

FREQUENCY SPECIFIC MICROCURRENT PODCAST

EPISODE 16 – PAIN CONTROL

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Kim Pittis: [00:00:03] Hello. Hi, there. Hey.

Dr. Carol: [00:00:06] It can't actually be Wednesday already, can it?

Kim Pittis: [00:00:10] I am. It couldn't have come fast enough for me this week.

Dr. Carol: [00:00:13] Oh, OK. You too, huh?

Kim Pittis: [00:00:16] Well, we have so much to talk about.

Dr. Carol: [00:00:18] Tell me. And we are. Thanks to Alf. Dr. Garvin. We actually already have a Q&A Q&A question. Oh, with so I get to steer the boat for the first few feet. Take it off. Does please review the protocols for an acute and chronic vertebral disc injury and the protocol for cord descending inhibition? We kind of already did that. But. It's acute is when the patient bent over and picked up a brick yesterday, and now they have pain down their leg. That's an acute disc. It includes frequencies for hemorrhage and torn and broken. And a lot of stuff for inflammation. And then I can't remember ever, except maybe on David Simon's treating a chronic vertebral disc. Disks are always acute on chronic. The patient has a back that goes out for what tacos? But that's another thing. your back goes out once a year for every two or three years. And then yesterday you pick something up, you bend over, tied your shoe or you bent over and picked up the jug of whatever and your back goes out. Everything spasms and you end up with pain in your butt. Or pain in your foot? That is acute on chronic or what we call subacute. And so that's it's really easy. There should be acute and subacute and you hardly ever use chronic and then descending inhibition is a concept. That loss of descending inhibition is a concept that really only exists in the FSM world because we're

the only ones that can treat it unless you're going to put in a baclofen pump on somebody that's totally spastic. So. Loss of dissenting inhibition. You have to get the concept that there is descending inhibition of spasticity. One hundred percent of the time go.

Kim Pittis: [00:02:39] So for the laypeople listening, do you want to just kind of briefly explain what descending inhibition is? Because that sounds complicated.

Dr. Carol: [00:02:48] It does. It's actually not exactly complicated.

Kim Pittis: [00:02:53] It's no, but I think people don't know it as that term. So if you could, true story.

Dr. Carol: [00:02:59] Ok, so see, nobody has landlines anymore, right? Remember when you there used to be landlines, there was a thing called a dial tone. You'd pick up the phone and there'd be this bzzzzz that was just 24-7. Says, Hey, the line is here. There is a constant signal coming down from your brain through your spinal cord to your muscles that says, don't spasm. And we don't know about that unless we have cerebral palsy. At which point the dial tone is missing and you have spasticity, right? That's loss of descending inhibition from an upper motor neuron lesion in your brain caused by cerebral palsy. There is also in probably in MS. There is a kind of increase in tone and spasticity and Ataxic gait. That's caused when this does the signals that come down from your brain through your spinal cord to your muscles that says don't spasm, when that signal gets interrupted, you get spasticity. The milder form of that is tone. Its tone, it's you can have strong muscles with normal tone and strong muscles with. Increased tone, the muscles are harder or tighter than they should be normally, and we find it because we can change it. So we run increased secretions in the spinal cord. And we think that what we're doing is increasing GABA, because Jay Shah asked me, What do you mean? What are you increasing when you increase secretions in the spinal cord and it's like, well, that's a really good question.

Dr. Carol: [00:05:15] Nobody knows because nobody's measured it. But since the descending inhibitory transmitter that the neurotransmitter that comes down the spinal cord and makes your muscles relax. That's GABA. The neurotransmitter that comes down the spinal cord and makes your muscles contract is acetylcholine and dopamine.

All right. Go and do and move the muscle. Relax is GABA. So what we're increasing when we run increased secretions in the spinal cord and relax tone has to be GABA. And of course, somebody someplace is going to want proof of that. Good luck. But so the place where you suspect it is the patient whose legs especially have really tight abductors and hamstrings my hamstrings are always tight. My QLs are always tight, and oh yeah, I have this disc bulge herniation in my neck and I had neck surgery five years ago and then my hamstrings are always tight. Ok, so the disk bulge was really central, and it pushed on the motor pathways and. When you push on the motor pathways with the disc, you make the myelin a little bit thin and that interferes with conductivity of gamma. And that makes your hamstrings tight and your abductors and your pectineus and your brevis and you kind of have to come to a practicum and feel it before, it makes sense. I'm really sorry.

Kim Pittis: [00:07:07] That's one heck of an intro. Like, we just packed a punch with all the Q&A like so fast.

Dr. Carol: [00:07:12] Yeah, they're catching on. We're doomed. You know that? Yeah.

Kim Pittis: [00:07:19] Oh man, there's so much that I want to kind of roll with with what you're just talking about because you kind of hit so many things just there. You talked about like acute and subacute and chronic stages of healing, and then you talked about descending inhibition. Let's just hit this Q&A really fast. That's on our live feed. And then I'm going to go back and bring the bus around, spin around the parking lot and pick up some more kids. So, Linda writes, in order to avoid 81/89, I'm OK. I recently used 98 on A and 255 on B and then 81 on a and 255 on B working with the Parkinson's patient. This seemed to work quite well to improve posture and gait, reduce tremors and avoid like movements.

