The Frequency Specific Microcurrent Podcast
Episode Thirty-One - It's Spring Time – Adaptability

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

Dr. Carol: [00:00:03] Hi. Hello. It can't be Wednesday already, right?

Kim Pittis: [00:00:09] I'm so happy it's Wednesday.

Dr. Carol: [00:00:11] And then being Wednesday, it can't be 5:00 already. Right.How are you?

Kim Pittis: [00:00:18] Great. It's springtime.

Dr. Carol: [00:00:23] Oh, my God. It's almost. Down in Portland. The trees are already losing their blossoms.

Kim Pittis: [00:00:32] Yes.

Dr. Carol: [00:00:33] Up here, we still have massive pink fluffy trees and white fluffy trees and amazing things.

Kim Pittis: [00:00:44] Well, I'm still in awe with California in the springtime because in Canada there's still snow up until the first week of June, usually where I'm from. And in my back yard, I have about four orange trees that have the most beautiful orange blossom smell.

Dr. Carol: [00:01:05] Yeah, the smell on orange trees. It's just like. Yes.

Kim Pittis: [00:01:11] Who knew? I had no idea. And I have a cherry tree in my front yard and the cherry tree is exploding. And it is so pretty. So.

Dr. Carol: [00:01:20] And the thing is, in California, you only think you have spring because California goes from you know, they don't actually have winter. They don't have winter.

Kim Pittis: [00:01:33] Yes.

Dr. Carol: [00:01:34] They no. So you come up to Oregon and what you thought was spring in California. Then you come up here and you go from, I don't know, a sparkler to a massive Ariel 4th of July. Display.

Kim Pittis: [00:01:53] Right?

Dr. Carol: [00:01:54] We have. Yes, but. Yeah, yeah. Yeah. No. And the orange blossoms. We don't get orange blossoms up here because it's too cold. Right. Right. So that's the thing. Yes, I, I what's on your list for today? Because I have a thing.

Kim Pittis: [00:02:13] Well, my list is always evolving because of you. You're kind of a hard co-host to plan around. So I wanted to talk about spring and April and my word for the day, because there's always a word and sometimes I don't get to say it because we have stories to tell, but it's about adapting. So adaptation was my word today.

Dr. Carol: [00:02:37] Oh, I like that.

Kim Pittis: [00:02:40] But I'll let you go in your room and we'll pick up we'll pick up my list when we when we can get a chance to get to it.

Dr. Carol: [00:02:46] That's a real perfect segway to this email that I got from a patient who emailed me through her practitioner. And I have to see now if I can find it. Oh, come on. Really? No. Well, maybe I won't tell the story, but she's a PTSD patient. Got treated. And there it is. Who got treated by one of our practitioners and. This is. "I'm new to FSM treatment and have read your book three times now. Enormous respect, blah blah blah and appreciate the hope I feel for recovery when I was losing hope." This is like the most touching email I've ever had from a patient. "I have complex PTSD and read with interest your observation that the biggest challenge for recovery using the PTSD protocol is adjusting to the absence of symptoms. I'm experiencing that this is the

case. However, it has nothing to do with believing the symptoms are gone or getting used to them being gone. It's spending a lifetime of vigilance, preparing for and surviving the onslaught of symptoms." Oh, so let that one percolate. Yeah, I can. "The nervous system and thoughts become habituated to that, regardless of belief and proof to the contrary." So all of the good things that happen are filtered through the brain's expectations of bad things happening. But it's something deeper than that, too. It's defending against the devastating disappointment of having the symptoms return because they always have. It takes time to experience trust in a new reality, and it's something deeper than that.

Dr. Carol: [00:04:59] "PTSD is an identity disorder. To have PTSD is to have a shattered identity. It builds a new slowly with a lot of help and time. It takes a strong core to trust in good new experiences and become aware of defenses against trigger experiences." I'm going to skip some of this because it's long. "Several times I've felt anxiety out of nowhere after the PTSD protocol. And that made me wonder if the practitioner is using the old version that had 81 and 89 right and finally realized that in the absence of pain, the I am nothing feeling comes back." I'm going to read that again. "Several times I have felt anxiety out of nowhere after the PTSD protocol and finally realized that in the absence of pain, the I am nothing feeling comes back. At four years of intensive PTS therapy so I could recognize what was happening, which made that anxiety stop. One in three, probably more, females have been sexually assaulted. Many don't remember some of that. 25% could be them. Many children are abused." And that's why we run 40 and 89 when there's. And for the non-FSM practitioners, it's quiet the midbrain, the amygdala, the hippocampus. So. "And even then, it's a lot of psychological work to do. One of the things that seems so amazing about FSM is the possibility of healing, otherwise unreachable conditions. That would include hypersensitive and or traumatized people who are otherwise hard to treat.

Dr. Carol: [00:06:59] I notice needing small doses spread out over time of FSM treatments. I notice being reactive to treatments even when they're working from aching to my skin. Irritating from just a current of 20. I've noticed having to consciously work with allowing the feeling of hope." I'm going to read that one again. "I notice having to consciously work with allowing the feeling of hope. I notice asking a million questions and having to know exactly what's going on. I notice intuitively knowing which frequencies might be right for me just by reading about them. Even though, for example,

I had to look up. What if a set point was. I offer these observations because I feel a natural kinship to that 25% and to PTSD people." Notice, she says, PTSD people, not PTSD patients. I like that. "And maybe for the many practitioners who luckily, don't have these identity issues and for many practitioners who luckily don't. And maybe for the many practitioners who don't have these identity issues, it would be helpful to have guidance about them the way they do psych physiological issues of all kinds. As this new medicine grows, so will the number of people like me who find it. I add my inexpressible gratitude to the constant wave of gratitude I'm sure we all feel and send to you and our practitioners. And I know you use such powerful, positive energy to continue your work." We can stop now.

