that's scary, and it's unpleasant. And so people avoid it. And so then they fuse up around the sort of the neck and the shoulders, they become very stiff, they don't move the head or if they do move their eyes and head and trunk, everything's moved together as one bit like a lighthouse or something. And so the brain doesn't get the feedback it needs. And then that's when you end up getting these more chronic diseases. Okay,

Steven Bruce 18:13

must be quite challenging with patients encouraging them to do something which might make them feel sick or make them feel encouraged vertigo, for example.

Alan Sealy 18:22

Indeed, yeah. And it isn't. That's why they have to understand the situation. But yes, you are ultimately asking somebody to do something, which is not very nice. But I always like to equate it with with physical training. And it's just the same as getting out of breath. If you want to get fitter you have to get out of breath. If you avoid getting out of breath, your heart and lungs, muscular skeletal system will never, never sort of proof and it's that kind of a thing.

Steven Bruce 18:46

You mentioned GPS excluding red flags earlier on, which particular red flags did you have in mind?

Alan Sealy 18:52

Well, with something like an acute onset, vestibular condition, dizziness, sudden onset dizziness, it really be thinking stroke. So that would be the most important thing. But yeah, but otherwise, you know, cerebellar problems and possible tumours, but they will be more gradual onset. But mostly,

Steven Bruce 19:11

I have to say that dizziness is not one of those characteristics that is commonly associated with stroke, is it it's not part of the fast test or anything like that.

Alan Sealy 19:22

It's about 5% 5% of people with stroke are dizzy. So no, it's not the most common symptom. It's not what you'd expect. But

Steven Bruce 19:31

doesn't mean does that mean that it could be the only symptom of a stroke?

Alan Sealy 19:37

And notice if, if you've had a stroke causing you to be dizzy, there will be other brainstem signs and the other central signs, okay, sure. Yeah, absolutely. So as long as you're following your normal, sort of, you know, more red flag pathways and things you will find you'll be fine. You pick up these things.

Steven Bruce 19:52

Yeah. All right. You mentioned that 50% of people will get better in in the course of a couple of weeks. if they if they're lucky, what happens to the 50%, you don't under the current NHS pathway,

Alan Sealy 20:07

they will ultimately be referred to en t. But unfortunately, that's a long waiting time nowadays. So they tend to sort of be pushed around the system basically end up sort of going to Indian tea and that the nature of dizziness is that by the time the client ultimately ends being seen by the specialist, almost invariably, the pathology is probably settled down and gone away. And so often you don't find really hard signs of pathology or diseases or wear or damage. And it's more the compensations or the way the body's adapted, which will maintain some symptoms. And so then they tend to go through a cycle of looking for these diagnoses, which no longer exist. And that's where, you know, they go and see the doctor, the EMT, the specialist, the neurologists, they have a scan and nothing is being found. And so you end up end up with this horrible to the treadmill where everyone's telling the patient what they haven't got. And nobody's actually sitting down with a patient and saying, Yep, this is the problem. You've got a chronic dizziness, which hasn't got better. This is what you now need to do about it. And that's where the rehab comes in.

Steven Bruce 21:15

So just where do you personally fit into this pathway at present? As osteopaths and chiropractors, we often struggle to get GPs to accept that we have any skills worth knowing about. As a physiotherapist, I imagine that you're, you're more readily accepted to them, but I owe you someone to whom they would refer straightaway, rather than waiting for months and months and months before they can get to a consultant.

Alan Sealy 21:42

It very much depends upon the individual in question. I mean, where I work, I'm working entirely privately at the moment. So I'm not within the NHS system. However, the doctors up here know me. And so they will tend to send their clients to me, which is fine. But the patients have to be prepared that it's a private service now. Yeah.

Steven Bruce 22:03

Yeah. So I think patients are becoming more and more accustomed having to pay for their treatment these days only,

Alan Sealy 22:08

sadly, just because of the demands on the NHS. Yes. And the delays involved that the service offered, although absolutely fine. Once you get to it, it's just getting to it is the problem, which is the issue. Caroline

Steven Bruce 22:20

has just sent in a comment saying it's a 12 months plus waiting lists for EMC in Cumbria at the moment. That's that's hideous, 12 months Good lord.

