*transcript is computer generated

FSM And Strokes Presented By Carolyn McMakin, MA DC

(00:00:00):

Welcome to the July 2020 FSM practitioner webinar. I had a special request for a webinar about strokes

because Jodie Adams, physical therapist was treating a stroke patient and she wanted to know more

about strokes. Now, this stroke patient, she was treating was a post-COVID stroke patient. So we covered

that at the very end, but before we start treating things, it seems like a good idea to know what they're

about. And in the process of treating patients and having friends and family who've had strokes. I

thought I knew some stuff about strokes, but other it's something today. So first we're going to look at

what a stroke is and how it works. There are two types of stroke. So a stroke is a vascular event. It has to

do with the blood vessels where the blood supply to certain parts of the brain or a part of the brain gets

interrupted.

(00:01:09):

So there's no blood getting to the part of the brain. That's a sudden interruption in the blood supply.

There are two types of stroke. One is an ischemic stroke, not enough blood or oxygen, getting to the

brain. And the other is a hemorrhagic stroke where blood vessel ruptures and that has, that causes two

problems. One is you have because the blood is going out of the vessel. The area of the brain that that

blood vessel should serve is not getting blood because the blood is running out into the surrounding

area and blood outside of blood vessels causes a lot of inflammation. Fortunately, they're about 87% of

strokes are Mmm. Ischemic. So people get strokes from blood clots or fragments of clots stuck in a

vessel there's about 87% of strokes are ischemic. 13% is hemorrhagic.

(00:02:27):

What causes a stroke? Well, clots from any sort of vascular turbulence, or I didn't know what word to use

adherence is when red bluff red blood vessels get sticky. So platelet stickiness causes clots, excuse me,

any infection anywhere can cause inflammation that makes red blood cells sticky, elevated blood sugar

is inflammatory, and that can cause strokes any systemic inflammation. And then COVID-19 is causing

strokes because sorry, do it was causing strokes because the virus enters the capillaries and the arteries

through the AEs two receptors. It replicates inside the blood vessels. And when it breaks out, it causes a

lot of turbulence. So you get a virus going in, you get a billion viruses coming out. And as they flood out

of the cells they cause a lot of turbulence and a lot of inflammation. And there are also ACE two

receptors in the brain itself.

(00:03:55):

So the virus, we think of it as a respiratory virus, but it's only a respiratory virus because there are two

receptors in the lung and the liver and the kidneys and various places. So one of the symptoms of COVID

is sort of brain fog and fatigue and cognitive and emotional issues that have to do with the effect of the

virus on the brain directly and indirectly from the inflammation that causes, you can get bleeding from

an aneurysm or a torn artery from trauma. So I've treated patients with stroke injuries caused by blows

to the head skateboarders with no helmets. Skiers with helmets, hypertension will tear an artery,

elevated blood pressure breaks. The thin artery walls sleep apnea is one of my pet things, you know, and

it causes sleep. Apnea causes severe episodes of hypertension, which can give people a stroke during

sleep or early in the morning.

(00:05:04):

So if somebody has a stroke or a heart attack in bed at four or five o'clock in the morning, they have

sleep apnea. So head injuries can cause mild tears and vessels as direct, as well as direct damage to the

brain, these blood vessels in the brain. I don't know if you can see them right here, see how convoluted

they are, how tiny, and this illustration is even better. So these blood vessels that go on the out, these

are on the inside. These are on the outside. There are arteries that go from the dura down to the brain

that feeds these arteries, those arteries, that between the brain and the dura have a lot of little kinks in

them. They're stretchy. The problem is that as people get older, the brain shrinks, and these arteries can

be put under tension. So when somebody has a head injury they can tear one of these.

(00:06:19):

So if an older person has a fall, the brain smacks around and you can tear one of those little arteries

between the dura and the brain and cause a subdural bleed. Okay. So why is lack of blood to a part of

the brain? So much of a problem? Why does a little teeny clot in this little, teeny distal blood vessel right

here, cause such a big problem in the brain while the brain is 2% of the body's weight, but it uses 20% of

the body's energy and brain damage starts at two minutes of oxygen deprivation. So 20% of the body's

energy means that the mitochondria are really active. It needs a constant supply of sugar and nutrients

to feed that part of the brain. And mostly it needs oxygen to pick up the oxidative products of

respiration and mitochondrial respiration. So brain damage will start at two minutes of oxygen

deprivation and it is irreversible and the brain tissue dies at four to nine minutes.

(00:07:35):

So this is another illustration of the vascular supply. What areas, what blood vessels supply, which parts

of the brain posterior cerebral artery are here. The middle cerebral artery is just, that's the Lennox strokes.

And then the anterior cerebral artery does most of the cortex. So that's the players, that's what we're

dealing with. And so what happened? Well, circulation gets impaired. There's a clot or bleed. You don't

get circulation. What does that mean? Well, you don't get oxygen. You don't get nutrients that leads to

oxidative stress. And that leads to severe inflammation. It's like a brush fire inflammation leads to sell a

pup ptosis or cell death. And when this little area of the brain dies, let's say that the clot is just more to

go, Oh, come on. Okay. Let's say the clot is just here. And initially, you lose just that little piece of brain

tissue, just those few cells,

(00:08:56):

Right? Where that little teeny clot is. But then you have inflammation that spreads from the fact that

those 25 or 40 cells, those died that create inflammation, the inflammation spreads. So if you've ever

seen anyone, that's had a stroke or having a stroke, they start with a little bit of drooping in their face.

You'll get the symptoms in a minute, a little bit of duping in the face. A little bit of this, a little bit of that,

a little bit of dizziness, loss of balance and the symptoms get worse over the next 24 hours. So this it's

them, not just the lack of oxygen to the cells, it's the cell apoptosis and inflammation that causes the

tissue to die. And for the symptoms to spread overtime when the acute inflammation dies down and

the emergency is over brain plasticity allows some recovery. So the brain does recover to some extent,

depending on how much damage there's been. So what are the risk factors? Who,

(00:10:21):

Who do you, who do you

(00:10:23):

You think of, or what do you think of when you're looking for stroke risk inpatient hypertension

because of the mechanical pressure on the blood vessels, that can cause not only a bleed but the

turbulence from the pounding on the blood pressure on the blood vessels creates clots. Sleep apnea is a

major risk factor for hypertension and stroke cigarette smoking because it causes inflammation and

heart disease, vascular disease, anywhere, diabetes, chronic infection, isn't on the list, but it should be

because inflammation leads to infection, leads to inflammation, which leads to sticky blood vessels risk

behaviors that put you at risk for head trauma. So the two I can think of today were martial arts

context, sports, skiing, bicycle mountain biking, where people are going zooming along at 20 plus miles

an hour and they hit a rock.

(00:11:44):

Even more

(00:11:44):

The helmet, some of these forces are enough to bruise the brain cause a bleed and give the patient a

stroke. Nutritional factors, essential fatty acids, and vitamin D. So this is just a little,

(00:11:59):

Mmm.

