

Episode Six - The Next Phase
Frequency Specific Microcurrent Podcast
with Carolyn McMakin and Kim Pittis

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Kim Pittis: [00:00:07] The Kim and Kevin show is the best show. Hello.

Kevin: [00:00:11] That's right. Ok, she's coming.

Kevin: [00:00:13] Ok. I know another conference call, so we're like

Kevin: [00:00:16] We're going from one conference call to another.

Dr. Carol: [00:00:18] I'm back. Yay. Oh, I like your T-shirt.

Kim Pittis: [00:00:23] I literally just walked in from the clinic.

Dr. Carol: [00:00:26] Yeah, I did warn you, right? Oh yeah. You start with, Yeah, I'm never. Yeah. Never know, you're in a different room.

Kim Pittis: [00:00:42] Yeah, that's a long story, too.

Dr. Carol: [00:00:45] Ok, so we're not live yet, right?

Kim Pittis: [00:00:49] I think we are I think we have 11 people on.

Dr. Carol: [00:00:52] Right. And I forgot my water bottle, so we'll figure it out.

Kim Pittis: [00:00:56] We will figure it out.

Dr. Carol: [00:00:57] Ok? Always do. Always do.

Kim Pittis: [00:01:00] At some point.

Dr. Carol: [00:01:02] What an interesting week this has been,

Kim Pittis: [00:01:04] And it's only Wednesday.

Dr. Carol: [00:01:08] Oh yeah. No. This week started about, I don't know, two months ago, but that's another conversation. Yeah.

Kim Pittis: [00:01:16] So it'll be a that'll be after the podcast conversation.

Dr. Carol: [00:01:22] Hi, everybody.

Kim Pittis: [00:01:23] Hi, people that are there. Yes, we have a few more minutes, I think, before we get started.

Dr. Carol: [00:01:29] Yeah. Do you have questions to guide us or you still?

Kim Pittis: [00:01:35] It's been. This has been the busiest week for an influx of questions and topics. And could we talk about this? And so I made a list like I always do.

Dr. Carol: [00:01:47] Of course.

Kim Pittis: [00:01:48] And I tried to see if anything matched up that I could throw into this week versus I don't know if there's anything like, you know, you're looking for the common denominator. So I think we're going to be all over the map, actually,

Dr. Carol: [00:02:04] And this is unusual how

Kim Pittis: [00:02:08] Unusual because normally I can string together something like that. There's been some big, big topics coming in. So I think we'll handle a couple of them and we'll just see how far we get and then we'll just table them for next week, whatever

Dr. Carol: [00:02:24] We can get. I just got feedback from one of our Pittis on a protocol I gave her for a patient with long COVID. Ok, and that one I have to share because it's like I. I've not done a webinar on it, I forget kind of what I told her, but then she

reminded me so before it falls out of my brain, it makes perfect sense. So that one I want to add. Sure. And what you say,

Kim Pittis: [00:03:01] Just to make sure because I don't see it on my Zoom meetings or all the attendees, and then I lost it, where to go?

Dr. Carol: [00:03:07] Yeah. All the attendees are muted. If you have a question, put it in the Q&A section. Yeah, yeah, yeah. Kevin Kevin is in charge of muting.

Kim Pittis: [00:03:18] Yes. So everybody should be muted. Yeah. Throw it in the chair.

Dr. Carol: [00:03:22] We have two more minutes. Yeah. So what I'm finding is that people are finding the podcast and saving it for later as we do, right? Yeah. So the 14 people who are here are not the 80 or 90 people that actually listen to us. And then I found out where on YouTube. Yes, which is why I have different glasses this week.

Kim Pittis: [00:03:46] They're very pretty.

Dr. Carol: [00:03:49] I have to keep up.

Kim Pittis: [00:03:51] You do. Yes, I like your necklace, too.

Dr. Carol: [00:03:54] Isn't that fun? Yes, it's I got it in Australia.

Kim Pittis: [00:03:59] Of course you did.

Dr. Carol: [00:04:00] Of course I did. That's that's a long story.

Kim Pittis: [00:04:03] Well, I got mine on Instagram. Yeah. So I think we should start with your COVID story before it falls out of your brain, and then I will guide us as needed.

Dr. Carol: [00:04:19] Ok, so what we've been using for COVID, what COVID itself, which we call? Flu, respiratory, because if you call anything COVID, you end up in Facebook jail or YouTube jail.

Kim Pittis: [00:04:35] So like cancer of starts with C-word.

Dr. Carol: [00:04:39] Those words so flu respiratory for long haul COVID we've just been using. Flu. Respiratory organs and brain, the. The long one with all those tissues. This patient had. Syncope. And body pain.

Kim Pittis: [00:05:01] Okay. And for the laypeople listening to US syncope,

Dr. Carol: [00:05:06] Oh, is. Thank you for translating. Is they faint? Right. So it's a vagal dis your vagus nerve controls. All of that doesn't control just heart rate digestion, it controls your immune system, your liver, your lungs, your heart rate, it controls lots of things. And when the Vagus gets, I think the technical term is wonky when the Vagus gets out of whack. You can go two ways. One is you can get really hyper agitated, anxious, bad digestion, high blood sugar. You can go that way or the Vagus. And this is where the pilot Vagus theory the Vagus gets super active and. Shuts down your heart rate and blood pressure, which makes you faint. Right? And so once your horizontal, then everything goes back to normal and the Vagus is happy. So that's what this patient had was body pain and syncope. It's like, well, there's no place in the flu respiratory protocols that include the Vagus. So I said, Well, obviously you take the six virus frequencies on Channel A that are in the flu respiratory protocol. And instead of running them on the immune system and the heart and the liver and the kidneys and the lungs, you run them on the Vagus. So she did that and then she did 40 and 10 reduce inflammation in the spinal cord for the body pain.