Alan Sealy 22:31

That's relatively relatively common. And the thing is, in that 12 months, you know, whether it was a crystals or whether a BPPV, or whether it was a viral thing, which triggered or a migraine attack, almost invariably, the condition the trigger for the problem will have settled. And that's often the way I like to think about these things is what was the initial trigger for a problem trigger for the dizziness. But then, except that the trigger may well have gone and we're looking at the effects. And so you work with the effects with the patient? Yes, yeah.

Steven Bruce 23:00

Just before we go on, Christina has sent a comment in saying that she had a patient who regularly contacted her to say that she was quote off her rocker quote again. And in this particular case, she found that adjusting her Atlas axis gave miraculous almost instant results that business disappeared. Are you yourself? Do you manipulate joints as well?

Alan Sealy 23:24

I do. manual therapist trained through manipulative therapy as postgraduate training through the physio world but although in practice with many of my DD patients, I don't because because of their age, and just because of the mix of symptoms, they often will come with my tend not to use the high velocity thrust manipulate eq as much, mostly because I find I don't need to. So you know, soft

tissue release and and sort of more gentle work around the neck will often be enough. Yes. There's no problem with these things. If you're competent and comfortable doing them, then that's fine. And they're indicated.

Steven Bruce 24:04

No, absolutely. And I think it goes it does depend on what the cause of the problem is. Peter has sent in a comment saying that the Epley manoeuvre helps with dislodged otoliths, if that is the cause of the dizziness and we were going to talk about Epley manoeuvre at some point during the show when we before we do so before we do that, we mentioned two causes of dizziness, BPPV and now stroke. What are the other principal reasons that people suffer dizziness that we might encounter?

Alan Sealy 24:36

Well, by far the most common is BPPV. And that's the one always to be looking out for. But if we then sort of bring it down to Okay, the stimulus ignore the central serious pathologies like stroking minor tumours and things. So we've got probably we're looking at anything which is going to trigger what we call a Hypo function or a unilateral hypo function. So where one side is weaker than the other side and And that would be something like, it could be a Vestibular neuritis, which is an irritation of the nerve between one inner ear and the brain. And so the signals are not getting in to the brain on one side. But it could also be you know, classic labyrinthitis where you get infection of the whole inner ear and you lose hearing as well. You could have bilateral loss of functions and both sides are down maybe due to sort of some major infection or auto toxicity from drugs, for example. You can have conditions called Menieres disease, which is less common, probably only about 5% or so. And it was frequently overdiagnosed in the past, but that would also again been in condition going on in the inner ear causing temporary imbalances between the two sides. And then the other big one was probably be vestibular migraine as a trigger and migraines are common and they're benign, and they leave no trace. But again, it's just a central imbalance. So one side of the brain fires away causing imbalance within the balance system.

Steven Bruce 26:09

Do you have a role in all of these cases or only BPPV or mechanical causes?

Alan Sealy 26:19

And no, I think I have a role in virtually every every source of dizziness as long as we ruled out stroke and even if we have got stroke, you know, once the patient has been stabilised, and on drugs and everything, then then yes, there's no no problem working with these causes as well. So really anybody who hasn't got better needs rehab. That's that's fundamental. Because the potential for rehab is good. And if it's a peripheral condition, as long as the brain is okay, the potential for rehab is extremely good, you should get better. And that's the key thing.

Steven Bruce 26:51

Does that mean that you get good results with stroke patients? Who are perhaps not getting better as a result of standard? post stroke care?

Alan Sealy 27:03

No, not particularly. No, no. But I would say that if dizziness and vertigo is one of the symptoms of that stroke, and remember, it's not not a common symptom of stroke, then yes, the patient can do well. So peripheral conditions, prognosis is very good, central conditions, the prognosis is good with dizziness, but it's slow, it's not going to be fast. The thing that's bad news is if you have a mix of peripheral and central conditions at the same time, because you need a good brain to compensate for a vestibular imbalance to the broken receptors.

