

FSM Podcast Episode Two

Carolyn McMakin, MA, DC & Kim Pittis, LCSP, (PHYS), MT

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[00:00:03] So we had some good fun feedback about this podcast that we started

[00:00:08] Impromptu as it was.

[00:00:10] You know, that's just I think that was my favorite part of the feedback was I love how just natural and organic and not preachy it was, and I was like, Well, that's just what happens when you and I talk about stuff or

[00:00:25] How we roll.

[00:00:29] I got some really cool questions that came in and some comments already, but we can we can save that for

[00:00:38] For time last time.

[00:00:41] Ok, yes.

[00:00:42] So that works.

[00:00:44] Ok, so I wrote down like four of my favorite questions and comments that we got, but one that I wanted to ask you. And it's kind of a generic question, but I mean, I think we can roll with this one for a little bit is what was the best piece of advice you've received?

[00:01:03] Advice I have received, yeah, from. Well. It's not advice so much as mentorship, right? I if you if you have listened since nineteen ninety five to Jeff Bland, yeah, the best advice he gave anybody was think about. I'm putting my phone on airplane mode. The best advice and he never gave advice. He just demonstrated it.

[00:01:43] Mm hmm.

[00:01:44] Where does it come from? How does it work? What's the pathway? Yeah, yeah. Yeah. They have leaky gut, so that's the end product. Mm hmm. How did it get there? You don't. You can't just fix leaky gut, you have to fix how and why they got it, so probiotics, diet restriction, blah blah blah. That was and that's. The people that really know what they're doing, don't give advice. That's what I have you found that, yes.

[00:02:21] And I found that the best people out there, the people that I want to velcro myself to, are always so inclined to help and teach. I found that with Dr. Mark Lindsay in the late nineties, when we were learning about, you know, some some of the really good clinicians wanted to just take some of the skills and morph it and do their own and not share. And the best of the best have been like, Yeah, you can do it like this, but come here. I want to show you something really neat and what do you think? And they've been like you said they're prompting your own critical thinking and sharing for the greater good.

[00:03:02] Well, and without saying it, the the message is my job is to make your job easier. Yes. Right? Yeah. So Leeann Chato. Those that know what they're doing, do what they do so well, what did he have? Eighty five bucks and. And then they encourage others to do their best. Yes, because of Leon. I am now the right this case report up as a paper and publish it. Nag. Because unless somebody tells you you should publish this case. No, no, no. Once it's published, then it happened and somebody can learn from it so that that was Leon. Jeff Bland and then the other night. I, you know, those nights where you wake up at two o'clock in the morning and there's this thing in your head that you have to get out of your head and onto paper. Yes, I wrote a thank you note to my GP that I've had since. Uh, nineteen eighty six, and he moved to another clinic that's too far away. About five or six years ago, so I don't see him anymore. But when I got to thinking about how I learned how to practice, he doesn't do physical medicine. But my son came in with contact dermatitis. You know, it was absolutely the. The outline of his T-shirt, so it looked like contact dermatitis from a new soap. And John did this, he went, Hmm. Hmm. Pressed on his belly on the right, pressed on his belly on the left, ordered a mono spot test and the kid had raging dangerous mononucleosis. Wow. And I said, What made you keep going? He didn't look right. Wow. So what did just by doing what he does so well? You what I learned from that is be observant. Follow your intuition and don't stop until it makes sense.

[00:05:27] Well, can we put that on like a slide right there?

[00:05:32] Ok, I'm writing it down. What did I just say?

[00:05:36] Be observant. But the last part is don't stop. And it makes sense. Yeah, and I think that's I think when people hit stumbling blocks when I look on our FSM practitioners page on Facebook and when I get questions after the courses and stuff, the questions are great because they they teach me where I failed to communicate something chyli.

[00:06:09] I thought I said that, but apparently I didn't say it in a way you could hear.

[00:06:13] Right, right. Yes. So I've got two angles I want to attack right now. Ok, I'll just go on the first one. Remind me to come back. All right. So when we get these questions, yes, the first part is OK. I failed to communicate that properly. And the second part is. Again, going on that riff of Don't Stop, and I think because we get this awesome rainbow of practitioners that take our courses, we don't just get trainers or Pittis or Kairos. We're getting veterinarians and pharmacists and acupuncturists and optometrists. Yeah, like you name it. And and then just lay people that want to learn more about what we do. But I think that's the problem is when you have a scope of practice, yes, you have to stay in your lane clinically, but you have to extend into those back corners of your brain and think laterally about, OK, well, I have this, this, this and this, and my scope and physical medicine doesn't. I can't go into the gut. I can't go into autoimmune disease, but have somebody that can for you because you're right, it will only take you so far. Your results will only get so far. And then if you're not getting that underlying cause like, well, you're just never going to close those cases.

[00:07:38] I have to raise my hand, do it. And that is part of what you said isn't true.

[00:07:44] Ok.

[00:07:46] Your scope of practice is physical medicine, right? Yeah. Ok. And somebody has inflammation and a facet joint or something in their neck, right? Yes. Is the vagus nerve a physical structure? All right. Sorry, but. Right. There's no way to treat a physical

medicine problem if the vagus nerve has been turned off by infection, stress or trauma. Correct. You can't treat infection because you can't prescribe antibiotics or the things it takes to fix mold. Right? But you can turn down. The limbic system is that do that, and by the way, I'm rewriting the Vagus presentation to make it into a webinar for Friday, and I can't believe how bad it's been the last three times I taught it, because now I completely rearranged it. Sorry. Anyway, so there's going to be a webinar Friday about about the vagus nerve. But it's a physical structure. Yes, that regulates everything, including inflammation. Yes. So yes, you can.

[00:09:09] Yes you can. Yes. And so that's the other side. Yes, you can. Yes, you can. And I remember taking my first in-person court in Austin, two thousand six.

