

Speaker 1: (00:01)

Hmm. And I'm back. So we had world travels in August, September and October. And then we just got back from Chicago. Totally magic class. It's been a great few mens. I missed everybody. Uh, okay. We have six people. Okay. So this is the, the title of this webinar is, it's all in the history and it comes from cases that I've done since we've been on the road. Plus, um, uh, just an update on the Vegas at the end because it turns out that the Vegas is like everywhere and does everything. So let's start out the theme if we have one is it's all in the history. And um, so this history was a 54 year old male patient. Well, the history of episodic low back pain going back 15 years, worked as a labor and construction. He worked as a janitor. Mmm. And when they did imaging on his low back, it showed a Mmm small disc bulge at L five S one no other imaging has been done.

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And his current symptoms. Presenting symptoms include three years of severe right hip, right lateral trunk pain up to the lower ribs, right lateral leg pain down the foot, down to the foot, up the medial leg, up to the groin, causing what he calls electrical shocks and burning pain at the tip of his penis. That is a weird pain pattern that is not Fossette said is not disc that is not nerves. So he rated, he described his pain as deep aching, this burning, stinging pain at the end of his penis. Or is it night hadn't been forward? No. Change the pain. Adam lean back, no change in pain. No change in pain with activity. It was better when he laid down, but it's not worse with bowel movements, sneezing or coughing and then no medication helped. Correct.

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They've done prolotherapy injections, physical therapy, nothing's produced surgery for the [inaudible]. Yes. So, Oh, let's go back and back patterns. If it was yes, it would be worse with bowel movements, sneezing, coughing and flexion. If it was a set worth worse with extension. Mmm. And yeah, Trump. Yeah. Yep. Trunk, leg. Media, leg. Okay. [inaudible] the um, okay. Think about that being he was pain free until one day, three years ago. Yeah. I see. When did you start? You said I took a nap. Excuse me. He woke up from a nap with severe. Yeah, that's red. Oh, the trunk. Hmm. Down the leg. Up the leg. And then affected the penis three to five days after onset. Consulted with general practitioner society, psychiatry, physical therapy, saas, therapy, no acupuncture treatments that produced no improvement included prolotherapy physical therapy. Okay. Gabapentin helps a little bit. Mmm. And here's the piece of history. I asked him if he's snored and he snores when he sleeps. He fell asleep. Mmm. Is bad. He fell asleep on his back. So we did physical exam.

Lumbar range of motion was normal. No change in pain and June screening because you could theoretically think that if you had a big nastiness, I drink strain that you could get and in your goin yup. Didn't explain why he would have no patellar reflexes were hyperactive on right. Normal on the left. [inaudible] on the right one. The owners, proprioception. Proprioception at the ankle was hypersensitive.

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Skin sensation was hyper static on all right leg the right. Yeah, and the trunk up to TA. The skin sensation was normal for sharp on West, so I'm presenting these reef, this fiscal exam because in 22 years I've never seen one. It's not like you're going to see this patients in 22 years is first 25 years short time I've ever seen somebody that presented with this, but that's the physical exam. The key is in my history, the key isn't any history. What's the mechanism of injury? He woke up from a nap was severe hip pain that spread to his leg, his trunk and speech. Penis and the patients. Yeah. Pattern recognition pattern and physical examination pattern don't match anything. I know that in the spine, this sets the nerves. Pain is described as electric on burning. That means it's probably nerve and so it's, it doesn't match. In his final hours, the only nerve left is the brain.

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There was the hat offices, the patient, how does girl during sleep and the sensory cortex, the thalamus causing central Islamic thing. If struck was in the sensory cortex, it'd be the first saw like that because there was no motor loss. He had no spasticity, no weakness, all it was pain. The stroke occurred. This is my hypothesis because he has sleep apnea and he snores. So this is the book you read in order to get as convinced as I am, that sleep apnea is a fatal condition. Well match, MD-PhD. It's called the promise of sleep is transformational. You'll never look at snoring or app news after that. This is the homonculus in both the soundness and the sensory cortex. Well, the pain pattern matches. Yep. Uh, the trunk halfway up the term down, leg to the foot. The toes. Oh, to the penis. Okay. Okay. So this is on the sensory cortex and that's what's range. And I actually, this is why you face assessments. I didn't realize that this part, that next to the foot, it was the general rules. So that's the same Oculus that exists in the film.

