Episode Fourteen - Back In Sync

Dr. Carol: [00:00:03] There you are. I got the memo. Ok, let's unmute you.

Kim Pittis: [00:00:11] There. There. I knew we'd be back in sync, it just, you know, we had to get over that full moon,

Dr. Carol: [00:00:17] Whatever that was blue and red, not. Come on. Look what I did to my tooth.

Kim Pittis: [00:00:25] What did you do?

Dr. Carol: [00:00:27] I bit into a piece of turkey wing. It wasn't even bone. It was just crispy skin. Took out the filling was probably lost. So I'm going to try and see Mary Ellen on Friday. Oh, I hope she says. Maybe we can fix it in two hours, and that will save me a separate trip down to San Rafael Santa Rosa because there's no way I'm letting anybody except her touch my mouth. I love her. Yeah. What's not to love? I don't know. No place to put the dental course this February. So I'm hoping now that she's finished with her master's and her girls are finished with medical school and halfway through dental school that we're going to be able to do the dental module next year.

Kim Pittis: [00:01:15] That's amazing. So for people who are just joining Dr. Mary Ellen Chalmers, I believe, patented the use of FSM with dentistry. Yep, amazing. Yeah.

Dr. Carol: [00:01:29] And it's and the thing with; Kevin is going to find my phone so it doesn't ring. The thing with the medical applications of FSM is that there is a law that says you can't patent a medical procedure, can't be patented. So and I taught it for a year before I ever talked to a patent lawyer and you didn't get my phone. He got his notepad. Well, so if the phone rings, I'll just silence it up here in the corner. Yes. So if you develop a new way of doing an appendix surgery, you can't patent teaching how to do the appendix surgery. But if your appendix surgery happens to require a new gadget, you can patent the gadget. Gotcha. So dentistry, there's a dental exception. So if you develop a new way of, if you develop a new way of. Doing a tooth thing. That you can. Sorry, I'm closing that are no go away. Thank you.

Kim Pittis: [00:02:55] Yeah, I can. You can tell folks that we do this live.

Dr. Carol: [00:02:58] Yeah, we totally. And I've been I spent the day, so the clinic opens in January. Yes. Well, I've been interviewing electronic medical records, software people. Yeah. Yesterday, today, and it turns out, yeah. So yeah, where was a dental exception? Yes. Mary Ellen was able to patent the use of Frequency Specific Microcurrent and the concept of using specific frequencies in dentistry. Amazing. Not only in the U.S., but in Europe. So it's a thing. That's Mary Ellen. And she is the one that found my dental infection that was causing my joint inflammation, immune system activation. And as it turns out, the damn infection is what caused the stent and the open-heart surgery. Wow. Yeah. So did you?

Kim Pittis: [00:04:03] Sorry, did you ever have pain running 40 on yourself?

Dr. Carol: [00:04:10] Oh, no. No, never, and I never ran it on my jaw. Yeah, so that was maybe a thing. Yeah. I've never had pain running 40 on myself, but the bone infection was like complete the back half of my jaw on both upper and lower. Up to the canine teeth was basically necrotic gone. But the cortical bone was so strong, so thick that my dental x rays were normal. Wow. And that's and Mary Ellen said she kept looking because. I had a stent in 2004, and she got on her inquisitive hat and she said, you don't have any risk factors like none, zero. I was running three miles, two miles, three miles, three times a week. I was good diet, no genetics, she said. There's no reason you should have a 99 percent blockage of the lad. You've got a jaw infection. I have no pain. I have seven-eight root canals, but I have no pain. So she did a regular CT that didn't show anything. Dental x rays were completely normal, not the tiniest bit of indication of anything. And then she found a friend of hers that had one of the first 3-D cone-beam called an ICCAT. We did the ICCAT and the whole back half of my jaw upper and lower was gone. Infected, so I've had 9 jaw surgeries, and that sounds really terrible because jaw surgery is really scary, bruising, and scary and you like, swell up like a chipmunk. And the reason they're not scary is FSM post-operatively. So I wrote along with Mary Ellen, I wrote up a, she has a surgical systemic protocol that you run during the dental surgery for adrenals and immune system.

Dr. Carol: [00:06:21] And I don't even know what's in it. It just runs. And then immediately afterwards, like while I'm still in the chair, still under anesthesia, because

these are not procedures you want to be awake for. So they put the sticky pads here and here, and we ran current. And then George took me out to the car and we went to the hotel and I packed in ice. I never took pain medication, I took one half of an oxycodone because I was still wide awake at 11 o'clock at night and it's like, would you shut up and go to sleep? So half hour. That's it. No pain, no swelling. No bruising. So when I say 9 jaw surgeries, five or six of them, five of them were for the necrosis. And four of them were to place the implants a year later. So I went a year with no molars. But 9 jaw surgery sounds scary unless you have FSM, at which point it's just, yeah, I get to fly to Santa Rosa, have dinner with Mary Ellen, have surgery the next day, stay overnight and the nice hotel run Microcurrent. Get on a plane the next day. Piece of cake. No swelling, no bruising. Lecturing three days later. So I have cottage cheese for breakfast instead of toast. It's like whatever. So that's Mary Ellen. And when I introduce her when she lectures, I said, This is the lady that saved my life. And Mary Ellen says, Carol, you saved your own life by making that choice. So when people wonder why I'm working until I'm 80, I have my retirement account in my mouth.

Kim Pittis: [00:08:14] But what a great mouth it is, and you're able to do what you do because of that. So we are grateful that everybody made the choices that they did.

Dr. Carol: [00:08:22] That's good. I like that. We're grateful for our choices. Yes, because even the bad choices teach you something if you're paying attention.

