

Episode Ten – Don't Panic...Remember Your Towel

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Dr. Carol: [00:00:03] Can you hear me?

Kim: [00:00:04] Yes, you sound froggy, but we can hear you.

Dr. Carol: [00:00:08] Oh, good. It's like it's one of life's little. Um, yeah. Is that when I get sick, I get laryngitis. I feel fine. Yeah, I can't talk, and talking is what I do for a living, so that's really annoying, honey.

Kim: [00:00:32] When the universe just throws you a curveball like that

Dr. Carol: [00:00:35] And it says, Go lay down,

Kim: [00:00:38] Right,

Dr. Carol: [00:00:39] And then you're too hoarse to actually tell the universe to shut up and go away.

Kim: [00:00:44] Well, I can tell it for you.

Dr. Carol: [00:00:46] Ok, thank you.

Kim: [00:00:48] As your as your wingman.

Dr. Carol: [00:00:50] There you go.

Kim: [00:00:52] Well, you look great, so thank you.

Dr. Carol: [00:00:55] Thank you. Yeah, feel good. You look kind of cute, too.

Kim: [00:00:59] Thanks. You know, we kind of have this like color thing happening each week where we don't even plan this. We literally just kind of show up wearing something very similar,

Dr. Carol: [00:01:09] To my surprise.

Kim: [00:01:12] Oh, you've got such a good story to tell us today.

Dr. Carol: [00:01:15] So excited. It was. It's been amazing because it doesn't always work out. Yes. So when it does, it's just like miraculous.

Kim: [00:01:27] Yeah. I kind of want to; kind of want to build all the kind of the questions around this case that you're going to talk about today, because some of the questions and comments that came in, not this week, but the week before I've been kind of tabling and this is a good week to I think I can ask you your opinion on some of these things after you tell your story, I think would be great.

Dr. Carol: [00:01:52] This is a patient that contacted me last. March and then some things happen, and they had to postpone. She has CRPS full body 2002 She had a surgery on her foot and the surgeon didn't know about CRPS and she woke up, woke up from the surgery with a cast on her foot with burning 9 pain. Ok. And he left the cast on anyway. Then 2007, she had a; basically, a brick wall, crushed her left big toe, OK, and that had to be amputated that the distal part of the toe was amputated. That turned into CRPS spread up to her knees.

Kim: [00:02:48] For patients that are listening, do you want to just do a quick definition of crops or sorry, we just have. We have a lot of laypeople listening these days.

Dr. Carol: [00:02:56] So it used to be called reflex sympathetic dystrophy, but that's not accurate. Complex regional pain syndrome is not any more accurate, right? Is a denervation condition where the nerves disconnect from the peripheral tissue. So it's like phantom limb pain, except you still have the limb. Right, right. So the nerves are disconnected, but the limb is still there. Right? And so then in 2017. In 2017 in One day it went from both of her legs up to her knees to her full body, including her head. And what that means is that instead of just her feet. Being represented in her thalamus

instead of her sensory cortex. Right? Her whole body became simple pain. It's like having a stroke, but on both sides of the thalamus at one time. Right? And so she's been between a seven and nine ketamine infusions, all kinds of meds, nerve stimulators. So everything that pain management can do in neurosurgery. And so we use the frequency to quiet 4D with the thalamus 18 9 the midbrain and you apply at Neck to feet. And then because both this is annoying,

Kim: [00:04:48] It's going to be the longest hour for you. But you know, everybody's just hanging on your words anyways. So. So lean in.

Dr. Carol: [00:04:55] Everybody in. Because both of the nerves in her feet were crushed. They weren't inflamed. They were disconnected, so to reconnect them from her knees to her feet. I ran increased secretions in the nerve. And when there's a traction, injury, or a disc, you want to quiet the inflammation that makes the nerve painful. When the nerve is painful because it's crushed, you increase secretions in the nerve. That's Jodi Adams did that and her CRPS presentation a couple of years ago. So neck to feet, knees. Two feet. She's been on oxygen for four years on, remember, her oxygen saturation is between eighty-three and eighty-eight. When her pain dropped after 15 minutes, it went from a 9 to a seven

Kim: [00:06:09] With 40 and 89 running?

Dr. Carol: [00:06:11] 40 and 89 and 81 and 396. And then I ran concussion and Vagus from her neck to her knees.

[00:06:19] So 3 machines?

[00:06:21] 3 machines. She's in a recliner covered with the blanket. Yeah. And I took her hand out and put the pulse socks on her, and her oxygen saturation was ninety-five and her pulse was sixty-three just from getting the pain down right at the end of an hour. Her pain was between a zero and a one. That was Monday, Tuesday. We did. She came in at a seven instead of nine, so I warned her it wasn't going to last. When it comes back if it comes back. You're going to mind it more. What's interesting is that she is a Pentecostal minister, she's a pastor, she. Builds churches, runs churches, it's on boards, and her faith sustains her, so she'd never identified as a pain patient. So when

she went from a 9 to a one, she actually wasn't surprised. And the person who told her about me was somebody that saw. A YouTube. Introductory webinar or talk to one of our patients, and it's a pain psychologist who referred her. And that's how she found me. So she went to a one I didn't see when she got down to a one. For everybody, practitioners, and patients. When somebody has thalamic pain, all of the information about her body stops, and the thalamus, there is no representation for her feet, especially in her sensory-motor cortex.

