

Episode Seven - FSM Podcast

Dr. Carol and Kim Pittis

This transcript is computer generated

Carol: [00:00:03] Hi.

Kim: [00:00:04] Hi

Carol: [00:00:05] Busy Day?

Kim: [00:00:07] Oh yeah,

Carol: [00:00:09] I know the feeling.

Kim: [00:00:12] It was like I woke up this morning and I was like,

Kim: [00:00:14] it's Wednesday, what? It was just Wednesday

Carol: [00:00:18] Wednesday sas like three days ago right?

Kim: [00:00:21] No. Yeah, maybe two days is crazy.

Carol: [00:00:24] Yeah. Well, your life is. Yeah, this year

Kim: [00:00:28] It is busy. Yeah, yeah,

Carol: [00:00:31] I had. I've got an amazing case to talk about briefly. Like.

Carol: [00:00:41] She came from the East Coast.

Kim: [00:00:44] Yes.

Carol: [00:00:45] And.

Carol: [00:00:48] She's had all this

Carol: [00:00:49] In her major

Carol: [00:00:50] Complaint is brain fog. I mean, I'll talk about the guy's brain fog is the major complaint and

Carol: [00:00:56] Memory problems

Carol: [00:00:57] She can't

Carol: [00:00:59] Read and remember she has to. She's an auditory learner, can't read and

Carol: [00:01:04] Remember, can't move

Carol: [00:01:06] Things from short term to long term

Kim: [00:01:08] Memory.

Carol: [00:01:09] What does that sound like?

Kim: [00:01:12] A couple of things.

Carol: [00:01:14] Vestibular.

Kim: [00:01:15] Yeah.

Carol: [00:01:16] And her mechanism of injury was 10 years ago. She was playing volleyball, went down to get the ball. It hit the floor in front of her bounced up full force, hit her In the head.

Carol: [00:01:27] And so the all the imaging she's had done, she's got hyper mobility. She's not full on airliners, but she's close. She's like a seven out of 9.

Kim: [00:01:40] Right Yeah.

Carol: [00:01:41] And so her neck is hyper mobile

Carol: [00:01:47] C1 is a little bit whatever.

Kim: [00:01:50] Yeah,

Carol: [00:01:50] she's had prolo. Seo C1 on the air and Transverse Ligamentous image-guided,

Kim: [00:01:59] Not bad,

Carol: [00:02:00] No bad side Effects great.

Carol: [00:02:02] And she still has brain fog, right? And so They did a Venography on her skull

Carol: [00:02:10] Found out the left, one of her jugglers, isn't filling. So there's this surgeon that came up with a procedure. To, OK, you're sitting down right?

Kim: [00:02:22] I am with my coffee.

Carol: [00:02:24] Ok, good. You might want to put your cup down.

Carol: [00:02:29] They take off the end of the stylized process and they make a groove from the front in the Transverse process of C1, the anterior part of the Transverse process of C1. They carved that out And Then they Separate the Jugular vein from the accessory Nerve and They tack the accessory nerve onto the platisma.

Carol: [00:02:59] And then they Clear away the adhesions between the jugular Vein and The surrounding soft tissue and fascia. And then the

Carol: [00:03:08] Jugular vein fills. Now, there's no guarantee that this is going to fix her cognitive or brain fog as her major comp. There's no no right and nobody even For neurologists,

Carol: [00:03:23] To neurosurgeons, blah blah blah. Nobody even checked her for Vestibular injury. We put, yeah. She went to Dr. Rusedski first on Monday, and she flew in on Sunday. Yeah. Put prison glasses on her left eye, which is where she took the hit right. We presume on there her brain cleared up. She could walk normally she could read. Wow. And I treated her for the instability, the disk. She's an 80 one in 10 lots of tight

Carol: [00:03:55] Muscles, joint pain. She's a 40 and 10. Yeah. And it? It made me a little crazy, and she Saw one of our practitioners on the East Coast,

Kim: [00:04:09] right,

Carol: [00:04:09] Dispensed one of the Chinese versions of An FSM device And. Amazing. It was programed, not correctly. And the battery was so

Carol: [00:04:24] Corroded it wouldn't run. And so and then she got an emergency call that she had to leave today, so we didn't do a Customcare, but.

Carol: [00:04:36] So that's my case, so I Can talk about what I did And we got From Seven out of nine on the bait and score To zero Out of 9 on the bait and Score L1 Lumborum all fingers or Normal Neck is fine. Neck pain is down Brain fog, a Programed or CustomCare with brain fog last night and she ran it on herself a couple of times and Her brain's all clear today.

Carol: [00:05:02] When the air pressure drops, they fed her a Meclizine. Yeah, and the brain fog went away in 30 minutes. Yep. And so how about we maybe postpone the surgery? Maybe let's do that. That was my big idea.

Kim: [00:05:17] Yeah, it's funny. You're like the queen of Segways,

Kim: [00:05:22] So oh

Carol: [00:05:23] Goody.

Kim: [00:05:24] Everything on my little list. You hit a couple of the things already, so I think we need to kind of go back to basics with a couple things that we need to touch on for all the practitioners that are listening, all the patients that are listening. There's been a lot of questions about devices and setups and the difference between like leads and all those things. So if we can touch on that a little bit today because you

Kim: [00:05:51] Kind of talked about it a little bit with different devices?

Carol: [00:05:55] Yes.

Kim: [00:05:57] And a couple of Podcasts ago we were talking about, I think irritation was the word of the day,

Kim: [00:06:03] Right? Like, I was just irritated at all these people that I was seeing who weren't checked for really basic

Kim: [00:06:10] Things. Like you were saying With your dissipation, Vestibular Vestibular has been a huge thing that I

Kim: [00:06:16] Think with me, with My athletes that are missed. I mean, 20 years ago, when I was in college, we did this whole component on post-concussion syndrome and whiplash or flexion extension injuries and how neck trauma mimics concussion, especially in the osteopathic world, even from the nausea and the brain fog and when there's neck issues. But the Vestibular part is, I think, still even 20 years ago, 20 years later, we're missing that with our concussion screens and

Carol: [00:06:51] Nobody, nobody Looks for it. The only reason I know about it is that in nineteen ninety eight ninety nine through about 2003, when I was in the really busy clinic. We had in Portland saw my

Carol: [00:07:12] Whole patient population was fibromyalgia, chronic fatigue, chronic pain patients, those circling the drain, folks. Yeah. And we had in Portland three Of the world's top Vestibular Specialists.

