

Episode Forty-Six - Pro Sports Use FSM

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[00:00:03] Hello. I guess we don't need our headphones. We can see each other now.

[00:00:08] Oh, and take the audio off the headphones. Turn the audio on. We're there.

[00:00:13] I got to turn you up. Now I can hear you.

[00:00:17] Okay?

[00:00:18] I can see you. I can hear you.

[00:00:21] Okay. I got to start first. All right. Everybody ready? Okay. Some of you may already have heard the news. I know Kim has and Kevin has. My son died on Thursday night, if I talk about it, I'm going to lose it. So I'm not ready to talk about it yet and certainly not on the podcast. It's just too soon, so we will proceed. So yeah, he passed away Thursday night and I still taught the practicum course on Saturday and Sunday. So there are times when medical professionals and professionals just have to compartmentalize emotions as a temporary thing. That's okay and necessary. So there we go.

[00:01:21] All right. Great. Good. I like the disclaimer. And any comments regarding that, please hold, because we're going to keep the podcasts business as usual so you can send those comments later.

[00:01:32] Yeah. Oh, there's plenty. Hey, Leif, you're here. Yeah. Hey.

[00:01:40] All right, we're back. And we have a lot to talk about.

[00:01:44] Oh, yeah.

[00:01:45] We never not have a lot to talk about. I was reading. It was funny. I was reading. Because you know what happens right when I like to do something, I develop like a healthy level of OCD, like I did with you when I saw the first, like, CustomCare and laughed at it. And that was a whole.

[00:02:02] Thing headfirst into the deep end of the pool and never stopped swimming. That that OCD.

[00:02:08] That's right. Yeah. So I was I took this little online podcasting course because I love doing this. I love asking questions and talking to you and other people. And I was reading it and it was like troubleshooting. When you run out of things to talk about.

[00:02:26] I'm like.

[00:02:28] Troubleshooting. I'm like, I have legal pads upon legal pads. Of stuff that comes out of my brain about the podcast. Like, so lack of material is something that.

[00:02:43] Problem is that who in their right mind does a two hour podcast? But we could probably talk that long. So probably.

[00:02:52] But I think it keeps everything like it's like we leave every episode on a cliffhanger. It's kind of like binge-watching Netflix, right? Like.

[00:03:00] True.

[00:03:02] Yeah. So. Let's talk about the practicum weekends actually first because somebody was asking me about the difference of all the courses. And we have a lot of different courses, a lot of different ways to get training now, which is fantastic. Online, in-person. So. I'll let you talk about the practicum. Weekends are going to continue on.

[00:03:27] Well, for this year, for the last two years, people have been taking the three-day modules and the five-day core online, and then they sometimes dive in and start treating anyway. But they actually know they don't know what they're doing. And it's kind of scary. And so this year, since we could go back and start doing things in person, we. Do the two-day practicum. So we do the supine surgical practicum, the supine neck and shoulder, the supine lumbar, which turns into a visceral, free for all. And then we dry lab nerve pain. And that's all really you can do in two days. And it has been working out pretty well except. For the last three two-day practicums this year it's been obvious that the one that's the most valuable is the supine cervical practicums number one, because it's mechanically so simple. You don't have to do a lot with your hands or arms. It's fingers. It's learning how to unlearn sometimes as much as 20 years worth of muscle memory about how to treat what you thought were muscles. So we talked about it practicum before this one, and I said, I'm just going to pull the trigger and we're going to do. We always have enough tables so there are only three students per table.

[00:05:22] One is the patient, one is the practitioner, one is the machine operator. So they. So we're going to do the supine surgical practicum three times in one day. So we did the circle exercise in the morning where we ran frequencies on everybody and found out who the 20% of non-responders. I think we got ripped off that guy. And the 60% of I think I feel something but I'm not sure what. And then the 20% of stoners that just get totally dwarfed. So that was the morning. And then we did the supine cervical practicum and then after lunch we did another supine cervical practicum. But this time. I had added, You know how I'd do that on the flight home? I'd added the slides on what to do after that treatment, what exercises to do, how to use 81/84 and 81/92, and what exercises to give the patient. And then we did another supine surgical practicum. And the reason I picked that one is not only is it really the best and only way to learn that the frequencies are also what change the muscles. 40/94, quieting the medulla. The only thing it does is get the upper trapezius out of your way and then, oh well, there's the splenius.

