

Episode Four - Coffee with Kim and Carol

Carolyn McMakin & Kim Pittis

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Carol: [00:00:03] Well, since we seem to be doing this every week, that's the thing. We have six whole minutes to just chat,

Kim: [00:00:10] To just chat and looks like we have seven participants here. We're like the early birds.

Carol: [00:00:16] The the feedback on these has been really cool, right?

Kim: [00:00:24] Yeah, I think it's been good. I've been getting a lot of questions on social media and emails and stuff. So I think I think the flow that we have is,

Carol: [00:00:36] I think so. I just I'm. Happy because I just float down the stream that you create, so

Kim: [00:00:51] I like creating the game. Yeah, yeah, it's funny. I think it's great too, because it's Wednesday and it's right in the middle of the week. And I've had a couple of clinical days under my belt and it seems like the universe has given me topics. By the time I come home from work, I work in the clinic Wednesday morning. As I come home at lunch, I'm like, I have this huge list of all the things that I want to talk about, and then I look at the questions and I'm like, Oh, and there's the topic du jour.

Carol: [00:01:22] It always, it always shows up.

Kim: [00:01:24] It always shows up. You say that in the resonance effect, don't you? What you need always shows up.

Carol: [00:01:30] It just doesn't always look like what you thought it was going to look like.

Kim: [00:01:34] So how do you recognize it then?

Carol: [00:01:37] Well, you proceed through it. Because you have to write, so consider some of the things that happen, that look and feel really uncomfortable at the time. And then five years later, you think, Oh. That was the best thing that ever happened to me. Right? And for that, what looked like bad thing, then I wouldn't have made this leap or it wouldn't have been forced to grow in this way. I mean, it's kind of the same. I don't say it the same way to patients, but it's kind of the same thing you do with chronically ill patients or chronic pain patients, so they go through. It's kind of like the stages of grief, but maybe we should describe it as the stages of recovery, emotional

Kim: [00:02:41] Stages of part of the stages of healing, right? And we kind of talked about this last week when you have patients that see you after and they're angry

Carol: [00:02:48] And how you can be relieved. They get angry. And then and there's grief. So there's anger and grief for what they lost anger at the guys that couldn't fix them. But before that comes the oggetti. I'm pain free. I think that's a good thing. Maybe. And then, right, so it's the same thing for each of us. So your office manager embezzlers thirty thousand dollars out of your practice or out of your business and you finally catch her? And that makes you put in. Business security measures that nobody told you you needed six years ago when you started and then you see where the holes are and you go, Well, OK. Lesson learned. I wish it hadn't been so expensive, but. Ok. I learned it. You put the business, small business security measures in place. And then you hire smarter and you learn to listen to your instincts and pay attention to the numbers. So when you have a clinic where you have employees, I'd rather just treat patients and that's what I did. I treated the patients and I left the business end of it to somebody else and that somebody else made off with about \$30000. It's like, OK, then. Right? I know you don't feel like it when you get home, but you have to compare the charge slips to the deposits and you have to do that, if not every day, once a week. And you're right. So what you need shows up. It just doesn't always. It's not always convenient, right?

Kim: [00:04:41] That's a great segue way to start our Our podcast, which is officially starting right now.

Carol: [00:04:48] There you go.

Kim: [00:04:49] So hello, everybody. Welcome. Kevin just wrote here, if you have any questions, please, if you're joining us, live at it into the Q&A tool here at Zoom so we can see it live. Thank you to everybody who's been sending in questions and topic ideas and all the things, so

Carol: [00:05:12] This is my favorite. This is my favorite hour of the week. It's turning out to be, I

Kim: [00:05:17] Know, and it's making Wednesday like a more important day of the week, right? It's more than just hump day. I've it's so funny I was touching on this little podcast. Previous when I first took the core. This was back through DVD time 12, 13, 14. Whatever years ago, I would put my babies down for a nap and I'd get a cup of coffee or a tea, and I used to have it in my head. Ok, it's coffee with carol time and I'm resurrecting it. Those who can't see us, I have my famous cup of coffee. And yeah, I look forward to to this as well.

Carol: [00:05:57] And I have my walk on water water bottle.

Kim: [00:06:00] You have your walk on water. So it's funny since this is show and tell. I have my famous mug that I got from the first quarter. It has a crack in it. It didn't survive my move from Candida, so now it's my pen cup at my desk. So it's still my cup. Oh, inspiration is what I call it. So jumping right into some, some questions and some comments and some stuff. One of the most common questions I get teaching the court class and I hear it at the advanced and when I help you at the core is and I see it sometimes on the Facebook message group talking about meniscus and Abram's. Oh, I know I didn't. I still am not sure like why it's so confusing or what the frequency is for it, or how long do we run it and where do we add it? But because I literally got it four different times this week. I feel like if we could just chat briefly about meniscus and LOX Abram's.

Carol: [00:07:08] So the first thing you need to know about the meniscus and the labrum is sometimes you can't fix it with FSM. That's the that's the place to start from. It's not a reason not to treat it, but so the meniscus, I think the frequency is 214 and that

one. As long as the knee doesn't catch as long as the meniscus isn't flapped over and there isn't a piece that either breaks off or catches. I've lived with a torn meniscus since well for twenty one years since 2000 did cross-country skiing, stepped up to feet and just crushed it and just put a tear in the medial meniscus offered surgery, said Nah-uh. Thanks. And it didn't bother me until maybe two or three years ago, and I just treated there's a protocol in my CustomCare called Carol's knee right, and it has one twenty four torn and broken in to 14, the meniscus that runs maybe thirty minutes. And when my knees drive me totally crazy then or knee, then I run that right. So with the patient, you'd have the patient do the normal things that you do to stabilize the knee quads heads, balancing the hip, the ankle, all of that to make sure that the meniscus is stable and then you treat it. And usually, the meniscus is fairly straightforward as long as there's not a fragment.

