Erica Meloe 0:00
Hey everybody, this is Erica Meloe. And welcome to our latest episode of Tough to Treat. And if you're listening to us live as as as, as these come out, you'll know that Susan and I are taking a bit of a break this summer. So we're releasing some of our more popular episodes. And, and also some of the episodes where we had a lot of questions on clinical questions, right. And so this is actually a patient of mine who she basically came in to see me, I think I recorded this record this in 2018 2019. And told me, You're my last resort. And when someone comes in to tell you that immediately, your nervous system goes on a high alert, right? You're like, Oh, my God, you're my last resort, okay? Or what else Or else right? And and this is basically what she said to me. And you'll listen in, you can see in the description and below. And throughout the entire episode, this, this girl had multiple injections should love low back pain. And injection surgeries should have an extensive history.

For those of you who are new to the podcast, the power of the story, I spent probably 30 minutes getting someone's story, because the narrative is so important. If you do not do that, right, you will miss things. And also, if you do not do that, right, it will make some of your evaluations less efficient, right? We want to prioritize when we're talking to the patient. After we hear their story. We prioritize okay, what regions of the body am I interested in? Right? Versus everything right? So in this particular patient, she had multiple regions, and her position was her low back, but she had multiple regions of the body and extensive history. So when you have somebody like that you really have to think about okay, well, you know, what set her up and what kept her there. And if you were at CSM with Susan and myself back in February of this year 2024. In the lecture I gave, I talked about what set them up in their injury history, what set them up and what kept them there. So when you have somebody like this, this, this, you know, bear in mind, this was recorded some years ago now, but it was, you're going to get these stories today. Right? So what set her up and what kept her there. And hope you enjoy it. And for those of you who are new to the podcast, thank you for listening and our website is tough to treat.com Susan and I have two PDFs on there. one's more of a clinical Pearl PDF. For those of you who are not on our on our email list, and Susan wrote a great piece on sleep and chronic pain really important. Enjoy the Episode

Erica Meloe 2:40
Hey, everybody, this is Erica Meloe. And Susan Clinton and you are listening to Tough to Treat. Let's get into this one. Yeah, let's get into her she is She's a tough one. So I'm going to sort of break her down into little into little bits and we can comment on the bits and pieces as we go. So this patient is a female and she is 39 years old. And came into see me with complaints of right low back and groin pain. That was her her major issue. What aggravated or sort of what exacerbated the symptoms were many things standing and walking, obviously being vertical twisting, like standing and doing a body twist. And she said sitting was generally okay except when she had to sit for long periods. Like an aeroplane, she travels a bit for her for her job. So she's got an extensive history. So I'm gonna go through that because I believe it's fairly relevant. So this started about eight years ago. She called I actually put it in quotes on my avow. This has been an eight year project quote unquote, and she had an injury where she was hiking and then

she fell onto her right side didn't really fall down the mountain but she actually probably fell onto some rocks and onto the onto some of the hiking trails. She thought she may be may she may have fractured a rib on the right side doesn't really remember if that was the case. She thought she developed a scoliosis from that, etc etc 24 hours post fall she had nagging low back pain into the hip into the right part of her ribs more laterally and down into her right hip. So that was sort of the the the the onset that's when it when it started. So she has been to I'm just looking at this now she's been to five physical therapist, a chiropractor and acupuncturist to orthopedists. She's had surgery for a labral tear four years ago had PRP into her hip One years ago times three injections prolozone into her quadratus lumborum. Two years ago times two. She had a nerve block and preset joint injections.

And then six weeks before I saw her she had I four, five steroid shot. Like oh my god, oh, mg all caps. I mean, Lord help us. And I just went, Oh, okay. And her medical history, past medical history, with the exception of all of that fractured her left ankle. She also had, which I thought was interesting. She had surgery three years ago. So there'll be this will be five years after her initial surgery for endometriosis. Exactly. So that's really basically what she told me to get to some of the questions I was gonna ask. So yes, then she also had a motor vehicle accident in 1993, where she had a concussion. And three years ago, she also had another MBA, where she was thrown. So we've got this extensive medical history with multiple injections, multiple interventions, a fall, a couple of concussions, endometrial surgery, and to top it all off, uh, she had some addiction issues, alcohol and drugs. Okay. And so this is what she said that, you know, jokingly, I think, but, you know, after she became sober, all these problems started, you know? So that's what I had the first visit. And without, I mean, just I looked at the history, and I went, Oh, my God, no wonder this poor girl is frustrated, you know, and she's been had multiple injections. I mean, yeah, multiple issues, interventions, and not better at all. I mean, seriously. So I'm not even going to go into the objective yet. So based on the subjective, what do we think's going on with this objective? Yeah, I think it's always good exercise to do. Yeah,