Speaker 1: ([08:02](#))

So the treatment was based on the hypothesis. That hypothesis was based on history with the school exam. The pain started when he woke up from a nap. So the point of this is kind of not the treatment. So neck to trophy 40 and 89 towards the lining pain. If you have Islamic stroke, he was pain free. Next leg

and foot 81 and 92 and then 40 and 92 just in case it was the sensory cortex, which didn't make any sense to me. And we ran the concussion protocol with magnetic converter at his waist. The result trunk pain receded first from six or seven down to a zero then his hip pain was reduced. [inaudible] pain in the penis went down last and it went down to a zero. Patient left pain-free and the treatment lasted about 60 to 90 minutes. Good portion of that was the history cause I'd never seen anything like this.

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So the key to this one is it's in the history. So the followup was recommended repeat treatment as needed. The patient was told that the pain would return in 24 to 48 hours. Patient is very likely a candidate for a custom care for home treatment maintenance. Four doctor Wang. I suggested that they order a brain MRI to establish the side of the stroke and order a sleep study and CPAP because the late of the lady last year that we treated that had the stroke. Okay. She was age 35. I treated her on, she's 38. We got rid of it, but they'd done surgery at river tonsils and adenoids. And uh, I didn't tell her to get a CPAP. So between the time I treated her last year and the time I got back this year, she had another stroke. So if somebody snores or somebody has sleep apnea, they get a seat sleep study in a C-PAP, continue Gabapentin as needed. Do not do pint spine surgery and do not do additional prolotherapy epidurals or any other physical medicine because this is in his bank.

Speaker 1: ([10:28](#))

Okay. So we all, this next one is post-polio syndrome. Now everybody knows at least common wisdom is the post-polio syndrome. It's permanent. Well, maybe not patient history. Ms patient was at a seminar or seminar in Germany. She has a 42 year old female medical physician. She has no complaint of body pain, but she had complete loss of muscle mass. Yeah. The left Delta league and her history was, it was caused by polio infection [inaudible] the age of two. So this is 40 years chronic, a physical exam. I confess it was observation only. I didn't do any specific muscle testing because you know, there's a big hole there or your deltoid should be. Mmm. The central medial and lateral portions of the deltoid were all gone. So she sort of starts with the triceps back here. Shoulder range of motion was limited. I lost that abduction and absence of all three areas of deltoid so you could see when she moved her shoulder.

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But deficit was, so our hypothesis was that the polio virus damaged the nerve and denervated the deltoid. So that's what we're working with is right there. So we had, Mmm Mmm. The time waiver device, which is effectively a

precision care, an auto care and accustomed care on the machine run by a computer. The treatment was based on a hypothesis polio virus. Mmm. As affected the nerve. And that caused atrophy in the muscle. Polio doesn't affect the muscle. It affects the nerves. So if the polio virus, here's what we think is the problem, then we treat the nerve as a tissue, not the muscle. So to remove polio, virus affection, the nerve 23 is the frequency and the advanced for poliomyelitis. It's also the frequency from old, but that's another conversation because I'm not entirely sure how those two things are related. But we put the context at the neck and the elbow and this is after 10 minutes. I'm going to flip back to, yeah, so there's the dance. Where are the deltoid used to be before we put the towels on and you see it starting to distal the proximal, the medial part of the deltoid started filling. This is in 10 minutes.

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Okay. Pairs the 23 and three 96 is time dependent. This is the muscle mass increasing. After 20 minutes central portion of the Delta would improved. The lateral portion is filling in from a bottom up. For reasons I don't understand. This is after 40 minutes. Hmm. Poster part of the deltoid is filling in and there we go. Muscle acids are stored tomorrow more or less after about 16 minutes, 23 and three 96 we now are nose time dependent, takes about 60 minutes. The muscle contracted, but it was not okay what you'd call an effective contraction. We could get a Twitch, we could get it to activate. So this was somebody who stands on the deltoid and asking her to abductor shoulder. Yeah, that's him. So compare that to the first photograph of the deltoid was completely missing. So how would you treat this? Well I treat her daily as needed, restore the muscle mass and then after one week of daily treatment at 81 and three 96 and 81 46th street.