(00:12:01):

I have a thing that I found on the internet, lower blood pressure maintains a healthy diet exercise that

improves cardiovascular health, quit smoking limit alcohol consumption, heavy drinking increases, blood

pressure, and your risk of ischemic attacks and hemorrhagic strokes. Mild, moderate alcohol

consumption has the opposite beneficial effect. It depends on what your definition is of heavy

control, diabetes, high blood sugar damages, blood vessels, which makes it more likely that clots will

form. So when the inside, when the endothelium of the blood vessel is not smooth, when it’s rough it’s

more likely to form clots red blood cells. When they hit a rough spot, get sticky and when they stick

together, that’s what causes a stroke or a heart attack to treat other heart conditions. Have you

experienced a heart attack? Been diagnosed, have arrhythmia arrhythmias. So if you’ve got atrial fib or

any sort of tachycardia you should be on some sort of anticoagulant because the irregular heartbeat will

cause this turbulence,

(00:13:27):

Mmm.

(00:13:29):

That makes the damages, the red blood cells and make some sticky and creates clots, get optimal sleep

that has as much to do with stage four sleep, deep sleep and reducing inflammation as anything else

besides general health be optimistic. That's interesting studies found a 50% reduction in cardiovascular

disease for those who scored highest for optimism and vitality and increased vitamin D levels because

low levels of vitamin B double the risk of stroke in Caucasians, why would that be?

(00:14:11):

Yeah.

(00:14:13):

Appropriate levels of vitamin D reduce inflammation, inflammation leads to strokes. So there you go. So

stroke symptoms, initial stroke symptoms are usually associated with loss of circulation to the cortex,

but any part of the brain can be damaged by a stroke. So these are critical strokes to the most common,

but there are a lot of symptoms of stroke and temporary ischemic attacks that will affect different parts

of the brain. And we have more of that coming up. Longterm symptoms will depend on the part of the

brain that's damaged. So be is the [inaudible] any loss of balance headache or dizziness eyes blurred,

vision face. So balance eyes face one side of the face drooping or asymmetrical arm or leg weakness,

difficulty with speech difficulty with finding words, time to call nine one one. So calling an ambulance is

really important because in the first four hours, if you can get to us, get to a medical facility and get a

clot digesting enzyme, basically peptide that dissolves clots, it can reduce the damage from a stroke.

(00:15:45):

Now there are gender differences. Women can have more subtle stroke symptoms. In addition to the

general stroke warning signs and for women that strokes are more likely to be missed or dismissed. If

you don't walk in with face drooping, arm weakness, and speech difficulty. But if you walk in with general

weakness, disorientation, confusion, or memory problems or fatigue or nausea, vomiting, and headache,

severe headache without a known cause. And you're female, the women have more symptoms and

more subtle symptoms of stroke in men. It's the B fast face drooping arm, weakness, speech, difficulty,

vision, trouble walking, lack of coordination, headache without a known cause there are more visceral

symptoms in women, the, and they're not always acute onset. So a temporary ischemic attack can be a

little teeny clot that doesn't really occlude the blood vessel but just comes and goes. The body tent is

able to dissolve the clot and the clot forms.

(00:17:06):

And you have, what's called a Tia temporary ischemic attack. And in females, that can be decisionmaking

emotional control, memory problems, speech problems, difficulty breathing visual problems,

eye, hand, coordination, eating, and swallowing. So these are the subtle symptoms in women that

can be widespread. Once again, this is off of the internet stroke symptoms. There are books about this.

My mom had a stroke. So I read up on it, right? And the damage to the right side of the brain and the

left side of the brain will result in different symptoms. Right-Sided brain damage. So the stroke is on the

right side of the brain and the damage, the left side will be paralyzed. They have left-sided neglect. They

actually aren't aware of where their left side is. They have spatial PR perceptual deficits. They tend to

deny or minimize any problems.

(00:18:19):

It's like the right side of the brain has these functions. And when there's a stroke on that side, it creates

different emotional problems than you get. When somebody has a left-brain stroke, rapid performance,

they're able to do stuff, but they have a very short attempt attention span. They tend to be impulsive.

They have safety problems, they do dumb stuff, impaired judgment, and impaired time concepts. So

these are the things that you're dealing with when you have a patient who has paralysis on the left side

of the body, which means that he had he or she had damage to the right side of the brain left brain

damage. So the stroke is on the left side of the brain. The right side will be paralyzed. They have tended to

have more aphasias because the verbal centers are more prominent in most people on the left impaired

left, right discrimination.

(00:19:19):

They can't tell left from right slow performance, cautious. They're aware of their deficits and they have

more emotional problems because the left side of the brain is linear. They have more problems with

depression and anxiety and impaired comprehension rates related to language and math. So left side

paralyzed, right? Brain entry, perceptual deficits, quick impulsive behavior, memory deficits, left-brain

entry. The right side is paralyzed speech and language deficits, slow cautious behavior. So people that

have left-brain injuries are kind of easier to manage because they're not so impulsive. They're not likely

to do a harm to themselves just because they're not sure where their body is in space. They don't know

where they are in space, spatial, perceptual deficits, and then they're impulsive when they make

decisions managing a stroke patient. If you're seeing one in your office it might be worth taking this slide

and cutting it out, putting it someplace or referring to it because it will change not only what you want

to do, how you want to hook them up, but what sort of safety considerations you have while the patient is

in your office now, conventional stroke treatments, there are acute treatments in the first four hours

tissue plasminogen activator is that clot clot-buster they call it.

(00:21:06):

And, but it's only given up to 4.5 hours after the symptoms first appear. So that's why that time thing

that is fast is so important. When you first have symptoms now getting a doctor to believe or an

emergency room to believe that you're having a stroke, getting you a TPA, maybe they're I came with

your insurance or whatever don't get me started. So the speed, the clot busters are only useful in the

first four, four and a half hours. Alta place is also a clot to salt. Dissolver sometimes if you're in a

situation where they can't get these products to you they'll give you aspirin heparin or some other

anticoagulation. Medication warfarin is not useful. It takes three days to start working. So giving

somebody warfarin in the emergency room is not particularly useful. Sometimes it does a procedure, put

a stent or an endovascular.