[00:09:29] Yeah, I think that was.

[00:09:33] And by the third day, we're going through like GI stuff, and I remember my brain wanting to just be like, you could just leave and get on a flight because you don't deal with organs.

[00:09:45] Yeah.

[00:09:46] And wanting to dismiss that all. And then I sat through it like a good student that I was and then being on the plane making a list of all the people that I had to call because it wasn't their SOE's. And why would I have treated anything but the SOE's? That's all I knew how to treat in the abdomen. And I've done some courses in visceral manipulation, but it's different than re feeling it.

[00:10:14] It's why we teach it that talk about learning how you didn't communicate it properly or how I didn't communicate it properly. Yeah, it's. I never put the SOE's, the ovary, the heart, the kidney. I never put that in the physical medicine section until four or five years ago,

[00:10:36] Because was it after we treated a certain Olympic swimmer

[00:10:41] Something like it was? Yes, after it kept smacking me in the face and saying, OK.

[00:10:46] And so,

[00:10:47] Yeah, it's never so AST.

[00:10:50] And I remember that moment where you just stopped because it wasn't doing anything and it was like, this moment, where did you ever slip and fall on the on the pool deck? And he's like, Oh yeah, I did. I'm like, Why would she be asking about that? Oh. Well, what would happen if he slipped, fell and landed flat on his back

[00:11:12] And his kidney got bruised and glued it to the QLs and so the QLs stopped firing? Yeah, actually tore his QLs by exercising a muscle that was inhibited.

[00:11:25] Right?

[00:11:26] It's like so there's no way to treat physical medicine without having some idea of how it's connected to visceral medicine. It's now there's that's why the physical medicine section is longer. And those terrifying slides that I mean, aren't they terrifying the one where they are? It's like, No, no, don't tell me about the large bowel it is.

[00:11:49] It's those gnarly Netter pictures, right? Or you're just like, No, I don't want to go back there. Oh, yes, you have to join us. Come on, come, come.

[00:11:56] But then this story about the rotund rheumatologist who had all the trigger points in his left QLs in his left obliques.

[00:12:06] Right.

[00:12:07] And it's like, Have you been in an auto accident or no, no auto accident? Have you started an exercise program and done 200 crunches in the last week? And he looked at me and said, Do I look like I have ever done a crunch? Ok, so it's not the muscle. If it's not the muscle, what is it? Right? And that's that's where you go back to look for the cause. Right. So this GP, I mean, I'm going to let you take your other tangent, but I got to do this other thing that this GP did, this is he's why I'm still here. After my open heart surgery, they said, go see your GP at two weeks. And he said, Why

are you here? And I said, no. They told me to come in two weeks, it's two weeks, so I'm here. And he said, Oh, OK. How are you feeling fine? Good. Wow. How would you do that? Blah blah blah. And he gets up and heads to the door and his hand is on the doorknob. And I said. Well, there is one thing. It's hard to get it's been ever since Monday, this is Friday. Ever since Monday, it's hard to get a deep breath. And he absolutely stopped cold with his hand on the doorknob. Who do you know that would do that? Yeah. So now that's the place where I learned to listen and take the time that it takes to get it right. Yeah, and that's that's why I teach what I teach. It's like you got to listen. Yeah. And when it doesn't make sense, it's like, why would she let me take a chest x ray? Let me, let's do a white count. Oh, and my left lung was two thirds full of fluid and I had left lower lobe Nuno Nina.

[00:14:10] Wow.

[00:14:11] And if it wasn't for him, I wouldn't be here as far as I'm concerned. Yeah. So, OK, now your other track?

[00:14:19] Well, that's mine was just to give to circle back to that question, the best piece of advice I'm going to say and I've said this multiple times now, it's what you said to me the very first time I spoke at the advanced and I think about it at least five or six times every single day. Ok, that's scary. So that's how profound it is. Ok. And it's what you want to say is not what they need to hear in order.

[00:14:47] What you want to say is not what they need to hear in order to learn what you want to teach them.

[00:14:53] Yes, I've I've shortened it a little bit from my little brain.

[00:14:57] Yes, but no, that's the shorter version is probably more correct.

[00:15:01] But it works with listening to patients and fighting my manual therapy skills of press harder. Don't need to press harder. You know, it's yeah, really listening to what they're telling you so that you know where to start properly and to not be. Get preachy or in their face like you. What did my dad always say? You have two years in one mouth for a reason.

[00:15:33] I love your dad.

[00:15:34] Yeah, so I I do try to listen more or speak less. So I mean, it's very helpful, obviously, with teaching. And yeah, when we're presenting and we're teaching, I have that in my head about what do they need to what concept do they need to keep here all the time so that it doesn't just go right through? Something has to stick. And I do it when I'm talking to my kids and when I'm training my puppy right now, like I want to do certain things and I have to fight against it because what do they what do they need? And I think with patients right now, I know I'm in this point of of playing with FSM that you have those days where you just really feel how profound it is, what we have and the changes that happen. And I think I really learned that and I spoke about that patient she was in the symposium. She had a very, very bad car accident. So there's just a ton of trauma and you want to get so excited as a practitioner because you have all these tools and you know, you're going to like change and you have to take it in steps. And I always think about what Dr. Blix said about you have to give them some good before you can take out the bad. So supporting the patient

[00:16:58] Put in the good stuff.

[00:17:00] Yeah. You know,

[00:17:02] And the thing I've learned I'd say in the last two years because since my practice is so small, I have this luxury of having one or two patients in an afternoon, sometimes only one. And when you have two hours with somebody. You make these huge changes. And what I've learned is they need time to get used to who they are now. Yeah, now it's like I give myself Wednesday off to work in the office, but. They and you have to warn them it's like, OK. The patient gets up and says this feels weird, it's like, yeah, have you ever downloaded a new operating system onto your computer? That's what your brain is doing right now, right? Your your leg only used to be pain and we took away the pain. We quieted down the spinal cord. We quieted down the central sensitization. We reconnected it to the sensory cortex. Then we drove it back down from the sensory cortex to the cerebellum, to the spinal cord, to the leg and the patient. At that point, you know, Glazer's over. It's like, did you do that? It's like, Yeah, we did that.