Kim: [00:07:27] Right.

Carol: [00:07:28] We had John Epley and everybody knows about the Epley maneuver. What they don't

Carol: [00:07:32] Know is that John Epley treated my son's swimmer's ear and the patients I was seeing that had already seen John Epley. I read his reports, his exam found out what he ordered on a Vestibular test, and then when I worked with Robert Graham, who was a neuropathologist who's published Papers When I worked with Graham, I got his reports, found out what he Ordered and found out

Carol: [00:08:03] How to do a screening exam by going over to his office and watching him work on one of my patients. Find out how to do a screening exam. And then over probably five years, I just developed this facility right? And then probably in two thousand two thousand, we found out that ninety four and ninety four, which Is concussion

Carol: [00:08:30] In the Medulla in the concussion protocol, which is really basic for us. Yeah, that one frequency caused Dizziness in a patient that I knew Had Endolymphatic

Carol: [00:08:44] Microamps. So. That gave me an excuse because I tell everybody it's like I will warn you about every side effect you're ever going to see in any patient.

Carol: [00:08:57] Well, ninety Four and ninety four in about 10 Percent of patients with Known Vestibular Entries.

Carol: [00:09:04] Ninety four and ninety four is going to make them dizzy Or nauseous, right? If you treat somebody

Carol: [00:09:10] With a concussion protocol and they call you the next day and say they've got a terrible Headache, They have a Vestibular injury and you didn't do the

exam, right? So that's why we do that forty five minute section in the core on Vestibular injuries and I'm dead serious.

Kim: [00:09:27] Yeah,

Carol: [00:09:28] at the When I say at the end of that, forty five minutes, All the Practitioners listening at the end of that forty five minutes, you know more About the mechanisms, the symptoms, The the screening exam, how to treat what To do for patients with Vestibular injuries than literally ninety five percent of the physicians in this country. This lady had seen four neurologists, two neurosurgeons. Maybe she'd seen 10, and it just and nobody Picked it up.

Carol: [00:10:05] And the the brain Fog Component of this is, I mean, it's diagnostic. She can't she can't remember things. She she has to write everything down, she said. I'll tell somebody to do something. So she's a she was a teacher and I gave this child a hall pass, you know, to go to her violin. Listen, but then I forgot where she went and when I looked up in the classroom and she wasn't there, I had forgotten that I sent her out And she's like, Well, yeah, you can't

Carol: [00:10:40] Transfer things from short term to intermediate term To long term. So once She knew what the problem was, I said, This is this is a Management problem. This can't be Fixed, right? And it's not going to be fixed by doing the surgery. The problem is that they did the videography, so they know that the one of the jugular veins is not Filling,

Carol: [00:11:05] But they don't know if that's congenital. Hmm. Has it been like that her whole life? And she had great grades and a great memory up until the time she got hit in the face with the volleyball when She was 17? Mm hmm.

Carol: [00:11:18] So you have no right and it's not innocuous any time you're carefully. I mean, the surgeon the video the surgeon has posted on Youtube is Brilliant. I mean, he's it's just exquisite. And there are questions that have to be asked how many of these have been done worldwide? How many have

Carol: [00:11:44] You done personally? What is the mortality? How many people die? What's the morbidity? So what are the side effects when you remove this thingy and. So then so she came in and she was really fine on Monday, Tuesday, she came in and she was just foggy brained and out of it. And I have this barometer, apt barometer, air pressure app on my phone. And on Monday, as I was explaining Vestibular injuries, I opened the app and I said, See, it's twenty nine point nine. And so I'm doing really pretty well. When she came in all foggy and blurry yesterday. I opened the app and I said it's twenty nine point seven. And that's why so I handed her a Meclizine and 30 minutes, no brain thought so, and her PRISM glasses get here Friday and gets shipped back east to her house because she had an emergency, she had to go home today.

Kim: [00:12:52] But the fact? Oh, and In our world. So I reached reach down. So she has a 40 and 10 pain diagram.

Kim: [00:13:02] Mm hmm.

Carol: [00:13:03] Not the fibromyalgia pain diagram for the patients in the group. And so shoulders, elbows, wrists, knees, hips, feet. And she's circled the pain diagram and I said, don't forget to put in your hands. And she said, How did you know? Don't. It's fine. So then I felt her quads And brevis

Carol: [00:13:26] And her Hamstrings tight As a drum. Even our forearms were tight. So that means increased descending inhibition. With the 81 and 10 that was on one machine. She was seven or. Probably seven out of nine on the beat and scores because she's hypermobility, she's HSD hyper mobility syndrome disorder.

Kim: [00:13:51] And so I ran Torn and broken one, twenty four and seventy seven active feet and every Ehlers-Danlos patient who's listening, every practitioner who's listening, every patient that has a whiplash injury or repeated ankle strains or Whatever, I make the bait and score part of my

Carol: [00:14:11] Incoming patient. Evaluation, yeah. Reflexes, she was hyper reflexive with Crossing, She's missing or C-5 reflex. Nobody checked her for C-5 six disc. And it's like I saw a cervical MRI. Right? You need this bulge at five six, but it's just normal and

it's like five six disc and you press on the scalenes on that side and it's Aloe said, Oh yeah, My there were

Carol: [00:14:44] There were going to do thoracic outlet surgery on her. Oh jeez. Good face, yes. So pressed on the disk, explained how this is. The Scalenes and the scalenes are tight and that's why you had thoracic outlet. So I treated the disk. I did the supine cervical practicums. So at one point I had five machines on her.

Kim: [00:15:07] Wow.

Carol: [00:15:08] Right. 124 and Seventy seven, 81 and 10 40 and 10 neck. All neck defeat and then neck to chest concussion And Vagus and

Carol: [00:15:18] The supine cervical practicums with just more time spent on torn and broken and the ligaments. Right. And then I ran discs of acute On her neck, and at the end Of it, her pain went from a six to one. And I just and and it's and and no one. Had done her Reflexes, she'd seen eight Neurologists, two or

Carol: [00:15:53] Three neurosurgeons, she had the Aloe therapy through the mouth. No one had done her reflexes. Just or sensation? Sensation was completely normal, but I said the disk bulge in her neck has to be completely central, right? Explain that the discs don't have to contact anything. They're inflammatory by their nature. So it's the play to in the disk nucleus that just leaks out and affects the motor pathways, the descending Inhibition and the pain

Carol: [00:16:33] Pathways, especially in our Ehlers-Danlos patients. Because the disk annulus is made out of connective tissue and Ehlers-Danlos and hyper mobility patients don't make sturdy. Athletic connective tissue. Right. So it's a whole there's when you And she said, I'm going To tell the IgG Ehlers-Danlos Support Group and Facebook pages. About this, so get ready,

Carol: [00:17:06] So everybody that's listening. Pay attention, go back and review the Ehlers-Danlos webinar and Yeah, we're she's she'll do it. She's she's. Impressed, how can you not be? I mean, Yeah, let's let's you know, you can always cut off your styling process And the

Carol: [00:17:36] Transverse process of C1, you can cut that off In three months. Let's see what the glasses do.