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Cause that usually works on kind of, no matter how chronic it is. And then do general exercises to activate and strengthen muscles. And then you'd have to use for increased creations in the cerebellum, increased secretions in the sensory cortex 92 and start to exercise it as needed. So the next one is a 70 year old female. Yeah. Mmm. Her friend was at the course and on London, and her friend said, I have a friend who's had M E, which is myo and several [inaudible] something encephalitis. It's chronic fatigue, 30 years. Crime of chronic fatigue. Chronic fatigue is a very particular diagnosis. Mmm. Turns out it was not, and it was not incurable because when she was 40 years old, they told her she had chronic fatigue and it was permanent. Learn to live with it. So let's do her story. So this was, the history started when she was 40 prior to age 40 she had five children [inaudible] on a farm.

Speaker 1: ([16:06](#))

I had a difficult marriage boot. She was really sturdy and hardworking. A lot worked on the farm, cooked the meals. Mmm. I took in sewing, worked in the fields, were worked a lot at age 40 she had her sixth child and there was about six years separating the six, the fifth child from the sixth. So there's about six or seven years between them. [inaudible] normal birth, no forceps. Well, the pain started after the child's birth. She said, I had so much arm pain and arm weakness that I couldn't lift my child, the pain spread to the full body. And then she developed fatigue and sleep disturbance. So within a year she was diagnosed with chronic fatigue syndrome and myalgic encephalomyelitis at age 40. Now chronic fatigue is commonly known. M M E is what they call it in in UK, it's commonly known as chronic fatigue syndrome or E chronic fatigue is a devastating multisystem disease that causes dysfunction in the neurological immune, endocrine and energy metabolism systems. The symptoms are post exertional malaise, body pain and fatigue and it usually includes the symptom of swollen lymph nodes, episodic fevers, and a sore throat. So that's [inaudible].

Speaker 1: ([17:47](#))

That is a real diagnosis. Usually comes from some sort of viral or retroviral, but it isn't differential diagnosis. It is different from fibromyalgia. So diagnostic trail, it's in the history. That's what this section is about is it's in the history. Was it a stroke, was it polio? Is, I mean patient presentation was, she's healthy looking, careful, well-groomed, pleasant, non-smoking, 70 year old female. Um, she was brought to be treated by her friend. She came in with a cane. Uh, symptoms were body pain was a seven or an eight out of 10, but she was not overly dramatic about it or, um, there was no pain. Amplification symptoms. Poor sleep, don't sleep well. Too much pain, poor digestion, bloating, occasional constipation, no history of sore throats when the lymph GYNs are episodic fevers. So that symptoms is not consistent with a diagnosis of chronic fatigue or Amie.

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Emmy patients don't generally have body pain. This a seven or an eight. So the person had diagnosed her when she was 40 words, confused and um, just sort of missed it. What it made much difference because both of them are, Mmm. Both of them are incurable. So tell me about your life before age 40. So open ended questions are good way to get patient histories. Hardworking, married at age 26 children between the age of 20 and 32. Well, maybe it was six and he was her seventh mentioned that she lived on a farm, raised six children, cook meals for the farm. Farmhands three meals a day. The kids and

her husband. Money was so tight that after the kids were in bed, she took in sewing work, lots of lifting, lots of work, and then pregnancy at age 40 with a normal vaginal delivery. After the delivery, the arm pain started.

Speaker 1: ([20:04](#))

That's, that's the patient that's her friend. Arpin started within three months. She couldn't lift her child. Within six months, the body pain was severe and when that, when her seventh child was seven years old, she finally left her husband leaving behind her six children and taking the seven year old boy with her. Now you have to think about what it's like for somebody that's 47 to leave behind her six children and going off into the unknown with a seven year old child with her. What it make you think of asking? Why would she do that? That was what I thought of. Is the marriage difficult? Yes. It was very difficult from the time we were married, we lived on this farm. I get pregnant pretty much every one to two years. Four, six years ago, she has six children. This was her seventh was your husband abusive?

