Episode Twelve - Treat the Cause Before Treating the Symptoms

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

**this transcript is computer generated*

Dr. Carol: [00:00:03] There you are. I didn't get the memo about the red.

Dr. Carol: [00:00:12] Here you are.

Kim Pittis: [00:00:14] We're off today.

Dr. Carol: [00:00:15] How did that happen?

Kim Pittis: [00:00:17] Well, it's a full moon or something

Dr. Carol: [00:00:20] I didn't know. Yes, actually, it is really good. I looked up. There was a break in the clouds and there was a full moon peeking out there. Wow.

Kim Pittis: [00:00:31] But explains it. Hi. Hi.

Dr. Carol: [00:00:35] I just we just realized. That's right. Earthquake, right?

Kim Pittis: [00:00:41] 3. Everything was there, too. Not earthquake.

Dr. Carol: [00:00:47] I just realized that the San Francisco Practicums is three weeks away. I know Thanksgiving's next week, the Practicums week after that.

Kim Pittis: [00:00:57] My camera's not cooperating right now. Hold still this. Close your eyes and time 9.

Dr. Carol: [00:01:03] Ok, hold still. Stop me. I'm not doing really well.

Kim Pittis: [00:01:09] Kevin's commentary in the background. There you go. That'll have to do today.

Dr. Carol: [00:01:12] Here we go. We're going to unmute Kevin. That'll fix him. Ok, let me turn.

Kim Pittis: [00:01:18] Yes, we are almost ready for our practicums. I'm so excited.

Dr. Carol: [00:01:22] I'm it's we just noticed that we haven't traveled in two years, right? We haven't packed up the garage. Like, there's you know how garages at night everything moves around and multiplies and where there used to be four boxes and a couple of things. There's now this huge pile. Yeah. All right. So we have 10 massage tables in the back of the garage now, and they used to be like a completely clear path because they came out once a month, right? And now we have to excavate, I think, to get to them. And it's hilarious. It's like, OK, but we have plane tickets we have. Are you going to do you want to come help be an instructor? What's your life?

Kim Pittis: [00:02:17] I'm coming.

Dr. Carol: [00:02:18] Are you going to come for the whole thing? You want to assist?

Kim Pittis: [00:02:22] Yes.

Dr. Carol: [00:02:23] Drop-in and say hi, and

Kim Pittis: [00:02:25] I'll double-check the schedule, but I haven't. I've had it on there for a bit. So unless something weird popped up, I think I'm good to go for the whole time.

Dr. Carol: [00:02:32] Ok, so it's you and me and Sue Spizer and Sue and Sue Battle and Marilyn Miller. Nice, Candice Elliot.

Kim Pittis: [00:02:43] Oh, so I have to come.

Dr. Carol: [00:02:44] Yeah, it's like, you know, The A-Team, and we've got about 20 people signed up already. Perfect. And we have two weeks for the other 20 because we're going to close it at 40. So if anybody listening, we have two minutes left before people are, oh, there's 20 people listening and taking the court ever. And you want to do the new practicums with the A-Team of instructors. It would be fun.

Kim Pittis: [00:03:13] We'll be really fun. Yeah. And just to have I mean, that's all the awesome stuff. But whenever you're around a group of FSM practitioners, there's something just magical about being part of these conversations. And whether you've been practicing for two weeks or 20 years, there's always something to bend your mind.

Dr. Carol: [00:03:38] Yeah, and you hear something new and it's like, you did that. That's the thing.

Kim Pittis: [00:03:43] You know, like you and I still have these conversations about patients, right? Like. And that's the that's we're going to be all over the map today with our podcast and just forewarning everybody listening. Like there is zero direction happening today, but I have two pages of stuff to go through. So, hey, but that was one of the things

Dr. Carol: [00:04:05] That the compass is broken,

Kim Pittis: [00:04:09] But that is that's perfect. But that's the thing like you can. This never gets old. No.

Dr. Carol: [00:04:17] No, it's yeah, and I mean, you've

Kim Pittis: [00:04:21] Been doing this longer than anybody, right?

Dr. Carol: [00:04:23] So '97, so twenty-four years. Twenty-four years, actually 25, because I started doing it in 95 with George, started working on my own in '96. So that's twenty-five years we've been teaching it since '97. That's twenty-four years. But actually doing it, it's twenty-five years and yesterday I did something that I have never done ever in twenty-five years.

Kim Pittis: [00:04:56] Share. Share. Share. Share. Share. Share.

Dr. Carol: [00:04:57] Ok. So I have a patient that has a history of various injuries. And then the solution were a couple of surgeries to release scar tissue in Ulnar nerve. And those of you that aren't watching but are listening, you can probably hear my eyes roll back in my head when I say somebody did surgery to release scar tissue ulnar nerve. So there's that. And then he started getting needling and pro therapy, and they didn't just parallel places that were unstable. They prolonged everything that hurt. So there's that had something on the order of, I don't know, 15 or 18 concussions. So we had a Vestibular injury that made everything caddie want us. So they preload everything and then they prolonged his sacrum. And then he wondered why his hips hurt because his sacrum didn't move because it had been prolonged and they prolonged his ankles and his knees and his pubic bone and pretty much everything. So I've spent maybe a total of eight sessions with him over three months dealing with scar tissue in the nerve. He's got a disk bulge in his neck that creates loss of descending inhibition. So that's 81 and 10. Once you run that, all of these places that hurt go away because the tendons stop getting shredded. And so we did scar tissue in the nerve, a lot of scar tissue.