Kim: [00:17:42] Right?

Carol: [00:17:42] You know, let's try to something A little more conservative.

Kim: [00:17:46] Yeah.

Carol: [00:17:47] So that was my Day, the last Two days.

Kim: [00:17:51] So that's a that's a big two days.

Carol: [00:17:54] Yeah, but this is Like becoming Almost standard, you know? Yeah. With with Ehlers-Danlos in the disk patients and the strange things I see.

Kim: [00:18:06] Right.

Carol: [00:18:07] All right. What's on

Kim: [00:18:11] the list is growing every single Wednesday. So I want to actually just kind of go back on a couple of things that you were just talking about and clarify and ask some questions because because we can and I should, and that's what this is all about. So when we talk about ninety four and ninety four a ton in the core, I think that's one of our warnings that this can make people nauseated. This is, I think, the Keith Pine story like, what do you do when you get an athlete that feels nauseated, lets them barf? And he continues on, and that's sort

Kim: [00:18:44] Of what What I what my take is because I think it's safe for me to say the vast majority of my professional athletes have had a or continue to suffer from a Vestibular problem. Yeah, football hockey, they are getting concussed and flexion extension injuries three Times a week. So it's it's a thing, But I have found if they don't react to ninety four and ninety for the first time, they never do. So it's not like. So the first time I give them a CustomCare or I run the concussion protocol, I always stay in the

Kim: [00:19:21] Room for until ninety Four and ninety four hits. Make sure they're still sleeping and they're not feeling like they're about to fall off the table or throw up. And then I put The blanket back on them and I leave the room, or I can give them the CustomCare safely knowing that they'll be OK. So that's good that you're verifying that, too. Going back to brain fog and our brain fog protocol have you, when you have people run it. You said that woman ran it at night and she

Kim: [00:19:50] Felt, OK. I have a lot Of athletes that can't tolerate it past, like 4:00 p.m.

Kim: [00:19:55] They get to wake. Oh, yeah, yeah, Because when it works, it, it works. And all of a sudden they have all the clarity and they want to do all the things and read all the books and call all the people and write down all the words.

Carol: [00:20:11] Yeah, well, and it's nice that we can do that. So you have to run it in the morning. And I Don't know if she ran it last night Or this morning, but

Carol: [00:20:19] I mean her brain injuries 10 years old. The Yeah. And so that's that's a good point. And I modified it. I noticed in the mode bank and the the PDI people are going to be really annoyed with me because I have to modify the brain fog program. There's nothing in there for eighty one and ninety. Hello and then I, that's a good face. There's not no. I went in and looked at it. When I loaded it onto the unit that I gave her last night, I went in and looked at it. Eighty one and ninety wasn't there, and because she has a Vestibular injury, I put

Carol: [00:20:56] Inflammation in the cortex because she's had I mean, her brain injury is right a long time. And then I also put in forty and forty four so quiet the Vestibular system. And when you're treating the supine cervical practicums forty four is the frequency for the inner ear. Ok. Yeah. And so if you're working on somebody's neck and you know they have a Vestibular injury and

Carol: [00:21:23] You're using a PrecisionCare, put the frequency on Channel A 40 to quiet the activity of and forty four on channel B the inner ear. Right. And keep your hands on the patient's neck and see what Happens, right? Pleasing. It's so cool. So I did that

Carol: [00:21:43] To her brain fog protocol because I knew she had a Vestibular injury, right? And and the civilians, like the athletes, are Motivated and they know, right? Yeah. If they react to ninety four and ninety four, they're always going To react to it. If they don't React to it, it's only five to 10 percent. And I've never figured out why.

Kim: [00:22:06] Right. That was my follow up. What's with that percentage and what can I say?

Carol: [00:22:12] It's a small percentage of, you know, if you ask a room full of 100 Practitioners at the advanced, how many of you seen this? There'll be 10 Hands.

Kim: [00:22:22] Yeah,

Carol: [00:22:22] it's about 10. It's about 10 percent. Yeah, and I don't know why, and I don't know. So I actually don't care. I just know that

Carol: [00:22:35] That means that when they have a certain constellation of complaints, I have trouble reading. So that was the one that That set me off

Carol: [00:22:45] With. I knew for sure. She said. I have trouble reading. I get really. She'd when I use the Computer, I get a Headache when I use the Computer. I get a headache When I try to read. So some of it may be positional, but some of it is that the neck muscles tighten up so much to provide proprioception to the inner ear when you're trying to use your eyes and one of them isn't tracking well.

Kim: [00:23:13] Right,

Carol: [00:23:13] right. So of course, you get a headache.

Kim: [00:23:15] Sure.

Carol: [00:23:16] So when you see that constellation of Symptoms in your intake? Why are they coming to you, right? Or if you Don't get pretreatment paperwork

Carol: [00:23:30] When they come and you do their history. What are you here for? Right, right. Then then automatically, your physical exam has to include fields of gays, webbers auditory pressure. I didn't even do a Vestibular Exam because their

Carol: [00:23:52] Symptoms were so. Yeah, diagnostic. Right. And. And so the First stop was Dr Rusk, and he put a prism in her left eye, and all of a sudden she would swing her arms when she Moved. Yeah, when the first Prism he put in her arms were really Stiff.

Carol: [00:24:22] The second one he put in her trunk rotated to the left. She was walking straight ahead. But her trunk rotated to the left and I was standing back with him watching and I look at her trunk, it's rotated. And he said I would never know to look for that. But you're right. So then when he got the correct prism in her trunk or straight, her arms were singing, her hips were moving because the brain was not having to compensate with. Compensatory proprioceptors. Right, right. So. It's just it's to me, it's just fascinating, and Dr. Smooshy is lecturing at the advanced in February, so I'm so excited about that.