Dr. Carol: [00:08:13] Linda, for Parkinson's, we have a frequency for the basal ganglia that makes Parkinson's like a slam dunk. It's like it's just mild to moderate Parkinson's, like it's is easy. Every time I say something like that is going to be easy, I expect to be struck by lightning or something. But yeah, it's just increased secretions in the basal ganglia, which I think is 988. Because the basal ganglia from the advanced. If you haven't taken the advanced, wait until you take the advanced, because then we explain the whole thing. What we did find out the hard way. Is. That we ran increased secretions

in the basal ganglia on a gentleman that was on a ton of medication. Early onset Parkinson's. Mid-40s. We ran increased secretions in the basal ganglia for maybe 20 minutes and at the end of 20 minutes, he said, I have to get up. I I have to, I have to get up. And he he shuffled into the meeting room space at the six o'clock hour. He shuffled in. He got up off the table, started doing jumping jacks to blow off some of the dopamine. Then he said, I'll be back and took off running laps around, running laps around the ballroom and then ran a lap around the hotel lobby and then came in. Oh, that's so much better. Wow. It's possible to overdo the production of Parkinson's. I'm actually not too sure what 255 is. Do you know what that is?

Kim Pittis: [00:10:01] No, I was going to ask you. I'm talking to my head. What am I going to go to my buddy? And I'll check.

Dr. Carol: [00:10:08] Yeah, I'm going to guess it's motor centers, but it's just easier lender to use the basal ganglia.

Kim Pittis: [00:10:14] Oh, you might be right, because I remember fooling around with that when we were originally trying to work that in with the sports course and just figured that 92 or 94. Yeah. Maybe I'm going to continue on with these questions before we kind of go further. Would you say that dystonia is also a form of lack of descending inhibition?

Dr. Carol: [00:10:40] Yes, the dystonia that I've treated so cervical dystonia. It really depends on where the dystonia takes place. What body part. And the trick with dystonia, let's say in the face, we don't have a frequency for the the part of the brain that does that. That was before it occurred that those cranial nerves come out of the PONS, not the Medulla. So you might be able to run increase secretions in the PONS and get rid of fascial dystonia, right? Cervical dystonia is going to be 81 and 10. 81 and 94. You just have to increase secretions in the Medulla. You have to be a little bit careful with because that's also the respiratory center. That's where the Vagus comes out. That's where is it? The Medulla is just a very busy place. So that's good.

Kim Pittis: [00:11:44] Yes. Ok, I just double-checked. Yeah, 255. We have 245, 253, 255, 415. We have brain motor centers. I don't use that one a ton.

Dr. Carol: [00:11:55] I don't use them at all because the times I tried them, they never worked. So I give up pretty quickly.

Kim Pittis: [00:12:00] Ok, I'm going to pause the question because this was something that was emailed to me is you and Dr. Carol speak quite frequently about the frequencies that don't work. Can we have a list of those?

Dr. Carol: [00:12:15] Let's see. Well, now we know that 46 works. Sometimes it's sarcoma. Lemme probably.

Kim Pittis: [00:12:22] Maybe, yeah.

Dr. Carol: [00:12:24] 40. That whole sequence. 47, 48. 50. That group. Yeah, 284 is great for bruises and blood clots, so you have to be really careful with it, but it might be chronic inflammation and on the other hand, it might not work much at all. Yeah, so I don't I haven't come to a complete firm decision about it.

Kim Pittis: [00:12:54] Yeah. 58.

Dr. Carol: [00:12:59] Yeah, we knew that Leif, its autocorrect, dystonia, OK?

Kim Pittis: [00:13:06] I want to I keep going on this frequencies that may or may not work. Track someone, write something really interesting before we knew 124 was time-dependent. Did we think it not worked?

Dr. Carol: [00:13:18] Yes.

Kim Pittis: [00:13:20] Yeah. So that could lead us down a rabbit hole. Could these other ones just be time-dependent?

Dr. Carol: [00:13:28] The thing with 124 is that it always worked, but it didn't last.

Kim Pittis: [00:13:34] So when 124 is our frequency that we use for torn and broken, right? Just for people listening.

Dr. Carol: [00:13:39] Yeah, and torn and broken in, let's say, the connective tissue or the ligament or the tendon takes the pain down in five minutes. But it doesn't. It didn't last, so I did it as a drive-by. I ran it for four minutes, right? I had no idea that if you ran it for 60-minutes, it would actually repair the tendon.

Kim Pittis: [00:14:04] Right?

Dr. Carol: [00:14:05] So that's. Hmm. That's a really good question, and the problem is, I have enough trouble keeping my treatment times down to 60 to 90 to 120 minutes, as it is, if 255 ends up being time-dependent, I'm just doomed. Right, right.

Kim Pittis: [00:14:30] Yeah. So but I think we always knew one, twenty-four and I'm maybe might be speaking out of turn. I always knew it was doing something because it would take the pain away immediately. So it was one of those things where it's like, it's not like I never got anything. There was something we just didn't know that it needed more time to heal because we could take the pain down right away.

Dr. Carol: [00:14:51] Right, right. Yeah, I agree.

Kim Pittis: [00:14:55] I never got anywhere with the 58s. I always felt like I had to is kind of like going to church. Like I knew I had to say something and stand up and do something with my hands, but I didn't know why I was doing it or what. The effect was

Dr. Carol: [00:15:09] True, and we started using the 58th in 1998 when Ryan Williams went and found them, and they seem to be the missing link in my fascial myofascial pain. And then over time, as we learned to use 13 and think you have to remember that in 1998, we didn't know that in order to treat the muscle, you had to treat the disc and the facet and the ligaments. So we thought in 1998, when we were using the 58s We. Thought we were treating the muscle right? Fast forward to 2000, when did we figure out that it's never the muscle? Probably 2017, at least. Yeah. What are we? Both have frogs today. It's not a lot of my commuting going on as we clear our throats. So. So the 58s back in 1998 did something, but we don't know what. And they do work the 58s do work in visceral adhesions and visceral. It's worth a try or a drive-by. But yeah, true story.

