

# Episode Forty-Seven - Head Shoulders Knees and Toes

Carolyn McMakin, MA, DC

Kim Pittis, LCSP, (PHYS), MT

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[00:00:04] Hello. You are muted.

[00:00:06] Yes. Now, I'm not.

[00:00:08] You're not anymore.

[00:00:09] You're cool. Microphone. That fuzzy thing.

[00:00:12] Normally it's out of the shot.

[00:00:17] You have two microphones?

[00:00:20] I Do.

[00:00:21] I'm impressed.

[00:00:23] Well, I just. I'm always worried something's going to fail.

[00:00:28] I'm never worried because Kevin does all that worrying I have.

[00:00:33] When you don't have a Kevin. You have multiple microphones and all the things.

[00:00:39] All the things. Kevin need to move her. I have to drag you up here. Oh, good. You just. And then. I have to go up there. There we go. We're playing video screen Tetris.

[00:00:51] Yeah, because you have to be on top otherwise, like, it looks weird.

[00:00:55] Okay, so we have a new shirt. I have to do. I have to show. Show. So Kevin had these made for the clinic. There's stitched, nice stitching. But then this is the cool part. Can you see the back?

[00:01:08] Well, the podcast are people are listening, so I'm going to do a verbal description. So Dr. McMakin, as you can see, is wearing a very nice Blue shirt with multiple colors stitched in. FSM as in our FSM blue and there's like a limey greeny yellowy "S" and a purple "M" with our Dr. McMakin waveform in red underneath.

[00:01:34] But look at the back.

[00:01:37] The back says there is hope here. So nice.

[00:01:44] Isn't that cool?

[00:01:46] Very well done.

[00:01:48] Yeah. Which leads us into today's topic of we're ready to do that.

[00:01:53] We have a couple of different topics today.

[00:01:56] Imagine my surprise.

[00:01:58] When I have to put my foot down, because otherwise you're going to take the train, you're going to take it everywhere.

[00:02:02] So you drive the train.

[00:02:05] Well, you know, it just seems like I'm the conductor. You actually just we'll start with your stuff. But you had texted me just now something very near and dear to my heart that I am not going to be able to shut up about because I could do hours on this topic. So we'll start with your stuff and then we'll get into it because I actually have a

bunch of information, really cool information to back up what we're going to talk about like studies and data.

[00:02:32] Stuff slight and we're talking about METH.

[00:02:35] We are talking about METH, not methamphetamines. Folks, settle down.

[00:02:39] This is M Capital E, capital T, capital H.

[00:02:45] Right.

[00:02:45] So coming through the airport from wherever.

[00:02:51] You are in Poland, I think. No, no. Italy.

[00:02:54] Philadelphia.

[00:02:55] Oh, just recently. Yes.

[00:02:56] Oh, yeah. Coming through the airport, I was hauling my briefcase and got it behind me. And I was in wheelchairs for various reasons. And I'm hauling it behind me. And that night my arm got really, really sore and I couldn't lift it without lifting it with my left arm. And I went, Oh, this is bad. So I get home Monday night and Monday afternoon and ordered an MRI. For Tuesday and got the results back and based on the ranges of motion that hurt. I knew which tendons were strained. And the nice lady at the MRI place said, Have you had physical therapy or have you have PT or something else. And I said, Are you kidding? I'm not going to let anybody touch the shoulder until I find out if there's a complete tear or if it's partial. And what I did to the labrum because it. Anyway, so I sent you the MRI report. And basically I have partial thickness tears in every single every, every shoulder muscle. And there are some of the nurses that have an opinion and some of the periosteum has been... It's not good.

[00:04:38] So I. Monday night I programmed my CustomCare for torn and broken on the round. Tendons because I knew the supraspinatus was nasty. And then everything else is flat. And the biceps was really obnoxious because I could not lift my arm forward. So.

Remembering mass movement elevation. The nice thing with the shoulders, it's automatically elevated and his traction and "H" is heat, which I thought would feel really good. But I didn't do any heat until like last night when I just moved my heating pad over. So I've been running this with sticky pads, it's a two-hour program and I run it and I can tell it's time to run it again. When the pain comes back. Pain level varies between a four and a seven. Two Advil in the morning, and I haven't taken that since 2006. And I just want to do show and tell because this is what METH does. I should not. And then my supraspinatus You don't want to know about What the MRI says, but according to the MRI, this is not possible. And then there's that. Can you see?

[00:06:18] We can see my hand.

[00:06:21] This is better. Earlier today, this really hurt. You have to have a conversation with that muscle. But I just keep running it. If you read the report, you did you read the MRI report. And none of what I just did is possible. Cannot be done with... We're three days post. And go.

[00:07:00] Okay, you might just fasten your seat belts and bear with me, because a lot of people listening are. This whole conversation is going to make them uncomfortable because ice has been the gold standard. Go to first line of treatment for any kind of injury forever. We used to say, you know, RICE, right? That was Rest, Ice, Compression, Elevation. So we're still loving elevation because, duh, we want to take information away from the site. So if our arm is sprained, anything above the level of the heart, it's going to bring that blood flow down. The rest component we're getting rid of also because rest means immobilization. We have gotten away from that for 20, 30 years.

[00:07:52] So could I put in the fact that it never worked didn't seem to bother anybody until about five years ago.

[00:08:01] Right.

[00:08:02] Thank you.

