

FSM Podcast Episode 120 - Treating Conditions Like Nerve Pain and Osgood Schlatter's Disease

Hosts:

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In this episode, the speakers discuss their experiences and techniques in treating various health conditions. They underline the importance of understanding the root causes of conditions such as Osgood Schlatter's disease and nerve pain.

The conversation also delves into FSM (Frequency Specific Microcurrent) treatments, highlighting the rationale behind them and providing tips for anyone dealing with related health issues.

The conversation further explores the need for adaptability in medical practices, reiterating that health treatments must be flexible and must take into consideration the patient's condition and capability.

Creating a safe and open environment for patients to discuss and understand their health problems openly and honestly.

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Kevin: [00:00:00] Please help spread the message of Frequency Specific Microcurrent by clicking on the like button. You can subscribe to us on YouTube or any podcast app. If you have any questions, please leave them in the comments. You can find the podcast transcription at frequencyspecific.com as well as more information about Frequency Specific Microcurrent.

Kim Pittis: [00:00:18] Today, I was at the clinic until very recently.

Dr. Carol: [00:00:22] Two seconds ago.

Kim Pittis: [00:00:24] Just enough time to... Oh, I have to show off my new mug.

Dr. Carol: [00:00:28] Ohhh.

Kim Pittis: [00:00:30] This is the new California logo edition.

Dr. Carol: [00:00:32] Sweet. Speaking of showing off. The team downstairs has ordered stuff for the Advanced. And so he ordered like one. And then it'll have a QR code.

Kim Pittis: [00:00:53] Yeah.

Dr. Carol: [00:00:53] This is the back of the sweatshirt.

Kim Pittis: [00:00:56] Yeah.

Dr. Carol: [00:00:57] And then it's a zip-up. And then there's bags and shirts and all sorts of stuff.

Kim Pittis: [00:01:03] But yeah, very nice. I also now I want to show off my other stuff. I'll wait till next week because I also got some new hats made this year and some new pouches. So I think that's one of my favorite things about going to conferences is coming home with the t-shirt and the pen and the water bottle and the bag and.

Dr. Carol: [00:01:23] The mugs.

Kim Pittis: [00:01:23] Mugs. Yes.

Dr. Carol: [00:01:27] Yes.

Kim Pittis: [00:01:27] It's so funny because we were talking about how or I was saying last week how excited I am for Wednesdays, even when there's so many things to do. And we're going and sometimes it's like stressful and what do I plan for today? And I hope my computer works. But then I sit down and I have my cup of tea and I'm like, ah.

Dr. Carol: [00:01:50] It's all just sitting in your kitchen or my dining room, and we're just kind of hanging out.

Kim Pittis: [00:01:58] And I got the dog sleeping at my feet and we get to learn and share and.

Dr. Carol: [00:02:03] All that good stuff. Yeah, Ellie is downstairs because she's having a very barky day.

Kim Pittis: [00:02:10] Well.

Dr. Carol: [00:02:11] It's one of those.

Kim Pittis: [00:02:14] You just never know sometimes.

Dr. Carol: [00:02:15] Yeah. I don't know the wind.

Kim Pittis: [00:02:18] Let's just face it. Everything we do is unpredictable. Especially the podcast.

Dr. Carol: [00:02:22] Or especially life.

Kim Pittis: [00:02:25] And I want to segue this to treatments because I think as different as you and I are in our approaches and our personalities, I think we have one thing in common, and that is to tackle each patient with as much educational knowledge hypothesis but to also have the flexibility to pivot and to discard your plans.

Dr. Carol: [00:02:51] Treat what you find.

Kim Pittis: [00:02:52] And treat what you find. Somebody had asked me the other day, what is the hardest lesson you've learned professionally so far? And I said, to be able to be adaptable and pivot, because humans don't get to fall into the little box that we want them to and it's a gift. But FSM expedites that gift.

Dr. Carol: [00:03:20] Most valuable lesson I have learned is never skip a complete physical exam ever.

Kim Pittis: [00:03:32] Yeah.

Dr. Carol: [00:03:32] Every time I do, every time I look at the pain diagram, listen to the history, think the slam dunk, I know exactly what it is every single time. There's never, ever been a time when I got away with it.

Kim Pittis: [00:03:44] No.

Dr. Carol: [00:03:44] After five years of educated arrogant, I'm pretty sure I know what it is. It's obvious. Two frozen shoulders, lifting 90-pound things for a job, and now you're 73, and both your shoulders are frozen and I still reflexes, sensation, neck range of motion. Don't skip it.

Kim Pittis: [00:04:17] Because what's it going to hurt? Absolutely nothing by doing it. And it verifies your findings. Great. You have extra confidence to proceed forward. But you're right. Every time you think and you start treating what you think is there and it goes sideways.

Dr. Carol: [00:04:33] Find out that what you skipped was important. And what I found was you doing the reflexes, the one thing I remember from geriatrics is that reflexes decline and disappear from the bottom up. So if there was an Achilles reflex in a 73-year-old woman, that would be abnormal, right? She had no Achilles reflex. Yay! Both knees one knee was a +3, normal. One was a +3, very brisk. Okay. Plus three patellar reflex and a 73-year-old woman is abnormal. I'm not going to tell her that, but because there's no other indication that she's surgical. So let's not worry her. But now we know for sure that her frozen shoulders started in her neck. And sensation was all normal. So that's three things. It's not. And now you know okay I'm dealing with shoulders and disc bulges at 5-6 and 6-7.

Kim Pittis: [00:05:50] And even for practitioners that don't necessarily go there right off the bat. So personal trainers, massage therapists, even some PTs aren't thinking about doing reflexes, sensory exams or thinking about nerve entrapment coming from the neck. They're looking at oh it's tennis elbow and that is that. So I had a very easy slam dunk trio of tennis elbow people come in. Two were repetitive strain coming from the extensors, but one was a cervical disc.

Dr. Carol: [00:06:25] C7.

Kim Pittis: [00:06:26] And instantly C7.

Dr. Carol: [00:06:29] C6, sorry, six is lateral.

Kim Pittis: [00:06:31] Yes.

Dr. Carol: [00:06:31] Yeah.