[00:07:09] Well, that's Dermatologically. And then. No, there's the posterior scalenes, the medial scalenes and right? So then you do the spinal cord. And then there's the splenius that's now in the way. And the other levator that comes off the transverse processes. So then you do 40 and 396, quiet the nerves because those are innervated from the dorsal roots. And then magically there are the Sub-occipital muscles which you

could not feel before. Then we proceed to the things that make the Sub-occipitals go smush. Then we come to the work which is getting the rectus capitis posterior minor, the little tiniest, most pesky muscle in the neck unglued from the dura. And then they move to the sets and then they move to the disks. And the most fun part about that whole practicum is, number one, watching the look on their face. It's not the muscle. It never was. You'll get over it. There's that. And then there was the opportunity to say, the reason we're doing this three times in one day is it's your money shot. It is going to be 60 to 70% of the people that walk in your office have neck and mid-scapular pain. And then I have learned that you have to put in the cloward diagram three times in that, right?

[00:08:46] And then there was a patient that was driven down by her husband from New York. She was injured two or three years ago and was convinced by various practitioners who told her terrible things that were wrong with her, that weren't really wrong with her. It's another conversation. She was convinced she had ligamentous instability and she had this and this muscle just doesn't fire. And it's like. So I did, as did a reflexes. They were all normal. Yay! No, actually, they were hyper. But babinski was down going. And she had sent me her MRI's. She had disc bulges. I'm glad you're sitting down. Are you ready? She had disc bulges at C-2-3-4. Nobody has disc bulges at C-2-3-4. And wisdom tooth was pulled. Kind of yanked out of her head, and that could have done it. And then there was a thing with somebody using an activator when like using the activator for her jaw soreness. But just as he was about to use the activator, she lifted her head and turned it and he hit her. It activated with an activator right there. Well, an activator is like no force. Like 1lb of force.

[00:10:26] Yeah, no, of course. Yeah.

[00:10:28] And she was convinced that that Activator had made her C-1 unstable. And that's a good face and had destroyed this muscle because the muscle was all gone. And what was missing over here turned out to be the splenius. So it's like you have disc bulges at two, three and four. So she was just finally upregulated and certainly centrally sensitized for sure. So we had one machine on 40/10. One to quiet the spinal cord, sensitization one machine on 40/89, just quiet the central sensitization that went from neck to feed one machine from neck to abdomen to treat concussion and Vagus and

one machine from neck to chest to treat the discs. And one machine from neck to chin because she was numb, here. Not here. So it wasn't four and five. It was here. Now this.

[00:11:45] And for people who are just listening, you're kind of pointing to the inferior jaw line from behind the ear down towards the angle of the mandible.

[00:11:56] And you have to look very closely at the dermatome map to find out that this is the sensory place for the C2 nerve root. It's like and it's numb. It's not even hypersensitive. It's numb. So I did 40/396. Quiet the nerve. And when a nerve is numb, you have to take it from numb to hypersensitive. So after about 45 minutes, because that's a short nerve after about four. And everything terrified her because she'd been told those air ligaments and maybe your transverse ligament were damaged and irreparable and this muscle was blah, blah, blah. And so we treated the nerve. And then when I checked the sensation, she said, Oh, that hurts. I said, Oh, that's wonderful. It is, yeah. So we switched to increased secretions in the nerve, and then the sensation went to normal. And then there was this splenius that really was nonexistent. The Splenius had no motor innervation. One of the students looked it up. I said, What innervates is splenius? They said, C-2-3-4. Oh, duh. So we did increase secretions in the nerve. And kept it there, just wrapped the splenius 81 and the nerve increased secretions in the nerve and then increase secretions in the muscle, which is the circle lima in your world.

[00:13:40] And whatever it was, the splenius filled in. Well, all of the care that she's had, I swear to God. Last week. No adult beverages allowed on television or on podcasts, but. It was probably a physical therapist who did dry needling into the facet joint. Now anybody listening who has ever ordered or watched or studied facet joint injections back when they did the facet joint injections into the joint knows that you always use a double needle technique. You insert one needle through the skin and then you leave the cannula and then you put a second needle that doesn't touch the skin. You go through the cannula and then you go into the joint because otherwise you carry staph into the joint and create a joint infection. And this. I'm sorry, this clown put needles into three of her upper cervical facet joints. So the first thing we treated was to stop bleeding because this was Saturday and she had it done on Thursday. All of the care that she's had has been passive. Oh, every time I use the muscles, it hurts. And it's like, well, of course it hurts. You have nerve damage and muscles that don't work, but we're going to do this differently.