Susan Clinton 7:06
it's a great one. And this is really a great one for us to kind of just hear this a lot from people. It's like, what do you do when you get something like this? You know, a history like this, where do you start with this person, you have to start with what they they're coming in for, because she's came to you, because my back is hurting into my hip. And it's been going into my groin, and it's been going on for years. Yeah, it all seems to have started at this fall. And, you know, she definitely has problems with compression, you know, standing, walking, standing, twisting, and or long periods of time of sitting. So our system doesn't really like compression a lot. So you can kind of like begin to, you know, think, okay, how can I what happens if we decompress? Would that be something that could help? We'd like to know, if, you know, if we did some decompression stuff that would, you know, begin to alleviate some of this a little bit or make a difference. But what I really find so very, very, very interesting in this. And I was gonna, that was going to be my first pinpoint until I heard about the motor vehicle accidents. Yeah. And the motor vehicle accidents are concerning for me, because she did lose consciousness, she had concussions. So now, I'm beginning to think about her trigeminal system is probably super

wound up and running the show. And whatever else was going on, all this is amplifying it. You know, she may not be having neck pain, she may not be having headaches, is she having dizziness, headaches, like that? And what happens when our heart rate goes up? You know, there would be some things I'd want to know. But no matter what else, even if she's not having those types of symptoms, it's probably amplifying the other symptoms that she was already having. Yeah, you know, so obviously, the endometriosis is a problem, or she wouldn't have gone to surgery for it. Yeah, she having painful periods. You know, what, you know, kind of what drove the, you know, my question is what, what drove the surgery for the Endo? You know, and what, and how much is that related to her back and groin pain? Because oftentimes, you'll see, you know, that this row, somatic crosstalk Yeah, and I'm there. And when can you know, they can be two completely separate issues, but they could also be kind of confounding each other a bit. Something to kind of sort out I don't, I don't know if you knew if she was on birth control pills or offer. I'll tell you what treatment they gave her because that could be, you know, a super factor here as well

Erica Meloe 9:36
as she was on antidepressants and Vikatan. Okay. That's pretty much it. You know, the morning she was worse. I mean, she's had X rays and MRIs. I mean, I was like, I don't even have them to be honest. I mean, it's just at this point, it's not really going to be helpful, right. And so, you know, I didn't write it down. So I highlighted it though, when I I think she was having obviously a lot of pain there. You know, I'm still seeing her and I certainly could go down that route. And I because I looked at all of this and I just said her nervous system has got to be so jacked up. It's I mean, so you're even though the endo was three years at five years after the first MBA was way before but the second MBA, she had the MBA and the endometriosis surgery three years ago, I don't know if you know, the same timeframe. I mean, she's getting a lumbar injections just six, six weeks prior to seeing me that many injections in your body. She her she is active, she rock climbs a lot. And she cycles and she does a lot of yoga. So she she does that really, the Yoga does there are certain positions in yoga, which don't feel good for her. And I've been in contact with a yoga instructor and we're trying to work out because she's a really motivated yoga instructor. So we've been trying to do that just based on that. I would agree. I mean, the trigeminal system, anything else that you gleaning from the subjective so

Susan Clinton 11:06
you know, when people when you have these multiple accident people? Yeah, it kind of makes me wonder if they're paying attention to what's going on around them. Interesting, kind of, you know, that's like, I find her comment that all of this happened after I got sober. Yeah, except for that car accident. And that was the driver. Yeah, led her to sobriety there's definitely a past in here trying to figure out the first way you know, you need to look at their their back, you need to look at them move, no question about it. But the, you know, my, my impression of going into work with this person, is to try to get this central nervous system to settle down. Yeah, you know, that those things are glaring at me like crazy, mainly because there is the endo in there. I'm wondering how much of you know, the triggers for her for her continued issues? I'm just, you know, kind of thinking what if this isn't coming from the back just like you always like to say like,

what's the driver here? And you know, my bias my conformational bias as well what's going on? Pelvic why's she got she have pelvic muscles that are overactive? Oh, yeah. I'm sure crazy holding you know, I still have some great questions for her gonna be like, you know, do you have you know, do you what's what's your pain like around your period? You know, what happens around your menses before and after? During, because those are big and though things and the other one is? Do you have pain putting tampons in gynecological exam? If they're not having sex? If they are having sex, so you haven't payment sex, right? You haven't at certain times? And not other times, you know? Worse, like closer to your period, you know? Or is it okay, when you're further away? Have you changed the type, you know the position and things like that for intercourse? And if they're not having intercourse, again, you can use the gynecological exam. When you go to see the gynecologist, right, Have you have you? Are you not using tampons and why? You know, because it you know, sometimes for people, it's preference other people it's like, they don't realize that they've self selected out because it hurts. Right? Those can be kind of ways to kind of tease out and siphon what's going on inside the pelvis as well, you know, because we're going to be taking a look outside, but it's nice to kind of know what might be rolling that inside as well.

Erica Meloe 13:35
Yeah. So I think I think doing like, especially with somebody like this, you want to just take a step back and just take in what they've told you. And I think it's a good exercise for physical therapists to do. After subjective, don't even look at your objective, just after the subjective. Just get a mental like a hypothesis of what you think the issue is.

Susan Clinton 13:56
This is a great time to also sit back and reflect with them. Yes, you know, tell me what you think is going on? How important do you think these motor vehicle accidents are to what's happening here? You know, what, you know, what was going on when you fell? You know, what kind of if you can get him to like, dig out some of the contexts around some of these things, I can help them kind of begin to start pulling some pieces together. But you know, just like you said, just take that whole thing in and you know, spend some time with the reflection on it. So that you really can get a real good sense of where this person is really. Where are they getting hung up? And what is what you know, what did they really think is happening here?