Speaker 1: ([21:10](#))

Yes. Physically and emotionally. So when she bailed, when she finally bolted with the seven year old boy, her next youngest child was 13. So she basically saved herself and boy and left the other six kids. She was still a strange from them, but when she left, she ended up living in a shelter and then moving in with her child, with the friend who brought her to the class to be treated. So it's quite a history. Physical exam, hyperactive patella reflexes, pain level was a six to a seven. She didn't take any pain meds, 40 and 10. I mean that's, there's simple positive pluralize positive, the context at the neck and the feet with the patient seated. I didn't want to try and get her on the table. Um, we ran concussion in Vegas. Uh, and uh, ed or abdomen, body pain was one at a 10 at the end of an hour.

Speaker 1: ([22:17](#))

And at the end of an hour it was like, how does it feel to be out of pain? Weird. So I switched the contacts, switch the machine at her neck from 40 and 10 to 40 and 89. Mmm. And 49 89 fix that. And then we rent scarring in the spinal cord, scarring in the dura, cause I was only going to be in England for another two days and I wouldn't have time to treat her again. So scarring in the core 13 and 10, 13 and four 43. So she was seated and I had her bender trunk forward, then back up to neutral, then side bend. So I decide, Mmm. Uh, rotate and flection again. And after about 20 to 25 minutes, she bent over and touched her toes for the first time in 30 years. [inaudible] so that was Thursday. And then I said, well, it's probably not going to last.

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We're going to be here till Sunday. Let me see you on Sunday. So she came in at the end of the class on Sunday and Mmm. She was pain-free until Sunday. Uh, she was running light as she ran to get to the hotel on time. And as she was running in these little shoes, as she was running, her pain went up to a four to a five. So we did. And 10 with the patients seated 81 and 10 with the patient seated to decrease bestest city and tightness in the legs, 40 and 89 to decrease the central sensitization and then scarring 13 and the cord, 13 in the dura and 13 in the nerves with rotation flexion side bending to get everything moving and gliding. And as far as an or the last I heard, she is still pain-free. So that was yay. Um, isn't that a great figure picture?

Speaker 1: ([24:18](#))

I just thought that part. Okay. So, um, those are the case reports just to remind you too, pay attention to the history. Mmm. All right. So, uh, those were all the slides I had for this webinars. So I thought, well, what are, what's important enough that I can put it in here and remind you about it? And we ended up at the Vegas. Mmm. Except for the post-polio patient. We treated concussion in Vegas on both of those pain patients and I'm ending up treating concussion in Vegas. [inaudible] just about everybody. Vegas is so important. We're going to talk about it frequently. So let's remember central sensitization, what that means when you have stress, right? Any kind of physical injury, infection, emotional stress, physical stress, physical injury, any sort of stress, the midbrain, this part of the brain actually is probably the hippocampus campus combined with the thalamus and the met Dulla and the amygdala.

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The midbrain 89 in our world remembers and puts an unconscious subconscious or rarely conscious memory, early childhood and past injury, pain, infection and stressful events so you can predict and survive future events. The patient, it's unlikely to be aware of this sensitization or any of these memories. The visual stimuli sounds, smells, even textures or furniture configurations can trigger the midbrain and set off a stress response reaction with no conscious memory of why it's happening or even what is happening. So the patient gets on the bus or the subway or train and all of a sudden pain in her shoulders goes up, painted the base of her skull, goes up, her stomach starts bothering here and she assumes for example, that she can, that she is EMF sensitive or that she's chemically sensitive. But you have to wonder that smell thing, the organization of the furniture and if you're on a frontier, what's your store?

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The smells, the sounds, the color of some shirt. All of those things. All of those environmental observations can trigger the midbrain and set off [inaudible] a stress response reaction with no conscious memory of why it's happening or even what it's happening. Somebody on the plane we're on the train is wearing a Calum that the man was wearing when he molested her when she was five. Yeah. Somebody on the plane, the train, uh, the street or in the meeting. So wearing a shirt. It's the same color as he wore or that somebody were, when it was a stressful event, that's what they hit. The campus gets paid to do. It triggers the midbrain and sets off a stress response reaction with no conscious memory of why it's happening or even what is happening.