Now your body is trying to, your brain is actually trying to figure out what to do with the changes we just made.

[00:18:32] Are they going to be permanent? I don't know how long is a piece of string. It's like, maybe, and we'll treat something different tomorrow. But. The the being patient part and letting them know what's coming. So what's that other thing? Tell them what you're going to say, then say it and then tell them again. Yeah. Marty says quiet down is one. Twenty four. Now quieting down is 40. To quiet down central sensitization is 40 and 10 Netter spinal cord sensitization AST 40 and 10. Quiet down nerve pain is 40 and 3 ninety six. Central Sensitization. What happens in the limbic system that makes it mind the pain so much? It's the limbic system, the insula, actually, I just wrote an article for Townsend letter. So it's the insulin, not the Thelma's, but it's part of what we have as the midbrain that. Amplifies pain gets used to it, so it. It feels weird to be out of pain, so the brain will recreate it, whether they're not peripherally, right, brain has a place that says this thing hurts, so that's what forty and eighty nine is for. And I have had patients with really chronic pain. This is why I treat with 5 machines on one person.

[00:20:09] I have one that's just running 40 and 10 the whole time. And another machine that's just running 40 and 89 the whole time. So take out the spinal sensitization, the central sensitization. Then you get rid of the pain and the patient says it's like, I can't feel it. That's when you turn off 40 and 89. Turn off 40 and 10. I can't feel it. What does that mean? That means the sensory cortex isn't connected to your leg, because all the only place your leg has been is up in the insula, up in the brain. So at that point, you do eighty one and ninety two to increase secretions in the sensory cortex from the brain down to the foot. And then pretty soon, the patient says, Oh, it's not numb anymore, OK, fine, is it hypersensitive? Nope, nope. How does it feel to be out of pain? It different, but. It's OK. Ok. It's OK. And it's because we have the ability to manipulate the whole chain. So treating the sensory cortex is not part of your scope. Right, right, right. Not it's. It's also very much a part of your scope because there's no way to get somebody's leg to work.

[00:21:42] Absolutely.

[00:21:43] Dealing with the brain and the nervous system when we have a tool that lets us do that right now.

[00:21:49] It's true. I mean, I think we just haven't thought of it so microscopic before when I was in college. I touched on this last time I wrote my thesis on pelvic instabilities, more specifically internal rotation restrictions. And we had three groups, one that just received manual therapy. One group that just got exercise rehabilitation and one group that got both. So no surprise here. The group that got both manual therapy and exercise prescription got better, blah blah blah blah blah. But then you have to break down. Well, why did that happen? And some of the

[00:22:27] Data and the discussion, right?

[00:22:32] But it's not just as easy as, oh, it's because they got stronger or it's because they've maintained length. A huge part of it was retraining balance the joint kinesthetic receptors. And so, yeah, maybe twenty four years ago, I wasn't thinking about the sensory cortex and the cerebellum and any of that because I was just thinking about balance and coordination. I was thinking of the last part of that whole arm.

[00:23:02] And all of that is turning time.

[00:23:05] Totally. So any patient of mine that comes in, whether it's a professional athlete or somebody who is sedentary, works in a library, they're getting some form of exercise prescription at the end because you have to close that feedback loop. And even if it's them just standing on a balance pad for a couple of seconds to re-integrate and asking those questions, how does that feel? I don't know. Like, just keep standing there, feels it feels good, like keep standing there like my hip. And now we're done.

[00:23:43] There we go. Yeah.

[00:23:45] You know, and it's it's funny. It's I found that it doesn't matter how long a patient has had that injury. I think the longer they've had it, the longer you have to convince them that it's OK to not be in pain anymore.

[00:24:00] Well, I'm the toe heel walking. That's magic. You know, one of our practitioners taught me that. Eighteen years ago. Yeah, and it uses all the same muscles that you do in regular walking, but it gets the information about the state of

those muscles by a pathway that the brain doesn't expect, right? And so the brain says, Wait, what the the the hamstring is, what how long is it? How do I wait? And so they get really wobbly and that's the be observant part. They're really wobbly. The first twenty five feet that they don't do toe heel walking. Mm hmm. And then. They do another 25 feet and they're less wobbly. Yeah. And you can you can see it when it smooths out, then the brain is now connected to those muscles in their current state. Right? Then you have to turn around and walk. Normally in the limp is gone and the hip drop is gone and everything's OK, fine.

[00:25:10] I use that even without a asymmetrical gait pattern. So if I have and it's in the sports course, I have it on video with a professional hockey player who had some, like misfiring with his hip. Nothing that anybody would see if you were a regular person. But if you're getting paid a lot of money to put pucks in the net, it's that last one degree. So the first thing we did on my golf to get this on on video, so I'm following him on the track and everybody I show it to like, he's a professional athlete. Dude can't even walk down a track straight,

[00:25:43] Just like

[00:25:45] You have no idea how hard this is after I've taken apart something and you're putting it back together. But it is. It's that. And I think especially if you've had it for a while or you're a professional athlete that's been training a pattern over and over and over again, the minute that person gets up off the table, they're going to go back to that default position because that's all they've known how to function. That's their survival mode, right? That's what's gotten them to work day after day. So putting them in a inorganic pattern right off the bat is, I think it's huge

[00:26:18] Has to be done because when you think about how it was, he was functioning in the state he was in, dude can't even walk down a track. And you look at what's torn and broken, and you fix that, OK? There's tendon offices there and so that muscles turned off and that nerve is glued to that and you had a kidney infection or a kidney stone. So you're so as is this long and that size is the other. And this all the cerebellum knows is that this guy is getting paid a lot of money to do this activity, and I'll do whatever I have to do to get the puck in the net. Right? When you fix the dysfunction. Your approach to getting them all all better, doing the frequencies is not just the thing.