Kim Pittis: [00:08:32] Yeah, it was like our whole conversation last week about gratitude and how things could have been drastically different for me had I gotten to vet school and so glad no one would take me.

Dr. Carol: [00:08:43] Exactly. And it's different for me if I had gotten accepted to medical school and something as simple as. Getting a red light instead of a green light. Yes. Used to piss me off, I used to get so irritated and it's like, Wait a minute, wait, wait, wait, there's somebody that needed the green light more than you needed it, so be grateful. There is an accident two blocks down the street that you would have been involved in that you didn't get in. Yes. Be grateful. And so red lights became a moment of gratitude and an opportunity to sit at the intersection and not be irritated. Yes. Opportunity for growth. So there.

Kim Pittis: [00:09:34] Yes, and that's like all the patients that make you want to slam your head into the wall after you leave going, how on earth am I going to tackle this? And then you have to stop and think, OK, they are here to teach me something. I'm going to learn something, I'm going to learn what to do, or I'm going to learn what not to do. I'm going to learn to phone a friend and check my ego and just throw everything we can at these people.

Dr. Carol: [00:09:58] So there was a patient. Last week and the week before, and she had a urine neurotransmitter test that was completely wrong. So she said, I am high serotonin and you look at this person and you say this is not a serotonin personality. It's like, No, and I'm high GABA. It's like, No, you totally or not. So I had her take. So first thing is, she was so high-strung and so agitated about her condition. She'd seen functional medicine practitioners, so she had four thousand five thousand worth of testing and somebody and she did have mold, but somebody put her on itraconazole at double the dose she should have been on started or way too high, which made her way to crazy, which made me like so I ran concussion and Vagus. I ran mold on the brain. I ran her SIBO. And I had a come to Jesus conversation about you participate in creating your reality. I what? Here? Read this list of words. And then the next week, she's still high strung. But at that point, she's filled out the Braverman. So we have Roger Billica as a resource for which I'm truly grateful she filled out the Braverman shows GABA dominant. Latissimus hates conflict. And Gabba deficient, because she; her brain is so inflamed, she can't do GABA, she's all epinephrine and norepinephrine. Right, right. And the infections, the SIBO, and the mold made her high glutamate, which eats up GABA. And it's like, oh, you're not crazy, you're garbage, efficient.

Dr. Carol: [00:11:58] Got it right, and she had calmed down enough because we ran the Vagus two weeks in a row. And I gave her the sale price on a CustomCare, she's now treating herself at home. But the resources we have. Take these impossible knock your head against the wall patients. So I think when you have those patients that make your brain hurt. The key is. Don't go down the rabbit hole with them. She wanted me to join her and her pity party, and that was the come to Jesus conversations like, No, if I join you in your pity party, then nobody wins. So I have empathy. Yes, portions of your life have sucked and I've been where you are. Excuse me. Yeah, I was on the old protocol that you're on. Only I was on it for two years and I was in primary pancreatic failure and I had SIBO and gastroparesis. So what's your problem? They're all fixable.

Nothing you have scares me and you want what? I scare everybody. It's like, What's scary about what you have? It's so obvious. When you have a good doctor that you're working with. He has you on the right stuff, but the wrong dose. So we can fix that. And so it's there to teach something, but you also have tools that help you. Not. Get sucked into the medical diagnosis that they walk in, that they're so hysterical about, right? Ok, so you have mold? Yeah. And that's a drama, because,

Kim Pittis: [00:13:43] Yeah, I think some people do fall in love with their conditions and they fall in love with the appointments and the attention, and it sounds so; it sounds so out there to some people. Why would you love being hurt? Why would you love being in pain? It becomes an identity. You know, we see that a lot with certain demographics, with people, right? They love. They just love the attention they love. If they are recently retired sometimes or empty nesters, I'll see a whole group of these people where there's some. There's nothing to do. There's no kids to take care of, and they have a condition and they have an appointment. And if you do it totally and you can still have something to do, but let's make it healthy, let's make it positive. Yes, your

Dr. Carol: [00:14:27] Homework this week is to watch a movie what your homework this week is to go to a bookstore and spend 20 minutes in the bookstore. But I don't. You have 20 minutes. It's a 10-minute drive to the closest bookstore. We'll look it up. It's 10 minutes back. It's 20 minutes. That's a total of 40 minutes. You have 40 minutes

Kim Pittis: [00:14:51] And it's like,

Dr. Carol: [00:14:52] Oh, OK, so this patient, the way to build serotonin is to go for a walk, right? Ok, so your homework is to walk five minutes a day. I don't. Oh, five minutes. I do that around the house. It's like, OK, yeah,

Kim Pittis: [00:15:09] It's so funny. Now I'm thinking that could have been what here it was. I thought it was me, but I had to. One frozen, shoulder-ish patient that was referred to me wasn't really frozen shoulder. It was just adherence in the Subscap Ulnar nerve. Nothing big, but we got him 90 percent better. Is that last 10 percent that typically lingers. It's like losing that last five pounds. You're just like, OK, how? What am I going to do is going through his workout? He's a huge like Peloton guy, right? So wrong, like screaming and music and hammering on the bike. And I'm like, Let's go off the peloton.

Just humor me and go for a walk. No phone, no music outside. He's like, I'm like, We live in California. You need to be outside. Just breathe. Just breathe. We're not in Canada right now, so just and it's amazing how the next week he came in. The shoulders are back, the shoulders are open. And yeah, he's not like this hammering forward on the bike, but just he's sitting upright. He's breathing. His whole face changed. I'm like, What have you been doing? I'm walking. I'm like, Yeah, I love walking.

Dr. Carol: [00:16:23] Great. Yay, Kim.