Kim: [00:25:10] Yeah, yeah. I think It's Staying on the Vestibular train for a little while. It can be overwhelming for a Practitioner to think about all These extra tests Like it's. I think it's important To note that you are your job is not to treat the Vestibular problem you can send them to should send them to a Vestibular who is trained on whatever mechanism they're going to use to do that. But this needs to be in. It needs to be in your forebrain as a practitioner That

Carol: [00:25:45] To watch for this because it is missed And It can save a life, right? It is. It is that important? Yeah. So yeah, between Vestibular Pittis and somebody that can help prism glasses, I think it's worth for all the practitioners that are listening to. If you don't have somebody in your City, find one. Find these people.

Carol: [00:26:09] And there's like in Portland, we have in Vancouver, we have one ENT left that Understands Vestibular injury. So I have somebody that I can send people to For Diuretics And medication That they need. Yeah, but the the biggest Thing I did for her was explain why she has the symptoms she has, right? She they they think they're

Carol: [00:26:35] Crazy, they think Right and And there's no explanation. And she said, why is it worse on low pressure days? So I hauled out Netter and I showed her that diagram that we have in the slides. Yep, and it's like, this is what happens. This is why rainy days are worse. And it's. That we can't treat it, We can we can compensate for it with 40 and 40 four, but the value that We have As a community, there's 4000 of us that have taken the core all over the world. Twenty three countries. And those people know About diagnosing

Carol: [00:27:16] Vestibular injuries. They know we can't treat them. They know they should diagnose them. Those screening exam takes all of six minutes, right? There's no reason not to do it. Fields of gaze. Tuning fork on the top of the head, do you hear it in one ear or both? Does this sound the same as that? It's six minutes.

Kim: [00:27:40] It just doesn't. And it's like doing reflexes, right? That's five minutes.

Kim: [00:27:45] Right, right? Yes.

Carol: [00:27:48] Yeah.

Kim: [00:27:50] I'm going to jump on the question really quick frequency pair for antidote for nausea or dizziness.

Carol: [00:27:57] Meclizine. So, Michelle, if You are, I guess you could try 40 and forty four, but I've never done it. The question is, is there a frequency to be an antidote? And in the core, as a chiropractor in Oregon, I can prescribe if that's the right word, dispense, prescribe Over-the-counter Medications. I don't know how, like massage therapists or Pittis would get away with it, but A dose of Meclizine, It's Boning. It's so it's the non drowsy motion sickness pill. A dose of Meclizine will take the nausea away in 20 30 minutes, and I've had had a couple of Patients that

Carol: [00:28:48] Literally stayed nauseated for three days and it didn't go away until I gave them Meclizine, so I actually don't know any other way. Forty and forty four might be useful, but I've just never done it and I'm not sure what causes it. So is it forty and ninety four? So the eighth nerve actually goes in, actually goes in the right around the top part of the. The Medulla or the bottom

Carol: [00:29:27] Part of the pons, depending on how you look At the anatomy. So you could do 40 And 90 four

Carol: [00:29:35] To try to quiet the dizziness. You can have 40 and for 50 for four, the pons Michel. It's the question is what about 40 and 5 sixty two? And it's like it's not a sympathetic response. It's central and it's when you get sympathetically agitated. Think of fight or flight. You're not nauseated. Yeah, you're you're running and you don't have time to be dizzy or nauseous. So this isn't a sympathetic response. It's it's going to be either the Medulla, the pons or the middle ear if we have a frequency for it. And I've just never. I use Meclizine, so those of you that don't have that option. Yeah. Melinda, Frank, yeah, the Vagus is related to nausea, but I don't know what to do to the Vagus. Do you want to increase secretions in the Vagus IgE? Decreasing secretions in the Vagus is a mess when you look at. The fact that most patients have not enough vagal tone, that that's part of their symptom constellation, the digestion, their SIBO, that's the other thing this girl had sibilance like, of course you do, right? But yeah, Melinda, yes, it is related to nausea, but I don't know what to do to the Vagus. And quieting the Vagus makes Me nervous, and I Don't know why. Ninety four and ninety four would cause nausea. The Vagus starts in the Medulla, so I would feel safer running 40 and 94 to quiet The activity Of the Medulla, then I would running. Anything on the Vagus

Kim: [00:31:25] Before we go any further, I want to touch on one of the questions that I got in and it Was actually on the Facebook. Well, I had to find it. It was on our Facebook practitioner group And the person Had screenshotted it and sent it to me and was like, I wonder about this all the time. Can you talk about it? And I couldn't really go back and read all the discussion and back and forth, but it was between 40 and to eighty four. And what really works better? And you see it? Sorry to catch you drinking. I should have made sure that your water was down in a safe zone.

Carol: [00:32:03] That's right. The screen's dry. I didn't lose it. I'm good.

Kim: [00:32:06] Good. So and then I didn't read all of it because I was just like, Okay, we'll talk about it Between you and I, and we'll We'll clarify it. So for those of you who are new to frequency numbers, 40 is our inflammation slash our quiet the activity of so when we when you have a practitioner like we need to run 40 and 10, that means we

Need to decrease the activity quiet, the take out the inflammation of whatever body part. So the question was

Kim: [00:32:42] We hardly Ever see acute inflammation. Why are we not running like 280 for more? And that's see, now I can say it, that's a good face. Mm hmm.

Carol: [00:32:56] We only see acute inflammation.

Kim: [00:32:58] Ok, thank You. I mean, I I took a deep breath here because I don't want people To Think Acute and I'm putting air quotes here for the podcast or listening. Acute inflammation is something that happens between like the first hour Of an injury Or trauma. We have acute Live, active, Ongoing inflammation consistently. And just because you have a Quote, chronic Condition or an injury that's older than twenty four Hours, that doesn't mean you Stop using 40.