Carol: [00:08:51] Once there's a fragment, it's like I'll treat you after surgery, right? So that part's easy. The labrum, especially the labrum in the hip, really, and the shoulder. Yeah. In the hip, it's really difficult because the labor, the way the anatomy, if you those of you that have Netter sitting next to you, you look at the anatomy. The labrum is like a sort of a cup and the femoral head sits in it. Right, right. So if the labrum tear is almost anywhere, the place that it Teres TENS to fold over and get caught by the femoral head. And I had a labrum tear on my right hip before I had my hip replaced, and it would it would catch. Without any notice and like literally, I couldn't take a step. There's there's there's just no way, right? Treat it with FSM. The Lumborum isn't really a meniscus. It's a different kind of tissue. It's not cartilage. It's a really dense kind of connective tissue. So you could I think you could use seventy seven for the for the labrum. And don't get your hopes up. Mm hmm. Hips are almost impossible. My experience shoulders, maybe. But we're talking 50 50. What do you show to Teres?

Kim: [00:10:26] So going back to meniscus and kind of going back to what you were saying, the meniscus doesn't get torn from space. So again, going back to why is it torn? That's the first thing I think of unless there was some sort of major impact. I'm always thinking there was could there have been tracking issues? So my triathletes that have blown out Abram's and Meniere's guy, it's no reuse injury. And a lot of times there is some sort of musculoskeletal imbalance that we're chasing back up the chain. So I do use one to 14 for a meniscus. I also use one fifty seven for the joint surface and for the

cartilage. Again, it's not just a one and done, and I think that might be the theme for today is

Carol: [00:11:20] And one hundred for the LEWK ligament, exactly because you've got the the ACL and the ACL and they they have to keep the knees stable so that the meniscus doesn't slide around too much.

Kim: [00:11:33] Exactly. Yeah, exactly. Yeah. So it's the neighboring tissues. It's also the joint capsule. So if something gets sloppy, the capsule is going to be impacted. At the same time, it creates pressure changes within the joint surface. So to 14 one fifty seven seventy seven, like, yes, of course. But again, I think it's important to remember when you have something like a labrum or a meniscus, you should be thinking, OK, I've got my b two-channel. But what's wrong with it? Most often it is one twenty four that you're going. The meniscus is not inflamed, right? So people, I always see I run 40 and no, it's not inflamed.

Carol: [00:12:19] It's torn, it's broken.

Kim: [00:12:21] Yeah, it's like this one's pretty clear.

Carol: [00:12:25] And it's the same thing with the ligaments, the inflammation. It's like Achilles tendonitis. Exactly. I treated my Achilles tendon for a month, right? For nine months, 10 months for inflammation. And it didn't do a thing. And that's because the fact of being torn and broken. Causes that tissue to express the genes. To release substance p and cytokines, and I think it's CGRP anyway, the inflammatory peptides. But the peptides are there, the inflammation is there because it's torn and broken. So treating inflammation doesn't do anything. You have to treat T1 in Brooklyn, right?

Kim: [00:13:12] Yeah, yeah. So along following the breadcrumbs that I'm going to to lay out for you when we talk about how long do we run something? So yes, we talk about one. Twenty four is time dependent all the time. Oh, and this is going to Segway very nicely into the next little comment that I jotted down. How come we only run it for a couple of minutes at a time and then they're out of pain, so yes, so I'll start, you finish. This is kind of our theme here. If somebody has pain because something is torn and broken, the pain will reduce instantaneously. So within a minute or two, they'll be like,

Ah, it feels better. But wait, you're not done. In order for the healing component, it's one. Twenty four is two fold. You get them out of pain in a minute or two. Yes, but you need to run it for a longer period of time to help the healing process.

Carol: [00:14:18] Now, to actually repair the thing, and I have asked two different biophysicist somebody. Well, three, if you count Diane across somebody, tell me why how one, twenty four and seventy seven can fix Ehlers-Danlos for an entire week. This is a genetic condition where the connective tissue is torn and broken constantly. It's made wrong, right? How is it possible that 124 and 77 normalizes range of motion? In 60 Minutes. And it lasts for a week in a genetic condition. I still can't get my head around that.

Kim: [00:15:03] Yeah, when you say that out loud, it's yeah, how do we do that?

Carol: [00:15:08] How did how does that happen? So we know we think that the frequencies change cell signaling and that changes the genetic expression of the of what the cell does. So that's the mechanism. But how do you do that when the gene isn't even there, right? How do you even? So we're going to have to leave that one on the shelf with things we don't understand. But the pain goes down in five minutes. But in order to actually repair the tendons, it takes 60 minutes and maybe 60 minutes more than once. So it may be right. That's right twice a week or three times a week for two weeks or one week and then spread it out because the Teres, the TENS, DIN's Capitis or the ligament strains or the lax ligaments, the lacks connective tissue will create compensations. And I don't know about you, but I never treat the same thing twice.

Kim: [00:16:14] No, it's know this is I love how organic these topics just seem to like, evolve with us. Me too, because one of the one of the comments I had on Instagram was If you are able to cure and that was in quotes and fix and that was in quotes conditions with FSM, why would they ever come back for a second appointment, let alone buy a device?

Carol: [00:16:41] Oh, OK. So there's a reason that every single topic has a stable state slide at the end. There's a reason that we start with, like in the very beginning and the introduction, the concept of creating a stable state. Yeah, and they come back for the second appointment when you fix. Ex, whatever that is on the first session and then the

compensations hit them the next day. So the the I think, three seminars in a row, Kevin was my supine cervical patient. He always was digging at his neck and digging at the spots in his arm and his chest. That hurt. And so I did the supine cervical practicums. He left neck was pain free. The next day, he was worse. It's like, hmm. So the second time I treated the dura more and the next day, and he felt great that night, next day, he was worse the third time I did a more thorough. Physical exam. And every time I don't do a thorough physical exam, it comes back to bite me. So it's one of those things I'm going to have tattooed on my back of my hand do the exam.