So the the worst stories I hear are the the patients who tell me the practitioners put them in a room and TAOS the practitioner puts them in a room with wet towels and then leaves them alone. Never touches them like, no. So you have to feel what's going on. Be involved in the process. You don't have to stay in the room if it's something easy, like a disc. But when you get the nerves on adhered from the old groin injury and all of a sudden is glued starts firing, and then when you fix the adhesion from the hernia repair that was gluing the. A cutaneous nerve to the skin, so that inhibited those muscles when you take away all those adhesions and you fix the tendons capitis. The mechanics are completely different. Yeah, yeah.

[00:28:17] Yeah, 100 percent totally. When you when you have a patient, let's just go off of musculoskeletal pain. If you have somebody who's got. I don't know. Pick one of your favorite autoimmune conditions or like Lyme or somebody that comes in with. Let's say not a palpable restriction. Right? How then are we going to close that loop because we're not dealing with balance, we're not dealing with so. Enlighten us.

[00:28:59] Thanks. No, that's where you have a team of people that you trust. Yeah. There is a Naturopathic here and I send my Lyme patients to her. Yeah. So I can't fix Lyme, a patient that comes in with one one Lyme band and not five Lyme bands in my and and she has all these symptoms in my world. She doesn't have Lyme, right? She has the downstream effects of having had Lyme,

[00:29:35] And

[00:29:35] Three people have told her she feels crappy for the last 13 years because she's had Lyme, even though she didn't have a tick bite or a rash.

[00:29:44] Right?

[00:29:45] Does that make sense to you? Not to me, but that's the other thing. It's like it has to make sense. So but you can't disagree with the patient because they firmly believe the three people that told them that they feel crappy because they have Lyme. Right? And then I do a Vestibular screen. And one of the members of my team is of a FCOVD. Optometrist. And she said, I feel nausea and I have all these symptoms and the fatigue and the anxiety and the depression and all that stuff. And oh yeah, I had an

auto accident, but I got better from that. Which way was your head turned? I don't know. Well, think about the accident, which way was your head turned? Well, it was turned. I was turned to the left and you got hit side impact, right? Yeah. Did the airbag go off? Oh yeah, hit me right in the side of the head, but I can hear fine. I know what. What do you? Ok, fine. So you do a Vestibular screen. She gets PRISM glasses, and 80 percent of the symptoms that she ascribed to Lyme aren't Lyme. Right? No offense to the Lyme committed doctors. But unless you've ruled out the other things that cause disequilibrium, nausea, fatigue, anxiety that whole host of diffuse symptoms, right? It's yeah. And.

[00:31:28] And that goes back to your point of never stop looking, you know, until it makes sense. Yeah, and then you can maybe stop.

[00:31:37] Well, and it it. It can always be something that you didn't think it was. That's another poster, isn't it? It can always be something that you didn't think it was, so just because I have a hammer. Doesn't mean that everything's nail. Fsm doesn't fix everything

[00:31:57] Now, and I think you do a great job of teaching that. Don't get too attached to your hypothesis, right? I hate being wrong. I will. I will. That's one of the things I I don't do well with that, but this is taught me humility.

[00:32:17] I will

[00:32:18] Be

[00:32:18] Wrong.

[00:32:20] Oh yeah. You know, and at the same time, I also hate when I'm right, because once you get a little savvy with it and you know, something more serious is going on, it's almost those times where you're sending people, you know, I think you might need to get some imaging of your spine or some imaging of this because there's something else going on or this doesn't feel right. And I can't tell you how many times I've been right because it never not works. And if what I'm doing doesn't work, there's something else going on.

[00:32:50] Did I tell you already about internal shingles?

[00:32:53] Was that that you did last week?

[00:32:56] Swear to God I treated him. I talked about it Wednesday. Yes, I treated him Thursday or Friday. As internal shingles now I went down the rabbit hole first, I had to make sure it was not pancreatic cancer, liver match, any of the serious stuff, all of that imaging was negative. Ok, and then

[00:33:19] The pity that remind the folks who are just tuning in today who maybe didn't hear that first podcast, maybe what that patient presented with

[00:33:27] The patient had abdominal pain that was just really sharp and burning and really painful, and it was the right upper quadrant like just below the ribs. But at first he was describing this all the way across, and he'd lost 25 pounds in eight months. Hmm. I didn't like that part, so I sent him out, I treated him. He got some better, send him out for imaging and we found out it's not pancreatic cancer, it's not his gallbladder, it's livers fine. His blood works fine. He makes amylase and lipase. We found out all the bad things. It isn't. And. I didn't. I didn't do a sensory exam because I just ran my hands over a skin, it was fine. Ok. The next week. I'm treating him now, we've all just we've decided that it's it's some sort of nerve thing. Ok. The Pittis, who works on him at her office and I are on the phone and she said, you know, there's a thing called internal signals. What you what internal shingles? They never get blisters. It stays internal. They never get blisters, so this time I did a proper. Sounds, for example, the pinwheel. Yeah. Nobody in the emergency room did it. He's been to the E.R. three times, been to urgent care two times, and he's seen me twice. And right, so it did a sensory examine. There was six to nine and Jodi looks it up and says internal shingles is a thing. It is not then I googled it on my phone. It is, it's a thing they never get. They don't get blisters. It's internal. But it manifests in a dermatomally pattern. That would make anybody. And so that's where they don't stop until you figure it out. So I treated him for nerve pain for this time. He hasn't slept in three months because of the pain. Pain is worse at night. It's worse at night is always central. So I did 40 and 10 with one machine, 40 and 89 with another machine did