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That's, that's the mechanism of how, of how a lot of digestive and sympathetic stress and even physical pain responses get triggered and we can't figure out why. Right. Because we have the same response to all stressors. The stress centers, the endocrine and nervous system reacts to all stress and more or less the same way [inaudible] stress centers in the midbrain suppress the Vagus in order to increase your heart rate. Suppressed digestion, increase inflammation so you can survive. It is the same response whether you're being attacked by a tiger, you're in a fight with a colleague or a bar boss. You're in the middle of some sort of confrontation. A family mom and dad are fighting and the two kids are, Oh my God. And these two little ones, Matt. Well, Syria, Ukraine, any of the war zones in this world, uh, us detention centers at the border.

Speaker 1: ([29:49](#))

So all of those are reacted to in exactly the same way. You have 30 minutes to live. What's going to keep you alive? What is most important? Well, you certainly don't need your digestion. So you decrease enzymes, decreased circulation, digestive enzymes, stomach acid, decrease the function of the gut, decreased circulation in the skin, in the hands, increased circulation in the muscles so the muscles feel congestion. The muscles in the upper trapezius and the neck get tight because of increased activity. And the brings down in the middle. Okay. Okay. Increased heart rate and blood pressure, increased cortisol to deal with inflammation. Well, if you increase cortisol, what happens to your gut? Increase immune system activation so you can survive the trauma and infection. It may not actually be trauma and infection, but there was stress response is the same no matter what it is.

Speaker 1: ([30:58](#))

Okay? If it's up long enough, it decreases thyroid stimulating hormone,

peripheral thyroid conversion, growth hormone, follicle stimulating hormone, so you don't make as much. Progesterone get estrogen dominant. In Europe, your periods change and luteinizing hormones change, so that reduces testosterone. In males, they're all reduced because they're nonvital. You've only got 30 minutes to live. What is the point of digesting your food or making longterm repair hormones? The Vegas gets in the way of survival during stress because the Vegas slows, the heart rate, increases digestion and suppresses the immune system. Vegas is inhibited by the central stress response, so the midbrain turns of Vegas off during stress, so the heart rate can go up. The immune system can be very active and the digestive system is turned off. The Vegas gets in the way of survival in a normal patient. Once the infection gone is gone, the traumas repaired and the injuries heal the [inaudible] fibers of the Vegas. Tell the brain that everything's fine, we're fine down here, it's all good.

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And then the Vegas stops sending stress or inflammation. The primitive stress centers calm down. The biggest comes back on the immune system, gets quiet. Digestion and heart rate return to normal. In a normal patient, the front Vegas Vegas stimulation gets normal. Heart slows down the digestion appetite. Stomach acid parasol says sphincter in esophageal function all returned to normal. The immune system is downregulated by the Vegas inflammation and macrofasia tr activity return to the normal quiet state. So the short version is the Vegas activates good things and inhibits bad things. So the Vegas increases cerebral blood flow, nitric oxide, brain derived nerve growth factor neuro trophism, which is what means to you, your nerves recover. Um, serotonin, norepinephrine, neurogenesis, right. Acetylcholine receptors. When the Vegas and the Vegas inhibits, look at what the Vegas inhibits. Glutamate excitotoxicity. Glutamate is what makes you crazy. Glutamate is what creates inflammation in the nervous system. The Vegas inhibits inflammation, 10 F alpha cell adhesion molecules. That's the Vegas does all the good stuff and inhibits all the bad stuff.

Speaker 1: ([34:03](#))

And a sensitized patient though that patient that was had early childhood surgery, um, had early childhood auto accident, had physical, emotional, or sexual abuse prior to the age of seven. The midbrain stress centers have a different and lower threshold and they fire with much less external object of stress. So those stress centers stay on from normal life stresses and events. That color shirt that smell, the way the furniture is arranged, the textures, it doesn't take a lot and that keeps the Vegas off or reduced. So what, Hmm?