Steven Bruce 27:38

So how does the diagnostic process work? Then how do you know which is which is which

Alan Sealy 27:44

and relatively straightforward. And if any stroke causing dizziness? Well, there will be other eye signs. So I go through the ocular motor function tests basically looking at smooth pursuits arcades, optogenetics cranial nerves, because you will see, you know, looking at how the eyes move, looking at the patterns of nystagmus that we see in the eyes, we can diagnose from peripheral, relatively straightforwardly. So I'm fortunate I work with a sort of set of video ocular goggles and equipment, which the patient will wear. So I can see how the patient's eyes are moving very, very clearly. You may not have those in your own clinical practice if you don't see many Dizzy patients. But even without them, you can still readily identify serious pathology by looking at how the eyes move to functions.

Steven Bruce 28:31

Earlier on, you said something about in many cases, you wouldn't use high velocity techniques because of the age of the patients and Dawn has says does vertigo has said it as vertigo get more common with age? If so why is that? And what can we do to prevent it getting worse.

Alan Sealy 28:49

dizziness and vertigo generally does increase as we age. Most things get a little bit worse as we age proprioception goes down vision goes down. And likewise the vestibular inputs, the sensory systems deteriorate as well. relatively less than the others though, and they actually are maintained quite well. But things like crystals, the BPPV as they become more frequent, frequent occurrences as we age because the crystals are crumbling and fragmenting more the older we are, so the older you are, the more bits of crystal you have floating around in the alternates, basically. So that's one reason. And I think also the other main reason is just you've been on the planet long enough or longer, so you're more likely to have attracted or picked up the stimuli conditions. Because one of the things that goes on is the vestibular conditions are really common, very, very common. So there's a high

likelihood that at some point in your life, you will have an imbalance causing you to be dizzy. But remember there is there's a natural recovery in the brain should compensate from that. Often it doesn't. Often you will just compensate in ways that will mask the problem rather than actually dealing with the problem. So for example, patients will Stop moving their head up, keep the head very still, and they'll just turn up in the neck instead. And so the neck muscles in the opposite occipital suboccipital muscles become very, very tense, very tight. And that may will mask the underlying imbalance and means they're not particularly dizzy, but then they may go on and get neck problems and headaches and, or it might be that you start to use your vision as a way of compensating. So you go the opposite way to a blind person. So whereas a blind man, obviously, obviously does not use their vision for balance, you do. And so you start depending on visual reference points to help you keep up right, and you'll find in the daytime, and if you've got nice horizon or vertical building to look at no trouble, but in the dark or at night, you're likely to be very wobbly, very unsteady. And you know, these compensations will carry on through life. But then what happens when the compensations fail, as you get older and your eyesight goes, that's going to leave you very, very vulnerable. And that's indeed what happens. When you look at the elderly population fall, for example, you'll find they actually have underlying the stimula conditions, which has just been masked by vision or by using their proprioception.

Steven Bruce 31:07

Right. Interesting that I suspect we've all got patients who were who have complained that as they're getting older, they're getting dizziness. And in many cases, I suspect that they're not getting any, any diagnosis of any value from anyone other than maybe the GP saying, well, it's just a function of age. Sounds good. Sounds like there is some hope for them.

Alan Sealy 31:30

There's always always hope in terms of dizziness. And you know, even if it's an 80 Plus person coming in, and they're dizzy, I'm always quite confident that we'll be able to get some improvement, even working within the frame that the bodies are at plus, and they've got proprioception, in muscular strength and everything. But yeah, there's always there's always room for improvement.

Steven Bruce 31:50

I'm going to get onto some some more specifics about rehab in a minute, but the questions are coming in. Cookie has said, has asked whether cases of vertigo have risen since COVID?