Dr. Carol: [00:08:22] It's all in the pain centers on the brain. So when she was a zero to one, I switched the lower leg frequencies to scarring in the nerve and I switched the net defeat to increase secretions in the sensory and motor cortex. And had her move her feet so that her brain before she stood up so that her brain would know where her feet were. And then wiper mode increased secretions in the cerebellum. And had her move her feet, and you could see the change in coordination. So at first, it was like she was looking for them, and then it was oh, and the movement smoothed out and went back to the sensory cortex, back to the cerebellum, and then got her to stand up. And had her stand and feel her heels because her toes are what we're injured, right, so feel your heels and then her posture straightened up and get her cerebellum engaged. I did the thing to do with Parkinson's patients, touch my finger and move the finger and touch it so that and you could watch her body get coordinated. We did the same thing the second day, only it took less time. And then last night I sent her home with a CustomCare, the one-hour program, and a four-hour program for the midbrain.

Dr. Carol: [00:10:08] So maybe she could get some sleep. So we'll find out tomorrow how that worked. And it's like it is a hundred percent full body. CRPS had four or five successes and one failure. So you just keep your fingers crossed and hope for the best. But it's putting it together. So the end of yesterday, the first surgery she had on her right foot, they actually attacked the nerve on the medial side of her right foot, actually attacked the nerve to the connective tissue, and that's what damaged it. So their scar tissue between the nerve and the system, the nerve and the fascia and to mobilize it. It's just if you can just lay your finger on top, just barely touching it because I didn't want to ramp it up too much. So scarring the nerve scarring in the to you. She was able to move it more ramped up the pain than I did 40 and 3 96. Because you take apart scar tissue, it creates inflammation and then finished up with 81 and 40 9 C2. With CRPS, you work both ends at one time because it's a peripheral to central, then central to peripheral. But

there's two ends of it and we have the ability to treat both. So that was like the high spot of my week.

Kim: [00:11:51] That's fantastic. I love stories like that. When you have something so complicated with the patient that thank goodness she has faith and people, patients don't need to be religious, you know, but hope, right? Something believing in something. The universe, somehow somewhere we're going to get better. And I think confidence as a practitioner, we touched on it before. When you look somebody in the eye and say nothing you have or say is going to scare me. Right. So there's like some faith and hope coming from you as well. Now, when you have a patient that has something as complicated as CRPS are you level with them from beginning like this might not last or yeah, OK.

Dr. Carol: [00:12:39] It's like a level with them from the beginning in this might not work. Yeah, right? Cautious optimism. Yeah. If it works, it might not last, as a matter of fact, it probably won't last. Right? My goal today is to not make you worse. Right? If you end up the same, that's a win. So you are there. And then when it does work, you know, inside of 15 or 20 minutes, her respiration changed, her body relaxed. That was the first thing before the plane went down, she said. I think it's down to a seven or an eight, but I feel more relaxed, and then it's like, OK, it's going to work. And then it usually takes 60 minutes, so I'll be back, right? My husband and I visited in the other room and she was in the recliner. I covered her eyes up with a towel. And she actually she was out of pain, and I left her run for another 45 minutes because she basically hasn't slept in four years, right? So I just let her sleep. That was fun.

Kim: [00:13:56] Touching on this, I'm going to just take us along the journey as I love to do. When you when you say like this has to run for a bit longer, you know, within 15 minutes. Is that just your experience with those frequencies in this condition that you; it's kind of time-dependent, I guess, right? This is not a put it on for a minute. And you know, the pain is going to go down instantly because we do have conditions and frequencies where something does happen and change within twenty-two seconds. This is not one of them. So practitioners, if you're listening, if you have a patient like this, this is a long treatment. This is not an in and out of your clinic and 40 five minutes. So 3 machines

Dr. Carol: [00:14:46] And it takes it's like cervical trauma fibro right through the same neurologic process, right? It takes 60 minutes. And then at 60 Minutes, I took her pulse and oxygen every 15 minutes and checked on her pain score, and it went from a 9 to a seven, seven to a four or five, and then 15 minutes later. So at the 60-minute mark, she was at one zero. And then I let her sleep for 40 five minutes, and then she was at a zero rate. So it's like surgical trauma, fibro, right? And then I had an Achilles tendinopathy patient just before this one. And the Achilles, you know, measuring around the ankle went from twenty-six centimeters to twenty-five and a half. Wow. Next day, it was twenty-four after an hour. Wow. So it's 124 and 191. Yeah. And then she had a fracture and torn ligaments in the ankle and around all of that sort of 3 machines on her ankle and the 81 when I palpate her abductors. 81 and ten. So her abductors on the leg that was affected were super tight, Meniere's and brothers. And that takes sixty minutes. The Achilles takes sixty minutes. There's no point in treating the Achilles without treating the tight leg muscles right. So that was 3 machines. 81 and ten on the PrecisionCare on a CustomCare. Yeah, 124 and 77 on a PrecisionCare. Yeah. And a PrecisionCare to do the ligaments and the bone marrow edema at the TAOS fracture that she had that started it all. So it's just time-dependent.

Kim: [00:16:52] Yeah, things just need to run and. Boning, again, I'm going to steer the ship just a little lateral right now, when you have a patient that has a; I'm going to put this in air quotes for our audio listeners. Adverse reaction to a frequency pain goes up. A heart rate goes up, anxiety goes up, something happens that the patient feels icky. Do you let it run because it's resonating with something that needs to be done or do you press, pause and? Shift the frequency.