Carol: [00:18:12] So I did a sensory exam and he's always digging at his collarbone, not because it was the scalenes, which I thought was coming from the disk and his neck. No, it's because T1 two, three four. We're all hypothetical. The pain that he dug out in the back of his neck, upper back that I thought was from the distance, his neck. No thoracic nerves. Ok, so the third time I treated him, I treated him with four machines, one neck to chest on basically supine cervical practicums, so that was manual neck to chest treating subacute disc one from the spine laying lengthwise down the spine down the front, treating the nerve and the disc and the thoracic spine. Because Thoracic nerve pain doesn't come from space, right? It comes from a disc and. Then I think we finished up with torn and broken in the ligaments in his neck, when you look at his looked at his accident history and that one, I think. Held right. It has never gone back. To what it was before, so there's always going to be something you miss the first time.

[00:19:47] Right? And I've had.

Carol: [00:19:51] Two patients out of, however, many hundreds or thousands, if had two patients with fibromyalgia that were fixed like 40 and 10, the pain never came back. They both came back the second time to say thank you. It's like I didn't come back last week because I was waiting for the pain to come back. I came back just to say thank you. Oh, that's too great. So. And then there's the stable state and when with all of the musculoskeletal stuff, I got that right, didn't I?

Kim: [00:20:35] Skeletal?

Carol: [00:20:36] Yes, it was skeletal stuff that you do. You have even more attention to the chain where you're working on someone's hip and they say they can feel that in the

right shoulder. Yeah. And if you know about fascial trains, it's like, Well, of course you can. Yes.

Kim: [00:20:56] Yeah. Yeah, I think I read that question a couple of times and I kept my brain kept going in different circles of how I wanted to answer it. And I mean, you, I think, summarized the two sides of that question so perfectly. One is because you missed something or it just didn't present. It's not that maybe you miss something clinically, it just didn't present itself in the way. And I think a big part of it, and this might be the theme of today is and we kind of touched on it last time about how how has your practice changed using FSM so much? We create change so fast. And it is, even after all these years, I'll have a patient and they leave, and I'm like, How did that just happen in an hour and a half? How did we just do that? So I think part of the there's many notices we need to give clinicians when they take a class is what you are about to enter. You need to have your seatbelt on your airbag checked. You need the panic button you need. You need all the things because I don't think we prepare people enough for how fast the changes can occur and you need to be, you know, thinking ahead,

Carol: [00:22:25] How can you prepare them in a course seminar for what's going to happen? There was the one practitioner who emailed me and said, You prepared me for my failures. You didn't prepare me for the miracles. Right, right. And I just I did a podcast the other day with a nurses group and we were talking about think about the 40 and 10 patients. So just the fibromyalgia or even nerve pain patients, somebody like Kevin or anybody that's had nerve pain for six or seven years. It it becomes part of what they deal with in their life. You know, I have a size eight shoe. I have brown hair, blue eyes. My teeth look like this. I got a little mole here and my arm hurts. It's all one sentence. And then all of a sudden the arm pain goes away. Not all. Well, yeah, it's all of a sudden because it's so easy, right? So it's an hour, and maybe it's even gone in a week. So let's say it takes three sessions to treat the disc and the nerve, the nerve pain will be gone on an hour. That's easy, then, to get the disk repaired. Ok, so it takes a week. But it doesn't just change the pain. It changes who they are, how they're we create an identity crisis that is unparalleled in medicine. If you have surgery for something. Well, you're worse for three weeks and then you recover slowly and then you do rehab and then it's better, but it takes eight to 10 weeks and by that time your brain has had a chance to get used to it. Right? With FSM. So that's where afraid to

move it. I'm. And 40 and 89 to just quiet down the part of the brain that minds it and then increase secretions in the cerebellum so the brain knows what to do with it.

Kim: [00:24:43] Yeah, absolutely. My my whole practice shifted five years ago because instead of just fixing range of motion and sending them on their way. So like, but I can move my arm again. I have full range of motion. I'm like, You don't actually, this will not stay and we need to catch your nervous system up because it has no idea what we just did. And you're totally right. There's there's a process when in traditional medicine and with surgery of. Psychologically, proprioception, there is a process that you go through as you go through your recovery, and when we go from, it's not even zero to 60, it's like teleportation, how fast it goes as far as the nervous system. So for those of you who are practitioners out there and when you create massive change on the table and then your patient gets up and they don't know how to stand or sit, you can see it in their face instantaneously. Walk, run those of you who work with athletes, you have to. I thought just getting them to do some running and jogging and squats in the clinic was enough. I have now people, you know, with the CustomCare's taking shots on the ice because they need to be physically loaded during the sport that they need to to catch everything up to complete the loop. So there's a huge it is it's warp speed, what we do and to get everything caught up. So that's why there isn't just a one and done and we talk about, oh yeah, that's that's easy. And we can do that in one treatment, and that's not really true. We need to watch our words, I think,

Carol: [00:26:28] And well, yeah. And even if the patient isn't an athlete, if the patient is absolutely right, the patient, I have started treating people for the mental component of it and the neurologic component of it before they ever get off the table. Yes. So you get rid of the pain you check. The sensation sensation is now normal instead of hyper nasty. And so, yeah, that's a word we just made up. Oh, sorry, hyper nasty. And so then what if you've gotten rid of the nerve pain? What is the nervous system have to do to accommodate to that? So in my world, the first thing I do is quiet down the limbic system because the hippocampus, the thalamus, the amygdala, all those what we have is midbrain. Parts they have the emotional and the learning component that mines that objects to mines. The pain that they had it, the hippocampus remembers. So what we have to do is give the hippocampus amnesia. It is just never mind the arm pain Pain's gone, isn't it? It is, too, it's still there. I know it is. So you're sitting there having an argument or discussion with the hippocampus? Yeah. And you tell the hippocampus,

No, no, it's fine. And the hippocampus objects. And so you just run 40 and 89 until the patient right will voluntarily move the limb. And then once you get the hippocampus quiet, then you can increase secretions in the cerebellum so they they will be allowed to move it properly. And then the last step that I sometimes forget is to increase secretions in the sensory cortex.