Kim Pittis: [00:16:30] So yeah, I think that's kind of summarizes those A channels. Do you have any? Oh, man, we have so many B channels like we just kind of talked about it. Now we have a whole bunch for different brain parts, but we don't use them. We use 92. Write Motor Center. For the most

Dr. Carol: [00:16:49] Part, 90, 92 89 sort of encompasses the whole amygdala, hippocampus, thalamus complex. There is a frequency for the amygdala. I've never seen it to do anything. There is a frequency for the hippocampus once again. Never seen it to do anything right. The Thalamus 89 works just fine for thalamic pain, so if it ain't broke, don't fix it. So use 89. The. Basal ganglia in '98, was experimental with on that investigational list until it has worked time after time, like literally dozens and dozens of times without a single failure in Parkinson's. So that has to be the base of ganglia. There's a frequency for the substantia nigra, and I've tried that in Parkinson's patients. It's on the investigational list and it's going to stay there because it's never done anything. With the basal ganglia. That one works. It's like, OK, check the box, right? What's the other one? All those motor and sensory pathway portions? Yeah. Didn't do anything. Yeah. Different cortical spinal tracks. There are frequencies that were developed or scanned for Daoust, for specifically for the group at Cleveland Clinic. And it surely Ryan that are treating a lot of spinal cord injuries. Those folks find those to be really useful. I don't have enough mileage to say yes or no. And speaking of Cleveland Clinic and Shirley Ryan, that group uses, you know, those spinal segment frequencies. 284 C1 C2 all the way down. Yeah, the only one I ever use is C1 and C2. Yeah, the Cleveland Clinic and Shirley Ryan folks use those segmental levels to treat patients with spinal cord injuries at those levels, right? And they work. Like Ben Katholi will wax poetic about them, and it's like, I'm just like, really? Ok?

Kim Pittis: [00:19:06] Yeah. What about some of the different skeleton components? Like, there's one for scapula? There's one for Klopp. Yeah.

Dr. Carol: [00:19:17] No elbow. No. No upper extremity joint, lower extremity joint. No. I mean, what we have is what is the clavicle made of? periosteum And 39 and 59 and want one year, I actually knew. What was 39 and what was 59 and then. I forgot. And now I have to use 39 and 59, both because one's cortical bone and one's Cancellous bone, right? I can't actually remember why I figured out which one did which, but now I

don't remember. So I use both of them clavicle, scapula. It just doesn't make any sense. That, yeah, no.

Kim Pittis: [00:20:05] Ok, that's good to know. I personally always start on periosteum because that's the pain generator anyways. So and that most of the time, right, I have it.

Dr. Carol: [00:20:18] Yes. He was doing something. In Boning Mets, if there was ever a study to be done. There is no successful treatment for the pain of metastatic bone cancer. Right. We haven't ever found anyone. This protocol doesn't work on. Hmm-mm. And it's pressure in the periosteum, which makes sense because the METS fills the marrow cavity and causes the bone to expand, making little tears in the system. Right. So pain, reaction, pressure torn and broken and inflammation in the period and then reduce inflammation in the bone marrow and the bone. Right. We haven't found anybody that doesn't work on. So that's. That says something. Very interesting. Yeah. And somebody wanted to do a study, please. Yeah. It's none of this stuff ever happened until it's published. We're working on it.

Kim Pittis: [00:21:33] Let's keep going here for a minute. Follow me down the rabbit hole for a second. Do you think there is a sequence that some of our channels need to follow in order to work? Like, I remember somebody when we were talking about the 58s not working and it's like, Well, no, you have to run the 58s after 13 or before 13, or it was something that somebody was saying and I was like, Oh, I never thought about having to stack frequencies in a way to make them more or less effective.

Dr. Carol: [00:22:07] Well, the 58s, like you said in musculoskeletal, it's like not a thing. Yeah, Visceral. Probably, yeah. The stacking, some of that is it's a Harry van Gelder thing. Ok, so you run trauma.

Kim Pittis: [00:22:23] You want to explain who Harry van Gelder is to for people just tuning in then, right? Sorry, I make you do these things because we have a lot of new people that are listening to us right now, so.

Dr. Carol: [00:22:33] So Harry van Gelder was the osteopath who came from England in 1946, bought a practice, an osteopathic practice and walked into the back room. Saw this thing cover up with a sheet, took the sheet off, saw the machine that was made in

1922. That machine came with a list of frequencies. He taught himself to use the frequencies. He was a naturopath, an osteopath, a homeopath and a medical clairvoyant. So when he treated people, he could see the effect of the frequencies on their field, on their system, besides being able to feel the difference that the frequencies made. And Harry taught George Douglas and George Douglas taught me so there are some things we do like the concussion protocol. Because Harry said so. Why do we do the concussion protocol and everybody because Harry said, So why do we run trauma, paralysis and allergy reaction as a sequence? It's actually the emotional component 970 then trauma. 94 or 294, paralysis, allergy reaction. Why do we do it in that order? Well, because Harry said so. We've adjusted, that sequence to include 124 and then follow it with 40. So if you think about it as OK, you have your office that you want to paint and you just want to come in and, you know, paint your office, you want to get around, you just want to run 40, right? But you want to paint your office. Well, first you have to take the stuff off the wall and then you have to patch all the holes and then you have to prime it and then you can paint your office. So if you think of 970 trauma paralysis, allergy reaction and torn and broken as priming it. Then. You can. That's that's my idea about it. I like that. There are times when I run 40 first because all the patient cares about is getting the pain gone and 40 is going to do that. But to actually repair the tissue? You have to prime it. You have to do all the pieces of it, right?

Kim Pittis: [00:25:13] Or nothing will stick.