(00:22:08):

See that little scrolly thing up there in the artery. They stick this thing up, they grab the clot, they pull it

out. They go in through the groin usually. And they'll take the clot out of the carotids. This is useful only

in the larger arteries and it has to be done under imaging. So it's fluoroscopy and radiations involved

longterm medications when somebody's had a stroke and they're in rehab, they'll put them on statins

because statins are set to stabilize clots and stabilize the plaque in the arteries. But that when

somebody is on statins, you have to remember, it does inhibit co Q 10, and cookie 10 is really important,

important for mitochondrial function and the brain. So if your patient has had a stroke, pretty good

chance, you're going to be put in statins. That means you have to put them on CO Q 10 or while the

Statens prevent them from having another stroke, they also prevent the brain from recover. They

should be on an anticoagulant of some sort, assuming it wasn't a hemorrhagic stroke. The trick initially

, of course, is to tell the difference between a hemorrhagic stroke and an occlusive stroke, because they

look kind of the same, there'll be on an antihypertensive and an ACE inhibitor. Those are usually the

generic medications that you'll, that they'll use, but you'll find your stroke. Patients are on a, quite a

laundry list of meds conventional non-pharmacologic treatments, speech therapy. So the speech

therapists you remember Alicia Thomas'

(00:23:56):

Presentation on the patient with aphasia that P a patient had had a stroke while speech therapy works

with patients and gets them to practice speaking and tries to get parts of the brain that are not injured

to take over the work of speech speeches, not only remembering words, understanding words, the

motor function of being able to move your mouth and your tongue in order to make words remember

the Vegas, it controls every muscle involved in speech. So we have the ability to treat the Vegas that's

important, physical therapy to strengthen the muscles that can move and occupational therapy to help

patients figure out how to do the activities of life. Do they need braces? Do they need special assisted

devices to help them navigate life once you've had a stroke and general stroke rehabilitation stroke

rehab, because strokes are so common in the United States, and it's one of the leading causes of death

in the US stroke rehab can be sort of cursory not all patients get equal rehab? There are some really

specialized and advanced stroke rehab facilities.

(00:25:30):

Ben Catholi works at Shirley. All I can think of is Shirley Hartman and that's not it. Ryan Shirley Ryan

rehab center in Chicago does advanced stroke rehab and a lot of robotics for strokes and brain injuries.

There are people that use neurologist that uses lasers. The infrared laser goes through the, through the

bone, through the Blaine and stimulates the area of ischemic injury at surrounding the stroke. And

helps salvage helps prevent the spread, prevent the worst name that's caused by the ischemia and the

inflammation. So the purpose of the laser is to reduce inflammation. The treatment session involves

pointing the laser. At 20 predetermined targets in the brain, there are lots of new treatments, STEM

cells, but when I read about those, they were mostly trying to raise funds for research, so different

locations in different symptoms. So in the advanced while in the core, we talk about the different parts

of the brain and what they do.

(00:26:48):

I had a friend who came in to be treated, actually, his wife, his wife, brought him in to be treated had a

temporal lobe stroke. It is the primary auditory lobe. It's in charge of longterm memory, emotional

balance. So his aspect was very flat. He was normally a really cheery positive, outgoing sort of person.

And as an effect was flat, his emotions were flat. There was just a lot of his life. He didn't remember he

had a lot of trouble with language and speech to understand and respond to verbal input. I saw him six

or eight months post-stroke. So he was already starting to recover,

(00:27:34):

But yeah,

(00:27:37):

He was quite affected and we have a frequency for the temporal lobe and it worked I think I treated him

six times and he improved each time, fell asleep during the treatment improved each time. And then he

went off to brain rehab

(00:27:53):

And that completed yeah,

(00:27:57):

His rehab. He was doing much, much better. And then he had another stroke. So that's the other

problem with strokes is once you've had one, you're more likely to have another one. The occipital lobe,

posterior part of the brain is fed by the posterior cerebral artery. Right.

(00:28:15):

And they have

(00:28:18):

The trouble with blindness that's the visual center. So they'll have, what's called cortical, Bron, blindness,

nothing wrong with your eyes, but your brain can't see or interpret that image, visual illusions. So you'll

see double or triple or visual hallucinations. It's kind of like when you lose the Thelma's, which is sensory

processing and pain when you have a stroke in the thalamus, your body sort of makes things up. It, it

makes pain. That's what happens in occipital strokes. So they have visual hallucinations trouble, visually

recognizing objects. So is it a banana or a Carkey looking at it, uses it and telling whether it's a banana or

a car key uses a different part of the brain than touching it. So stereognosis is can't remember what part

of the brain it is, but it's how you feel a car key and know that it's a car key as opposed to a banana face

blindness. They can't recognize faces.

(00:29:32):

Husband, wife, daughter, child is nothing personal. The part of the brain that has that visual image just

doesn't work. These patients can, right, because that's in a different part of the brain, but they can't

read. Pons is kind of like a brainstem stroke and it is a very difficult to balance, double vision, trouble

swallowing. So the motor impulses that control swallowing numbness vertigo, loss of coordination,

speech difficulty, because motor impulses to the vocal cords, it's more like they control motor

coordination parietal stroke. So the parietal lobe is up here on the top of the brain. So the parietal lobe

integrates sensory and spatial sensation. It's the dorsal pathway for vision. So it's, it's kind of how you

tell where your world is. You don't have paralysis when you have a parietal stroke. It's a silent region of

the brain. Sometimes there are no obvious visual symptoms as there are when you have a frontal lobe

stroke that deals with the sensory and motor cortex, contralateral neglect. So if you have a parietal stroke

on the right, when you neglect your left side, you look at you, you don't know that your left side is

there. You don't see it. You don't know it. You can have infarcts on one or both sides because of the way

the blood supply works. So the parietal low, what it does. It senses your body in space, using information

from the visual and auditory cortex. So it's like

(00:31:32):

Integration center determines where objects are in the environment. It's, it's spatial location neglect

syndrome ignoring the left side of the world. So you can look to your right and the right side of the

world exists, but you literally forget to look to the left spatial, disorientation, and unable to find the way

home. So this is

(00:32:03):

Oh,

(00:32:05):

Part of the brain that's affected probably in Alzheimer's when people wonder pride, a loop, strokes,

visual symptoms quadrant, and op SIA. So there's just a chunk of like a quarter of your visual field that

just disappears nerve fibers, carries inflammation from the lower parts of the visual field and travel

through the polite to lobes, to the acceptable lobes. So it's not that the parietal lobe does vision. It's that

the nerves that go from the visual field back to the back of the brain get damaged, the axons, get

damaged, spacial disc perception, hand, eye coordination, difficulty bringing the hand to a spot where

you're looking. So you look at your fork to pick it up, to eat, you reach for it, and you miss it. You can't

grab it. So the patient looks at the coffee mug and a table means to pick it up. But the hand overshoots

can't grab the mug individually to visually scan surroundings. So primal strokes are tricky.

(00:33:24):

Having to collect parietal strokes in the nondominant language side of the brain, tends to completely

ignore the opposite side of the body. So hemiplegia due to stroke affecting both motor and sensory

cortex is, but the patient ignores the fact that one side of the body is completely paralyzed. Also

can't recognize their own body parts on that side. So they won't shave or wear lipstick on the side that's

affected by the stroke. That's part of what they do in stroke rehab is to see if they can get them to see

that left-right confusion, profound, inability to differentiate from left from right difficulty reading,

writing, and math thalamic strokes. Thalamus has a major sensory transfer area, and we have a case

report and thalamic stroke thalamic strokes create body pain following the homunculus that's in the

Thelma’s. So you have pain patterns.