[00:36:14] It neck to

[00:36:15] Neck, two feet from the spine to the abdomen. I had three machines. One ran the shingles protocol, right? The 3 frequencies for shingles. Yeah, one ran one. And that one. When those were done, I ran one 60 malignant virus in there. So treated the virus with one machine, NASH 40 and three point ninety six. But then the other one was eighty one in 396. The problem with post-traumatic neuralgia is the nervous destroyed. What he had was the equivalent of phantom limb pain from T six to 10. Wow. Yeah. So reducing inflammation in the nerve wasn't going to get it. And I knew that from all the times you failed. Thank goodness. Right? Yeah. And then I did eighty one and three ninety six, and it took an hour with 5 machines on him. And then he said it hurts when I move. What's that? Scarring in the nerve. Yeah, when you move and it hurts. It's never the muscle. Yeah, now when you have that. So I did 13 and three point ninety six and he said, Oh, that feels good. So I got into his belly and moved all those nerve roots and mobilized his chest. A deep breath had him cough. And it was still sore. Oh, and that's when he said it feels numb. And that's when I turned off 40 and eighty nine turned off. 40 and 10 ended eighty one and ninety two, yeah, and then the numbness went away.

[00:38:13] Did you have him move with eighty one and ninety two? Yeah, yeah, just a.

[00:38:17] And then eighty one on eighty four, it was. And he's still it's it's not finished. There are. Have you found this with male humans? If it's not 100 percent gone, it's it's never. It hasn't changed. Yeah. Is that is that a thing?

[00:38:36] It's it's definitely a thing, and it doesn't matter if they're professional athletes or not. And I have some women, especially athletes, that are like that and you have to say, well, do. And that's why taking the pain score before treatment and before and after with range of motion is so important. Because then you can say, do you remember when you came in and you could only do this and your pain was innate? Oh yeah, where are you again right now? Oh yeah, I can do this and your pain? It's a too, OK? So trying to leave on that cognitive note that there was progress, you know? But you're right, you don't want you never want people leaving. They feel like they haven't done anything right or nothing's really changed so

[00:39:25] Well, and it says once again data yes. What's your pain score, right? Oh, well, then then they're scared to say it's a 3, because what if it comes back? Well, it comes back. We got it to 3 this time. That means we might be able to do it again, right?

[00:39:46] Yeah. Um, I had a teenager who was dying to return to sport following a procedure who was lying through her teeth about pain because she knew if she had pain. Mom wouldn't let her play. Pdi wouldn't let her play or she would modify the exercises because.

[00:40:12] It was dangerous.

[00:40:14] It was and pain, so we had to have this come to Jesus talk. That pain is a good thing. It tells us where our healing is at and in order for healing to progress in the right direction, we need to respect the pain. But it's really hard when you have an athlete, whether it's a teenager, professional or just certain people, they just pain score. Sometimes just you have to have a backup. So like whether that's range of motion. Right, right.

[00:40:44] Yeah. And the Oswestry score the neck and low back and the TAOS scores, any of the functional measures are really helpful. Yeah, yeah. Data data is a good thing.

[00:41:02] You need it. But then going back to any of those systemic conditions, you can't do a range of motion on the viscera.

[00:41:09] Yeah. Well, there are people that like they've they've had SIBO for 40 years. Yeah. And. We get them to know SIBO. Like, they don't have SIBO anymore, and three weeks later. They have an episode, right? Well, I still have SIBO. Well, yeah. Yeah. And what was your stress level like five days before you had this episode of SIBO? Oh yeah, I had to travel for work and I sometimes, yeah. So what turned her Vagus off that changed the pH in got that allowed the bad bacteria to come back. So it's dealing with patient expectations, especially after they've read about us on the internet. Oh my, gracious.

[00:42:06] Right? Because I think it's going to be a one and done. Yeah, no. I've actually should put a sign up and say I am not the judge shot.

[00:42:14] Yeah, right? Yeah. Well, and the other thing that patients need to understand on, if you might have a way that you tell them, it's like you and I form a team. I am not going to do anything to you. I I will. I'll be able to correct some inflammation and scar tissue and imbalances and repair. I can do lots, but the stable state. And how you progress. That's a team effort that how do you how do you tell them that?

[00:42:55] Yeah, really similar. And again, I have my other favorite quote of yours is you can't want it more than the patient. Now with my athletes, that's never in question, because they will run through a brick wall, if I say that will make them get on the ice or the field faster. But there are so many times where I do. I have patients that I know like we've got profound changes on the horizon, but this is not my journey. Like you said, I'm just the facilitator, the hand holder, the background cheerleader, but they have to do the work. And I think, you know, similar to to an athlete who spends two hours, I'll go to hockey for a minute, two hours on the ice. The great athletes are not the ones that just put all the emphasis on the two hours on the ice. It's what are they doing, the other twenty two hours? How are they eating sleeping? So the stable state with athletes is really easy because they're they're quite pristine now. They might have the psychological stress that happens with sport, but you're right, it is. It's conveying to them these exercises that you're doing. You might have to do them for the rest of your life in some sort of fashion to take care of your spine in order for you to keep being active or shoulder exercises or and sometimes they look at me and they're mad. What do you mean? I have to keep doing these stretches. I'm like, Well, not these exact stretches will keep modifying them, but you're going to have to keep moving. No, I don't. I don't want to do that. Oh, OK. You might need to find somebody else to help you then.

[00:44:38] Yeah, it's hard to bail out a boat while somebody shooting holes in the bottom of it. Right? I mean, the the same Olympic swimmer that we treated. Yeah. And we got the kidney thing sorted out. We got the Suez thing sorted out. Then we came back for the second session in the afternoon and they had a bunch of trigger points in his rectus abdominals and I said. This. Why do you have terror A1C erectus abdominal, so I treated the muscle, I ran inflammation and allergy in the small intestine and said, What did you have for lunch? He said DIN's Subscap found that down the road, it was dead. Yeah, and

[00:45:28] Was probably hear my dog in the background.