Dr. Carol: [00:25:14] There's there's that. And then you increase secretions and vitality. It's a sequence and it. It's. Because of Harry, it's how we have come to think about how cells and the body work. Right? It's only in our world,

Kim Pittis: [00:25:35] You know, and it's and I think again going back to how much the core education has changed in the last five years, for sure. 10 Years, absolutely. So people who have taken the core like. Anywhere, like after like or before five years ago, you need to revisit it because it's it is like learning a completely new, it's a new course.

Dr. Carol: [00:26:00] Yeah.

Kim Pittis: [00:26:02] And so, yeah, not just memorizing the stack or memorizing the list. And yeah, there's some things that you have to kind of memorize a little bit. But like

you were just saying, I don't care about memorizing what 255 is or scapula, because what is the scapula? Well, it's made of what's causing the pain. It's everything pulling off the periodicity. And why is it pulling off? Why is that tight? So you're following your own rabbit hole every single day with every single patient, with every single pathology.

Dr. Carol: [00:26:33] And it's not just a matter of learning the language, it's learning how to think you can walk into a cafe? And if you've just learned English, you can say, may I have a bagel, please? You just learned those five words and you memorized them in the language lab and you can walk in and say those words. If you're fluent in the language, you come in and you look at the pastry case and go, Wow. Those muffins look great. Is that poppy seed? I want to. Can I have the I want a poppy seed muffin, please? So that's the difference, I think that's what's changed in the last five years is instead of teaching people to learn the frequencies. It's teaching them how to think about how the system is organized once you have frequencies as a tool, right? Nobody on the planet thinks of full-body myofascial pain that is not fibromyalgia because nobody on the planet besides us has 40 and 10, reduce inflammation in the spinal cord. That's right. Nobody on the planet thinks of tight hamstrings abductors percutaneous and Brevis loss of descending inhibition because nobody on the planet has a way of changing that right. And for us, it's like, Well, that's easy. It's 80, one in 10. Yeah.

Kim Pittis: [00:28:17] Great transition once again. So there was a case, so I'm barely ever on our Facebook practitioner page, I'm barely ever on Facebook these days, but I like to go on and see some of the questions once in a while to see if we can add something because if someone's asking it on the Facebook group, people are probably thinking about it anyways. There is one practitioner I'm going to kind of butcher her original post, but she had a patient that came in, early forties, who had fractured his ribs and it was four to five weeks old. Only had a CustomCare and ran chronic fracture.

Dr. Carol: [00:29:03] Oh, bad, oh bad. Oh oh.

Kim Pittis: [00:29:07] So I this was me reading it at 4:30 in the morning because it woke up at 4:30 to check Facebook having a cup of coffee. And I was like, What? I'm like, Hey, just relax. This person came on asking for help, but this is go, OK? So yes, that person obviously felt worse the next day. And so I want to talk a little bit about failures and your favorite failure. My favorite failure. This is how we learn. This is also

how me as the biggest skeptic learned it wasn't what the success is because I was like hours because of my hands. It was the failures. It was the patience that I made worse, that I was like, Oh, this stuff really works. The stuff is really doing something. So we kind of started the podcast off talking about stages of healing, and that is a really important, crucial component of thinking about the frequencies, the way that if you do anything else diagnostically, it's stage the healing and think about what your intent is within that stage of healing.

Dr. Carol: [00:30:13] That's a great idea. Exactly.

Kim Pittis: [00:30:16] For safety, right? And I think you've said it first because you've made so many mistakes and that makes people like us go, Oh if you're making mistakes and I can make a mistake,

Dr. Carol: [00:30:28] Oh, this is the thing that you need to know. It is not possible for anyone in the FSM universe to have made as many mistakes as I've made and 25 years to do it. So I'm way ahead of you, right?

Kim Pittis: [00:30:46] But with that comes why you teach the way that you do because there is a legitimacy to our work when we create pain when we make people worse. And you say that with new patients like we don't oversell it. You come out. And I think you pretty much say to patients like my goal is to not make you worse.

Dr. Carol: [00:31:06] That's the plan for today is don't make you worse. Right? Because so many other practitioners have already made them worse.

Kim Pittis: [00:31:13] Right. And I think that's that's fair. Some people freak out when they make somebody worse and they get all this anxiety. And it's like, even without FSM, you always have the ability to make your patient worse. Like, that's just I don't care what your practice is.

Dr. Carol: [00:31:29] I had a physical therapy assistant. I had, let's say, leg pain or low back pain or whatever? And she gave me exercises that for a normal person, would have been fine? Well, doing the exercises in the gym that day, she tore my SI joint because that SI joint had been torn before and because of the condition of my muscles.

We put too much leverage and we just tore my SI joint. We had to go back to getting a taped, had to go back to treating it. So you always have the ability to make somebody worse. Right? But the stages of healing, it's such a learning experience. I thought a fracture was a fracture. So in six weeks, the fracture is healed, right? Except for ribs and except when there's a plate in eight screws. So I had cloud in the fracture in my shoulder at six weeks, which meant it was going to heal. But it wasn't healed for four months. Five months, ribs, ribs. I worked on a patient. All I did, I swear all I did was scarring in the nerves. I didn't do scarring in the periosteum. Right, scarring in the nerves. He was worse for four weeks. Every time it's so ribs, normal fractures take six weeks. That was a good learning experience. Rib fractures take 12 or more

Kim Pittis: [00:33:12] Because they're always moving. It never stays still.

Dr. Carol: [00:33:14] I know it's terrible. So don't feel bad, right?

Kim Pittis: [00:33:19] But I want to go with this a little bit because I kind of went on one. I did end up answering this person, and I want to kind of talk about this because this is, there's many different angles, so some people are jumping on her and whatever. And it's not just because you have a CustomCare doesn't mean your hands are tied. You have so many options. I only had a CustomCare for the first year and a half, almost two years. And again, with the way that we're teaching the course, you have the ability to write programs. So the person was like, I didn't see acute fracture on my CustomCare, so I just ran chronic fracture. Ok, I've got problems with that.