Dr. Carol: [00:06:53] And the thing that made her nervous was she actually ran increased secretions on the Vagus for 60 Minutes, so she had three machines. That's a good face. I've done it before in patients that are really inflamed. Autoimmune gastroparesis SIBO. Their Vagus isn't working. Yeah, and it's like you take the trauma out, you take out the known pathologies and then you just tell the Vagus you go to work now and you turn down the parts of the brain that are turning the Vagus down. So we have the ability to. Kind of balance the whole system out, Will. Right? So she ran the virus frequencies on the Vagus specifically, she ran. 40 and 10 to decrease the body pain, and then once she ran the virus frequency, she ran increased secretions. I think she said for 30 or 60 minutes between increased secretions and vitality on the Vagus.

But it was a long, long time and I've used increased secretions in the Vagus for 30 minutes to 60 minutes on people and not having you just keep a pulse oximeter on them. Yeah, so that's and for patients who don't have that particular constellation of symptoms, just running the flu respiratory protocol is

Kim Pittis: [00:08:20] Adequate, right? And on the CustomCare, we have flu, respiratory flu, respiratory plus organs. And that what? And then there's a two is in their flu respiratory organs, too.

Dr. Carol: [00:08:33] Yep. And that one includes all the brain frequencies because in that virus attaches, somebody said, Well, it's so weird because it has so many symptoms. It's not like the flu. It's like, Well, duh it sorry. You know, there's just no filter.

Kim Pittis: [00:08:48] I know I love that about you.

Dr. Carol: [00:08:50] Yeah. Anyway, so the virus attaches to the ACE2 receptor. In wherever it is expressed and it is liberally expressed in blood vessels. And so all of the, well, vascularized tissues. Will be susceptible to the virus, so that webinar I did last year. Patients come in with kidney failure and they have COVID. Well, they wouldn't be in kidney failure if they didn't have COVID. So all the stuff on the internet that says, yeah, they just made that up. The patient had kidney failure and because they tested positive for COVID, they made it up and they said it was covert. It's like, No, no, no. Covid causes kidney failure. It causes elevated liver enzymes because the ACE2 receptor is so widely distributed in the liver in the lungs, think about how well-vascularized the lungs are. It's in the heart, so they when the virus reproduces inside the blood vessels. It comes boiling out and just the turbulence of the viruses boiling out of the cells causes blood clots, which leads to covered brain right at the heart. And in the lungs, when they come boiling out, the immune system has an opinion about it. So you have the cytokine storm, but they found out. Now, it was before March 16th, because that's when I did the first webinar, right, March 19th. They found out that if you give them steroids to suppress the cytokines, the fatality rate goes up. So in the U.S., they've started using lower doses of steroids, and I think that has that's become the standard protocol, they just use less. So it doesn't have the negative effects. So it's a really complicated topic. But the fact that it affected the Vagus, the Vagus is turned off by infection, stress and trauma. So this is the same thing to people for people that have

vaccine reactions, infection, stress and trauma. Tens the Vagus. So I got a vaccine and now I have X. Is X related to the function of the Vagus? Well, yeah, I have this and this and this, so. Turn the Vagus back on.

Kim Pittis: [00:11:30] Right? So do you recommend in those cases say somebody is having a reaction to the vaccine to just run forty and eighty-one?

Dr. Carol: [00:11:40] No, you'd run the virus and you run the whole vagal tone protocol. Ok, but fourteen, 91, forty and 94, then the basics on the Vagus. And then before you get to increase secretions in the Vagus, you run all the viral frequencies and it depends on the adjuvant. So have a frequency for aluminum, I think. But some of you might just run toxicity in the Vagus, right? Mm hmm. Because the reason I don't know about anybody else, but the reason I couldn't get the Pfizer or Moderna was they used what do you call it, a preservative that I'm allergic, then I'm known to be allergic to. So. If somebody has a reaction to the vaccine, is it to the vaccine or the preservative that was used so you could try 57 point nine hundred and 9 20, the toxicity frequencies in the Vagus and whatever system is being affected,

Kim Pittis: [00:12:49] And that really just summarizes how we treat almost everything with FM. If it was that easy, we would just run increase vitality anywhere that sucked.

Dr. Carol: [00:13:00] That's yeah, well said.

Kim Pittis: [00:13:02] Yeah. Like, you have to figure out why, why, why is it Vagus in trouble, right? So like you just said it's

Dr. Carol: [00:13:11] What happened,

Kim Pittis: [00:13:12] What happened, exactly?

Dr. Carol: [00:13:14] Well, when somebody asked me about something nonspecific like the beamer? Well, it's not to hurt you, but it's not like it does anything, any close to FSM. They've got pictures which I wish we had. But yeah, it's not going to hurt you, but it's not going to do what we do, right?

Kim Pittis: [00:13:35] Ok, so that was that was great.

Dr. Carol: [00:13:40] Oh, it makes your brain hurt, I can see that

Kim Pittis: [00:13:44] It stretches, I wouldn't say hurt. It stretches our brains because I think those of us in well, in all, all of the practitioners, we're going to start to see these long term long haul, however, you want to call it, people who have had long term effects, either from the vaccine or from the virus itself. And this is a great starting point as we can't just treat X, Y, and Z, we have to remember why are they in trouble in the first place?

Dr. Carol: [00:14:14] Well, and it really is different if they have long COVID. Or vaccine reactions? Right. And right now, I'm texting back. Never mind. And forth with a patient who had a vaccine reaction went to an FSM practitioner. The FSM practitioner didn't fix it. She had one session on August 2nd. And this patient is saying the practitioner did all this damage, it's like, wait, wait, wait. You saw her for a vaccine reaction, and now you have all these symptoms, FSM didn't cause that the vaccine caused that. So. Go see a neurologist and ask him about Guillain-Barre, right?

Kim Pittis: [00:15:03] Yes. I'm going to follow up with this one question that was on here just relating before we change topics because I have an old CustomCare program and haven't updated yet to new program. I have the flu rasp organ, but don't have the brain portion. Where do I find the added brain program?

Dr. Carol: [00:15:21] Hi, Janet. Hmm. Where do they fund the brain program? I mean, I have it. You can email me because I know Janet, I remember very well. Email me and I'll send you a PDF. You're going to have to hand. Enter it to the Frequency Specific Microcurrent virus. Oh, OK, Kevin says. You go into frequency specific backslash virus and the whole webinar, and it's the second webinar. There's March one in April and the brain one is in April, and all the frequencies are listed so that you can look it up that way. Or you can email me and hope that I. I'm seeing patients again and having like, I get to do emails on Wednesday and Saturday because I get home from the clinic at eight o'clock or sometimes midnight, eight o'clock at night and then. Yeah. So sometimes I don't get to emails. So you have two options. There you go. Good question.

