

# Episode Forty-Eight - Spinal Muscular Atrophy

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[00:00:05] Oh you have a little different background today.

[00:00:10] I have been moving some things around and I'm back in my office finally. So.

[00:00:16] Oh, yeah. Oh, and they're sure. They're sure. Ruth Johnson Award.

[00:00:24] Yes, The plaque is in my office in the clinic because I'm not one to like. Put that stuff out there, but I felt like it had to be there. Yeah.

[00:00:36] Yeah.

[00:00:38] Yeah.

[00:00:39] Yeah. All right. So the thing that you and Ben.

[00:00:47] I know we're. I'm having technical difficulties. I can't hear you today.

[00:00:52] I'm talking. I know you were. That one. That's all right. You can't hurt me. I'm not muted.

[00:01:01] It's just. It's just low. I think it's my computer.

[00:01:04] Okay. I like it when it's your computer. And actually, if it's my computer, then Kevin fixes it. So. And you're playing the part of Kevin. Is being played by Kim. The matinee cast.

[00:01:24] Oh, that's so funny. How was your week?

[00:01:29] Interesting. So we're planning Adam's memorial. So that's coming up. And it's turning out to be, like, 100 plus people. Wow. Out at George's place. So there's all that. And the team that's doing here, I'll do this and I'll do that and I'll do that. So that's all done. And then I have the most interesting patients. And one is he had COVID and was in a coma for 10 weeks. So two and a half months. And the positioning that they did cut off the blood supply to his tibial nerve. So he has foot drop and this is maybe his third or fourth treatment. And when we were in Philadelphia a couple of weeks ago Christina Allcroft accidentally. She was working on an SMA patient, Spinal Muscular Atrophy.

[00:02:44] Yes.

[00:02:45] And started getting this amazing. Like really surprising increase in muscle mass and mobility. So SMA is a genetic condition where they don't have the enzyme in the spinal cord that does make muscles. So these kids have complete muscular atrophy because the motor signals from the brain, they have normal brain development. The motor signals simply do not go down the spinal cord because the spinal cord doesn't work.

[00:03:25] She presented a Symposium case two, three, four years ago. I treated one SMA patient in Germany and got her arms working and she was 29 and we had an SMA patient come at the end of the day on Saturday and Sunday. And Christine was treating that patient because I was treating somebody else. And the muscle mass was increasing more quickly than it usually does with that. Usually you use the frequency for repairing DNA from the solfeggio with the spinal cord and the nerve, so it takes two or three machines and then you run increased secretions. And it was working faster than it usually does. And she looked over at the PrecisionCare and it was polarized, negative.

That's a good face. And because what do I always say. It's like we never polarized negative because. And then it made perfect sense. Positive polarity, positive current sedate nerves. So it's ideal for calming nerve pain.

[00:04:59] So having that fresh in my mind when I treated this patient yesterday. We've been measuring the girth. Sensory nerves are easy. That's just increased secretions in the nerve and inflammation in the nerves. So we got the phantom limb pain gone the first session. That was easy. And sensation is normal. But motor is always more difficult. And yesterday on him, measure the calf and we already have increased his calf girth by a centimeter and a half, almost two centimeters. So the calf at ten centimeters below the patella didn't change. He can flex his foot. He can't dorsiflexion his foot. It can't bring his foot up. We got movement back in the toes. That was last time. And the big toe is still on strike. But I used repair DNA. What killed the nerve was cut off the blood supply to the nerve by positioning him in such a way that it's compressed against something for ten weeks. Completely reasonable that the nerve would choke.

[00:06:34] So I did increased secretions in the nerve and it polarized it negative. Had already done trauma to the nerve. Then I did repair DNA in the nerve. On the second machine. And then hypoxia. Ran that for 30 minutes. And then occurred to me it's like, well, what causes hypoxia? Will you squish the blood vessels? Now, nerves aren't fed by arteries. They're by capillaries. Little, teeny, tiny blood vessels that feed the nerve. So on the third machine I ran trauma to the capillaries torn or broken. That didn't feel right. I ran vitality in the capillaries thinking Ben Katholi and. The portion of his calf that's 20 centimeters below the patella increased by a centimeter and a half and he could flex his foot. So he's doing exercises. He can now walk. He'd been walking without his brace. And then I did increase secretion. Well, first we had to increase secretions in the cerebellum. And then he said, oh yeah, no, my left hip. Oh, yeah, that's right. Left hip. They had a left knee replacement.

[00:08:17] So this is the right foot that got squished at a left knee replacement. And I said, Oh, trochanter, bursitis is never the trochanter at bursa. Everybody knows that, right? It's not. I don't look good. Well, everybody knows that. So it's never the trochanter versa. So I thought, Oh, this is easy. They just put a tourniquet on. There's adhesions of nerve.

[00:08:44] So I treated him as a go back to his knee because of the knee replacement and treated inflammation in the nerve. That didn't do anything. Scarring in the nerve. That didn't do anything. And this is where you talk about flexibility and it's like. Okay. Why else would his femur be locked in internal rotation?