(00:34:26):

I had one patient at Cleveland clinic that had a subdural bleed. So he was skateboarding hit the back of

his head fractured his skull had a bleed that bled down into the thalamus and the bleeding in the

Thelma’s took about 18 months to two years to create the lamp, to create thalamic pain. And he ended

up with pain just in his right arm, in his chest. And I was, I was absolutely certain that he had just

tweaked a disc in his neck and that this was nerve pain, but I used 40 and three 96. I didn’t work. And

then I asked Dr. Katholi to look up his MRI and they found scar tissue on, in the Falmouth that

coordinated with this part of the homunculus. So it was just this part that was painful just as arm and

chest. So we treated it like Kalanick stroke, 40 and 89, and he was better. Pretty good chance. It wasn’t

going to last, we’ll talk about treatments a little bit coronavirus and stroke. That is that’s actually why

we’re doing this webinar because the coronavirus enters cells through

(00:35:56):

The AEs two receptors that are in the blood vessels, the capillaries in the brain, the liver, the kidney, the

lung, it’s not a respiratory virus. It’s an H two receptor virus enters the cells wherever these two

receptors is when the virus replicates and exit the cells exits the cells, it creates turbulence and

inflammation, and that can affect any and all parts of the brain. Something called that we talked about

in the virus webinar CA they're just calling it covert brain, anxiety, depression just brain fog, hard to

think. And those patients aren't necessarily having strokes, but the virus itself causes inflammation in

(00:36:46):

The

(00:36:49):

In the brain and interferes with function. Okay. So now we get to the fun part. How do you treat strokes

with FSM? Well, the first thing is to do the right thing, follow the accepted medical interventions if they are

available. So if you're stuck in a desert island and all you have is FSM by all means start treating

somebody as soon as they have symptoms. If you are in suburban Portland, get the patient to an

emergency room, go with them. If you somebody, you know, and tell them the patient's having a stroke

insist that they are seen urgently because, from the time you first noticed the symptoms, you've got four

hours to get this clot-dissolving drug. And you have to be prepared to be a patient advocate out to place

is another clot. Dissolver, it's, it's a type of TPA, I think aspirin heparin or other anticoagulant

medication even essential fatty acids.

(00:38:09):

These are useful to help slow down and dissolve the clot. A problem is if they're having a hemorrhagic

stroke, all of these anticoagulants and make it worse. So that's the thing. Sometimes they'll do a

procedure, a stent, or surgery or insult in cert one of those little grabbers and try and grab, grab the clot

and pull it out. Carotid endarterectomy is a little bit risky, but sometimes if the carotid is what is

blocked, they'll go in and remove the clots out of the carotid right on the spot. So acute stroke in an

appropriate medical facility is that's how you do it. Most of the time, our FSM patients see us long after

the stroke, once they're stable. So, by all means, use FSM in combination with conventional rehab, use

FSM to reduce inflammation uses the frequencies for the known pathologies and the ones you can guess

at than increased secretions and vitality.

(00:39:23):

And because we're driving secretions, as you'll see in the, in the case reports that follow or driving

secretions, you have to be able to replace the products that those brain cells are secreted. So if you're

driving acetylcholine or if you're driving dopamine, or if you're driving now, those are the two things

you're going to drive acetylcholine and dopamine by and large. You need to supply neurotransmitter

precursors, and that is a whole nother workshop. So if you have not recently watched or listened to

Roger's bellicose molecules of behavior are that it molecules to behavior. He'll, he talks in detail about the

precursors to specific neurotransmitters, and that's the stable state for post-stroke patients, essential

fatty acids. The water problem is a lot of times they will have difficulty with swallowing. So that's what you

do first, the right thing. So this is a cortical stroke, and you actually see this patient in the core.

(00:40:52):

I think now she was 38 years old. She had a left-sided stroke at age 35 secondary to sleep apnea caused

by adenoids and tonsils obstruction. She had surgery to remove the adenoids and tonsils. She had right

upper extremity, spastic paralysis, flaccid paralysis, and foot drop on the right leg during the gate. And so

she had the left stroke. I'm going to go back. No facial plastic says no speech, difficulty, sensory loss on

the right side. So left side of the brain. Let's go back to that other slide left side of the brain, right side

paralysis, speech, and language. She'd had rehab. She was three years post. She could speak. She was

slow and cautious. We didn't see any men Epic, any evidence of the memory deficits, but this part is

good to keep in mind. Anyway. So what we did with her was had one unit that was running just the

basics trauma, probably torn and broken paralysis, allergy reaction, reduce inflammation, and increased

secretions in the sensory and motor cortex.

(00:42:22):

So that was running with the concussion protocol and I'm 81 and 10 from back to the abdomen. And then

we'll use 81 increased secretions in the sensory and motor cortex because that's where her stroke was.

And we set her up the neck to feet, 30 minutes on 81 and 92. And I pretty much figured that we got what

we were going to get the spasticity in her hand, in her arm, relaxed, Kathleen Kasmin was mobilizing her.

And you have to move stroke patients very slowly. If you move quickly, there's a feedback loop and they

spasm again. And she could mobilize around the hand as long as we did it slowly. I thought we finished and I

moved to 49 and 92 while Kathleen Kasmin was mobilizing the shoulder and the spasticity relaxed even

more so 30 minutes on 49 and 92 92 is the sensory-motor cortex.

(00:43:34):

And she actually was able to actively move her shoulder. We moved, moved the machines, and she had

almost full active range of shoulder motion. Now, as soon as she moved her arm spasticity in our hand,

came back. She had the normal sensation for soft, soft-touch, sharp proprioception. The loss of sensory

input was gone. That was on a Wednesday. We saw her on Monday, she's still had active range of

motion. And her hand was clenched butts. And the spastic sensation was reduced, but present almost

normal, right leg, still flaccid and spastic with foot drop. Kathleen treated her again. We treated her on

Monday and there's Kathleen mobilizing the hand to machines, neck to feet, neck to hand

trauma increased secretions vitality in the sensory-motor cortex, and then machine number two

increased secretions in the spinal cord and treat scarring and the dura. And that's what we got.

(00:44:56):

We needed additional assistance with motor secretions. So we tried 94, 81 and 49 with the motor

centers of four 15 and two 45 worked. So there are the brain motor centers have no idea what those are

or where they are, but four 15 and two 45 worked two 53 and two 55 and not so much sensation was

normal, right hand tends to clench with movement. But look at the range of motion. When we went

back the following year, I asked how she was doing, and she'd had another stroke because she still had

sleep apnea. And this one was much worse. So that was interesting. So you have to treat the cause the

hypertension, sleep apnea, diabetes, whatever puts them at risk. That's what we talked about.

Risk factors. That's a stable state. That's what you have to do. Now. This is more subtle.