[00:08:02] Well, so it's funny. So the term RICE came from a gentleman by the name of Gabe Merkin, and he coined this term in the seventies. So that tells you how long ago this was. And even he himself has gotten away from using ice and is now on using heat in clinical settings. Now, I know you think heat is going to make inflammation worse, and it doesn't, especially when you are [00:08:34] icing [00:08:35] the right areas. So when you are I mean, when you're heating up the right areas. So when you have a muscle or connective tissue that has an injury. And. You need inflammation. I'm going to talk about this in a recovery setting just in just a minute. You need that initial proinflammatory response within measure because it is bringing. The important line of defense that's going to come clean it up and take it away. So there are two newly published papers, one in the Journal of Applied Physiology, the other in the Journal of Strength and Conditioning. Proving getting away from using ice is helping recovery. I'm going to keep talking until you shut up and just put me on mute, just so I'm just saying.

[00:09:31] I'm just going to say that heat causes vasodilation and that causes increased circulation. And in the circulation, all these wonderful little white blood cells that do their little munchie cleaning thing. And oxygen. Oxygen is good.

[00:09:48] Yes. So I'm going to actually, I just have to I had to write down notes because as soon as you said that you were going to we want to talk about METH. I kind of went crazy.

[00:09:59] And how did you look up these papers that fast?

[00:10:02] I didn't have to look them up because I cited them on the talk that I gave at the Advanced. You know, you make me do this hacks talk every two years. And so the 2022 hacks talk was about using... Getting away from using ice baths because that seems to be one of the favorite go-tos in professional locker rooms. All my triathletes love it. And it's terrible. So the Journal of Applied Physiology, it was in 2021. So a very, very new cool study had mice and I called it ice the mice. So they had, let me just see how many of my story. I believe there were 30. Now there's 40 mice.

[00:10:48] Like real rodents.

[00:10:49] Mice like real legit mice. Yes. So we used 40 of them. Hang on. Let me just exit this full screen so I can see it. No, exit the full screen. Anyways, they use these 40 mice and they gave them STEM. And that's great. Stem is wonderful. So they stemmed their legs and then they took half of them and they ice them. They ice the mice. I don't know how you put little I had this little vision of like little ice cubes on this poor little mice and.

[00:11:21] Part of the mice when you took them into a glass of iced tea or something.

[00:11:25] Something like that. Right. So they iceD, half of these mice, and then they did nothing and use a little bit of heat to the other half of the mice. And they did samples every. I think every 24 hours they did inflammatory samples. As you would imagine, the iceD mice had very low inflammation right after they were iced. However, on day three, they were not recovering as fast as the mice that did that did not receive the ice that were left alone or had a little bit of heat applied to them. Why? Like you just said, after you have, especially in activity or even with hypertrophic changes. So when you're bodybuilding and those muscle fibers are tearing apart and rebuilding to get bigger, you need a certain level of inflammation that's going to come in, build it, have those little munchie things, and then get it going in circulation again. Using heat can really help that. And you can even use heat away from a joint. So I know there's still some people that are listening, rolling their eyes going, okay, this is crazy stuff. You might not want to heat up a joint, but you can heat up a muscle belly away from the joint because the same thing is going to happen. The inflammation is going to chase the heat and draw it out of the joint. Yes, hand goes up go.

[00:12:53] So here's the other piece of it. None of the program that I am running is 40.

[00:13:02] Right?

[00:13:03] The whole program is 124, broken. So every, every cell has genes that can turn on and create inflammation, but they turn on and create inflammation when the cell or the tissue is injured. Especially tendons. So Diana Cross's presentation from '17 probably on tendinopathies, which is what I have in this shoulder. When the tennissite cell, when the cell body detects that there are tears in the tendon that can't be repaired in 24 hours, that's why my shoulder didn't hurt Monday night when I came home. But by

Tuesday morning, I was a mess. And when it senses that there's injury, the cell starts to express the genes that release inflammatory cytokines, substance-P and CGRP, which are all peptides that produce pain and inflammation. So my shoulder is not inflamed, it's torn and broken and you could reduce inflammation all you wanted and it's not going to repair any faster. Right? So it's torn and broken in our world.

[00:14:45] And when you add ice to an area, again, you, just said that you need rich blood flow to come in and help heal the torn and broken. You need to get the inflammation stuff out of your mind. I do want to mention two books for people who don't believe me. They'll probably believe you before me, but there is some cool data besides those two studies and you can just google those. The man who coined the term METH, he's a Canadian, so I love him just because of that. His name is John Paul and I always butcher his last name. It's Catanzaro or Captinzero, C-A-T-A-N-Z-A-R-O. He coined the term METH movement, elevation, traction and heat. He has a lot of very cool data. I believe he named it that after reading a book by the name of Don't Ice, that ankle sprain written by Dick Hartzell that also is chock full of amazing data on just how bad ice can be for an area. And then the last, but not least, a book called ICE The Illusionary Treatment Option by Gary Raynal.

[00:16:00] These are great titles.

[00:16:01] Yeah, right. So these guys have had some amazing. They're the pioneers on METH or using heat and movement. I think we can all agree we're definitely casting and splinting far less than we ever used to. I mean, we do need a little bit of immobilization here and there, but the data has been the proof has been in the pudding for the last 20 years that we need movement to heal. And why do we need movement to heal? Because, again, it brings blood flow and circulation. And this is why I love the hypoxia frequency, because it can go in and really help change the game on that tissue that has been scarred and it hasn't moved and it's not getting the blood flow that it needs.