Dr. Carol: [00:34:01] That's our bad. I found out that when the staff loaded the CustomCare mode, bank Britney changed the name of the acute fracture. So it's not fracture acute.

Kim Pittis: [00:34:12] I don't know because like stress fracture or something, I think it's something weird. Yeah, OK. But I'm not going to accept that as an excuse because of the way, because of the way we're teaching the course. Write your own program, especially if you work in the person, was like, why work in a busy physio clinic? I couldn't do it. So I said, on your day off or on the weekend, sit down with the mode bank. And if you're quasi-new to this, this is the best way to learn is make some one or two liners that we and when we say one or two liners torn and broken in the Perry

system. 124 and 783. Put that on for 20 minutes. Torn tendon. That's one I always have on the clinic. 124r and 191. Put that on loop for an hour.

Dr. Carol: [00:35:00] 124 and 77. Yes, most of the tendons are flat, not round. But that's another conversation. Go.

Kim Pittis: [00:35:06] Yes. So that's my first thing is write your own. Like, and that's how you learn what the numbers are, how you memorize things, write your own one or two liners for your busy practice. That's point two. point number three. Let's just say you can't go back in time or you can't go ahead to the weekend and write this, what would have been a better option? So we know that we don't have acute fracture in there and we're dealing with ribs. Scan the list and again, go back to that stage of healing. We're in an acute phase. We're only four to five weeks out. We're with a very movable area, so it's the rib, but the ribs also a joint. So go through your mode bank. Maybe soft tissue acute would have been the better option or extremity joint acute. We have so many little ones. When in doubt, go with the stage of healing.

Dr. Carol: [00:36:03] Well, I'm the other thing is when you make the patient worse, and it's not if at some point you're going to make somebody worse. Yes, that's like that's a given. Yes, when you make them worse, don't panic. It's like, Oh, that's interesting. You should come back tomorrow. I can fix that, right? It's when you treat somebody for inflammation, we talked about this last week, treat somebody for inflammation and they have an undiagnosed dental abscess. And you make them worse. That's good news.

Kim Pittis: [00:36:40] I'm sorry, and you're welcome.

Dr. Carol: [00:36:42] Yes, so come back this afternoon. We'll run the frequencies for infection. We're going to quiet it down and then you're going to call your dentist and tell him you have an abscess and you need to get in tomorrow, right?

Kim Pittis: [00:36:56] So how would you advise this person who created more pain in the person who had the rib fracture? What would be your antidote if that person said, OK, come on back. What would you do? What would you run?

Dr. Carol: [00:37:09] Single frequency combinations are a good way to go if all you have is a CustomCare. Yeah, acute fracture. Stress fracture. Actually, I'll make sure that the mode bank is fixed. Now that you mention it, I would probably do single frequency combinations. 124 and 783. So torn and broken in the periosteum, because that's what you did with periosteum, is what creates the matrix that the body fills in with calcium to repair a fracture. Right? So you un-fixed the periosteum. So Torn and broken in the system and inflammation in the periosteum. So 20 and 20 or 20 and 10, 30 minutes, I'm torn and broken, and 10 or 15 minutes on inflammation. And the other thing you might do? This is a thought if you're a manual therapist in your a PT, so let's say you only have 30 minutes, so you're on 20 minutes of torn and broken on the periosteum. Ten minutes of inflammation. And then you must massage do manual therapy on the hips, the low back. And the neck, so you provide, actually probably the neck work on the neck. You provide competing information using the pain gate premise, pain gate model. Use competing information by massaging the neck. Why are you rubbing on my neck? Because your neck is really tight, because your ribs hurt. And what the patient doesn't need to know is that you're using. The pain gate mechanism to provide competing information. To compete with the pain from the ribs and the're Oh and their neck is really tight because the ribs hurt. Yes. So and they're trying to breathe with their scalenes instead of their ribs. So of course.

Kim Pittis: [00:39:19] Thank you. So that's exactly so we learned as the gate control theory of pain. I'm sure it's the exact same thing we're talking about. So this is for the laypeople listening. This is a theory of, you get up in the middle of the night and you go to get a glass of water and you bang your shin on the coffee table. What's the first thing you do after you swear you rub your shin? So the pressure and the touch helps negate the nose receptors or those pain receptors. So doing manual therapy on their neck? Same thing. You're creating this influx of good feelings away from the pain. I would also say to add heat, we know now all this great research. We're not doing rice, we're doing meth. So movement, elevation, traction and heat. So traction in the neck. If you have like if you're using the towel warmers in your clinic with your FSM, you have a nice hot towel behind their neck. This is all going to feel good. This is all going to help with inflammation and the person is going to leave happy because, you know,

Dr. Carol: [00:40:20] And for the geeks in the audience, you just look up melzack and wall pain gate. Think it's pain gate, OK? Because it was the concept is and we use this

to our benefit when we run 40 and 10. So you can't. So there's this concept of ascending pain messages, TENS units work by providing muscle contractions and sensation above the level. Let's say you have low back pain and you provide a lot of muscle contraction and sensation above where the pain is. The muscle. This input blocks this input. And that's melzack and wall if you want to look it up. It's been around well, it's why TENS devices were developed by Oh, what's his name? It'll come to me anyway.

Kim Pittis: [00:41:21] Go. No, that's good. One other thing with this case and kind of going back to Facebook is, I mean, it's that time of year. People are a bit testy and it's a hard, stressful. But let's just try to be kind on Facebook because it's hard to it's hard enough to make a mistake and make somebody worse. So my hat always goes off to people who ask for help because this is what makes us better. So let's just try to keep it like empowering and caring. And we don't need to like point fingers and say what? Like, it's let's keep it positive.