[00:09:13] So in our world, trochanter bursitis is caused because the external rotators, performance, has to pull too hard and it irritates the bursa. That means something that does internal rotation is too tight. You had a knee replacement on that leg, right? Hmm. I wonder. A little bird on the shoulder. And I ran metallic. And the knee replacements. Titanium. I ran metallic toxin in the bone marrow. And all of a sudden he could externally rotate his leg. So I had one machine running for 30 minutes on metallic toxin on the bone marrow. One machine because the poor performance is so. Time and it's been working so hard that it has tendonitis.

[00:10:11] So there was one machine I'm torn and broken and the connective tissue, and then there was another machine running on just inflammation and the bursa and then metallic toxin in the bursa. And then we went to internally rotate the hip and you know how it jerks and it's like, oh, you're afraid to move it. So we ran one of the machines just switched to quiet down the hippocampus. It's just you just need to forget that the leg ever hurt. It's fine. And then quiet down the cerebellum for Kim and then increase secretions in the cerebellum. At the same time, you're still removing the toxins from the. Bone marrow, and all of a sudden the motion was smooth and easy, and then I had them do it actively. You'd be so proud. Now I hear your voice in my ear all the time. It's a thing. It's really fun. That was my week.

[00:11:19] Okay. Lots to unpack there. And it's. Amazing. Now, people don't understand that you and I don't plan the podcast. Like we literally show up and I have legal pads. But you don't know.

[00:11:34] I have no legal pads.

[00:11:36] Not only do we coordinate our outfits, but we coordinate what we're uploading into our brains.

[00:11:43] So in the universe consciousness someplace, right?

[00:11:49] So before we get into some of the stuff, I want to talk to you about that patient. Last week we talked about METH and Rice.

[00:11:59] And to ask you about METH. METH.

[00:12:01] Okay. So the man who coined METH, he's a Canadian trainer. I reached out to him to see if he would like to join our podcast away. So he's got a very crazy schedule. So we're going to see what we can do. At the very least, I'm going to record some stuff with him because he's amazing.

[00:12:25] But so for a month. So that's you got four weeks.

[00:12:31] I figured I could do like what I did in June. So METH is movement, elevation, traction and heat. There's another acronym that I wanted to talk about. It's doesn't flow as nicely as Rice and METH. It's arita ARITA a it stands for Active Recovery is the Answer.

[00:12:54] Okay. I like METH better.

[00:12:55] But I know. But this guy, Gary Randall, who is the author of ice'd the Illusionary Treatment Option, had coined it. It's a fabulous book. So some of the feedback I got where people wanted to know about the studies that is disclaiming ice right now and that component of right. So Gabe Merkin was the what was he a trainer or a PT in 1978, came up with it and he is now saying he was wrong.

[00:13:27] ice.

[00:13:27] Yes.

[00:13:28] Oh, right. He came up with Rice.

[00:13:31] He came up with RICE. Yeah. He's the guy that did RICE. Ice, Compression, Elevation. RICE is the answer. RICE is not the answer. So the two journals that I was talking about is the Journal of Applied Physiology in the Journal of Strength and

Conditioning. If you just Google RICE versus METH, you are going to see a plethora of articles and information and all the things. There is also a web page that I'm going to bring up also. But John Paul Catanzaro? I'm not sure how you pronounce his last name. He is the one that came up with METH. So. A lot of what the RICE the ice portion was about was a purely analgesic effect. Numbing the area felt good. So people love doing it because it numbed it very similarly to taking Tylenol numbs pain. But what is it doing? And when you work with athletes, when you work with people that are paying you to get them better. We as practitioners should be doing everything that we can to promote healing. So robbing a vascular area of blood flow. Doesn't make a whole lot of sense. You need that. The study that I was talking about icing the mice. And yes, the initial mice felt great and they were running around and playing. But when they did all their metabolic counts and they did all their testing after they found that those mice that were ice'd weren't recovering, because you need that acute inflammatory response to bring, like you said, all those little yummy platelets to come and clean up the area and then they leave, right? So that's why things like blood flow restriction therapy is becoming more and more popular. We're including blood flow and then we're letting it go. So we get this influx of really good nutrient-dense circulation.

[00:15:31] So you alternate compression and then.

[00:15:35] Exactly. So it's like back in the twenties when these manual osteopaths started doing ischemic compression on trigger points. And why it actually feels and it works so well is because you are taking an area that doesn't have good blood supply, excluding it further. And then you get this reflexive hypothermia when you take the pressure off and again, you're using your body's natural circulation to come in and vascularized and feed an area that's been robbed, which is why I think the hypoxia frequencies work so well. And especially with manual therapy and movement, you're bringing vitality, you're increasing secretions, you're doing all those things to an area that didn't have anything for so long.

[00:16:20] It works for me.

[00:16:21] Right? So I even like it in an acute setting because somebody else is saying, Oh, this is fine for a chronic condition, but no, it's not in any acute condition. You have to

get out of your head that you're making an inflamed area worse because that's not the case.