Erica Meloe 14:38
Ya know, for sure, and she's a lovely person and no one had really done a thorough Valley. So since standing was her main issue. I will not her main it was one of them. I just looked at her and standing and she said people told me not to twist and I'm like, here we go again. The twisting thing is gonna drive me nuts. I mean, she does yoga for God's sake she sits and does those you know, sitting rotational poses. So basically, without going into every little nitty gritty detail, because I actually did go into every little nitty gritty detail when I saw her bias and standing, ironically, was to get her weight on her right leg. Which makes no sense. But she was significantly shifted in her pelvis to the right. So she was she was shifted to the right. Her thorax was to the left and her whole body was turned to the left. So a lot of weight bearing on the right

leg. her right foot was gripping, you know, her navicular was just, her whole foot was very rigid. Her, you know, she had no play, you know, plantar glide in the foot in the towel, as I kind of went up everywhere. Her hip, the femoral head was forward, everything was just turned her right iliac crest was, um, it was just this was obvious. I mean, you look at her, and you this was an obvious, obvious postural issue, which she compensated for and who knows if that's the way she was before? I doubt that's the way she was before fall. But who knows

Susan Clinton 16:05
how long it was her fracture of her left ankle?

Erica Meloe 16:09
Good question. Let me see some years ago, within that 888 year timeframe, so she had that fracture during this time? I believe so. Yeah.

Susan Clinton 16:20
Very interesting. Because that was her left, though. Yeah,

Erica Meloe 16:23
yeah. Yeah. Standing on the right, right. Yeah, of course. Right. Right, right.

Susan Clinton 16:28
You gotta think about that, well, maybe that's what started to drive her over to drive her

Erica Meloe 16:33
over. But I mean, she, so when you see her, her pelvis has completely shifted her right iliac crest is up. I mean, she's compressed there. So and she had issues with her neck. And you know, her head was a bit shifted. And it's pretty much the usual you'll see with these types of patients. But the big issue was the weight bearing. So I had her, let me just see how you do a body twist, because that was one of her issues as well. So actually, before I do that, I tried to shift her back onto her left leg. And I literally could not do it. It was just so hard to do. She was so committed to that right side. It was just, I just couldn't do it. I mean, I felt a huge block at her left hips. So what I ended up doing so let me see how you do body Twister, she turned to the right, no problem. She turned to the left and she couldn't turn to the left, you had the right adductor kicking. And that was an issue. And she sort of felt it on the right side of, you know, right above by the psi SS. So I said, Okay, that seems she's just not was not moving. Well, she wasn't standing Well, she wasn't moving well. And so what I ended up doing in standing just because this is how I started off with her, I just started making modifications to different to different body parts, and to see if that made her body twist better, because that was that that was because she could forward bed, no problem, she could back bend, she had a little bit of pain with back bending, but the twisting was the thing that that was her meaningful issue. So I started, you know, got the pelvis over, I applied some compression patterns. It's interesting, because when I started doing the cumbersome compression patterns in real in just getting her weight over on the left, made her worse. And I said, well, obviously compression is you know,

the an issue which we know from her history, right? So it's nice to just sort of validate that I can practice, compress the posterior the anterior different oblique compressions, know better. As a matter of fact, worse than I said, let me let me look at her foot, because she's so committed to that right foot. So I ended up trying to and we've talked about this in other podcasts, neutralizing her foot, and

Susan Clinton 18:40
just getting those little toes to like just

Erica Meloe 18:42
a splay and the yoga toes and the big toe long and just relax. And her pelvis, she felt a bit better, but everything else was not better. Like in terms of she was a little bit better subjectively and objectively the same. So it wasn't like, Oh, this feels great. And as I'm going through this, I'm thinking I don't think I'm actually going to get one issue in this. I don't think that I'm going to find one main issue as I'm doing this. So I ended up correcting the foot, make doing the pelvic compression patterns, not really the hat not really making a difference in her overall feeling of movement. Because I think at the beginning, you want to get them to feel the difference in the movement pattern and she really wasn't a little bit one thing

Susan Clinton 19:31
that I do like though is that there was when you got the footer change. There was a difference. It was a huge difference but getting people to do that had been doing this for like eight years. Yeah. They're not able to see the grayscale they only see the alarm bell and they want that alarm bell off. And you know, getting them to like appreciate that. Okay, it's doesn't take away all of my symptoms, but it's different. Correct. You know, that I think that's a right there. In the very beginning, like you said, there's so many things that need to be, you know, that need to change for her. But you got to start somewhere. And man, that was a good one, you know, just get off the pelvis. If it's not getting better. You know, you know, and you shifted, it didn't get better you compress. It didn't get better. That's also ringing some intro pelvic belts for me. Yeah. You know, but the idea is like, go to the foot, the foot, right, next pelvis on the homunculus. You know, it's exactly that and see what happens. And at least that didn't make it worse. You know, that didn't know barbells. For her, it didn't know worse. So it's like, okay, you can mess with the foot.