[00:45:32] So. And I said, You want to go to the Olympics in two years? Oh, I know. I asked him. It's like. Has anybody ever told you you shouldn't eat gluten? Oh yeah, my Naturopathic says I'm gluten intolerant, gluten sensitive, and I said, Well, you want to go to the Olympics in two years? That's the last sub sandwich and last last gluten you have. Yeah, for two years if you want to go to the Olympics.

[00:46:01] Yeah.

[00:46:01] And athletes will do that.

[00:46:04] Yes. So yeah, yeah, I think well, I'm hopeful like the patients. I think by the time they find us are at a level of desperation and open mindedness. I think they come in in both fashions, other they've tried everything else and they're willing to throw reckless abandon to whatever you tell them.

[00:46:29] Yes.

[00:46:31] Or yeah, or they're just a little bit more open minded because they know what they've tried, it hasn't worked. Do you have a favorite like steady state stable state set of frequencies that you like to to give people with

[00:46:50] These days concussion and Vagus? There's absolutely no way. You'll see there's there's no way to get anybody better. Unless they're Vagus nerve is working.

[00:47:04] Will you give them that daily or sometimes

[00:47:09] They watch the news? Right. So, so it used to be just run the concussion protocol and then it, then it's concussion and Vagus. So did they drive in traffic? Have they been on the freeway today? Did somebody yell at them at practice or at work? Did they watch the news? Did they read the newspaper? Yeah, those are the things. Yeah, infections, stress and trauma. So it's it's the the lives we lead are. Compared to what life was like two hundred years ago, two hundred years ago, we just had to worry about tigers, and if you broke your leg, you were dead, right? If you had a heart attack, you

were dead. That was it was easy. Now we recovered from those things, but the lives we lead are. From a primitive physiologic standpoint, they're incredibly stressful, so I literally run concussion and Vagus on myself every single night. Yeah, or yeah, I am insulin resistant and I had pancreatitis for five years. Right? So I treat insulin and leptin and the pancreas. That's a almost a three hour program. Wow. Right? Seven to eight minutes. So I run that and then I wake up at 3:00 or so when it's finished and then I run concussion and Vagus. So it's it's like it's the reason to make like a CustomCare and a Magnetic Converter package. Because yes, it's four thousand or four thousand five hundred dollars. Yes, it's that much money, but what's it going to save you, right? In terms of how much money you spend with me? I'd rather have you treating yourself at home and right, for sure.

[00:49:24] Yes, when it comes to those things, I think you would almost rather be in the comfort of your own home. I I have profound feelings when I run concussion and Vagus. I want to experience all that in the comfort of my house. I don't want to be on a table talking to anybody.

[00:49:39] Yeah, exactly. Yeah, no. It's it's important.

[00:49:44] I have another question for you that came in here. Ok, so I'll let you start with these. Do you always treat everybody on alternating current first as a default?

[00:50:00] Older patients, so like if you're I'm assuming they're they're talking about neck to feet stuff where you might run into stenosis an older patients, yes. So if they're over, let's say, 50. Yes. Which isn't as old as you think it is once you're 75. So, so I'll run it alternating for like a minute or two. And but in general, the the spinal cord, the Vagus central sensitization, any nerve. All. I polarize them right away the night, the only one that ever gives people trouble is the spinal cord. Mm hmm. Stenosis and basically you watch their face. And if they start to squirm or make faces, it's like what's going on? I got a headache, really? Ok? So then you make it alternating because the two things that will give them a headache are the ALT, the polarized positive current when it backs up enough that it increases the spinal fluid pressure in the brain. But the other thing that happens is that because they have, let's say, a disk bulge, it's causing the whole thing. Mm hmm. They tend to lay in by habit. They they put themselves into extension, right? And so then you go up to the top head of the table, you put your fingers under the base

of their skull, you tuck their chin and you traction it just a bit. How's your headache? Oh, that's much better. So it's the C2 3 percent. Yeah. So C-5 six disc goes with C2 3 cassette. It's have you ever found that it's not? No. Yeah. Ok, good. It's not just it's like a cassette C-5 six disc.

[00:52:15] Yeah, yeah. I mean, most of my athletes and I probably ask you this every year why athletes love being polarized. And I never say, well, no.

[00:52:28] Even weekend warriors for people that are particularly muscular and work out a lot.

[00:52:33] Yes, it doesn't. I don't know. And I've been asking you this since the very first course, and it's I don't know. There's a lot every year, something like, Oh, I think I have an idea and there's a lot of pretty cool like hypothesis that come out from there. But I had an athlete who I was treating and gave him a CustomCare. He purchased one after and he called me within hours of taking it home. Like, this one doesn't work that you gave me, and I get works. I'm not stoned, it's not working. And this was a guy that would have to leave his keys at the front desk and we'd have to call him an Uber home because he he would get stoned. And I'm like, Maybe it's just because you're doing it at home. Send me a video, make sure that the battery is plugged in. And he sent me a video. Everything was running. He's like, I'm not stoned, I'm fine. Look at my eyes, look at my eyes. I'm fine. Then it dawned on me. I just threw everything on there alternating.

[00:53:33] Now, isn't that something?