[00:16:44] An inflamed area already is. If you look at what inflammation is. It's heat. Right? Heat and pain and vasodilation, right? Yeah. So there's already a lot of circulation there. That's what causes a swelling and ice takes down the swelling. But these days, don't they alternate ice and heat? Isn't that a thing?

[00:17:18] You can. And one of these big trainers in sports medicine with professional athletes is using Rice and METH together. So you can put ice on the joint short term and you can also put heat in the muscle belly that's a little more proximal to help draw those inflammatory cells. Do your thing, go clean up the knee, but then come join the vessels in the clot and let's get up and put this into circulation again. So yeah, we're seeing we're seeing a big shift that way.

[00:17:51] And I remember something, a paper that David Simmons sent me showing that ice applied externally doesn't do anything to a joint. It just cools things superficially and reduces swelling or inflammation in the superficial tissues. But it doesn't do anything to the muscle because it doesn't go deep enough. You can't do anything cold enough to do. And yeah. So that's in print someplace. I don't remember where because I read it and I'm like, Wow, that's cool.

[00:18:35] And then there's only so much bandwidth that a human brain can hold. And I think you're like.

[00:18:40] I'm not around.

[00:18:46] It's funny my daughter who's recovering from ACL reconstructive surgery. She's right in the sweet spot right in the middle now where, of course, she's cleared to do everything because we're ahead. For various reasons. Imagine that. But she was running on a type of treadmill called the Alter G. I'm not sure if anybody knows what that is developed like by NASA scientists. It's an antigravity treadmill, so you jump in it similar to like a kayak and it has a bib all around it. And you can it's anti-gravity. So it's a wonderful tool to get people back to weight-bearing exercises because it will measure what's left and right to make sure that they're weight-bearing equally. And then we drop

from eight things up to like like 80%. They're almost like floating on it. So it is developed by the scientists that were working with the app, the astronauts for the space shuttle. But it was a reverse gravity so that they were forced to weight bearer so they wouldn't lose muscle tone and muscle mass while they were up in space. So then some brilliant thought, well, why don't we flip that instead of using like water, which what we typically get people in have it.

[00:20:06] So it's amazing tool. So she's on the treadmill and she's running and she's 50/50. Of course she is because we're using ton of the frequencies for afraid to move it all the time in these like weight bearing stages. So she gets off the ultra G and the she's like, Let's get you, let's get you iced. And her face. Her face went to being so proud to running on the treadmill. Looked at me like. Are you going to say something? We don't ice. I'm like, Oh, I think she's okay. We'll just, you know, and I have the CustomCare in the car to help for recovery. So my point being for RICE and I know it's hard for some people to not use ice because you're right, it numbs it. But you have to think what like what we think about when we use FSM, what is wrong? What is happening? What is occurring? How did it get like that and what's your goal like? What's the end game here? Your end game is to get that patient recovering. So. There's not a lot of data to show that the ice helps with healing.

[00:21:16] Just. And just to. Get people to think about numbing it. It doesn't. I'm not sure it actually makes it numb if you think about how the spinal cord works.

[00:21:33] Right.

[00:21:34] So the patient that I had with when his foot was painful was always when it was non-weight bearing. As soon as I stood up, the pain went away. It's like, okay. It's because when the sensory nerves, when you give them something, when you give the spinal cord something else to transmit to that area, it distracts it. It pain, it takes bandwidth away from up going pain signals. And all of a sudden you're you've got up going cold signals. And up going proprioceptive signals. So if you think about the spinal cord pathways. And how Paine transmission works, then ice doesn't actually numb it. It gives the brain something else to think about. And heat could actually work the same way, basically because of you. So every night I sleep with a thermal for. It's a big heavy. The heating pad that's got a felt covering is supposed to be moist heat, whatever, but I

sleep with it from my collarbone pretty much to my pubic bone. Well, because of you, I now pull it up on my right shoulder and and leave it warm for half an hour, and it's like, Oh, that's good. It must have been the Advil. No, it's good because now my brain has heat to think about it instead of the person. The tandem that are cranky.

[00:23:20] And heat is soothing. Like being warm is comforting. You know, like these are these are also things I also want remind me to talk about this part. Comforting warmth, stuff like that.

[00:23:36] Talk about comforting, warm stuff. Okay, okay. Okay.

[00:23:40] I hate when my kids do that, but thanks. One of the concepts that you were talking about with your patient just now, with the strength, you know, increasing. Girth. I've been doing this with a lot of patients using 49 and 81 with 46, which I am not sure if it is using.

[00:24:08] If you start Humira sarcoloma? I don't know. I like both of my hypothesize. This is equally. But and it's funny how like you you meet so many practitioners at the Advanced meetings and certain things that people say are engraved in your brain. So I'm going to talk about Roger Basilica again because like worship the ground man walks on. I could I could listen to him, read the phone book to me.