Dr. Carol: [00:06:50] And that connective tissue, which turned out to actually respond better to torn and broken in the connective tissue. And then there were four or five spots. Yesterday, that would not soften with the frequency for scarring. I don't even try fibrosis because he's a 91 to 17 kind of guy. And so I thought, wait a minute, has this been prolonged? And he said, Oh, dozens of times. Ok, so what is Pro Aloe therapy? It's glucose, right? Glucose, I wonder if we. I wonder if we have a frequency for sugar because that's what prolo is sugar. This is a Shirley Hartman channel, as you never think of moment. So I looked up on the FM buddy. And sure enough, in the West Indies frequencies, there's two frequencies for sugar. I don't remember what the first one was, but the second one was 70. And it's like, Well, OK, 70. And what? What did they prolo? They probed the connective tissue, they proloed the fascia, and some of it leaked down to the curiosity. And I swear to you, he had the idea that they proloed his facet, joint capsules that they do imaging. No. They probe the facet joints in my lower back. No, no, they didn't. Did they do it under fluoroscopy? No. They just put a needle in there. So do you understand in somebody that's six foot three and 240 pounds that there's seven inches of adipose fascia muscle before you even get to the four sets? Everybody

remember when you did dissection anatomy to get to the lumbar spine in so many built like him, say dentures.

Dr. Carol: [00:09:01] Did they have an eight-inch-long needle? Oh no. So they dropped prolo into his lumbar fascia, which is actually connective tissue when you get to that thing. So 70 yesterday after 25 years and conservatively 200000 patient visits in 25 years. There we go. So that's and then at the advanced you know, the first day is sort of a free for all. Meet your friends, everybody talk about everything. Candace Elliott had this brilliant idea. The second day and I'm not sure how it's going to work. We're going to put topics on the lunch tables outside. So there's going to be a PTSD table and a fibromyalgia table. And I don't know, sports table. And so there's we're figuring we can accommodate up to two hundred people, a hundred and fifty people in person. And then the people that can't travel or don't want to travel can watch it live stream. But we'll have topics at the tables. Would you like to be a fly on the wall? All of those tables? Yes.

Kim Pittis: [00:10:14] Be fun. So much fun. So that's an amazing, very good idea. Mrs. Elliot, thank you for being you.

Dr. Carol: [00:10:23] Yay, Candice. That's great. She's going to do a tai chi break. I don't think I've told her that she's going to do that, but I think she's going to do that.

Kim Pittis: [00:10:37] This is how I think I got roped into my very first advance. You came to Calgary and you're like, Oh, well, Kim's going to be speaking at the advanced this year, and I was like, Look at her how she just did that so sneakily. I can't even say no now because, you know, I am.

Dr. Carol: [00:10:54] I'm speaking. Really? Ok, cool. There we go. So. Kevin, just put a new section on the website, which we don't have any content for yet, but we have so many case reports for the advanced that we're going to take them on. Zoom on video. Kevin's going to record them. You know that right? Yeah, he volunteered. Ok, good. So we have FSM. Webinars. Right. And we have podcasts on the website, and now there's going to be some case reports. There's a section for that where case reports will be videoed and we'll move the case reports the videotaped case reports from the advanced and all the ones that we can't don't have time for live at the advanced. Very cool. So that's all my stuff.

Kim Pittis: [00:11:43] I love it. Ok, that's good. I wanted to talk about the advanced and the sports. Make sure that we remind people to sign up early while you still get the early bird pricing that you have an in-person and a live stream option. So there's something for everybody and then some and bring your kids and your spouses and your dogs because the complex that we have it in is like a compound. Like, one of my favorite things about where we have it is that you don't even need a car. You've got like seven of my favorite restaurants all within, like skipping distance. And so it's a good time. So I want to backtrack a little bit. One of the, actually had two comments this week about how much fun they had with our first podcast because it was like getting to know us on a personal level. Hmm. So I want to do like a couple 3 quick like speed dating questions that we'll just throw out there for fun before we get into some of the heavier questions that I have for you today. Ok. Ok. One of my patients would kill me. She's a listener, and she'd kill me if I didn't ask you this. So I'm going to start with this question. What is your favorite sandwich?

Dr. Carol: [00:13:06] Oh, OK. Back when I could eat like this turkey, avocado and. Probably Jack Cheese on Saturday. That's the number one, the number two, which is close, second is salami. Salami, and what's that other thing? Pastrami. With. Provolone and. Anthony, so you're

Kim Pittis: [00:13:50] The Italian and you comes out because when you talk about food, you close your eyes and you kind of do this like magic thing of I don't know why this is salami, but it is in Italian

Dr. Carol: [00:14:02] Salami and it has to have oil and vinegar dressing on it. Yeah, me. Yeah, so those are two guys. Either one of them, what are your favorite sandwich? Blt Oh, well, duh.

Kim Pittis: [00:14:16] Just straight up BLT, and that's something I can still have on my gluten-free bread.

Dr. Carol: [00:14:20] So that's a great idea. I haven't had one of those in so long.

Kim Pittis: [00:14:25] I just you can get really good. I get Butcher Box. Have you ever heard of that butcher box bacon and a nice, ripe California tomato? Yeah. And yeah, so

Dr. Carol: [00:14:38] About that much lettuce?

Kim Pittis: [00:14:40] Yes. And yeah, that's my it's my Canadian BLT.

Dr. Carol: [00:14:46] Crunchy thing.

Kim Pittis: [00:14:47] It's a sandwich thing.

Dr. Carol: [00:14:50] I think it would be almost dinnertime, right?

Kim Pittis: [00:14:52] It must be. It must be. I'm going to splice in the other two-speed dating questions as the podcast goes on because I don't want to take up so much time because we have a lot of questions. Ok, so before I forget, this one has been circulating a couple of times, this person reached out to me. I think it was Instagram, Facebook, and an email, so it's important that we address it. Ok. Is Vagus one 9 in the PTSD protocol?

Dr. Carol: [00:15:21] No, and it should be OK.

Kim Pittis: [00:15:24] So is the Part B. If it's not, why not?