Dr. Carol: [00:42:01] Well, and everybody has to have a first day. Everybody has to have a first day. Yeah. So, you know, the people that have the training button on. Yeah, everybody was a trainee at one point.

Kim Pittis: [00:42:14] I know I love. I love thinking about that, right? Like we all and I remember it clearly the first time I did things and I kind of wrote, like these, you'll remember this case. You'll remember making this person worse. And this will make you better because you'll never make that mistake again, hopefully.

Dr. Carol: [00:42:34] Well, I've made the same mistake two or three times. Like, I can't believe I did it again.

Kim Pittis: [00:42:39] So I'm going to jump to some Q&A before we go any further. Here we have one ulnar impaction syndrome slash ulnar abutment. Never heard of this before. Wondering if either of you have encountered it impaction syndrome? Oh, I have a thing when I hear the word syndrome at the end of anything, I get angry. Made that up.

Dr. Carol: [00:43:02] It's not. It's not that that is not a thing.

Kim Pittis: [00:43:05] The reason you never heard of this before is because the person made it up.

Dr. Carol: [00:43:08] Yeah, they whoever, whoever it was, the patient comes in and says they have. They said, I have this thing and it's like, No, you don't ulnar abutment. So one of the reasons I took four years of Latin in high school, I went to a Catholic high school and I was on the geek track. And so I took four years of Latin and it figured that it lets me take things apart because the English language is based on it. So ulnar abutment just means so if you look at a skeleton and you see what the ulna is shaped like, it's really complicated. It makes the knee look easy. The ulna is an impossible joint. That's right. So there is this ulna and abutment just means it's running into the other end of the...

Kim Pittis: [00:44:07] So those of you who are watching both of our faces got scrunched up because the person just wrote says her bones keep growing and it sounds like osteoarthritis.

Dr. Carol: [00:44:18] Well, duh. Yes. So we have an x-ray. And you can't take away bone that is there that grew because your body thought you needed some. The thing to remember with any osteoarthritis is inflammation and tone. The body classifies you have bone spurs because some ligament or some tendon is pulling on the periosteum. And Wolf's law says, you know, if it moves salute it, if it doesn't move, calcify it. So, it pulls on the. And so you grow a bone spur. The ulna is complicated because you have all of the forearm flexors and Accenture's attaching someplace open up Netter and look at the tenderness attachments to the ulna. It's all tendons. Find out where the bone spur is. Find out what tendon is there and then go looking for why that tendon is chronically tight. That's what I would do. Right ulna is not. And intuitively obvious place to develop arthritis. Right? Makes sense. Yeah, makes sense. Hips makes sense. During joints. What do you do with your elbow that makes it make bone spurs?

Kim Pittis: [00:45:58] Yeah, and the ulna radius, right? It's not just like you said, it's the knee is really super easy. Slam on Ken joint and moves in one plane, the ulna. We have supination and pronation that's in the mix. So. And where in the ulna? Is it at the elbow or is it? At the wrist, a button.

Dr. Carol: [00:46:23] Oh, that's a good point, I forgot about the wrist.

Kim Pittis: [00:46:26] Now there's two articulations, right? Maybe the person will add on where the

Dr. Carol: [00:46:31] I don't ever count the one at the wrist because the ulnas so tiny down there.

Kim Pittis: [00:46:34] I know, but it's still there. So wrist rest, it's at the wrist.

Dr. Carol: [00:46:40] You win chocolate.

Kim Pittis: [00:46:45] So even more complicated is you're not having pronation supination. You're having everything to do with the carpal.

Dr. Carol: [00:46:53] Wait, wait, wait. Wait. Done that. The owner carpal joint is there's three bones there, and there's a triangular cartilage that's in the ulnar section in Netter, is it?

Kim Pittis: [00:47:10] The FCC is. Yeah, yeah.

Dr. Carol: [00:47:12] No, no, no. They made it up

Kim Pittis: [00:47:16] And basically says her pinky finger bone keeps growing and only diagnosed in people after they reach 30.

Dr. Carol: [00:47:25] Ok. Maybe they didn't make it up, but why would that? But that's a good face.

Kim Pittis: [00:47:33] That's I have it's your face, so those of you who are listening, you're missing the faces. But this is super interesting, which is why it sounds inflammatory. So inflammation is just one small component, though, of treating anything osteoarthritic or bone spur-y, correct? I mean, what?

Dr. Carol: [00:47:52] What does she do for a living?

Kim Pittis: [00:47:54] Yeah. What are the

Dr. Carol: [00:47:56] Whats the bone Doing?

Kim Pittis: [00:47:57] Right. So we need to know what the activities of. Child care. So lifting kids probably.

Dr. Carol: [00:48:05] Ok, thank you, Dana. I have no idea.

Kim Pittis: [00:48:11] Took five minutes to figure out, we don't know what to do with this case. Ok, so let's break this down, though. So it sounds inflammatory, but osteoarthritis is calcification, bone spurs is 91. Right, so if we had to.

Dr. Carol: [00:48:30] How do they know? Wait, wait. How did? Wait, wait. How do they know that bone keeps growing? Do they have a baseline? X, Ray, from when she was if she's 30. Do they have a baseline x-ray from when she was 25?

Kim Pittis: [00:48:50] Yeah, how do they not know that it's just not like malformed in? It's always been like that.

Dr. Carol: [00:48:55] Genetically, it's a-Aha! Post spinal tumor removal by the laser. Over a month so far painless. Yeah. Oops. Wait, wait. She wait. She had a spinal tumor removed by laser. And that gave her pain in her hand. And that is caused what?