Dr. Carol: [00:17:34] That's a good question. Thank you. Hey, you know, it depends on what the adverse reaction is, so they get anxious. That happens when I think when the endorphins go up so high in some patients, that triggers a sympathetic response. So they just say, Wow, I don't feel good. Are we done yet? I think I have to. Maybe I left the iron right. They just get anxious. It's absolutely; just give me a second and you go to 40 and 562 to just quiet down the sympathetics. And that takes about two minutes. Thanks, Roger Billica. So you quiet down the Sympathetics reaction if you're running 40 and something and the pain goes up. You push pause. You ask about infection and you go to 61 or 64 and 42 and 64 and 63. So there are certain side effects that are predictable. That you can either treat. With 40 and 562, or treat with the frequencies for infection or

just push pause. But the important thing is not to panic, right? I have in the core seminar, we've warned everybody about virtually every adverse reaction I've ever seen. So. If you listen to the core, often enough of them Suttich, and maybe I should put them all in one place, you can read all the adverse, all the scary things all at one time, right? L4 wants to know the settings for infection person plus encapsulated. You talk. You tell me, what are the settings for infection?

Kim: [00:19:44] What do you mean, the settings for infection?

Dr. Carol: [00:19:46] 64 and 42, 64 and 63 oh, encapsulated, right? Yeah. I'm so

Kim: [00:19:55] Sorry. I was like, Where is this coming from? I don't have my questions up.

Dr. Carol: [00:20:00] There we go.

Kim: [00:20:02] Right, right. So yes, so it isn't just cut and dry of what's the adverse reaction? I know we talk about Keith Pine lovingly when we talk about 94 and 94 and there is a quote-unquote adverse reaction. Some patients, when you run 94 and 94 get sick, you don't press, pause and abandon it in the sports world. You roll them over on the side, give them a wastebasket, let them throw up, and then it's done. So that's a whole other way of thinking of it with certain patients. That's not going to work with the general demographic, though I think what practitioners need to know is if you make somebody worse and if you've been doing this long enough, you will. And that's OK. We have antidotes like there's virtually an antidote for every adverse reaction that we have. So like you said, don't panic, you're on the right track, you create a change. You know this is going to help lead you down the road to potentially what's really going on. So nothing drives me crazier is when I see people talking about, don't use the forties on the Facebook page,

Dr. Carol: [00:21:18] What is with that? Who started that?

Kim: [00:21:21] I don't know. It's like, it's like when you're in junior high and there's a rumor going around about something. Please stop the rumor that forties are bad. Forties are fantastic. I wouldn't be able to practice without 40s if you.

Dr. Carol: [00:21:33] The reaction to 40 is diagnostic that only happens with hidden or occult infections, right? And an occult infection is a bad thing, right?

Kim: [00:21:47] So the time the times that I've encountered that were dental infections and the patient sent me chocolates and flowers after because we found something that was hidden. So yay for us. So yeah, things are adverse. Reactions are diagnostic and you've got enough training between the core and all these webinars and all the things that we do to figure out what's going on. And it's like I said, it's a good thing. It's diagnostic. You probably found something that you can alter your treatment to. So that was one of the questions with when something bad happens, do we let it do? We let it run its course. And if something bad happens the first time, so anxiety, let's say somebody's anxiety comes up, will it come up again? Is this a frequency that we need to avoid? You know where I'm going with it?

Dr. Carol: [00:22:47] No, it's if they the anxiety. Comes up in two places, one, when they have a Vestibular injury and you hit 94 94, right? Or you run concussion and that night they have a terrible headache and they're sick all the next day. That's a Vestibular injury, right? If you are running, let's say, 40 and 10 or 40 and 80 9 and they get. First, they got stoned, but then they get anxious, the endorphins ramp up so high, so fast that I think it triggers a sympathetic response. And it's like when you can tell that they're getting anxious, you, you stand there and you watch their face right and then you just in my world, you just switch to 40 and 5 62. If they're a patient that tends to be anxious anyway, you're going to run concussion and Vagus and maybe throw on another machine that has 40 and 5 60 to while you're running 40 and 10. Right? So the CustomCare's are so inexpensive that you can afford to have single frequency combinations plugged into a CustomCare that you just have on your cart, right? And you can just do 40 and 562. It's like, I just don't feel right. That's just it's making me really nervous. Is there something wrong? It's like, Oh, here, let me push pause, right? This washing up, that'll pay. And then you run 40 and 562 for. It only takes two or three minutes and they calm down. Then you keep that running when you go back to 40 and 10.

Kim: [00:24:33] Right? Have you ever had anybody that had a adverse reaction to 81 and 10?

Dr. Carol: [00:24:43] Um, yeah, there's one. Maybe it's not actually adverse, it's predictable, right? If they have both full-body pain and they have full-body or leg increase in tone or spasticity. So you know that they are a 40 and 10, but 40 and 10 will make 81 and ten patients worse. And this versa. Right. When that patient? There were two machines from the beginning neck ft 40 and 10 and 81 and 10 at the same time. Idea how the spinal cord sorts it out. Wow. But her body pain went down and the spasticity, her tongue went down. Over 60 Minutes, she had a glioblastoma at the age of 18 months. She had surgery at 18 months, and then when she was 3, the tumor came back and instead of doing surgery, they used radiation. And by the time I got her, or she was 20. Seven. She was ataxic. Her pain level was eight. All the time. Her. The tone on her legs was spastic, and it's like, OK, the body pain diagram was clearly 40 and 10. The tone and spasticity was clearly 81 and 10, but with the pain level at a seven, you know you can't run 81 or you're going to increase substance p because that's the secretion on the spinal cord, right? Right from the beginning. I use two machines on her. She was there for a week. At the end of the week, she went home with two CustomCare's 40 and 10, and the one in 10 were on both of them. And Smooshy L1 40 and 10. And this was seven years ago. Wow. Since finished college. Back to work. I mean, she's got a life, but she has Teres Microcurrent every day because the radiation destroyed her spinal cord. Well, the blood supply to that section of her spinal cord. Right, right. So yeah, it's. They antidote each other and they do different things.