Kim Pittis: [00:08:55] And thank you for joining. I'm just kidding.

Dr. Carol: [00:08:59] No.

Kim Pittis: [00:09:00] But how very well written. How very well thought out. I'm sure she represents so many patients that wish they had a way to express that. So I'll let you. I'll let you. Very much.

Dr. Carol: [00:09:17] So. Yeah. And it's. And so what I want to send her is the. What I didn't teach you.

Kim Pittis: [00:09:25] Oh yeah.

Dr. Carol: [00:09:26] Workshop that I did, which we have to do is webinar one of these days.

Kim Pittis: [00:09:31] Oh but that's exactly you said that from the practitioner side and she's picking that up from a patient's perspective and for patients and practitioners that are just listening. The thing that hits me right in the heart and the gut and what you just said is but there's something deeper but there's something more. And we all experience that at some point when we're treating somebody, you're like, What? Why is that? What is that?

Dr. Carol: [00:10:02] Yeah. And the concept that she points out of. If I'm not in pain, who am I?

Kim Pittis: [00:10:12] It's huge.

Dr. Carol: [00:10:13] Even if all you do is get rid of low back pain that they've had for three or four years for us, that's like, duh, right? And if all you do is get rid of their headache, their tension headache that they've had for three or four or five or ten years. Right. You get rid of that. For us, that's a supine surgical practicum. But her. Her way of expressing. If I'm not in pain, who am I? And I always think of that as your brain looking for the pain. And there's nothing there. Yeah. But she addresses a more complex identity issue. That. Is even broader than the pain stuff.

Kim Pittis: [00:11:04] Very much so. Yeah. We talk about it a little bit in the Core, you know, and I think that's one of the biggest things when we work with chronic pain patients and we have this new tool is chronic pain patients, they're finding you because they want to get out of pain, but they're not expecting to get out of pain sometimes.

Dr. Carol: [00:11:29] Nothing else has worked. Why would this?

Kim Pittis: [00:11:31] Totally. And that in itself is a huge concept. And I think you talk about it with some of the fibromyalgia patients who discontinued in the study for various reasons. I've had many patients that have discontinued treatment with me and it used to keep me up at night. Where did I go wrong? And then it hit me. I made them better. That's why they left. That's why they stopped coming because they were getting better. And then to your point then who am I now?

Dr. Carol: [00:12:05] Well, and better enough. So if their pain level was a six or seven out of eight and you get them down to a four. If that's the level of pain they're comfortable with, then they're done. Why would they continue? Right? And if your goal is to get them down to a zero or a one and to be able to go for walks and bicycle and run, but that's not their goal. That's the place in the Core, I think, where I say you can't want the patient's recovery more than the patient wants it.

Kim Pittis: [00:12:46] Yeah, you have to make multiple slides about that because I didn't get that concept until very recently.

Dr. Carol: [00:12:53] Yeah, it's. Yes. It's and it's not only that, but there used to be a peace in the advanced. And I took it out and maybe I need to put it back in. But it comes to the point of who are you doing this for?

Kim Pittis: [00:13:17] Mm hmm.

Dr. Carol: [00:13:19] You're if I'm doing patient treatment to make myself feel good about me and what cool things I can do, then that might not be the best way to go about it. Yes. If I'm doing this to help the patient achieve their goals, then it's worth asking the patient what's good for you? When will you know we're done?

Kim Pittis: [00:13:48] Right. And that should almost flag when you're doing your charting or when you're seeing that patient instead of always going to the sensory exam and the reflexes and the range of motion, going back to that. What are your goals like this week? How can I help you with your goals? And that is very, you're right, that's very different from me as a practitioner who wants everybody to be running and lifting weights. That's not for everybody.

Dr. Carol: [00:14:21] And sometimes for the patients, it's well, I have another $300 to spend on self-care and I just spent $150 of it on you and you got me down to a four and I'm going to save the other $150 for something I might need later, like groceries or a movie or whatever. Sure, this is good enough and I can recondition on my own.

Kim Pittis: [00:14:42] And that's those are very valid statements.

Dr. Carol: [00:14:45] Isn't that. And then. But yeah. And her. The language, the insight of, believe it or not, as powerful as that was, it came in two days ago and I haven't replied.

Kim Pittis: [00:14:59] How do you reply to that right away though? So to the person that wrote that, thank you so much. Because that that touches every practitioner out there because that's. That's huge.

Dr. Carol: [00:15:13] Yeah. And every patient.

Kim Pittis: [00:15:15] Yes.

Dr. Carol: [00:15:16] Not just PTSD patients, but especially PTSD and fibromyalgia patients. Because she did talk about it's one of the paragraphs that didn't read the fibromyalgia patient. So we had. 25% of them didn't. We had 54 patients and 58% of them recovered from fibromyalgia, where they all were out of pain, 100% at the end of the hour were out of pain. But there was that 30 some odd percent that didn't come back or didn't stick with it to get better. And she addressed that eloquently back in '99, 2000, 2001, when I was collecting those cases. I was so excited about being able to get them out of pain. I didn't realize how difficult that is. So your word adaptability is perfect for today?

Kim Pittis: [00:16:26] But it's not an easy concept for anybody. It's a very simple word, but it is. It hard. It's hard for a lot of practitioners for us to adapt how we treat patients. Not even just with that skill set, but just how as you were talking about the mindset, what's, what's my goal versus what's the patient's goal?

Dr. Carol: [00:16:50] And your goal actually doesn't matter.

Kim Pittis: [00:16:52] Means nothing.

Dr. Carol: [00:16:54] I'm really sorry.

Kim Pittis: [00:16:56] And you're welcome.

Dr. Carol: [00:16:58] Yeah.

Kim Pittis: [00:16:59] Wow. What a what an opener. How do we follow anything after that letter?