Erica Meloe 20:38
Yeah. So it's very interesting, because when I did correct the pelvis, as I said, I made everything worse. And I'm like, Okay, I'm moving on. I'm not interested in the pelvis. Right now. I'm moving on. Just, I don't care. I'm going elsewhere. So that's how I proceeded. Then, based on the history, my bias when I see somebody like this, I'm thinking dura nervous system, cranium, something in the nervous system. So I ended up trying to shift the thorax over a little bit as well, that was my last intervention, before I actually got her to sit. Because when I find that, nothing I'm doing is making a difference. I have to do some nervous system stuff, because this is not about the foot or the pelvis. So I ended up sort of trying to get the thorax over the pelvis, just literally manually. And she was doing her twist. And I felt this huge resistance again, I said, You

know what? I'm moving on, because nothing I'm doing in standing is making a difference. It's making it worse. And it's making me understand or think that there's this an underlying nervous system impairment here versus a joint, you know, or, you know, a muscular imbalance because you have a muscular imbalance. Yes, I didn't think about that in Chapelle intro pelvic issue at this point. But now that I'm talking to you, there could be some things in there as well. So I'll get to that in a second. So I also did, so I started doing I did systems, some slumps, I sat around the table, started doing some slumps, you know, just slump testing. And it was just, it was reproducing her right sided back pain, but wasn't like flaring up a nerve or anything. I mean, after eight years at this point, I don't think she's going to have an acute, you know, nerve issue. So what I ended up doing because she was sitting, I ended up literally just getting my hands on her head, and just trying to put some just brings input to the nervous system she had, she had this shift in her head, and all I literally did was put my hands on her just shifted the got the head over the thorax. So just do your slump test again for me. And she was like, Oh, that feels a lot better. So for me, I said, interesting, because I didn't really do anything with the head in standing. Because everything else, right, exactly. And I said to myself, Okay, let's let's go down, let's get on the table, do an active straight leg raise, just whatever do the active straight leg raise, I did the exact same thing with the head, you know, I was I was sitting as well as the head of the table. And I just supported the head. And she literally was able to do the straight leg raise. No, but you're

Susan Clinton 23:20
decompressing through the through the head, rather than decompressing through the thorax through the through the pelvis. Correct. You know, you just had to find where to get and remember we talked about in the very beginning, it's like Compression Compression is the enemy here for hers, you know, so to speak, because it that's where she had her problems, right? It was in compression, but you have to figure out how then that's what I love. It's like because you know that trigeminal systems, you know, just jumped out at me those motor vehicle accidents in that upper cervical stuff. And then you went in and you got your hands on there. And it was, you know, even if you want to do a whole lot of stuff, just putting your hands in that area tells those muscles that they don't have to work so hard that it's for some people that can be at and that I love it because it took her out of you know, her system can decompress itself. Basically, what it did is that just gave her a signal that was like I don't have to work so hard here and now my system can change here and that's dramatic. That is dramatic. I love it. So

Erica Meloe 24:21
I think with her, her all her little shifts and head moves and rigid foot was, in a way her nervous system trying to shorten itself at some point, depending on the task that she was doing to make her feel better or to try and make a few try to make her feel better. So what was really so that was the event that Annabelle took way over my hour. Let me tell you for people. So for people who Yeah, my time management is always an issue with us and I will tell you, I do you know have an hour for evaluations. This took way more than the hour and If I didn't want to stop the flow, basically, I didn't want to just stop at the hour and say, I'll see you next week or whatever, I would have lost it, I needed to be sort of in the, in the, in the groove, so to speak. So after that

was done, I was explaining a basically what I thought I thought there was some neural issue some nervous system issues. And I said, I think that you'll be able, I think, I think you'll get better, you know, and we made a plan to see like each other the next week, she was referred by a friend of mine, and she called my friend up on the phone and said, You know what, this is the first time someone's ever given me hope, and I just lost it when I when I heard that, you know, and I just I feel for people that ringer like this. Yeah, right. So,

Susan Clinton 25:41
so real quick, just because I think it's really, I want to know is what did you send her home with,

Erica Meloe 25:48
or your ironically, you're not going to believe what I did. Because it's, it's, it's was the first thing that jumped out at me, I actually taped her foot. I just did, because that's the one intervention I did there. Because her foot was I know, it was Dural. And neuro, which is I gave her stuff for that. But I wanted to see if anything with the foot would make her better or worse, all I did was take the twist out of the foot with a tape. That was it. And then I sent her home with subdural glides, basically lying on her back, chin tuck, opposite arm leg, or trunk rotation, lumps, anything, you know, shorten one part of the nervous system lengthen the other part, that's what I gave her plus I taped her foot, that's what then I gave her down to all with alternating knees, you know, things like that.

Susan Clinton 26:31
But you can do around her yoga. Perfect. Correct, correct.

Erica Meloe 26:35
And that's basically what I did, it was just taking tension off one part of the nervous system and lengthening the other. And

Susan Clinton 26:44
this is where I'd love to get into that whole thing that I like to call greyscale is that this person is already going to yoga. Now you're taking something that she's already doing, and she's in I mean, that's her thing, she's in there, she's ready to go with that. And you're actually taking that and saying, let's do some variation around it. Let's change it a little bit so that you don't have to feel like you've got to, like walk through and do things and, you know, make it you know, just rigid, but you already started the idea that you know, she could be a little bit more changeable in her yoga practice. Exactly. It actually you know, because she's gonna go to yoga, you might as well do the downward dog and then do like these little things in here. You know, this is great to do right in the class. So it's been Yeah, it's not just a series of exercises, to just do there was meaning behind it, too. Yeah, love. Exactly.