(00:46:01):

Do you remember Hannah? The little girl that had the craniosynostosis at birth. So that meant that her

skull was fused in the center. They did a laparoscopic surgery. So went in, in between the skull and the

dura and cut away pieces of the bone and cut little wedges in it so that her skull would be normal

shaped, but she had a lot of dural, adhesions, and constant pain. So we treated her, I guess she was 20

months, 22 months, about age two for the dural adhesions. We did that in 2018. She uses her custom

care at home, and this is Hannah doing a dural stretch. 2018 was just durable. In 2020. Her mom came

back and took the core seminar in Phoenix. They live in that area and brought Hannah with her. And at

the end of the day, we, she said, there's something wrong with her right arm.

(00:47:11):

And you can see it here. Do you see that? How she's holding it like that, how her left arm is moving

normally and her right arm when we palpated it, it was really tight, almost spastic the hand clenched like

this lady's hand. So the only thing that made any sense was that when they went in laparoscopically, the

tool that they used compromised, either the blood supply to the left side of the cortex or the cortex, the

sensory and motor center itself, it affects mostly her right arm and hand, but there was a little bit of

increase in tone in her trunk. The leg was pretty normal, a little bit of increase in tone, but certainly

nothing like this. So I did what you do in strokes treated for trauma torn and broken, increased

secretions, 81 and vitality in the sensory and motor cortex. And following Kathleen Caspian's edgy

education.

(00:48:27):

I moved her arm really, really slow. And ultimately the spasticity in our trunk muscles in our arms

relaxed. And we got her hand and up behind her head. And it actually lasted with the nice thing with

children is that they are very plastic. There's lots of nerve growth factor. So you can do lots in kids, go to

Cleveland Clinic and pediatric rehab. There are children that have strokes in utero. There are children

that have strokes when they're one or two or three years old. So don't be surprised when you might

have a child to treat anyway. So Hannah's still doing well. That was kind of an interesting discovery and

it was just a subtle finding it's just tone. There was a gentleman that had a thalamic stroke. He was 50

year-old, 54 years old. He had low back pain going back 15 years.

(00:49:32):

He worked as a laborer. There was low back imaging that showed a small L five S-one disc bulge. Hi,

Heather, Hannah's watching right now. Hi Hannah. Mmm. I had an L five S-one disc bulge and his, but his

current symptoms include three years of severe right hip, right? Lateral trunk pain up to the lower libs,

right? Lateral ribs, right? Lateral leg pain down to the foot, medial leg pain up to the groin causing

electrical shocks and burning pain at the tip of the penis. Pain is rated a five to eight worse at night, no

change with activity, not worse with bowel movements better when laying down, no medication helps.

They've done prolotherapy physical therapy. And they were honestly considering doing surgery, for now,

five S-one one disc. And for some reason, nobody had taken a careful history. The patient was pain-free until one

day, three years ago, he woke up from a nap with severe hip pain that spread up the trunk down and up

the leg and affected the penis three to five days after onset.

(00:50:48):

So the severe hip pain was, I don't know if I have the Nope. The homunculus for where in the Thelma's

the hip is. That's where the clot was, was in that area. And then as the inflammation from that clot, from

that place, spread the pain spread as the parts of the thalamus died. And it was only on one side, spread

up the trunk, down the leg and affected the penis three to five days after onset. So from the first

symptom to the end of the spread, it was five days. And if you look at the homunculus for the thalamus

it's the trunk, hip leg, he follows his pain pattern. He saw an MD, physiatrists psychiatrist, physical therapy,

massage therapy, acupuncture, prolotherapy, physical therapy medication. And then I asked him if he

snored and he snores when he sleeps, lumbar range of motion was normal. No change in pain.

(00:52:02):

As I joined the screen was negative, with no ligamentous laxity, but the reflexes were hyperactive on the right

normal on the left. And he had right leg pain. Ankle jerk was one beat of myoclonus. What does this tell

you? It’s an upper motor neuron lesion. Proprioception at the ankle was hypersensitive on the right, but

not on the left. This is central skin sensation was hyperstatic on all of the right legs, hip and trunk up to T

eight skin sensation for sharp was normal on the left. The key was the mechanism of injury. When did the

pain start? I took a nap. He woke up from Annapolis, severe hip pain that spread to the trunk leg and

penis, the patient snores. He slept on his back. He had a stroke in his sleep. So if you haven’t read the

promise of sleep by William Dement, strongly suggested that this book is why aware of C-PAP. If the

stroke was in the sensory cortex and there was no motor less. So it would be sensory only the patient

had a stroke during the sleep. And I have the sensory cortex of the thalamus causing central pain. It’s

sensory only. So it had to be in the thalamus stroke occurred because he has sleep apnea and he snores

and he slept on his back homunculus pain pattern matches, right? Genitals, toes foot,

(00:53:37):

Right,

(00:53:39):

Right up there, right up. That's it that's the pain better. And that is it in Thelma's treatment

was based on the hypothesis. So what do we do for the lambic pain, 40 and 89 from neck to leg and

foot? Why the neck, while it's closest to the brain, I guess, and then down to the foot, neck to leg and

foot increased secretion in the sensory and motor cortex. And then we did 40 and 92 and ended up

being 40 in the 89. Then we did the concussion protocol, his trunk pain receded from six or seven down

to zero, then the hip pain, then the leg pain, the pain, and the penis went down the last, it took us 90

minutes to get him pain-free. Now, is it going to last probably not? We have to do a lot more to work on

the filmless and get rid of the scar tissue and try and restore normal metabolism to that area of the

brain order brain MRI, to establish the side of the stroke order, a sleep study, get this guy's C-PAP so he

doesn't die of a stroke.

(00:54:53):

Some other time continues Gabapentin as needed, do not do spine surgery. So in general, what do we do

for strokes? Well

(00:55:06):

Use as early as possible. And sometimes it's two weeks and sometimes it's eight years, the older, the

patient is the longer it's been since the stroke. The harder it is. So a 10-year old that has a stroke or a 12

year-old that has a stroke, has lots of nerve growth factor. 70 year old that has a stroke, not so much. So

was it a clot or a bleed that makes a little bit of a difference in what you're going to treat and what your

considerations are? How long has it been since the stroke, 10 years harder, realistic expectations,

patients are desperate. They read things on the internet about FSM, and it's important that we not

(00:55:58):

Give them

(00:55:59):

Unrealistic expectations. And that's a typo that is obviously 94. So the general considerations, subacute

strokes nine 70, 94, 84 that's type out one 24 torn and broken it's broken. It does work three 21 allergy

reaction inflammation, increased secretions in whatever the brain part is affected. Reduce the

inflammation in the area around it. The area of the brain around the injury will remain inflamed for I've

read things that say for as much as a year, but usually, it's worse than the first one to two months,

reduce the inflammation, and reduce the spread of the damage. Then once it's chronic. So at the three

years Mark, when they come to see you looking for help, 54 necrosis 58 degeneration, calcium influx,

once there's inflammation, at least to calcium influx calcium and nerve cells, don't get along 91, three 59

and six Oh six. These are from the advanced than deal with scarring, increased secretions, and vitality. I

have treated patients who had strokes, where we've had tremendous success and I've treated ones

where we've had absolutely no success at all. Older patients and more chronic are less likely to be

helped. Concussion protocols, not going to hurt anybody,

(00:57:31):

But it's the chronic,

(00:57:35):

The more chronic and the older they are, or the frequencies for the brain. We have this in the core

seminar for the brain, the nineties, sensory and motor cortex, the Modela 94 people that have a stroke in the

Mandela, don't usually live the brainstem regulates breathing, and they tend to just stop breathing.