[00:16:45] So and there's data going back, I think. I want to say it's the seventies, eighties, because it was before I even went back to school. If you take a perfectly normal bunny rabbit, sorry. Perfectly normal bunny rabbit leg and you put it in a cast so that it doesn't move in four weeks, that joint will have arthritis. Joints have to move. And so that part of the Core where we talk about where the bone spurs come from? Bone

spurs come from tight muscles. Where are the muscles tight? Well, because the joints inflamed or there's a disc bulge and the muscles pull, really, the muscles get really tight to immobilize the joint because that's what the cerebellum tells them to do. And when the muscles are really tight, they pull on the periosteum and the periosteum says, Oh my God, we should calcify this. And so you have a bone spur, the bone spurs. Not the problem in this MRI, there's a bone spur here. Well, duh. This is. The muscles been tight for a really long time because my left arm was broken in six places and my right arm has been doing all the lifting in the work. And as soon as we get it fixed, it's going to go back to doing that. It does that. That's not possible. Anyway. So movement in a pain-free range.

[00:18:33] This reminds me of like when my kids used to make snowmen in Canada and we're just kind of rolling this ball around and around and around. You really just hit the nail on the head movement in a pain-free range, because if you have an athlete that blows through the stop signs because they just have to get that movement because they have to get the ball or the puck, they're going to do the movement. Your patients are going to do the movement, especially that type that doesn't have the time to deal with an injury. So it's not just athletes. These are moms. These are CEOs that can't take a day off. These are police officers and firefighters and all those people. When you're blowing through the stop signs and the muscle that causes pain is in pain and it's going to shut down what's going to happen. Three other muscles are going to chime in and then you're getting this whole compensatory.

[00:19:31] Or even worse, even worse than the patients that do it to themselves are the... No offense to the good physical therapists out there. Are the physical therapists that says, oh, yes, you have to do that movement to that range with that weight, even if it hurts.

[00:19:52] See, I wasn't even ready to go in that direction.

[00:19:55] Well, you know, wait till you're 70 and then the mouth just, like, takes off. So eventually this is going to segue to that other condition we were talking about before we get off on this. But we're not finished. You keep talking. Your brains can explode if you don't get this all out.

[00:20:13] No, most of it. Most of it is out. But I think and because we are, I think, getting better and better all the time at having people do critical thinking. This should make sense. It should make sense to apply heat and improve circulation and pliability. These are all words that we have frequencies for also. So we're not we're not doing one or the other. And that's the reason why I love using hot towels in the clinic. And that's the reason why I've got multiple towel warmers and a lot of towels for people and I switch them out all the time to keep it warm. yes, it makes people feel comfortable to have a warm towel on them, but it's 100 degrees here in California. They don't need the warm towel. I'll keep my clinic nice and toasty. But it is bringing it is helping FSM because it's warm and it's vascularized and we're bringing good energy and good blood flow to an injured site. It's not about inflammation.

[00:21:17] And the other thing that FSM does. In conventional medical wound healing. I'm not sure about tendons, but conventional medical wound healing. I talked to a wound care physician that had to be there early, 2000s and I wanted him to do a study on FSM and wound care and he said, well, what does FSM do? I said, it reduces inflammation and it increases ATP. And he said, just stop right there. Because the science says that the natural progression of wound healing is inflammation goes up and the tissue disruption caused ATP to go down. And I said, yes, but we are doubling or tripling the rate of healing by reducing inflammation and increasing ATP with just the current. That doesn't even take into account what we do with 124. And we weren't even at 124 in 2000 when I saw this guy. And he was just like, he couldn't go there. And I said, I just need to do the study. Bunnies, people. I don't care. Give me five people. I'll do. I'll do a pilot for you. Nope. Wouldn't talk. So the fact that we increase ATP, reduce inflammation by either treating the inflammation itself or treating the cause of the information, which, in the case of my shoulder is 124 torn and broken. The only reason it's inflamed is that it's torn and broken. Right. And that's everybody that's listening. I need you to come with me through cellular genetics. Are we ready? So there's this little receptor on the outside of the cell, and it's connected to kinases that are connected to something else, that's connected to the DNA, that's connected to the messenger RNA, that's connected to the micro RNA, which is what makes the cell produce whatever it's going to produce, whether it's bile or inflammatory peptides.

[00:23:42] So this little receptor. Senses tissue fragments so camps or pathogen-associated molecular patterns and DAMPS, Damage Associated Molecular Patterns.

Damages associated molecular patterns or tissue fragments. So the tissue gets torn. Tissue fragments floats by lands on the receptor, the receptor changes, its configuration, changes the kinase is that change the whatever is next on that list, that changes the DNA, that changes the messenger RNA, that changes the micro RNA and that creates inflammation. And inflammation in the form of CGRP, interleukin one, and substance P and every cell in the body has that same capacity. And so treating the inflammation kind of doesn't make any sense because you're treating the end product, not the cause. Pathogen associated. That's why somebody has belly pain and what they have is appendicitis. The way, you know, that is you treat inflammation and the appendix and the pain goes up. You treat infection in the appendix, the pain goes down and you tell your person that you're treating. You need to go to urgent care because you have appendicitis. How do you know that? Same thing with shoulder.

[00:25:31] Yeah, exactly. Pain is there for a reason, right? It alerts us that there's a problem. And if we're just throwing ice to numb something, that is wrong, people.

[00:25:49] Well, tell us what you really think Kim.