Kim: [00:27:15] That's fantastic, that's really, really, really interesting.

Dr. Carol: [00:27:19] Wouldn't you love to know what they're doing?

Kim: [00:27:23] Yeah.

Dr. Carol: [00:27:24] Where's Terry Phillips when you need him?

Kim: [00:27:27] It's just what you think about this mathematical equation that these two just kind of cross each other out and then nothing happens. But how the body sorts? Well, even just how the body starts out having two and three machines, how that works or 5 machines, you know, that's a question I get all the time, too, is when you're running

two machines, can you put the contacts on the same towel? Yes, because otherwise you if you're running four machines on a patient, you don't need force. You don't need eight towels on the patient, two towels. Most of the time, you sometimes all shrink it up, so they'll be four sets right. You have like one neck to feet, and then maybe I'll have one under the low back or working on on the abdomen, so on and so forth. But yeah, it's amazing how just the two machines can or 3 machines or 5 machines can talk to each other.

Dr. Carol: [00:28:21] And if anybody's that's listening is thinking, that's not possible. You and me both. I do not. It does not make any sense to me. But Short says it's because the machines don't see each other, the frequency clicks, and the patient, and I'm not sure I believe him, but what he says makes more sense than my complete inability to explain it.

Kim: [00:28:50] And it's one of those things that once you do it and you know it works, I'm sort of over it like, I don't really care how it works. I know it does. We do it all the time.

Dr. Carol: [00:29:00] So when you scramble an egg? Yeah, no. The exact chemistry that happens when you put the heat in the frying pan and you there is a chemistry that happens to the egg white and yolk protein as it turns from a liquid into a scrambled egg. Yes. I don't know what that chemistry is, but that doesn't keep me from making scrambled eggs. That's very true.

Kim: [00:29:30] It must be getting close to dinnertime because the egg analogy and my lasagna analogy. Yeah. When I teach the SportsCare AST, I have this lasagna slide about layering, and I kind of want to talk about that because that was another question about you say, once a frequency is done, you know that it's done and then to change it. So that's kind of we do say that I think in the core, though, right, like when we're doing the practicums, well, we're running something and then you have the ability to be like the smush is now firming up. It's done. That doesn't mean you never go back to that frequency, though it's done in that moment. I'm not done forever and ever and ever. So with really common kind of musculoskeletal things, you will always kind of start off with the nerve to quiet the pain down. But then let's just say you go deeper and deeper into a different layer and then the pain goes up while that's the nerve again, right? So you

want to treat for scarring or inflammation in the nerve that'll quiet down, so it's never a one and done.

Dr. Carol: [00:30:42] I like it with her foot

Kim: [00:30:45] Right,

Dr. Carol: [00:30:46] Treating the scar tissue with one machine. And then switching to from scarring in the nerve to inflammation, in the nerve scarring, the system to inflammation in the pancreas, and back to scarring in the nerve. Because you, you tease the scarred tissue apart, right, a little bit at a time. Yes, pain ramps up. You don't just keep pounding on it. You take the pain back down and then you tease it apart again, and then you take the pain back down and you and you just do what the patient tolerates. There's a point at which pain patients are used to being abused. Right? Physical therapists? Yes, it's supposed to hurt. No, no, it's not. It's not good for your brain, for your foot to hurt. That's not good for your brain, right? Oh, take it. When it gets to L4, then you take it back down to a one or zero. Then you play with the scar tissue until it gets to a form. You can watch the patient's face. The face changes when it gets between a four and a five. Right?

Kim: [00:32:03] Yeah, there's a lot of questions popping up, but I just want to finish this one thought before we go to the questions is and you just said it. Most of the patients that you see that have been in chronic pain or athletes are expecting you to beat them up in the clinic. I can't tell you how many times four patients are like, can you press harder? I'm like, I could. But why would I want to create trauma to the tissue? What do you mean? Trauma? You have to squish it. No. A lot of the times we're working on really deep muscles, and I don't care how good your hands are. You have to go through healthy, superficial tissue to access the deep stuff. You're creating trauma to the superficial stuff. So you have to explain to your patients that the current is doing all the heavy lifting. Your hands are just there to guide and help and palpate. And so I think for the practitioners listening out there, it's different. Your hands, your palpation, your treatment, everything changes and lightens up because it's healthier for the patient patients that are listening. I'm sorry any FSM practitioner worth their salt is not going to stick their elbow into you.

Kim: [00:33:20] They don't need to. So it doesn't help. When I was in college, I had a professor throw a big tenderloin on the counter and we're all staring at this big, thick piece of meat. And he stabbed it with his hand really fast. And he's like, What happened? We're like nothing. He's like, You're right. And he was telling a story. And as he was telling a story really lightly, he was just putting his fingers and cross fiber, very gently and slowly. And by the end of the 20-minute story, his fingers had gone right through the meat, and that visualized stays with me. You don't hammer, you don't pound, you don't jam anything in there. You go lightly to get through the tissue and then enter the world of FSM and you just you don't need to. So patients don't expect to get beaten up and practitioners. You just added 20 years on to your manual therapy skills because you're not going to be digging around. Ok, let's get to some questions. Oh sorry, go ahead.

Dr. Carol: [00:34:25] All right, frequencies, you just follow the wave down. Yeah, something sharp pain with gentle pressure. It's scarring in a nerve.