[00:15:24] So close your eyes, move left, move right. And it affects her vision when her eyes are open, depending on the position of her neck. And like, of course, your Sub-occipitals aren't working. What do those have to do? Just close your eyes and move your eyeballs. Oh, okay. They contract. Then had her do active exercise and when she got up off the table, it's the first treatment ever in... She's seen 50 doctors in two and a half, three years. And it's the first time ever she's gotten up off the table feeling better. The nerve pain was gone. The Splenius was at least back in place, and she was still scared, but not as scared. And then Sunday we finished it off. We did the same thing more 40/89. One practitioner actually ran... Remember in the TTH sequence, there's that one frequency resistance to healing? At this point. I finally met Ben Katholi record. With 7 machines and they ran 88/65, resistance to healing. Yeah, I was on Saturday and that was magic after running a bunch of 970s on that practitioner on that machine. And then Sunday, we ran the whole TTH. What is that thing?

[00:17:01] Your phone is going off.

[00:17:03] Okay, but I don't know how to silence that. It's on airplane mode anyway. And then. Then Christine Ashcroft did the.

[00:17:20] Before you go on to that one. Let's unpack the pain part, because you through like 2 hours worth of stuff out just now.

[00:17:30] And but it's just like so simple when you have a tool that lets you deal with each piece of it effectively, but unpack it. Check.

[00:17:44] Someone has to keep the train on the track. Otherwise you're taking us into mountains and stuff. We have to just.

[00:17:53] No, what I do is I take the high-speed train.

[00:17:58] Yes, you are. You're like on that super euro train. And I have to keep it like the old coal stuff with the smoke and the choo choo like that stuff. We have to stay on that train for everybody listening. Okay, so let's back it up to the cervical practicum. How we're walking through frequencies in a systemic order in order for the practitioner to re-

feel what they're supposed to feel. Because if there's anything that you're going to walk away from, from a core module or any of our stuff, is your palpation changes forever because you have to listen with your fingertips?

[00:18:46] And actually the supine cervical practicum in particular is the only one that teaches you that the specific frequency combinations do exactly and only what they are described as doing. That's the only practicum that does that, correct.

[00:19:12] And it teaches you patience because you can't blow through the stop signs when you are in somebodies Sub-occipits. You can't do your scrubbing circles. You can't get your elbow out there. You have to just sit there and wait. And I promise you, it is a religious experience. When the Sub-occipit. And I don't say they smush, I think they fluff. That's they almost like go from these dehydrated little scallops on the back of the head to rocks.

[00:19:50] Rocks to this. I can't explain it other than it just. She's.

[00:19:58] What she's doing with their fingers is like so if you're a baker it's like bread dough. It goes from three day old stale bread to raw bread dough.

[00:20:12] Yes. The fluffy stuff that, you know, when you're kneading it is going to make you the best pizza you've ever eaten. I think it's so important because when I took the Core, it was at the end the cervical. And I get it because you didn't want to rush people's meat hooks in someone's neck when they didn't know what they were doing. But when you slow down the practicum and you explain everything and you have them wait. I think it's such a. I'm at a loss for words. It's it's indescribable because for learning FSM, it's not I say this all the time. It's not like learning how to tape somebody where you take a two day class and you can on the plane ride back to your practice. You can tape every single person on that plane. FSM is not like that. And even though you've gotten. So crystal clear at telling everybody and teaching everybody how to think for ourselves and how to use critical thinking and how to figure out what's wrong. And it's not a recipe. You still have to think about the tissue. You have to think about what is happening when somebody's splenius is nonexistent. That matters. If you're palpating that and you're doing a test and that muscle isn't there, shouldn't you stop and think, why is this?

[00:21:40] And then you look at the MRI and there's these significant disc bulges that C-2-3-4, and there's an numb spot at C-2 and C-2, innovates the splenius. Those three things go together.

[00:21:56] And now you have a way of fixing and changing and making a dent in this and not making them worse. However you want to phrase it on that first treatment because without FSM, sure, you could probably get to that. Splenius is nonexistent, you know, and then you're checking the disk bulges and yes. What innovates the splenius. Well, this all makes sense, but that's where the story would end. Oh yeah, that would make sense. Moving on. Right. So it's like, okay, well, no, what can we do to change this?