[00:25:52] I'm hanging out with you too many Wednesdays because now I'm getting a lot more. I used to be a lot more Canadian about my approaches, but I do feel very strongly about using heat. Obviously, we're not throwing ice away for everything, but even post-surgical. I went toe to toe with my daughter who had ACL. I had one of my daughters had ankle surgery last year. She had a fusion in her talus and they wanted to put ice on her in PACU. I said, No, you're going to put this machine on her instead. Thank you. They listen to me. Same with the ICE.

[00:26:34] I might look cute, but I can be. When it comes to my children, I get a little mama bear. Even my daughter with her knee, with ACL surgery, no ice. We just used FSM and heated up the quad and the hamstring that had. It was a semi-tendonosis reconstruction so that hamstring isent inflamed. It was literally the semi tendonosis was torn. They drilled into a bone. Yes, it's inflamed. But because there was all the torn and broken in the surgery.

[00:27:08] It makes me so happy. It's like I see like now I don't feel so bad about how excited I get because it's like, oh, look, Kim did that. Yay.

[00:27:18] Right? So there's a reason why both of my kids are. We're not out of the woods yet with the ACL, but she's far ahead. And I'm not just going to blame it because of ice, but.

[00:27:32] I have one. Speaking of knees. So lateral thinking patient had knee surgery. Now he has hip pain and he points and they say, yes, trochanter bursitis in the same leg that, that's a good face, in the same leg that he had the knee surgery in. And he grabs the wad that is the glute-minor and the attachment of the performance. And at the trochanter. And then it grabs the muscle. And he said, that's what hurts. And I went. They've been treating the bursts and it didn't help. And I said, Do they think that trochanter bursitis comes from space?

[00:28:29] He had knee surgery. All right. So understanding the process of what they do in the O.R., if you have knee surgery. The first thing they did was. Inexcusable. They did a femoral nerve block without putting him out. That's a good face. He was awake for it. And then I said, okay, well then there's bleeding. You said, No, they just did it to the nerves. It's nerve artery vein lymph. And the femoral artery at that point is about the size of your index finger and the femoral nerve is a little bit smaller, but it's right next. And it's really easy to have the artery just right under the nerve. And all you have to do is nicked the artery and you've got a little bit of whatever. So but before I did that. I just reached up and grabbed his abductor. The little short one, brevis. And the pectineus. I just reached up in one end of the femoral space and grabbed those muscles and he went, owe. Yeah, that's what's wrong with your hip. And he said, Excuse me. So this is without even looking at the mechanics of what they did to his knee.

[00:30:10] It was the adhesions in the femoral nerve clear down to his knee. All through the quads caused internal rotation in the femur. Because is your cerebellum going to let you externally rotate something that started to the femoral nerve and the femoral artery? Why would you do that? So this nicely. I look nice, don't I? I said, because your femur is internally rotated, your piriformis in those external rotators are operating at about three inches longer than they should be. So they're pulling harder on the trochanter and hence the trochanter, bursitis that you have been diagnosed with. And it's like, no, they don't think of it the way we do because they don't have a way to treat it. It's just like and you said, Well, what are we going to do? Wrap a towel around his back, put a washcloth

in his brevis, and then treat for scarring in the nerve and the artery and clear down to his knee. And then treating the bursitis, with a second machine, treat torn and broken in the connective tissue. Because part of the pain in his hip is because the performance is tendonitis. And why does the performance have tendonitis? Everybody, raise your hand. Come on. There's no chocolate that I can throw. But the pair of performers has tendonitis because it's strange as longer than it should be. And it's a mechanical disadvantage in having to work twice as hard. So that spot hurts. And the bursa is inflamed because the tendon is working too hard and getting little teeny tears in it every day. Rachel That was.

[00:32:28] And this isn't rocket science. This isn't this is just simple kinesiology, biomechanics.

[00:32:34] Well, in our world, it is. Who on earth would think of working on the diagnosis? He's had PTs and even an FSM practitioner treating the Bursa. I failed. And it's like, okay, so now everybody that watches this now knows. Think about what goes on.

[00:32:58] I want to make a parallel to a shoulder really quick because it's the same, but not so. When you have something like I don't want to say frozen shoulder because I think that term is just really thrown around for any clinician that can't figure out why someone shoulder isn't moving properly.

[00:33:17] What was six tendons torn? Partial thickness tears. Thank God I keep externally rotating my shoulder because the most common cause of frozen shoulder besides just random whatever is partial thickness, tendon, tears, inflammation, and then they stop moving it. And then there they go.

[00:33:40] So either before or after this happens and I want to make a parallel. How many times you have a patient come in and they're pointing to this part of their shoulders sore and they're pointing to those of you who are just listening to their glenohumeral joint self. And the first thing I do is I do my upper extremity test or I'm getting them to touch the backs of their hands up over top of their head, all my range of motion and I'm standing behind them because I care what the scapula looks like. I don't care how their arms get to the top or if they get to the top. I'm going to make a note. But

if the scapula are not upwardly rotating for every three degrees that you can abduct your glenohumeral joint, your scapula has to properly rotate on the thoracic cage one degree. There's a 3 to 1 ratio. I've seen it a 4 to 1 in some textbooks, but this is necessary for abduction. The shoulder blade must rotate 3 to 1 ratio if the scapula is stuck or the mechanics look to borrow your word cattywampus on the way up there, you know you have to start at the scapula. You have to look at the scapula. So humeral rhythm, which starts on the rib cage, if the subscap is stuck, if a nerve is adhered, there is no.

[00:35:06] Well.