Midbrain will be the thalamus people that have thalamic stroke folks have body pain, but it can also

affect the amygdala and the hippocampus. And that will affect memory and emotions. And midbrain

strokes are complicated. Hindbrain or cerebellum, you'll see strokes in that area, anterior pituitary,

posterior pituitary area. I've never seen strokes in this area or the pineal gland. So I should have taken

those off the functions are, this is all in the core seminar. So almost at a time. So let's look at the

postcode stroke, which is kind of why we're here.

(00:58:36):

Thank you, Jodie Adams. Think about the process by which COVID could cause a stroke. There is the

direct effect of the virus on the brain because there are two receptors in brain tissue. So the virus can

actually enter brain cells itself, but the effect of the virus in the blood supply, they're more likely to

Ander the capillaries and the arteries go in, reproduce, break out that causes turbulence, that causes

clots. You can get micro clotting. So some of the reports you've read on the internet say, Oh, this is a

clotting. It's like, no, it's when the virus breaks out of the cells, it creates turbulence and inflammation,

and that causes clots. So they're finding clots in the lungs, clots in the kidneys, the liver. And it's because

of the effect of the virus on the blood supply that causes inflammation, turbulence, and clots turbulence

is bad.

(00:59:42):

And if you're a blood vessel, treat the virus first, as what we found out on Jody's patient she's co-treated

a patient who had a code stroke and they tried running 40. The patient did not like it didn't feel good.

They ran just the virus with the capillaries, the arteries, the capillaries, and the parts of the brain and the

two and the two and three treatments into it. The results were really quite positive. I'll see if I can get

her to present that a case that as a case report at the symposium once you treat the virus and that may

be the first one or two sessions, then see if they tolerate 40, right. We're reducing inflammation in

COVID patients have increased mortality. So see if they tolerate 40 after you've treated the virus Jodi's

patient, she did be careful with two 84 in case there are tiny clots.

(01:00:55):

If they're really tiny clots, two 84 should help dissolve them. But using two 84, one, we know there are

clots that makes me nervous. So this is the flu and respiratory organs plus the brain. I think it's just the one.

Nope. I copied the wrong one, rats. Okay. this is the flu respiratory and organs. It was supposed to be

the second one that had the brain parts in it, but the immune system, the virus itself, the capillaries,

these are the tissues, and this is all in its frequency, specific backslash virus. That's where these

protocols are. The lung, the heart, the liver, the kidneys, and then the capillaries again. So if you were

training somebody who had COVID symptoms in the cortex, you'd add 90 as a tissue. If they were having

difficulty with shortness of breath or difficulty breathing, you treat the lung 17, obviously, but you'd also

treat them a dial-up, right? Maybe the Vegas one Oh nine Vegas is everywhere.

(01:02:13):

[Inaudible]

(01:02:14):

And then the capillaries. So this is all in from that second flu protocol we did in April. So in general uses

early as possible. Find out what kind of stroke is bleeding or clock. How long since the stroke general

considerations, you can tell, I copied this slide because there's that same type of nine 78 94, one 24,

three 21 nine. Reduce the inflammation in general, not every stroke patient. You see, we'll get it from

COVID reduces inflammation. And that's good for all of our brains, chronic stroke. You're dealing with

other pathologies, look through the advanced list and see if there's anything there that I forgot. And

then remember to increase secretions and vitality in whatever that brain part is. And then drive the

current from where

(01:03:16):

The stroke starts. So at the neck, maybe in the ear, if you're really brave and then down at the distal end

of the affected body parts. So if they've lost the problem lost hand to foot, you can put the distal contact there.

If it's speech, if it's more parietal or temporal strokes, you just go from the neck to the chest and just

keep it local. Don't put it on the forehead, don't put it in the ears. Just keep it local. And by and large

FSM, can't put the tissue back. That's not there, but it can promote brain plasticity and encourage turn to

function. Oh my God, this is, I finished these sites at three 15 today. So, and return of function.

That's hilarious. So, okay. I can't stand that, but if I get out of my slides, it's going to be a problem, right?

(01:04:18):

So that's the stroke. I'll clean up these slides before Kevin sends them out. Don't miss the module

live streams. We're working next weekend, July 10, 11, and 12 to do the neuron visceral module. I'm so

excited about it. The pain and injury module has got new information compared to last time. So we did

the modules and what may, may I think and we modified the module one slides to the pain and entry

module slides. In June when I was sitting home and something to do, and then Kim added some of her

slides to it. So I'm pretty excited. She, assuming travel is allowed from California. Kim Pytest will be here

for the pin and entry module. David Masonic will do day three of the neurovisceral module. And it's all

updated material. And I hope he comes, it's been really fun to have everybody with us.

(01:05:25):

So this is FSM. We get to change medicine and change lives. That's the low back guy. Oh, Q and a. Yeah,

we'll do the Q and I'm having a good time. And then changing even one patient's life. Look at Hannah,

how is her world going to be different? Because she's not in pain. How is her world going to be

different? How's her mom's world dad's world because her world is better. How will this man have his

life without that horrible pain? And this doctor will never miss the lemon pain again, I guarantee it. So

that's what we're about. It just looks awkward, doing frequencies and treating patients. What we're

doing is changing the world. So Kevin has got Q and a, where am I? Are you going to give me the

questions I guess, or do I have them someplace?

(01:06:34):

Well, this is going to require a different set of glasses. I can tell what symptoms do cover patients'

experience when you run 40 on them. Oh, Diane, what symptoms do COVID patients experience?

When they run 40 on them? They don't like it. It's like, no, that doesn't feel good. I don't even know how

to describe it. If you're feeling for smush, you feel for smash and it doesn't smash, it gets firmer. But

they'll tell you. It's like, no, that doesn't feel good. Anything new with the visceral module

compared to may? Hmm, I don't think so.

(01:07:32):

David Masonic's always tweaking the visceral day. That's pretty fun. But I think the neuro, the neuro

section is pretty much the same. The visceral might be different. Oh, what's the difference between

healing and FSM? Oh my God. Okay. Here's the thing time waver is the company in Germany that put

FSM protocols on their big-time waiver. Mcmaken time over frequency McMaken device. The time

waver device McMaken device is kind of like custom care, auto care and a precision care, all in one

thing. And that's the time over time, we were also makes this little single-channel device called the

Healy. Healy is one channel. It's a little teeny thing. They program it from a cell phone. It uses

frequencies from some gentlemen named Nuno. Nina. I have no idea what the frequencies are. There

144,000 of them at a single channel. And unfortunately for me, they decided to market the Healey as a

multilevel marketing device.