Dr. Carol: [00:17:05] Yeah. Bye.

Kim Pittis: [00:17:08] Just kidding. We have so much more to talk about today.

Dr. Carol: [00:17:11] Tottally.

Kim Pittis: [00:17:14] And it's funny, this came off of a week. I was sharing a little bit of the text messaging with my patient. It was those small things that we do. I get so caught up with range of motion, strength, pain, all the big things, especially working with athletes, that you forget when you have a teenager who's been in chronic pain and you get a message that the pain is still down to a two when it was an eight. And they're going out with friends and they're doing things like cleaning their room and organizing and things that they love to do but stop doing because they were in pain and they gave up. So that to me was a big part of its not just range of motion, it's not just pain, it's when you start seeing those markers of restoring joy in a patient's life, even if it's for a week.

Dr. Carol: [00:18:13] Well, and that's why the Oswestry use and the Tallis functional scores are actually more. They're actually as useful as the visual analog pain score because it's not so much what your pain level is, it's what you're doing. Can you sit up for an hour? Can you walk? Can you do this? Can you do that? And the other, going back to adaptability, just occurred to me. When you become injured. Or develop a pain problem. You have to adapt everything you do to that issue. So back, whenever that was, I had my hips replaced in 2008 and '09. So 2003 when I started walking with a limp in my right hip. 2004 I went on a cane for my right hip. 2005 and '06 I was in wheelchairs in airports because I couldn't walk that far. And I had to adapt to the accommodations that made my basic life livable. Right? So the patient comes to you and they've already adapted to the fact that they have to sit a certain way, walk a certain way. They can only plan on being vertical for X number of minutes or hours. They can't do this. They can't. They've already adapted. So when we talk about twice a week for 4 to 6 weeks, the first two or three sessions is to get them out of pain. The next three or four

Dr. Carol: [00:20:10] s to undo the accommodations or the adaptations and the compensations that they had to create in order to deal with the problem they had. So after I had my second hip replacement. So. Two weeks, three weeks after my first hip, I sort of positioned myself in bed to get weight off my left hip. My left hip rolled out of the

socket subluxation and tore the labrum. I spent the next; that's a good face. I spent the next year in prehab. I called the next day to schedule my left hip replacement and it was six weeks after my second hit, after I had both of them replaced. Six weeks later I parked my car two blocks from the pharmacy or from the shop I was going to, and I walked across the street and down two blocks and I was just getting across the street when it occurred to me. I just walked across the street. I haven't been able to do that in nine years. Wow. Holy smoke. Right? So I wasn't looking for the pain, but it was still to the point where I noticed when it was gone.

Kim Pittis: [00:21:45] Right.

Dr. Carol: [00:21:46] And so patients have I don't know whether and I'll let you talk about this, because you're starting to see the chronic pain community. Whether to talk about it with them or let them figure it out by themselves. I like pre-planning. It's like this might come up.

Kim Pittis: [00:22:06] Right. That's a great question because sometimes you bring light to something that they're not really ready to see yet. We see in the sports community with athletes so much adaptation that happens so freakishly fast because these athletes; and it doesn't have to be a world class athlete, anybody that trains a movement pattern over and over and over again has going to have fast adaptation because.

Dr. Carol: [00:22:36] They're so kinesthetic.

Kim Pittis: [00:22:38] They're so kinesthetic. And I was I saw one of my patients and I'm going to bring him on the podcast one of these days because he's just a phenomenal human. He's a nationally ranked Olympic lifter. And the amount of; I can't remember how many kilograms he can throw up over top of his head, it's not humanly possible. Some of the things that these Olympic lifters can do.

Dr. Carol: [00:23:03] 400, 700lbs, something like that.

Kim Pittis: [00:23:06] Yeah. I was going to say, I think he's he's at like 270 kilos. So that would be about or maybe 230 kilos. That would be about 400 and something. He

was saying it looks like I have some atrophy on my left lat low trap. Like that's not possible because of what you do. But when you look at it, it does look smaller. And when you break it down and you follow the spark and you find that there was an adhesion and the subscap ulnar nerve. And again, I would have never looked for that as fast had I had not had so much history with FSM and then I verbally just spilled it out to him. I said, Your brain is never going to let you traction and rip and nerve. So it's not going to send signals there. It's going to do a phenomenal job of sending signals to every other muscle that could remotely help you balance 400lbs up over top of your head. So you're and because with his sport, he's not holding two dumbbells, he's holding one bar. So the opposite side is going to adapt and take on way more load than it needed to. I was even worried about explaining that to him because I didn't want to have that in his head as he was lifting 400lbs up over his head. Am I in balance?

Kim Pittis: [00:24:32] Working stronger.

Dr. Carol: [00:24:33] Fixed the adhesions and the subscap and retrain is lower trap and let him figure it out.

Kim Pittis: [00:24:38] And we did that in 52 minutes and still had time to reprogram his CustomCare.

Dr. Carol: [00:24:45] Don't you just love being us.

Kim Pittis: [00:24:46] Yes, so I adaptation comes in so many different shapes and sizes and I think you have to read the room. You're always you always talk about that. You have to kind of adapt every day with your patient and say, how much are you willing to let them figure out? I almost feel like you just kind of have to be there waiting for it to.

Dr. Carol: [00:25:11] And you have to honestly, you have to be willing to be wrong.

Kim Pittis: [00:25:16] You have to adapt. You have to adapt your hypothesis so much.