[00:35:07] We can't bleep bleep anything, but you know what I'm saying? There is no way your arm is going to be able to float up. And what happens when it's stuck is these little teeny, tiny shoulder muscles like your anterior delt, your supraspinatus have to work 97% harder. And of course, you're going to get fatigued. Of course they're going to get torn. Of course this is going to set off a whole cascade. And any tranquilizers today like this is emotional.

[00:35:40] This is emotional. I've got some, but I can't. So. And I don't even know that stuff. And the first thing I do with any shoulder injury is put my thumb in somebody's armpit and release the subscap ulnar nerve.

[00:35:54] But now you know why you do it.

[00:35:56] Yeah, well, it's like now I know. Why do I. That'll fall out of my brain. And that is why I'm getting on a plane and I'm flying down to see you on Friday. So the nice lady up here said, Well, have you seen the. It's like, yeah, there's no there's only one person that's going to touch the shoulder. So we get to have fun. It'll be.

[00:36:15] Cool. We get to have fun and watch your thoracic your scapular humeral rhythm.

[00:36:21] Oh, you don't get. Oh, I do, do we?

[00:36:24] Do, I do, I do.

[00:36:26] Like, all right, so.

[00:36:28] We have a whole other set of stuff we're going to chat about today. But let's get to some questions because the people that come here live, come here live to ask questions. So I want to go to Leaf really first, though, because Leif just sprained his ankle on Saturday. So this was a great timing for you. You're not going to ice it.

[00:36:46] Sorry about your ankle.

[00:36:47] If you're going to throw heat on those muscle bellies and you're going to elevate it.

[00:36:52] Elevate it, and you're going to keep moving it. And with your whatever machine you have, you're going to run 124 and 101 24. And the thing is, there's no way most of them are inversions, friends, and there's no way to spring an ankle without doing 124 on 191 torn or broken in the round tendons that come around under the lateral malolos get out your copy of Netter and look at the outside part of the ankle.

[00:37:22] Right. The other one thing I want to forget, when we had Peter Twist on here, he came a bit late. So I did a little webinar on my sprained ankle, I had my slides up and people were asking me if I can redo it. I'm going to just record it myself and I'm going to pop it like somewhere. I'm going to give it to Kevin so that you guys can see some of the slides. But my favorite part, Leif, for sprained ankles to get the movement and the elevation and the traction and the heat all in one happy little package is elevate your foot, put something underneath your calf, make that something underneath your calf like a pillow or a rolled up towel. Make it hot like the hot face cloth. You can clip your FSM onto it that way and draw the alphabet with your toes. So capital A, B, C, that way you're getting the traction, the movement, the heat and the elevation all in one. Just do the alphabet.

[00:38:17] And most of us get bored about the time you get to F or G and then you go back to A, you don't really don't have to try and do an Asante.

[00:38:27] And spell your name. But the fact of the matter is doing doing letters incorporates flexion, extension reduction, all the things that you can do with your ankle. So that's why I love that Cynthia's got, like three questions on here. So glad you've been finding it helpful. Go to the middle one because it's faster. Is there a program on the CustomCare that targets ovarian cysts?

[00:38:50] Yes.

[00:38:50] Yeah. It's in the mode bank, I think, just as.

[00:38:54] Is called ovarian cysts.

[00:38:56] Yeah, that's what I thought. Okay. Client came in today four weeks post-op from a compound wrist fracture with pins and such casted to Madame. Well, the program I guess fracture program or any other with FXCM get us any bang for his buck or shall I wait till it casts off? No. You know, you work around the cast, you use the stickies, you use like we're running FSM minutes after surgery with casts. So, no, don't wait. This is where you want to work. This is her middle question, I think, or her second word.

[00:39:32] Is four weeks post-op from a compound is cast. It's missed.

[00:39:37] Don't wait till the cast is off. You can't you have to do it now.

[00:39:40] And you have to treat acute fracture. So the just because it's four weeks post, it's like it's acute fracture, especially if there's pins, especially if it's compound rest, that's going to be an ugly acute fracture. And then afterwards, you really simply get get your precision care sooner rather than later. And because with the wrist to get the motion, once the pins are out to get the motion back, you have to treat adhesions in all of the tendons and the soft tissue and the nerves in the wrist. Right. There we go. Yeah, yeah. All the way up to forearm.

[00:40:30] I'm all over the place here. I should have just started at the top. Sorry. Okay. So the very first question we have here. Webinars are incredible. Helpful. Great. Been using FSM on post liposuction patients and using soft tissue. Cute on my CustomCare.

Hope to buy a PrecisionCare next month. Is that the best choice? Several patients get sort of soft tissue rocks about two weeks post. I have a client who is five weeks post and there is three weeks to her daughter's wedding and he thought how to address the soft tissue besides.

[00:40:59] 1391 it doesn't. So inflammation just before you get to 13 and rocks, water, rocks, rocks are hard. They're integrated. That means calcium. So inflammation leads to chronic inflammation. And then the iron that's in the bruising and the inflammation. Brings in calcium, and then that leads to scarring, that leads to sclerosis. So the progression you're seeing is absolutely inflammation leads to, leads to and so calcium and scarring and probably sclerosis and the adipose. So if you think about adipose as vascularized immune active held together with connective tissue. So sclerosis in the adipose and scarring in the connective tissue. And after liposuction, I wish it was so simple. After liposuction, you have to think about torn and broken and the connective tissue. And Sclerosis in the adipose, depending on where you are on the timeline. Does that make sense?

[00:42:19] Yeah, I might add. 49 142 I love using increasing the vitality of the fascia after stuff like.