[00:24:42] Yeah, but and these coming in February, we have Roger Billica and Neil Nathan at the Advanced. Wow. Like, just put it on the calendar.

[00:24:52] Okay, just do it right now.

[00:24:53] Yeah. And I'm going to make both of them talk of both the Advanced and the Symposium just so we get to your room twice because it's really fun.

[00:25:00] Yes, it is.

[00:25:01] Because I can. Yes. Okay, Roger, go.

[00:25:04] So he was talking about see and that's the thing that I don't remember, like the prequel to his quote, because it was very complex. Roger Billica has a brilliant way of taking extremely dry, complex material and making it fun and entertaining and digestible.

[00:25:20] for anyone in the room. And we have such a diverse group at these meetings from MD, PhD to veterinarians and massage therapists and trainers and everybody in the beautiful spectrum. So I believe he was talking about supplements and working with the adrenals, and I know for a fact it was about adrenals because he was talking about be careful of taking away the bad stuff before you give them the good stuff.

[00:25:54] And this, good and bad was a catalyst for getting a patient that I presented at the Symposium, not the last one, but the one we did over COVID. She was in a horrific car accident that had plummeted 250 feet off a cliff and broke every bone I think I could count and is held together with pins and plates and multiple surgeries and has a plethora of scar tissue. That you have to be very careful about breaking down because it is holding certain things together. So it is this balancing act of strengthening areas before you take away too much scar tissue or. I said, why do we even have to take away the scar tissue? Why don't we just make it more functional? Oh, yes.

[00:26:54] In my. The way my brain works, the scar tissue you take away is between the fascia and the nerve.

[00:27:02] Yes.

[00:27:03] And once the nerve is free because the muscles aren't weak, they're inhibited and they're inhibited because the cerebellum doesn't want the nerve to get hurt.

[00:27:13] Right.

[00:27:14] So how do you get the muscles uninhibited? What's the cerebellum protecting? And the cerebellum does not notify and it does not negotiate. So what is the cerebellum protecting? Usually, it's a nerve that's adhered. I don't take away scar tissue and the fascia or the connective tissue. I just release the nerve and I let the cerebellum decide how much it's safe to move. And you still because everything goes to the

hippocampus and the limbic system. So you still have to do 40/89. Quiet the limbic system. No, you don't have to be afraid. Just calm down. Then you tell the cerebellum. Well, then you take the scar tissue out of the nerve. And then you tell the cerebellum to forget that there was ever scar tissue there. And then you tell the cerebellum to increase secretions in the cerebellum to activate the nerves that were inhibited. And that's when you find out. What scar tissue is left. Because now you have ten more degrees range of motion. And then it stops. What's the cerebellum afraid of? Oh, that nerve.

[00:28:46] In my world, it's. I confessed to being neurocentric, but taking out the bad stuff and putting in the good stuff. There was no point in treating just metallic toxin in the bone marrow unless you treated the torn attachment of the performance to the periosteum and the inflammation in the bursa, right? Because the cerebellum was never going to let the hip externally rotate as long as there was a partial thickness tear in the performance attachment to the trochanter and bursa inflammation. And so I ended up with four PrecisionCares on this guy. And when you charge that much per hour because David Musnick threatened me with bodily harm if I did not charge \$200 an hour. But I can get three months, six months worth of work done in an hour by using four PrecisionCares. And the PrecisionCares, I mean, the clinic had to buy them. But when you when you can do that. Patients don't mind paying \$400 for 2 hours work because you just did three months worth of work.

[00:30:05] Right. Absolutely. And these types of patients, what you're just talking about, this car accident patient, I could never treat her with one machine because I do 124/77 just on loop for an hour because there is so much torn connective tissue that you're right. That is what the nervous system is responding to, that all her brain can comprehend is everything in my body tore and broke and it's not wrong.

[00:30:43] You get why certain muscles are spastic, you get why certain muscles are inhibited. There is also a two-month span where she was almost septic because of all the infections after the surgeries. So for the first few, well, at least the first month.

[00:31:03] There wasn't a lot of things other than metal toxicity, all the bacterial infections torn and broken.

[00:31:11] Isolated.

[00:31:13] All of that. Right. Because that's what the tight muscles are reacting to. It's not just that something tore and then scarred and healed. That is not what's happening.

[00:31:27] Well, and it makes you feels it makes me feel sorry for the people that think it's the muscle. It's like I'm bless their hearts. Just bless their hearts. They think it's a muscle because they don't have the tool that we have now that allows you to treat the cause. Right. What cause? Well, that depends. Sometimes it's easy. And so this guy said in your book, you made it sound like it was the one to visit fix. And it's like no, twice a week for 4 to 6 weeks. And we talked about the fact that what we had already accomplished in two sessions or three sessions, three sessions this time was impossible. You do not get back a foot drop that happens from damage to the tibial. It just doesn't happen. So there's that sign and we'll give you the graphics if you want to. There's that sign in the hallway that's "Be realistic. Expect a miracle, but be patient. The impossible takes slightly longer than the difficult." And he, I. I brought him over and I said, read that sign. This is so go.