[00:53:36] I'm like, OK, I go and I hate it when I'm wrong, I'm like, OK, just bring it back and I'll see what I can do. So and in there, I clicked everything to positive. Go, OK, go home tonight and try it again. He's like, OK. And then I never heard from him. Because passed out, he was like googly after. So it works. And I I don't know why, but it's

[00:54:02] Speaking of athletes. I have a thing. I think. On my desktop, on my, you know, file thing, there was this file that literally had never looked at. It was under like, why would you read this right? Endocrine implications of a traumatic endocrine implications of traumatic brain injuries? Tbis Endocrine. Ok, fine. Whatever. How bad could how good could this be? So last night I just opened it up because I didn't want to

do what I was supposed to do. So I opened up this thing and it is. It's two hundred and forty four slides. It's an osteopath in Reno. Okay? And. It's mind boggling, mind boggling things we never check. Testosterone growth hormone, progesterone, DHEA. What was the other ones? I mean, two hundred and forty five four slides, how can I? Anyway, the good news is that I emailed him, he answered me today. He will take my son as a patient, but the important thing is he's got two hours at the advanced in February. Very cool. That may annoy David Musnick, who's used to being the TBI guy, but

[00:55:40] This is a whole other spin that I think is incredible

[00:55:45] Trick. And it's amazing. I'm so excited. I can't even remember his name, Clearfield. He's in Reno, so we will. And he's he's going to ask me, Why do you want me to talk to your group? Because we treat traumatic brain injury patients,

[00:56:06] But we don't think about that side of the coin.

[00:56:08] No, because not that many of us are days. This is about a quarter of our practitioners or medical physicians.

[00:56:15] Yeah, but even even for those of us that aren't to be able to ask the right questions or just kind of go that way to refer for that because.

[00:56:27] Yeah. And so isn't that exciting?

[00:56:30] That is so exciting.

[00:56:32] Yeah. I want to have a new thing for the for the packet. And is it is the what's it? What do they call it, the brain injury vision symptoms survey. This is going to be part of the first time you take the core. Um, things you never thought of that would send people to an FCOVD.

[00:57:02] Excellent, and that's going to be for all of us at the advanced.

[00:57:06] Yep, it's at the advanced. It's it's I'm so excited. So, yeah, okay, you were going to ask me something or say something.

[00:57:17] No, I think I think we're almost.

[00:57:20] Oh my gosh. I know.

[00:57:21] Again, you did it again. So we're so close on.

[00:57:28] Do you have any questions? You're getting the questions.

[00:57:30] I know I love getting these questions, so I want to do. I do want to end on one just because I have it out here. So do you have a absolute favorite textbook?

[00:57:43] Besides Netter.

[00:57:47] This is what my answer was, yes,

[00:57:50] So AST Netter,

[00:57:51] It's I I haven't found even like there's a lot of really cool software that I have on my laptop for patients that I can try to explain, but nothing gives me the visual and the comfort than going into mine, and I don't even know what additions they're up to. This is Netter number two. This is only the second edition that I have.

[00:58:11] We're up to eight.

[00:58:13] Yeah. Well, they can't. They couldn't have changed that much. But I I think anybody should have a Netter. And I don't care how good your anatomy is because you learn anatomy differently with foam. You. Yes, you care about. Origin insertion, action, innovation, but it's the shape of the muscle that's different, it's what's its neighbors, what is it touching? What is it near to and not even

[00:58:48] Whether the nerves go?

[00:58:50] Yes. So I want to just so I was working with somebody's shoulder blade rib area. I'll just give you that information. And she comes in and my doctor says, I have a

rib out. I'm like. Ok, when I hear that, it's like when someone says I have tight Romberg's. I mean, so for the tight Romberg's IgE, my romberg's fill tight, I'm like, OK, if you had tight Romberg's, you would be walking around like this. So like I would, I'm like, you have chronically elongated, scarred Romberg's because you are walking around like this, everything that we do is in front of us.

[00:59:36] So this flex forward, the discs bulge and that creates pain in between your shoulder blades, whether on Boyd's. Ah, yes, but no, there's nothing wrong with. There's never anything wrong with the Romberg's.

[00:59:52] Never, ever, ever.

[00:59:54] Ok, thank you.

[00:59:55] Thank you. But people only know what they can touch and feel. So and you again, hey, this is the theme of this talk is don't stop looking because just because you feel something that appears to be on someone's wrong boy doesn't mean it's the wrong boy there is. So this is one of my favorite pictures that I show patients again through letters. But so, so many people go, Oh, those are my Romberg's, right? I'm like, No, that's right. Ast posterior, that is super deep. And look what's underneath it and this is your spine. And under that is the disk. And then there's a nerve. So no, you don't have a rib out. And I say it in my my smiley face, and then I run frequency for the disc and they're like, Oh, oh, what you're doing on my Romberg's? It feels great. So going back to my question about the book

[01:00:55] C2 the there's two, there's one other one that I use, but it's so esoteric and it's so rare that I need it because Netter is the go to,

[01:01:07] Yeah,

[01:01:07] There's that one and then the two neurology textbooks. I can't even remember the the authors, but I show the pictures of them, and they're four really weird, esoteric stuff. Hmm. And the other thing that happens with Netter is it. I pretend that I remember all this stuff, and I have a lot of Netter stuck in my brain. Yeah, but when you can't figure it out, I think it's OK to tell the patient. What is this? Let's work together, and

you look at the. And this does that and it's like, OK, my favorite OBGYN when I was in my 20s was a doctor that kept the physician's desk reference back when it was a real book. Yeah, he kept it on a on a reading stand in every treatment room, every single time he prescribed any drug. He looked it up and it's like, OK, that's a good thing.

[01:02:16] And you probably never once thought, Gee, this guy isn't very smart. You probably thought, Wow, he's being really thorough, and I really appreciate that.