[00:22:27] And you have a patient who is so emotionally traumatized by her. I mean, she was a very high-powered business person, shall we say, and she's been in bed for two years. Her husband can support the family in New York City but all she has to think about is the pain in her neck and that nobody can help her. And so the emotional overlay is what has confused or focused the doctors who've been treating her well. They don't have a way to treat it. You need to see a therapist. Here, have an antidepressant. I'm not depressed. I have this pain in my neck and I can't hold my head up. My head falls this way. Well, of course your head falls. Actually, the head falls to the right because the splenius anyway. To have the tools to be able to treat 40/89, quiet the amygdala and the hippocampus. And to treat concussion and Vagus to have a tool to do that. So you could treat the emotional overlay so you didn't have to get rid of the physical problem and let the emotional overlay fix itself. You can actually change that, right? All at one time. We have a tool and. Ken, I feel. I'm not sure what I feel about it because it's taken me 20, 75, 25 years to learn how to teach this. To teach the practicum, to teach the core, and to learn to say, Wait. Keep your fingers still. Not not only no scrubby circles, but keep them still and put your eyes at the end of your fingers. But if you're a musician and you're an auditory learner, put your ears. Listen to what the tissue is telling you. Put your brain at the end of your fingers. How are that works for you. And to not only to say that, but for the visual learners to actually make a slide that says that.

[00:24:59] So the two-day practicums have been huge, but instead of being full of 40 people the way we thought they would be, there's 20. And since it looks like COVID is

on its way out next year, we're going back to the five day in-person practicums and we'll do them every other month just because I can't be out of the clinic that much. And so we'll do them every other month. And we have one in one core in Hawaii and one core in Australia. So Hawaii will be in August and then we'll have two master classes and the master class is. My private tutoring. There's no slides. There's no recipe. There's no. Nothing. You come and you ask the questions. I need to know how to treat this. I have this patient with this or more often I have this. So we end up treating the practitioner who asks the question or the practitioner asks a question, and somebody in the class magically will say, Oh, I have that great, we'll treat you. And it's organic. And because it is 15 minutes from two-step, which is the best snorkeling in Hawaii, the class is going to go from 9 to 1 and then I'll see it tomorrow morning because I'm going to to-step. So we'll do a Core first in the hotel in Kona and then we'll do the two weeks of master class and then we'll probably go to Australia I think in October and then it'll be February, April. June. And then August. So that's we'll go back to five-day course because those are the ones that filled up with 40 people. And that's the way we're wrong.

[00:27:21] And I think that people want to go back to in-person learning because, yes, anybody can watch you read slides. We can all read our PowerPoints at home, but it's the collaboration of learning on the fly, getting treated, feeling smush I had a practitioner fly in to see me as a patient, but who is an FSM practitioner who's been practicing for quite a few years and said, Do you know I've never felt Smush? And I'm like, Okay, like on yourself or like on patients. She's like, both. I don't feel so much. So I don't think I'm ever doing anything right because I don't feel smush and there is like this panic and urgency and anger to that statement. And I get it because I felt that was why I got addicted to it so fast as I felt smush right away. And as a manual therapist, I objectively knew what I was feeling couldn't have been possible because

[00:28:28] tissue doesn't feel like that after 20 seconds. It feels like that after 3 hours of being under a rolling pin, maybe. Even then you're not getting that. So. I mean, of course, we got smushed and we both got, like, daft together, and it was a religious experience. But I think going back to having the Core in person, having the practicums in person, there is so much benefit to be gained by kind of going off the script. Like, yes, we do a practicum and we walk everybody through the steps, but you're going to find things. Somebody is going to have trigger points in their abdomen. Someone's going to

have, I don't know, we're all going to find different things. So I think that's where all the fun stuff happens and like, yeah.

[00:29:22] And at lunchtime, even in two days at lunchtime and afterwards, there was this bonding thing that happened. They all want an email list for the whole class, which Kevin sends out. And it's we were there until 8:30 Saturday and Sunday, and I'd say 50% of the class stayed the whole time. Some of them had to leave. And then Sunday night when I finished up, they didn't want to leave.

[00:30:09] I remember my first sports course that that happened in Arizona because you came by at the end and it had been over for about half an hour and the room was just as full. Maybe one person left and you said, and this is how you know you've made it. This is a successful course because they're still wanting to play. And in the sports course, they're still jumping off of tables and trying to do jumping jacks and like stand on their head and do all the things that they were doing. But yeah, and I think there is, there's, with the new way of thinking about everything, that's what sparks the excitement because you're not brain dead at the end. You're not like you've been bombarded with 2000 number combinations. You start thinking in your seat, Oh my God, I got to call that patient from last year that had the thing, because now I have the thing to fix, the thing that had the thing that caused from the thing. And then it's like a thing.

[00:31:08] Almost every practitioner in even the three-day classes, but 3 to 5 day classes, almost every practitioner by the end of the first day has a pad of paper on which they've written a list of patients they have to call the next week.