Alan Sealy 32:03

I would say no, because they've always been common. So there's still common. I don't think it's significantly changed. And what is true to say is that you do see quite a lot of clients who come in whose symptoms have been flared up or triggered by either having COVID or some other flu or bug and or the COVID jags. And it's really important to emphasise there is no direct link between either COVID and dizziness, or having the inoculation and dizziness there is there's no connection. But having any other illness is going to run the body down it runs the immune system down and so

you're quite likely to become vulnerable then to having a flare up of any dizziness. You must I must some sort of say don't don't get don't get your Jags and don't get COVID and things that there's no connection. Absolutely none. But it is the case that people do report increases of symptoms.

Steven Bruce 32:56

Yeah. Someone who I'm being told is called centres little helpers helper says I had an attack three months ago and acute attack three months ago presumably of dizziness, and was just encouraged to do online research for home remedies. The GP was very apologetic in telling me this. And yes, pulled me in after a telephone consultation face to face to check for stroke undiagnosed BPPV. Yeah, I mean, I think that that will be discouraging for anyone being told to go online and look for home remedies, wouldn't it?

Alan Sealy 33:27

Ya know, that's fairly typical, sadly, is that people are just not getting access to the help they need. And, and really, you know, if after a couple of weeks, things are not significantly better, you have to go back to the GP again. And you have to sort of really ask and hustle for referral to somebody who knows how to do the rehab. But that again, is a problem because there aren't that many people out there who know how to do the rehab. So that's a big, there's a big gap that

Steven Bruce 33:54

we've had another question about long COVID and its relationship to ongoing dizziness, but I think you've answered that one already. It's there was no no direct connection between the two.

Alan Sealy 34:05

Go on, I was just gonna say anything like these long COVID conditions, they will cause an increase of sensitization within the nervous system. So the nervous system is now reacting inappropriately to relatively ordinary inputs coming in. And that's we get rubbish outputs basically.

Steven Bruce 34:22

Can we can we get onto some specifics as far as it's possible in short show like this about what your approach is to the problem.

Alan Sealy 34:32

Number one, it's really to look at the patient. I think in the past sort of the stimuli rehab has got a bit of a sort of a poor judgement, because people just used to give a list of exercises, like anytime if you give a recipe, a list of exercises to somebody, it's it's better than nothing, but it's really not very effective. And the most important thing is to actually base your intervention on the person right in front of you, which is obviously what you guys will osteopaths do most of the time anyway. And so I

tend to look at my assessment, and I'm looking for dysfunctions or things that the patient can't do, or things that are not working well. So for example, eye movements or whatever, and are looking for things which provoke symptoms. And so then pick one or two key movements or symptom provocations, or one or two key dysfunctions, like for example, the ability to, you know, to follow a moving target with your, with your head, for argument's sake, and, and just give the patient these two or three, four key things to work on. And like anything in the body, if you work on something, it gets easier, it gets you practice, it becomes more straightforward. And so they then get easier and will become asymptomatic within a week or two. And then you progress to another thing and you find something else that the patient can't do or something more challenging, or you make the exercise harder, or you just keep on pushing on homing in on the problem, as best you can.

Steven Bruce 36:00

And are these techniques you've developed yourself? Or are they the basis of in depth? randomised control studies?

Alan Sealy 36:06

No, it's, I mean, disability rehab has been around for a long time. These are sort of quite well established ideas. And probably all I do that maybe some people don't is just sort of pulled different strands together from different areas, rather than just religiously following. That the stimula pathway, or the muscular skeletal pathway or the neurological pathway, I tend to pick things from each, because it's all we're all trying to really restore normal movement. However we do, that doesn't matter. But in restoring normal movement, we're restoring normal proprioceptive feedback to the brain. So everything is going to be a lot easier for the brain to work out.

Steven Bruce 36:44

Yeah. Somebody's purpose asked about tinnitus, is that something you get involved with as well?