Does that do in a sensitized patient? When the Vegas is off, the immune system remains unregulated and creates allergies, autoimmune conditions and chronic inflammatory responses. The digestive system changes, create leaky gut and further activate the immune system. The stress response system works well for short burst, but if you're not dead in 30 minutes, it's pathological.

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When it's prolonged, right? There are motor and sensory branches to the Vegas. The Vegas nerve accounts for 80 to nine per 90% of the a Farron nerves from the body to the CNS. Okay. The motor nerves of the Vegas regulate all of the muscles involved in swallowing except for one. Look at the branches of the Vegas. It's the longest nerve in the body. We think of it as regulating the heart, the esophagus, the gastrointestinal system, but it also regulates all the sphincters and it has pain nerves, [inaudible]. It has a sensory component that provides sensation from your Bronco, your chest, your lungs, your lungs burn when you're coughing and you have pneumonia or bronchitis because this, the sensory nerves from the Vegas. Tell your brain, Oh, this is not good. Hmm. Look at the Vegas anatomy. [inaudible] everywhere. Look at these branches. That's the brachial plexus, but this is the Vegas. It comes out of your brain goes soup. Superior cervical cardiac branch of the Vegas goes down. One branch goes behind the esophagus, the other branch goes in front. You can find this. This is from, um, essential anatomy. Who knew? I didn't know this. The Vegas controls blood sugar by fibers. That's stop gluconeogenesis in the liver. I didn't know that.

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Vegas anatomy. Look at all the branches. The accessory nerve. There's the Vegas, there's an irregular branch. There's a tympanic branch that goes to your ear. Glossopharyngeal branches that regulate the fan. It sort of joins in this ganglion, no dose IOM nodosum for the pharyngeal and laryngeal branches. Look at this sympathetics, parasympathetics hypoglossal. It's tangled up in all of these nerves. So there's the vagal nuclei [inaudible] our world. That's 94 they're in the Medallia. The Vegas nerve is one Oh nine so think about neck range of motion. Is the cerebellum going to allow you to move your neck full range of the Vegas is adhering to the fascia? I think so. Cerebellum is very vigilant, especially about the Vegas. What could lead to Vegas adhesions? When I looked at this anatomy, I thought about people with neck surgery, people with open heart surgery. So look at these branches and think about what they do during open heart surgery.

Speaker 1: [\(38:06\)](#)

They slice that open, they pull it apart. Look at all the branches of the Vegas that are everywhere in your chest. There's going to be adhesions. So heart surgery with lash injuries, neck surgery, even if you've ever had a sore throat or a sinus infection, you're the lymph glands get inflamed and they, the lymph glands in the lymphatic system run in between fascia along with the Vegas scarring in the Vegas, scoring in the fascia increases neck range of motion. I've done it six or eight times and it never doesn't work. And as a matter of fact, syncer is also a branch of the Vegas that goes to the dura. Did you know that there's a branch of the Vegas [inaudible] goes around behind [inaudible] enervates the dura. So those patients that have those would be the do cranial sacral work. Patients that have adhesions or whiplash injuries where that branch, the Vegas gets adhered in between the fascia. You're going to have a constant strain on the dura caused by the Vegas caused by adhesions of the Vegas. Who knew?

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So think about autoimmune disease. We did this last year. We're going to do it again. Um, next year we're going to keep doing it again until everybody gets us at, at least straighten their head. What was going on in the patient's life in the year preceding the audit? Onset of the autoimmune condition, early childhood trauma, calm environment. How did you or you and your mom get along? Do you have any history of your home environment being uh, violent? Were your parents fighting all the time where you physically, verbally or sexually abused? Did you have a lot of infections as a child that will turn off the Vegas? Did you have number of surgeries? Did you have a really bad auto accident when your father, so far, every autoimmune patient history has reported some dramatic increase in stress three to 18 months prior to the onset of the inflammatory autoimmune condition.