Kim Pittis: [00:06:32] Anatomical position You've seen my little room. I have one really ugly poster and I hate half of it, but the other half is very clear because it shows the dermatomes. And it's so nice when a patient can be like, oh, that blue part is me. I'm like, huh? Yes. And then that always reminds me to check. And so treated her neck and she's like, why aren't you treating my elbow? I'm like, just bear with me for a second. Everybody treats it and it hurts. I'm like, no kidding, because it's not coming from your elbow. And she talked about manual therapy makes it worse and this makes it worse. But two treatments and it was gone. But I don't know if I would have gone there that fast without all the extra tools. And what I want to get to is I, we never say FSM is a replacement for other modalities or a replacement for.

Dr. Carol: [00:07:29] It is an Adjunct.

Kim Pittis: [00:07:31] It is an adjunct, and the training that we do, it's not sitting in a seminar memorizing frequencies. It's all the little bits and pieces. And as I'm repackaging my talk for the Advanced and the sports course and the Sports Advance, the more like people are using this and the more feedback we get, the more the course changes, because you realize, oh, I have to teach them this so that they can do this so they can unpack that. And that's why the core changes every year.

Dr. Carol: [00:08:02] Yeah, I've got the core show that it's really it's too long, it's too much. It's the same complaint every time. I'm sorry. You tell me what to leave out. And it's the thing that makes us different is that nobody thinks of lateral elbow pain as nerve pain because they have no way to treat nerve pain.

Kim Pittis: [00:08:29] Right?

Dr. Carol: [00:08:29] Because we can treat both the nerve and the tendinopathy, we are in a position of having to decide whether it's the nerve or the tendon. Is it really a tendon strain? That's easy. It's 124/77 and 124 and the periosteum and maybe the Bursa.

Kim Pittis: [00:08:52] Yeah.

Dr. Carol: [00:08:54] And because this muscle is innervated by this nerve, it can be both.

Kim Pittis: [00:09:03] And when you're in a pinch and you maybe don't know, or maybe you blew through the sensory exam. Multiple machines, one on the nerve, one on the connective tissue and it's going to work.

Dr. Carol: [00:09:03] Yeah.

Kim Pittis: [00:09:03] So sometimes it's not being that quick and that brilliant. Sometimes it's just covering your bases because the context are going to be the same. I'm going to put one behind the neck, I'm going to put one on the forearm or on the wrist and it's easy to treat that way.

Dr. Carol: [00:09:32] Yeah. I love being us. Today in the lawyer's office, I was having a conversation with the business manager at something else, and she said, what do you do anyway? And I said, we have these fragrances, blah, blah, blah. And we were able to treat nerve and muscle pain, she says. This happens every time, she said. I have this numb spot and she points to this place on her thigh that's an oval. Starts at her hip, and it's an oval down the lateral. It's a lateral femoral cutaneous nerve. And I said, is it painful? She said, no, it's numb. And it tingles. And I said, it's a lateral femoral cutaneous nerve. Did you have a seat belt injury? Did you have a hip replacement? Did something happened up here where that nerve comes out and it makes that nerve numb? Said no, that they told me it had something to do with

sciatica. Now the sciatic goes down the back and ends up in your foot and your butt. This is the lateral femoral. Can you fix it? Yeah. So far it does come from your back, but it comes up high.

Kim Pittis: [00:10:57] Right.

Dr. Carol: [00:10:58] L1 L2. And she said I do have back pain up there. I said then maybe there's two things to fix. Maybe it is a little disc thing and I'll give you some exercises. Just lay on your stomach at home and lift your foot up eighth of an inch off the table and make an appointment. I think I can see in April. Okay. That's the curbstone diagnosis but because you know that the only thing that's there is the lateral femoral cutaneous nerve, because you have that dermatome poster up there that has this little oval right there, and you look at it for 30 years.

Kim Pittis: [00:11:37] Yeah.

Dr. Carol: [00:11:38] It's yeah, that.

Kim Pittis: [00:11:43] Okay, so I want to unpack a couple of things here. I feel like the word sciatica is one of those trigger words that I have, along with frozen shoulder.

Dr. Carol: [00:11:53] Eye rolling.

Kim Pittis: [00:11:55] All the things and sciatica, even if you think you have it, it's not a sentence like you have gray hair. It is a pathology. Don't accept that. There's something that can be done with it and break it down and figure out. If it is a sciatic nerve, why is it irritated? And how come we're not unpacking that more?

Dr. Carol: [00:12:22] Yeah, and I have sciatica, but it stops at my knees and it's worse when I've been back. They really do have sciatica. And have some gabapentin. Yeah, I know it. It's what makes it so easy to have an elevator presentation. Somebody says, what do you do? I use this technique that was developed for treating nerve and muscle pain. That uses frequencies that were developed in the 1920s. You are treating nerve pain. Yeah. I have this sciatica thing goes clear down the back of my leg, hurts like hell, and the drugs make me all stupid. And can you fix that? Yeah. It's not that hard. Usually. Do you have an MRI? We can try. It's like. And then the next thing that is said is, when can I get in? Call my receptionist? Probably next week after. Right.

Kim Pittis: [00:13:30] And something like nerve pain. I know we always say it's not that hard It can be challenging to make it long-lasting and to close the case, but we can instantly take the pain down when it truly is the nerve. That is one of the easiest things that you treat, which is crazy to think about that you can do that so quickly.

Dr. Carol: [00:13:53] We just said that out loud is the easiest thing we treat now. Repairing the disc. I tell people, you have this jelly donut in your back in between the vertebrae. I take out this

little spine, and this is a jelly donut. And the donut has got 14 layers, 17 layers of donut. And then, the jelly on the inside is like battery acid and when you bend forward, the jelly goes out the back. And right next to where the jelly goes out are these nerves. And they get really irritated because jelly is really irritating. And so we can get rid of the nerve pain. But to fix the donut, you have to pretend that you have a sprained ankle in your low back.

Kim Pittis: [00:14:43] Right.

Dr. Carol: [00:14:43] So you are not allowed. Nobody likes to say I can't.

Kim Pittis: [00:14:50] No.

Dr. Carol: [00:14:51] But you're not. You just tell whoever I'm not allowed. To lift anything more than 5 pounds. I'm not allowed to bend over at the waist because when I bend over it pushes the jelly donut. I'm just not allowed. Not forever. Six weeks. Twice a day you land your stomach. That makes my nerve pain better. Well. And you left your leg like this. And then you come see me twice a week, three times a week, and for two weeks. And then pretty soon, the donut starts to heal. And then, in six weeks, the sprained donut is better and the nerves should be better. Until the next time you do something stupid.