Kim Pittis: [00:16:32] I like those options. Just before we, we moved on. So like, this always organically evolves. I'm going to go with another kind of systemic question comment that we got about and I'm going to put the acronym close to me, so I don't mess it up. PANDAS and kids PANDAS. Yes. Pediatric autoimmune neuropsychiatric disorders associated with strep.

Dr. Carol: [00:17:02] Right. So it's kind of like autism, but it's from a strep infection, so they get a sore throat when there is a perfectly normal kid. If I'm understanding PANDAS, right? And it's really complicated. Yeah. The person to ask about this is actually Dave Burke. But as I understand it, perfectly normal kid, they get a strep infection and strep is always dangerous because it affects the heart and all that. But there's something about the immune system reaction to the strep that affects the brain and the sensory cortex, right? So sensory integration disorder, they're super sensitive. So. From the webinar or something I did recently where inflammation changes. How the brain works. Sturup. If I had to treat PANDAS, if somebody came to me with that. This is the part where I admit openly, you guys know we make this stuff up as we go along, right? This is true confessions time. So my guess would be obviously the concussion protocol. But then and that's on one machine and then. The the guess I would have, we have three, four, five, four or five frequencies for Sturup and you'd run those in the sensory and motor cortex just in case the Sturup actually affects that.

Dr. Carol: [00:18:53] And it's not just because the Vagus is turned off. Strap in the sensory motor cortex, the frontal lobe, we have a frequency which is experimental and investigational, so I don't know whether to trust it for the anterior cingulate cortex that's involved. And I'd run concussion and Vagus. And or I mean, I. Ron vagal tone, but modify vagal tone to treat the Vagus for the six, five or six sturup frequencies. Right. So you're doing the basics for the Vagus 40 and 91 forty and 94 94 in the Vagus and then struck frequencies. General infection frequencies then increase secretions in the Vagus and vitality in the Vagus and see what happens. I don't know that anybody, Burke might have a different way to put it. I just I need to get we need a way to transport him from Cleveland to Phenix. But that would be my best guess because the best way to turn down inflammation in the brain is to treat the Vagus let the Vagus turn it down. Some make sense.

Kim Pittis: [00:20:10] It does totally. I think the other side comment is aside from running the concussion protocol, what else could we run? So you inflammation

Dr. Carol: [00:20:19] All the brain parts and especially forty and ninety two? Yeah. So if if the strep effects. The sensory and motor cortex, because they they call it sensory integration, and that's going to involve probably the mid brain, the hippocampus, because these kids are really emotionally sensitive too. So that's going to be the limbic system. So you'd run Sturrup in the in 89, 40 and 89, 40 and 90 to so reduce inflammation in the sensory motor cortex and the for the civilians and non-medical people that are listening to this. We have absolutely no proof. We have lots of clinical data, but we have absolutely no proof that 92 actually affects the sensory cortex. You can see it in the patient. I can take somebody from wicked ticklish to not ticklish at all. And about 15 seconds. By treating the sensory cortex. But I have no data that says we do so. When I use sensory cortex, there's air quotes around it, right? So strap inflammation. And you just think about the brain parts that are involved in PANDAS. They all have digestive problems where the digestive problems come from. Vagus, right. They all have inflammation and immune system problems. Where does that come from? The Vagus how? What is what turns that Vagus off? Infections, stress and trauma. So how do you get to turn the Vagus back on? Treat for infection, trauma, increase secretions. Right.

Kim Pittis: [00:22:06] Um.

Dr. Carol: [00:22:08] Oh, that's OK. Gretchen, let's do you first. I'll get to Gretchen in a minute.

Kim Pittis: [00:22:13] Ok. It's kind of one on that side note, the other person said, I hear you now talking about concussion plus Vagus. What about just straight up concussion? Do we ever just use that anymore?

Dr. Carol: [00:22:24] Oh, sure, I don't. But because I don't, it's like there are some patients where I do. But by and large, every patient that needs the concussion protocol needs the Vagus turn back on because of where the I mean, the Vagus comes in comes out of the Medulla and we treat the Medulla with the concussion protocol. So if the Medulla has been whacked, that's where the Vagus starts. Is there any way for the

Vagus not to be whacked when the Medulla gets whacked, when you shouldn't use it, when should not you use it? We shouldn't use the Vagus. When should you not use the Vagus program?

Kim Pittis: [00:23:09] I question Kevin.

Dr. Carol: [00:23:18] Well, think of it. I had four hours sleep last night, it's not my fault. When shouldn't you use the Vagus? When do you not use the Vagus?

Kim Pittis: [00:23:29] I have a few athletes that get rip roaring stoned with it,

Dr. Carol: [00:23:36] Actually stress and trauma,

Kim Pittis: [00:23:37] Which is a daily occurrence in their world. So sometimes it's just a little bit too much for them, and they need to do it on a day off.

Dr. Carol: [00:23:47] So or you can just keep it really short. I mean, the nice thing is you can run it for one or two minutes and not the full, for sure.

Kim Pittis: [00:23:56] Some of these guys, though, I don't get to see every day, so they just have it on their CustomCare. So I just give them a concussion protocol in those days where.

Dr. Carol: [00:24:04] They feel they can't handle the other place I don't run it is when the patient is in a situation that's not safe. So you if you have a beat cop, if you have a police officer that is in a car on a day shift or night shift worse on the night shift. He's not safe. The Vagus. Quiet, when you turn on the Vagus, it quiets down the stress centers in the brain. Police officer on duty, a black ops. Military person, and we have those, too. They. Um. They are always under threat, so like with your athletes, you run it on the night before their day off, so they have at least one or two days where they're. And for the military, they run it when they're on leave for police officers and firemen. They run it on their days off just so their digestion returns to normal. The sympathetics go down and. To tell you the truth. Those particular professions, police officers, probably FBI and firemen, for sure, their dopamine guys. They live on the stress and they don't they don't particularly care for because they're not used to it. They don't care for being out of

sympathetic dominance. Does that make sense? So they may not like it. So if you run it, they don't like it. Don't do it.