Kim Pittis: [00:16:26] You know, and

Dr. Carol: [00:16:27] So it's a neurotransmitter and cortisol thing. This is the other thing. I went to the gym the other day and I do a very specific weight routine, and I'm in and out of the gym in 40 minutes. Perfect because I'm old. Charles Poliquin was like the master of physiology. Yep. Charles guys. Well, Charles found out that cortisol goes up at more or less exactly 60 minutes of hard workout, which all the guys do, right? So it's 60 Minutes. Your cortisol goes up. His guys were under these strictest orders. You get into the gym from the minute you touch a weight, you are out of the gym and fifty-five minutes and you walk to your locker, you walk to the car and that keeps cortisol from going up, and cortisol inhibits growth hormone. So what your guy built was growth hormone. He reduced epinephrine and norepinephrine. He reduced cortisol. And he and reciprocal motion. So cross-country skiing or walking increases serotonin? Right? It's like. Right? Yeah.

Kim Pittis: [00:17:53] Well done. Well, you know, it's funny, I was right after that patient came in, I had to run to the grocery store really quick and then back to the clinic and there's a guy walking towards me. He had the best T-shirt and we need to get one for some. And it had, you know, some atoms and some chemical diagram on the front and it said science like magic, but real.

Dr. Carol: [00:18:20] Oh my god, that's awesome.

Kim Pittis: [00:18:22] And I thought that was just it because so many people say, like, you're just like a wizard, you're like a magician. It's like, No, it's just science. But I'll take magic. I'll take magician

Dr. Carol: [00:18:33] 3 my tagline. It's always been reproducible magic. There you go.

Kim Pittis: [00:18:37] Yeah, that's right.

Dr. Carol: [00:18:38] And you don't have to have a wand to make it work.

Kim Pittis: [00:18:43] You don't. So keeping the train on the tracks here, we're December 1st today. We're rolling into our Christmas season. I try to have a different mug every time we come on today. I thought I would bring out my reindeer mug

Dr. Carol: [00:18:58] And I've got it.

Kim Pittis: [00:19:00] You have a beautiful home. Yes. So with Christmas, we're going to kind of go with the theme or lead it up into actual Christmas time. But what I wanted to start with, and maybe it's not as cheerful as Christmas, but holidays and so kind of rolling from Thanksgiving into the Christmas season is very festive. It's very busy, but it is also an incredibly lonely, depressing, anxious time of year. So practitioners out there, you need to be aware that sometimes your pain patients will amplify during this time, and it's nothing that you're doing wrong. It's just this time of year. So I wanted to kind of talk about this for a little bit.

Dr. Carol: [00:19:46] Well, and it's not so much that their complaints aren't real. Yeah. People who had difficult childhoods that were abused, molested, had surgeries, injuries, auto accidents, death in the family. Any sort of trauma prior to the age of seven is centrally sensitized. So. Something stressful happens that would not bother them in August, but because every Christmas dad used to get drunk and beat up mom when the kid was three or four or five. And thought it was his fault. Right? The mid, the hippocampus, the amygdala. They never forget. So central sensitization, a stressful event that would not bother you in July or August. That stressful event happens December 15th. Your hippocampus goes, Oh my God, we're going to die. And the low back pain that used to be would normally be a four or five is now a six or seven. Is it

really a six or seven? Well, on the patient's mind it is. And the pain is it's real. There's pain generator for facets joints. It's the same facets that he jacks up. Every time he works in the yard and decides to pull weeds in November, whatever. Right. But this time it's sensitized. And you don't know, you've never asked, we don't ask. Did your dad used to beat up your mom, get drunk, and beat up your mom every December when you were age three to age seven? Why would you ask that and wouldn't remember it anyway? Pet, the puppy. I heard him so on in our world, you treat the facets and then you say, I'm going to put this wrap around your neck and put another one down on your abdomen.

Dr. Carol: [00:21:59] It just tends to quiet the nervous system. You don't have to explain about central sensitization, but you have to turn on the Vagus, right? You're going to be reducing inflammation in the lumbar facets that you can do on an AutoCare or CustomCare. The concussion and Vagus runs forty-four minutes, if you've got a 30-minute treatment slot, you take concussion out or shorten it, take out the pituitary. You don't need that. Just don't tell Harry that I said that you quiet the Medulla quiet the thalamus, turn on the Vagus, and the Vagus will turn down the inflammation quieting eighty-nine. The midbrain will quiet the central sensitization. And if you have a suspicion about this particular patient because it's December because they come in. The pain level is really probably a four or five based on the physical exam, but they mind it a seven. Right? That's sensitization. So you take your CustomCare and while the patient's changing into a gown, you change 40 and 89, quiet the midbrain from four minutes to eight minutes. Quiet the Medulla from four minutes to eight minutes and then increase secretions in the Vagus from four minutes to eight minutes. That takes it to 30-minute program. So you're just running vagal tone. And the lumbar pain. And then you do your manual work so that you in... Do you know, don't you just love neurology? You know that just the process of touching somebody, for now, hugs have to last for two minutes. But touching somebody for 15 to 20 minutes raises oxytocin. And who doesn't love oxytocin?

Kim Pittis: [00:23:58] I know it. That's when I went to manual therapy college. We had. Well, this is back in the nineties, but that's when all this data was coming out of the Touch Research Institute. Just on that. And you know, it made that's what drove me to this path because when I went to physical therapy and they just put me in a room with

an ice pack and it TENS device and they left my glove didn't feel good. But when I went to a really good massage therapist and I'm like, Yes, yeah, what is this oxytocin?