[01:02:23] Mm hmm. I have to tell you one more thing about, Oh, OK, it won't take very long. Ok, lady comes. And she's had just incredible pelvic pain like they flew from dead Colorado. And she'd had pelvic pain. Somebody decided she had endometriosis, so she had a laparoscopy, and that did one set of things. And then somebody told her that her endometriosis would go away if she had a hysterectomy. Mm hmm. Ok. So they did that, and that made it worse, and then she had some sort of prolapse because and so they put a mesh in. Ok, so I'm very gentle with the scar tissue and, you know, doing international work and this and that and. But the way she described her pain was before she had a bowel movement. The pain was absolutely excruciating. Ok. Number one, I've never seen that before in my life or heard of that symptom. But as her rectum fills. She the pain is excruciating. So if you so you go back to plan, go back to first principles. What happened when the stool comes down your descending colon through the sigmoid into the rectum? Right? It's filling. You know how much that stuff weighs. Ok, so we're talking four or five pounds of poop. All right. What's it doing? Well, it's pulling on things. Ok. After all. Oh my God. And what the physical therapists have done to her. That was I mean, there was one day later thing that they did that made everything worse. So then I opened up Netter and we looked at the pelvic floor. Pelvic floor muscles are these sheets, and they're attached to the Patriot system with three millimeters of connective tissue all the way around, the brain affects it one, twenty four and seventy seven for an hour,

[01:05:06] For an hour. Did the pain change right away? Sometimes the pain changes right away with one twenty four, but to fix the issue, it takes a bit longer.

[01:05:15] The pain started to go down and then I had to treat the system too. But then we had to take the scar tissue out of the rectum. That was right. All the surgeries and the trauma that she'd had in her pelvis IgG to scar tissue out of the rectum so it wouldn't

pull on things. But the concept never before in my life have I treated one, twenty four and seventy seven T1 and broken in the connective tissue for the pelvic floor.

[01:05:44] And but man, does that make so much sense

[01:05:49] When you look at Netter,

[01:05:50] When you look at Netter and then when you think anybody that's had a baby?

[01:05:55] Oh yeah, there's that right? Yeah.

[01:06:00] I mean, I've done a lot of good work with Dehiscence Recti with one, twenty four and seventy seven pelvic floor neighborhood, but not in that way, but. Wow. Good for you.

[01:06:12] It was like, Oh, well, she comes here for a week, right? Yeah, to see Yoda and it's like, it's Wednesday and Yoda is like looking for the back door. Right. So but then it was like, it's it's those teachers we've had. It's been bland and the John Denker and the Leon Chato and the John Charkhi and everything's connected to everything. Yeah. Although I'm really going to know John Sharkey because it's never the Fasher. It's like, that's really going to annoy him. I take

[01:06:46] A lot.

[01:06:47] So but the fact is innervated. Yeah, so you have to treat scar tissue ulnar nerve anyway. Oh, for sure. One, twenty four and seventy seven. It's like the pain started to go away right away and then I just one unit on her that ran four point seventy seven. For an hour while I treated scarring in the rectum internally. Yeah, right. So it was pretty fun.

[01:07:16] Amazing.

[01:07:17] It's 5 after 5 already it is.

[01:07:20] These hours go by so fast. So keep your questions coming, everybody. These are great. I know. Do you have any announcements for the week other than you've got a webinar on Friday for the Vagus nerve? That's on Facebook? I think right? That'll be or no, you're doing it. You're doing it through Zoom again.

[01:07:43] Yeah, I will do it through through Zoom. It'll be an FSM practitioner and it's different. I decided. Because not everybody comes to the advanced now this year we're doing it livestream and in person at the advanced. So not everybody has seen this Vagus thing. And if I make it a webinar, it will always be on the website and people will be able to find it.

[01:08:14] So I and get caught up and then they can hit the ground running at the advanced.

[01:08:19] Yeah. And what's what time?

[01:08:23] Oh, hour on Friday.

[01:08:25] What time's the webinar? Four o'clock, four o'clock Friday. Pacific Time. Australia and New Zealand, India and Ireland. You'll have to figure it out. You can ask.

[01:08:41] And then I have another quick announcement was asking, but the next live sports course, that's what I just thought. So I think it's going to be at the advanced in Phenix, the next live one. I'm on the fence about doing another live stream before then, but I think we'll just since it'll be live streamed at the advance and in person. We'll just go with that. And for all of you have taken the FM sports course, there's going to be an advanced FSM one day course. So any of you who have taken the FM sports course, the one day will be more intense, like biomechanical troubleshooting, some cool manual therapy skills and a lot more proprioception balance work. That neural patterning stuff that I'm a bit of a geek with.

[01:09:27] Does that mean I don't have that day off and I get to come, sit and watch? Yeah.

[01:09:32] You can come play in balance and do all the fun things.

[01:09:35] I've got lots of things you can play with. That'll be fun.

[01:09:38] We'll turn you into like a Cirque du Soleil person after. How about that?

[01:09:41] Oh, OK, that's optimistic. That's great.

[01:09:44] Hey, you got to aim high. Aim for the stars aim high.

[01:09:48] What a good time questions.

[01:09:51] I don't know if you want to get them really quick. Oh, we think you answered them already. It was being recorded. You answered. The quiet down is one twenty four. You got that and 40 and then you got the what time? We did everything awesome. So if there are more questions, email us and you know where to find everybody.

[01:10:12] If you register for this webinar, you are automatically registered for the next two months. What webinar?

[01:10:18] Perfect for this one, our podcast.

[01:10:21] That's a podcast. A podcast, but it's still it's a webinar. It's a webinar on Zoom, but it's a podcast.

[01:10:28] Yes, so come join us. So come and join us every Wednesday and get it live as we're doing it, because that's so much fun. And then you can replay it and listen to it after.

[01:10:37] I suspect we may graduate to champagne or fizzy water or something, right?

[01:10:42] Oh, that's a great idea. And eventually we'll have a theme and we'll have guests. But right now we have just way too much to talk about.

[01:10:49] So yeah, there are guests that are coming. We're already working up a list.

[01:10:54] I have such a great list. We'll talk about that in private, though after,

[01:10:57] Hey, yeah, bye guys.

[01:11:00] Bye, everybody.

[01:11:02] Thanks. Thanks, Kim. Bye bye.

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