Kim Pittis: [00:15:45] It's so true. And I'm grateful that you're talking through that story, because I always say this, it's not a party trick what we do. And of course, we want those results that we have in the clinic to last. But there are also some responsibility to educate the patient that this nerve pain came from somewhere. And that's the thing too. So we broke down sciatica. But again, people are just happy with the phrase. Oh, the doctor told me I had sciatica. Did they tell you why you have sciatica? And if it really is sciatica? And how do they know it's sciatica? And then they're just looking at me like, those were three questions I don't have answers for. And I'm like, but you have every right to ask, where did I get this from? And guarantee you they're going to they're not going to say they know, they're just going to give you a prescription for it. But our job, my job is to be the detective and figure out why is this nerve inflamed, or is it inflamed, or is it adhered to something? Or is the muscle putting pressure on it? Or is our Bursa putting pressure on it? And we can do all that very easily with sensory exams, biomechanical tools, range of motion assessments,

Dr. Carol: [00:16:57] Pinwheel and a straight leg raise.

Kim Pittis: [00:16:59] Yes.

Dr. Carol: [00:17:00] But the pinwheel says prickly aawo. Okay. That's sciatica.

Kim Pittis: [00:17:04] Yeah.

Dr. Carol: [00:17:05] But it's just now they know where it is and that it feels different than other places where the nerve isn't irritated.

Kim Pittis: [00:17:14] Right.

Dr. Carol: [00:17:14] And so that's the pinwheel. Straight leg raise, aawo. Okay. That stretches the nerve. And so now we know that it is the nerve actually that's ticked off.

Kim Pittis: [00:17:26] Yeah.

Dr. Carol: [00:17:27] That's a technical medical terms for sciatica is ticked off nerve.

Kim Pittis: [00:17:33] It's a time that everybody can understand, right? So yeah, walking a patient through those steps and then treating the nerve, getting them out of pain, but then explaining we're not done here. And I think sometimes I lose people for a couple of days, especially new patients because they're like, but it's gone. I don't need to come back. I'm like, oh, it's going to come back. It's going to come back because we didn't fix the root cause of it. Muscles are weak. Muscles are not firing. Things are offline that have been offline for a very long time, and they will not come online until there's a safe environment for them to reappear.

Dr. Carol: [00:18:08] And hence, when I do the exercises, which I learned as a patient from the folks at New Heights, you lie on your stomach that makes your nerve feel better because the jelly goes back towards the front and then you think about lifting your leg. They should contract hamstring, glute, ipsilateral lumbar muscles, contralateral muscles. And if the contralateral muscles contract first, you lift it too hard, the ipsilateral the ones on the side of the disc and the nerve. Those are inhibited because of the disc. So you don't lift your leg two inches, you lift it 16th of an inch and that's what it takes. And then you put the patient's hand back there so they can feel the muscle that's supposed to contract. And have them feel hamstring. Feel that now your glute now that one. Oh, I can feel it. It's patient education.

Kim Pittis: [00:19:25] Right. And patient awareness is really important. I get very lucky because I work with a lot of athletes that have an insane amount of self-kinesthetic awareness. So many patients will come in and say, my piriformis on the left too tight, my QL on the right is jacked, my psoas. I'm just like, they just know that's what they get paid. The big bucks to do is to be tuned into their body. But for the most part, patients don't know their own anatomy. And especially, like you said, when a muscle has been inhibited because of danger and trauma, and those muscles have every right to be offline, because at one point that would have been a cascade of world of injury, world of pain, again to create that safe environment. And then they'll be skeptical. I can't feel it, I don't know, is this right? So yeah, putting their hand on the muscle can be a great way to connect the two.

Dr. Carol: [00:20:21] Connects the sensory cortex with the periphery.

Kim Pittis: [00:20:26] Yeah.

Dr. Carol: [00:20:27] So if they can feel it with their hand, then the brain knows. Oh, that's what it's supposed to feel like.

Kim Pittis: [00:20:33] Yes. It's a big hue when we do knee rehabilitation, especially for contracting the VMO, it's your small little muscle on the inside of your knee. It should look like a little ball. A lot of times it's atrophied in patients, we tend to be more on the lateral side, so the VMO will atrophy. And to get that muscle to target, we focus in on that last 30 degrees of extension. So just slightly bent to fully locked. And I'll have the patient look at it and poke it. I'm like this little guy because it's hard to differentiate between your quadriceps I understand that, but just looking at it and like you said, connecting the periphery to poke it like, oh yeah, I see it like you don't see it, but I'm glad you're aware of it.

Dr. Carol: [00:21:15] But internally and externally rotating your foot and which makes it more bulgy. And I've got my hand on my VMO right now and it's oh, if I internally rotate my foot, it makes it more bulgy. Okay. It's making it simple.

Kim Pittis: [00:21:34] It is. And that's one of your Carolism, right? Be a student of easy.

Dr. Carol: [00:21:39] Yeah.

Kim Pittis: [00:21:40] So I think about that a lot with patient education. And it's hard because we want to give them all the structures and all the exercises and all the heat and ice and this and that and blah, blah, blah. But you have to give the patient what they're going to do. So when patients like, what's the best thing for this? I'm like the one that you're going to do. Oh, I'm like, so if I tell you to walk a mile outside, I think it's great that you're outside and you're on unstable surface and you're with the sunshine and you're breathing the fresh air, but if you're not going to go outside when it's -30, then walk around your house or go to a gym and walk on the treadmill like you have to do what you're going to do. And you have to be honest, right? That's the one thing with my patients. I try to always say, just be really honest all the time. I'm never going to get mad. This is a safe place, but be honest with what you can take on and what you're experiencing.

Dr. Carol: [00:22:32] Well, and this week I have a patient who said I went to this functional medicine practitioner and she gave me this whole list of things and I have them all, but I don't take them because literally on the second visit, that first visit was all this testing. Second visit were 14 supplements, no instructions about when, how much, why, I give people, 2 or 3 things to take. What they're taking it for and then we'll see if that improves your symptoms. Okay. And it's all written on a piece of paper. Then they lose the piece of paper. But. Well, but at least they have it. And same thing with diet. That's okay. Make this huge change in diet. Todd Robinson used to say it's easier to change somebody's religion than it is to change their diet. And do you think you could avoid gluten? Okay, let's not start with gluten. How about. Yeah. No. You've been sick for about 15 years. Can you do six weeks without gluten? And they get the Bambi in front of the Peterbilt look and it's like it's six weeks. This is Oregon. It's really easy. And even in the Midwest these days, there are gluten-free options. Just give it a try for six weeks. Swear to

God if it doesn't work, if it doesn't change anything, then we don't ever have to do it again. But the end of six weeks, if you're feeling better, then Friday of that week you get to have gluten three times in one day. Why Friday? If I'm right after the way you feel Saturday, we're never going to have this conversation again. Oh. Okay. You can do anything for six weeks. I have a little gluten. I said, that's like being a little pregnant.