Dr. Carol: [00:24:30] Yeah. So it's like we have the ability to deal with the unconscious stressors without even running emotional relax and balance. You treat the nervous system. Emotions come from a place. So the unconscious stressors that bring your lonely pain patients in in the winter and you have the ability to give them homework. Yes, your homework is to go to a bookstore so they don't want to go to movies because there's too many people in, you know, there's COVID. You go to a bookstore, there's people there and there's books and there's companionship. Or, you know. Yeah.

Kim Pittis: [00:25:18] Very good. So this is again organically just taking us down the rabbit hole and all the right ways. So I'm going to steer, I'm going to steer the ship over to a question and answer because we're just talking about low back pain. So I want to just jump on the second question here from Nancy says, would you please comment on using, these are B channels, 630 versus 710 and 330? I used to think 630 on B Two-channel is a lazy way to address the disc, rather than to go individually to the annulus or nucleus. However, we found some patients respond better to 630, then 710, even if an MRI shows an annulus tear. Also 45 on the B channel nervous system versus individual nervous system components like 396, 475 Thanks, Nancy Chow. You like read my mind today because if you'd see my yellow notepad, I wanted to talk about 46 and 475 and stuff like that. So let's just kill a bunch of birds with a stone, and I'll let you jump on that first.

Dr. Carol: [00:26:22] Well, I'm with Nancy, except that 710 is my go-to the annulus. You wouldn't have discogenic pain unless the analysts had a microchip in it. Yeah, and the annulus is what creates midclavicular pain. So the patient that has arthritis in their thumb and does this and then you ask them, Do you have pain in between your shoulder blades? Well, yeah. How'd you know? That's Cloward. That's 710. So I. 710's my go to. 330 I don't go to because the nucleus is pure Phospholipase A2. It is the most inflammatory biologic substance on the planet, possibly at least on a person. So 630, I had some good responses, but 710 is my go to. So maybe I'll go to 630. I'll give it a try. 45, I'm not a believer. I treat the specific parts I. I'm not going to get in trouble will I? It's like I to be a nonbeliever, but 475 is a frequency that was scanned for it is the [nerve sheath] nerve sheath. I've never had it do anything and I keep trying when it seems

appropriate. I haven't, so if Nancy, you've had good luck with it. It's like nervous system as a whole. The reason I don't use that a lot is that whole chain intellectually doesn't make sense to me. How is it that 46 is muscular system as a tissue type? 45 is the nerve the whole nervous system? Really? 47 is the digestive system. 50 is respiratory system. Something else is the urinary system, and they're all right in a row. Yeah. I don't believe it. I just and so I've never been able to get my head around.

Dr. Carol: [00:28:43] I'll run it like you'll find it in the AutoCare some places because I needed something that would treat the whole system. But I am all about if you need to treat cognitive function, you treat the Cortex 90. If you need to treat emotions long-term, short-term memory to treat the midbrain. I don't mind using the experimental frequencies like the temporal lobe at a patient. This week, with a bad fall and a subdural bleed in the cortex, right at the temporal lobe that involved a lower portion of the right sensory-motor cortex because he had left-sided weakness that lasted about a week. And so you treated the cortex, treated the temporal lobe, treated the sensory motor cortex. And now he's walking around without his walker. So hey. So there you go. And Susan, it's no. The Magnetic Converter converts the frequent electrical pulses to magnetic pulses. How they do it. That is an engineering thing that Bartlett and his band of merry men can tell you. There are a bunch of retired engineers that wanted to create a frequency specific, pulsed enough device and how they do it. I have no idea. When they sent me the prototype, I used it for an acute facet. I'd done something, I think, at the gym and. It's clearly Lumborum four sets, I put a cute four sets on the Magnetic Converter, put one in the back one on the front, punched a button, read the newspaper and in 20 minutes, my back pain was gone. It's like, OK, it works. So then the next week we started marketing them. So. Now we took care of two questions,

Kim Pittis: [00:30:49] Yeah, but I wanted to jump back to the desk question for a second and some of the the forty six for seventy five. I've also tried for seventy five so many times because I love the idea of being able to treat the nerve sheath. It's like the Patriot system, right? If you think about a Saran wrap around a nerve and you think how adhesions are formed within a muscle and the fascia and the nerve, this sounds like something that would be so useful for us to use. Yeah, I've been completely disappointed using it all the time.

Dr. Carol: [00:31:22] I thought it was me.

Kim Pittis: [00:31:24] No, this is kind of like our fifty eight question, right? I thought it was me too. So I've tried and tried and tried. I've tried using it with variables on a two-channel also, because they're really, really, really want for seventy five to work. I'm just not there yet, and I think if I do get something to work, it's because something is running on the second or the third CustomCare that's caused it to work because

Dr. Carol: [00:31:47] Like this,

Kim Pittis: [00:31:49] This didn't really happen. Forty six, on the other hand, I am seeing big results with, but I don't believe it's sarcomere. I think I called you about this months ago. I believe forty six is actually sarcomere. Because listen,

Dr. Carol: [00:32:08] Listen. Hey, wait, you have to tell me what the Sarcomere is versus the Sarcomere? I'm a chiropractor, so sarcomere.

Kim Pittis: [00:32:17] This is our sliding filament mechanism of the mile fibro and a muscle, right? So when a muscle shortens, the action in myosin causes the micro filaments to shorten. That's when we get a contraction. We should think that this would be very helpful with athletes and for all of our muscle injuries, but it never works. It never works with 13. It never works with ninety one. It never works to fifty one. Anything on any of the scarring and the eighty one eighty one. It doesn't work. I don't love it. But listen. So when I get an athlete who is acutely full after competition, so hockey players, especially their legs, are double the size after a hockey game because there's just so much lactate and byproduct stored in these muscles. I ran forty with forty six, and you could see within minutes the recovery that was happening in these large muscle groups get out. I am telling you it happens all the time, this is going to be a new case report. Ok, so it wouldn't make sense that 40 and 40 six would do anything like that if it was a sarcomere or the mile fibril, because that itself doesn't do anything but sarcomere. Lima is like the fluid that surrounds the mile fibril. So this is when you get a pump after you. This is what we call acute hypertrophy. So when you're when you're doing a bicep curl and then you get this pump after, it's not that the tearing and the rebuilding happened. You get a pump full of juices for lack of a better term finish.