[00:42:26] That and.

[00:42:27] I can feel really.

[00:42:28] Good and increase secretions.

[00:42:30] Yeah.

[00:42:31] Oh my God. I beat Ben. Speaking of 49, I beat Ben Katholi record.

[00:42:36] Yeah, I know. You have to tell everybody it's coming. Okay, I'm going to jump again in the middle. Rhonda asked, Are you running torn and broken in the nerve while you release some scapula nerve? No, it's scarred. It's stuck.

[00:42:49] It's first you actually you can use two machines at once. I found out you run inflammation in the nerve because the first time you put your fingers in somebody's axilla, they go out and the muscles, then you go, then you run inflammation in the nerve and then you press in harder than you were pressing before. And they said, that doesn't hurt. Are you pushing as hard right or don't push as hard. I then then you start running scarring in the nerve and release the subscap. And the same guy that had the hip pain also had shoulder stuff. And that's what I did is just and that's when I found the to tell thing. So that was pretty fun. Oh, and in Philadelphia, so cool. It's the first time ever I've done this in the practicum weekends we did the supine cervical practicum and instead of doing demos, we did the Supine Cervical practicum three times one day so that we have enough tables. So every table has three people. And the supine cervical practicum now that we have rules in place. So there are no scrubby circles on the barrel receptors. Supine cervical practicum is the money shot if that is the only thing you want to do with FSM supine cervical practicum. It's it is the place where you learn that the frequencies do only what they are alleged to do and exactly what they are alleged to do. Right up or torn and broken. And the light bulbs that went off what were just astounding. It was just so wicked cool. And I already talked about that last week.

[00:44:52] I think. So when we talked about it, I can't remember if.

[00:44:54] We were just.

[00:44:56] By ourselves or if we had the audience.

[00:44:58] I have five second satellite delay. Okay, go.

[00:45:03] I want to get to these questions. So we've just been doing all that extremity joint sprain protocol, but that has a lot of 40 in it. So need to adjust the protocol I guess.

[00:45:13] Oh yeah. That will see the the CustomCare protocols were written a long time ago before I knew what I know now and they all have to be rewritten. But then I have time, have to have time to go in and rewrite them. And then then the nice thing with the 3.0 software is the next time you turn it on, the updates will all be pushed out and your software update. So it's just really a matter of me having time tember. October sometime f three days in London. We're going to London, by the way. Yes. Still not sure

about Ireland because NCTC is not sure about whatever. But I'll I'll have time in between the Korn Advance and London where I can maybe, maybe get after that. Perfect.

[00:46:10] But in the meantime, it's so easy to tinker with that stuff on the bank.

[00:46:14] You can fix it yourself.

[00:46:15] Yes. Hello. This person has cervical stenosis. See you. Five, six, seven with disc osteo disc protrusion. Core compression for one and one half years has neck pain. About a four out of ten arm pain. Five out of ten tingling fingers, six out of ten. But wants to avoid fusion. Of course you do. And anaplastic surgery she used or he used disc nerve or sorry nerve disc joint protocols 6 hours a day for two weeks with not much improvement. Is FSM a viable treatment for the pain and tingling? Can we get some recommendations?

[00:46:57] Okay. So so Jillian, the first thing I watch, the first thing I want you to do is reach down and feel your adductor brevis and your pectineus and see if they're tight. That's the first thing because you want to find out, is 40 and ten a thing or is 81 and ten a thing? So are you having lower extremity tightness because that. Stenosis is pressing on the central part of the cord. And are you losing a descending inhibition? That's the first thing. The challenge that we have is what you need to be running is neck pain, which includes the sets disks. The arm pain is just 40 and 3096, reducing inflammation in the nerve. The problem that exists with stenosis is it's calcification of the disc annulus and it's bone spurs. So what they're talking about doing is roofing. So a laminate to me takes the bone, spurs off the outside, doesn't do anything for the calcification in the disc that's pushing on the cord from the front. Another conversation and the bone spurs. So if the stenosis is from the facets from the back. I guess it alone is not enough to. Fix that so you can run remove calcium and even to 17 and colossus from the periosteum and the connective tissue. But in order to reabsorb bone spurs, you have to get it to move and.

[00:48:54] Because the joint is so inflamed and degenerated, cerebellum is not going to let you move the little muscles, the multifidi and the rotators of the tiny muscles right at the joint. And they're like, I'm not moving. You move and I'm not going to move.

Cerebellum says, You guys are not going to move because that point is inflamed. So the big muscles move in, the little muscles don't, but the little muscles get really, really tight and that's where the bones first come from. So the the look that I have had professionally comes from these physical therapists that I work with that. Showed me how to exercise the multifidi and the rotors, and they only fire in the first 5 to 10 degrees of motion. So you run FSM, but somehow we have. That was the other thing that we got to do during the practicum was I got to show the exercise portion of the rehab. Mm hmm. Getting them to do that. So, Jillian, good news and bad news. You can reduce the symptoms. You're not going to be able to do the osteo fights. And unless you can find a physical therapist that's trained the right way. There are there is a point at which the stenosis becomes dangerous. So don't wait until you're a toxic. Check your doctors do 81 and ten increase, decreased descending inhibition in the cord to relax your leg muscles.