Kim: [00:28:38] Yes.

Carol: [00:28:39] So that there's now that sensation is normal and not painful. You turn off the mid brain, the part that minds the pain, you increase coordination and then you increase. Connection eighty one and ninety two to the sensory cortex. And then you can I don't know about you, but then I go back to the cerebellum. Mm hmm. Right. So it's eighty four, ninety two, eighty four. And fortunately for us, we have a tool that appears to let us do that. If anybody listening has access to a spec scan, a functional MRI, an EEG, I want data because we do this clinically, you can see it happening on the table.

Kim: [00:29:29] Mm hmm.

Carol: [00:29:30] I want data. I want to know how we're actually doing. It looks like we know what we're doing.

Kim: [00:29:36] I know and you know. That's why we spent an entire day at the sports course just doing this because it is something that you've never done before, you can't believe it when people are balancing and squatting and moving and the look on their face is just like, Did I just do this? You just did that. So it's it's a huge component. I think of all types of recovery, no matter what the condition, how long they've had it. I think as a general rule, the longer you've been restricted, the more important this whole segment is to retrain. As clinicians, we've all had those patients where they've been in pain for 10 years and they come to see you and you get them out of pain and they love you and they're giving you their first born and the keys to their Mercedes and all the things. And then they come back two weeks later and they're like, Yeah, it just didn't hold.

Carol: [00:30:36] Oh, God.

Kim: [00:30:38] Well, yeah, but before this, you were like, darn it, do the same treatment, repeat it and like, no, they don't need a repeated treatment. You've loosened the condition, you've dissolved the adhesions, you freed up the limb. What they need is neural retraining. They need those muscles that have been turned off for a decade to not just temporarily fire, which can happen in the clinic. I think you're the really good practitioners are the ones that give the patients the tools to create these long term changes. And like I said, we go from zero to 60 teleporting. We can expect everything to fire optimally after one treatment.

Carol: [00:31:23] Well, then there's always compensations and. Biomechanical dysfunction. Totally. You can do whatever you want to fix someone's shoulder, so now the impingement is gone. The shoulder pain is gone. And two weeks later, it's back because the step I skipped was teaching them to find. There lower trapezius and they're serious. Right? And they. What do you mean? Well, feel this muscle. Yeah, pull your pull your shoulder blades down toward your waist and they fire the Romberg's and crank their shoulders back. It's like, No, no, it's this muscle. But there's a muscle there and you just keep pinching them and working with them until they get it, because so you have to, especially with the shoulder and the hip, you have to coordinate the the muscles, the nervous system, the neuro emotional system. And there's something else we're going to have to put on the wall, and that is everything is connected to everything. Yes. So if it's the right shoulder, then what's going to be going on with the left hip and the left knee? Right, right. I hate Sharkey's right, but there you go.

Kim: [00:32:46] I love it when Chuck is right.

Carol: [00:32:48] I love it when John Turkey's right.

Kim: [00:32:50] It's so funny. We at the last was it 20 19 that we had him at the advanced. Yeah. And he had brought somebody up on stage who had some shoulder pathology, and he was compressing the rib cage to create a different line of pull the fascia and got her arm to move up. And at lunch, everyone's like, Wow, how'd you do that? And they're talking? And he says that was impressive, right? And I'm like, kind of like a party trick. He's like, what? And whoever I was sitting next to is just, I'm like, I don't care what you can do on stage in two minutes, I want to know what her shoulder is

going to be. Will she have that range of motion in two weeks from now? And then that caused a big discussion,

Carol: [00:33:36] As did

Kim: [00:33:37] You just being the little poop disturber that I like to be from time to time? It's good. But, you know, I think, like I said, we have so many tools at our fingertips and we're always talking about thinking laterally. And if we're going to go on that pathway, it's not only laterally we have to start thinking two and three steps ahead of what. You normally would be seeing,

Carol: [00:34:03] And some of that depends on the patient and their expectations in some ways. Fifteen years ago, it was easier because we weren't all over the internet and they came in expecting very little. And when they got a lot, they were happy and they were willing to come back twice a week for four to six weeks. Now. Because of what they saw on YouTube or what they read, wherever they come in expecting a one and done for something like, you know, Ehlers-Danlos and it's like, No. So it's managing. This is new for me in the last two years. With the book out and the things that we have on social media and on YouTube. They come in expecting a miracle in an hour and a half and managing that expectation is something new for me. So it's that's and our practitioners are probably dealing with the same sort of thing. The patient has a condition that's 20 years chronic and when it's not better in two visits, she did the wrong thing. She doesn't know what she's doing. So I get emails and phone calls. Yes. No. No, no. It's it. Yes, you've had this 20 years. It's the thing.

Kim: [00:35:26] Yeah, it's still a process. And as good as we are, it's still a process. And I know we've got some probably some people listening now who are just patients and not only therapists and practitioners. And so this is a really great message. Like we we do fix really complicated, hard to fix things, but it's never just a one and done. So I want to kind of go back to that other part of the question. If we fix and cure people with the air quotes, why would they ever come back for another or buy a device? So all my athletes buy devices because the trauma is continual, like it wasn't like it was. They're never going to get flexion extension injuries because they they get flexion extension injuries every single Sunday. So. And part of part of it is is just that maintenance and that continual recovery. I talk about a patient in, I think it's in the SportsCare, so maybe it

was in the advanced who had her gallbladder out. This was one of my early. What the heck's when I started practicing because I thought she just had to hip pain that looked like pseudo sciatica like this should have been really easy to fix once I balanced her Cecum out and then started plunging deeper and deeper into her history.