Erica Meloe 27:33
So with her, you know, with people like heart, any bit of movement. I want to send her home it's something movement wise. That's why I did some of the the nervous. Is there girl stuff because

it's obvious movement helps her rock climbing, cycling, yoga. She likes to move,

Susan Clinton 27:50
right? She's already had all those passive things.

Erica Meloe 27:54
I mean, checked it

Susan Clinton 27:56
to be checked and injected, injected, you know, she's had things done then then then then the her. You're the first person who ever gave her permission to like, Well, then let's find a different way to move. Right. Yeah,

Erica Meloe 28:06
I know. It's crazy. Actually. I'm just looking at my vowel. So I did actually I take that back. I did treat her the first visit. I actually did some work on her foot a little bit and did some girl stuff. So basically, yeah, I sent her home. I did not do a little bit with it. Yeah, yeah, exactly. So I did. I'm looking at her charts like so. It's crazy at this point. But I did. I did some manual work on her. I taped her and then I sent her home with all that. And so she came back. Probably three weeks later, not ideal. She had been everywhere and I think tapped out her financial resources in terms of getting physical therapy, which is sometimes tough when you're the last person they see they're like, I have to come every so often. I'm like, fine. So she came in probably three weeks later, and ironically, she was feeling better but her neck was sore.

Susan Clinton 28:57
That's interesting. Surprise me and then we starting to like do something different. And I know you're gonna like they're gonna talk at you a little bit. Yep.

Erica Meloe 29:07
So the second I mean, I'm gonna go through quickly because I want because I'm still treating her and I'm, and I've hit a bit of a plateau with her. So I want to get your input. So basically, so what I ended up doing similar, I did some cranial work with her. I did some just general movement. Lump standing. I had to do assisted squatting, just with movement, doing one arm out just just honestly I was making it up like Tai Chi to be honest. It was I was really, honestly I was I had heard just doing some squats with movement with the arms. I had her lying on her back. I had her doing some lateral lunges to get her off the right leg more lateral to the side. Since she likes to rock climb. I ended up having her do some. So when she did her body twist that really bothered her. So I had her extend her arms basically above her head is to do your body twist, then it'll decompress you. She had no problems. I had her doing a lot of that. like standing and rotating, standing and reaching. And things like that to grant a compression, right? Anything like down dog child because I, I took the base postures, and then I just added on to those. So and I and I did that. And then ironically, this is what I did this the third or fourth visit, I noticed she was really hyperextending her right knee, like, why are you doing that? No, you're

hyperextending your knee, your right hip is up. And this is the biomechanical coming back in me. But I just simply know what, because we were experimenting, I just I did X taping on the back of her right knee to prevention, you rager bottom to take the twist out of that part of her system. I just did no reason I honestly no clinical reasoning behind that, except that I thought she needs to have part of her system unloaded. And I you know, so that's why I did that.

Susan Clinton 30:58
I don't have any other reasons, just like the way that the way that I look at that is that I don't have a problem with her, you know, standing on her right leg. But I have a problem with his her spending her entire time there. Yes, No, it'd be it's become a dominant posture. And it's one that's comfortable for her. It's what actually drives her symptoms. Yes. So if you use a little tape or your what you're basically doing with tape is you're putting sensory input Yes, into the system. And so the system is going to change out of that, you know, if you're tugging on the skin, they're going to move so that their skin isn't being tugged on. Why not give it a try, didn't help.

Erica Meloe 31:32
It didn't help actually. But I ended up also doing some I like to do with people like that who liked to move, I like to do dynamic work. So I had a dynamic release work, I had her in a down dog. And doing the alternating that she was doing at home, I had to do some reading, I was trying to decompress the thorax, just getting some manual input while she was doing the movement pattern. I also did that with her on her back when you know chin tuck, to let heel slides, you know arms out into sort of doing like a reverse fly just doing movement while I was in her head or in the thorax was doing some decompression and that and I mean decompression, I'm literally just putting my hands and just giving her some input and decompressing to doing some cranial work while she was doing that to just get some more dynamic release. So and that did help. So she This is she was coming in to be every three weeks now. So I would say the fourth or fifth visit the work I've been doing with the movement patterning and the neck work had been helping. And she took a trip to California for works on the plane, she had no problems. So the sitting was better. That's right. So she got the sitting was good. That's where I'm at with her. So the setting was good. And there came a period where I didn't see her for a month. So she started to do a lot more walking and a lot more standing and that was starting to bother her a bit more. Okay, the sitting was good she could fly no problem sitting on a hard share those still got her but she said it was significant, significantly better. I gave her as what we call reset exercises for reset the system. Like child's pile, Child's Pose down dog her neural glides, her you know all of her nervous system stuff I gave her the Down Dog with the alternating legs, the child's pose, the slumps lying on your neck, the things we just talked about that those she didn't feel good. That's what she did. And she said those helped quite a bit. But I needed to get her I needed I needed to get that carried over to to standing like standing in a museum. You know, we get a lot of people here in museums in New York. That's a big it's a big complaint. Okay, and and I think the rock climbing is good for her. So I ended up just having her just do some basic triceps, you know, we call them skull crushers, I wanted to see what loaded if I added some load to the system where her buckle point was and she was losing the control in the head even on that she was supine on the table just doing some skull crushers or shifting your thorax was shifting her