Dr. Carol: [00:25:21] The difference between the master and the student is that the master has failed more times than the student has even tried. I saw that in a card that I

had around someplace that's like, oh, yeah, that. So you take a chance when you tell them. And I am such a teacher, I can't help myself. It's just. It's hilarious. So I had a patient in this week that had a compression fracture at T-12, L-1, and she had this pain in her iliac crest. I talked about her last week, and it was still there, but less and it was lower down. So it went from T- 12 down to L-1. Without FSM, it would have been a pain in her groin, but it wasn't. It was 40 and 396 inflammation in the nerve and scarring and the nerve. And that went away. But her gait was off and her external rotators especially on the left were really weak. But that's because she was in 81 and 10. She has a disc in her neck that gives her left shoulder pain and that makes both of her legs tight, especially the hamstrings, the penis and the adductor brevis. So she's internally rotated in the femur and that turns down the external rotators. So treated all that. Got her facet pain gone. Got the legs quiet. Treated the tendinopathies in her knees. So she came in with knee pain. Wasn't knee pain. It was 81 and 10. The muscles were too tight. We had one machine running on torn and broken in the connective tissue at the knees. And then at the end we put her into the gym on the reformer, externally rotated her feet by ten degrees and had her exercise it. Gave her exercises for the lumbar disc. Prone. Exercises for the cervical disk. Prone. And sent her home. I'm too expensive to see. Twice a week for 4 to 6 weeks. And so I have to do a lot in a short period of time and then send them home with the CustomCare and exercises and then hope that they can adapt. Right? They can retrain themselves.

Kim Pittis: [00:28:10] And what we do with what I call wipe and load or you call like neural integration, however you want to call it, expedites that process. And I think. I've been doing this for 20 years and I've been doing training even before that. So let's just say 25 years working with exercises. And the hardest part is getting that retention, getting them to do it at home. And a lot of the times in this rehabilitative phase and the early adaptation phase, the exercises are so small and they're tedious and you have to do them to build a strong foundation so then you can build. But when you can expedite that process using a CustomCare at home and integrating them with movement and the results go faster, they can feel themselves getting stronger. Their adherence to that exercise program is exponentially better. So for the practitioners listening, if you can incorporate FSM in the phase where maybe you wouldn't think that you need FSM anymore, maybe you think, Oh, we fix their disc or we fix their labrum, and now they just need exercises. No, you're not done. You need to keep integrating that. That's going to

help the firing. That helps undo the bad adaptation or the compensation and helps just rebuild everything on a brand new slate. That, to me is what blows my hair back.

Dr. Carol: [00:29:41] Well, and the other concept that was that we used last week with the same patient was to turn off the cerebellum. It's not just re-coordinating it. It's like, wait, wait, wait. So you quiet down the midbrain and then you turn off 40 and 84. Quiet the cerebellum, just like cerebellum. You're wrong. It's going to be fine. Just chill for a few minutes. Just give us some minutes. Then you quiet down the midbrain, quiet down the cerebellum, get the patient to move. Increase secretions in the spinal cord, increase secretions in the nerve, and then turn the cerebellum back on. And the cerebellum says, Oh, wait, everything's different. Oh, I can oh I can find that now. Oh yes. It's just.

Kim Pittis: [00:30:33] Exactly. Well and that's, that's my wipe part. You have to wipe it. That's 40. Exactly. That's tearing a cerebellum. Go in time out. Take your blankie, take your pillow. Go. Nighty night for a while. We got.

Dr. Carol: [00:30:46] It. Yeah.

Kim Pittis: [00:30:47] And once you've rested and you're ready to join the group again, you're not having a temper tantrum anymore. You can participate.

Dr. Carol: [00:30:55] It's just that the cerebellum thinks it knows everything.

Kim Pittis: [00:30:58] It's like a know it all, like four year old.

Dr. Carol: [00:31:01] Yeah, it's like. Exactly. It does not negotiate and it does not notify. It's like you don't need to know that your left lower trapezius is not firing as strongly as the right one. You don't need to know that, right? You don't need to know that the reason I'm doing it is that your subscapular nerve which you didn't even know you had, was adhered to the subscapularis. You don't need to know any of that. I got this. Just I'm taking care of you. Like favorite overprotective mom.

Kim Pittis: [00:31:37] Helicopter, mom.

Dr. Carol: [00:31:39] Helicopter, cerebellum. Exactly.

Kim Pittis: [00:31:43] We have a huge, long list. We have a couple of questions. Let's pause for a second. Get to. I'm not going to.

Dr. Carol: [00:31:48] Whoa.

Kim Pittis: [00:31:49] Whoa, people. We are on a live podcast point form, please. So the first one, Anonymous, asks you, Dr. McMakin about hydration, wondering how do you stay hydrated? Are there any books, neurology, question mark, to help learn what parts of the brain do as to help with writing our own protocols?

Dr. Carol: [00:32:14] Hydration is easy. Back in the day, I had people drinking way too much water. It's four ounces an hour. That's easy. And people say, I hate drinking water. It's like, okay, you don't have to like it. You just have to drink it and you don't have to drink a lot. Four ounces is that much. That's three sips of water in an hour. Oh, how hard is that? So as you get older, your natural thirst declines, especially if you aren't drinking water. It's very paradoxical the less you drank, the less you drink. And the thirst center, I think, is in the Medulla. But I could be wrong, so don't quote me. How do you help? What parts of the brain to do so as to help you write your own protocol? Take the neuro-visceral. Take the advanced. Do not ever run 81 and 89. And other than that.

Kim Pittis: [00:33:20] Don't run frequency through the brain. We're not putting things.

Dr. Carol: [00:33:24] If you put a contact at the back of the neck and a contact on the forehead, the current follows facial planes. And one time in 25 years I had a practitioner get in trouble doing that because the patient had a skull fracture she didn't tell the practitioner about.

Kim Pittis: [00:33:41] Oh, wow.