Alan Sealy 36:53

Yes, but again, indirectly, and that's a whole nother topic in itself. But a tinnitus again, it's just a you know, it's a brain sensitization, it's a reaction to something that's happened. And it goes along with some of these vestibular conditions, because if the inner ear is not working very well, then the brain will tend to crank up the volume and crank up the intensity become more sensitive to signals coming in from that side. And so then you'll start misinterpreting your survival signals or your jaw signals as signals from the ear. And therefore the brain starts to perceive sounds which aren't there. So So yes, I do work with tinnitus a lot. But it's it's an indirect, indirect sort of function of of a problem,

Steven Bruce 37:33

right? But you get results with it, you can improve the problem. You can

Alan Sealy 37:37

do yes, again, but it depends. It's one of those things, though, that the patient has to understand the sort of the pathophysiology, if you like, and the fact that if it's a perceptual thing, and they're paying too much attention to a signal, which normally the brain would filter out. So if I say to the patient, don't think about elephants work. You have to get the patients thinking about adding screwdrivers or sausages instead. And as long as the patient's focusing on the screwdriver, they're not going to focus on the elephant. Yeah.

Steven Bruce 38:11

Well, you mentioned libre and finances earlier on as well. And in my experience, my limited experience of dealing with this, the patient concern, I think, was prescribed antiemetics. And that was about as far as it went. What's, what's your protocol there? And what's likely to be causing that problem?

Alan Sealy 38:31

Probably, it's not elaborate, lightest in the first place, because unless they actually lose hearing as well, it's probably not a labyrinthitis. Yeah, that's the first thing. So Labyrinth is the hole of the inner ear, inner ear, balance and hearing. So if you lose hearing and vertigo together, then yes, that may well be labyrinthitis. So if it's if they only lose balance, if they're only dizzy, then it's more likely to be what we call distributed neuritis. So there you have a lot of function on one side of the system. Yeah, so one there, for example, on my left side, the signals are not getting into the brain. And the brain has to reset that system, okay, which it can do, and the brain will just gradually reset. But it will only do it if it gets enough feedback, which means movement of the head moving to the eyes and movement of the neck. In so doing, you will generate a mismatch, what we call a sensory mismatch between the different signals because the brain will be getting the signals that I'm moving my head when I turn my head and the eyes will confirm that but the vestibular system will contradict that because it's wrong because it's not working. And that sensory mismatch is what the brain needs in order to get it right to improve it. So it's a bit like you know, I suppose more philosophically, when we need to get things wrong in order to learn how to, to improve or get things right. But it's the same principle. But if you if you give the brain that feedback, then the brain will sort itself out and that really just means getting the head and the neck moving again and getting the eyes moving again and often you have to end up sort of doing coordination exercises between the eyes and the head just so things get a little bit sharper. But ultimately, it's get the head and the neck moving and people will start to recover, when you may well need balance exercise as well, because the dizziness is ultimately just the symptom of the balance system not working very well. So you may have to get the patient balancing, whether that's some hard ground or soft surface, one leg or two legs up sleep depends on the patient. But

Steven Bruce 40:31

there's a progression in this in, particularly with labyrinthitis, where it's cold, quite scary for the patient, you do gentle snow first, inevitably,

Alan Sealy 40:37

let's just it's just a training programme. You know, if I want to run a marathon, I don't start running a marathon tomorrow, I build it up gradually. And exactly the same way you just start off with something the patient can tolerate in like small, achievable goals, 30 seconds, gentle movement would be enough, for example. And depends how they come to you. If they come in a wheelchair, you've got to do things sitting down. But if they walk into the clinic room, then obviously everything's in standing and you're gradually progressive.

Steven Bruce 41:06

Have you got any ideas on what would provoke that neuron itis in the first place.

Alan Sealy 41:12

Good point. We think that mostly it's just a reactivation of dormant virus. So probably something like the herpes or chickenpox virus, which is dormant in most of us 70 80% of his habits is sitting there. Every now and again it flares up typically seems to affect the vestibular nerve between the ear and the brain. Because the nerve is one of the few nerves that runs through a bony tunnel through the skull, very narrow tunnel, and therefore it's a little bit more easily squashed. If it becomes irritated. If you squash a nerve it stops working. Yeah.