(01:08:43):

And because I'm on the advisory board a time waver, they listed my face and my videos with when they

released the healing. And so the healing network marketing people are running around telling

everybody that the Healy is FSM and it's driving me crazy. It's that they have a cease and desist order,

their regulatory compliance people are on top of it. Now it does not do FSM. FSM is two channels. The

Healy is good for something. It just isn't FSM. It is not specific. It is it's Nuno, Nina. And yeah. So that's the

Healy story and tell anybody, you know, the problem is that the network marketing people went to our

website, scrubbed have looked at our practitioner list. And a lot of you will have been contacted by ULI

people wanting to enlist you in this network marketing thing. That is the elite.

(01:09:45):

Fortunately for me, the network marketing portion of this has been so difficult, contentious from a

regulatory standpoint that they are not going to market the mech Healey as network marketing.

They climbed down off of that tree. Within a couple of months, it just can't be done with something that

is as powerful as FSM. So Matt Keeley will not be multilevel marketing. There will be a version of

[inaudible] that comes out for FSM practitioners. We just don't know what it's gonna look like, and it's

not going to be called the Mackey. Lee has to be called something else because it's a long story anyway.

Yes.

(01:10:32):

Okay.

(01:10:35):

Oh, we don't have a frequency. So the next question what is the frequency for the prior to Loeb? I think

we just use 90. We don't have alike we have one frequency for the whole cortex and we don't have a

frequency for just the bridal section. It's like that top part behind the sulcus. We don't have one. So I

guess I'd use 90 for that. It turns out that the temporal lobe that's a frequency investigational frequency.

George came up with that one seems to work. So maybe if you have a patient that has had a pride lobe

stroke,

(01:11:14):

There has to be pathology in that part of the brain. We can ask George to see if he can find a

frequency for it. And then we have to find out if that frequency is correct. And if it actually does what it's

supposed to do,

(01:11:31):

This is skin pain all over the back prior to the appearance of viral infection. Oh, the skin pain, all of the

back prior to the appearance of the viral infection symptoms related to the thalamus or the neural

sequelae. If it's prior to the appearance of the virus, it's interleukin one and six there are cytokines, it's the

inflammation caused by the virus infection. It sensitizes the skin. So, you know, when you get the flu or

any sort of viral infection, your, your skin hurts, your body hurts. It's just a magnified version of that. It,

it, I, I don't think of it as it's. I don't think of it as a, as an effect on the brain protocol for foot drop. Yes. In

the neurovisceral module, I actually have two or three slides on foot drop is from the low back

is one thing that's nerve three 96.

(01:12:43):

And it's treating are 42, 84 then increased secretions in the nerve. And then you need a second machine

to go from the neck, down to the foot and reconnect the foot to the sensory and motor cortex, the

cerebellum, the spinal cord, and the nerve. So you need to treat the whole, the whole chain, but yeah, it

works pretty well. We actually had, one patient. Who's also a practitioner. He had foot drop from

polio. He was 54 when I treated him. He had polio when he was five. And we use the frequencies for

polio from neck to feet from the low back to feet and fix polio and then did the basics. And then did increase

secretions, fix the foot drop. And it was permanent. So I saw him 10 years later and he came to the exhibit

that we had at ICM. And he was telling everybody that was standing at my booth. It's like, see, it's

worked my foot. It still works. It never went away. So that was pretty cool. You got to treat the cause.

And in his case, treating the nerve wouldn't work, you have to treat polio, especially in post-polio

patients.

(01:14:02):

[Inaudible]

(01:14:03):

Oh, treating and managing clonus ODIHR Maddie. Okay. Oh, wait. What's the difference between one

and two currents. Seriously. Can you see what the difference is with one, two currents? Somebody that

hasn’t gone through the class yet. Okay. How are you on this webinar? If you have not taken the core

seminar they’re registered for it. Oh, they’re registered for the court. Okay. Two channels. We have one

channel for conditions and one channel for tissues, a single channel. You can’t do FSM. You have to have

one for condition, one for tissue. And what we found out is that both channels have to be correct and

both channels are required. So yes, that’s the difference. Diane, I will see you at module one or two

treatings and managing clone as well. It’s an upper motor neuron lesion. It’s probably going to be

temporary. So it depends on what’s causing the clonus usually spinal cord or brain increase creations.

(01:15:08):

And I have still a positive event scan one or two beats of clonus in my left foot from my myelopathy in

my neck. And I treat 81 and 10 pretty much every day to keep the spasticity down. And when you check

close, I still have one or two beats. So can petition back. There’s not there. Myelin is your friend. Yeah.

Problem with ms. The question is, will the foot drop protocol work on an ms. Patients can petition back

this, not their ms. Patients are missing myelin. So there’s a peripheral mile and there’s central myelin.

There’s increasing secretions. There’s reducing inflammation. I can’t put the tissue back. That’s not there. So

you can make temporary changes in the spasticity from demobilization. So basically I, my spinal cord is

deemed, Oh, sorry. I'm batting my microphone. Spinal cord stim myelinated at C five, six, and C six-seven

from that disc herniation, I had 10 years ago. And so I have spasticity in my left leg. It's really, really tight.

And it's, it's not as bad as I'm asked. Cause it's only in that one spot. I know where it is. It's in the court

and there's no, there's nothing in the brain that backs it up. But yeah, it will be temporary. Three-Year-

Old bone with the effect is man,

(01:16:39):

Three-Year-Old Gore born with a defective Corpus callosum. Where'd he go? His Shum? I don't think we

have a frequency for the Corpus callosum. It's, it's a connection between the two sides of the brain. And

I've never treated it before I can check with Ben Catheline and see if he's seen it. But it's worth a try. It's

not like there's anything anybody else can do. So I'll think about it, email me footdrop can be treated with

dual, dual, dual channels. So foot drop can only be treated with the two-channel device in our world.

And actually it takes two of them because one of them has to treat if it's a low back problem, it has to go

from low back to foot, one device from the low back to foot to repair the nerve, the other device from

the neck to the foot to reconnect that D nerve added foot to the brain.

(01:17:48):

So, yes I've always used two machines because I have them. I would work on the nerve first. And then

after you get some return of motor sensation, then if you only have one machine, you can go from neck

to feet and drive from the sensory-motor cortex down to the cerebellum, down the spinal cord to the

nerve. You can try that edited version of the April seminar, not looking in the right place. I met Debra

typer. Kevin, we'll get back to you. Which April seminar? The webinar. Oh, okay. Yeah. It's may core

modules of the core modules in April. I was, that was April. April was a very busy month. I

don't know what happened to them. We have the, we have David eats his video of modules one and two.