Kim: [00:34:33] Yeah, right? Yes, exactly. Ok, first question up here. Can you use more than one Magnetic Converter system simultaneously on a patient along with several towel electrode setups?

Dr. Carol: [00:34:47] Done this on pediatric patients, so we've got a towel when we were treating. Heather's daughter, Hannah, we had. Heather had her hands on the baby as one contact, and we ran concussion and Vagus with the Magnetic Converter with the two AF-S kids. Oh, it's a full-body neurologic condition, it's viral and they have flaccid paralysis. And we did neck to feet with wraps, but then we ran concussion and Vagus with the converter across the abdomen with kids, it's not so weird. I don't tend to use the converter in the office with adult patients. It's weird enough having current you can't feel and frequencies you can't hear, but when you start with something with blinking lights and what is that? It's too I don't like spending 20 minutes of the visit explaining what this thing is. Right? But with children, nobody cares.

Kim: [00:36:00] No, that's true. I'm going to pop down to the bottom because it's back on the Magnetic Converter. What do you suggest running on Magnetic Converter versus what towels example is concussion and Vagus better with wet towels or all okayed to

use Magnetic Converter and use wet towel to treat the musculoskeletal injury? Say shoulder injury from checking.

Dr. Carol: [00:36:22] For me. In general, concussion and Vagus is OK with the converter, unless you're treating somebody with atrial fib SIBO gastroparesis where you actually need to just drive the vagus nerve electrically to conduct. I want to go from where it starts down to the pubic bone and you turn the current up to one 50 and you polarize it positive on 81 and one nine besides the rest of the vagal tone. So that's when I use current. But at night, when I run concussion and Vagus on myself, I use a converter.

Kim: [00:37:10] I never used a converter in the clinic like ever like I just am. What TAOS an electrode girl.

Dr. Carol: [00:37:15] So 124 and 77 will work like the first thing I treated on myself and we very first got the converters 10 years ago, seven years ago. Wow. It was an acute facet injury. I've done some sort of extension thing that made my lower back sore. I said, I'll try this and I put a cute four set on the converter. Yeah, put it on my back. And then I sat at the kitchen counter doing emails and then it's like, Oh, that doesn't hurt. So that's when I found out the converter worked. Hmm. Ok. Matt. I want to answer any failures you've experienced with treating a patient you might have done differently now.

Kim: [00:38:09] Oh my God, yes. Can I get the first five years of my practice back, please?

Dr. Carol: [00:38:13] Exactly. Everybody I treated between 1997 and 2010. I'd like to get back because there were so many back in '97 through 2005. We still thought it was the muscle, right? I was treating the muscle. What an idiot. Right? It took until 2010. Before 2005, I began to suspect, but by 2010 we found out. It was never a muscle. It's never the muscle, so

Kim: [00:38:50] That's not I want to pause for a sec because that's not to say we don't treat the muscle, we treat the muscle, we treat the connective tissue. We treat the fascia. We don't treat the muscle like the quad is tight. Must treat quad like that. That's no, we don't do that treat,

Dr. Carol: [00:39:08] Causing the muscle to be tight.

Kim: [00:39:11] Right.

Dr. Carol: [00:39:12] Continuous adductor and quadriceps is 81 and ten. Right. And that leads to 124 and 77 at the knee and maybe the ankle. Right. So you're treating the tendon allopathy, but unless you relax the quad by treating the spinal cord. And the patient didn't know they had a disc in their neck anyway until you push here on the front of their neck. That hurt. Yeah. That is what's causing your leg. Excuse me. Right?

Kim: [00:39:47] Yeah. Now again, going back to our very first podcast is what is your why you have to think, well, why is the muscle tight? Don't accept that it's tight. Just don't accept it, just don't it's not tight, it didn't come from outer space, it came from a reason muscles just don't get tight ever.

Dr. Carol: [00:40:08] Yeah. Then you ask them if they ever had a kidney stone. Why do you ask? Well, the QLs on the left is really, really tight, and the QLs on the right is not. So what side was your kidney infection in? Go left. Imagine that

Kim: [00:40:28] Right. Well, even in an acute injury, when I see an athlete that just fell, got smushed, tripped, did something. Yes, muscles are tight, but it didn't just get tight. That muscle tightened up to protect a torn ligament tendon connective tissue. There's bleeding that happened there. So like treating the muscles so far down my list.

Dr. Carol: [00:40:57] Treat the bleeding, treat the torn and broken.

Kim: [00:41:00] Yeah. Treat all the things. Yeah, that's all I wanted to make sure, because people are like, well, what do you mean? It's never the muscle, it's just. It just never is. We treat it. We treat muscle tissue. But yeah, I'm going to jump to another question really here before we go on any further. I will read it because your voice is bad. I have just started a case of stubborn infertility from endometriosis. Plus, question mark also features constipation. Ibs him if you show significant worm-shaped parasites, history of antibiotics and steroids tests shows locked the LOX dominance in bowel and absence of E. coli age thirty-six. Yes, sir.

Dr. Carol: [00:41:57] And then Phil, Phil, and Matty are both from Australia.

Kim: [00:42:02] And hello, Australia.