Kim Pittis: [00:24:52] Right. I had a trainer friend of mine that would say that, but I can have a little bit of that. Yeah. Do you want a little bit of heroin? They're like, no. Okay. Moving on. It's the same thing, right? You're right. It is really hard to change someone's someone's diet. And I don't think anybody should be expected to make all these changes right away. And again, it's hard as a practitioner where you're reading through the history and you're getting all the signs and symptoms and they should be off of gluten and they're not exercising or drinking water. But you can't expect everybody to make all these massive changes.

Dr. Carol: [00:25:29] Pick one

Kim Pittis: [00:25:30] Yeah. Exactly. So I have one patient that hates to be outside. And has a dog. And I'm like. Could you try to do some exercise with your dog outside? Maybe. So when you're letting them out to pee, just go with them in the backyard and just have a couple of breaths.

Dr. Carol: [00:25:57] You should go outside.

Kim Pittis: [00:25:58] . Yeah.

Dr. Carol: [00:26:00] Do you know what that makes me think of instantly? The BIVSS. You look for a Vestibular entry. Instantly you do a Vestibular screen and give them the BIVSS. How they feel when they watch television or try and read a book. Because when you go outside, there's moving visual information. In your house, you have horizons, you have straight lines, you have window shades.

Kim Pittis: [00:26:27] Yeah.

Dr. Carol: [00:26:28] And nothing moves.

Kim Pittis: [00:26:30] You're right, you're right.

Dr. Carol: [00:26:31] That's right where my brain goes.

Kim Pittis: [00:26:33] When I went to one of the first course in person, you were just talking about it and you said, do you hate going into Costco? And I remember the lady sitting next to me was like, oh, that explains it. And why she couldn't be in shopping malls, or because you're right, in Costco there is no horizon. It is just. Massive shelves, no toppling on top of you

Dr. Carol: [00:26:59] Carts and everything moving and the way it's turned out in the last 15 years, actually, the Vestibular screen is improved, the Vestibular sections improved over the last ten years, but in the last 15 years, when we get to the Vestibular section, in a class of 30 people, it's 20%. But I've had people in class just start crying because now their life makes sense. And when I ask how many of you have symptoms that now make sense? Six hands out of 30. It's 20% every time. And then how many of you have patients where you now recognize why they have the symptoms they have. Another, probably 30% to 40% of the class will raise their hands. It is the most, that mold are the two misdiagnoses that are just

Kim Pittis: [00:28:02] And that in itself, because I was really spoiled in Calgary where I practiced. You remember the big building that I used to work in? All the practitioners. We had an amazing Vestibular PT there, and I'm still on the lookout for one here in the Bay area, but I couldn't treat it, but I could at least identify it and flag it enough to send them to somebody. And that was life-changing. And it's funny, I listened to a talk last week and the speaker was saying, our most primitive desires and needs are to be seen and heard. And he was talking about personalities and childhood trauma and how it all kind of filters in through there, and I was thinking about that so much of when patients come in and you can make sense of their symptoms that nobody else has been able to put together, or they thought they had five separate illnesses, and it was actually just one that had five faces. And the look that's on their face when they're like, wait, this makes sense to you? I'm like, yes.

Dr. Carol: [00:29:10] It's all connected.

Kim Pittis: [00:29:11] It's all connected.

Dr. Carol: [00:29:12] And why does it come and go? It's here. You put see this barometer app on your phone when it's 30.0, you feel pretty good on a sunny day. Yeah, the summer I'm pretty good. And in the winter, I get so tired and I feel woozy and my stomach's upset and I think I have chronic fatigue. And then it's summer again. It's okay. And then we explain the connection between air pressure and the inner ear and how it's more than they want to know, but it's a management problem from then on, and Vestibular PT doesn't always work. These days, I just send them to [00:29:54] Dr. Ruski [00:29:55] or tell them about Prism glasses. We do the BIVSS and their score is one woman, I swear. Her score was 56/18. Huge. And having it on a paper test is that one tool has been a game changer.

Kim Pittis: [00:30:16] Yeah And like you said, you don't have to treat it. But to be able to identify it and point them in some directions, that could be helpful.

Dr. Carol: [00:30:26] And not all Vestibular therapy works.

Kim Pittis: [00:30:29] You're right

Dr. Carol: [00:30:30] If you understand why your symptoms are there and to look for a horizon or take a Meclizine, until a panic attack passes, it's a management problem because Vestibular PT doesn't work for everything.

Kim Pittis: [00:30:51] Yeah.

Dr. Carol: [00:30:52] Yeah, and prism glasses help a lot. My patients get prism glasses first, and then they can go to PT.

Kim Pittis: [00:31:00] Okay.

Dr. Carol: [00:31:00] Yeah, that's.

Kim Pittis: [00:31:02] Are the prism glasses a temporary thing or is it okay, now you have to wear these. Will it correct and get better with the glasses? No.

Dr. Carol: [00:31:11] No, because the inner ear, like if you don't have my glasses on now and let's see if I can find a place to look in the camera, if I look straight ahead at the camera, you'll see that this eye is straight and this side bends in about five degrees. Can you see that a little bit? Okay, I'll put my glasses on. And then look on the camera and they're both straight, right? I've Meniere's in my right ear and it makes my eye track differently. Makes it go inward. The prisms bend the light and make the eyes straight, so it improves my balance and improves my sense of equilibrium. Relaxes my neck muscles. So sometimes patients with chronically tight neck muscles, you do a Vestibular screen. That's the other thing I do on everybody now. Ehlers-danlos and Vestibular screens. Because if somebody has an inner ear injury, you can do anything you want. And unless you run 40/44 quiet, the inner ear, the neck muscles aren't going to relax.

Kim Pittis: [00:32:24] Yeah.

Dr. Carol: [00:32:25] It's. And who knew, right.