Dr. Carol: [00:33:54] But then don't let me forget.

Kim Pittis: [00:33:56] Ok, so when you get all full after you work out, like I said, it's not because you've built muscle within 20 seconds, it's just that rep. You've got the extra fluid in the Sarcomere Lima. So we have chronic long term hypertrophy and we have acute hypertrophy. So I have been using 40 and forty six for my athletes right after I've been splicing that into the post-workout recovery program. And they're like, What did you do to the CustomCare this year? It's amazing. Yeah. Forty and forty six.

Dr. Carol: [00:34:29] Ok. So the first place I ever used forty six successfully was in Milos CHF. So Milos tore his quadriceps tendon away from the patella, doing that's a good face, doing a squat with four hundred and fifty pounds on his shoulders. Well, he's Mr. Universe, it's what they do, right?

Kim Pittis: [00:35:00] Yeah, I know, but I know.

Dr. Carol: [00:35:02] So they did the surgery, believe it or not, laparoscopically because people that body build at that level can't have skin scars. So they reconnected the tendon. And after a year with Charles. Milos looked like me, except the last five inches of his vast AST Lateralizes was completely flat. Completely flat. So went from the low back to the knee, treated the scar tissue in all the tissues from the from the surgery, and then I ran 40 and three point ninety six, which. Had always. Plumped up. Muscles that were Naturopathic chyli atrophy, right, so tnr na 40 and three point ninety six pops right up. All right. So I ran that. Milo's contracted it twice. It went flat. Around 40 and 396, it popped back up. Contract price. It went flat. So Iran increased secretions in the nerve. 40 and 3 ninety six then increased secretions in the nerve, and then I ran increased secretions in forty six. And it doesn't make any sense that increasing Sarcomere Sarcomere TAOS don't have a secretion, except for ATP PH does. But the Sarcomere does, and so the muscle popped up and stayed up, and then I get goosebumps remembering the event. Here is Charles, who's Charles? And there's Milos and Charles says to Milos. Ok, I want you to contract it from the bottom up. You're saying this last week?

Kim Pittis: [00:37:01] It's amazing.

Dr. Carol: [00:37:03] And Milos thinks a minute and then contracts it from the bottom up, and it didn't go far. And the re strengthening it eccentrically and concentric chyli, but by contracting it without moving his knee. From the bottom up and the top down, and the Sarcomere makes so much sense out of that muscle out of that model. Yeah. In that experience, because you're treating people that have Naturopathic atrophy, the sarcomere TAOS are still there. What's missing? And we've always wondered what makes the muscle? How do you treat neuropathic atrophy of the thinner and thinner eminence and even T1 Microcurrent in ENT? Increase, reduce inflammation, ulnar nerve increased secretions in the nerve and then increase secretions in the sarcomere lemme. You did it.

Kim Pittis: [00:37:59] Yeah, well, actually, you did it, but now. And that's why the advanced and these case studies and everything is so fascinating, because when we hear about when what people are trying and in different models, you go back to your own patients and your own history and you're like, Oh, maybe that's why that worked, because I didn't treat this. I treated that. And that just that just makes sense.

Dr. Carol: [00:38:25] It didn't work because I didn't treat that I treated this right.

Kim Pittis: [00:38:29] And that's another question that we get a lot like when we're increasing secretions, what are what are the secretions like, what is secreting? And I don't

Dr. Carol: [00:38:38] Know. Ok. Ast Pittis. So and that's when GGT asked you a question. You really want to have an answer, right? That makes some sort of sense, right? So he's asking. So I talked to him about. Because he's he's the master of ascending pain amplification, central amplification, descending motor acetylcholine, those pathways. Right? And I said, let me talk to you about descending inhibition. You have a patient with increased tone from a central disk bulge that interferes with descending movement, and they understood the concept. Of loss of descending inhibition. Tone, what what's tone and it's like, well, it's just increased tone, either unilaterally or bilaterally. And if we increase secretions in the spinal cord, that tone returns to normal. And he said, well, what secretions are you increasing? I said has to be Gabba Gabba is the neurotransmitter that's involved in descending inhibition of tone of spasticity. And he thinks of increasing secretions of dopamine as an acetylcholine, as

increasing motor transmission. But you want to inhibit motor transmission, you're going to increase secretions in the spinal cord. How does that work? I have no idea. But when you take a twenty two year old cerebral palsy to a walker or a forty two year old to a walker and relax all this plasticity in 60 minutes and get them to walk normally. You're doing something

Kim Pittis: [00:40:34] Right? So there's that there's that we have a couple more questions popping up, I want to make sure we get to those before we move on. Go. So the first one, when you mentioned the mid scapula pain and thumb osteoarthritis, which other frequency are you using with seven 10?