Dr. Carol: [00:42:05] Love Australia. So Phil, treat the parasites. That's the first thing because. The parasites are turning off the Vagus, the Vagus is why she has constipation IBS, so there's no point doing anything for the IBS, including diet and all those other things we do until you get the Vagus turn back on and the Vagus isn't going to get turned back on until she gets rid of the parasites. So parasites are first you can treat. The scar tissue and the endometriosis at the same time, so being an Australian Naturopathic, you're going to be using herbs and wormwood and whatever other things you use and then. The. Antibiotics and steroids. Well, then. Once you get rid of the parasites, and that's what. Ten days wait six weeks and do another round, so you're six, seven weeks into it before the parasites are gone. Then you can start treating the Vagus once the parasites are gone, then you treat the scar tissue from the endometriosis and the Lactobacillus and E. coli thing is interesting. I was taking 50 billion. Colony-forming units of Lactobacillus and Methodist every single night, maybe a hundred billion like two little capsules.

Dr. Carol: [00:43:50] And. I've been doing that for eight or 10 months, and we did a stool test. I had zero Lactobacillus and zero Methodists. And Neil Nathan said, Well, they're there, but they don't colonize because you were delivered by C-section and you never got Lactobacillus and Methodists. When you were born, those are colonized when they get up in your nose and mouth as you're coming out of the birth canal. You have a C-section, your flora is not going to be normal. Anyway, so that was news to me. So I don't know how to give somebody E. coli because an awful lot of types of E. coli are pathogenic. So I would say maybe give her butyrate because the bacteria are supposed to create butyrate to heal the gut wall. So and then start once. Once you get the Vagus working and you can start teasing apart the scar tissue that scars the fallopian tubes, the ovaries, and the colon altogether. So that's twice a week for four to six weeks. Yeah. Clever from there. Thank you, Phil.

Kim: [00:45:20] There is somebody that had asked something about treatment duration, I don't know that if the question went away like how often I don't know what it was

directed to. How often do you treat trying to? Oh yeah. So how often should you treat every day, every week, every? I'm not sure what that question was about, because it's all so different. There is never a magic formula.

Dr. Carol: [00:45:46] In general, it's twice a week for four to six weeks. So if you're local and you're seeing patients that are local, it's twice a week. So you treat. You change the real estate and then you don't want to wait a whole week because then we go back and you'll end up treating the same thing over and over again. Right? You treat on Monday, Thursday, Tuesday, Thursday, Tuesday, Friday, two or three days in between. So that what you treat the next time will be compensations, and you might have to do a drive-by on what you did the first time because it will be different. I see patients. These like these people are here from out of town, so they're here for five days and I see them Monday, Tuesday, Thursday, and Friday she went home with a CustomCare Tuesday night to see what she needs on Wednesday and Thursday. So I'll find out tomorrow afternoon at one o'clock how she did and what we have to do if she was local. I'd see her three times the first week, twice the second week if it's something easy like neck. Twice a week for four to six weeks. And if you're done at three sessions, you're done. So that's my thing. How about you?

Kim: [00:47:12] Yeah, pretty close. I for sure we'll see a new patient. I try to get them in twice a week for sure for the first two weeks. Things snowball really fast with them, like in a good way, right? So we're always kind of building momentum. I agree. You're never treating the same thing. Like back to back, back to back, you might have to for sure, like you said, do a drive-by on the nerve, right? You might have to be treating for scarring almost all the time as you're getting deeper, as you're on coiling those layers. But I think what practitioners need to know is that you're going to increase pliability tissue health range of motion so much faster with FSM than you're ever used to. So with that, you can create some instability. Compensations can fly up a lot faster, so your exercise rehabilitation comes into play a lot sooner than it used to before. We'd be treating patients for weeks and weeks and weeks and weeks just to get range, and then we'd be talking about incorporating strengthening programs. I'm almost doing it instantaneously, even if it's an isometric muscle setting exercise for them to do because the connections are happening faster. What the brain is perceiving, the brain can understand it. It's like, Wait, I was in pain and I was restricted. And what? I don't hurt and I can do this. All of a sudden it's like, Yes. So it changes a lot faster. Marilyn Miller writes a really, really

important comment here. Patients have learned the bad message. No pain, no gain. You couldn't be more right. And so they do. They come expecting this treatment that's going to hurt, and you have to explain to them that that hurt was just creating more trauma, more bleeding, more inflammation

Dr. Carol: [00:49:13] Sensitized anyway, if somebody's been in pain for more than three to 10 days. The spinal cord, when Jay Shaw lectures on that Thursday night said no. Because the spinal cord becomes sensitized, the brain becomes sensitized, the sensory cortex map changes. And when you cause more pain, you reinforce the sensitization that makes it worse. I mean, neurologically, not locally. Right, right. The other thing I wanted to say is, if you're doing exactly the same thing, every time you're doing something wrong, you're missing something.

Kim: [00:49:59] Totally.

Dr. Carol: [00:50:00] It's like there's it's either unfixable and it's not your fault, right? Six surgeries you didn't need in the first place. How do you fix that? And but if you're doing it, exactly. I hate reruns. So that's what actually makes me stop and think if I have to do the same thing more than once, you miss something. And that's where I found 40 and 10 and 81 and 10.

Kim: [00:50:30] Right, right? Yeah, exactly. You missed it. Where is it coming from? Otherwise, you're just chasing your tail. Ok. I can tell it's almost getting towards the end because all the questions keep coming up and I have so much more to cover. So really quickly here. Please define again how you differentiate between acute, subacute, and chronic conditions.

Dr. Carol: [00:50:51] Acute is usually the first week. That's how we categorize it in the core, and it's in the first week because that's when you're treating bleeding. Yeah, subacute is usually acute on top of chronic, and you're not always treating bleeding, but it's anything from week one to week six. Right? You can't use anything for scarring. And until week six at the end of week one, the bleeding is usually done so in the courts separated into onset to the first week one to week five or six and then chronic is after week six. I can't think of the last time I used just like something on an AutoCare for

chronic. No, because everything we see is acute on chronic. This generally hurt, right? It hurts when you bend over and crack the annulus again.