Kim Pittis: [00:49:26] Oops! Ok. Oops. We're on live, folks, so.

Dr. Carol: [00:49:32] Ok. Different person. Ok, good. Oh, OK, thank you.

Kim Pittis: [00:49:36] Yeah.

Dr. Carol: [00:49:37] Maybe we should get back on Kim's track and we'll take care of Dana later, OK? Because the train just went right off the tracks there,

Kim Pittis: [00:49:45] It did so. Ok, we'll go back to my list and everything. There is one more question that's on a different side. I'll let you talk about this quickly. Help for an 11-year-old with breast tumor cancer. I have done 51 on A 500 on B, should I massage?

Dr. Carol: [00:50:08] Whoa. No, no, no, we don't treat cancer. End of discussion, period. And cancer is inflammatory. It's not fibrotic. So if you're we do breast health on healthy breasts, reduce inflammation to prevent cancer. Yay. But no, Marty, once you know that patient has cancer, you're out. Especially if she's 11.

Kim Pittis: [00:50:35] And even aside FSM, or not, I correct me if I'm wrong? I was on the council a long time, while not too long ago, but even massage with a cancer patient is contraindicated. We're not increasing circulation to cancer cells. We don't want to.

Dr. Carol: [00:50:50] And if she's 11 it's a Triple E positive, she just now is having increased estrogen level. Yeah, I don't care if it's inconclusive, it's like you wait until it comes back negative. And if it's inconclusive, then she has really good health insurance. That I'm what is an 11-year-old? Ok. That's wow. Ok. It's all right. And I like the 160, malignant virus that helps in many treatments. Wondering what you think 160 is actually treating that one I can answer for the rest of these are like,

Kim Pittis: [00:51:35] I know it's crazy.

Dr. Carol: [00:51:37] 160 What we think is happening with all of these frequencies is we're changing the effect. 160 is not big enough, not a high enough frequency to actually modify a biological organism. But it's enough to change the effect that organism has on cell signaling. So, so there's so that's what 160 does. And it's magic. It's just magic. Right. And Viral plexopathies viral infections of all sorts. 160 is your friend and. With the 11-year-old Marty, the thing to do is put her on phosphorylated B6 because you can't metabolize estrogen without methylated folate and phosphorylated B6, so you can't touch her. You can massage her back. You can run immune support. You can run concussion because imagine being an 11-year-old who's getting biopsies and told she might have breast cancer when you're 11 and you're just getting breasts and now the breasts are, I mean, yuck. So concussion protocol, adrenal support, immune support, and phosphorylated B6 and methylated folate. So if you look in the nutritional pathway

that leads you to cancer, you, it's that's what we can do safely. And as Shirley Hartman will tell us in February, is lots of vitamin C OK?

Kim Pittis: [00:53:26] Yeah. So reiterate we do not treat cancer with FSA. Ok. All the questions are piling in. We only have about 10 minutes left, so I want to just. Ok, we'll just kind of go with what's on here. So the other person wrote Paraspinals tumor remover removal by laser over a month ago. So far, pain is partially controlled by hydrocodone, but still very uncomfortable. Suspect she has to get repeated surgeries.

Dr. Carol: [00:53:58] So this is eighty-five years old has to lay down most of the day. FSM will help pain inflammation. Oh yeah. So 40 and 10. So the spinal tumor, was it in the bone or the cord? Usually, spinal tumors are in between the dura and the cord. So unless it's a primary bone tumor, so 40 and 10 will take the pain down, treat the bone. How did they? So look at the mechanism of the surgery, so this takes us back to Kim's point about. Stages of healing. Any surgery you look at the path of the trauma. So where did the scope go? How did they get the laser to the tumor? Did they have to go through the bone at which point you run basically acute fracture? Is it just trauma to the cord, then you run 40 and 10 that. And that takes us to. Spinal cord sensitization, so for spinal cord is now inflamed, pissed off, then any peripheral. Input. So why is she more comfortable in bed? What's up with that? Hmm. What's the difference between standing up and laying down? When you stand up, you have sensation from your feet and your knees. You have proprioception, you have clothes. And all of that input goes up the spinal cord, if the spinal cord is inflamed, all of that input. So remember from the cytokine paper, if the pain pathways are interrupted, any place between the thalamus and the spinal cord.

Dr. Carol: [00:56:13] You have essentially thalamic pain. So all incoming sensation is going to be converted into pain signals. That's why she wants to lay down because there's no thing going up her spinal cord when she stands up. Sensation from her feet, her knees, her hips gets turned into signals that go the spinal cord that get. That make pain. That turn into pain signals. So I would try 40 and 10 and 40 and 89, the, reduce inflammation in the cord, reduce inflammation in the thalamus, reduce the activity of the thalamus. And this takes us back to what you started with. Think about the process. So this isn't a recipe for treating everybody that's ever had spinal surgery, but it's the concept of central sensitization, spinal cord sensitization, and the fact that if you

interrupt the pain pathways any place between the spinal cord and the thalamus, you end up with thalamic pain, right? So we have a tool, this lady. She may end up needing a CustomCare to keep herself. But if you can get her out of pain for 24 hours, then my guess is correct. So this is an educated guess. It's a hypothesis that you get to test 40 and 10. 40 and 89.

Kim Pittis: [00:57:48] Do you think any C2 and I just kind of went to the mechanical part of standing up, you have all the compression through the discs and through the cassettes, so you want in a totally different way that I would have started but centric

Dr. Carol: [00:58:05] Instead of osteopathic retrained. Yeah.

Kim Pittis: [00:58:08] But like, I would have got to where you were going. So again, going to people are like, Oh, I wouldn't have gone there. You probably would have. It might have just taken you a different path to get there.