Kim: [00:36:54] And I knew she had her gallbladder taken out, but I stopped there because what would I have cared if she had her gallbladder out? I felt around for adhesions, things I thought felt good. But then you go further down the history, and the little birdie starts talking about how she reacts to any type of metal and it doesn't matter what it is or. Long story short, she obviously saw a clip in her, and I, with your help, was treating her for allergy and metallic toxins, and there was something else that we had done. Oh yeah. I remember calling it like phantom gallbladder pain. I'm like, Could there be something? And we treated the small bile duct and I was thinking, Got my Netter out. What's around here? So in this woman's case, again, that that that state she has clips or a clip in her body that she's not getting removed. So she bought a CustomCare. She runs her gut protocols, metallic talks and protocols once a month, and that keeps the pain away. And she's been pain free at least eight or nine years now. Mm hmm. So that would be a reason why or if you have a condition like Ehlers-Danlos or whatever, that's why you would need to have a CustomCare.

Carol: [00:38:12] I don't actually know how people live without I. I don't I don't know.

Kim: [00:38:20] It's I don't know how our family

Carol: [00:38:22] With a concussion and Vagus or vagal tone, but I I slipped on every protocol I run on myself at night while I'm asleep. The Vagus is in there somewhere, right? And one of my patients asked me, What do you treat? How often do you have to treat the Vagus? And it's like, Well, how often do you drive on the freeway? Yeah. Oh, how often do you listen to the news? Oh, do you ever watch a movie that scares you? Oh. It, you know, all of the things that creates stress. Turn off the Vagus. So what would be wrong with trying to turn it back on every night? Right, right. So yeah, I I'm prejudiced, mostly because I'm 75 and I have all this medical history. That's really kind of scary. But I I I do just fine. Thank you very much. Right? It's like, how do you do that? Can you imagine trying to do that without a CustomCare that you can use on yourself when you need it? No, I can't imagine it now.

Kim: [00:39:32] Yeah. All my patients get a little slice of Vagus all the time, just like you said, like regardless of how great and fluffy their life is. They're humans and it's twenty twenty one

Carol: [00:39:46] And you go well and they have pain. So the Vagus is turned off by infection, stress and trauma. People don't come to us because everything's rosy and they have no pain and they just want to sit by and visit.

Kim: [00:40:00] Right. Well.

Carol: [00:40:01] If the Vagus is turned off by infection, stress and trauma, you can assume that virtually every patient you see needs to have vagal tone running on them from neck to feet. Yesterday, I saw somebody who had what was her. She had her complaint was concussions from. Auto accidents, maybe three or four over a 10 or 15 year period. So the first thing that was interesting was she said, Yeah, I have your book, but I haven't read it. Why not? Well, I have a really hard time reading, so I did a Vestibular screen on her and she's saccadic on the right Webber's Lateralizes to the right, and she's hyper acoustic on the right. So that was the first clue that, OK, your next. Your next step is to go see the optometrist that makes prism glasses. So this is why you can't read. This is why your neck is always out. And so then I started treating her and we did basically the supine cervical practicums, but as part of the exam, I palpate her legs. Now she's fit right. But her leg tone was hypertonic was too. It was too tight. And she said, Yeah, I got these tingly sort of buzzy things in the bottom of the bottom part of my legs. So around 40 and 10 and I ran 81 and 10 two separate machines, so increased secretions in decent increased descending inhibition in the spinal cord.

Carol: [00:41:52] I swear we're increasing descending GABA, thanks for her quadriceps and started softening up so it softens up the front and then up the back and her arms were so tight that her the skin on her fingers was really dry and stiff, so I had to get her hands on her tummy. So that went there. So those all softened up, and she had a bunch of visceral complaints that I mean, somebody said, Oh, you've got Lyme? Oh, and she had some mold issues, but her visceral issues were from the disinter, her neck. And. And if you've got a disk bulge bad enough to cause loss of descending inhibition. It's so

we ran the Vagus. And I was doing the supine cervical practicums and. The Vagus was on my CustomCare, and she's chatting, chatting, chatting, and then all of a sudden, she says. Oh, what is that? And it was not it was the moment that ninety four and 100 9 started. Yeah, trauma to the Vagus and that whole, the whole time the Vagus was running, she couldn't talk. She was just gone. Yeah. As soon as that finished, she woke up and I went, Oh, it's done. So I started vagal tone over again. I kept working on her neck, so everything's connected to everything.

Kim: [00:43:25] It is connected to everything. Just like our podcast topics, I'm just checking here in the Q&A. I think you should answer one of them while we're kind of talking about knees and stuff before we go any further. So the second second question, I'll just read out loud here. Can we help a female? Seventy one years old now who had a bilateral knee replacement, 2008 with Smith Smith nephew, joint replacement. They never were able to restore flexion. Cannot ride a bike due to the loss of flexion the first knee. They perform manipulation under anesthesia during second knee surgery, and it is somewhat better. Can we improve on the flexion? I take this you start using