Dr. Carol: [00:15:27] Because back historically we wrote, Well, actually we didn't. I can see her face, so I can't remember her name. It'll come to me. She developed the PTSD protocol in 2005. I shortened it in 2012. Because we actually ran the Medulla twice. And if you're treating the Medulla for inflammation to quiet the Medulla and quiet the membrane, you actually get to the Vagus, but not directly. And so historically, the PTSD protocol, because we had so much, so much case report, we knew what it did predictably. And so it just stays that way. I didn't change it, concussion and Vagus, we didn't start treating the Vagus until we sd- I didn't start treating the Vagus until. Four years ago and before then, you've heard the story, the first time I ever treated the Vagus was in 2001, and there was somebody in I was working in a cardiologist's office. This patient was in ventricular tachycardia. I ran increased secretions in the Vagus and

dropped his heart rate from 148 to 70 in 15 seconds. And it absolutely scared the hell out of me. So after that, I didn't treat the Vagus and then Diana across as she does. Did this presentation on how cool the Vagus is? So I came home from that symposium and two days later sat on the couch and put a pulse oximeter on myself and my resting pulse is sixty-four.

Dr. Carol: [00:17:30] And put a rope around my neck, put a washcloth on my tummy. Turned. The blue box on PrecisionCare on and ran increased secretions in the Vagus. Watch the pulse oximeter, and it went from sixty-four to sixty-one and then back up to sixty-four. So then I started using it on my kids and George and it's like, OK, this is all right. Then I started using it on patients, and what I found out was if the pulse is normal. Increasing secretions in the Vagus will not change it. And then all of the other things that are true about the Vagus that are now in the Vagus webinar. All of those things do seem to respond, so inflammation goes down, blood sugar goes down. Vocal cords get repaired. Inflammation goes down. So now instead of treating the immune system, I treat the Vagus right. So the vagus nerve can decide between it and the spleen. How much reduction of inflammation is appropriate? If you have an infection, we can turn the Vagus on for maybe 60 Minutes. But sure, midbrain and the vagal afferents will turn it off faster and you turn it on so you're not going to do any harm.

Kim Pittis: [00:18:58] I just had that. You saw that synapse just now,

Dr. Carol: [00:19:00] So I'm just explode right

Kim Pittis: [00:19:02] There. It did. It's exploded all over the camera, so. I've shared with you, I've had some autoimmune stuff in the last few years, and this year was the first year my inflammation markers are below. Yeah, right? Are below threshold. It's the only thing I've changed this year is I've been running Vagus on myself.

Dr. Carol: [00:19:25] Oh my gosh. Well, same thing. I have this autoimmune thing and it's finally turned around. And what happens is I run concussion and Vagus on the Magnetic Converter almost every night.

Kim Pittis: [00:19:40] So what's up with that? Remember, I was telling you my ANA's are undetectable, so that's wow. Have do you have anybody that feels agitated when you run anything on the Vagus?

Dr. Carol: [00:19:56] Not so far. Most of the time they fall asleep or. They keep talking, but I haven't felt why would anybody get agitated the way we usually run concussion and Vagus together? Yeah, right. So people that get agitated. I suspect that it's 94 and 94, so I have two versions of concussion and Vagus on my office. Customcare if somebody has a Vestibular injury and I haven't and I know they have, so I've done the exam and I don't have time to deal with adverse reactions. I just run concussion and Vagus. That's minus 94. So it's 94 and 94. That usually makes them agitated,

Kim Pittis: [00:20:50] But I have one patient that can run concussion fine and feels anxious with concussion, and Vagus is an athlete professional athlete.

Dr. Carol: [00:20:59] Oh, well, yeah, there, yeah. I can guess, but I don't know. Right, so professional athletes. Do you know any professional athlete that isn't sympathetic, dominant? No. Ok, so if you are used to having a certain level of sympathetic tone and your brain is used to operating with epinephrine and norepinephrine right up there in the forefront, yeah. And you push the Vagus, which is kind of flip that from sympathetic parasympathetic. I could see how that would be disorienting. Yeah. Not sure why it would make them agitated. Yeah, it's this is clinical research. This is the point at which during the seminar we say it's not like we know what we're doing.

Kim Pittis: [00:21:59] Yeah, yeah, yeah. I'll sneak it in sometimes when he's in person and I just do it blinded. See if he truly does like wake up and you know, yeah,

Dr. Carol: [00:22:11] Never get away with it. No, no. It's a real plan.

Kim Pittis: [00:22:15] It's a thing. Yeah, so

Dr. Carol: [00:22:18] So that's good.

Kim Pittis: [00:22:20] Oh yeah. So this is a beautiful organic Segway into programming questions that we have. So one of the comments? This wasn't really directed to our

podcast. It was more directed. It was not a personal attack, but it was directed at me that I had a. I took on a patient that was had a CustomCare from another practitioner that set them up, right? So those are you listening? Carole just rolled her eyes because she knows where I'm going with this. And for all you practitioners out there, this might be something for you that you've gone through, and for patients out there, this might give you an understanding of how practitioners differ from one another. So about 10 years ago, I think most of us were really good at just clicking down the mode bank loading CustomCare's with patients. And that was that. So when I took over this patient and this patient's CustomCare, I do charge a reprogramming fee and kind of like a retainer for the year because I believe in updating and changing, and morphing the CustomCare all the time. So if you're a patient of mine and you have a CustomCare, I make you bring it to every appointment because we never know what we're going to find, and I really believe in customizing programs as specifically as possible. Great.

Kim Pittis: [00:23:43] So so for those of you who didn't get charged very much for your initial setup for your CustomCare and maybe you'll see a practitioner that charges you, there is a lot of thought that goes into programming a CustomCare and tailoring it specifically to your needs. So that's why practitioners charge what they do because it keeps us up at night. Sometimes, you know, it's not just a quick click down the list. Our programs are our mode bank is great, but I think when you really start getting mileage and especially the way the course is taught now, it it is. We say it's like learning a language. So here's my analogy that I came up with on my drive home from the clinic today. There are some practitioners like when you want to learn a new language you just want like the Babbel version, right? Just tell me how to say, Where is the bathroom? More wine, please? What time is it? We're teaching you like the linguistics course of verb conjugation. And yes, it can be tedious and crazy, but you're going to be able to speak exactly better phrases because you're learning it organically from the ground up. We're teaching you how to think about it or teaching you how to troubleshoot, how to create. That's the beauty of what we do.