Dr. Carol: [00:33:42] So they did this to this. A skull fracture was here. A patient had scar tissue into the sensory-motor cortex, and she had a seizure. The practitioner was terrified, very experienced, very good. She was an MD. She freaked out. I happened to be in the city they were in, and I stopped by and met with her and the patient. And I

said. To the patients, like, are you okay? Well, yeah, I used to having seizures. And so the patient wasn't freaked out. She said, I just want to know why. And I said, Show me where your skull fracture was. And it was right there. And so she had a complex sensory-motor seizure. Not sure that's what they keep changing the names of the kind of seizures. They use to be grand mal but they're not called that anymore anyway. And the practitioner was just so upset because she'd caused this thing. It's like, you didn't know. Patient didn't tell you. And the current follows fashion planes will. In this case, the current went through the scar tissue down to the dura and it happened to hit a motor locus in the sensory motor cortex. When I was 19, 18, I worked at a summer camp, Easterseals summer camp. And in the 10 to 12 to 13-year-old group.

Dr. Carol: [00:35:07] Some of them were amputees. One of them was there because she had seizures. And a lot of our campers had seizures every single day. And this was back in the day when your number one priority was to get something in their mouth so they didn't bite their tongue. Every single camp counselor had two tongue depressors with cotton and tape. White adhesive tape. We were. It was never off our body night or day. So when we were being go-go dancers at the parties, we had them in our right in your back pocket. So I'm hiking along. This girl is behind me. We're going for a walk in the woods. This girl is behind me. I heard her knee hit the ground. I had the tongue depressor out of my back pocket, had her on her side, caught her before she fell and got it into her mouth. And she had three more seizures in the two weeks she was there. So at the age of 18 or 19, I got desensitized to seizures being a big deal. Now, for some patients, they are a big deal. But so it was just you just everything you learn, everything you experience, you adapt. It goes in that matrix of information, of stuff that you know about and stuff you don't know about.

Kim Pittis: [00:36:34] Yes. Nancy. Three quick questions. Two paragraphs later, Treinen Trigeminal Neuralgia Patient has 50% improvement after about 6 to 7 FSM treatments. We suspect vascular compression on the trigeminal nerve are 20 and 39, 36 and 2062. Good logical choices.

Dr. Carol: [00:37:00] And so is 50. Mm-hmm.

Kim Pittis: [00:37:04] And do you want to translate 20 and 20 pressure?

Dr. Carol: [00:37:09] Yeah. 20 is pressure on the nerve and pressure in the artery. The reason that they're suspecting vascular compression on the trigeminal nerve is that is one of the favorite surgeries for trigeminal neuralgia, is they actually go in and do something weird to the blood vessel where it runs right next to the nerve. And I only see the failures for that procedure. So that's not my favorite. But I'd give her a Sudafed. If you think the blood vessels are congested, try 50 and 62 and 162 because the trigeminal nerve is really tiny. So that's got to be a capillary rather than a nerve.

Kim Pittis: [00:37:55] Her second question was about a knee. Patient had total knee replacement with artificial joint eight months ago. She has 8 to 9 inch long semicircular incision. We've been able to use FSM to help reduce swelling, pain and scarring. However, FSM has not improved with repeated 13, 51,9, so those are the scarring protocols with various tissues. They've tried Abram's as well. Her max range is about 90 degrees. Could there be a malfunction with the joint? Her surgeon says no such thing.

Dr. Carol: [00:38:30] I would go with metallic toxin in the bone marrow in the tibial portion of the implant or the femoral portion of the implant. If she's allergic to the metal, that's a possibility.

Kim Pittis: [00:38:50] For me, being physical medicine, I'm asking now first, is it a tightness? Is it passively unable to go further or is it a weakness she won't bring it further. So not all range of motion is equal. So that would be my my kind of follow up. Is it a strength or is it an actual, the joint just can't move.

Dr. Carol: [00:39:10] Yeah. And knee replacements are incredibly complex. The surgeon's comment is hilarious. Hip replacements have been around for a really long time. And even then prior to the surgery, they measured the angle, the length of the femoral neck, the angle that it's at. And they've got all different sizes the size of the ball, the size of the socket. The hardware is really refined. The knee is ten times more complicated than the hip. Because of the curved. You've got four curved surfaces. And plus side angulation. So bagless and various. There's just so much with the hardware. And these patients who get stuck at 90 degrees. Your question is, is it active or passive? I've had, we both had patients who had manipulation under anesthesia to break up the adhesions. Those are universally disastrous, but they keep doing them.

Adhesions in the nerve. And I'm assuming that you've done that. What, about 81 and 10?

Kim Pittis: [00:40:43] That's what I was thinking.

Dr. Carol: [00:40:45] So I have never done that.

Kim Pittis: [00:40:47] I haven't but I think it's funny. That was exactly what I was thinking. When I first started thinking, increase in the secretions of vitality and then I went back up. It's not happening in the knee. It's probably happening up higher, maybe? Worth a shot, 81 and 10.

Dr. Carol: [00:41:01] Since you've been bashing on the knee for six weeks. 8 to 9-inch long semi-circular incision. That's really long for a knee replacement. That's not what I'm used to.

Kim Pittis: [00:41:26] The component of the question. Bell's Palsy patient has not improved after four treatments. We've used 40, 13, 81 and 49. I'll translate inflammation, scarring, increasing secretions and vitality to the nerve. They've also run virus. They've also run torn and broken in the nerve for 45 minutes. Any suggestions? Bell's Palsy.

Dr. Carol: [00:41:49] It really depends on how long the Bell's Palsy has been in place. So Bell's Palsy, that is a month old or even two weeks old, but the patient is already on steroids. Those have responded really well. Bell's Palsy, that is. Two years old. I'm four years old. 12 years old. I've never had any luck with. And that's in part because you can't get at. The nerve nucleus. So spinal nerves are kind of easy, reversing atrophy in the hand or foot drop. That's easy because the nucleus, that nerve, you can get at it in the spinal cord and then to the periphery, the nucleus for the facial nerve is in the skull, in the brain. So you could try the pons. Because that's -7. -7 is still on the Medulla or is it up in the pond? I don't know. -10, -11, -12. So I think seven. -5, -6, -7, -8. Those are all up higher. They might be in the ponds. You could try 81 on the ponds and see if that helps.