Dr. Carol: [00:40:52] Oh OK, so miss the diagram from Cloward. That is, you can Google it actually disc referral, cervical disc referral. The Cloward diagram will come up and it's the discs disc annulus specifically. So he injected saline into the disc, made the annulus stretch that created predictable, referred pain at each spinal hole down the mid in the mid scapula line. So mid scapula pain means that the disc annulus is bulging or has partial Teres. So some some pain that is not some pain is the C6 nerve root. That's, you know, you say, take somebody like me that says I have some pain and you look at a thumb, I have arthritis in my thumb. Well, no, no, no. But you know, your thumb muscle is a little bit flat and this muscle how fluffy it is and see how fat that one is. Yeah, no. So the trick is not to get suckered by the diagnosis the patient walks in with, so use your pinwheel and you do C-5, that's normal. C4 is normal. Seasick is ALT. That's icky. So you run one machine 40 and 3 ninety six from the neck to the thumb that takes care of the osteoarthritis that is nerve pain. And then six C-5-6-disc C6 Nurvorum C-5-6-disc is the most commonly degenerated, so you run from neck to chest. To treat the 5, so you run subacute disc from neck to chest, and you don't have to do anything to the mid-pack unless you're an osteopath or a chiropractor or you. And then you can mobilize the rib because this is so fun. The because it comes to synthesis, right? So because when you look at the innovation of the longissimus, cervicis and Thoracis.

Dr. Carol: [00:43:20] The nerve to Longissimus Thoracis, which starts in the cervical spine. That nerve is the C6 nerve root. So when the nerve gets irritated, this gets flat and painful, but the muscle that's attached to the rib. Gets tight. And that pulls the rib up, so you've had some chiropractor or osteopath adjusting the rib, I've actually had patients where they are EFT, the thoracic facet joint because they could. That's a good

face because they couldn't get the pain, the mid scapula pain down, right? And it's like the Cloward diagram has been around since nineteen fifty seven. Wow. Great. Oh, you treat the disc, you treat the nerve. And when you read palpate the patient, the rib will still be rotated up. You mobilize the rib, but you'll notice that the tight band that was the muscle that's gone. So it's two machines, one mobilization and explained the patient that they have a sprained ankle and their neck. They're not allowed. You're not allowed. It's not that you can't. You're not allowed to lift anything more than 10 pounds from waist height. You are not allowed to use your cell phone down here. You are allowed to put your cell phone on a pillow and use it up here because every time you flex your neck, you bulge that disc. And we start over the six weeks to repair the sprained ankle starts from the last time you did something stupid. So I mean, I can say that because I'm old and people, you know, they don't care.

Kim Pittis: [00:45:10] No, I pretend I have my own list here, but let's let's go to my list really quick and then we'll go back to Dana's question before before we close out. So this person reached out to me on Facebook and on Instagram regarding a tight muscle. I put tight in quotes someone's adductor that they've tried everything and the pain the attachment site didn't go away. So as a young athlete, so a young athlete does not have a tight adductor from space, and if they're coming in with the pain not in the muscle belly, but in the attachment site. You have to think again, this didn't come from outer space, so this is a wolf's LOX sort of idea. So the. The muscle, it's not scarred, it's not adhered. When you think of the mechanism, what happened this was a skater went on a full stride and then came back. So what happens when someone goes on a full eccentric contraction? Everything elongates and or

Dr. Carol: [00:46:32] Teres one, twenty four and seventy seven and one. Twenty four and seven, eighty three and forty and seven eighty three.

Kim Pittis: [00:46:39] Yes. So so that so I know when they palpate the adductor and the chrysalis, it feels tight. For sure it is. This is called a stretch reflex when something your your body is never going to allow things to tear off the bone unless you're Milos and it's four hundred pounds above your head. For average everyday people, these eccentric contractions are just causing micro Teres. And for the most part, RBI does a great job of repairing that, and we move on with life. Sometimes we go a little too far. So

when you have a patient that comes in with something that is tight after an activity, it's a reflex. That's all it is. So do you hear that right now in the background?

Dr. Carol: [00:47:24] Vagus going completely crazy.

Kim Pittis: [00:47:26] She's going savage because she hears my voice.

Dr. Carol: [00:47:29] So let me in.

Kim Pittis: [00:47:32] I'll let her in when I'm done talking. Okay, so so when when you when you think it's tight and you think it's 13 or ninety one, again, think of the mechanism, how did we get here? So there was an activity. So sometimes you say it's never the muscle, sometimes it is. It's the muscle, but it's torn.

Dr. Carol: [00:47:53] But it's actually not the muscle that's torn. It's the tendon. And the muscle is tight to protect the tendon, and the pain is in the initial tuber RSD because the system is torn and therefore inflamed totally. And so it can happen. The trick is that can happen for months or years.

Kim Pittis: [00:48:15] Yes, it's I was just about to say that this doesn't always happen in an acute situation, so I'm lucky I see athletes, they come and see me when something happens on the weekend or before a weekend. So my Fridays and Mondays are the busiest days of the week because of this, but you don't have to have an elite athlete at your fingertips. These are the people that have hurt themselves, and they forgot about it because they moved on with life and it really wasn't that bad. So torn and broken and again growing older.

Dr. Carol: [00:48:46] And it's just like it never goes away and it hurts when I do this. And it's like, Well, it's torn and broken. And the Teres minor.

Kim Pittis: [00:48:53] Hello, don't we? And it's easy to palpate and you want to go to 13 because you want Smush. You want. You think that it's scarred and then and it's calcified because it's old, but it's not torn and broken. One twenty four in a in an acute situation chronic situation that's going to get you your smooshy because that's what happened. It tore sometimes it Teres in the connective tissue and sometimes it Teres

and that muscular tendons junction or in the tenderness junction into the system. So that's that's it. So person on Instagram and Facebook. One twenty four go back. And like you were saying, I would throw one twenty four and seven eighty three, one, twenty four and seventy seven. That would be my go to and one twenty four and 9 one ninety one. Yeah, pericardium, tendon, connective tissue. Yeah, they're all together, but I one.

Dr. Carol: [00:49:53] Sorry for interrupting, but that is the one place where you can take 3 CustomCare's program them, park them with a blanket, a heating pad, a book or a movie. I'll be back in 60 Minutes and then I'll see you in three days. Have a nice nap, right? Yeah, because you be there for that part and manual work comes later.