Dr. Carol: [00:25:03] And you can always use the mode bank as a foundation, right?

Kim Pittis: [00:25:08] Usually, yes.

Dr. Carol: [00:25:09] And then I wrote the mode bank, and every time I program a unit, I take things out of the mode bank, put them in the patient's prescription, and go, I don't need that. You don't need that. You need 20 minutes of this not to. Why was that? What was I thinking? Two minutes of that? What that takes 20 minutes. So they're all customized, and these days it's coming. We are very close. L3 CustomCare that goes out should have with it programming cables because we are able to reprogram devices. There's patient software. The new CustomCare 3.0 software is so close they had their second to the last meeting today with the new fixes. And there's a programing cable that goes with it. There's a patient version of the software that goes on the patient's PC, and then you can go in and modify it, but you charge for your time. So when I see a patient, I charge X amount an hour and the last 30 to 40 minutes of their appointment is me, programing their CustomCare and putting in the instructions. So I have an Excel sheet where I've got used this protocol for X when X put the contacts here. That's all in their summary. And then every patient I sent you one today. Every patient also gets a list of their frequencies because if aliens come and steal me or my computer explodes, that's their only record of what's customized on their unit is that list of frequencies. So they pay me for two or three hours of time and the last thirty to forty-five minutes. They get charged for that organically. Yeah, in the first visit. But if they mail in a unit, they expect us to do it after dinner for free. That's just not reasonable.

Kim Pittis: [00:27:22] Right? So right. So good. Good.

Dr. Carol: [00:27:26] What's that? Do they work for free?

Kim Pittis: [00:27:29] Yeah, no, no. Ok, so so that spreadsheet that you're talking about, you design that that's part of the software or this is just something that you tack on onto the side

Dr. Carol: [00:27:40] The excel sheet that I made. I think we're giving that. Are we giving that out given to practitioners by the CustomCare unit that it's actually in the core resources? Oh, really? Ok. That's kind of scary. It should only deal with the CustomCare software. That's another conversation, obviously. So the Excel sheet with the instructions, however. The practitioner has to look at it and see if they say the same things the same way I do, and I'm in the state of Oregon, I'm a primary care physician, so my scope of practice and my clinical authority is maybe different than it would be for

a massage therapist. So I may put things in there that aren't appropriate for a pet or an otter or a massage therapist. So read over the Excel sheet, but you have that as a baseline and you can modify it. Yeah, I don't want to say it that way. I want to say it a different way.

Kim Pittis: [00:28:51] That's fantastic. That's a great resource for practitioners because I think that's one of the hardest things is when we do give patients CustomCare's, they're like, OK, well, how often when do I run this and how often do I run that? And it's really time-consuming because all I give up my cell phone, I give up my email. And when somebody wants to run something, I want to say, Oh, run this, not that. So that's great to give them a list of.

Dr. Carol: [00:29:15] I got tired of having to type in and every time. So I started building this Excel sheet eight years ago. And now it's got just about everything I program.

[00:29:30] Perfect. There's a giant long question I want to get to before we continue on because this could be a good segue way. Well, there's that earthquake again. Hello, Dr. McMeekin and Kim, this is Nancy. We have a question about frozen shoulder. We've been using FSM for a year, mostly successful except frozen shoulder. We've been on both of your trainings. Watch Dr. McMakin's shoulder demo on YouTube multiple times taking notes. We've also read Dr. McMeekin Frequency News notes the shoulder solution. However, we are unable to loosen any lock joint. We have zero success in frozen shoulder so far using multiple machines. One running 40/396 C-5-6 nerve root two axilla for pain, another running 13 396 142. So lay people listening, they're running inflammation and scarring on the nerve and fascia. We also have used 91 calcification on the fascists and 62 muscle belly or vascular tissue. 124. Also addressing Bursa. Nothing loosens the lock joint. When we work the joint to the range, we can feel spasm running. 81 and ten forty and 94 together appeared to have reduced the spasm, but nothing will loosen the joint. We must have missed something. Can you both shed some light? I have lots to say, but I'll let you go

Dr. Carol: [00:30:51] First, because you're so nice. Mine is easy, so there's two things frozen shoulder sucks. That's just I'm not 100 percent with frozen shoulder either, and the frequency they forgot is the joint capsule. So frozen shoulder is there's a cleat at the bottom of the joint capsule and into that pleat, the humeral head will roll down and use

up that plate. So a frozen shoulder is where the Sunovion and the joint capsule get glued inflamed inside and get glued together. So the missing frequency here is joint capsule Sunovion and maybe even the labrum, which is kind of like a meniscus sort of in the shoulder. So missing tissues. But then you have to understand that sometimes frozen shoulder is surgical there. There really are times when you have two choices. What's strange to me these days, these days now I sound old, but, you know, with the hair I can. I'm old. Twenty-five years ago. If they did manipulation under anesthesia, they really did anesthetize the patient and just bash the shoulder and break up the capsule. But then they found out they didn't get paid for that, so now they call it manipulation under anesthesia. But they bash the shoulder, then they go in laparoscopically anyway because that's what they get paid for. Not that I'm being cynical, but I think that's how the game works because if you're going to do manipulation under anesthesia, you just do manipulation under anesthesia. If you're going to do surgery, do surgery, why would you do both? So joint capsule Sunovion. Bill Abram's, if it's a torn labrum, it's surgical, and then I bet probably 70, 80, 70 percent with frozen shoulder, and even then I can help speed them up, but you can get rid of frozen shoulder goes away. Most of the time by itself in 12 months, but it's painful. It's excruciating. You can help, but it takes work. Go.