Kim Pittis: [00:25:52] I think that those characteristic traits are also synonymous with professional athletes, which could be also why? It's not that they get stoned, it's just like you said, that feeling of like they live up here. You know, and when you take that down, it's a

Dr. Carol: [00:26:11] Run in the off season just so that they don't end up with IBS or Crohn's.

Kim Pittis: [00:26:15] Totally. Why I run it on the off day with them, they need it. So it's like you can relax. You're in a safe spot. Lie down, watch movie. You'll be fine.

Dr. Carol: [00:26:23] Exactly. And then there's a point at which I look them in the eye and say, and I don't care if you don't like it, you get used to it. I love that I'm older, I can get away with that stuff, I'm Dr. Mom at that point.

Kim Pittis: [00:26:37] I love Dr Mom. Let's get to these two questions because they're musculoskeletal stuff that I have some stuff to say about it, but let's get into there before we go any further with our topics. Okay. You choose which one you want to address first.

Dr. Carol: [00:26:55] Oh, there's the Gretchen Pope. I have a client who has very tight muscles in the hips, the quads. So as QLs, whenever we stretch deeply and we all know how I well, maybe you don't know Gretchen how I feel about stretching. You can ask John Sharkey or Kim from the face that she made she belches almost at the point where it sounds like she might throw up every time. Have you ever seen this? Well, yeah. Sympathetic response? No. So here's the thing. There's a slide and there's only one slide, and it should actually be a webinar, but I don't know how to describe it until you do it on that patient. Gretchen. Put one contact around her neck. One contact round each foot and run 81 and 10. For 60 Minutes. And the first thing that relaxes is the front of the leg. When the pettiness and the abductor brevis relaxes, then go up to the QLs. It'll go up the trunk. You should do reflexes because when somebody is this type, they either have an autoimmune disease like me or they have a cervical or thoracic disc. If

they have a central disk there, it pushes on the motor. It pushes on. It irritates or inflames the motor pathways and reduces or eliminates the descending inhibitory. Don't be tight signals that come from the brain down to the body. And I learned this because I blew two discs in my neck that turned my spinal cord from a circle into a peanut and trashed the motor pathways on the right side. So my left side was basically spastic and paralyzed at sometimes, and maybe one in 10 would fix it. And so from that, it's evolved to. Recognizing. This its tone when you say very tight, what you're describing is not spasticity.

Dr. Carol: [00:29:21] Its tone really tight. So the reason that. She asked is because the Vagus is going to guess about her history, there's been some sort of abdominal trauma, either a seatbelt injury, abdominal surgery, there's IBS, Crohn's endometriosis, any place where the Vagus is scarred in the abdomen, you try stretching the trunk muscles. The Vagus will have a traction injury that doesn't go well when you run 81 and 10. The C for physical medicine people, we feel we have to do something so you can do something run the supine cervical practicums on her neck while you're running 81 and 10 on her body and just every now and then get up from your stool at the head of the table and reach down and feel her legs because they're going to relax from the bottom up up the front. Up the front and then from the back. Gas trucks. And Solace, hamstrings go AST, the hamstrings drive me crazy, then the glutes, then the QLs, and you have to make sure that the QLs aren't tight because they've had a blow to the kidney. Kidney infection or kidney stone. And then on some patients, including me, 80 one in 10, will relax the tone from pretty much the neck down from wherever that disc bulges clear down to the feet. It's so that's the solution. It's not a sympathetic response, you're creating probably attraction entry in the Vagus. And according to John Sharkey, stretching is always a bad idea because muscles contract. When you're stretching fascia or tendons, all you're doing is tearing them. Now your hand go. Ok. Netter. Pretend you're 70, it works great, I don't

Kim Pittis: [00:31:40] Have to pretend I'm like, I'm like an old person stuck in like a mad person's body, so I get it. For those of us in physical medicine, we see something that's tight. We want to smush it, beat it, stretch it, pull it, push it, do all the things to it. But you have to ask yourself when you see it on paper, how does someone with quadriceps tightness so as tightness, QLs tightness and then she writes, et cetera. So I'm thinking there's other muscles. And especially if it's bilaterally, this is not a myofascial injury.

When you see multiple things, it is something systemic is in place, so you have to back away from the muscle because physical medicine people, I know this is going to hit you like a ton of bricks. It's never the muscle.

Dr. Carol: [00:32:32] No, never.

Kim Pittis: [00:32:34] So to your point, and I won't go as far to say I'll never stretch somebody. I have athletes that need to be stop it, that needs to be mobilized. So I start. I have stopped using the word stretch and I start seeing mobilization. We have to get things moving.

Dr. Carol: [00:32:52] Active, it's as long as it's active, you're balanced.

Kim Pittis: [00:32:56] Totally. I incorporate, and especially with FSM, it goes so fast when you start doing TNF type moving. And I don't even say enough stretching its mobilization, its contract release, it's getting the toes, the joint kinesthetic receptors, it's in the muscle spindles, it's getting everything balanced. So to take somebody who has especially bilateral air quotes for this tightness and to make them stretch and then you right, stretch deeply. All I'm seeing is tearing.

Dr. Carol: [00:33:28] Yeah. So if you stretch them, you're also going to have to run 124 and 77

Kim Pittis: [00:33:34] And 124 and 142 because if you've got this gummy tissue and you force it into a stretch and then when you say deep stretch, you're really pushing that plasticity. If there is not even just the Vagus is scarred, but if any peripheral nervous, scarred, you're just exacerbating that because your central nervous system is going to say no.