[00:31:25] Yes. Yeah, that's the exciting part. We have a couple of questions before we go back to your patient. I had a question that came in a couple of different times about a hiatal hernia being addressed with FSM.

[00:31:42] Okay, I'm missing.

[00:31:44] No, this was this was sent to me separately on this. Yeah.

[00:31:50] It depends on if it's a real hiatal hernia or hiatal hernia that they made up. So this is no filter today. It's like it's. Right?

[00:32:02] Today? I think that's a common occurrence but go on.

[00:32:04] Well, no, it is. It's like just wonderful thing that you can all look forward to when you're seventy. The filter that's on between your mouth and your brain just gone. Just gone. No need for it. What are they going to do? So hiatal hernia, so real hiatal hernias are where portion of the stomach which produces acid goes above the diaphragm and makes this little pouch.

[00:32:36] Well, in order for that to happen, the lower esophageal sphincter has to, like, not work. There's that. And in Chiropractic College the chiropractors who had been in practice for 40 years had a simple solution for getting the of the hernia back down in the stomach where it belonged. The first thing is active from the patient's part in the morning. They drink eight ounces of water on an empty stomach. They go up on their toes and they drop down as hard as they can on their heels. And then they do it again and they do it again and drink all that weight from all the water pulls the hernia back down. And then they're usually pretty good chiropractors. And I would guess osteopath take a tissue hold just below. And this is not something I would recommend for the untrained. Take a tissue, hold just below the sternum and press in.

[00:33:54] So you're applying pressure on the upper part of the stomach. And you just pull down so press and pull down fairly quickly. If you are a massage therapist, that's not a great idea. If you're an osteopath or a chiropractor, go for it. PTs If you've been trained in that kind of visceral manipulation, that's worth a try. The other thing with hiatal hernias is there is no way to have a hiatal hernia if your vagus nerve is working. I'm beginning to sound like a broken record with the vagus nerve. I did talk about the other one last... Good. For people with hiatal hernias. It's increased secretions in the Vagus. But you have to. I would do concussion in Vegas and increase the amount of time that is on 40/89, quiet the midbrain and the hippocampus, quiet the medulla and increase secretions in the Vagus. I would increase the time for like 4 to 8 minutes for each one of those and get the Vagus working. And the lower esophageal sphincter says, Oh, you want me to do that? Oh, okay. And all of a sudden the phone lines connect and it does what it's supposed to do. So.

[00:35:25] You know, I just had a thought, you know how we do like the Leap award and Ruth Johnson and stuff like that. I think every year we have to have a frequency pair like highlighted because you know, there's one year where we're talking about 124, it's time dependent. We ran with it and then we had Vegas and then we're going to run with it. I think 40, 89 is the frequency pair that's been the pair of 2021, 2022.

[00:35:54] Just it's everywhere.

[00:35:56] It's like everywhere with every condition, with every person.

[00:36:01] With it sensitized you can't run it on an athlete because the athletes are very busy suppressing their pain and you don't want to suppress their ability to do that.

[00:36:11] Unless they're not moving it because of pain, because of where they thought it used to be stuck. Now I'm very excited to share some video later on with an athlete that was going into a squat pattern that used to be limited due to tight quads and I don't want to say inhibited glutes, but cattywampus firing patterns. And they would stop. I'm like, Why did you stop there? And then they don't know. There's no pain, there's no tightness anymore. It's because it used to stop there. So you have them in that position, you say, could you go a little deeper? And then you see this kind of... They all do it. All the athletes kind of smirk. No, they don't wince. They smirk. There's a spark of joy. Of course, they're up for the challenge. Of course they want to do what Coach tells them to. So they go a little deeper and then you use 40/89, and the next time they do it, boom, it sets. You've got that extra 30 degrees or whatever. But you have to make sure they're not in pain, that you have to be at that stage of healing.

[00:37:24] Well, and the way we've described it on that slide is 40/89 quiet the it's really the hippocampus. I'm going to put it on the hippocampus. It's quieting the hippocampus because they're afraid to move it. So 40/89 is central sensitization. It's afraid to move it. And I'm going to add it. I just haven't done it yet because I've already changed the slide so much. There's only so many times I can resuscitate Kevin. If you think about the 970s, I mean, we started with 94/200, 970/200, emotional tension, nervous tension. It has to start with 40/89. Emotions are names that we give to things that feel a certain way but they are creations of the amygdala, the hippocampus, and to some extent the thalamus. But basically, the amygdala is the emotional part of the brain. The

hippocampus has as its job to remember everything that ever hurt. Everything that ever gave you emotional pain, physical pain, threat stress. So what's anger? Well, anger actually fear. What's resentment? While resentment is from anger and anger is from fear. And then you go through the list of emotions. And how do you have those emotions without having the midbrain jacked up?