Speaker 1: [\(40:31\)](#)

So is there any point and treating the immune system unless you quiet down the midbrain? No. [inaudible] [inaudible] on the membrane, mostly 40 and 89 so stress turns off the Vegas when the stress is gone, you want to help reduce the activity of the stress centers. So 40 and 90 but 40 and 89 mostly in 40 and 94 quiet down the stress response system and then turn the biggest back on 94 trauma, nine 71 24 increased secretions and vitality all in the Vegas on 24 supposed to be time dependent, but I don't know if it is time dependent in the Vegas. 81 on one Oh nine increased secretion suppresses the immune system, improves digestion. So as the heart rate and reregulate the immune system, then you still need to repair the small intestine because all this time

the Vegas has been off. You've got CBO, you've got IBS, you've got CBO, you've got IBS, you have to Mmm [inaudible] repair the small intestine and then quiet the immune system directly. So I think this still applies even when the patient is on the biologicals. Um, I don't see any harm in doing it. The biologicals are Mmm.

Speaker 1: ([42:03](#))

TNF alpha blockers, they are monoclonal antibodies. So they actually attack the, Mmm. 10 F directly [inaudible] itself, vitamin D and phosphorus phosphatidylcholine support, vitamin needed support. Mmm. Immune system regulation phosphatidylcholine to support acetylcholine because the Vegas uses a sealant combing as a neurotransmitter. Treat the effected tissues locally. Scan, you want to treat the scleroderma and psoriasis, the synovium in rheumatoid arthritis. You want to treat the thyroid and Hashimoto's. You want to take the intestines in Crohn's disease, ulcerative colitis, autoimmune disease is there an immune adrenal component, by and large can put tissue back. It's not there, so you're not going to make this hand look like that hand, but it does explain how dental infection turns off the Vegas and can cause arthritis audit antithyroid antibodies or any autoimmune disease. The Vegas is the connecting link. CBO Vegas has to be involved. Gut bacteria are V very pH dependent. The small intestine, intestine bacterial overgrowth can happen if the sphincters are working properly, if the small intestine is acid enough and if food is digesting properly. What stimulates acid production? Seven I guess what stimulates pancreatic enzyme production? The Vegas. What stimulates gut motility and sphincter production? The Vegas. So how would you treat Sabre? Well, concussion protocol.

Speaker 1: ([43:54](#))

Okay. Okay. Treat the concussion protocol and treat the Vegas at the same time. Okay. Mmm 40 and 89 40 and 94 you might want to quiet down the sympathetics maybe about five minutes each, but you also have to think about is infection gone? Is the living environment safe? Is the trauma repaired or resolved? So if the patient has inactive infection, mold or some sort of parasite, I'm turning the Vegas back on is going to reduce me in such STEM activities. So that's not a great idea. 94 increased secretions in the parasympathetics. Be careful about turning on the parasympathetics of the CBO is causing a lot of diarrhea. I'd put the context that the neck and abdomen and then how are you going to treat CBO? Oh, person person capsulated fermentate IV and putrifactive toxin four 50 and six 50 trauma, paralysis, allergy reaction, inflammation, increased secretions and vitality and the pancreas and the stomach.

Speaker 1: ([45:05](#))

The C com, the small intestine and the large colon, large bowel, maybe pre, pre and probiotics and enzymes. The thing that always bothered me about CBO is that people had it for years and they were on this horrible diet and they took all probiotics, probiotics, and then five years later they still have a diagnosis of seatbelt. I think the missing piece in CBO is treating the Vegas. So that's where we live. Um, this is just a reminder in order to change lives and change the world, um, be sure to subscribe to the FSM practitioner list. It's \$89 a year. The listing will include all your FSM courses, your clinical degree, a link to your practice website, your practice specialties. So if you have a special interest in fibromyalgia or CBO or chronic fatigue, patients will find you. And FSM spends a fair amount of money, um, to promote frequency specific microcurrent, but it's designed to build patient awareness and support your practice as well.