Dr. Carol: [00:33:57] Well, and especially since we know that the cerebellum does not negotiate, know if you have loss of descending inhibition and you try and move that muscle. I'm here to tell you it's not going to, it's not going to work. So 81 and 10 and then the other thing, but this won't be peripheral if it's body wide, it's 81 in ten. That's just that's a given. Yeah, if it's. Out on a limb. And the muscles are tight. To me, a favor and run scarring in the nerve, yeah, and torn and broken in the connective tissue

because those are the two places where the cerebellum will say, Yeah, no, you're not going to move, this won't let you. You don't need to know why. I know why I'm telling you this muscle needs to be tight and. I win so you get rid of why the muscle is tight, which will be the cerebellum is trying to protect a torn tendon. Or connective tissue torn fashion, maybe, but also scarring in the nerve. Absolutely. And it's just,

Kim Pittis: [00:35:06] Yeah, we see that time and time again with frozen shoulder especially. Yeah, it's never what you think, is it? We're used to thinking it's subscap. Yeah. Oops, right? It's not. Yeah. So yeah, I would treat the nerve. And yes, you can. You know, I'm going to say for sure you can run Vagus and run concussion. That's that's always a good thing, especially when there's multiple criminals involved in the crime.

Dr. Carol: [00:35:37] Well, and the other thing is that if we assume it's 81 and 10, then you must also assume that there's a disk bulge in or neck. So check her knee reflexes. And if there's a disc in her neck, where does the Vagus run? Go back and look at the vagal the Vagus workshop? Any. Any neck injury, so whiplash? I don't know what her history is, but if the Vagus is adhered and you start pulling on things, the Vagus goes from the base here skull to your pubic bone. And if you start stretching the trunk, you're basically creating a nerve traction injury in the Vagus. So treat scarring in the Vagus in the neck. So while you're working on this disc in her neck? If you've got a PrecisionCare, you just throw in scarring in the Vagus and see what goes Smush. That was a religious experience the first time I did it.

Kim Pittis: [00:36:41] So. Yeah, and then I hate to I hate to sound like a broken record with this stuff, but once you release the scarring and you get the length returned, you're going to have to work at getting balance strength return so that these results hold and we get to speed that up with our neural re patterning stuff that we do. But when you have, like I said, when you have multiple criminals involved in the crime, you're going to have to do some work with strengthening. And those of you who are new to FSM and practicing with it, this goes fast. So I get it in your textbook that you have to increase the length and decrease the tone and then you work on stabilization and muscle setting in our world because we're doing what we do in an hour. Clinically used to take me hours and weeks what I can do in an hour. So I am. I'm bringing in corrective exercise

immediately, whereas I used to just kind of wait, no, we have to strengthen the joint sooner than later.

Dr. Carol: [00:37:56] And the other thing I think you do in your course, and I at least cover is afraid to move it. So when I have a patient with a chronic, painful condition had a hip replacement that didn't go well and the joint capsule is scarred. And you start mobilizing the joint and you can watch the movement of the femur be jerky. So you do 40 and 91. Don't be afraid, it'll be fine. You quiet down. They have the hippocampus and the limbic system who's afraid to move it? And if we move this joint, we're going to die. No, no, really, truly. It's going to be just fine. And then. After you quiet down the afraid to move it, then you've got a word for this in yours, but then it's increased secretions in the cerebellum to get the cerebellum to coordinate it. And then from the cerebellum, the signal goes to the sensory-motor cortex. So that's the order. I do it in quiet down the limbic system. Turn on the cerebellum. Turn on the sensory cortex. Then go back to the cerebellum. And if the movement is still cautious or afraid, go back and do it all over again. Tell them how the limbic system just is going to be fine.

Kim Pittis: [00:39:19] Right? We term that the FSM sportspeople listening. This is your WIP and load, so we have to wipe it. You have to wipe that memory. You have to wipe that pattern before you can load it. And I know Dr. Balika talks about something kind of similar talks, but you've got to put in the good stuff before you take out the bad stuff. We flip flop that here would take out the bad stuff and then we load it with the good stuff, so we wipe it and we load it. The other thing you can do with patients who, if you don't have all the time to go through wipe and load is a resisted active range. So if that patient will go to the shoulder because it's easy to demonstrate and we see all the time with frozen shoulder, they're only used to moving it, maybe twenty-five degrees. And you know, after all your work, you've got another 30 degrees. They will stop where they used to stop. It's not that it's restricted, it's not that it's painful. They are used to stopping here, especially patients that have had the longer they've had it, the more prevalent this is. But if you just put your hand down on their forearm and I'll just go with shoulder abduction, just say I'm going to have you just resist me pressing down. If they are resisting you, they will fight you and they will increase the range faster because it's not just them moving it. They have help and they have resistance, and you can use that anywhere in the body. But if you just lightly apply 10 percent resistance, they will.

Instead of stopping, they'll want to show you how strong they are, and in that process, they surprise themselves. They blow past that first barrier that used to hurt so.

Dr. Carol: [00:40:57] The other thing we found rehabbing my shoulder was that if we couldn't get concentric contractions, they would passively raise my arm. Yes, and if you can do an eccentric contraction of this, let's say super splenius or infraspinatus, so you externally rotate the arm and then you have them actively internally rotated. So an eccentric contraction is where you're controlling against resistance. The sort of the opposite movement, so the muscle has to lengthen. Yes, once the muscle figures out how to lengthen. And it doesn't hurt. You do that two or three reps. And we're talking I don't know how much resistance you use a pound. 100 grams, whatever you use that and once you've done three or four reps of that, then you'll find that the muscle will asymmetrically contract without freaking out.

Kim Pittis: [00:42:03] Yes.

Dr. Carol: [00:42:04] Right, totally, yeah. Oh, I love it when we're on the same page.

Kim Pittis: [00:42:08] I think we almost always are.

Dr. Carol: [00:42:10] I think so.

Kim Pittis: [00:42:11] Pretty close. There is a couple of things we will, but our little horns against. But no. Yeah, you have to look at it globally. It's never just the muscle. There's always something attached like a nerve.

Dr. Carol: [00:42:24] Okay. Well, it's like for the chiropractors and osteopaths in the room. Here's this is why I'm a terrible chiropractor. I confess it. They want to adjust or mobilize the joint because the joint doesn't move. Ok. But basic anatomy, muscles move, bones, nerves move, muscles, the brain and the spinal cord moves the nerves. So where do you why would you do anything to the bone? Why would you mobilize the joint without treating actually starting right? Muscle, nerve cord brain?