[00:39:26] I remember my first day of psychology in university and we were talking, the statement was, maybe it was in the first days, the first week for sure. The statement was, anger is not a true emotion. Of course it is. And I was the loudmouth in class. Anybody have a comment? I have a comment. Anger is totally emotion. I had anger driving here today because someone cut me off. I had a huge amount of road rage and he's like, Ha, it wasn't anger. Anger happened after you were terrified because you almost got into a car accident. Oh, you're right. So I think about that premise all the time, working with athletes who don't come in with that emotional; I'm so scared about this injury. Of course not. They're angry. They're pissed off. They're frustrated or they're quite neutral, and they're going to be very excited to have you as their therapist and to help them. But you have to treat that because, of course, there's emotion. There's something tied to it. They're not robots. So you have to put that in the beginning of... We have it as part of, it's not the soft tissue basics or maybe it is when... I think the slide is if you've ever applied a Band-Aid to a squirming three year old, you get that. But you're right, 40/89 has to come before those 970s.

[00:40:54] And I haven't put that on the slide yet, because there's a point at which I worry about adding so much to the core that people's brains are actually going to explode. And it's like.

[00:41:04] I think if you explain it in that format, it makes a whole lot of sense.

[00:41:08] And the use of 40/89 are quieting the midbrain is different than it is, you've already found this out, when it's with chronic pain patients. If you've been in pain for more than two or three months, the nerve is sensitized. That's just. Read the journal articles, the nervous sensitized, the spinal cord pathways are sensitized watched Jay Shah's lecture and if the spinal cord is sensitized, then the thalamus and the hippocampus are sensitized and they're both in the midbrain. So with chronic pain patients who are. It's just neurologic and there's no other way to treat it. You can't give

somebody enough gabapentin to allow them to be conscious and deal with central sensitization and just it just can't be done. And in our world, it's like, okay, that's what the third machine is for. You have CustomCare where the first thing that's on that CustomCare is 40/89 and you have a second CustomCare where the first thing that's on that CustomCare is 40/10. And then you have another one. That first thing that's on it is 40 and 396 because those are no.

[00:42:40] How long do you typically like to run 40/89 for? I know it depends. It depends. It depends. It depends.

[00:42:47] And any place from 10 minutes to 90.

[00:42:55] I have a CustomCare that I use in my clinic that I never lend out. It has a whole bunch of one-liners that I need when I need them. 40/89 is the very first program on there, and I set it for 10 minutes. So that's funny because I found the minimum it needs is about 10 minutes. And if I have to run it longer, I just kind of I have a longer one for an hour on it. So for people that are writing their own programs like I think the one-liners are really an asset to use in the clinic. If you don't want to get multiple precision cares, there is a way with CustomCare's. If you just need 40/89, we'll just write 40/89. And if it's just.

[00:43:39] And speaking of, how do I do this in practice? Well, if you are a manual therapist, you need a PrecisionCare. If you're a PT, DO, or anybody that does physical medicine, you have to have a PrecisionCare. There's no way I could have done that girl's neck. And there's really no way that Chris Allcroft could have. Everybody needs to realize that SMA2 spinal muscular atrophy is genetic. The child is missing an enzyme in the spinal cord. It is fatal. It is untreatable. There is no thing that treats it. Right. And. Christine Allcroft using the Solfeggio frequencies for repairing DNA.

[00:44:39] They're not on our laminate, are they? The Solfeggio frequencies?

[00:44:45] There on the Advanced. It's like there's only so much. So they're on the advanced and then increased secretions in the spinal cord while there's, there's no enzyme there to secrete. So you have to repair the DNA and then do 81/396. And she found out that using negative polarity worked better. Well, the way you play with the

PrecisionCare to figure out what's what. That's what the PrecisionCare is for. But the the no brainer stuff. All of mine. Like if 40/89 is done in ten, I program all mine for 60 minutes. Right. So and if it's done in ten and you can tell by the look on their face if it. And I don't get to treat athletes much anymore so most of my patients need it for 30 to 60 minutes. Yeah. Anyway, and you can always switch it off and 40 and 10 and 40 and 396 and concussion and Vagus. That's for CustomCare's and it. People. People ask me, it's like, How do you get so much done in an hour? It's like, Well, because I do five or six sessions in one hour because I have five or six machines, and if you only do one piece of it, then it takes you eight weeks. If you do all six pieces the first session, you get it done in four sessions, and they're done, done, especially if you put them in the gym. And it's a melding. I mean, the lady where her score and the brain injury visual system symptom questionnaire. Her score was 18 as predictive or diagnostic. Her score was 55. I've never treated anybody with a score that high. And so at the end of the first visit, I gave her two Meclizine wrapped in a tissue and told her to take them at bedtime. Right. And she said, the next day I slept for the first time in 23 years. And then. That day after her treatment. We wanted her to go on the gym and get on the reformer. And she looked at the reformer and said, I can't do that.