head was moving even with like a three pound weight and and I'm not saying that that's you know indicative of a standing load but but she was capable of controlling that load couldn't control it. So I sent her home with continuing what she was doing and then I added some you know to some skull crushers with some weight and now we're at the point where she's feeling better. Walking is better, still gets her when she walks a long distance. The standing is still an issue. Okay. You know, I had given her squats a little bit as well. This was the last visit and I saw her that she just for basic squats lunges just to get her that movement pattern out of that right side explained to her that being on your right side. Okay, but you need to that can't be dominance. You need to get off that side. She bought she's got she's got it. All right. So I'm right now I'm at the point where she's feeling better. But the standing still an issue, okay, and I've done some work in the thorax. And because of this history, I just want your thoughts on, you know, where maybe I'm missing something, or maybe I just need to take something up a notch. So I'm really abbreviating what I've done. But this, but the the main issues I've mentioned. So

Susan Clinton 35:28
no, and it sounds like you know, the standing is the hardest piece because that's where the neural tension system is going to be under the most load. Yeah, it just is. I mean, now you can bend over and make it worse. But we're talking about something that a human needs to do for long periods of time, a lot of people have trouble with standing, they just really do. And depending upon the surfaces, you stand on the worst, the more unforgiving the worst it is. I grew up in the Southwest, and we had people put that beautiful, beautiful Spanish Tile all over their homes, and 10 years later, we watch them take it all up and put carpet down because they couldn't take it. It was like too much. Yeah, so some of it could be that. But the other part, you know, just her history here, you know, this whole idea that whenever you started to decompress the system is when she could get better and then you added movement, you know, especially rotation seemed to really help her begin to make the changes plus she was doing active things and not passive things. And and it takes a while to get that neural tension to really change some of that my thoughts are I like the way that you actually decided what happens if I start to load her and give her some loading exercises to do in supine? You know, what would happen now if you did some of those loading exercises and sitting? Yep, oh, great idea that she can wear, it's not standing, you know, but she could be sitting and started. And some of the ones I'm thinking of, I love the ones up above, you know, with their arms up overhead, like overhead presses, and, you know, maybe some tricep stuff overhead. Things like that, ya know, but one that I that is just hitting it for me, for whatever reason, is the latissimus dorsi just the pull down? Oh, that you start with your arms out and you're pulling down and breathing and you know, bringing in some different muscles and, you know, something that might just trigger, you know, her postural muscles to kind of maybe kick in a little bit. Yeah, great. Oh, and it may be even, you know, a couple of like, some crosses, or some kind of when they call them chops, you know, the movement, you know, for some of those but sitting, I think because you started her Lane downloading, I think sitting is good standing still kind of a problem when she could sit and do some loading. And I think that that would be really cool to kind of see how she kind of works it out. And then you know, eventually work up to doing some of that loading and standing so that she's loading more than what she normally does. You know, when you're standing you're

loading, but that's doing as loading standing. But I would start with it sitting because you do have to stair step it up a little bit because our system is still sensitive.

Erica Meloe 38:07
Yeah, it's interesting. She I'm just looking at my last note, she said especially when she carries a backpack. That's when she that's when she feels it and so

Susan Clinton 38:17
put everything in a rolling suitcase. Yes.

Erica Meloe 38:22
Not fashionable, but

Susan Clinton 38:25
you gotta you gotta get what you got hurt. And this is a person who has to be on our feet so yeah, I know for sure. They make some cute bags with rollers now i They do I know really? Do. I really do really

Erica Meloe 38:37
pretty colors.

Susan Clinton 38:39
Sometimes it's stuff we don't think about we just think about okay, well, instead of carrying it my arm on my right side, I'll just put it on my back. Yeah. And it's like, okay, but you just kind of traded one load for another.

Erica Meloe 38:49
I know. Exactly. It's because I'm looking at the last night again and I I rechecked her her active straight leg raise. And the corrections in the past still worked. decompression, the dural the cranial all the sort of modifying the head position and also worked. But I wrote down in my note, last three interesting, my little pee and my soap was needs to increase load on weights on current exercises. And and I do think I think those as the sitting one is great. I mean, that's it. That's overhead presses lat pulldown skull crushers, which OPERS. That's all great. And I will do that. Because I have found that, especially with people who've had these persistent issues for so long. How you Yeah, yes. And how you progress the exercises. I think that's going to be that was in a prior podcast that we did. That is key to getting these people better. And I mean, key with all capitals, I found that in my own practice, you cannot be lazy when it comes to this stuff, but I have to be smart. So you know, they really do and with somebody like This, the movement helped her. But now it's the standing. It's the carrying. It's the this and that's the load issue. Right?