Kim Pittis: [00:43:24] Jane writes a long comment that says "Patient's letter and your heartfelt response to her story bring to mind that post-COVID long hauler client that I've been working with since June of last year. Lost her voice and ability to swallow shallow breathing, poor digestion decreased circulation. Recently, her progress has improved as I started applying emotional factors. So the 1970s that we use various effective tissues like nerves, fascia, muscles throughout her mouth, throat, torso. I realize that she's likely developed what might be diagnosed as PTSD, as the fear of never recovering. Anger, resentment of her situation grew. Yes. And all the symptoms that we've had in place for a full year before she came to me or already been began running specific frequency combinations for each of those emotions that I mentioned. And her grief, constant crying, has diminished. But it was just an impulse that made me think of applying the 1970s. So thank you for reading the letter.

Dr. Carol: [00:44:26] Yes, that's the other thing you need to think about is all of the problems that she has, including the emotional stuff, is vagal. Every single symptom you listed was dysfunction. Lack of function in the Vagus. The Vagus is turned off by infection, stress and trauma. So the thing you do every single time you see her is take those six or seven virus frequencies and run them in the Vegas and run vagal tone plus those viruses from the neck to the pubic bone.

Kim Pittis: [00:45:10] She says she's treating Vegas every session.

Dr. Carol: [00:45:12] Every single surgery.

Kim Pittis: [00:45:14] Yeah, that's it. Yeah. She says she has been great.

Dr. Carol: [00:45:17] Good, cool. Great. Then you already did that then. The 1970s are absolutely brilliant because there's a there's the next phase is; and I finally think I'm ready to write the second book, because there is the phases of grief. We're all familiar with that. But there's phases of healing. When you get to the point where you've been ill or disabled for a period of time, and then you start getting better and it's even worse when you get better in 60 minutes, that's just disorienting. What are the stages? Well, my experience is just anger, resentment, anger that you had to go through this resentment for the doctors that told you you were crazy and it was all in your head and they couldn't do anything and it wasn't real anyway. And if it was real, it was your fault

and not their fault that they didn't have a drug for it. So there's anger and resentment and then, well, fear. That is going to come back. 27 is kind of a colon yang sort of fear. Yin sort of fears like worry over concern, and then grief. And it's the same way we treat emotions all the time. But I think your idea of running 970 and helping them through that phase. And if you're running vagal tone every time, then every time you're also running 40 and 89. The emotions of healing. That's a good title for a chapter.

Kim Pittis: [00:47:08] Woo! I like it.

Dr. Carol: [00:47:10] Yeah, it's. And it's something really nobody else has to think about.

Kim Pittis: [00:47:15] No, no. Jane brought in here. She. She was told that she had ALS, and it would only get worse.

Dr. Carol: [00:47:26] Huh? Without an MRI, with contrast and a spinal tap, somebody told her she had ALS. Wow. Okay.

Kim Pittis: [00:47:39] We have more to talk about. We have two more questions here. I'm going to go with the bottom one really quickly because this one is going to be fast. This morning my son said the moon makes my legs sick. We've been dealing with what I guess are growing pains seem to be worse at night. Any advice for growing pains in a four-year-old? Yes, it's easy. You first.

Kim Pittis: [00:48:02] Growth. I have teenagers. I see young athletes. Growth is torn and broken. It is 124 on everything that hurts. A lot of times the physical plates open first the soft tissues like now. So their muscles and nerves hurt because their skeletons are growing faster than the tissue can keep up with so torn and broken in the periosteum torn and broken in the nerve turning broken in the fascia. Those are your first three favorites.

Dr. Carol: [00:48:29] 77.

Kim Pittis: [00:48:30] Yes, and 77. So that's the connective tissue. Those are your four big ones. You can run 40 in 33, 96. People do that, but you're circling the drain. The

cause, the reason why people are in pain when they're growing is because they're growing and it's stretching and it's pulling everything apart. It's literally torn and broken. So 124 that will help. And you can put the leads in the with kids. When my kids were little babies, the best time to treat them with FSM is in the tub in my opinion. So plunk the leads in the tub, especially splashy or at nighttime.

Dr. Carol: [00:49:11] And the way to decide what tissue to run is to ask him, show me where your knee hurts. Yeah. And then put your finger where his fingers are. And it's pretty likely to be connective tissue and periosteum. And then if treating him three days a week because kids take baths almost every night because it's a good way to kill time and quiet them down before they go to bed, if treating them three days a week for two weeks doesn't fix it, you get an x ray. Just to make sure it's not any of the things that it shouldn't be. Right. I order probably more negative imaging than anybody because there's never a negative image. Insurance companies don't want to pay for negative images because you're supposed to know somehow that it's there before you order the image. And it's like when you order an image, you find out the six really bad things it's not. Right?

Kim Pittis: [00:50:09] Right. Yeah. No. No harm in that. And like my case study at the Advanced where everybody was telling this 11-year old that it was growing pains. And it's not growing pains because growing pains don't last for two years on one foot.

Dr. Carol: [00:50:24] Exactly.

Kim Pittis: [00:50:25] Just saying so whenever it doesn't seem normal. Follow that.

Dr. Carol: [00:50:30] You got it.

Kim Pittis: [00:50:32] Last question before we continue on our list. "Hi, Carol and Kim. Wondering when treating fibro noncervical trauma and I've run 40 and 10 neck to feet and have only had 40-minute timeslot with improved sleep, but no change in pain. Symptoms started at 14 when her brother scraped foot and a door and glandular fever two years later. She now is a brain nodes on hands and feet. The wind hurts when it touches her skin. Constant headache. Global Hypermobility. Oh, I have to read anymore. Number one goal physio is headaches to stop. Next appointment with her is 2

hours and just way over my head wondering suggestions on how to layer this with our next sessions. 124/77? Dura? Thanks heaps. Yes. 124 because we think it is...