(01:19:02):

Yeah, we just got him, so, Oh, he just got them. All right. Is there a frequency for the breast? Yeah. Pang

says it's in the core. There's a whole section on breast health in the core seminar. So I'll let you look that

up. Mammary glands, adipose, connective tissue, duct tissue hemangioma just sent me an op yet. I

have no idea. Okay. It's not something I've ever treated. Jennifer, anyone in four 75 helps with the

myelopathy. It's one of the things I've treated. I've tried, but so far nothing's permanent. I have to treat

it at least every two or three days where it gets intolerable 496 Hertz. Judy, where did you get those

frequencies? So somebody in the Q and a says she has four 96 as Corpus callosum and six 47 for prior,

prior to the lobe. That means so many muscles tested for them. Judy, where did they? Do you get them? It's

only advanced. Okay. Well, you can tell it's not something I've ever traded. So if it's on the advanced,

then they're experimental. George probably came up with him and it's a, it's worth a try. There's this

one.

(01:20:45):

Okay.

(01:20:48):

Why? Oh, Amy, that's a really good question. Can you tell me why increased secretions are consistently

part of the stroke protocol? Okay. So think about what happens when you have a stroke, right? The

brain tissue dies and you lose the secretions that that part of the brain would normally give out to

function to create the functions that that part of the brain creates. So if you treat the cells and you just

treat the pathologies, theoretically, the cells in that part of the brain might start secreting on their own.

But from experience, we know that 81 actually drives those secretions and drive them hard. So you do

81 increased secretions and that restores function. And you can usually tell if somebody's going to

improve, they improve at the end of the session when you're using 81, then vitality, but then at least in

brain injury patients.

(01:22:03):

And I'm assuming it will be the strain and stroke patients. You need to replace the neurotransmitter's

like you're driving the secretory granules at the end of that snaps pretty hard. And you deplete them

well, you've got to fill them up again. So it's a coordinated effort. And if you're going to drive parts of the

brain and the spinal cord to try and recover takes Co-Q-10 takes lipoic acid. It takes all of the things that

you do. It takes phosphatidylcholine. It takes all of the things that you do to rebuild and restore

mitochondria to repair that neurologic tissue. So it's not a slam dunk. And the stable state is really

important. Essential, fatty acids, sleep water, vitamin D if your vitamin D levels aren't between 30 and

90, you're not working on it. And so I'm just saying any success in treating ADHD? Yes. That's in the core,

that's in the neuro module, that's in the advanced Dave Burke has a symposium presentation case

report on 80 D and ADHD.

(01:23:22):

It's, it's a complex condition, prefrontal cortex stuff, brain stuff. And I think dr. Burke uses the

depression protocol of all things because the depression protocol focuses on 89, the midbrain and that's

it's kind of like the prefrontal cortex is between the membrane and the core and the frontal lobe. So

yup. Stroke tread run concussion four to five days later. Of course, it's gonna set off the heart monitor.

Oh, dear. Was she still in the hospital? Okay. So if you run, if you run an electrical crunch on somebody that

is on a heart monitor, it's going to scream because the current disrupts the signaling between the

monitor patient's heart and the monitor, the magnetic converter for some reason does not set off

monitors. It wasn't the concussion protocol. It was the crack, assuming she was on a heart monitor. She

was three days post four to five days later. Was she still in the hospital? What was she doing on

monitoring six 47? I had no idea.

(01:24:46):

Now. I feel stupid. Oh, sorry. Sunday it's using the magnetic converter. It's it's great. We were able to treat

George in the hospital and he was on constant cardiac monitoring because of his age. And I could just

sort of put the magnetic thing right over his hip bullet AF postoperatively. He never had any pain, never

any hip thing. It was pretty funny. Okay. Six 47. I don't know. Did that. Okay. Kirsten's patient was difficult to

get a complete history. Three concussions. Oops. After Kachin, the patient collapsed. Yeah. The stroke right

side is spasticity and weakness. He had a stroke that happened two years ago.

(01:25:38):

Well, how old is the patient? So Kirsten, how old is the patient? And w is the sensory and motor cortex,

the place where the stroke happened? How old is the patient? It's for two years. How can they be unsure if

there was a stroke, somebody collapsed and has right-sided spasticity and weakness, and nobody's done

a brain MRI or CT, excuse me. So the first thing you do is have the patient, ask their doctor for a copy of

the imaging. If the imaging hasn't been done, it is a worthwhile question to ask why there has not been

imaging done. I'm just saying yeah. Anyone in 92, sometimes just mother has been difficult to work with.

How old patients? 27. And mom's been difficult to work with one wonders. Why what's up with mom, a

FSM help with deep emotional Tama from sexually abuse? Yes. that's concussion in Vegas. And I just

wrote an article for Townsend letter on mental health, the brain, and PTSD. But the short version is yes.

There are other things you have to do. What's up with the mom.

(01:27:17):

So, Kirsten, I'm not sure what your clinical specialty is or your massage therapist or PT or naturopath or

chiropractor. I tend to be fairly direct. So it would be worthwhile to ask the mom, is there some reason

that you don't want me to treat him? Is there some other thing going on that I should know about? Why

is it so difficult to get a history? I'm just curious. It's I mean, that's, I tend to be direct. I mean, ask

the question if the patient has, what, what side is his paralysis on?

(01:28:13):

Can you go back to that? Is it gone? So the patient may have which side right side is specificity and

weakness. So it's the left side. So at least he's not, he's not impulsive and dangerous. I don't know. That's

always a good question. Imaging is your friend. Somebody needs to do an MRI of that kid's brain. Now

what nature path, what was traumatized in the hospital? Whoa, that's messed up. Yeah, I'd say it's a

strange case. I would treat concussion, treat the Vegas just because it's not going to fix the spasticity,

but, and then do the pathologies on the sensory-motor cortex check on asleep. If you're a nature path,

give him supplements. They expect that from nature pass essential fatty acid phosphatidylcholine will

increase the subtle Coleen that's worth. You can do this 27. He's got, he's got enough nerve growth

factor that he should start to improve. So treat from neck to feet all the way down, have him put his

right hand on his tummy so that the current gets through the arm. Have one machine just doing 81 and

92 and the other one doing the other pathologies for the sensory-motor cortex, also 81 and 10. What

the second machine kind of has to play with it.

(01:30:21):

Oh yeah. Concussion protocols. Sorry. The good question. Thank you, Debra. Concussion protocols,

always basics. You've got to get the constitutional factors turned off and get them a dollar functioning

correctly if you want to do anything. So sometimes that's the third machine. So yeah, concussion

protocol is always a good place to start. This is really fun. Did you have a good time? That's why it's five

30. We'll send the video link with the slides this week and I'll go in and correct the typos and move that

illustration to where I needed it. You guys have a good week do good things change the world change

lives, and I will see you at the next webinar. If not at the module, I.