Susan Clinton 40:07
So she needs to learn how to load more in a way that doesn't, you know, drive her symptoms,

which is why said started sitting. Yeah, it means better. Yeah. And then progress up, you know, she can progress to doing lat pull downs and standing. Yep, might be one that if I had to give her one to do in standing, that would be the one that I would go for. Because, VA Yeah. So she start up, she likes her arms up. Yep. And then you're pulling down, but as you're doing that the latissimus is gonna get you compress her a little bit. Totally, you know, so I mean, that would be, you know, a great one to, I think, to kind of like, dip your toe in the water with a little bit. Yeah, get some of that going. And I think that that would be fantastic. But the thing that I would I would take I would do with her is to either a unload the backpack or be just get a rolling, you know, a rolling thing that she can. And there's something about decompressing with that you know, to a little bit when you push down on that. It kind of helps you decompress a little bit. So if she's walking a lot for exercise, she can also grab a couple of Nordic sticks. And use those because that can help a little decompression. While she's walking, she's going to go out if you're in New York City, if she's going out to Central Park for a walk for exercise, you know, grab a couple of Nordic sticks and go great idea that we can be something she can try and see how that you know how that works with her. She may find that one works you may find that she likes to she may find that she doesn't like him at all. That's that's okay is Yeah, yeah.

Erica Meloe 41:41
That's a great idea. She Yeah, no, that's that's an awesome idea. Because she she likes to cycle and cycling is good for her. She should do all of those things. She she does and the rock climbing. I mean, you lifted your hands above your air and wonder she feels good. Yeah.

Susan Clinton 41:57
So the the loading will help her performance and rock climbing. Yeah, yeah. Which is kind of seeping kind of drive it that way. Like this is gonna make you a better rock climber, you give me more power. So I have a couple of other thoughts that come into mind, mainly because we started off with this motor vehicle accident, yes. And of the cranium really helped. I would look to her, you know, another way into this system to begin to change it again. It's through the servco ocular reflex, okay, and I would go after her eyes. Got it. Okay, get her moving those eyes and give her those vor type exercises, you know, where they're like, their eyes are like having a target hit, you know, like a clock on a wall and target their eyes. And all of those things, where they're holding their heads, their eyes still in their head is moving to all of those targets. And, you know, making sure that get these eyes going and make sure because oftentimes, when people if she's standing and she's hurting, she's probably freezing and compressing the eyes can help bring her out of that, yes, it's just another way into the system that will news back up and get her you know, and doing that. So some of the things that she does with rock climbing, she should probably do in standing, do a few twists, you know, around, you know, kind of, don't stand you know, she's gonna have to desensitize standing. So, yeah, hope stands still for an hour, don't do it. You know, you always have to kind of be maybe doing a little shift and maybe a little move, but patient in the eyes can help. So she can kind of like as she's standing there think, Oh, I just need to kind of make my eyes go a little bit. And then all of a sudden, maybe her body will kind of Yep, um, through and respond. And, you know, people like this too. If this is something she has to do for her job, or, you know, she's going to be recreationally in positions

where she needs to stand a lot is she needs to bring a change of shoes. Yeah, there's nothing like changing your shoes on your feet to get your body to do something different. That's great. Yeah. Oh, so that that can be kind of a relief thing. It's kind of like what I do with cyclists who like I, you know, I love to cycle but after, I don't know, 20 Miles perineal area just has had it and it's like, bring a different bike seat in your backpack on you know, or put it on your bike so that when you stop and take a break, you can change seats. Yeah, go in a matter of you know, just giving them something else to sit on, you know, people like sit on the blankets and off a blanket, raise the tear up, lower the chair down. So I think you know, standing is a little bit more challenging to vary, but there's all these movements that you were doing with her she can kind of just remember that it's okay to sway and move and rotate and things and then she's gonna need to like time her breaks out, you know, if you're before you know if you can stand for 10 minutes and you're okay, that's great. You know, figure out how long you can stand. But you need to like stop and you know, even if you can't get to a chair or bench to sit on, you need to at least go find a wall. have to lean up against, you know, to just give your system a rest a little bit. Yeah, that's the time to you know, and then maybe do a little walking and then back to standing some. So all of those things kind of apply to there, which can be very helpful as well. But yeah, I just wanted to mention the eyes because I felt like you had some great stuff going on with the system. And one of the things that can really help drive that trigeminal system down is really getting some great movement in the eyes again, yeah, they get stuck. And so

Erica Meloe 45:29
I was gonna say those all the time. And we do. And that's.

Susan Clinton 45:34
And then, of course, as you've been doing with her breathing long exhales give me know that she's doing the yoga, just bring that yoga in. Yeah, you know, a little cat cow and standing, you know, the language that she can understand. And speaking, I love the way that you were using the rock climbing stuff with her, you know, because that's, it feels good. So what in rockclimbing? Can she do? You know, in standing, what can that you know, how can you pull those things together and maybe see and see what she can come up with to Yeah,

Erica Meloe 46:06
because I've been doing a lot of the unloaded stuff with her. I mean, a little the squats and things, and just the lunges, but that's got her sitting better. But I really think that, you know, I do think that the lapse in time between appointments is a factor. But you know, what, you work with what you got, and Chico?

Susan Clinton 46:24
I mean, there's just a chance to, versus some isn't gonna bounce back. I mean, this is a no, she, I think she's made remarkable progress. Yeah, due to this sensitivity and stuff. And she's into it. Right. She likes it. Yeah, you know, she's got other factors in her life that are issues as well. And you have to deal with those. I mean, she has to, you know, maybe a little counseling would be a good thing for her, he or she's on antidepressants, and beckoned him for a while. There's other

issues, obviously, in her life. We all have other issues in our lives. So you know, been able to do things a bit differently. And, you know, sometimes they they can't come every week, they need to know, yes, you know, and there is I can only do this once every so often and make little changes, and that's fine.