Kim: [00:52:00] Right, right. Exactly. Hopefully, that helps when to move over to the other question and answer really quick. I think it was just a comment. This is back to Australia. Ultrasound shows possible successful follicles now 11 days. What should my timing be regarding the cycle? Must assume possible fertilization because we don't want to use

Dr. Carol: [00:52:25] What's pregnant or pregnant. She's thirty-six, so she's still got really good progesterone in the follicles, at least age-wise. Assuming you get her Vagus working FSA and LH will come back to normal. You get rid of the abdominal adhesions. My experience we don't treat once they know they're pregnant. So at week eight. In the first eight weeks, the drive towards implementation is so strong that I've never had difficulty, so she has follicles, so oh, good has her on progesterone plus Klonopin? Ok, yeah. Good luck, Wayne Phillip. Good luck. It'll be fun. You'll be a godparent.

Kim: [00:53:25] One more quick question before we get to our closing remarks here, the comment was you'd mentioned protocols to run before and after COVID boosters or vaccines. What about flu shot? What about shingles? Don't you love how I throw that in there with nine minutes to go?

Dr. Carol: [00:53:50] Ok, well, here's my thing, OK? I'm the last I have in my twenty-five years treated eight cases of Jillian Brae. Every single one of them was caused approximately by a flu shot. Got the flu shot on Monday. Jillian Bray hit on starting Wednesday or Thursday. Absolutely. Cause and effect the flu for me. I go to bed. I take vitamin C. I run the flu protocol. I go to bed. And when I get a bacterial infection on top of the viral thing, I take antibiotics. And for me, anyway, with my health, the flu is not a threat, so I will never in my life get a flu shot because Guillain-Barre will kill you and the flu rarely does. Although they do have statistics saying, Hey, this is why you should get a flu shot. That's just my thing. If you want to get a flu shot or if you have to get a flu shot for whatever reason, I would run the flu protocol afterwards to just keep the immune system down and

Kim: [00:55:14] After the after, not before.

Dr. Carol: [00:55:17] And then the other thing I do is run concussion and Vagus about 24 hours to get the Vagus turned back on. Um, there would be that and shingles once again, the last eight cases of shingles that I've seen came on virtually immediately, like within a week of the time the patient got a flu shot. Shingles vaccine. And the doctor said, Oh, it's a good thing you got that shingles vaccine because otherwise, the shingles would have been so much worse. So people get very passionate about vaccine versus anti-vaccine. I only it's kind of like there are certain medical procedures where I only see the ones that fail. So I have a skewed view of what the risks are. And with every procedure vaccines, surgeries, drugs, it is a risk-benefit ratio. You have to decide what your risk level is. You have to look at the statistics and decide what the potential benefit is, what the risk is of the illness. We have a treatment for shingles that's virtually 100 percent effective. So why would I do that if I get shingles? I know it. Within about twenty-four hours, I treat myself and goes away. Right, right. The flu? Not a thing for me.

Kim: [00:56:58] So for those patients who do get the flu shot, shingles shot, COVID shot. The advice is to run those programs after you get your vaccine.

Dr. Carol: [00:57:14] I would. I mean, that's what I did.

Kim: [00:57:16] And concussion and Vagus.

Dr. Carol: [00:57:17] Yeah, I ran. I didn't do concussion and Vagus till about five, four days later, but I took an aspirin before the COVID vaccine. The JNJ. Yeah, I got my skin was sore, so I knew it worked. And then I ran. The COVID protocol that night, took another aspirin the next day, and ran the COVID protocol the next day and I was fine. So.

Kim: [00:57:43] Perfect. Was there another question or comment that popped up really quick before we? Um, no, I don't think so. Ok, good, we're all caught up. So I had a whole bunch of people asking questions about the advance about the sports courses, all the things we're bursting out of our seats with excitement, with the advance. It's a week of crazy, good stuff.

Dr. Carol: [00:58:07] I got the schedule done.

Kim: [00:58:08] Schedule is done. Schedule is

Dr. Carol: [00:58:12] Awesome. We have the 5-Day Core.

Kim: [00:58:15] We start with the five-day core. So the starting date is February 18th 19th. No, the court 12th.

Dr. Carol: [00:58:26] I went to the core and your that's through Sunday, I think,

Kim: [00:58:33] Yes, the sports course starts Monday, February 21 and 22, so that is live and it will be live-streamed now. People who take the sports course, if you can come and you feel safe to travel, it's highly recommended that you come and play because you're never going to have more fun with your clothes on. Well, actually, people do get their clothes off, but that's for assessment and science purposes. But what we do is so much fun, but that will be streamed then we have on the 23rd. The new advanced sports course. So for all you geeks that have taken the sports course and you want a little more, this is heavy on the biomechanics really going down our new theme of why? Why is the shoulder like this? Why doesn't this move? So trying to troubleshoot biomechanically, doing all the new stuff rigidly proprioception and balance and intrinsic muscle setting? And it's just the coolest stuff that we've been doing. So that is on Wednesday, the 23rd Jay Shaw is all day Thursday. If you've ever been to jazz presentations, they are fantastic. Just when I think my slides are good, he like knocks. I don't know. Like if you could be a professional power pointer like that's his next job, but fantastic.

Dr. Carol: [00:59:56] All of the graphics department at NIH, at his disposal.

Kim: [01:00:00] So right, there's that. Sure.

Dr. Carol: [01:00:03] And he's been doing FSM or knowing about FSM since 1998.