Dr. Carol: [00:58:21] The other thing is, there's no reason you can't do both, right?

Kim Pittis: [00:58:26] So you would run

Dr. Carol: [00:58:29] What was my cat is in the room. It's like, What is that noise? It's cat. So there's no reason you can't do both. So you would run subacute four sets on one machine back to front at the level where the surgery took place. Run 40 and 10, with one unit in 40 and 10 with the other unit. And so you get all three hypotheses at one time with three units that. Lets you do a miracle and probably 45 minutes.

Kim Pittis: [00:58:59] Right, and that's a bonus of having multiple machines is that you can test multiple hypotheses simultaneously. So we are almost out of time for today. It's a true story. We have two minutes left. There's one last question. Let's just try to get to it in a minute and then we'll wrap up here. Are there any recommendations for palliative comfort care on woman with returning and multiplying brain tumors? She's had two brain surgeries for removal 16 and three years ago. She's post-op op.

Dr. Carol: [00:59:32] How old is she?

Kim Pittis: [00:59:35] Doesn't say here. Maybe if the person who wrote it can

Dr. Carol: [00:59:38] Just go and three years ago. Right. So yeah, no, no. Concussion protocol, if she's having with that many, that many surgeries. Pretty good chance. She's got thalamic pain. So I would try 40 and 89 as a palliative care. She should move her bed so that she's out of the magnetic field.

Kim Pittis: [01:00:06] That is, she's 40, 40 years old.

Dr. Carol: [01:00:10] Oh my, gracious. Number one, stop using your cell phone up against your head. Don't ever do that. Number two, move. Move your bed. So there's. It's more about breast cancer than it is about brain cancer, but who knows, 60 hertz is what our current flows at. It's 60 cycles per second. And there is evidence out of a study in Norway. It's in my section in the functional medicine textbook, but 60 cycle walk run the magnetic field created by 60 cycle while current interferes with the ability of tamoxifen and melatonin to prevent breast cancer in breast cancer mice. So the important part about that study was. Tamoxifen, we know, is used to treat estrogen-dependent cancers, but melatonin is equally effective for breast cancer as tamoxifen in this mouse study. I figure I'm a big mouse and breast cancer increases as you get older. And what else changes as you get older, you make less melatonin. So there's that. But then if you expose these mice to a 60 cycle magnetic field or walker, but it was a magnetic field, 60 cycles, they get breast cancer even if they're on tamoxifen and melatonin. So move your bed, stop using your cell phone. It is not a coincidence that John McCain's. Glioblastoma was on the left side of his head. He's right-handed. Hi, let me shake your hand with my right hand and I have my cell phone glued to my head. There's that. So that's a whole nother conversation. So and then she's this is palliative care sleeps in the recliner. No electronics. It's I don't know. Sorry.

Kim Pittis: [01:02:26] Well, like you said in the concussion protocol is, I think, a wonderful starting point to help people at least sleep better. You know,

Dr. Carol: [01:02:35] These are the weirdest cases we've I've ever heard.

Kim Pittis: [01:02:39] You would think it was a Halloween special. This is a very strange day. It got through a tenth of my list. I had this very holly jolly lead-up to Christmas thing planned. I'll have to table that for next week.

Dr. Carol: [01:02:51] So Holly Jolly

Kim Pittis: [01:02:54] Pre-christmas? Yes. So going on the theme of not surprising you, I'd like to start you thinking about your Christmas wish list, so I want to think about. I want you to think about some things that you are wishing for FSM, our future. So I'll put that in your brain for you to think about for the week.

Dr. Carol: [01:03:14] Speaking of wish lists, I have to tell you, yes. Having told Kevin yet so it's Healy out and so it'll be fine. Bill Clearfield has agreed to do a three-hour block on the endocrine aspects of traumatic brain injuries, and he's going to be opposite Lori Chaikin, who's doing FSM in the eye. But I talked to the hotel today and we have enough room to do both of them. So usually we do the 90-minute section on one day and then the deep three hour dove the next day. Dr. Clearfield has got Saturday afternoon for 90 minutes on the endocrine aspects of traumatic brain injuries, and there's Sunday's all case reports. So he's going to do a three-hour deep dove on Friday morning. He just agreed to that, and the hotel has rooms. I found that out today, so that's what that's my first Christmas thing.

Kim Pittis: [01:04:14] Yay. Well, that your wish list is we're just checking things off for you early. Well, that's fantastic. I'm so excited for the advanced one more thing just people who are listening, who are practitioners. The precision distributing has their end-of-the-year sale, I believe, until just the end of the year. So those are great Christmas presents for your practitioner friends. It's a great deal. Still taking registrations for the advance. So don't forget about that. That's also a great gift. The gift of education.

Dr. Carol: [01:04:44] Yes, that's a great idea.

Kim Pittis: [01:04:46] Yes. An hour. I know. You know, so hopefully we entertained some people and answered some very interesting questions today. We always have

Dr. Carol: [01:05:01] Fun people found out by listening to us puzzle our way through these things. How do you think about it? And no, we don't have this weird stuff figured out, and it's just fine to not treat it right. It's like, yeah, out of my scope. Yes. And I don't know how to approach it, but I can think of something maybe, and we'll see if it helps and if it doesn't help, no harm, no foul, right? Yeah. Like taking one hundred and twenty dollars and going to Las Vegas, it's either going to help or it's not.

Kim Pittis: [01:05:36] No, I love that. All right. Have a fantastic evening. We will talk about our Holly Jolly Christmas lists and all the fun, happy things next week. You got it. Keep the questions coming, everybody, and we'll see you all week from now

Dr. Carol: [01:05:53] Bye

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