Kim Pittis: [00:32:27] No, and again people with chronically tight neck muscles, they just, Oh I carry my stress in my neck. Okay. I'm not doubting that they do. And I'm not doubting that... Stress makes everything worse. But again, people don't walk around like this because their stress like that actually doesn't happen. They will tighten up. Absolutely. But they're making corrections because something else internally is going on. And you're right, more often than not it is a Vestibular.

Dr. Carol: [00:32:58] Or Ligamentous instability.

Kim Pittis: [00:33:00] Yes. Yeah, yeah, for sure. Lots of reasons that it could be.

Dr. Carol: [00:33:05] At these days when I talk about the Core, I warn people it's 50% of it is diagnosis. I can hand you a frequency list and turn you loose for 30 years, and maybe you'll figure it out. But 50% of the Core is diagnosis because what we treat is so specific. If all I had to do was wave a laser at it, then it'd be easy. But we have to treat what's there in order for the treatment to work.

Kim Pittis: [00:33:31] And it was so funny when I first, I grabbed everything on DVD and I'm laughing because this is just so funny. And then I signed up for my first in-person course, and I remember just flipping through the binder trying to find muscle, because that's all I needed to know. I just needed the one frequency. And what a waste of time this big binder was, because I'm just going to treat the muscle. And it's just so cute.

Dr. Carol: [00:34:04] And I'm sorry.

Kim Pittis: [00:34:05] It's just so funny because. And even hearing it and I remember it was like, treat the disc, treat the joint, treat the. And there was like a thing.

Dr. Carol: [00:34:15] Treat the muscle. Treat the joint.

Kim Pittis: [00:34:17] Yeah.

Dr. Carol: [00:34:17] And now it's treat the nerve. Treat the joint. Treat the muscle. Because it's never the muscle. Never. I'm sorry.

Kim Pittis: [00:34:25] Never. And even in the sports course, they're all like we're just going to treat muscles. I'm like, you're we're not actually We're going to treat the muscle just because it'll make you feel good inside. But that's not the causative factor, right?

Dr. Carol: [00:34:39] Yeah. You're going to actually find out that it's hardly ever the muscle because unless you hit the muscle of the machete, the muscle is simply reacting to whatever it takes to protect itself and the joint is attached to. So.

Kim Pittis: [00:34:53] I have to get a new analogy. I was going to break it out, but it's like doing psychotherapy and just wanting the prescription to numb it or to self-medicate it with drugs or alcohol and never getting at the root cause. You might feel better, but you're not addressing the root cause, right?

Dr. Carol: [00:35:16] You are actually making it worse by just numbing it.

Kim Pittis: [00:35:21] Yes.

Dr. Carol: [00:35:22] Yeah.

Kim Pittis: [00:35:22] A lot of people don't want to go through the work of why do I feel like this and why am I anxious and why am I depressed, and why do I have both and why? So it takes a lot of work. And so that's why when I have people that come to me, right away, I applaud them for taking this on because it's not just lying on my table for an hour.

Dr. Carol: [00:35:43] Ah, no.

Kim Pittis: [00:35:44] And as a practitioners that are listening like, no, you're not just throwing frequencies on somebody for an hour and expecting magic to happen.

Dr. Carol: [00:35:59] True. Yeah.

Kim Pittis: [00:36:01] And I know there's some conditions that you're not maybe manually treating, but you're never just throwing frequencies on somebody and leaving and that never works.

Dr. Carol: [00:36:14] It drives me a little bit crazy when the patient when I get feedback from patients and they say, yeah, I had an FSM treatment, she put these sticky pads on me and pushed a button and left the room. And it's like, she really. I'm really sorry.

Kim Pittis: [00:36:31] No.

Dr. Carol: [00:36:32] That's doesn't. No. Didn't do exam. Yeah.

Kim Pittis: [00:36:36] No. And to the patients that are listening, that's not accurate. And that's not indicative of the training that we provide like that's not the message that's ever.

Dr. Carol: [00:36:47] No.

Kim Pittis: [00:36:48] Just to leave is not right.

Dr. Carol: [00:36:51] No, and I can't help it. If that's the way somebody practices, Then, I tell patients that or the person in emails. I just teach the class. I can't write and practice.

Kim Pittis: [00:37:03] No. Again, there's definitely times where you don't have to do a ton of manual therapy or exercise, but in those cases, I'll give somebody a CustomCare to take home and say, you know what, you can do some of this at home, like concussion or even some of the anti-inflammatory things. If something's really acute. I'm not doing a ton of work anyways, but I'm sending them off with that so that they know that,

Dr. Carol: [00:37:27] Something easy like nerve pain comes.

Kim Pittis: [00:37:31] Or post-op. Right? Something that's like acutely post-op. Just take the machine go. Have it.

Dr. Carol: [00:37:37] I don't have to be there. I have one kid that had a fractured femur and they put a pin down in the bone marrow in the femur instead of plating it from the outside, they put a pin down the inside. They didn't put a screen on it. And so he had fat embolized strokes and some of them were in his thalamus. And so he has thalamic pain. He was on a bicycle that got hit by a car. So he has two burst fractures one in his thoracic spine, one in his neck. So he's got nerve pain in the thoracic spine, nerve pain in his neck and because of the ways walking, he also now has a lumbar disc. So when he comes in, he's on disability. I don't even charge him and I park him in a room. He can't afford a CustomCare. He runs from neck to feet for thalamic pain, from the spine to the front, for the thoracic pain, from the low back to the foot, for the lumbar pain, and from the neck to his hands for the cervical nerve pain. Punch a button, cover him up with a blanket, give him his iPhone and leave for an hour. And it's just nerve pain And nobody's using room too anyway, so have a seat. There are sometimes you can when it's that straightforward. But almost everybody we treat needs a sensory exam, physical. And I had to do that on the first visit, that one since I found out how easy it was. It's okay.

Kim Pittis: [00:39:20] Yeah, but yeah, definitely the first visit. I have heard that too.

Dr. Carol: [00:39:23] Yeah. That's cool.

Kim Pittis: [00:39:25] So there's a question. Let's talk about that Denise is asking. Let's back up. So she's asking about a tuning fork. So tuning fork you can talk about what that exam is like too because some people don't understand. It's just a tuning fork. You stand behind the patient, you hit it and you put it by their ears.