Kim: [01:00:09] Amazing. Yet he's so cool. And what is he lecturing on? What's Jay Shah's workshop going to be on?

Dr. Carol: [01:00:14] It's almost don't care.

Kim: [01:00:17] Yeah, you can read me the phone book, and I wouldn't care.

Dr. Carol: [01:00:20] Yeah, exactly. No, I'm pretty sure it's on central sensitization and combining FSM with myofascial pain and chronic pain management. The description. And he's got great course objectives and learning objectives that will all be in what Kevin sends out. That's interesting, OK? Friday and Saturday is the advanced Friday Friday afternoon we have you and David Musnick.

Kim: [01:00:53] And can I just say I hate it when we go back to back? Like, I say this every single year, but this year I'm really upset. Just saying, OK, really? Put it out loud.

Dr. Carol: [01:01:06] Maybe I can get somebody else to do that, not even a section. And then you just do the three-hour session the next day or whatever. And then Saturday, I'm really excited about because we have John Reski, who is the neuro optometrist that gave me PRISM glasses, and just this week. A patient that I saw in 19. So in two thousand two, who has high drops in a fistula is just tough it out. She got her prison glasses and she can walk in a straight line for the first time in 20 years. It's just extraordinary, and John Rescue will tell us how that works. And then after Dr. Askew rescues Dr. Clearfield, which is the endocrinology of traumatic brain injuries, so people would think they can fix brain injuries with just FSM. No, just no. There is a stable state and it's not always just ever that you need. There are supplements and there are endocrine considerations. And then Sunday we have our panel how to. Doesn't matter what your specialty is. How to implement FSM in your office and get it to work. So there's four or five different clinical specialties. And then the rest of the day is case reports that are awesome. Tammy Ben Catholique, Dave Burke, there's just a whole list, and the topics are some esoteric, but some are the sorts of things you see every day. Yeah, and the case reports are all 30 minutes.

Kim: [01:03:02] I love it. Yeah, it's so exciting. So yeah. And then that will all be streamed as well, correct? So there will be an in-person and a streamed. And the other question I got is if you take do you get the recordings of all the presentations?

Dr. Carol: [01:03:19] I would say Kevin is nodding, so that's a yes.

Kim: [01:03:22] Ok, so if I do have to go back to back with David Musnick and you choose to go to David's, not to mine, you will eventually get my recording correct.

Dr. Carol: [01:03:32] Exactly. Ok. And we are you bringing our cameraman from here, David makes using local cameramen to pick up B-roll and additional shots so that the quality of the feed should be really good.

Kim: [01:03:52] It's just going live, especially when if you're able to, there's nothing like it. It's yes, the conference material is great and the content is good and the slides are good and the food is good. Yeah, it's a whole like the hallway conversations that you get to be part of. Yes. Yes, you're exploding and we have to go, but I know.

Dr. Carol: [01:04:13] Get it. All right. So the first day the lunches were in the pergola, so it's outside and it is, you know, Arizona in February. So it's going to be seventy-six degrees. Yes, that's the first day. The second day we are going to have special interest group tables, so we'll put a clinical condition on the table. And so there'll be PTSD, Ehlers-Danlos, IBS, neck and low back pain. We'll put different conditions. So if that's kind of your jam, you can sit with that team. And this was Candice Elliott's idea lunch. It goes from 12:30 to two and from 1:30 to two. Candice Elliott is going to do a tai chi class for everybody, so

Kim: [01:05:12] There is literally something for everybody. Question about the sports course. Yes, if you've applied, if you've taken the normal sports course and you've applied for the sports master's course, I will be sending out lists and you can go to frequency specifically to get all the information about the advanced and sports courses and everything on frequency, specifically website specific

Dr. Carol: [01:05:38] Sports frequency, specifically combat sports.

Kim: [01:05:43] Oh perfect. There's a sports segment, but for all the stuff, just go to Frequency Specific Microcurrent and that's where I send everybody. When are we coming to the land of Oz? I don't know. Let's do it. Let's go.

Dr. Carol: [01:05:54] Well, the TimeWaver device is approved in Australia, and as soon as David Suzuki gets a CE mark, which is coming closer and closer, we can taste it then.

Kim: [01:06:09] Perfect. All right. Ok. This was the fastest hour I think we've ever done. I don't know what happens when we sit down but thank you everybody for joining us here live and for listening later. Keep your questions and comments coming

Dr. Carol: [01:06:27] To your sales starts on the Monday after Thanksgiving.

Kim: [01:06:32] Well, there's a sale what's that?

Dr. Carol: [01:06:34] PDI end of the year

Kim: [01:06:36] Sale end of the year sale.

Dr. Carol: [01:06:37] Yes, it's the Monday after Thanksgiving Sunday, whatever it's.

Kim: [01:06:44] Not Black Friday. What do you call it on Monday, Cyber Monday,

Dr. Carol: [01:06:47] Monday, the PDI sale starts on that Monday and it goes through the end of the year, and I went to the clinic today, the training

Kim: [01:06:58] Center. Oh yes,

Dr. Carol: [01:07:00] We have ceilings, we have lights. We have cabinets. We will have floors next week and we'll talk about that next week.

Kim: [01:07:13] Oh, I can't wait. And then one day we will do a live from the clinic podcast. You and I

Dr. Carol: [01:07:21] Absolutely that would be so fun. Hey, what's in the video conference room, which we have at the clinic?

Kim: [01:07:28] Yes. I love it. All right, everybody. Thanks for joining us. We got to go see you all next Wednesday. Bye-bye. Bye-bye.

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