Kim Pittis: [00:33:23] So, yes, what you said. But so I did a webinar and I did a whole lecture at the advanced on frozen shoulder, and there's two there's actually two types of frozen shoulder type one and type two. Type one is from trauma. Type two typically has a viral onset that nobody talks about. So if there's been a viral exposure before the frozen shoulder, you need to run virus to help remove it. I know it sounds out of left field, but there is a there's been many patients that I've seen, especially when the onset has been viral or trauma and not like car accident trauma, but divorces, kids left for college, things like that. So when there's been a nervous neurological or viral onset. Wait, wait, wait, wait.

Dr. Carol: [00:34:22] Frozen shoulder. The classic female 40 foot inflammatory 40 frozen shoulder. Yes, infection, stress, and trauma is so you

Kim Pittis: [00:34:34] You didn't let me finish. Yes, I

Dr. Carol: [00:34:37] Couldn't stand it. Ok, go.

Kim Pittis: [00:34:39] So you have to treat the Vagus. So treat the virus, treat the Vagus. Nothing you do will ever work unless you treat those first. Because like the detectives that you are, you have to treat the cause before you treat the symptoms. The other thing I want to say is for those that is just straight up, there is an injury or trauma and then things got stuck. Yes, the capsule is a huge part. When you look at all the early research with frozen shoulder, there is two trains of thought, one we used to call adhesive capsule itis. So adhesive, we have a frequency for that capsule we have. But it is I don't agree with because it's not inflamed. The capsule is not inflamed. It's I have a slide on my webinar of it's a split-screen. It has stucco that's coming off in layers. So that's your 13. Where things are stuck together, it can be peeled apart. That's your 13. But adhesive capsule8 is the way they're talking about. The contracture is an actual shrink-wrap on the capsule. Yeah, so these osteopaths of the thirties in Germany believe that the capsule itself was constricting upon itself. Yeah, your A-channel is 51 in this case. 51 and 48.

Dr. Carol: [00:36:04] 51 Actually works.

Kim Pittis: [00:36:05] It works.

Dr. Carol: [00:36:06] I didn't think of 51 like it's 51 is like soft and no, really.

Kim Pittis: [00:36:11] It works with the capsule and it works when you think about that shrink wrap capsule. So these are the frequencies. So the person that just wrote in, Yeah, you did all the right kind of obvious steps for what should work. So those of you listening? Yeah, frozen shoulder, A, it sucks. But when you're able to have these little things in your backpack, so treating the Vagus when there's infection, stress, and trauma,

Dr. Carol: [00:36:35] I never would have put the Vagus together with frozen shoulder.

Kim Pittis: [00:36:38] That's when the onset has to do with a viral load or neurological stress

Dr. Carol: [00:36:45] Where it's idiopathic. Like it came out like you're forty four and you wake up some morning and your shoulder just really hurts. And then and it never you can't externally rotate it in the day after that. You can't move it. Yeah, that's the thing. Forty five year old female frozen shoulder and I never would have. That's brilliant. Thank you.

Kim Pittis: [00:37:05] Our brains are exploding everywhere today. Hey, I'm going to shift gears. I'm going to do one of our speed dating questions really quick before we ask another one, what would somebody be surprised to learn about you?

Dr. Carol: [00:37:19] Oh, wow. Really? How many surgeries I've had, how sick. That's the we. Yeah. I mean, before I went to chiropractic college and before I started practice, I was really athletic, healthy, all that stuff before I got exposed to mold in 1998. I climb mountains in Switzerland. I trained hunters and jumpers. I did 3 outward-bound courses. Incredibly healthy. The black mold in 98 changed all that and I the number of surgeries I've had between 2004 and now and then the little ones before that, like 9 jaw surgeries for the for the root canals and the dental infection. Thank you, Mary Ellen Chalmers, for saving my life. And then. Gastroparesis SIBO, I was comparing medical histories yesterday with a patient who was just so put upon because she'd been sick for so long and it's like, Yeah, I had that. You did. Yeah, had that too. Yep, yep, took. I was on that drug that you're complaining about having been on for two weeks. I was on that drug for two years. But your doctor is giving you too much and you need to reduce the dose anyway. So I guess that's. I guess that's what they'd be surprised about, because I am happy and healthy, and I love what I do and. If you look at my medical history, it'd be a little bit scary.

Kim Pittis: [00:39:10] And that's your stable, steady-state right there.

Dr. Carol: [00:39:13] Yep, well, in FSM, can you imagine me without FSM? No, no, no, no, no. Just two.

Kim Pittis: [00:39:22] I don't have anything. I don't think that insightful. I'm an extremely stubborn person. I think people don't think I'm just like this. Let's go with the flow Canadian. I'm extremely stubborn.

Dr. Carol: [00:39:34] That somebody would be surprised, but you cannot you?

Kim Pittis: [00:39:40] You've known me for a long time.

Dr. Carol: [00:39:41] Good luck with that. Ok. I think people would be surprised to find out you had an autoimmune disease.

Kim Pittis: [00:39:48] Yeah. Ok, there you go. I was

Dr. Carol: [00:39:51] Like all healthy and I went about it at all, and

Kim Pittis: [00:39:56] They ran half marathons and made some dietary changes. And I sleep and I don't drink alcohol and I run after kids and two dogs. There you go. All right. A lot of questions today. So I want to make sure that we get to them. Any precautions using 284 with any brain part with a patient who has had a brain aneurysm.