Carol: [00:44:17] Knee replacements that were done in 2008 until it was that 13 years ago, the hardware for knee replacements in 2008 was less than optimal. Let's just put it that way the knees are really complex joint. And because of the curve at the femur, the at the femoral condyle and the curve in the tibia. The the early hardware. Wasn't. Designed or wasn't there weren't enough variables to match the patient's normal curvature. Then if you look at the knee, it's an incredibly complex joint joint replacement hardware. 13, 15, 20 years ago was really pretty primitive. So, Dana, the answer is maybe not because of the limitation in the hardware. So that's one possibility. The other is torn and broken. We had a patient that we treated for two years at new heights and it was the same problem. She couldn't walk upstairs. Manipulation under anesthesia made it worse. So at least yours got better for manipulation under anesthesia. Oh. Selection, you have to get the hamstrings to fire. And if the cerebellum thinks that there's some reason hamstrings shouldn't fire, that's non-negotiable. The other thing I'd look at is 16, if she is. Allergic to the metal that they used, and back in 2008, they were all stainless and chromium. Oh, I can't remember the number. There's some large percentage of patients that are allergic to stainless steel, so you can try running 16 and 9 with the bone marrow. So knee replacements have spike up into the femur and a right spikes down into the the tibia. Um, so try running 16 and 9 with the Perry team, the

bone and the bone marrow. And see if that helps. And then try torn and broken in the Ligamentous. You have an idea.

Kim: [00:47:11] Yeah. Well, yes, what you said, I was going to T-shirt, what she said. Yes, what you said. Again, I'm going on the the trainer side of me is saying those hamstrings have been told to not move the knee into flexion. So a big part of it. You know how in my lenses, why can't a limb move a situation into something is restricted, preventing the motion or something as weak, preventing the motion? So in this case, I would think there is a weakness to the hamstrings to look at, and that's that's an easy fix. That's a forty eight, forty and eighty nine, eighty one and ninety two sort of answer. And you could see really quickly when you override the nervous system with what we do and you can get them to fire in the clinic. That could be and then, yeah, right away, I think about two, if there is a metallic metallic toxins or allergy to the hardware, that would also prevent it. Let's do a couple more questions before we.

Carol: [00:48:21] I've got one over here about Dish.

Kim: [00:48:23] Yeah, I see it. Yeah.

Carol: [00:48:28] Either of you ever treated dish. I had dish. I was diagnosed with dish. I didn't have dish, but I mean, I did on X-rays. I've been wearing FSM client with this condition to remove mineral buildup in the tendons, ligaments, fascia. Rolfing, that's good. Isn't a lot of depth, and I don't talk about it. It's a treated her for the dirt and rust or store for a year. It's more upright after treatment doesn't hold longitudinal ligament. Ninety one, it's been a year. It doesn't hold for more than a week. Well, the fact that it holds for a week is pretty miraculous.

Kim: [00:49:09] You want to explain to people who don't know what dishes.

Carol: [00:49:12] Oh, diffuse idiopathic skeletal, hyper osteoarthritis, ptosis. So when I first went to chiropractic college, they take X-rays of your neck, thoracic and lumbar spine in the neck and thoracic spine. It's an X-ray. It looks like dripping candle wax, so you have bone spurs on the the ligaments enter your longitudinal ligament. For me, it alternated levels on the sides at one level and then front and back on the next level. So I had these dripping candle wax bone spurs. Or calcifications, right, right? And then in

2011, when I herniated the two discs and I was trying to avoid surgery, I ran. Just what you're running? Mary Mair Ninety one seven, sixty six to seventy six to 17. I ran all of those and the ligaments and connective tissue, and we did. With a resistance band or with a weight and pulley. Really small exercises just like that to get and road arteries. The body classifies what doesn't move, so dish doesn't come from space. Calcifications don't come from space. It's Wolf Law if it doesn't move. What is it, they say in the Navy, if it moves, saluted, if it doesn't move, paint it and an f efforts in the body, if it if it moves, yay.

Carol: [00:51:07] If it doesn't move. Calcify it. Yeah. So that's when they did the disc replacement surgery on me. They did x rays of my neck during surgery, and all of the calcifications in my neck were gone. Not just at five six, six seven where the surgery was, but I had dish from C2 to every place you could see T1. So the fact that it lasts a week is great. This patient is going to need a CustomCare to treat herself at home. This is not something that's a one and done, as Kim would say. And ninety one, don't forget 217, because it's a kind of ankylosing, which is more what you'd see with Dish. It's more like an ankle dosis rather than calcification. And get her to. To tiny exercises, someplace, somewhere, I think it's in Jodie Adams presentation, the last one she did in two thousand. Twenty. One. Twenty one. The the last upper C-spine rehab that Tony Adams did, she nailed it, and you can see the exercises and how they work to get the segmental muscles moving. And that's the only thing I can think of to create a stable state for Dish.

Kim: [00:52:48] You got something. No, nothing. Nothing. Again, I'm. Humira lost everything. Yeah, so as everything is connected to everything, everything always needs to move. That's my T-shirt.

Carol: [00:53:05] Let's say it again.

Kim: [00:53:07] Everything always needs to move like me to move everything all the time. We just need to move.

Carol: [00:53:12] But not what's that? But not too much. Nah-uh Ehlers-Danlos.

Kim: [00:53:21] Yeah. Ok. Ok, yes, there's there's an exception to every rule and 3 to a couple more questions. And then we'll go with our concluding thoughts here. Is there a good treatment protocol for severe PH? I'm guessing HS is electromagnetic hypersensitivity. Question mark? I don't know. Do you know another? Uh.

Carol: [00:53:45] I have no idea.

Kim: [00:53:47] Ok. That's the only acronym I know for. That's not like environmental, health and safety.

Carol: [00:53:57] What is it? Eosinophilic esophagitis. I had a phone call about that. Somebody said, I have Eosinophilic.

Kim: [00:54:07] You mentioned that last week and

Carol: [00:54:10] It's like, that's easy. But it just, yeah, yeah. Electro hypersensitivity. Yeah. You got OK. So David Musnick does a really good job with stable state for electro hypersensitivity. One would be concussion and Vagus. That would be one. The other is all of the things like turn off your router at night if don't let them put a one of those. Meters on your house that the smart meter, smart meter don't let him do that, he says no alarm clocks within 10 feet of your head. And for me, that means, well,

Kim: [00:54:49] I guess we're not waking up.