[00:47:20] Right. You explained that last week. Yeah.

[00:47:23] That's week. Yeah. But what I'm talking about is there's not. There's no reason not to combine what you know about what's within your scope about nutrition. Prescription drugs over the counter drugs which are in my scope, supplements are in my scope, and prescriptions were in the scope of a third of the class and MDs. So there's a melding. FSM is a tool that makes everything that you do easier. That's.

[00:48:07] Everything that you do.

[00:48:09] Yeah.

[00:48:11] One question came in from Summer. Treating osteonecrosis of the knee patient hopes to avoid knee replacement. And yes, we are going to Hawaii. The info should be on the website.

[00:48:25] Is Hawaii on the website for next year? Is Hawaii, the Core in Hawaii on the. No, He has the page mostly built it's just not up.

[00:48:40] Sign up is coming. We know it's going to be full.

[00:48:45] No it's yeah. Let me see if I can find on my calendar and I will tell you exactly what week.

[00:48:51] And leave leaf. Right. Sounds like my friend Meclizine reference. Thank you.

[00:48:58] You're welcome. Yes. Yes. It was your friend. The Meclizine reference. That's the one. It's August of 23, and it is.

[00:49:13] When is it? Because I'm coming.

[00:49:15] Oh, really? Oh, so much fun. Okay. I have the Master Class at Derek's the seventh to the 11th. So that means the Corps is from July 31st until August 4th.

[00:49:36] There it is.

[00:49:38] And then we have two days off because. I've said this before. I'm going to Two-Step. Yeah. This is my year. And then the 7th to the 11th. And then the 14th to the 18th. And, Derek, if you're listening, I just haven't gotten back to your email to tell you what we're planning. And there's a limit. There's only 20 people that can come to those masterclasses.

[00:50:20] Okay, let's get to a question. Let's go back to osteonecrosis of the knee.

[00:50:25] Osteonecrosis. For those of you that don't know what it is or haven't treated it is when the blood supply to the bone dies. Osteo is bone necrosis is dead. Shirley Hartman did a presentation, I can't remember what year, but she had osteonecrosis in her shoulder because she had sarcoma and they did radiation and the radiation kills the blood supply. And 20 years later, she ends up with osteonecrosis of the shoulder. So she told in that slide how she fixed that. The difference between the shoulder and the knee is weight bearing. The knee and the blood supply to the knee is compressed every

time you stand on it. It's impaired when you don't move it. So you want to it's easy to treat with sticky pads on your shoulder, which I'm sure that's what Shirley did 12 hours a day for six weeks. It's easy to do that with the shoulder, putting a patient to bed for six weeks until then, telling them to keep moving their knee. And I don't know how to do that. Everybody in their right mind would desire to avoid a knee replacement. If you can get the patient or the surgeon or somebody to test the patient for metals allergy prior to the surgery.

[00:52:32] They used stainless. Apparently they used chromium, which is strange because chromium is the thing in stainless steel that people are allergic to. And titanium, those are the most common knee replacements. Knee replacements are complicated because the architecture of the knee, architecture of the hip is fairly straightforward. There's this angle because you've usually got one hip that's good and one hip that's crummy. But the angle of the femoral neck is roughly the same, and the size of the femoral head is roughly the same and can be measured.

[00:53:29] So you can fit the implant to the patient, right? Small, large, whatever. And it's simple, right? The architecture is simple. Think about the architecture of knee replacements. People have rehab from knee replacements are tricky because you have the curve of the end of the femur. You have the curve where that curve meets the medial side and that curve meets the lateral side. And then you have this; I mean, knee replacements are difficult. The rehab is difficult, and that's if everything goes well. So we have tools for treating them if they go badly. But some are for what you would treat for osteonecrosis of the of the knee.