[00:43:17] Yeah. Oh, I have one.

Dr. Carol: [00:43:20] It's not related, but. But it's it came up this week, and it's one of those things where. If I were younger, I would walk out in the hall and scream and pound the walls and then come back and look and come. This is a patient I had four years ago and starting in late August, early September. She has this horrible stabbing pain in between her shoulder blades right at her bra strap line. No neck pain, just horrible, horrible level. Seven Pain when it's really bad. She saw a chiropractor and she saw a medical doctor who is a physiotherapist. Ok, physical medicine doctor. Nobody. Tested sensation. I like that face. Nobody tested her reflexes. The physiologists did push on the top of her head and then he said, well, it might be referred from your neck. So she was convinced she had a rib out. She finally talked them into an MRI. They did an MRI of her thoracic spine. That's a good face. And so I showed her the picture that we use in the core seminar of Cloward, you just look referred pain cervical disc and there's the Cloward diagram. I showed her that. And is that where it hurts? Yes.

Dr. Carol: [00:45:02] And then you press down the front and you find the 5-6 disc ALT. Yes, you check her reflexes. She's hyper reflexive with crossing both sides. But all the upper reflexes are intact, so I can look her in the face and say, remind me when this started and she was doing a bunch of lifting, she works on a farm. She did a bunch of traveling all bad neck stuff. What makes it worse? Oh, bending over to tie my shoes looking down? Blah blah blah. And it's like, OK, so we have the whole disc conversation. But the fact? That. To physical medicine, train providers missed a cervical disc, and it just made me crazy, so I treated the nerve pain down to both her hands because she was hyperesthetic at five and six on both sides and told her it wasn't surgical because the reflexes were intact and ran the disk protocol taped her. I put tape on the back part of her neck for about six or eight hours and. So that she couldn't so she would get used to not bending her head down because she's tall and she's learned to slouch her whole life. And she left pain-free pain in the middle of her back was gone.

Dr. Carol: [00:46:30] Sensation was normal. I didn't do the reflexes because I said, You have a sprained ankle in your neck. It will heal. I know you're 58, but it will heal. It's going to take eight weeks and you are allowed to lift five pounds for two weeks. You are not allowed to look down any time your back hurts. Look at where your neck is. You are not allowed to lift more than 10 pounds for four weeks. So five pounds for two weeks, 10 pounds for another two weeks, and no more than 20 pounds. And if you do it and it hurts, you're not allowed to do it. It's not. People don't like to say, I can't do it right.

That's an impairment. Yes. But you can just say I'm not allowed to lift that. And she left, she's happy she ended up buying a CustomCare, I said it's stupid for you to drive from halfway to the beach to my office in Portland when you can treat this every night at home and get it better in half the time, right? So anyway, so that was the one that I had to get off my chest.

Kim Pittis: [00:47:42] Yeah. Thanks for sharing.

Dr. Carol: [00:47:45] Kevin, we need picture and picture to see the faces of Kim that careful URL references.

Kim Pittis: [00:47:50] But everybody could see me. I think I think you have a choice when you're on Zoom to hit view and then you can do gallery view and then you can. You should be able to see me and carol side by side.

Dr. Carol: [00:47:59] Well, I can see. I can see you and I'm in this little square up at the top

Kim Pittis: [00:48:04] And I have a side by side, in my view. So Zoom has many options.

Dr. Carol: [00:48:08] Oh, here it is. I'm afraid to touch anything because

Kim Pittis: [00:48:11] I'm not going to go away. I promise next

Dr. Carol: [00:48:13] Time. Okay, what else is on your list?

Kim Pittis: [00:48:16] Ok, so. I want to just go up to the other question that we have, because that will tie into part of my list, actually, I treated nerve pain, but when I addressed the fascia, it magnifies the pain. Why is that?

Dr. Carol: [00:48:30] Ok. Do I get to do this?

Kim Pittis: [00:48:32] I think it kind of always works like you go and then I pad it and then, so why not just go

Dr. Carol: [00:48:38] With it and then I'll add it. So for me, you treat nerve pain, and I'm not sure what you mean when you address the fascia. That was my custom to move the fascia. Inflammation leads to chronic inflammation leads to scar tissue. So you treat the nerve pain 40 and 396. That's easy. That takes 30 minutes, let's say if it's an arm. But then when you want to move it, you have to treat scarring in the nerve or when you. Move or address the fascia. The nerve is going to get traction and it's going to increase the nerve pain. So you have to get rid of the scarring between the nerve and the fascia because nerves run in a fascia nerve artery vein fascist sandwich. And so there that's my hit. But yours.

Kim Pittis: [00:49:30] Similar, but not okay. So when I first started teaching the sports course, I threw up this pitcher of lasagna and I labeled the different layers of the lasagna like muscle nerve Dasha. Well, you know, and it was very close to the lunch break. People were hungry and they're like, Ooh, lasagna. And so they'd pay attention. And I'm like, I'm tricking you into learning right now. So I'm wondering to the question here, if we're sometimes I think we get caught up thinking that once we treat the nerve, you're done treating the nerve forever and ever. And that's not necessarily true. Sometimes you're go back to the shoulder because it's easy for me to demonstrate and to talk about. But if we're doing, say, external rotation and they're stuck and you're treating the nerve and also like, Oh, it feels better, and then they relax, and then you think, Oh, I have to treat the fashion now. So then maybe you're doing something with the fascia. And then it increases the pain. It's not that the fascia increase the pain, that external rotation increase the range of motion. You still had some more work to do with the nerve. Deep down, you know, so so sometimes we think, Oh, I, I changed it to bone and it increased the pain or something with the bone. No. Think about what you did. You increase more range of motion pain increase. The more I would think. Maybe you have to go back to run more scarring on the nerve. So sometimes when the pain quiets with the nerve and then we change our frequencies and then other, we're going deeper into the tissue. So we're accessing something a little bit deeper that needs the nerve again, or we've increased more range. It's not really the fashion that's magnifying the pain. You still have some more work to do. So don't don't think that just because you ran 40 and 396 inflammation in the nerve or scarring in the nerve, like 40 minutes ago when you started. Don't be afraid to go back there. And that's my little add on,

Dr. Carol: [00:51:31] And I have one more way that I work it because I can in my and my little clinic, I have 3, PrecisionCare, Teres, a CustomCare and an AutoCare. And so if somebody has nerve pain? I have one machine, I mean, just a CustomCare. I have one machine that is just programmed to do 40 and 396, and it does it the whole hour because I have a 60-minute slot. And then I have a second machine that's a PrecisionCare so I can get in and work on the adhesions between the nerve and the fascia, while the same time that I'm treating inflammation in the nerve. Right, both. And then we'll have a third machine that goes from the back of the neck to the chest and use that to treat the disc that caused the problem in the first place.