Carol: [00:54:50] I guess I'm not. And then 9 fifty four in, I would guess, at least for me, electro hypersensitivity. Comes from the Vagus, the cortex and the midbrain, right? What do you think?

Kim: [00:55:10] I agree I don't have too much mileage with that, but I would I would defer to what you were saying. Yeah. Something I don't really see clinically any frequency recommendation for kiddos with hypo tenacity to lower extremities. Again, why are they hypertonic?

Carol: [00:55:28] Right. That's my question. Yeah. Catholics should come and be a guest.

Kim: [00:55:34] Ok, let's remind me to talk about concluding thoughts about yes, because I have a whole thing I need to talk to you about. Ok, another question. Or do you want to go with it?

Carol: [00:55:44] Hypotonia RSD. Yeah, what?

Kim: [00:55:49] There's got to be a reason why a child doesn't have tone, so.

Carol: [00:55:54] Eighty one and reduces tone, except maybe if it increases tone. And he wanted for. You know, the first thing I'd asked is what caused it and what's the official diagnosis? Have they biopsy the muscles? Is it some sort of muscular?

Kim: [00:56:15] No, no diagnosis. Yeah. Hmm. There's a reason why a child doesn't have time.

Carol: [00:56:28] Um, that's a good face diagnosis, referred for motor delay. I'm not sure how old the child is, but. There's more to the story than that, so I'd start with concussion and it's two years old. Find a different doctor. That's the first thing. There you go. Candace Elliott was the child of premie. There's that. Yeah, find a different doctor. That's the motor delay is of what? What I call a BS diagnosis, it's a non diagnosis diagnosis, so I run concussion and the sensory and motor. Cortex ninety two. The other motor centers go from 92 to 84, so the sensory and motor cortex, the cerebellum and the cord and run. Ok, so they did do genetic testing. I was saying my OK, so my apologies to the doctor that saw him. No genetic thing. I'm assuming they biopsy the muscles if they were looking for. Difficulties that way in the FSM world, they'd still start with concussion sensorimotor. Sensory cortex and cerebellum and cord, and I've seen children at Cleveland Clinic pediatric rehab that have strokes in utero. Whoever heard of that? Right. But the kid had a stroke in utero, so maybe. Maybe that sudden hearing loss unilateral will be treated with FSM. No, no.

Kim: [00:58:25] It said continuing on, friend with this moderate severe hearing loss has not yet received any benefit from oral nor 3 prednisone injections to her inner ear. Hmm.

Carol: [00:58:37] Ok. We're not even going to. Address why anybody would do a prednisone injection into the inner ear, but that's another conversation. It can be viral. That's that's a thought it can be. Hypersensitivity to were they taking Advil? Mm-hmm. So you can have so, Ohta toxic, but it's only unilateral. That just no outside my skill set.

Kim: [00:59:14] I'm speaking of outside skill set, the next question is any protocols or frequency sets for Stargardt's or other degenerative eye disorders? So be careful with the folks.

Carol: [00:59:26] I took my skill set. Unless you're Jamie, unless you're an optometrist or an ophthalmologist, you send the patient to. Or it's shaken or what's his name in Utah? Roger Bullock has taken special courses in treating the eye, surely Hartmann, but she's just now. Would you believe that she she had a Whipple? She beat pancreatic cancer and she's back in practice full time?

Kim: [00:59:56] I would believe it, actually.

Carol: [00:59:57] Yeah. Well, it's exactly it's it's a combination of alternatives. So all the supplements she did, all the FSM, she did. And OK, fine, I'll take this chemotherapy, but not that one. Thank you very much. Yeah. And she did it. So. Yeah.

Kim: [01:00:15] Oh, I love that.

Carol: [01:00:17] Wait, we have six more

Kim: [01:00:18] Minutes if six more minutes. So we are doing so well with this one of the last but not least questions before I do my concluding thoughts and have some great announcements to make, here is something that I also received twice. People are starting to get their flu shots now at the same time as their COVID shots. So for. Yeah.

Carol: [01:00:43] Wait. Wait, wait. Both at the same time, apparently.

Kim: [01:00:51] So this is a podcast, people can always see our facial expressions, except for the thirty seven that are looking at us right now, so maybe it's a good thing.

Do we have recommendations for support for people who are getting their COVID shots or their flu shots, preferably not on the same time?

Carol: [01:01:11] Ok.

Kim: [01:01:12] So are you having people around like immune support on their CustomCare's? What's your FSM CustomCare support for people who are getting their shots right now?

Carol: [01:01:23] Because I know for sure that I'm allergic to polyethylene glycol, which is in the Pfizer and Moderna. I knew for sure I couldn't get those two, and because I travel, I got the Johnson and Johnson vaccine because of the history of blood clots with all of them. I took baby aspirin that morning. Heparin doesn't work, aspirin does. So I took a baby aspirin. The morning had the vaccine just just the coated, just the JNJ. And then my about four hours later, my skin got sore the way it does when you have the flu and saikia, my immune system recognized it. I took a six hour nap and I ran the the our our COVID protocol, the flu, what do we call it? Flu, respiratory plus organs like because the and I ran that that afternoon and I ran it maybe twice during the night. The next day, it took another baby aspirin. When the flu, respiratory plus organs plus brain protocol the next day, and that's it, and I had no side effects, immune support. I don't know that I do that because you want your immune system to react, but not overreact. Right? The concept of having both of them a regular flu shot and the COVID vaccine on the same day. Isn't. Interesting concept from an immunology standpoint, I won't get a regular flu shot just because of all the cases of the Guillain-Barre that I've seen that followed just the regular flu shot. But Channel A or the COVID vaccine because of the travel and gathering restrictions. So when we go to San Francisco in December for the Practicums weekend people because of the state regulations. Any group gatherings, you either have to be vaccinated, they won't even take testing. So you can't have a negative test. You have to have a vaccine passport when you go in and any sort of group in San Francisco, so when we start traveling, that's just the way that goes. If you're not going to travel, then you can modify what you do. But that would be that was my solution.