[00:51:31] Ding, ding, ding, ding, Ehlers-Danlos or A. Yeah. And then the thing with glandular fever. So her brother scraped her foot in the door, I'm assuming. So she got a cut on her front foot. And then glandular fever is mononucleosis in Australia. They call it glandular fever because it makes your lymph nodes swell. So. If she's hypermobile, you've got 124 and 77. Usually, 40 and 10 does something, but it maybe wasn't enough. So 124 and 77 and concussion in Vegas because glandular fever is going to turn the Vagus down or off and that's going to make her gut weak and affect your microbiome. And so it could be a combination because every Ehlers-Danlos patient has digestive dysfunction, because the Vagus is constantly being turned off. So. One of the other kinds of fibromyalgia. So, Mattie, if you get the fibromyalgia workshop, one of the other kinds is just food sensitivities which are macrophage mediated. And the macrophages are controlled by the Vagus and they're controlled by the small intestine leaking and freaking out the immune system. So you're on the right track, I think 124 and 77. Treat the Vagus, treat leaky gut depends on how many machines you have. Oh, by the way, sorry. Lane change squirrel. Okay. David Suzuki and Microcurrent Technologies. The people that make the CustomCare and the PrecisionCare have persisted and completely converted their quality system to the new standard. And they have met the criteria for like there's eight, six or eight companies in the country in the United States. That have met this MD-SAP criteria. We just did it. Yes. Nice. That means that as soon as he gets a certificate, it really depends on how weird the TGA and Health Canada are going to be as to what it takes for them to get their certificate from those two countries. So now you meet the requirements, then you send that to Canada, Health Canada and the TGA in Australia. But we did it and I'm just so proud.

Kim Pittis: [00:54:13] That's exciting. I love our devices. Just to follow up on that really fast, I've been talking about the whole hip utensil back and forth I've had with the psoas release person. So, so one of my patients.

Dr. Carol: [00:54:30] That person has continued the conversation with you?

Kim Pittis: [00:54:33] Yeah. So it gets better. One of the patients that I have listens to our podcast and she was laughing about the hip utensil and this patient actually saw

that practitioner because that person, that practitioner is a PT not too far from me here in the Bay Area.

Dr. Carol: [00:54:56] So sorry.

Kim Pittis: [00:54:57] And I, I kind of made a comment that anybody worth their salt would be, if you were that good as a practitioner, you wouldn't resort to selling these utensils to make a buck because you'd be good at what you did.

Dr. Carol: [00:55:15] Running down the gantlet.

Kim Pittis: [00:55:16] I did. And but I stand by it, you know. And that person wrote to me, Well, you're doing the same thing, selling your quackery devices. So I just want to I just want to I want to use this platform to say, no, we're not Amazon and we don't. Sell these. We are helping educate people on how to use FSM. The frequencies are not proprietary. There is nothing secretive. There is nothing. We give all the information to our patients. So it is a tool to help them heal, not to make them worse and create more microtrauma. And what I'm going to say.

Dr. Carol: [00:55:59] We don't sell devices to people who have not been trained.

Kim Pittis: [00:56:03] So absolutely. That's the biggest thing. We're not Amazon.

Dr. Carol: [00:56:07] Yeah. And one practitioner has to treat the patient to know what they need on their CustomCare. The other thing is I'd really like to hear from that practitioner how many published papers and textbooks there are in the use of that device.

Kim Pittis: [00:56:25] You know, I think maybe this summer. Well, I'll have that person on our podcast. Maybe.

Dr. Carol: [00:56:30] Oh, no. Oh, mud wrestling 2.0.

Kim Pittis: [00:56:37] No, but you're right. You're right. There's exactly. I'd love to see the paper on that, too. Just one paper would be great.

Dr. Carol: [00:56:44] Well, and David was using a Thericane on his QLs and is so hours every single night like the father of Trigger Points was sitting there mashing on his QLs every single night for eight or ten years. Yes. And I got all the trigger points gone in about 30 minutes by tweeting the diss and facets. Now, you think that it would have occurred to him that if this device was working. That the trigger points in the QLs and the psoas would go away at some point if it was actually effective. Just saying.

Kim Pittis: [00:57:25] This is good, critical thinking. One last question. I have one more question for you. So the last question here, we say we recently discovered our four-year-old has rapid resting heart rate, 120 to 140. We have a cardiac appointment four weeks away. His mom has tachycardia caused by dysautonomias Vagus issues diagnosed by autonomic neurologist after car accident. Just wondering if little guys could have Vagus issues too.

Dr. Carol: [00:57:51] Oh, you think they have a vagus nerve? They had an auto accident and the nucleus for the Vagus, the two nuclei for the Vagus are in the medulla. So when you have an auto accident, even if the little guy is in a car seat, he's still going to do this. So run concussion and Vagus, run vagal tone from his neck to his tummy.

Kim Pittis: [00:58:14] Child was not in the accident.

Dr. Carol: [00:58:16] Child. Wait. The child was not in the accident? Well, who's anonymous and who's Dana?

Kim Pittis: [00:58:22] Probably the same person.

Dr. Carol: [00:58:24] They are the same person.

Kim Pittis: [00:58:25] Maybe.

Dr. Carol: [00:58:27] But. Oh, Mom had the car accident.

Kim Pittis: [00:58:31] Yeah, child did not.