Carol: [00:33:32] Right. And as you and I talked last week, it's like, I think we said out loud. Do you ever use 284? And it's like, No. Yeah, the the thing that. Thanks to Diana Cross, the thing that we need to remember is that every tissue. Let's say the Achilles tendon empathy, so that was what her paper was, her presentation was on. Yeah. Ok, so the tennis site, the tendons cell Body

Carol: [00:34:06] Has sensors that are notified when there's an injury or a tear in the connective tissue if there's a tear in the tendon. He. Length. Yeah. That is not repaired within twenty four hours. The TENS site, the tendons cell body. Begins to express the genes for inflammatory cytokines. It expresses the genes for substance, p interleukin one, CGRP and One other one. So virtually every cell in the body, I guess, or maybe it's just connective tissue and perry System and nerves? I don't Know. They have the genes in that tissue present, but not activated. Right. Yeah. To that would create these inflammatory cytokines, and that's 40. But the thing that we do is we fix Why the tendons

Carol: [00:35:27] Cell body is expressing those genes. So on my Achilles tendon apathy, I ran 40 and 24. On and off for 11 months, 10 months. Didn't work took the plane down for 30 minutes, so I just stopped treating it. In December, after having it since January, so 11 and a half months later. Kathleen Casben ran torn and broken in

the round tendon that is the Achilles. And in an hour, the tendon was normal sized, pain free and never needed a second treatment. So treating inflammation didn't help. Treating chronic inflammation didn't help. Treating why there is inflammation, so what's wrong with the tissue, right? The thing that 284 is good for that we have both found is dissolving bruises. Yeah, it's like you got a hematoma from a hockey stick or a baseball or a bat or a fall, and it's superficial. You just park it on to eighty four and in about three hours, it's gone. Yeah, you have a DVT. There's a great big do not use 284, because when you have a DVT, you don't want to

Kim: [00:37:01] Dissolve that Clot in the vein because there's absolutely no guarantee that is going to come apart all at one time with no fragment. So 24 is Good for dissolving bursa's. And I think you and I both agree it's like all and that one illustration in the in the Cornell and the 5 day where there's cytokines released in the knee. That go up to the spinal cord, go up, up to nerve, up the cord, to the brain, to the sensory cortex, right? Yeah. And it's it's cytokines and that's 40, right?

Kim: [00:37:46] So yeah, I I'm happy that we took a moment to clarify that because and it's easy to do. We want it. We want to like the Quick fix, Right? And it's That whole. You're welcome. I'm sorry that sorry. That's true, though, that that is our that is our world. You can make it as complicated or as Clear as As you want it to Be. But I think for the practitioners, Listening, listening is you have to Think y. Like enough Of the this is Tight. Let's loosen it. Like, think of the bigger picture. Why would something be bilateral? Does that make any sense that one thing is tight? Of course not. It's not the muscle, it's not the connective tissue. It's bilateral. So starting to think. Same thing. Why is that tendon thick? Why would something be inflamed for so long?

Kim: [00:38:43] And you know, This is to your point, you're talking about the 40 help for maybe half an hour. And then beyond that, it comes back. So the practitioners out there that you're getting success in the clinic. But by the time the patient gets home, all the symptoms are back again. You missed something so great that you got them out of pain for 20 minutes, but that's not what my practice is built on. You know, I you want to close the cases as fast and as long as possible, you.

Carol: [00:39:14] So I think that's why we change the our made at such a. A piece of the pain and injury Section, and in The 5 day, it's like torn and broken. And then there

was that patient that we talked about last week or the week before where every place he said he was tight, right? Scarring, he said that scarred the fascist, scarred to the nerve that's that scarred down, I've had that, that's this that's that. And it's like the only thing that worked was torn and broken. Yes. And it's like, OK, that's right. It's just so the purpose of the core seminar and the modules is to teach you how to think about conditions when you have frequencies to use as a tool.

Kim: [00:40:06] Right, right. I want to touch on scoring, too, because that was the other question. Facebook thing that I was looking at and a little bit about setup. So we're talking about going kind of back to the basics here, and we have the practicums in place and talking about Where do we

Kim: [00:40:23] Put it, head to feet Or we sandwich apart, or we put it, Where the nerve Exits and we follow the spark to where the symptoms go. So I'm going to paraphrase the question And Forgive me if I'm not saying it correctly, but you'll get the gist of it. There was a patient that had a new head scarring on one side that was old and chronic, but had surgery on another Side and Was trying to figure out if they could run scarring just on the left side That it wouldn't Affect the right side.

Carol: [00:40:55] And there's there's a there's a slide that says don't do that,

Kim: [00:40:59] right? So evenThough it's Left versus right toe versus finger neck versus ankle People, This is slide number, whatever right in the Beginning, we are Semi-conductors like. And yes, so we Have we have Practicums in place and we try to give you the setup to make it as accurate as Possible. But it You can't think, Oh, just because I'm sandwiching the right elbow, that there's not an effect over onto the other side of the Body. So and

Carol: [00:41:32] there's no place where it isn't. And in the core and both modules and your course, we have the the the pledge, the promise that I will tell you about every mistake I ever made. Yeah, we had actually it was a practitioner. She had a sprained ankle and she was working on a patient who needed the frequency for scarring. So the practitioner's ankle sprain was three or four weeks. Right? Yeah. Not finished. Not repaired. And she thought, Oh, this will be fine. So she worked on the patient with just

her bare hands, running the frequency for scar tissue at the end of the 60 Minutes. The practice, the practitioner's ankle recovery was set back by about two Weeks,

Kim: [00:42:25] right?

Carol: [00:42:26] So it's an and then the patient, it's like, I know you have this is chronic, but we'll treat you in two weeks when this is six weeks old, right? Then I found out that six week thing applies to everything except rib fractures.

Kim: [00:42:47] Yes, yes, yes.

Carol: [00:42:50] So everything except for IgG fractures

Kim: [00:42:52] And rib fractures are taking how long?

Carol: [00:42:55] 12 to 18 weeks for. I mean, my son has nine fractures and eight ribs.

Kim: [00:42:59] But if you think about it, it makes sense. We're always breathing. I mean, That bone, those bones, Those articulations are never immobilized.

Carol: [00:43:10] So I, I just. And all they Ran was removed. Scarring from the nerve. Yeah. And and the Blood vessels, I think nerve. And maybe anyway, I just wanted to take adhesions out of the nerve to set him back for weeks. Right. Chest pain came back. He had to start wearing his his course. Of course it again. It's like, OK, fine.

Kim: [00:43:35] Right? So the last part of that, just because something's on the left, you can't sandwich it on the right. The follow up was, well, why the heck do we even have lead placements the way that we do? If there's a global effect or there's a field in Place,

Carol: [00:43:52] you want to, you want to concentrate or focus the current? Yeah, especially when you're treating nerves. So I had and I found out about that by a mistake as well. I had an associate that really didn't want to think about placement.