Steven Bruce 41:48

Lucy's brought up an interesting point, she says she's treated a number of cases that were emotional in origin. One notable one she says was unresolved grief that was manifesting as vertigo and it took work from the therapist and herself to resolve it Is that something you've come across?

Alan Sealy 42:05

Not not so so very often, generally, always is a pretty much clear physical trigger for these things. However, you know, as I was saying, if any other sort of emotional event or insult, it's going to cause a great increase in sensitization in the nervous system. And the nervous system isn't going to work as well. It's going to be more sensitive and relatively ordinary inputs going into the nervous system, we're going to get exaggerated or false outputs. And so that could well be triggered. Often these things are kind of member hidden and are masked, because remember, we're dealing with common conditions. So there may have been an underlying vestibular problem, which has been masked to some degree. And then it takes some emotional event to upset everything and make everybody Yeah, making notice the symptoms. Again, I suppose

Steven Bruce 42:55

there's a strong argument that we can't resolve any condition properly unless we address the emotional component if there is one as well as part of the biopsychosocial model, isn't it? So

Alan Sealy 43:04

we are dealing with an individual we're dealing with a person not a disease, and this is something I've sort of bang on about a lot and there is no guidance. There's no recipe, there's no sort of set prescription of exercise or interventions. You just have to base it all on the patient in front of you. Yeah.

Steven Bruce 43:21

elvina has asked for clarification. She says, Are you saying that ocular motor function is central and anything else is peripheral?

Alan Sealy 43:30

Depends which ocular motor function you're talking about. So So for example, if you're talking about smooth pursuits, the ability to suppress a vestibular nystagmus through head movement, or a sack aid, or optokinetic. These are all central pathways. If you're thinking about gaze stability, which is the ability to keep your eyes fixed on a target, as you move your head, your eyes should remain fixed on the target. That's a peripheral pathway. That's the vestibular ocular reflex. So depends on what you're looking at as to whether you're going Central or peripheral, but they're very accurate and very reliable guidance of function.

Steven Bruce 44:10

And Kansas asked. She's supporting a client that has had a relapse of their MS and the main result is a balanced problem with dizziness, which is compounding just about everything else. She seems to have lost a lot of proprioception and cows are spoken to a neuro physio, who said to stimulate her vestibular and proprioception system, reduce time constraints didn't explain the best way of doing it. Have you got any advice for cars? I'm guessing Cannes isn't in Aberdeen show. So

Alan Sealy 44:40

number one is get getting moving the head. Move the head and the neck. You know, if you want to stimulate the vestibular system, move your head. My head is rotating turning going upwards and downwards. Then I'm generating the stimulus inputs into the brain. Now it kind of depends as to where the ladies are the patients Ms problems lines and which pathways are not working very well? Is it the peripheral nerve going into the brain that's not working? Well? Is it a central sort of MLF problem within the midbrain? So it's very hard to be any, any specific to give any specifics at all. But basically, yeah, any anything involving movement and the head and the neck is going to be a good thing.

Steven Bruce 45:25

Right. Okay. Well, I got something more specific for you here from Helena, who's very well informed on these things. Helena says, Do you recommend particular rehab exercises once you've seen people

or is it all tailor made? And Helena is thinking about variations of Dix Hall pike manoeuvre or current Dr. Carol Foster's self treatment of BPPV technique, and have Cooksey Cawthorne exercises been discounted, so there's quite a bit in there.

Alan Sealy 45:53

Just didn't last point. First of all, cookery course on course, on cooks, the exercises are a recipe of what to do if you're dizzy, the better than nothing. But generally, you can be a whole lot more effective just by honing in on the key couple of key things for the patient and adapting them as you go along with the patient. Inevitably, with Cookie calls and exercises, the patient ends up with a whole list of things to do. They do them all. They gradually feel worse and worse and worse. And eventually they're sick, and then they stopped doing the exercises. So they're not terribly useful. So no, I'm always based in the exercises on the client. For that reason, there isn't a particular set of exercises that you should give, you just have to look at what the client is struggling with. But as I said earlier, I think I like to start by assessing the patient, and then looking for dysfunction. So anything which appears to be dysfunctional, and I tend to start with the ocular motor function, but then also looking at just a more ordinary balanced type of things as well. So any dysfunction, we'll work on that, and anything which provokes a symptom response, I'll work on that as well. And then the fun is how you progress those because you have to obviously keep on progressing them to keep on engendering change. So that was that. And then

Steven Bruce 47:10

Dr. Carol Foster's self treatment of BPV.