Dr. Carol: [00:40:16] Yeah. Don't do that, but so, oh, you can't take me anywhere. I can't. No. So here's the thing. 284. Kim and I have decided really isn't good for much of anything except dissolving blood clots. So. An aneurysm. Isn't technically a blood clot. But if somebody has a stroke that involves a clot. Dissolving the clot is something you let. The MDS do with drugs because they have known outcomes and they have known ways of dealing with it. I don't know, aneurysms that has a brain aneurysm.

Kim Pittis: [00:41:10] I would imagine that has to be a past tense right, had a brain aneurysm?

Dr. Carol: [00:41:14] Well, if they have an aneurysm in their brain that has not burst, you run one, 24, and 62 torn and broken in the artery, torn and broken in the connective tissue. Because it's the basement membrane and the artery and the capillary that is ballooning out and you send the patient to a neurosurgeon. And when concussion and emotional relax and balance and you can run 124. But this is there's a list I'd leave it to common sense, but there's a list of things you don't mess with and things like aortic aneurysms, brain aneurysms. I don't know if this is my common sense, maybe different than other people's common sense.

Kim Pittis: [00:42:00] No, it's good medical common sense, anybody. It's about a decent amount of training, right? That's yes.

Dr. Carol: [00:42:06] So and anything you could be sued for.

Kim Pittis: [00:42:09] Right?

Dr. Carol: [00:42:09] Yes, there's so there's Teres.

Kim Pittis: [00:42:12] Yeah.

Dr. Carol: [00:42:12] You treat the patient. On Monday, something bad happens on Wednesday, and their son or son-in-law happens to be a lawyer. And you were the last person that saw them or treated them, and you didn't send them to the emergency room. You don't have in your chart notes that you told them to go see a neurosurgeon the next day and you have, in your chart notes, treated for blood clots. Bad idea. So every single time, at least for me. My malpractice insurance company sends out these new letters, newsletters about people that got sued for things in the silly things they did. And I took that very seriously. So every single time I see a patient, the chart notes are written as if I am going to be sued. So they have to be complete. If anything weird happened at all, you document it, document it, document it. Yeah, and

Kim Pittis: [00:43:16] Yeah, and you do a great job in the core when we talk about this a little bit. I'm not sure what training this person has, but I mean, there's very few of us that can write in our chart notes. I treated the midbrain for an aneurysm like nobody can say that, so you can write 284 / 84. And if somebody were to ask you, Well, what is this and you're a massage therapist or our very polite, response would be this is just frequency that I use to loosen the neck muscles or, you know, because that's your scope, right? So again, when you're charting, I hope people aren't writing that and black and white treated for kidney stones. Not a urologist can't say that you did that, but we're doing that to soften the QLs or the lumbar thoracolumbar fascia or whatever.

Dr. Carol: [00:44:08] Exactly.

Kim Pittis: [00:44:09] Ok. Another question. And then we're going to get to some more of my list protocol for prolapsed uterus. Is it possible and how long will it take?

Dr. Carol: [00:44:19] I. So the answer to both of those is I have no idea prolapsed uterus is it's the pelvic floor fash. If you if you look in Netter ALT, the pelvic floor muscles that sort of support the uterus, the bladder, and the intestinal contents, there's connective tissue that. That connects the pelvic floor muscles in the middle prolapsed uterus happens when that connective tissue stretches or breaks for whatever reason. So you can. The challenge, as with anything that's torn and broken, is you have to support it while you run 124 and 77 torn and broken in the connective tissue with the patients basically standing on their head. So you have to put it in the position that it needs to be in. And if we do that with a partial thickness tendon tear, you run that for an hour and then you put tape on it to hold it in position. You can't put tape on the uterus. So is it possible? Yeah. I'm not overly optimistic, but we've done so many impossible things that may be. And how long will it take? Once again, it takes an hour to two hours to fix an Achilles tendonitis.

Dr. Carol: [00:45:51] And or a partial thickness tear in one of the flat rotator cuff tendons. So if you had if the patient had a CustomCare and Magnetic Converter and they put one puck on their tummy and one puck under their. Back blowback and you ran 124 and 77 for six hours while they slept. So they're horizontal, there's no gravity, would that work? I have no idea, and if Shirley Hartman was here and she's going to be here in February, there is a frequency for prolapse, but I don't know what it does. I use it for varicose veins. I don't know if it works. I've never used it on a prolapsed uterus, so you could a second night try prolapse in the uterus? Depends on your model like the uterus doesn't actually prolapse. It's the pelvic floor connective tissue. That pro abscess. Right? Yes. So I go in 124 and 77 overnight, five nights in a row. And I have no idea if you can get this done by December 9th. The other thing to discuss with the patient before she sees the surgeon is to discuss mesh.

[00:47:17] And robots. So.

Dr. Carol: [00:47:21] So when surgeons are repairing pelvic floor, they often put in mesh the number of times that I have treated patients who have toxic or painful or scarred responses to mesh. I've kind of lost track of over twenty-five years, but it's not

always good. So have the patient ask about are they going to use mesh? Can they do the surgery without mesh? Is he going to use his own trained hands or is he going to use a robot if he's in a teaching institution? You tell him I will not sign a consent that allows a resident to touch me. Those are my my rules. I've had 13 surgeries in, I don't know, 15 years. Twenty years. And those are my rules. So no mesh, no robots, trained surgeon, no residents, and whatever the other one was.

Kim Pittis: [00:48:28] Ok, those are good ones. I'm just thinking I'm doing a talk on diastasis. No, so not the same as a prolapsed uterus, but part and parcel with anything that's prolapse stretched when we're trying to train musculature. And part of the prolapse is going to be those deep pelvic floor muscles getting those to engage that you can definitely help with. Even if they go surgical, you're going to have to get those pelvic floor muscles to engage and be strong again. So that's the other kind of component to it. And then one last question before we go on with our stuff. So acute lower back pain 10 out of ten lots of yellow flag illness behaviors only have 16 minutes to treat with one CustomCare. Why would you run concussion in Vagus first or 40/396? To calm the nerve pain, he has referred pain into the knee and has right umbilical hernia.