Dr. Carol: [00:39:43] Yeah, I stand in front. But the Webers, it's called put it in the middle of the forehead here, and you should hear it equally in both ears. And I use a 128 and that's bone conduction. And so it should be heard equally in both ears. If they hear it only in one ear, it means there's something wrong with one of the two ears. And I know I should know whether it's the good ear or the bad ear, but it's a screening exam. All I know is it should be equal. And if I once knew whether it's the good ear or the bad or that's fallen out 25 years ago, but it should be equal. And if they can't hear it at all, you're probably holding the tuning fork wrong. So you have to hold it below the split and hit it and then put it here. And hold it like this far from the end, about a half inch, an inch from the end and do it right after you've struck the tuning fork. They should hear it. Sometimes they say, I don't hear it, I feel it, it's okay. Which do they feel the same? The equal because they describe vibration as hearing. so that's one. I have one here that we came in, we got on email and it's about, Osgood-Schlatter disease.

Kim Pittis: [00:41:16] Osgood-Schlatter. And it's in my talk.

Dr. Carol: [00:41:19] Yes. And thanks to you, there's now a slide and pictures of how to treat Osgood-Schlatter and she's treated everything except Osgood-Schlatter. I'm thinking of treating the psoas, the abs, superficial linus. No, treat Osgood-Schlatter. Let's look at the core, slides again. I end up saying that a lot sometimes

Kim Pittis: [00:41:48] Yeah, I know, you and I were. I was venting last week. I don't know, it's nice to be able to email people for advice and I'm all for that. But when it's in the notes, it makes me feel sad that I didn't do the work as an instructor to make that clear enough. So I take that to heart when someone asks me something that I know we teach, I'm like don't be lazy like you're not supposed to retain everything, but at least make a concerted effort to check the slides, especially when there's.

Dr. Carol: [00:42:18] The slides are I think they're searchable, aren't they?

Kevin: [00:42:21] Yeah.

Dr. Carol: [00:42:22] The slides are searchable.

Kevin: [00:42:23] PDFs.

Dr. Carol: [00:42:24] As long as they're in PDFs, you can search them. And there's in the Core in five days, there's 1046 slides. I don't I tell them right up front, you're not going to remember this. And they all get this determined look. And you can see in their lives I'm going to remember it. And by day three, they're glazy. And they understand why they're not going to remember it all.

Kim Pittis: [00:42:45] Yeah. For sure. Yes.

Dr. Carol: [00:42:48] But it's searchable. So look it up.

Kim Pittis: [00:42:50] Yeah. I think the one thing to remember with Osgood-Schlatter is there are various degrees of it. Not all of it has to be confirmed by an x-ray. Sometimes it takes forever. So you're not going to have that big notchy calcified bump on the tibial tuberosity all the time. Osgood-Schlatter is just pain from that tendon pulling up on the tibial tuberosity.

Dr. Carol: [00:43:13] And Debbie says the email was about why the girl can't lift her legs. Relieve the pain in her right knee. She has no pain anyplace else that makes she could not do raise legs from a sitting or lying on the floor position? No, because that involves contracting your quads and the quads attach to the place where the Schlatter is and it's pulling on that. So no, you can't lift your leg because you can't contract your quads because it's attached to the place that's broken.

Kim Pittis: [00:43:54] Yeah. No, the whole.

Dr. Carol: [00:43:57] Thinking through the mechanism.

Kim Pittis: [00:43:59] Right. There's trauma to that tibial tuberosity because the quadriceps. Right? So a lot of times these kids, the femur is growing faster than the connective tissue can accommodate for the length. And they're active. So I hate to say it's a teenage boy disease

because teenage girls get it just as much as boys do. Yeah. Again, it's an inhibitory mechanism because contracting the quads creates more tension on the tibial tuberosity, which creates more inflammation and more pain.

Dr. Carol: [00:44:30] And teres it.

Kim Pittis: [00:44:31] Yeah it does. Micro traumas and macro trauma keeps happening to the tibial tuberosity every time the quads contract and create tension on there, so it will be inhibitory. I don't know what the email says, but.

Dr. Carol: [00:44:43] Pretty much it's. She hasn't treated her except for treating. 40/90. So she traded the brain rather than the. And she did lift them off the table a little. Yeah. No. Treat Osgood-Schlatter. It's just 124/77 and 124/783 and

Kim Pittis: [00:45:07] So Debbie's mentioning wrong strong. So that's a phrase that that I use. But it's not about being wrong strong. Like the quads have to contract to extend the knee. Rectus femoris has to contract to bend forward at the hip. So it's a management problem until that femur and the connective tissue decide to be on the same team again. And it will happen. But the name of the game is controlling, torn and broken in the attachments. The calcified. It's 124, I got a really crystal clear slam dunk case study that I can pop up. The orthopedic surgeons will say, stop doing all activity. That is the absolute worst thing that you can do. That is going to make the muscle even more tight. It's going to make it even more viscous. It's going to shut more things down. They have to use heat. They have to use FSM. You have to do active, passive, resisted range of motion proprioception. So 40/89 is a nice idea for sure. But there's a reason why it's inhibitory. It's not an outrageous thought to inhibit that muscle. It's well warranted.

Dr. Carol: [00:46:19] Yeah. No, it's like in the x-ray that we have on that slide for Osgood-Schlatter is the periosteum is like Grape Nuts.

Kim Pittis: [00:46:29] Yeah.

Dr. Carol: [00:46:29] It's just shredded and the tendon couldn't contract.

Kim Pittis: [00:46:35] No.

Dr. Carol: [00:46:36] There's no way. And so if you turn off the brain, it's going to make the knee worse.

Kim Pittis: [00:46:42] Yeah.

Dr. Carol: [00:46:42] So Osgood-Schlatter is the thing.

Kim Pittis: [00:46:45] It is. It is a thing There are bands that you can do to put on top. That kind of creates a different lever. So the attachment can take a bit of a break and there's pressure a little bit above. Rock tape is great. So retaping the insertion can really help while you're treating the inflammation. It's temporary but definitely manageable.

Dr. Carol: [00:47:06] It's like treating a fracture basically.

Kim Pittis: [00:47:08] Absolutely. Yes, absolutely it is. And that's what it is. It's microfractures where the tendon is pulling up off the bone.

Dr. Carol: [00:47:16] Yeah.

Kim Pittis: [00:47:16] It's like a fracture and a shin splint love child.

Dr. Carol: [00:47:20] Yeah. Fracture and shin splint fell in love.

Kim Pittis: [00:47:26] They would have an Osgood-Schlatter. Oh, I love a.