Alan Sealy 47:14

So BPPV is perfectly treatable by the patient themselves, because it's just you just have to move the head through a certain set of positions depending on the canal that's involved in defending which is the Epley manoeuvre. Yeah, please. One of just one of those manoeuvres depends on which canal your deputy is for the posterior canal, or supposedly perhaps an anterior canal as well. But there are other manoeuvres which are just as effective. For example, for if I have someone who has come to see me, but maybe they live a long way away, or maybe I've tried them, I've seen them a few times. And yes, the treatment helps, but it keeps recurring, which case I want the patient to be self treating, then often rather than Napoli, I will tend to give them a similar manoeuvre. Because it's simpler than an EPI, it only has two positions as opposed to three and it doesn't involve tipping the head back into such a sort of extreme extension rotation position. So it's a little bit safer for for most patients. So yeah, you could give that I think a lot of people get given these things called Brandt Daroff exercises, which again for treatment of BPPV. But I have to point out that for BPPV. They're absolutely useless, they are physiologically incapable of clearing crystals from the canals of BPPV. So they called again, Brandt Daroff. And Randolph a basically involves sort of turning your head one way in lying down into one side, and then coming back up and turning it the other way and lying down the other side. And you repeat that. And all you basically do is you kind of slosh crystals from one side of the canal to another and it doesn't really achieve anything. So if people get better doing brand thereof exercises, it's probably just time giving them something to do whilst X's course, which is nothing wrong with that that's a good thing to do. But it's it's not the movement, which is clearing

the problem. So I wouldn't bother giving those but some of these other self treatments. Yeah, as long as physiologically the draining crystals out then yes, they're fine.

Steven Bruce 49:20

We you and I spoke a few days ago about the courses that you run. How long does it take to train a physical therapist with a chiropractor or osteopath or physio who doesn't have your specific expertise to be competent in providing bespoke vestibular rehab exercises?

Alan Sealy 49:39

One day one of my courses

Steven Bruce 49:43

Well, that was always going to ask and I was hoping we might tempt you to come down here and and run one of those one day because I think a lot of people will be interested. We've got we've got we've got a few people short of 500 watching the show today. So there's clearly a lot of interest in what you have to say.

Alan Sealy 49:57

I think the important thing is to depends on the individual, doesn't it? I mean, I know, therapists who have been on to week courses in the States with renowned international expert experts and got all the badges and ticked all the boxes, and they're still useless. Whereas I know people who've never been on any of my courses who are really switched on really engaged with patients and achieve great things, even if they don't understand exactly what they're doing. So much more dependent on the individual. It's cuts down to your attitude and your clinical reasoning and decision making.

Steven Bruce 50:31

Do we get a badge if we come on your course? I can give you one I can. Yes,

another another question from this time from Amanda. Amanda says, my mum had years of dizziness, and after a fall where she broke her hip and wrist at home, the hospital carried out a full review and concluded she should come off all of her BP medication. She'd been on it for years and I'd queried side effects with her GP. Plus her BP had become much better with healthy diet related weight loss. As soon as she stopped her medicine, dizziness went away and hasn't returned. BP is monitored at home new GP says subsequently prefer to run elderly patients slightly higher, rather than aiming for 120 over 80. Well, of course, yes. We should previous so. Yeah. I mean, what is the pharmacological implication here?