Kim Pittis: [00:52:34] Yes. Yeah, that's great. Great note if you have the ability to run multiple machines, that kind of. Takes care of all that.

Dr. Carol: [00:52:44] Well, then they honestly, they pay for themselves.

Kim Pittis: [00:52:47] I mean. Oh yeah,

Dr. Carol: [00:52:49] That's just like their profit center. So it's just it's just overhead and it's paid off in four weeks and that's.

Kim Pittis: [00:52:57] Yes. Yes. And it goes fast, so I hope that answered that question. Give you a couple options anyway.

Dr. Carol: [00:53:03] That's good. Thank you. So I think we did good.

Kim Pittis: [00:53:05] Perfect. Yay. Happy to hear that. Ok, we're going to just keep rolling down my list. A little bit of my list are good and it actually did kind of organically work its way. We're doing a lot of my fascial stuff today. Can we please talk about lumbar stenosis? I know what, not what not to do, but I don't know what I can do. And actually, that came up a couple of times this week, and I do think we do a great job of saying if 81 increases pain with a cervical stenosis protocol. 40 Sorry, yes and polarized. Exactly. I mean, I'll let you start because you always do start and I finish. But stenosis is pretty easy.

Dr. Carol: [00:53:54] But well, it's easy depending on how bad it is. I've actually had one patient that had so much stenosis I couldn't touch her, even alternating with really low current levels. But in general, if you know a patient is fanatic, you do use alternating current, not polarized and cervical stenosis. You have to check the bench can make sure it's safe to treat them because they come because they're in terrible pain. Yeah, they have nerve pain in both their hands and they're having maybe even a toxic gate. Or you check the Dubinsky and the Verbinski's positive. They go after the surgeon. That is. At least if you're sensible and they're sensible, it's just not safe.

Kim Pittis: [00:54:38] Yeah, but say non-surgical lumbar stenosis,

Dr. Carol: [00:54:42] Ok, let's say non-surgical lumbar stenosis. Inflammation leads to chronic inflammation, leads to calcium, influx leads to scarring. What is stenosis? Stenosis is usually a bulging disc that has become calcified and scarred. And how do you get rid of that? Wolf's law, I think, is. The key, if you can get it to move. The body will absorb the calcium. In Lumbar stenosis, especially cervical stenosis, but let's say a mild lumbar stenosis. The L3 is usually where the stenosis occurs. Why is that? Well, it's because foreign 5 degenerate. First, they get stiff and they stop moving. And when you walk, you move your side joints and your trunk has to rotate every place you every time you take a step. Well, a foreign 5 aren't moving what's going to rotate. L3. Ok, if you think of the disc as a jelly donut and the annulus is the donut and the jelly is battery acid. Then you have an inflammatory. Complex with connective tissue, and it gets little cracks in it. And then the muscles say, Oh, this can't move. So the brand says no, no moving. And then you move from T1 L2. So sometimes those stenosis, patients come in with pain at B-12. Yes, because that's the only thing that's moving. Mm hmm.

Dr. Carol: [00:56:38] The trick is to get L3 to move. One millimeter at a time. So you're running inflammation in the nerve, inflammation in the court of the leg pain, inflammation in the nerve. And then you treat the disc for. Inflammation, the disc annulus, especially inflammation, 02:17, is the encloses, the really hard kind of calcium 91. And I think twice about doing too much with scarring was softened the disc, but at the same time, you have to stabilize T. So that and then you have to give them exercises where they don't know if you can see me, let me do this. You have to get them across their hands on their chest. And this is an exercise. You contract your obliques and you rotate your spine, the whole spine, 5 degrees. And that forces the

motility and the road arteries to contract, which will rotate that segment. And you're only going to get one or two degrees of motion in the lumbar spine. And I've never had a patient who stuck with it long enough. But except me and it works it. It just takes six months. So they are using a CustomCare at home. And. And what sort, if you can get it moving, it'll reabsorb? Not right away. Right? You go.

Kim Pittis: [00:58:37] Once again, I will build on all the good things, all the good nuggets that you said, but movement is the big thing and these people are afraid to move. Sometimes they've heard a really poor description about the stenosis, so it's super scary and that makes them not want to move even more because they think that this desk is like a grenade and it's going to explode if they move. And I'm like, It's going to explode. If you don't move, it's in that position because it hasn't moved. So a lot of that kind of wipe and load is really important with the back doing these really small what we call like vertebral segmental exercises. So using that rotation, locking up the thoracic, just letting the lumbar spine do what it needs to do, treating the disc torn and broken, send these people home with a CustomCare, have them purchase one because seeing them twice a week in the clinic, they will be there for years like they need to do all the disc stuff at home. The other thing I'm going to add that I've had a lot of really good clinical success with is the meth acronym. Way back in the day, we used to do rice right for acute injury, rest, ice compression elevation. We are not doing rice anymore in the sports world.

Kim Pittis: [01:00:01] Leave it to Canadian data to show that ice wasn't doing a whole lot as far as inflammation. It feels better because we've numbed the area. We did nothing as far as promote healing, so we want everybody to be doing meth. I don't know why we couldn't figure out how to say math, but it's math. Thanks, Candida. M is for movement. We want to keep everything moving. H is for elevation hard with stenosis, but we want to. If there's an acute problem, we want to bring it up. T is for traction, which you don't need to do clinically when you do movement. You're also transitioning a joint for the most part, and h is for heat. So we want to use deep, moist heat in muscle bellies away from a joint surface so the inflammatory cells will chase the heat source. They'll go into the muscle belly and then you're getting this great circulatory. So when you're getting issues with sinuses, when there's things like you said that are like calcified and it's becoming a vascular, putting a heat near the pair of vertebral muscles

is a great way to bring good, good source of vascularization to the area. The nerves like it, and then you can do your movement.