Kim: [01:04:02] Yeah. Here in California, my kids can't go into the rink to play hockey without their vaccine passport. So kind of where we're at. The question was really quick

that just came up. Can you explain, explain flu, respiratory and organs protocol that is on the CustomCare software now?

Carol: [01:04:21] Right? And it's you can't call anything Koven. So it's it is a unique respiratory flu and it's every frequency we have for every flu virus. I think six of them, plus 160, or maybe it's six total and we won that with just zero zero point one. And then we run it with the organs that are. Affected by those viruses, that would be the arteries, the capillaries, the kidneys, the liver. The heart and the brain. So those were the. The organs that are most affected because that's where the ACE2 receptor is most widely distributed is in the blood supply and then the really, well vascularized organs like the kidney, the liver, the heart, the lungs and the brain. So that's that's where that protocol runs, I think it's two, two and a half hours, which is why I run at it, I.

Kim: [01:05:30] Right. So the next question here, and this is a great segue way to my little announcements do we need the COVID vaccine for the Arizona seminar? I'm guessing she's asking for the advanced.

Carol: [01:05:42] Yeah, it's that's pardon. I think Arizona has be restrictions. Yeah, that's actually going to depend on Arizona. We aren't requiring them it. I don't know what the restrictions are going to be as far as wearing masks. What what we're going to do is the ballroom holds three hundred people and instead of having the chairs three feet apart, we'll have them six feet apart. So there's just common sense to put on a meeting and an in-person meeting. You really don't want to turn it into a superspreader event. Right. So we'll we'll restrict or hope. Let's say we hope for one hundred people to be there in person in a room that normally holds 300 and it's going to be live streamed. So if you're worried about being in a group because we everybody falls into two groups, ones that are really worried about getting COVID and ones that aren't so sure will we're having it live streamed and some of the presentations will be video or virtual, and some of them will be in person. And if you come in person, then we're still going to do what we can. The hotel has like the the buffets are all behind plastic and and they're the food service is safe. And then we just hope for the best. Yes. Oh, I know. You know what we can do? You know, we usually run concussion and brain fog and emotional relax and balance. Yes, so we'll run immune support. Yes. Respiratory flu, yes. And concussion?

Kim: [01:07:35] I love it. We are so prepared for this going along this theme really quick. With the advanced, I've had a couple of people that wanted to take the sports course and then the sports advanced course right after that will be a lot of information for people. So I'm doing it on a case by case basis. If you have the professional background to take in all this information and have taken some FSM stuff in the past will grant you permission to overload your nervous system for three days. Because yeah, we want everybody when they come down to take as many stuff as they can without losing their minds. So you can reach out to Kevin or to myself. And if you have any questions about that, we'll do it on a case by case basis. The next announcement that we have for the podcast is while we have so much fun talking just the two of us and answering your questions, we're going to start bringing some people on as like co interviewees. So if you have any ideas, like I said, topics or people that we should interview. I think what and I'm kind of springing this on you right now. I think what

Carol: [01:08:50] We thought about this, right?

Kim: [01:08:52] Yeah, you know, so I think what because we're kind of taking two tracks I think you can maybe think of, you know, we talked about Ben Keighley and Dr. Musnick, and some people may be on the functional medicine side. I'd like to take some of the professional and elite athletes that I've worked with and maybe bring them on to hear their experiences using FSM and maybe some of the other trainers and Pittis that we've worked with.

Carol: [01:09:22] So Mark Lindsay to come on.

Kim: [01:09:25] I've texted him already. Just the other day, I will let you know when I hear back, but I'm thinking all along those lines of those, those folks who have been

Carol: [01:09:36] Therapists than than patients, although the patients are are interesting too.

Kim: [01:09:42] And just because we have our podcast open to the public and I know a lot of patients are listening, so it might be nice to once in a while hear from a patient who's had some, maybe not athletes, maybe just even some chronic pain patients, just to have it quickly. You know,

Carol: [01:09:56] Athletes, athletes are good too, because we know what we know it. From our perspective, it's really interesting to hear it from a patient's perspective. So I think that's a great idea. Thank you. Yeah, no, I'm I'm looking forward to that part because there are going to be there are a couple of these podcasts, some of them where I'm just going to be out of the country and I'm going to be on your own with a guest and vice versa. Yes, right? So maybe we can organize, organize our guests that way.

Kim: [01:10:30] I have a list of 15 I made today of people I'd like to bring on.

Carol: [01:10:34] Of course you did

Kim: [01:10:36] Off the top of my head and I've I've texted and emailed a couple of them. So yeah, we can compile a list and again, back to anybody if there is a topic that you want us to cover. You can email that to Kim at FSM Sports 365 dot com or contact at Frequency Specific Microcurrent and we'll compile all this questions and topics and get everything ready and organize the best that we can. So thanks to everybody who joined us live. This was fun, as always.

Carol: [01:11:05] As always, it's always like my favorite Wednesday our

Kim: [01:11:10] Coffee with Kim and Carol. We need a name.

Carol: [01:11:12] Ok, well, well, that's a good start. I like that.

Kim: [01:11:16] It's my name. Anyways, it's my Wednesday. That's what's on my calendar. Yeah. All right, everybody.

Carol: [01:11:22] Thank you very much. Talk to you.

Kim: [01:11:26] Tasty, and next week, I.

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