Dr. Carol: [00:47:31] Certain geeky weirdness that happens when we talk. That's just so much fun.

Kim Pittis: [00:47:36] This is what happens when you start thinking in frequencies all the time. You start thinking in numbers because fracture, what's happening with fracture? It's torn and broken. Periosteum, cortical bone like how to heal it. What to do.

Dr. Carol: [00:47:50] Yeah. And what goes with what? And the thing is the last part you treat after you've gotten the knee pain down and the fracture healed. And then you treat the brain.

Kim Pittis: [00:48:06] Yeah.

Dr. Carol: [00:48:07] Actually, I never even thought about putting in that precaution. Don't turn the cerebellum off while it's still broken. You want the cerebellum to pay attention

Kim Pittis: [00:48:19] Yes. It's validated. Absolutely, you're right to do this in this moment, I think. Okay, that's a really good point. I'm going to go in to my slides as well and say 40/89 is useful when the condition is not present anymore, or at least it's not presenting as a danger.

Dr. Carol: [00:48:42] Yeah, yeah. No, it makes perfect sense.

Kim Pittis: [00:48:45] Because it's not safe now.

Dr. Carol: [00:48:47] No, it's absolutely not safe. Yeah. No If you have a torn labrum in your hip, there's a reason the muscles fire in the order they fire.

Kim Pittis: [00:48:58] Yes.

Dr. Carol: [00:48:59] And there's a reason you walk the way you walk. Because if you don't walk that way you're going to catch the edge of that labrum and it's not going to be pretty. So the cerebellum says, don't you worry about it, I got it. We're going to contract this in this order and you're going to walk funny. But on the other hand, you're not going to end up on the ground because the labrum catches? Okay. Do we want to turn the cerebellum down just because we can? No.

Kim Pittis: [00:49:29] Yeah. No.

Dr. Carol: [00:49:30] Cerebellum's got it. You fix the labrum.

Kim Pittis: [00:49:32] Yeah.

Dr. Carol: [00:49:33] And if you can. And then correct the muscle imbalance if you can.

Kim Pittis: [00:49:40] Right.

Dr. Carol: [00:49:41] And then retrain the cerebellum in that order.

Dr. Carol: [00:49:47] Where do I put that in the Advanced? I'm rewriting the advance with the thinking part. In the beginning and then the tissues later. And it doesn't matter if I get to the tissues because the tissues don't matter. It's like, how do you think about it? Right? So now there's another section. That's okay. Fine, I've got this weekend. The slides aren't due until Monday. So.

Kim Pittis: [00:50:13] What? Really? It's Monday.

Dr. Carol: [00:50:15] Yeah, Monday the 12th. You got that email?

Kim Pittis: [00:50:18] It's so excited. It's so funny. When I start getting these emails, it's like the advent calendar, like the lead up to Christmas, where because I'm so excited about the advance. But then there's all this pressure about getting everybody's gift and getting the swag and getting the slides and booking the flights and closing up.

Dr. Carol: [00:50:34] I have to get a plane ticket. I just don't know when the rest of my team is flying.

Kevin: [00:50:44] I don't think I got.

Dr. Carol: [00:50:45] Oh good. Kevin doesn't have flights either. That's what we're going to do after we get off the podcast.

Kim Pittis: [00:50:51] It's funny you sent me an email and was like, I got your hotel for this and this. I'm like, but that's great, but I'm coming. And actually four days before that, yeah.

Dr. Carol: [00:50:58] I don't know how big an award to give Kevin for what he does. I don't even know how he does it.

Kim Pittis: [00:51:04] It's like.

Dr. Carol: [00:51:05] Everybody bring a puppy and everyone like, Will just give Kevin a puppy from everybody. And then.

Kevin: [00:51:10] Oh, no. No, that would be.

Dr. Carol: [00:51:11] 150 puppies. That would be bad in his apartment. Okay, I'm wrong, son.

Kim Pittis: [00:51:18] Are we done with the questions?

Dr. Carol: [00:51:20] Debbie. Is the condition from the disease? Yes. Or it's not a disease. It's a condition.

Kim Pittis: [00:51:29] It's a condition.

Dr. Carol: [00:51:30] It's not a disease. It's not like appendicitis or pancreatitis. It's Osgood-Schlatter, which is what Kim said. It's like the femur grows faster than the lower leg, and so the quadriceps can't keep up. And it pulls and they're running and it pulls on the periosteum and makes little grape nuts.

Kim Pittis: [00:51:51] And then the body repairs it and calcifies it, and it pulls apart, and then it tries to repair. And then the micro fractures turn into Grape Nuts.

Dr. Carol: [00:51:59] Yeah. Great. I love it. So now we have discs or jelly donuts and Osgood-Schlatter are Grape Nuts.

Kim Pittis: [00:52:08] Everybody laughs at my slides because like, I have this big lasagna slide and it's got like the nerve and like the cheese and the ground beef. And it all is a thing. And everyone's like, why do you have so much food in your presentation? I'm like, because I love food. But I clearly get it from you because, yeah, Grape Nuts and jelly donuts and there's a whole bunch of other.

Dr. Carol: [00:52:30] Yeah. See, your slides are so much fun because you have such great pictures and mine are so content dense because people have to go back and reread them.

Kim Pittis: [00:52:40] Yes.

Dr. Carol: [00:52:40] I don't.

Kim Pittis: [00:52:41] I've taken your approach, but I give them the slides separately.

Dr. Carol: [00:52:45] Yeah,

Kim Pittis: [00:52:46] I can be a little more lasagna slides and they have the stuff, but they have all the juicy content from you already. So I get to have a little bit more fun with my stuff.

Dr. Carol: [00:52:58] I still use the one slide from you on the sending in the circle, running frequencies, and some 20% the bell shaped curve. The dog that's my favorite. It's like, ah, I see colors.

Kim Pittis: [00:53:13] I don't know how I found that slide, but it was just so perfect for what we do. And I remember I almost felt like I was in church that first Core that we're standing around and I'm closing my eyes. And I'm trying to feel something, and then I'm looking around to see and somebody just debacle. And I'm just like, I want to be that person.

Dr. Carol: [00:53:36] Yeah, eventually. And it's really important that nobody feel wrong. So I have a class of 30 people and I said, 20% of you won't feel anything. They're 20% of you are going to feel pretty stoned, and 60% of you are going to think you might feel something, but you're not sure what.

Kim Pittis: [00:53:57] Yeah.