[00:33:02] I just want to briefly summarize this before we get to all the questions that I see are popping up. So again, going with Roger's, give them the good before you take out the bad, because I'm not really done with that. I love this concept so much. So, I mean, I got into this world as a personal trainer. That was my very first stop with health and wellness. And then I went back to college and did all the other stuff. But getting somebody strong is always, like you said, you're like neuro centric. That is always. My centric part is getting. Getting somebody stronger. So this is not making the next Mr. Olympia. This is helping somebody who has MS be more surefooted when she gets in and out of her car, like so little things like this.

[00:33:54] In my world, I want to give them the strength first. That is the foundation and then we work with length. John Sharkey can put his hands over his ears. When I say length because I won't say the word stretch anymore, I'll say length or flow because both of those things have to happen. That is just pure biomechanics for a muscle, for a limb to move, you need a component of strength and you need the opposite component of length. Like that is how we move things. So we have strength and we have length. But the hidden component that people are not doing enough, in my opinion, is proprioception or balance and. Manipulating the joint anesthetic receptors and the gtos

and the muscle spindles are. It's a complex environment, but with FSM it holds things so much faster because when you can run 40/89, afraid to move, and then put somebody on an unstable surface and watch them stand like a tree, like a mighty oak in the wind. Right? So that's where I geek out. And again, its neuro centric. That is the nervous system. Golgi Tendon Organs and muscle spindles and GTO and joint kinesthetic receptors is a crucial component of what we do when we put people back together.

[00:35:24] That's the other patient I saw on a new patient on whatever day that was, Monday. She took the FSM course and then she came to be treated. I had one session with her and she said, Oh, I have neck pain but my major complaint is my right shoulder. And then the right side of my neck and. I shared one little fender bender. Hmm. Okay. There was just something. So. Fender bender. Right neck, right shoulder. That's. And then she said, Oh, my range of motion. And she went to, like, here. And so my range of motion is good. And my runner, it's like, no, no, no, that's not good. And you could. So I knew it was neck subscap that part was easy, but there was something about it. Speaking of length. I said, Just put your hand on the counter and bend your little finger up. And it went to 95 degrees. And I went, hmm, let me see your elbow. Minus five. How about your knees? And they were minus five. And then can you bend over and touch the ground? And she put the backs of her hands flat on the floor. And I went, Has anybody ever told you you have Ehlers-Danlos? Or actually, she was seven out of nine. Her knees weren't backwards. And she had a just a she was hyper-mobility. I know. She said I treated my neck and it locked up. So I did the neck pain protocol without the manual stuff just off of the CustomCare did neck pain and it locked up and her chiropractor adjust her like it wouldn't move chiropractor adjuster so that was good nobody had done a sensory exam so that was the thing but.

[00:37:41] Long story short. Yes, she had a disc, the 2-3 facet at the top. So she said, Oh, and I get migraines. Tell me about your migraines. Oh, they do this. And I went, That's the 2-3 facet. And it's really bad. And it's yes, it's this. So we treated one machine neck, two feet, which is 124/77 for an hour and a half. Torn and broken on the connective tissue, and that fixes the error. Ehlers-danlos So she went from seven out of nine on the Beighton sCore to zero out of nine on the Beighton sCore. That was cool. At the end of an hour and a half. And then we treated supine, cervical practicums. Then I got into her axilla and did 13, scarring in the nerve. And then her arm was like this, and then the other shoulder went to about 180 and it's like, Oh, we can do better than that.

So at the end of it, I taught her the exercises to get the muscles strong. And her multifidi and rotators were completely inhibited. They were contracted twice and were exhausted by the third. Attempt to contract. And so we got her exercise program. You treat the Ehlers-Danlos once a week and then neck pain and subacute disc. And it's like, it's not that hard. Then it never was her shoulder. I have shoulder pain and impingement. It's like. No. Just. But. Sorry.

[00:39:42] But patients like that teach us how to be patient. Right? With what they think. So many patients come in, so attached to the condition, and Kevin put all these little YouTube shorts on, and there's one of me just going on a riff about something like, I didn't realize how passionate I get about certain things. But there is one where I'm talking about dancing, and then I go like, I didn't realize how animated I am when I talk about something.

[00:40:16] But certain patients will come in, convinced that it's just the shoulder or it's just their neck. And I had somebody this week who has come to see me quite a few times. I have a lot of out-of-state patients in the last year.

[00:40:29] Is convinced that I need to press harder and I need to stretch him more aggressively and I need to do all these things. And I had to just stop for a second and I said, I don't do that anymore like I have, and I held up my CustomCare and my CustomCare in my PrecisionCare. I'm like, because of all these tools, I don't have to wreck my hands anymore or traumatize you. Now, if you want to be traumatized, there's the door because this is not what I do. So you make a decision what kind of treatment you want. If you want to get better, you can stay. If you want to be traumatized, you can leave.