Dr. Carol: [00:49:31] So, Matty, do a sensory exam and find out if the nerve is involved in the knee pain. So 10 out of 10 pain. They are not sitting in your office talking to you. So that's the point at which you have a conversation with the patient about there's two parts to pain. One is how much it actually hurts. The other is how much you mind it. I understand that you and it's a male. So that's the thing. I understand that you mind it a lot, but if you can separate those two and physically. And so there's that been forward, does that make it better or worse, been back? Does that make it better or worse? Check reflexes check. Aloe reflects, I know that's not something we usually do. You can have the patient check on themselves, do a sensory exam, pain to the knee can also be the four or five percent. So is it or is it disc? What preceded it?

[00:50:47] And. Um. Yeah.

Dr. Carol: [00:50:52] One CustomCare. So the first instruction is by a second CustomCare. That's good. And then you have to know what your forward flexion is worse. So it is a disc. Thank you, Maddie. It is a desk. Check the nerves. I'd run 40 and 396 because that's the kind of pain that the patient minds the most. And running

concussion doesn't do any good if their pain level isn't eight or nine. Because pain is a concussive force, so you've got to get rid of the pain before you run the concussion protocol and do sensation to event. There's a there's a thing. Male, I don't know how old he is, but if he's over 45. Palpate is abdomen. Ok. So for reflection is worse, that aims at a disk pain to the knee. The thing that screams at me with a 10 out of 10 pain. Is an aortic aneurysm? That and if it's just above the iliac arteries, so aortic aneurysms or, yeah, the aorta, they can happen anyplace from the aortic arch down to the iliac arteries where they split. If you have a low aortic aneurysm. Um. And it is about to rupture.

Dr. Carol: [00:52:30] You palpate the abdomen, you feel for the pulses. And if somebody comes in with back pain, that's a 10 out of ten. I don't touch them. We're going to do imaging or I'll treat the nerve, and if they're not 80 percent better by the time they leave, it's like we're going to order an MRI. I want you to see your GP and get an MRI. No, Maddie is in Australia, where and like Canada, where MRIs are not something you can just order and get twenty-four hours. But MRI was ordered. Okay. That's good. Yeah, but you send. Here's the trick. You send the patient to the emergency room with a note that says the patient has suspected aortic aneurysm, evaluate and rule out urgent, have them hand that to the lady at the desk, and then it's not your problem anymore and document that that's what you did. Once that's ruled out, then you can treat it like a crazy guy with Yes, Maddie, you ordered an MRI yesterday. Have I mentioned that? I love you? Yeah. And that will tell them. That will tell them so. Disc or. The worst thing.

Kim Pittis: [00:53:45] And I'm assuming it's unilateral this is not bilateral referral, right, because when something's it's going just down to one knee, I'm assuming.

Dr. Carol: [00:53:55] Yeah, that could be. And it would. And it's right umbilical, right? umbilical hernia that suggests it's not going to be because aortic aneurysms are on the left side, so it can be kidney stone pain. That's a possible, but that doesn't refer down to the knee. So good decision ordering an MRI. If if you were here, if I could throw a piece of chocolate clear to Australia, I would do that.

Kim Pittis: [00:54:21] Yeah, the thing that stumps me with the whole thing is 10 out of 10 pain in a male, like you said, like true, 10 out of 10 pain. They're not coming into your clinic like they're screaming on the floor somewhere because 10 out of 10 is legit. So I think that's a huge take on what you just mentioned. One part of it is the true pain itself

and how much you mind it. That's a brain exploded three times today because those of us who treat athletes, you can you can never use pain as your guide because they could be in pain, but they're never going to admit it to you because they want to get back and play. So they think if they're telling you, I'm in pain, you're going to change your treatment somehow. So and

Dr. Carol: [00:55:09] Even weekend warriors,

Kim Pittis: [00:55:11] Absolutely. It doesn't have to be a professional athlete, but people,

Dr. Carol: [00:55:14] I'm a skier, he says TENS of four to six. Yes, and you have to call him on it. Yeah, you just say, aha. Six.

Kim Pittis: [00:55:25] Yes. And again, that's why going back to your detective assessment skills is so important because if you're just using pain as your guide, you have to do your sensory reflex range of motion. All the tools that you have that anybody can perform like anybody can do a pinwheel exam or a reflex exam. So those are important. Ok, so

Dr. Carol: [00:55:50] 10 out of 10 pain in a male. My money is on a kidney stone, especially if it's right-sided, right? And the MRI will pick that up.

Kim Pittis: [00:56:00] And then what would you do then we can treat for kidney stones

Dr. Carol: [00:56:03] Money in 60 and actually you could do that on the first visit. It's like if 40 and 396 doesn't touch it in 20 minutes, the next single frequency combination on your CustomCare is 20 and 60 and 20 and 20 3 and you run that. If that changes the pain he's got because that's the only thing that will give a male 10 out of 10 pain is a kidney.

Kim Pittis: [00:56:26] So she could totally run that before, say, the MRI takes a month. That would be a cool thing to try to just set them up with. Is it kidney stone on the road bank? For her to use

Dr. Carol: [00:56:38] NO,

Kim Pittis: [00:56:40] So she can just run that, so hopefully, that answered that question. Yes, our last like speed friendship question thing before we get into some other things really quick because I know we're almost running out of time. Is what is your strongest characteristic trait? Wow. No sandwich was just the warm-up one, and then I got to some good, but