Dr. Carol: [01:01:15] So do you put the heat if the stenosis is usually at all 3 if you put the heat at L3 or do you put it above and below?

Kim Pittis: [01:01:23] I like to do above and below, so a lot of times people with lumbar stenosis sometimes will present with a flank pain. It'll go on the ilium. It'll feel like it's going down glute glutamine to Tfl. So having deep, moist heat along the glutes can feel really nice. And then you can once it's warm, like, Oh, they're going to want to move it because it feels warm. So stenosis people, patients, please get them off of using ice because you're only going to constrict everything and make the problem worse. It might feel good temporarily while the ice is on there, but an hour later, it's going to be worse. Worse, worse. So stop doing ice and do math well.

Dr. Carol: [01:02:04] There's got to be a method, but it's we'll

Kim Pittis: [01:02:08] Figure it out. Well, Canada, come on.

Dr. Carol: [01:02:11] Let's see. The other thing with the Heat is that's the other thing the exercise does is especially a small exercise brings circulation to the area. Yes. And then the heat? No, it's not five o'clock already.

Kim Pittis: [01:02:24] I got a buzzer. So yeah,

Dr. Carol: [01:02:26] Wow. Ok, so heat. Yeah, increases circulation. And that's going to move the calcium out and help relax the muscles.

Kim Pittis: [01:02:37] Yes. Yeah. And I'm going to build this one more. You talked about it with your cervical patients using tape who are not familiar with taping, you know, the world of FM brings with you and it's like, you're welcome. And I'm sorry all at the same time, you're going to have to start expanding your knowledge bank. So I tape a lot more than I ever used to because we're going from zero to 60 in a really short time with these patients. So and I'm not talking about really aggressive bracing taping, but muscle taping. So I use rock tape because I work with athletes and I really like the

quality of it. But can you still tape anything besides tape? Because I think it's worthless. I don't like the stretch and I don't like the adhesive on it causes allergic reactions in a lot of cases. But to help either relax a muscle or stabilize a segment can be really beneficial, especially after you've released a lot of scar tissue. Sometimes these patients need a little extra just support while things are. Waking up again, but all that can be super helpful first analysis.

Dr. Carol: [01:03:40] When I learned about skin taping, so you put a pre-tape on and that brown that's called Is that Kate rock tape

Kim Pittis: [01:03:49] Now that these are all Katie? Katie Vinicio and rock tape is very elastic enough. You just go straight on.

Dr. Carol: [01:03:57] They're totally not stretchy. Yeah. So if you put non stretchy tape, the skin adhesions restrict the motion below it. So when I tore my AC joint or had my AC joint torn, we kept it taped for it took a year for any time. We took the tape off the leg. Pain would come back on. So I was at Pitt once or twice a week when I was in town and we would retape the joint every one to two weeks. And the reason I put this lady's, I taped her veteran to good posture and put. Non-stretchy tape. You put a pre-tape on that white stuff that protects the skin from the adhesive, and then you just take a narrow strip and take the inch wide. Cut it in half lengthwise and then just make a little x. And it just reminded her, and it's like she ought reflexively when to bend her head down to put her pants or shoes on, and she went, Oh! Right? And after two or three days, she'll learn to. She'll learn to keep that proper posture. Yes, yes. Fantastic.

Kim Pittis: [01:05:29] Don't already we are. So closing questions is meth now used for acute injuries? Yes, ma'am, it is. If you Google meth instead of rice, you will see all the data that shows why we don't use rice anymore, even in acute injuries.

Dr. Carol: [01:05:42] Rice actually never made sense at all, ever, anyway.

Kim Pittis: [01:05:46] No, I'm glad I wasn't the only one. Kim, where are you from in Canada? Oh, hello. I was born in central Canada, in Winnipeg, and that's where I went to college and university. And then I moved to Calgary on the West Coast, and now I'm here in California and I'm never going back. Just kidding.

Dr. Carol: [01:06:04] Well, over here in the middle, isn't it? It's in the plains.

Kim Pittis: [01:06:07] Winnipeg is right above like Fargo, North Dakota. Yes, that's where I grew up.

Dr. Carol: [01:06:11] And then Calgary

Kim Pittis: [01:06:12] Is it west right above Montana? Yeah. Okay. You came to town. You came to Calgary. We brought you there.

Dr. Carol: [01:06:19] We had so much fun.

Kim Pittis: [01:06:21] We saw ponies and everything.

Dr. Carol: [01:06:23] Yeah, we got to go to what was what's the name of that?

Kim Pittis: [01:06:26] Spruce Meadows, Spruce Meadows.

Dr. Carol: [01:06:28] That's where my ovarian mare came from. Right? Remember that that crazy protective mare was just kind of thing. Yeah, I bit the bars when we walked next to the stall because she had a baby with her.

Kim Pittis: [01:06:41] Yes, and we look so threatening.

Dr. Carol: [01:06:43] Yeah, no. You're just you're not a horse. And no, we're not. That was pretty fun.

Kim Pittis: [01:06:49] This was fun. Yeah. Thanks, everybody for coming. This was fantastic. I hope everybody loved it. We're going to get to those of you who wrote some of the clinical questions. We're going to get to that first thing next week. So we had some practice management kind of cool questions.

Dr. Carol: [01:07:06] So you get paid for this stuff.

Kim Pittis: [01:07:11] Wait, what? You don't just do this for fun. Wait a

Dr. Carol: [01:07:15] Minute. Fun is just just a bonus.

Kim Pittis: [01:07:18] It is just a bonus. All right. You and I have stuff to talk about, but we will end the podcast here, I believe. Those are our alarms, thanks everybody for joining.

Dr. Carol: [01:07:27] Thank you for being here. We'll see you next week.

Kim Pittis: [01:07:30] See you next time.

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