[00:50:39] And if you have to enter, listen up, folks. You're ready. All right. You are the one that is paying the surgeon. He works for you. He is your employee. You do not hire employees without interviewing them. You go and talk to orthopedic surgeons and neurosurgeons because there are spinal cord and bone both involved and. I interviewed three of them, all of whom I'd worked with, and I picked the one that would look me in the eye, had a good sense of humor and knew how to talk. That is rare in a competent surgeon. You have to have a surgeon that you can. Trust and talk to and the way Kim won the argument with the two surgeons. You have to be able to do that. And you do that by doing your homework and. And and then picking someone that you trust just because somebody says he's the best guy, but he's a jerk. It's like, I'm sorry when I have my hips done. My requirement was to my GP. I need. A good orthopedic surgeon. That's not a jerk. And there was one in town and he's now retired. Oh, I love that story. So I could go either way. It's like sometimes it's just dangerous not to do surgery.

[00:52:27] Yes. Right.

[00:52:28] And and then you do post up.

[00:52:31] I was going to say and then it's not like there's never a time where we can't help. Right. And it's not. It's the best adjunct you have because you can work it in any situation so safely. Yeah. Jillian wrote I talked with seven neurosurgeons, liked one in

Florida, but still trying to avoid the surgery. Yes, I've been doing chiropractic and acupuncture for over.

[00:52:57] No, no, no, no, no, no. Unless the. No. Oh, no. Oh, dear. Okay. This is the part where I become the chiropractic heretic. If you have spinal stenosis. Unless the chiropractor is using an activator. If when you have spinal stenosis, it's Boning. Chiropractors lock the joint and rotate it. If you have a bony impingement on the spinal cord, you're every time you do that, you have the potential of. Injuring spinal cord long tracks. So once my disc herniation got big enough that it was pressing on the cord, I'm not allowed to do traction. I wasn't allowed to do traction because you you press on the cord and the traction it and you damage the motor. You damage the pathways. Oops. So no, just notice. And and once the chiropractor. Oh, I'm so proud. Yay. Once chiropractor knew I had stenosis, she stopped doing adjustments on my neck. You can give her a piece of chocolate for me. Thank you very much. We have 10 minutes and I have to tell.

[00:54:20] The I know.

[00:54:21] We have 7 minutes and the eight machine story.

[00:54:25] Yes, you do.

[00:54:27] Okay. The history took 3 hours, so you're going to get the abbreviated version. And I'm watching the clock. This patient. Was born at 27 weeks because when they went in to do the amniocentesis, the kid ziggled and the needle sagged and they hit her in the heart with it. So sorry. I just made Kevin sort of green.

[00:54:53] I heard that when Kevin got up.

[00:54:59] So emergency C-section. 27 weeks. And then she had she said, I have hearing hearing loss. They said either because the antibiotics or something else. And I said, it's the antibiotics. And she said, How do you know? I said, because they had to use gentamicin or vancomycin. And she said, How do you know? And I said, Because those are the only two antibiotics. If they mention antibiotics and hearing loss in the same sentence or paragraph, they use gentamicin or vancomycin. So the hearing loss,

she has hearing aids, same kind of idea. And then she had Saccadic pursuit with her eyes and she saw the nice chiropractor brain guy that stopped the Scuds. But. Anyway. So I had her fill out the brain. Brain injury visual system symptom questionnaire with 18 where a score of 18 is predictive. Her score was 42. So that's all I have to tell Dr. Reski. And I swear to God, she went to somebody else in his office who sent her to this vision therapy. And I went. Did that make you sick? She said, no, but it didn't work. So I stopped. It's like, that's a good idea. Because anyway, so there was that. And she said, And I have Ehlers-Danlos. Okay. And my shoulders really hurt. Okay. And I have this numb spot. At T right across your chest. T 45 And I have lumbar disks, so she had great imaging every place except the thoracic. And I went and oh, by the way, her pituitary is sort of missing. So she's on hormones are totally outside my pay grade. So the machines are 124 and 77 torn down.

[00:57:06] I was trying to broken in the connective tissue neck defeat and oh by the way, when she lays flat o and she has a tethered cord. Okay. Once she lies flat for any length of time, even with a roll under her knees, then she can't move her legs. And that's the tethered cord. So. Our last analyst was first. Then she has all of these vagal symptoms with their Ehlers-Danlos. So we treated concussion in Vegas and then she was numb at five, four, five and six on the right and four and five on the left, hence the shoulder pain because she was numb. So basically she had nerve pain for two or three years and then she had phantom limb pain in her shoulders, really horrible. At night, level nine would wake her up. So we just treated the nerve, got the nerves normal. That was fun. Treated disc back to front on an AutoCare. I just kept running this subacute lumbar spine to legs and and abdomen, surround the disc back to front across your low back and then had another machine low back to feet to treat the nerves because I three, four, five, six one and six two were numb. And they went from numb to hypersensitive to. Normal and at the end of I've never spent sick. It's been a really long time since I spent 6 hours with the patient, especially when I had eight machines running at one time. But there'd be this. I'm sorry about the flight. Then there'd be this. Oh, I have this. It's like, Oh, I can fix that.