Kim: [00:44:14] Mm hmm.

Carol: [00:44:15] So she treated everybody neck to feet. Yeah. And her nerve pain patients like. Ridiculous up of these six and seven. It didn't work right, and sciatica didn't work, and I can't remember how it came up, but I walked in to just sort of kibbutz on a patient who was treating and just treating him neck to feet for sciatica. And it's like, No, you have to treat it from where the nerve comes out to where the nerve ends, right? And that is, it's really specific. So if I want to treat the C seven nerve root and I have the contact at the neck, I have to put the other contact on the wrist. And then if what the patient says now my hands are better, but now my shoulder hurts. Then you take the contact off their fingers and you move it up to their elbow, right? C-5. Yes. So you want to concentrate the current and the frequencies for the local effect. But the a semiconductor, so the frequencies are going to go everywhere, right? But the current, I think,

Carol: [00:45:27] Can be Concentrated in. Yeah. One area.

Kim: [00:45:34] Right. And you know, for those of us in physical medicine, we're almost always treating the nerve. So it just makes sense, especially to start off. You're going to set them up to quiet the activity of the nerves, get that patient out of pain First and then You can move things around or not, you know, like if it's close enough, like you're not going to fail by not shrinking up that contact, you're just going to be a little bit more specific. It's going to go a little

Kim: [00:46:04] Bit faster, so it's a little bit More effective.

Carol: [00:46:07] And for the visceral practitioners, there is. Well, yeah, for physical medicine practitioners, if you're working on something that's chronically painful. Um, let's say it's more than eight or ten months.

Kim: [00:46:25] Yeah.

Carol: [00:46:25] You will Always run one unit neck to feet on 40 and 10, because once the peripheral pain generator has been More Than actually three months, you're going to have wind up or facilitation in the spinal cord pain pathways. And that's Jay Shaw on Thursday, right in Phenix. And but the visceral practitioners, if you're treating any visceral problem, doesn't really doesn't matter what it is. You need a contact around the

neck and one at the pubic bone and run at least concussion and Vagus. Or if you're short on time, run at least vagal tone, right? There's there's No visceral condition that I can think of That doesn't benefit from.

Carol: [00:47:20] Improving or dealing with vagal function? Right? So, yeah, and so in this patient, scarring in the Vagus was a thing in her neck. Yeah. And she said, Oh yeah, by the way, I have SIBO and I'm allergic to a bunch of foods. And well, yeah, and this is why. Oh, so We did Vagal tone a lot and did scarring in the Vagus. And when you treat scarring in the Vagus as you're treating the neck, the the neck muscles just turn to pudding, especially up around the ears where they're planning on doing the surgery, right? It's like, OK, then right? So yes, OK,

Kim: [00:48:07] OK. Moving right along and continuing on our basic Train here, we touched on Set up. I want to talk a little bit about the different devices out there, both the ones that we use and others, And Because there's differences. Mm hmm. And let's just talk about the ones that we use first and why we use them. Maybe.

Carol: [00:48:36] Ok, so can I.

Kim: [00:48:37] Can we go there? Is that OK? Can we talk about it?

Carol: [00:48:39] It was me. I mean, I get

Kim: [00:48:41] Questions all the time, like, can I just buy this one? And I say, no?

Carol: [00:48:45] Yeah. So here here's the thing. So we started out with Bio-Therapeutics in nineteen Ninety seven, The first time I wanted to teach the core. I had to get permission to use the graphite gloves because that's what we had back then, right? And then when the blue box became Impossible to build, They built the PrecisionCare. For us, The first automated

Carol: [00:49:12] Unit they built was the home care, the simplest, and then they built the CustomCare that came out with software in two thousand seven, I think. All right. And so the thing with these units is they are made in the U.S. I've been to the factory. They

there's. It you could make a unit in your. Dining room or your garage that could get a 5 10 K Is just equivalent to a

Carol: [00:49:49] Previous device used to be 50 thousand. Now it's two hundred and fifty thousand. But whatever getting a 5 10k is like doesn't count. Almost you have to Have one, but it doesn't mean anything. Then there are safety and quality standards that are EIC, I think 16 six hundred one And Iso, and I'm not sure what ISO International Standards Organization, I think 13 40 5. It's a quality. There's a quality standard and a safety Standard

Carol: [00:50:22] And the safety standard when because I used to, my dad And George used to own precision Microcurrent when you send a device off to be certified for safety. You get it back Completely destroyed because of what they do to it. So this is battery operated devices and they hook up line current. They hook it up to one 10 volt instead of a nine volt battery. And they but that's the last thing they do. They just destroy it. That very last thing. And the ISO 13 45 requires. Site inspection at the manufacturer. So the devices whose name I like, I'm not going to badmouth them, but the what I call them, the Chinese Knockoffs, because

Carol: [00:51:17] They're imported, they're Made in China, they're imported. They've got good software because the person that distributes them in the U.S. is a good software engineer, right? But the devices, if you look at the difference, like I tried to have him make us a unit and his leads were illegal from the day that unit was released. The safety standard was set in 2000. We had to have sheaths leads. Well, I got a unit from him in 2000. I think 14 is when we started trying to work on one and there was a pin plug and I wanted the colors to be the same as ours. So I sent those little skinny white leads with the, I don't know, blue and orange and yellow and whatever. Yeah, but sent them to our lead manufacturer in Canada to See if he could put our colors on the tips. Right? I call them two weeks later said, Still haven't heard from you? What's happened? He said. They never got here. And I went, Why not? And he he said, Send me a picture. So I took a picture of the lead. Send it to him, and he said, Oh, those have been illegal since 2000, they were confiscated at the border. So I called the distributor and said, Hey, your leads are illegal. He said, really? So they've been illegal since that unit was released in 2000 and 5. And now it's nine years later, and his regulatory people never figured it out. And he never figured it out,

Kim: [00:53:04] what Would cause leads to be just like a safety thing, the conductivity.

Carol: [00:53:09] Those have been illegal since two thousand.

Kim: [00:53:11] And why would they be just a safety thing or

Carol: [00:53:14] You did or not? The rationale? I'm glad you're sitting down. There's no coffee in your mouth. No, the rationale is that we couldn't have pin plugs that plug into the device as a metal pin. Because somebody could put that pin in a wall socket. And it would conduct war current. That's a good Face while

Carol: [00:53:38] Current down the leads and electrocute somebody, and that's technically true, but wow. Yeah, right. So that's that changed the standard in two thousand. That device came out in 2005, and all versions of that device, there's now two other. Distributors, I guess you'd call them, have that company making devices for them, so there's three versions of this little square box made in China.