Erica Meloe 47:07
Exactly. Because I was like, I don't need to stress you out financially come in every week, because that will definitely backfire. Yeah, so I was like, you do what you can and you know, you

Susan Clinton 47:16
know, and then it doesn't improve as fast and then kind of like, well, PT didn't work. Exactly. Yeah, PT in a hurry isn't gonna work. But I'm totally willing to help. Yeah,

Erica Meloe 47:26
I love that. Because people, you know, come in five times, they're gonna three times a week. So I'm like, please, not with this type of patient. This it just wasn't gonna happen. And at the end of the day, I think, yeah, looking back on it now, it gave her nervous system a chance to sort of adjust in between visits. And I think the only thing is, I'm wondering if I should just before we sign off here, should I revisit the endo surgery or ask her? I don't know. I mean, I don't know if I'm interested in the pelvis at this point. But I mean, no offense, but I don't know. You

Susan Clinton 47:56
don't know. No, no, I'm taken. I mean, the only thing that would be of interest I, well, there's so many things of interest. But if it's not of interest to her, then it's not, you know, she just needs to know that if she's suffering in other ways that she may not have been talking to you about right? Sex doesn't hurt my back, but I don't like it because it hurts my vagina, got it, then she doesn't need to suffer. You know, there's ways to help us, one of the things that would like to know is around the time when she's complaining of her back. Does she ever associate that with menses or not? Okay, I'll ask her No, and that would be of interest to know, you know, like that. And the other thing is that, just teaching her how to, you know, you've looked at everything else, she probably is over gripping her abdominal muscles. And that may be part of what's going on with her and standing is that those muscles are over firing, they don't need to work as hard. Kind of teaching her to turn those guys off a little better. Maybe even just massaging her belly. And

Erica Meloe 48:56
I've done that a little bit actually. Yeah, so those kinds of

Susan Clinton 49:01
things are wonderful things that can help the other pieces because then you're getting the somatic somatic visceral reflex going the opposite way you know, so just kind of massaging the belly learning that was to understand you know, just kind of take a look and see what our bellies doing in standing make sure she's just not over gripping. That can be maybe one of her, you know, kind of another dominant type thing that might be going on that can be a changer for her.

Erica Meloe 49:24
I think she's doing that actually.

Susan Clinton 49:26
So that would be that would be the piece that I would start with does she have urgency frequency? I don't believe so. Yeah, that's usually a sign that that pelvic floor is like over

Erica Meloe 49:40
I think I asked that. No, she doesn't I mean, I'll ask that again. Yeah, you know,

Susan Clinton 49:44
the biggest thing is that is you know, to see a payment bachelor insertion because she that can be desensitized just like the thinning and the you know, the other stuff could too, so you can send her off to somebody good to she's interested in getting that feeling better as well. If it's problem if it's a problem. Yeah, got it. You know, maybe one of those things she's not talking about because this is getting better. And it's like, well, there's a lot this has been this way since I've been 12 probably has no idea that that can ever get better.

Erica Meloe 50:10
I mean, she's had so many nervous system attacks on our nervous system over the years that my guess is that one of those answers to those questions is going to be yes, but I will ask her next time I see her yeah.

Susan Clinton 50:21
Just so this, you can kind of complete the picture because you know, the

Erica Meloe 50:25
system is for sure. Yeah. Yeah. Yeah.

Susan Clinton 50:27
That doesn't have to feel bad either. You know, like, everything is getting better. We'd love for that. You know, if that's an issue for you, we'd love to help you get that better as well. Yeah, yeah. All gonna work along with everything I'm doing here. So ya know, for sure. What a great scene. This

Erica Meloe 50:42
is interesting. I'm still treating her. So I will report back. Yeah,

Susan Clinton 50:45
that's that. I love it. I love the idea of getting together and just talking through it. And yeah, some ways to think about how to move forward. Yeah,

Erica Meloe 50:57
totally. Because I don't want I was so happy that her that she came, she seemed five PT me she spent is everywhere, you know, and for her to still continue to stay in the system here is a testament because the friend that referred her is also a PT, but not in, in New York, obviously. So I really think that, you know, we can really work on getting these types of patients better than, you know, will advance our profession and you know, word of mouth. And I and I think it's really important to stick with these patients, a lot of people would give up on her. But I think, you know, people like her are becoming much more common in society, and they're accessing health care later and later, and their symptoms are going to become much more persistent. So I think it's great to talk about this stuff and get ideas for other patients. So I'll keep everybody posted. And that's that. Right.

Susan Clinton 51:52
Thank you, everybody, for listening. Thanks, guys. See you next time. Yep. And remember that you can leave us a review on iTunes, we'd love to hear from you. And if you haven't signed up for our emails, do so because that's where we post information on mentoring and other little goodies that will be coming out. Yeah. And we all went into our second year of podcasting. Exactly.

Erica Meloe 52:15
And we've got our tough to treat website tough to treat.com still a bit of a work in progress, but we've got signups and feel free to go there as well. Okay.

Susan Clinton 52:24
All right. Sounds good. Bye.