[00:59:05] So then another machine would come out, and pretty soon there were just wires everywhere. And at the end of it, the Ehlers-Danlos, she went from 90 degrees to 60 and she went, What? And then. Oh, yeah. And then I did one machine on 40 and 89 because of all the birth trauma and run concussion in Vegas like three times. And then

so they Ehlers-Danlos that in the beginning, one of the Beighton signs is you bend over and you lay your hands flat on the floor. Well, she showed off, and not just the palms of her hands on the floor. She laid the backs of her hands flat on the floor. Wow. So at the end of 4 hours of 124 and 77 arrows down this thing. She couldn't touch the floor. She was three inches short. And so and all the nerves were normal. She was no longer anxious or depressed. Oh, and then then we treated the tethered cord was scarring in the dura and scarring in the cord. But when I had when I treated scarring in the dura and moved her knees, she said, oh, that hurts in the middle of my head now. So we did scarring on the dura and had her take a breath blow about the third time, the door and her brain sort of and then her spheroid, like did not move at all. And she said, it's it hurts here when you bend my knee. And I said, you understand that's not normal, right? Okay. So. Oh, that was the other thing. One more thing. Can you stand it?

[01:01:01] No. Yes, of course.

[01:01:03] All right. So. So we did. Cranial sacral, almost osteopathic because this has been glued since she was born and we did bend the knees with scarring in the dirt while I just riffed on her spheroid and pulled on her ears. And then that. That let go. And then. But okay. So she developed sexually normally. Pubic hair, breasts, menses. All of that was normal. From birth. Right. And now the seller. It's empty, like her pituitary disappeared when she was in her twenties. And they didn't. It came from space psych anyway. So she's on all the hormones. So it's another thing I was going to say. I'll remember it after we're off. But it was it was just like and then the next day, I treated the thoracic nerves. The thoracic disc redid her cervical spine and reprogramed her CustomCare. So that was, she bought a used one from somebody.

[01:02:34] Right.

[01:02:34] Failed to mention that the thing is more than ten years old and it can't be repaired and charge her \$800 for it.

[01:02:43] You. That's icky.

[01:02:45] Well, the person that sold it to her is kind of icky, too. So that makes perfect sense.

[01:02:50] That's not cool.

[01:02:51] No, it was cool, but I'm just excited. She's. She's just adorable. Oh, my gosh. Can we please video the session with you treating Dr. Carol?

[01:03:07] Maybe.

[01:03:09] Not sure about the cameraman thing.

[01:03:12] I mean, I've got enough still recording stuff I could set up. We'll do some pictures, some video. I always do some video with patients before and after so they can see themselves. And then I have to borrow it for a case study. So just to be able to do it. We can shoot it on our iPhones.

[01:03:28] I just like showing off my range of motion. This actually hurts here. That's that bony thing that they don't like. But it'll be okay. We'll have fun.

[01:03:38] Hey, I've got two things here. I've got a quote, and I have an announcement.

[01:03:43] Okay.

[01:03:43] What do you want first?

[01:03:46] Announcement.

[01:03:47] The announcement is because his podcasts have been such a favorable event. I've been doing some interviews not live because the strength coaches that I want to and the trainers and the teams that I love talking to are very busy right now because is the off season and training camp for hockey and football. So I will be with the help of Kevin posting these very shortly. We did an hour long interview with Dr. Charlie Wingrove the other day. He is always so raw and unfiltered and fun to talk to. And I did a a great interview with Mark Fitzgerald, who is another trainer up in Canada. So for the sports minded people, I think you'll find a lot of value these. Mark Fitzgerald does not use FSM, just like Peter Twist, but just bringing some really innovative ways of

thinking about training and muscles and all that stuff that we could use as an adjunct in your practice.

[01:04:51] The nice thing is when you interview them, you have the opportunity to infect them with the idea about maybe you might consider.

[01:04:59] Yes. And a lot of these guys just know me as like what I do. So they're very intrigued and respectful of it. So that's the announcement. So these will be populated on the YouTube channel and on our podcast recordings.

[01:05:14] So any chance you can get your hands on Mark? Lindsay Yeah, yeah.

[01:05:20] That's how I would answer it.

[01:05:21] I haven't seen him since 2003.

[01:05:24] He's like a unicorn.

[01:05:26] Yeah, there's not. It doesn't really exist right now.

[01:05:30] He does. Okay, here's my here's my very profound quote for the day. A bird sitting on a tree is never afraid of the branch breaking because its trust is not in the branch, but in its own wings.

[01:05:44] Oh, I like that.

[01:05:47] So it's a very kind of deep one, but it kind of builds on the hope lives here sort of. T shirt thing that we started with, right? It's your own. It's the hope and the trust within yourself to overcome the external stuff.

[01:06:04] Well, you take someone who has been more and more debilitated over her life. She has lipid. Oh, that was the other thing we treated was lipoedema and that and we reduced the size of our calves by three centimeters. So that was pretty cool. But you take someone who has spent their entire life. Debilitated and in pain and having difficulty in one thing after another. Swear to God she was not diagnosed with Ehlers-

Danlos until she was 28 or 30 and and to to have two sessions with her and have her lead with a glow in her face and a sparkling or eye and pain free and better posture and hope. There's never, never any certainty. But hope lives here. Yes. So it's like trust for the practitioner. Trust your wings.

[01:07:14] Yes.

[01:07:15] Keep. Yeah.

[01:07:17] And for the patient. Right. Trust the process and trust your body. Wants to heal, wants to do what's right.

[01:07:23] Read the quote again, please. Okay.

[01:07:26] I know it's such a good one. A bird sitting on a tree is never afraid of the branch breaking because its trust is not in the branch but in its own wings.

[01:07:38] Who came. Let there be wings.

[01:07:41] Right?

[01:07:42] Yeah.

[01:07:43] All right. This was, again, fastest hour that I get to do all week long.

[01:07:49] Yeah. Love it every.

[01:07:51] Time. Yes. All right, everybody, thanks for joining us. We will see you all next week.

[01:07:56] See you next week. Hi.

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