[00:41:10] Well, and you think being traumatized works because you've been traumatized before? And do you notice that it didn't work?

[00:41:21] Well, this is what I just said here.

[00:41:23] Right. Yeah.

[00:41:25] How's that working for you? It's not.

[00:41:27] No. If it worked, you wouldn't be here. There you go. Right. Yeah.

[00:41:35] Let's get to some questions. Like cool down a little bit.

[00:41:39] What time is it?

[00:41:40] We have quite a few. Oh, Cynthia, please explain the mechanism that has the same frequency as both a condition and a tissue. 94/13 come to mind, like 94 and 94.

[00:41:53] Yeah. And the answer to that is, I have no idea. I got a list, and it's the only thing I say during the course is it's not my fault. And I have no idea how they came up with conditions versus tissues. And it is confusing, but 13 and 13 scarring in the lymphatics works really well when the lymphatics are scarred. And scarring in the nerve works really well when the nerve is scarred. Cynthia, I can't explain it. There you go. It is one of life's mysteries and we just have to live with it.

[00:42:40] Right. But it's still an A channel and a B channel. It's not like you're doing scarring and scarring. No. It just works a little bit differently.

[00:42:50] And the fact of the matter is that the channel and B channel business seemed to apply back when we use the blue box, because the blue box channel fired literally a millisecond before channel B and it worked better to put the condition on a and the tissue and be back when we had the blue box when they built the digital units. The programmer couldn't get his head around having one channel fire a millisecond before, so they both fire at the same time. On the digital unit and it still works. But students, as you know, don't like to hear. It doesn't matter. Right. It makes no. You have to have certainty in sight. It does matter conditionally and mostly because FSM at this point is a language. So you have to have a certain language rules. And so there you go. All right.

[00:44:02] Let's follow up on the CustomCare unit. Why did the channels appear to switch condition and tissue tissue on channel A, the top number and condition on channel B. I missing something? No, it's just a smaller number goes on top.

[00:44:15] That's it. Always, always the smaller numbers on top. And once again, that's the program around the software. When there were first when it was first built back in, whenever that was, I've lost track 27 and it was just. That's the way it goes.

[00:44:32] Yes.

[00:44:36] Because they both fire at the same time.

[00:44:39] Right. And when I was learning, when I was learning all of this, I just had a CustomCare. Because let's face it, it's a big investment at the time and you're not sure it's going to work. So I thought, let's deal with the CustomerCare. It was great because as a manual therapist and watching someone's movement, I didn't have to think about too much. I could run, oh, let's try FTP short or let's try extremity joint and let something run. And then I would look but I would print out the program. So like I said, sometimes I realized it would put the smaller number on top. So with the new software, it's great because you can print out the program and follow along if you get confused. Sounds like you're still learning, Cynthia, how things are working and then you can just. I love paper. I think a lot of manual therapists do love something that we can manipulate. That's why I love the laminates. As much as I love the buddy, I'll always still have laminates.

[00:45:37] The laminate is my friend.

[00:45:38] Yes. So that's with the new software. It's great. You can print it out and if you're stuck you can see it like in its correct pairing to help you figure out what's what's running.

[00:45:49] Software does the same thing. I mean you can go any particular program protocol and right-click it and say print it out. Yeah.

[00:45:59] So I just think the new stuff works a little bit easier.

[00:46:03] They're trying to teach it to me.

[00:46:05] Just somebody is wondering where to recommend putting the pads for a dental surgery all four quadrants where wisdom teeth are being cleaned up. I assume trauma pretreat. Would you also use trauma fracture because of excavating the bone? There's an oral. Bony oral surgery. I don't know what trauma pretreat is.

[00:46:28] I don't either. And there's bony oral surgery is in the CustomCare mode bank.

[00:46:34] Yes. It's all there for you because.

[00:46:36] I have so many oral surgeries. We designed that for me. And then so it's in the CustomCare where I don't know.

[00:46:45] Okay, go. Also with dental, you can put a cloth on either side and have the patient hold it that way. That's nice for.

[00:46:55] We put sticky pads on when I had so many surgeries I put even when the surgery was on the lower jaw. Yeah. Sticky pads up here, right on the right. Green on the left. Because I can always remember red. Right. And then the black one. You can put down here on the neck of black and yellow on the neck or even on the clavicle. And I tell people, I had I've had nine jaw surgeries and it's like, oh, it can like, no, there was never any swelling, never any bruising. And I never took. I took maybe half, you know, they give me 20 oxycodone and I take half of one just so I could get to sleep. So there you go.

[00:47:44] Given the discovery that PrecisionCare being polarized, negative with a good, great result, is that something that will be explored as a treatment option?