Speaker 1: ([46:18](#))

So those of you that are on the FSM practitioner list, Mmm. Got a lot of phone calls after the body electric summit and then after each of the webinars that I've done, Mmm. All of that has built the seminar attendance, but it's also helped to build your practice. And I just want to remind you, I'm so excited. I finally got this F the advanced and pre-conference schedule done for 2020. Um, next year we are moving the core seminars to two, three day modules. So there will be a pain and injury core that's taught by myself and Kim Pitt us. And there is a three day neuro and visceral core that's taught by myself and Dr. David Mutchnick. Um, so we'll do one five day course, two five day course seminars in the U S next year. Uh, the first one will be February 19 to 23rd. There's just no way to do the core in four days anymore.

Speaker 1: ([47:23](#))

There's just too much information. So it's five days. Mmm. FSM that five days is the 19th of the 23rd FSM sports is Kim Pettus. Um, we take Monday off and Kim teaches that sports seminar, which is just got great reviews and just great information. That's the 25th and 26th. I'm going to repeat the fibromyalgia workshop that the last time I did it was 2012. I'm going to update it, include the information about the Vegas and update the material on the other five types of fibromyalgia. Um, John Sharkey is a world renown clinical anatomist. Mmm. And um, he teaches, Oh, he does fascia dissection in is worked with the plastination folks and the Oh, his fashion bio tensegrity secrets for FSM practitioners. Kevin is going to be mailing out, emailing the schedule and posting the schedule on the website, so be sure and reserve your space. Four those two pre-conference workshops.

Speaker 1: ([48:40](#))

And then the advanced is February 29th and March 1st it's a leap year and 2020 is going to be a leap year for us in more ways than one. And I'll tell you more about that. And fabric. February. The advanced topics will include, I'll be doing the advanced the two mornings, but for people that have already taken the core, uh, the advanced, uh, David home attended the core seminar in Portland last year and what he did was so good that I invited him to give this three hour workshop on personal energy sensitivity protection and management theory and practice of subtle energy for FSM practitioners. You have to have taken the advanced already too, have that three hour block. We'll probably have David redo this course as a, as a full day workshop at some point, treating TBI and distibular entries with optometry. Bruce Ward Koski is an optometrist and a fellow of the college of optometry and visual development and this is, everybody's coming to this.

Speaker 1: ([49:47](#))

It's physical, physical medicine. It's visceral medicine. It's what you didn't know you needed to know about saving lives with prison glasses. I don't even know how to tell you how transformational this work has been. My personal experience, whether it's so Dr. Bruce is the man, don't miss it. The Vegas range of motion, pain and auto immunity. I'm going to do the Vegas again. Turns out the Vegas is the key tip. Virtually everything we do. Um, visceral medicine tracks sleep is the crucial stable state. David Muslim is going to do a one hour on sleep on the Sunday functional medicine and FSM strategies to help them sleep so they can recover from everything. Physical medicine track is FSM for CRPS, nerve pain and maybe cervical spine. That's Jody Adams treating CRPS and nerve pain when you didn't think you could. Jody ended up in the deep end of the pool this year and ended up treating five or six CRPS patients so she's got a lot of advice on how to deal with that.

Speaker 1: ([50:49](#))

Treating TBI and cognitive default. Klein David Mazdak for 60 minutes on this FSM and functional medicine strategies for treating traumatic brain injuries and cognitive decline. Kim Pettus is going to tell us about treating frozen shoulder and she's got to be better at it than I am. So physical medicine that's also on Sunday. Combine this role and physical medicines track is the last thing on Sunday night and it is an interdisciplinary panel discussion. And with time for Q and a, we will have at least three or four different disciplines rest represented in this workshop. And this came about because of what you asked for on the Mmm. On the FSM practitioners page and Facebook. Be sure and look into that if you aren't already on it. Closing, um, remarks on

Sunday night plans for FSM 2020 and beyond. Don't forget on Friday night, the ah, certified practitioners, the FSM practicum instructors and the faculty will have a private dinner that is, um, just for them up in that nifty upstairs area and lunch the first day we will do awards and recognition of the new FSM practitioners and we will present, Mmm. The check for published paper. So this is it.

Speaker 1: ([52:22](#))

Think about how the world changes because this lady got her life back for pain, has been between a six and an eight for 40 years, 30 years, and she's pain-free and will stay that way. So do good things, change lives, take care of yourself. And I'll talk to you next month.