Kim Pittis: [00:50:18] Totally. You have to just get all that inflammation and tearing out of the way, and then you can do what you need to and get them moving and mobilizing and strengthening after that as well. Really quick before we go on, I used to tell my patients that. So with my high level athletes and my high strung CEOs, they'd come in and they'd be on their phone and I just needed them and their attention. So I used used to tell my patients that I work. Customcare's and the PrecisionCare Teres scrambled their iPhones so they would shut their phones off. Oh, so I just sent some CustomCare's NASH. Well, I had to say they would never shut their phones off otherwise, especially these young male 20, some odd years old. They were like even these women texting and instagramming and all the things phone goes off in the clinic. So and they wouldn't just listen to me. So I said, Well, yeah, our CustomCare's interfere with your iPhone, so you should just shut it off.

Dr. Carol: [00:51:15] Oh, iPhones interfere with the CustomCare's.

Kim Pittis: [00:51:18] Right? So I wanted to clarify that live. They don't. I just was telling everybody to do that, so they would just pay attention to me and shut off for an hour. So that's that. Well, you know, sometimes you just need to chill out and decompress and do some breathing. One other question that we got from from social media was talking. This, obviously, was a practitioner asking about the mode bank, all the different brain protocols that we have. Should I always hear you talking about concussion and concussion and Vagus, but you never talk about forebrain subacute? Or do you want to talk about all the programs on the World Bank and if you use them?

Dr. Carol: [00:52:00] So every brain part has an acute, subacute and chronic. Mode bank thing in a CustomCare. They all have to be modified, right? So the cute one you hardly ever use unless you catch somebody within 24 hours of a head injury or a stroke? Right. So if you're treating soccer players or hockey players and they get a ball in the head or hit whatever part of the head and you see them the next day and they're still confused and nauseous and light sensitive, then you run acute forebrain. Right. For the average person. That just is having trouble with mild cognitive decline or even like on myself, if I have a trouble word finding that becomes just. Too annoying. I will sit there and run subacute forebrain on myself. So it's just it's just inflammation is the enemy of the nervous system. I have a version of concussion Vagus and I added the cortex because I had a patient that had she put her head through the windshield 15 years ago. So it's still subacute. I don't want to be running scar tissue because I or 284, because I don't know what's in there. I don't have an MRI. But her short term and long term memory and her ability to cognitively process we're all impacted. So I added subacute forebrain now in the new CustomCare software. Don't get too excited. We're still a couple of weeks away. You can just add things. You can pick a whole protocol and add it so you can create one program that's two or three hours long that somebody can run at night on a converter. And so that's acute. Subacute is the average everyday thing, and I we've corrected the midbrain. So the midbrain is basically central sensitization memory amygdala patients that have head injuries that.

Dr. Carol: [00:54:36] Find themselves emotionally unstable or angry, like they have emotional outbursts their cortex can't subdue. The amygdala and the angry parts of their brain. So you run subacute midbrain, so the acute cortex in the mid brain. You take out increased secretions in the mid brain. It's been removed from the food bank, as far as I know, but you increase secretions in the cortex. So this is why I spend so much time on neurology and the advanced. Because when you can manipulate the brain in real time it, you got to know what it does. Yeah. So you can recognize the behavioral components that tell you that's a mid brain thing. Right? The hind brain is balance and coordination. You deal with that a lot in the sports. So acute is acute hind brain is what you do on a Monday and a Tuesday and a Wednesday after they smashed into the boards with the back of their head or fell down on the ice because somebody just slammed them right? Football players, soccer players, that's acute hindbrain nah-uh balance and coordination. I hardly ever run it on the hind brain, on the cerebellum. But it's that that's where you run increased secretions. Chronic hindbrain is balance and

coordination in somebody with generalized dementia where they they're falling a lot. Whether or not falling because their cortex doesn't work, they're falling because their cerebellum doesn't work right. So that's it's looking at the behavior of Parkinson's we cover in the advance. That's the basal ganglia. And that frequency started out as experimental, but it's now really clear that it's spot on. Yeah. So does that help?

Kim Pittis: [00:56:45] I hope so. I think so. That person, I think that's very clear. But yeah, you have to have some sort of neurology know how and savvy to use these effectively. Someone just wrote in when you were speaking, what is subacute setting. So it's not a setting. It's a stage of healing that we modify our protocols for. So it's not in the acute, it's not in the first. Yeah, I use subacute protocols probably the most. I think we see patients the most in that subacute stage. It's not chronic as far as. I mean, it's chronic, but they're not coming to see you because they're coming to see you because it's an acute flare of a chronic condition, which gives you a subacute

Dr. Carol: [00:57:37] Most like the subacute disc. Yeah. Nobody comes to saying I have a chronic disc like you saying my back is out again. Yes, that is an acute flare up of a subacute of a chronic acute flare up of a chronic condition. Yes. And that's we call that subacute because I didn't know what else to call it.

Kim Pittis: [00:58:00] That's that's totally it, you know? And in some books, will will call an acute stage of healing the first seven days. Some people call acute the first twenty four hours. It just depends on your model and what you're talking about. Yeah.