[00:47:51] Certainly not in the Core. If I put anything more or confusing in the Core, it's we're really going to have a thing. So I'll talk about it at the Advanced. And just so everybody knows, I found out in Italy that I have to completely rewrite the Advanced completely. Like what I did with the Core during COVID. I have to find time to do that before February because it's just wrong and I haven't changed the basic structure of it in 18 years. So we'll talk about it at the Advanced. We'll let I'll have Christine Ashcroft present her. She now has three SMA patients. And she's the one that. That accidentally polarized it negative. And so I'll let her present that as a case report and then we'll talk

about it. Cynthia. Cynthia, welcome, Cynthia. The Advanced is in Phenix and it's on a Thursday, Friday, and the Symposium is Saturday, Sunday. And what it's been, isn't it the middle of February? I don't have my phone. Which part? The Advanced. The advance is still in February. something? Yeah, February.

[00:49:31] Like the third week, isn't it?

[00:49:33] It's a third week. It's the Advanced is 23-24, February. And we got we get to do the podcast together on the 22nd. I'm so excited.

[00:49:50] That was so much fun.

[00:49:52] It was. And then 25, 26 is Symposium. And at the Symposium already we have Katholi and Burke.

[00:50:02] I know.

[00:50:03] I have goose bumps.

[00:50:05] They're my people. We have a text feed, the three of us.

[00:50:09] Okay. I could tell that you guys just sort of gang up. And I'm going to Chicago in October for two-day practicum and text with Ben and Dave. And Burke says, you're going to be in Chicago. What dates? I'll be there. So I got both of them in Chicago for two-day practicum. And next year, we don't have dates yet, but we're going to start doing Five-Day Core's again only every other month. And we'll do them live because that's way more fun. And you can still take it on video. And we recommend you watch it on video before you can take it live. So you're easier that way.

[00:51:02] Derek is asking recommended placement for towels to treat an ear infection.

[00:51:07] We don't treat. Derek. Derek. We don't treat ear infections. We don't. It's ear infections can make people deaf. That's bad. I did treat a baby this week. It was so much fun. And he's got a cleft palate. So when he drinks this milk, the milk goes through, the cleft palate goes eustachian to inner ears. So he's always pulling in his left

ear. And there is, used to be, an over-the-counter product called Oralagain, it was in a blue glass bottle and it was glycerin and then antipyretic. So an anti-inflammatory and an antibiotic. And because I worked for the company that sold it. I happened to find out that the antipyretic and the antibiotic are kind of to make it look nifty. The really active ingredient is the glycerin, which is listed as inactive. So when he gets fluid. Before you get an ear infection, you have fluid behind your eardrum. Right? And then bugs grow on the fluid and then you get an ear infection. But first, it is called otitis media, I think. And you just get fluid behind your eardrum and it hurts. Well, you put these drops in and the topical anesthetic does make your eardrum stop hurting. But it's the glycerin that's in the solution that pulls the fluid. Just straight up osmosis, high school chemistry, straight up osmosis, the glycerin and the liquid pulls the fluid out of his inner ear.<sup>53</sup> And this kid had awakened every 2 hours because of his ear and because he was teething. So she bought the drops there now still over the counter. But the other really cool thing is teething. We have a frequency for the gummies. What is teething? Well, it's torn and broken in the gums, and it's bleeding because the teeth do their thing. And so she ran it on him. They had a Magnetic Converter. She ran the teething protocol on him, torn and broken and the gums, 18/62 bleeding. And he slept for 5 hours for the first time since he was born or since he started teething. So that is my feel-good story for the week.

[00:54:02] I love that. All right. One last question before we wrap. Yes.

[00:54:09] We have 7 minutes left.

[00:54:10] I know it takes us at least 10 minutes to wrap up. If you don't know that.

[00:54:15] Cynthia had a client in for lipo treatment and she was dizzy and concussion and vagus dizziness went away while supine. But when she sat up, she vomited and did so on the way home. She had just come from P.T., where it sounded like they were addressing it as a health issue with exercise. She slept through 94/94. Could that have contributed to her nausea? Recommended a vestibular clinic.

[00:54:41] Slam dunk. If you run concussion and vagus and somebody gets nauseated or throws up, they have a vestibular injury. Which is why the other thing you do before you do concussion in vagus on anyone is at least do fields of gaze, check them for saccadic pursuit and ask the questions. So that whole vestibular section that we do in

the Core, that 45 minutes, the history questions, just pick two or three. And I picked out, I think, two or three in the last two weeks in new patients. So to our ehlers-danlos patients or hyper-mobility patients and two or three vestibular patients. And they hints are subtle, but after you do it 100,000 times, you get pattern recognition. But honestly, before you run the concussion protocol on anybody, you do. Hold off on concussion/vagus if they have saccadic movement. Actually, I have two versions of concussion/vagus in the CustomCare I have in the office. The first one is concussion/vagus and the second one is concussion and vagus -94/94 because 94/94 is the only thing that makes them nauseous or makes them vomit. And I still don't know why. And but it's only that one. Who know.

[00:56:33] Yeah, it's 94/94 is funny. I love 94/94. I will sniff that frequency out when I'm teaching. I know exactly who's on it and I really want to just drop myself on that patient and just snack off of that current. I adore 94/94. I want to put it on a t-shirt. But you're right. It is a scary one. And I, I agree there should be two versions of it on your CustomCare because it's, it's a real thing. And I have found if they react the first time, they will always react to it. It's not like it's it goes through them and then they won't react.