Dr. Carol: [00:58:32] Little guys have Vagus issues too. If a four-year-old has a resting heartbeat of 120 to 140, I'd run vagal tone on him and see what happens because the only thing they do for rapid heartbeat is put them on metoprolol. And doing that to a four-year-old, there's no studies that I know about on pediatric use of metoprolol. I haven't actually checked, but, there's that. So you run the Vagus, put a pulse oximeter on and run the Vagus and see what happens. Can't hurt him. If his pulse needs to be that fast because of some cardiac anomaly. The running vagal tone isn't going to be able to override it.

Kim Pittis: [00:59:21] Right.

Dr. Carol: [00:59:22] Can't hurt. Might help. That's right. Okay.

Kim Pittis: [00:59:26] Well, we have one last question. That's my question to you. So some of our biggest, greatest feedback where when we do like the gratitude podcasts and we talk about things that are kind of like FSM, but not really. So I was going through all these questions that I had from one of our first, I think it was the first podcast, because I'm trying to. I know, I know. How is that even possible? How are we still just running out of time, hour after week after week to it's this crazy. So as I'm compiling the questions and making sure we're not like losing some of the great ones that we get, I came across one that I jotted down to ask you and. I think it's a great one. So a lot of times we love doing what we're good at. Right. But what do you love doing that you're not good at? Oh, and I love your face. So that's another thing, too. I'm patient. That's like, I love listening to you guys on the podcast, but half the time I have to go back and watch it on YouTube because you guys are like, Oh, that's a good face. That's a good face. So I have to see your faces good at. Right. Isn't that a good one? Because normally we love doing what we're good at.

Dr. Carol: [01:00:51] Oh, there's so many things I'm not good at. I'm trying to pick which ones.

Kim Pittis: [01:00:56] What would be your favorite?

Dr. Carol: [01:00:57] Like balancing a checkbook? My Gabba score was a seven. I struggled for four or five years, I got it up to 20. So Gaba is the detail-oriented like to

make lists. Things still didn't make me good at balancing a checkbook, so I hire somebody for $100 a month and she saves me from having to balance the checkbook. Why would you waste time doing something you really hate and you're not good at?

Kim Pittis: [01:01:26] Right.

Dr. Carol: [01:01:27] Right. Cooking. I'm not very good at that. But I can broil a barbecue lamb chop and make a salad. That's good enough.

Kim Pittis: [01:01:36] And you like it? That brings you joy.

Dr. Carol: [01:01:38] There you go. And broccoli is a good thing. I don't quite know. Well, there are there is a thing. There are things I'm really not good at. And I have decided over time that. So trivial conversation. Can't get it done. Just I tried. It is really hard to have a trivial conversation with somebody with a, no, just I... I can be pleasant. I can be polite. How interesting. And then I go find somebody I can talk to. Even if it's only once a year in February or Wednesday from 4 to 5. It's like, I don't know. I guess I tend to avoid things I'm really, really not good at.

Kim Pittis: [01:02:35] Right. I think that's I think that's normal.

Dr. Carol: [01:02:38] To try to learn how to play the guitar. And I finally decided that John Denver makes it look easy, but it's not. And lecturing. I'm really good at that. I make it easy and.

Kim Pittis: [01:02:52] And you love it though so that goes hand in hand.

Dr. Carol: [01:02:55] And I make it look easy. And I finally figured out it's not by watching people who aren't good at it. It's like, Oh, that is the thing.

Kim Pittis: [01:03:04] I'm going to say. My thing that I love doing is riding horses and I'm not good at it.

Dr. Carol: [01:03:09] And you what?

Kim Pittis: [01:03:10] I'm not good at it, but I love it. Oh, and I try.

Dr. Carol: [01:03:14] But it's teachable.

Kim Pittis: [01:03:18] Yeah. Right. And I say that about running, too. Like, I say, like, I'm not a great runner, but I love running. So these are all things that, yes, I aspire to get better at.

Dr. Carol: [01:03:27] So I love riding horses. And when I was in writing, I went to a British riding school in San Jose when I was 16, 17. And when I was about 19, I went and took a lesson from a German writing master. My lesson was on his dressage mare, who was notoriously hard to ride. And she and I had a lovely collaboration and he just sat there and watched me for 10 minutes as I just rode his merita trot around the arena. And the best compliment I've ever had ever from anybody was, yeah, someone taught you to ride. And so you're never and I watched people riding dressage in the Olympics and you can't see them move. No. And their horses do magic things. I will never be that good. But it's really fun to love something that you're never going to be perfect at.

Kim Pittis: [01:04:37] Oh, that's a beautiful closing statement, because that is what we do with FSM.

Dr. Carol: [01:04:43] Going to be perfect, right?

Kim Pittis: [01:04:45] No. But when you love it and it's good enough, that's all you need.

Dr. Carol: [01:04:52] And it's something you can continually grow and love and do.

Kim Pittis: [01:04:56] Yes. Thank you.

Dr. Carol: [01:05:00] That was fun. Is it really 5:00 already?

Kim Pittis: [01:05:02] It is. It's after five. I have had alarms going off for 4 minutes, so we'll save it all till next time. We're going to keep going on. April is going to be adaptation month, I think, because there's a lot we can still talk about.

Dr. Carol: [01:05:15] And how about. Blossoming month.

Kim Pittis: [01:05:20] Ooh, I love it. It's springtime, it's spring.

Dr. Carol: [01:05:23] And it's new growth and blossoming and developing.

Kim Pittis: [01:05:27] And let's do that.

Dr. Carol: [01:05:29] And actually, after adapting, because all of those plants and trees had to adapt to survive the winter. And now. I don't know. You'll figure it out. You do every week. I just.

Kim Pittis: [01:05:45] You just jump on the bus with me and go for a ride, okay? All right, everybody. See you all next week.

Dr. Carol: [01:05:53] See you next time.

Kim Pittis: [01:05:55] Bye

Dr. Carol: [01:05:56] Bye.