[00:54:32] Which part of the knee is the first question? Is it in the femur or the tibia. And you're treating the bone for necrosis and degeneration. That's obvious. But you also have to treat the capillaries. And capillaries more than arteries, but probably the arteries, too. And it depends on what their vascular supply is. So if they have a lot of calcification, so if they know if they have heart disease and they know that their calcium score is 320, yeah, that means that the blood supply to their knee is not going to be great to begin with. And you can try but it fixing osteonecrosis is months. It's not a two-visit fix and the necrosis in the bone proliferates because dead bone makes more dead bone. Same thing with the talis. When the talis dies, when you get a non-union and a portion of the talus or the; what's the one on the wrist that dies? So that you'll get a non-

union of the navicular and sometimes both have slaves and one, sometimes one half gets necrotic and it just lays around being a space holder.

[00:56:08] Right. Right. That's right.

[00:56:15] Yeah. Because? Because the blood supply to the dead half, there's a thing. It's moving on.

[00:56:25] Well, I just would add to that. Increasing the vitality afterwards to the tissue. So I have a new love affair with 49, especially after talking to Ben Katholi, he kind of validated some of my emotions and feelings to 49, especially with fascia. Especially after talking to so many people, that fascia is innervated. So just again, to close that loop, increasing the vitality is such a 49 is such a yummy frequency.

[00:56:55] And in an austio necrotic tissue, you're not going to increase vitality in the fascia, you're going to increase mortality in the capillaries and 59/39, not even 783, but you could add 783 but.

[00:57:12] What about 157 joint surface and cartilage? What about there?

[00:57:16] No they don't die. The bone dead. Yeah, it's that the problem.

[00:57:23] Before we end I have some fantastic news that I want to share with you.

[00:57:31] It's not 5:00.

[00:57:32] It's true story. We have 2 minutes. I'm learning that I have to do like our closing wrap up a few minutes before five because it always takes us like 5 minutes to actually stop talking. So I shared this news with you like, I think it was a week ago or two weeks ago. So this news is now located since I talked to you. I'm just going to keep it all anonymous still. But the news that I was super excited to share with you was that we have professional sports teams that are now taking our training executively privately, and it's such a testament to the educational material that we're putting out. People used to ask me for Preprogrammed CustomCare's for the locker room and that was great and I felt like, well, it's something, but it's not everything. I think that started to die off and

people lost their they kind of lost the efficacy because it's not a one size fits all. Not everybody will benefit from the same program. It has to be tweaked. So over the years, people that have taken the Core and the Sports and has proliferated into the professional sports communities, athletes are seeing the relevance and the benefit of having CustomCare's that are programed specifically to them and their needs and having things dialed in. So now we have three sports teams simultaneously taking the training this summer.

[00:59:11] And you have to give yourself credit because the real impetus to this are the athletes that have seen you that show up. On the plane on the way home with their preprogrammed CustomCare. Or get injured on the field. And they're better in two weeks instead of two months. And eventually. The trainers and the other players are actually the drivers. The other players say, What are you doing? Where did you get that? I want to see her. And then the trainers get well, I would say jealous, but let's say interested. And they say, What are you guys doing? I got to talk to her. And. And that's how it has always spread. Is what? Yes. Congratulations. That is major. Finally.

[01:00:19] So, everybody, congratulations. This is a group team effort.

[01:00:23] So are they taking the sports core or the three day pain and injury? And then the.

[01:00:29] Sports right now they're taking the sports core because I have the videos because it's the off season for many different sports right now. It's just a bit easier for their staff to watch the videos and watch the practicums on video. And then we're going to be doing some private practicums that I'll be going out with, maybe a helper to do some stuff with.

[01:00:51] So it's so exciting.

[01:00:53] And it's not just one sport, it's three right now. So it's the universe is sports.

[01:00:59] Three different sports finally. Thank you, Kim.

[01:01:04] Hey, thank you, everybody. Here is my quote to wrap up today.

[01:01:09] Okay.

[01:01:10] It's a good one. And maybe you'll know who said that. I don't know. Let no one ever come to you without leaving. Better and happier.

[01:01:20] Amen.

[01:01:21] That's Mother Teresa. And I think that one is last time we said. You don't have to fix everybody. It doesn't have to be a slam dunk. What you're doing is enough and be great and be awesome. And I think that's just if you can make a dent and have somebody leave you just a little bit better and a little bit happier. That is a successful treatment.

[01:01:42] I would go with that.

[01:01:45] And this was a successful podcast. We did it. We made it.

[01:01:48] Thank you very much.

[01:01:52] Keep the questions and comments coming. We will keep adding it to all my legal pads that are sitting here. Questions are not forgotten. Thanks, everybody, for joining us. We'll see you all next week.

[01:02:04] Next week. Bye.

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