[00:57:12] You'll never get away with it.

[00:57:14] You'll never get away with it.

[00:57:15] And honest to God, it is not every Vestibular patient. No, it's no, it's it's about 10%.

[00:57:25] Thank you for that because I have patients that have diagnosed, slam dunk, vestibular issues and they're fine with.

[00:57:32] It. Yep. And it's 10% of the stimulant patients. But it gives me an excuse to spend 45 minutes on what I think of as the most important. I love FSM, but honestly, the most important thing that we do for people with vestibular injuries is tell them they're not crazy. And our students, literally, when you leave the room, you know more about vestibular injuries than 95% of the medical physicians in this country that are gatekeepers. No GP has ever heard of it. Most ENTs have never heard of it. So there's

one in ENT left in Vancouver and one in Portland that know about vestibular injuries. And you find that person by calling the audiologist at the vestibular lab that's in the hospital in your town that has a vestibular lab. You just Google it. Look it up. Hi, I'm so-and-so. I treat patients with vestibular injuries. Who would you send your mother to? Who in town orders testing it knows how to treat patients. And so with many meniere's, I'm on Lasix and I have an EMT that grew up with Robert Graham, John Epley, and Owen Black. And so he was part of the team that knew how to treat vestibular injuries. I love 94 and 94 and I love honestly, I love 40 and 94.

[00:59:32] So if you 94, 94.

[00:59:34] 90 is concussion. 94/94 is concussion in the medulla. And 40/94 is to quiet the medulla. And you have to quiet the medulla before you bring up the vagus. So you take out the bad stuff, then you bring in the good stuff. So it's just it's a fascinating it's what makes me Eurocentric because the nervous system runs everything and. Just don't get me. We don't have enough time to get me off on vestibular injuries and because. Yeah, no. And then you have to find a FCOVD optometrist that will prescribe prism glasses and do that properly before you put the patient into vestibular rehab.

[01:00:37] Right. So everybody on the question answer. I was panicking because thank you for everybody, first of all, for coming an hour early from here on out, because my side job as a mother is a little busier than normal. So I have a young one to get to practice now on Wednesday. So I appreciate the hour bump up. And it's funny because a whole bunch of my East Coast colleagues are like, thank you so much for making it early for us. I'm like, Yes, that's right. It's for you guys on the East Coast. It wasn't about me and hockey practice.

[01:01:12] Well, and we have 40 instead of 25.

[01:01:18] Maybe it worked better.

[01:01:19] It does.

[01:01:20] Maybe. And I know a lot of people like play it back and watch it on YouTube and listen to it while they're commuting. So thanks however you are listening. So my

quote of the day is one that I believe I've done before because it's on my list, but I haven't checked it off. But it's actually the motto for my high schoolers school by Francis Decell and is be who you are and be that well.

[01:01:49] Do that again.

[01:01:50] Be who you are and be that well.

[01:01:54] Wow.

[01:01:56] And I think that is almost like the summary at like the Advanced and at our courses and for everybody listening because of the rainbow and spectrum of practitioners that we have. Again, I went off on a riff about people who are overwhelmed and all these conditions that you have to treat. No, you have options and you have people to refer to, but stay in your lane, whatever your scope of practice is, and be that well, be that amazing.

[01:02:27] And what happens with our practitioners is you start in the lane and then you find that the lane gets a little wider as you learn more. So when you do the supine lumbar practicum and your physical therapist and your lane includes treating the muscles and you have a short, tight, painful psoas, and you run scarring in the ureter. And sclerosis and the kidney, fat pad and scarring in the kidney to release the QLs. Are you still in your lane? Well, of course. What does the frequency 13 on A and 62 on B do? It quiets trigger points in the psoas and makes it non-tender and appears to lengthen it. And what's 13 and 60 mean? It means that the psoas is less painful and it gets longer and that's. So be who you are. And in my world, the role of FSM is to make everything that you do more effective. And when I do the. I just did a webinar with the Institute for Functional Medicine, and the challenge was functional medicine and certain even physical medicine. It takes too long and it's too expensive and doesn't work really well all the time because patient compliance is a problem when you tell them, Well, we'll get this done in about six months. So the role of FSM is to make medicine, whatever kind of health care you do more effective, more efficient, less expensive. And more fun.

[01:04:47] And more fun. Just like this hour. Flew by. Told you it takes us 10 minutes to wrap. Who said we have 7 minutes? Now, we have 10. It's McMakin time. Thank you, everybody, for coming.

[01:05:00] And we'll be back at 3:00 next week.

[01:05:03] We'll be back 3:00 from here on out. Pacific Time.

[01:05:06] Pacific Time. You're welcome, Derek. Look up the drops with the glycerin in it. Okay. We have to go now. We have to go. Okay. Bye.

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