Alan Sealy 51:22

It's Yes, generally get the patients off the medication. I mean, we say dizziness gets worse as we get older. As we get older, we collect more and more drugs. Every drug has dizziness as a side effects, particularly as you as your colleague mentioned, the blood pressure things is crucial. Lots of the elderly are on weight, your weight, your high blood pressure medication. And yeah, they stand up, they get dizzy, they fall over. And the other issues. A lot of these people leave they have a dizziness, which may be multifactorial, as if they're 80. Plus, you know, lots of things going on, they become dizzy. And they get put on the vestibular suppressant medication as well. This is the proper pyrazine. And the scenarios even be the histamines and all these things. And these are the patients who most need their distributed systems to work, you know, because their vision is not very good. And their proprioception is not good. And the balance isn't good. They need that better input, and yet we're blocking it with the medications. So it just doesn't make sense to me.

Steven Bruce 52:20

Okay. Very quickly, a couple of other points here. Nikki says I wonder how much of this ageing experience is also affected by the primary or primitive reflexes that are reemerged again? ie we stopped doing specific movement patterns. Is that something that rings a bell with you?

Alan Sealy 52:39

Yes, I tend not to get too much into reflexes. The vestibular response is basically like a tonic neck reflex. And if I turn my head to the right, I will get a there's an extension on that side. And that is masked, isn't it as we developed from newborns, or other suppressed. And I think basically it's more to do with how we move. And if we stopped moving, if we stopped stimulating the system, then it's going to cause problems. And I think that's probably more the way to think about it. Rather than worrying too much about the reflexes in terms of the vestibular system, we just think, yeah, get it active, stimulate it, like any system, the body, it needs stimulus. If you stimulate it, it'll work better. And overall them will function better.

Steven Bruce 53:24

Caroline says, Do you use laser pointing exercises?

Alan Sealy 53:29

I do. Yes. Sometimes. If it's always, I'm always trying to think about what's the main component to my patients dizziness. So is it more of a stimuli? In which case we'll concentrate on head movement? Is it more visual? In which case, you know, we're going to use more visual stimulus and optokinetic kinds of stimulus? As are things going by the vision? Or complex backgrounds? Or is it more proprioceptive? And yeah, and a lot of they can't get time to this proprioception to some degree. And most of the chronic disease patients you see will have bits of all of those going on. And you've got to say, Okay, today, this week, what's the main component? And this week, it might be proprioceptive. So in which case, let's work on some improving the proprioception and that may well involve Yeah, training. Once again, using laser Yeah, yeah,

Steven Bruce 54:14

I was probably the time to go into this but he says I've come across patients with Vbi with loss of sight and those cases were associated with extreme stress, which resolved over time and wants to know what proportion of dizziness is stress associated but we talked about emotions a little while ago, so

Alan Sealy 54:34

I'm really having to stress is always linked with dizziness, they go together, but the thing I always very, very painted to take care take care to explain is that patients are stressed and anxious because they are dizzy. They're generally not dizzy because they are stressed and anxious. Okay? So dizziness, almost invariably will have a physiological physical trigger physical background to it. That's why they're dizzy. Because it hasn't got better. They become very anxious, highly distressed, disabled, depressed, all these other emotional states will start firing in. And of course that feeds back into the problem and amplifies the signals and amplifies the symptoms. But invariably, if you get rid of the dizziness, all those emotional problems disappear. So it's most people are anxious because they're dizzy, not dizzy because they're anxious. Alan,

Steven Bruce 55:22

thank you for that. We've just tripped over the 500 margin, we've got more than 500 people watching the show at the moment. And you know, just shows the level of interest there is in this. And if we can get you down to run a course, we'll see how many people we can get to come on to it. I think it will be very, very interesting. Very, very attractive to people. Mike, I'm sorry, I've missed your question out about deafness. But I will put that to Alan, after we've wound up here. I think it's probably outside of the scope of today's discussion anyway. But Alan, thank you very much indeed. And hopefully we'll see some more review from Sir perhaps next year.

Alan Sealy 55:57

Yep. Very happy to get involved again. Yes. Thank you. That

Steven Bruce 56:02

was That was great. Thank you.