Dr. Carol: [00:57:06] The strongest positive trait, I would guess, is synthesis and intuition. So I've ever since college, I'm bright enough, but I hang out with people that are smarter than me. Jim Oshman, Jeff Bland, Leon Chato, John Sharkey. They you, they know things. They have skill sets that are outside what I have and I, it's like a buffet to take a little from here and a little from there. And you have a major I have a matrix in my head where I can stick things. And then what comes out of my mouth is a synthesis of all of. Those things and things I come with. And synthesis and. Listening to yourself. Right. What? Being open to your own synthesis, right? But also being open to. Your heart's calling. That's what the resonance effect is about being open to that. I just got phone numbers today for the new clinic. And as I'm and I bought, we bought fire extinguisher, put in the wall and I'm sitting here looking. They're going to install the doors on December 6th and we open January 10th and I leave for Phenix on February 12th. And there's a part of my brain that's saying. I am absolutely out of my mind. This is stupid and my heart says, Yeah, I know, but I win. You need to do this. Why? I don't know. You just do. It'll be fine. Ok. So. I don't know where it is for that. Now, you ha

Kim Pittis: [00:59:23] Ha, so it's funny, I had the cutest shirt on and scarf today and I spilled coffee on it walking into this room, so I had to change really quick and my daughter's like, Are you wearing that shirt on your podcast today? It says love is my superpower.

Dr. Carol: [00:59:39] Oh, I like that. That, yeah,

Kim Pittis: [00:59:43] So I think that might be my strongest characteristic trait, it's almost my demise, though, because I, you know, like some people are just total empaths. I'm not sure that I'm quite there, but I genuinely love helping people. So I don't

care if I'm the one that fixes you, but if I can refer you to somebody that fixes you. I love fixing people.

Dr. Carol: [01:00:11] And that's what I love about you. That's why we get on so well. Yeah, yeah. Love is an awesome superpower.

Kim Pittis: [01:00:19] Yeah. I had a patient that gave me this actually after I helped her through something, and I thought that was just so special because, yeah, and I think I think that's why I want where I want to see FSM practitioners go with it is the love of learning and the love of being that detective for your patient and asking the questions. And it's just so exciting being part of teaching the core now because it's just you can see it when people are learning it, like you could see the gears and the synapses firing because they're thinking, I have to call this patient and I have to call that patient. I wonder if that would work as opposed to. A list of recipes to just follow or plugin or to not even know what's running, and I had a practitioner say, I don't want to know the frequencies, just tell me if they sprain their ankle, what, what to put on on them. So I actually said, I don't think this is right for you.

Dr. Carol: [01:01:22] Oh, go, go buy a machine with just a recipe list. You'll find it would be on the internet. Yeah, I. And there are. You have to start someplace. Yes. Starting with the mode bank is a good thing.

Kim Pittis: [01:01:37] Totally. That's how I learned was with the CustomCare and a preprogrammed one. And yes, it's a beautiful place to start.

Dr. Carol: [01:01:45] And I learned, I hope. To make the core comprehensive without being over terrifying. Oh, it's automatically unavoidably overwhelming, because by the end of the second day, you realize that everything you thought was true is not the way it works. Yeah, that everybody lied to you. Of they didn't mean to. But yeah. And that there's a different way of doing things. Yeah. And Jay Shaw, I had a lovely conversation with him. He's coming to the advance. He's the pre-conference day on Thursday, and he's the scientist. And I was explaining to him about increasing descending inhibition and tone. And he and GABA, the only thing that makes any sense that we're increasing is GABA. And he said, Is there a way you can measure that? I said, no, Terry Phillips is retired and how to. And so he's the scientist and I'm the clinician and we're going to do.

And he has to be on a plane at 3:30, so we have to finish it too. So he can get to the airport, then we're going to have lunch, and then we've got two hours to hang out from three 30 to 5 and just visit so we can do Practicums. We can do things. But the concept of being able to increase descending inhibition and reduce tone in a patient with myofascial trigger points is completely foreign to anybody but us, right? And we do it all the time. Yeah, it's so cool, so cool. That's our secret weapon.

Kim Pittis: [01:03:44] That is our secret weapon and our superpower, and that is our podcast for today.

Dr. Carol: [01:03:50] Yeah. And Medulla says she's going to buy a second CustomCare the PDI is having their end-of-year sale, starting on Cyber Monday up until December 31st. Kevin is nodding yes. So that's there's that. And it has to be over.

Kim Pittis: [01:04:12] It has to be over. So I'm going to direct everybody back to frequency specifically. For more information on all the stuff that we talked about, our show notes. The podcast will be on wherever you get your podcast, we have it on Apple Podcasts. I think it's on Spotify. Just head over to Frequency Specific Microcurrent. You will see it all there. Don't forget to register for the advanced because prices go up December 31st. There will be a little SportsCare for sale also rate on Cyber Monday. So look for that

Dr. Carol: [01:04:47] San Francisco in December 4th and 5th and Cleveland. I get to give Dave Burke a hug will be in Cleveland in January,

Kim Pittis: [01:04:59] When in January that's all going to be on the

Dr. Carol: [01:05:03] Twenty-second twenty-third. Kevin's nodding. So I got it right. Ok.

Kim Pittis: [01:05:08] Yeah. Keep the questions coming. You can again send them on the website. I think Kevin put a special landing page to put the or a form or whatever for the questions over there. You can also send me the message on Instagram. Fsm Sports 3 six. 5 is where you'll find the handle and we'll see everybody and speak to everybody next week, Wednesday, next week. Bye bye.

Speaker3: [01:05:34] The Frequency Specific Microcurrent podcast has been produced by Frequency Specific Seminars for entertainment, educational, and information purposes only. The information and opinion provided in the podcast are not medical advice. Do not create any type of doctor-patient relationship and, unless expressly stated, do not reflect the opinions of its affiliates, subsidiaries, or sponsors or the hosts or any of the podcast guests or affiliated professional organizations. No person should act or refrain from acting on the basis of the content provided in any podcast without first seeking appropriate medical advice and counseling. No information provided in any podcast to be used as a substitute for personalized medical advice and counseling efforts. Fss expressly disclaims any and all liability relating to any actions taken or not taken based on or any contents of this podcast.