Dr. Carol: [00:53:57] So we run a frequency and there's three people that raise their hand or nod that they're not feeling anything. And I said, okay, there's three more of you in this room that aren't feeling anything and you're embarrassed about it. So who are you? And it's I don't feel anything. Okay, good. That's it. Because it's always a straight up 20%. It's great.

Kim Pittis: [00:54:17] Yeah. And like you said, like you don't feel bad about it. It's so it's funny. This is a very good segue for me to say this quote that I found. So I'm taking another coaching certification right now. This one's having to do with mindset and all this stuff. And I think it's important when not even just athletes that I work with, but everyday people that we're coaching them and using good wording, empowering wording. So the quote that we had last week was

"when people feel safe enough to raise their hands and say, I made a mistake or I need some help, the leader has created an environment where people feel safe enough to be themselves."

Dr. Carol: [00:54:55] Right.

Kim Pittis: [00:54:57] So as a boss, as a clinician, anything. Again, it's feel. It's making sure that your staff feel safe to ask for help and your patients feel safe enough to say, yeah, I didn't like that or I didn't do any of those exercises last week. I'm just going to be honest with you, and I

appreciate that, because if I'm giving somebody like some really great exercises and they're not feeling better, automatically, I'm thinking, was that wrong or did they do them wrong?

Dr. Carol: [00:55:27] Yeah.

Kim Pittis: [00:55:27] But if it meant. Yeah, you know what, I had a busy week. I'm like, okay, then your pain coming back makes total sense. So.

Dr. Carol: [00:55:34] So let's make the exercises easier.

Kim Pittis: [00:55:36] Yeah.

Dr. Carol: [00:55:36] When can you do them?

Kim Pittis: [00:55:38] Exactly.

Dr. Carol: [00:55:38] What fits in your schedule? If we made them two minutes in the morning and two minutes at night, could you do them?

Kim Pittis: [00:55:46] There's always some flexibility. Right? So that goes back to how we first started talking about it. Like you can't get hung up on a prescription or a hypothesis because it has to work for everybody or it works for nobody. And that's another Carolism.

Dr. Carol: [00:56:01] So first one of Carol's rules. There's always a win situation.

Kim Pittis: [00:56:05] Yeah.

Dr. Carol: [00:56:06] Solution. It has to work for everybody or it doesn't work.

Kim Pittis: [00:56:11] Yeah.

Dr. Carol: [00:56:12] That's just I was really fun writing down Carol frills. There's Carolisms, the one liners I use in the Core. But Carol's Rules was be a student of easy. There's always a win solution. Has to work for everybody or it doesn't work. And I don't know, there's 8 or 9 or 10 of. I think there's 10 of them.

Kim Pittis: [00:56:37] Yeah.

Dr. Carol: [00:56:37] There's clear agreements make for good relationships.

Kim Pittis: [00:56:44] Yes, yes. Again, this all like summarizes what we're talking about.

Dr. Carol: [00:56:50] Yeah.

Kim Pittis: [00:56:51] One of the quotes from the certification is "leader of one leader of some."

Dr. Carol: [00:56:59] Run that by me again.

Kim Pittis: [00:57:01] "Leader of one. Leader of some."

Dr. Carol: [00:57:05] Okay.

Kim Pittis: [00:57:06] So this is that one was a lot to unpack. But it is talking about putting your mask on first before you help somebody else. So making sure that you are in a good space to help others.

Dr. Carol: [00:57:20] Yeah love. What is it? Love somebody else as much as you love yourself. We're not talking about narcissists who don't love themselves. We're talking about. It's easy for me to care for you if I'm here for me, right? And then I have enough left over love to love you.

Kim Pittis: [00:57:45] Right? Yeah. Oh, the alarm is 4:00. Alarm. I hate this alarm. I have 2:30 alarm. That's my happy alarm. Like podcasts in half an hour.

Dr. Carol: [00:57:55] Yeah.

Kim Pittis: [00:57:56] That I am where I need to be. And things are working. But the 4:00 alarm is sad because it's.

Dr. Carol: [00:58:02] Come so fast.

Kim Pittis: [00:58:03] It's come so fast.

Dr. Carol: [00:58:05] And then we didn't have many questions today. Do we miss anything?

Kim Pittis: [00:58:09] No, I don't know, I think just the from

Dr. Carol: [00:58:12] There are 31 people here. So either we're making sense or I don't know.

Kim Pittis: [00:58:17] Sometimes you just have those weeks where.

Dr. Carol: [00:58:19] Glad you guys are having fun.

Kim Pittis: [00:58:21] Yeah.

Dr. Carol: [00:58:22] That's good.

Kim Pittis: [00:58:22] Yeah. And we always have so much to talk about. So sometimes.

Dr. Carol: [00:58:26] No, I like this one. Kevin is going to end up finding a good title for this.

Kim Pittis: [00:58:32] Yeah, Kevin always does.

Dr. Carol: [00:58:33] Yeah. This is good. Hey, Kevin.

Kevin: [00:58:37] I get help.

Dr. Carol: [00:58:38] Geek. What was it? Geeky. What did I say about geeky something?

Kim Pittis: [00:58:43] I don't know.

Dr. Carol: [00:58:44] I don't either.

Kim Pittis: [00:58:45] But we do geek out on all the things.

Dr. Carol: [00:58:49] Yeah. Okay. The fastest 60 minutes of the week.

Kim Pittis: [00:58:53] That's it. That is right now. But I can't wait to see you in person soon.

Dr. Carol: [00:58:57] It's going to be so much fun. Yay!

Kim Pittis: [00:59:00] Doing the podcast together on Wednesday night is.

Dr. Carol: [00:59:03] Oh.

Kim Pittis: [00:59:04] I love it.

Dr. Carol: [00:59:05] Yes. And then are we going to be able to, even though you're doing the Advanced, we're going to do it an hour later.

Kim Pittis: [00:59:11] Yes. Yeah. I think I'm going to try to start a little bit earlier that day. And then if we start the podcast a bit later that day should be good.

Kevin: [00:59:18] Notice.

Dr. Carol: [00:59:19] Yeah. Kevin will send everybody a notice. It'll work.

Kim Pittis: [00:59:22] Perfect. All right. We'll see you next week anyways on here.

Dr. Carol: [00:59:25] See you next week.

Kim Pittis: [00:59:26] All right. Everybody thanks.

Dr. Carol: [00:59:27] Bye.

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