Kim: [00:54:12] Yeah. The.

Carol: [00:54:14] Contacts are pretty similar, but they will never, never, ever be able to have ISO certification because it requires inspection of the manufacturer. The distributor can quarantine the parts when they come in.

Kim: [00:54:34] Right.

Carol: [00:54:34] But the factory never will. So. And and I just and the leads, those little thin white leads. Yeah, they have a little strip of mylar in them. And we tried that one year, Bio-Therapeutics gave us little thin black leads. Same as the white ones, but they were black, right? And the resistance in the Mylar was so Great that

Carol: [00:55:04] The, you know, our units are all, what do you call it? The voltage will increase to keep the current, their constant current generators, the voltage will increase to keep the current the same right. So when the mylar gets little fractures in it, you get increased voltage and it causes AKI. So the first sample of the device that he sent me

with this new. Sheathed lead, I tried it on a patient, and the prickling was so horrible that I couldn't keep it on even with wet towels. And then they improved it, and by then my confidence was completely shot. So there there's a reason that our leads are. The Suttich doesn't exist as a USB charging, but the leads on the CustomCare Precisioncare are this thick

Carol: [00:56:04] And black, and the DIN's plug is required to meet the safety standard. So technically, anybody that's using one of the Chinese don't mean to be rude, but the Chinese knockoffs because they created those devices specifically to go after FSM practitioners. That was way back In the day old news. But those devices were invented. To. Poach FSM practitioners, and if You look at it, there are only five

Carol: [00:56:39] Dollars less expensive. And what do you get for it? Right. So and without. Iso thirteen, forty five. Units cannot be used in medical facilities. So it's fine. What is that thing is fine until somebody you know, gets poked in the eye, it's fine. It's all fun and games until someone loses. Yeah, right? So it's fine as long as nobody gets hurt. Right? So if. You treat a patient on Monday, and something bad happens to them on Wednesday. Let's say you treat them for SIBO or shoulder pain or whatever, and you have the towel around their neck and towel and they're on their arm and you're treating their shoulder. And on Wednesday, they have a stroke. Well, dad's only sixty eight and his 40 year old son is a lawyer and decides that the person that treated dad on Monday is the proximal cause, even though what was done to his shoulder on Monday and what the stroke that happened on Wednesday are probably not related. That doesn't do you much good when you get a malpractise lawsuit and you have to do discovery. What were you using Microcurrent device, right? And does it have a 5 10k?

Carol: [00:58:14] Yes. Does it meet United States safety and quality standards? And you have if you're a Pete and MD, a Dio massage therapists might be easier or harder, I don't know. But. You're a medical facility. You have requirements for chart notes, you have requirements for right safety and quality, all that stuff and you get under court. And it's like, Where is this device made China? Where did you buy it? Oh, some guy in Arizona. Ok? What are the quality and safety standards? And you got nothing. So my. There's two. Two parts of my dedication to FSM one is to get people to use it and use it knowledgeably, effectively and with skill and to avoid. We've been 25 years without a malpractise suit.

Carol: [00:59:18] Knock on wood, right? Yeah. And to avoid. All it takes is one. Right, it just takes one, and then we're that were that technique that's on the front page of the National Enquirer and It killed somebody in Philadelphia because the practitioner did something bad and that's it. We're done. Twenty five years of work, two books, 14 publish papers, and we're done. Yeah, that's all it takes is one.

Carol: [00:59:50] So that's The only Reason why I'm so careful with precautions and contraindications, and it's the Only reason that I've just held my ground, like with my little spike heels in in the Dirt about Device safety. We've been working on a CE mark for, I don't know, about \$200000 so far. And three years They change

Carol: [01:00:22] The standard in two thousand fourteen and. It you have to have a CE mark, so the German device, the TimeWaver that I work with, they have a CE mark, but they keep upping the standard, they keep upping the hoops you have to jump through. I think deliberately to make it impossible for electro medicine to be used. Right. So and it's all just paperwork. And there are colorful adjectives that I could use fluorine. It's PDI shipping to Canada again. Yet and no Candida used to be easy. It was just Sam de CAS, which we met for years. And then two years ago, I think Canada shifted to not only needing a CE mark,

Carol: [01:01:17] But to have An additional level of safety and quality. And Bio-Therapeutics is on that. He's he keeps saying he's getting close, but every time we get a Response back, The notified body changes what they need to change, right? Most of the Canadian practitioners have their Devices

Carol: [01:01:42] Shipped to a U.S. location and have it brought across by a courier or they have somebody pick it up or I'm not sure how that works because I don't hang out in the PDI office. It's like I George owns it. Danny and Wendy run at day to day, and I just the only thing I get involved with is making keeping track of the manufacturer and contributing having PDI contribute funds to help achieve the CE mark because it's what we we need to do to get into Italy. Italy, even Germany is difficult. Canada, Australia, we need CE marks for that. So we're on it. We're trying.

Kim: [01:02:28] I've sent CustomCare's to my hockey players up in Canada, But you're not the manufacturer. No. So for practitioners, I mean, there, yeah, there are ways, you know, there you go.

Carol: [01:02:41] Yeah, you can send them the practitioners can send them. Yes, manufacturer has to do an international shipping commercial invoice, right? And there's all kind of no. And just like we Can't, we can't Pdi can't get it done, but you can ship them

Kim: [01:02:56] Right. So the workaround could be to have it sent to a practitioner who programs it and then sends it off. So we're going to go through one question here first, before we tidy up And there went our Our already.

Carol: [01:03:13] I have a clinic already

Kim: [01:03:14] in close. So the question is, first of all, thank you for FSM. My football player is back on the Field playing football For weeks after Fracture therapy. Do you have The protocol for integrated tissue post-op, poor movement? What tissue scars, what tissue hardens and what tissue sclerosis?

Carol: [01:03:37] Okay. I'll take 13, four or five hundred, so it's a square. Yeah, so. So it depends on where the surgery is and underrated, I'm assuming means scarred

Kim: [01:03:55] Post-op A.k.a. total total knee.