Dr. Carol: [00:58:16] And the biggest difference between acute and subacute in our world is the frequency for hemorrhage. Right? Anything that can bleed. We run 18 in that thing. So 18 on the capillaries in the brain and racehorses, the poor things, their lungs bleed. Right. Their kidneys bleed. Because they give them Lasix and to keep the fluid out of their lungs and that messes up their kidneys. So when you're treating racehorses on Monday after they've raced on Saturday or Sunday, you treat. Hemorrhage, the lung doesn't have much in the way of arteries, it has billions of capillaries, right? The brain has arteries sixty two and it has capillaries one sixty two. So you treat bleeding in the acute phase and you emphasize or increase the time. That's wonderful thing about the CustomCare software. You increase the time based on the tissue, right? That has been acutely traumatized. Somebody gets a helmet in the back

in a football game on a Sunday. Monday, Tuesday and Wednesday you're treating hemorrhage in the kidney, but hemorrhage in the capillaries that make up the kidney, right? Right? Yes. It's just common sense.

Kim Pittis: [00:59:46] Yes. Well, it's now reasonable expectation. I had a professor in university that said we can't use common sense because it's just common sense. No, because common sense is not that common anymore. We say reasonable expectation.

Dr. Carol: [01:00:02] Ok, fair enough. Yeah.

Kim Pittis: [01:00:05] So I hope that made sense. The other thing in the chat was when our Carol and Kim coming to Taipei,

Dr. Carol: [01:00:12] As soon as they open up Taipei. And it's like Typekit. I don't know. It has to be next. Has to be twenty three because twenty two's booked. I'm in Germany, Poland, Italy, in London and I'm running a clinic. What was the thinking? I don't know. Like a good idea at the time.

Kim Pittis: [01:00:36] Remember what you said last time? The how is not important? Yep. The how doesn't concern you and you just have to show up. And then Dana's question before we get to our closing stuff, I'm working with Dr. Lori Chaikin with FSM for my eyes and our karate instructor recently had an eye flare up from start. Right? She said her condition has become has come from her toxin exposures from navy service 20 to 30 years ago. I believe Dr. L3 is still off the grid right now. I'm wondering if I should refer her to an FM practitioner specializing or if general inflammation is the main. Oh, that's so funny. I want to talk about general inflammation protocol.

Dr. Carol: [01:01:20] Ok, sarcoidosis is an autoimmune condition that causes inflammation. So Laurie uses muscle testing as a way. So that's how she decided that toxicity at least. I believe that's how she decided that toxicity from navy service is from 30 years ago is what caused the autoimmune condition. So it could be the Navy service itself. Because what turns off the vagus nerve sarcoidosis is an autoimmune condition. It is not possible to have an autoimmune condition if your vagus nerve is working right. So you look for what turned off the Vagus. So I got Giardia camping 15 years ago, and now, 10 years later, I have rheumatoid arthritis, inflammatory bowel disease, ulcerative

colitis, sarcoidosis, whatever. Ok? So treat the inflammation. But Sarcomere IgE is a 42 tubercular constitutional type once again and the advanced and you have to turn on the Vagus. You have to figure out what turned it off. If it's stress, it's easy to treat the midbrain and whatever. If it's infection, that can be more complicated. So figure out what, turn it off, turn the Vagus back on. Treat the local inflammation. And. So far. Aside from infection being able to cure or turn off. Infection that keeps turning off the Vagus mold parasites GI. Dysbiosis, pathogenic bacteria in the gut. Those those are outside my scope. Infectious disease is my worst topic, so. Um, it's not a dog, it's a Boning. It's good to say there's

Kim Pittis: [01:03:31] People coming in.

Dr. Carol: [01:03:34] Oh yeah, I, I send them to somebody, especially if you're in Northern California, one of the practitioners that's got experience in. A functional medicine and treating inflammation on autoimmune disease, because sarcoidosis is an autoimmune disease that can attack anything at once, does the lung. The first case of Sarcomere that I treated was in the heart. That was a thing kidney. Lung eye, apparently. And the patient is in Texas. I don't know, you'll have to use the practitioner search, so it's not either five o'clock already.

Kim Pittis: [01:04:28] All the alarms are telling me it is. They start going off now at four 12, so I can just keep us on track. A lot of people wanted to know how to read, how to watch it live on the Zoom. I'm not sure if you guys have that on the frequency specific website. I know the podcasts are all listed there, but maybe we could have it listed so people can have a faster way of clicking and joining our Zoom Live because it is so much fun to see and hear the puppies and the dogs and the people, and to make sure outfits match and our Christmas mugs.

Dr. Carol: [01:05:05] So it's Backslash podcast and we don't have an estimate about the new website due in January. I'm sure that they're pretty quick, I think, but I'm pretty excited. Our website, which is very cluttered and difficult to navigate right now, is about to get really, really simpler. I'm so excited. Yay.

Kim Pittis: [01:05:26] Hey, there's also going to be on the FSM Sports 3 six 5. There's going to be a new podcast section there where you can also ask questions because I

needed to streamline because people were asking questions to all different ways. So FSM Sport 3 six 5 you'll be able to have a clicky, easy section for people who are not computer savvy like myself.

Dr. Carol: [01:05:51] Cool.

Kim Pittis: [01:05:53] That's it for today. Yay. Yay, I love Wednesdays. I love four o'clock

Dr. Carol: [01:06:00] And I am going to see you on Saturday.

Kim Pittis: [01:06:04] Yes, I will be there, not for the whole day, but I will be there for a big chunk of the day

Dr. Carol: [01:06:09] Or morning afternoon, right?

Kim Pittis: [01:06:11] Yes. Yeah. I'll be there at some point. I'll let you know,

Dr. Carol: [01:06:14] But I'll know when you walk in the room,

Kim Pittis: [01:06:17] I'll be there, but I'll be there Friday to deliver the big screen for you.

Dr. Carol: [01:06:22] You've got the projector screen

Kim Pittis: [01:06:24] And you took that home with me a couple of years ago. All right, everybody. Thanks for joining us.

Dr. Carol: [01:06:31] Thanks for joining us. See you next week. Next week by

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