Carol: [01:03:59] Oh, total knee replacements are difficult because the hardware the there used to be just one kind, right? But if you look at everybody's knee, the curve in the femoral femoral condyle and the curve in the tibia curves and the tibia where that articulates, there's different angles of arc. Ok. And then they they they take apart the joint. They pull apart the joint that creates a nerve traction, injury and just Gobs of bleeding. And the knee

Carol: [01:04:42] Is surrounded by a web of nerves. If you look in Netter, right? So they pull that apart, they put in the metal and we've had one case report where the patient. Was six months post knee replacement And could not

Carol: [01:05:04] Activate her quadriceps, she couldn't straighten her knee passively. The motion was fine, but actively the quadriceps wouldn't fire, so we ended up running metallic toxin in the bone marrow and the bone and the quadriceps activated just fine, but you needed a CustomCare, right? So underrated tissue number one. What scars and a total knee is the system, the joint capsule number one, the nerve. So you have

Carol: [01:05:38] One unit running from low back to foot, basically 40 and 3 ninety six and scarring in the nerve. So that unit would hopefully be a PrecisionCare AST so you could change the frequencies. That's why I have literally 3 PrecisionCare Teres in a room and the nerve scars the blood supply. Fascial blood supply, Perry Austin is the other big one

Carol: [01:06:13] That scars and hardens if you think of calcium or ninety one as little glass crystals that are on the Perry team, which is super pain sensitive, it's like Innervated felt. And then I, according to Tom Meyers, the adipose is the only tissue that's sclerosis. So when you're looking at a total knee? You've got the sciatic nerve, has a fat pad around it, that's probably this big round if you remember your dissections. And so the sciatic runs down to the back of the knee and then it splits up into the tibial and parochial nerves and all those. Right? And so that fat pad comes down the down the back. Well, when they yanked the joint apart, that gets. It's not just a nerve that gets traumatized. It's the adipose and the adipose sclerosis. The nerve tends to scar and sclerosis because the nerve is 85 percent opposed. And then there's the joint capsule and then. The Nah-uh is connected to the hip, is connected to the foot. There's that, and then the unfixable part is the architecture of the knee. So the replacement, if you look at it, even if they've just done what they call a partial knee, knee or they just put new little condos on, What's the

Carol: [01:07:51] Curve? Right. So when my orthopedist did my hip replacement, he put my x rays up and looked the angle of the femoral neck to the femur. And perhaps because the joint is simpler, there's not a lot of. The knee is really complicated, the hip is relatively simple, so he measured that angle, and the hardware he ordered for my hip replacement was the same angle that I was that we were replacing with the knee. You've got complex curves this way and this way. And then the tibial part of the knee

replacement is has has to match this. And the hardware just doesn't always work out well. It's. Your turn?

Kim: [01:08:54] So what you Said, Because I have to contribute. No, I have more to add.

Carol: [01:09:01] Yeah, absolutely.

Kim: [01:09:02] Taking the Scarring out is one Component, though of rehabilitation. Hmm. So you have To remember we are very good at what we do. So when we are taking scarring out, we are a lot of times creating Instability and we're leaving Joints vulnerable. So you need to follow up with good exercises To make sure that when You're increasing Length that The proprioception is back there, that the central nervous system has a chance to catch up and be like, Oh, freedom, we can move again. So. So sometimes It's not, you know, taking Something super chronic and creating length right away. It's just catching up those joint kinesthetic receptors, the toes, the muscle spindles, and it doesn't take months

Kim: [01:09:59] And months in a gym To do exercise. It's just some simple patterning to tie it all together again to make sure that all those muscles that should have been firing that shut off because they were scarred know that it's OK to fire again.

Carol: [01:10:15] And it should be done in the same visit. So absolutely you work on them, on the table and before you let them stand up so you have their knee bent on a roll and you've been working the scar tissue and working the whatever, and then you have them. Ok, now straighten your leg now internally, rotate your leg now. Externally, rotate your leg with your legs straight. Now bend it. And then it's like and you may end up working on the performance or the abductors and the pettiness and the brothers. And you have to. That's before they get off the table.

Kim: [01:10:54] Absolutely, yes.

Carol: [01:10:55] And you can run eighty one and eighty four while they're doing that because the cerebellum actually doesn't believe you. No, no, no. You didn't just do that. No, not 60 Minutes. I don't believe it. Totally.

Kim: [01:11:07] Yeah. So like I said, we're very good at what we do and you have to catch up all those other components to it. All right. We're already four minutes past. No. We are. I'm going to keep tacking on the questions and we'll just keep building and building. We have A different week next week because you and I Are not in the Same place, so we're going to have to do something different next Wednesday.

Carol: [01:11:33] We're going to have to talk about it because I'm not sure because there are actually going to be weeks this year when I'm in Europe or England, Germany, Poland, we're going to Poland. The resonance effect has been translated into Polish thanks to one of the FSM practitioners In That came to a course in Germany. And she had the book translated into Polish. So I'm going to be speaking at the university and I guess whatever the main city is And in Poland, After I leave Germany and then we're

Carol: [01:12:09] Going to Italy in June And Then London in September. So there are going To be weeks where

Kim: [01:12:18] We're doing different things,

Carol: [01:12:21] Where you're at.

Kim: [01:12:22] I love it. I have a I have a list of twenty two people. I would like to bring on an interview. So sweet. We'll start talking about athletes, other practitioners, patients who had chronic pain. I think it'd be great to hear from some personal life experience With Practitioners, patients, all of the stuff. So it's fun. Well, that's it for today. Yeah, I have a great time. Well, you and I have a great time. I hope the other people who are listening, watching

Kim: [01:12:53] All the things. It was a great one. I love the back to basics stuff. Good, good things to keep in mind and Keep in our little four brains. Yeah.

Carol: [01:13:02] And it's and it's really fun to see the number of practitioners that are here live and then the number that see it on YouTube or our website or Get it Podcast channel. It's it's really pretty fun.

Kim: [01:13:15] We're everywhere. Yeah, you can see us listen to Us, you know, got it all the way. Yep. All right. Can have a good rest of your day And see you All next week at some point or not. We'll figure it out. We'll make an announcement.

Carol: [01:13:31] Yeah, we'll figure it out.

Kim: [01:13:32] We'll be back.

Carol: [01:13:33] Yeah. Oh, and by the way, case report notices went out.

Kim: [01:13:39] Yes. Yes.

Carol: [01:13:41] So I have to sort through those. And yeah. All right now, really good.

Carol: [01:13:47] Bye bye for real.

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