Innovative Pain Solutions You Haven't Heard Of Transcript

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Introduction and Guest Background

Through. Hello, this is Doctor Pollack. Today I have a special guest. I just recently met him and have been, really quite enthralled, actually, by his experience.

And what he's going to help to share with us. So welcome again to the PMF Healing Summit. And I have with me today, doctor IRA travels and Doctor Shadows is a podiatrist in Tampa, Florida, and he's a very enthusiastic person.

So, let's welcome Doctor Shadows and Doctor Shadows. Please tell us about something about yourself and how you started your career. And go into the things we're going to really get into today.

Thank you. For having me. I graduated at the Temple University College pediatric medicine in 1977. I went for residency to a private hospital in Philadelphia called the Oxford Hospital, with an affiliation with the University of Pennsylvania Sports Medicine Center for learning, surgery and Therapeutics, especially in sports injuries.

Following that, I. Went into practice and allowed myself to research what medications could possibly be curative for injuries of the feet, ankles, and legs that would commonly come into the office.

I wasn't looking for a treatment. I was looking for a cure and using certain discoveries that were already made. Which is funny because I'm not looking for the better mousetrap.

My, studies of history have showed me the better mousetrap was already created. We've just weren't paying any attention. And so this is the, the laughable part of all this.

Everything I'm curing patients with is between 60 and 90 years old for today. And, the, the cure rate with using the proprietary injection approach that we had without pulsed electromagnetic, therapy was 70%.

And that was not satisfactory to me. I mean, if I really, as a physician, supposed to be curing people, I'm looking for 90 to 100%. And I thought that was well below the standard of care.

In my opinion, I know that's what they preach it medical conferences. But I, I think my, my standards are a little bit higher than that. So in my research, mysteriously, in 1986, at a 20 year high school reunion, up walks a classmate of mine who has to be a gradual happened to be a graduate in engineering from Columbia University.

And he bends my ear and says, you're practicing medicine in Tampa. Listen to me. A salesman will come into your office very shortly marketing a piece of equipment called the Dial Pulse.

He don't ask any questions. Listen to me. You buy that machine. You will see sheer miracles. And there's an engineering student in electrical engineering from that university.

Prominent as it is, where the machine was actually developed in 1934. And this is a, my classmates were all academic, and not over 90% of them go on to college.

Was that type of a high school? So this was a big deal. And, he had that to say. He was felt so strongly about the almost wish to buy arm. He didn't have to twist my arm.

He gave it to me by verbiage. In came the salesman a week later. No joke. And he sits down. He says, I want to tell you about the machine. And I said, I'll take it.

Early Research and the Search for a Cure

Pause, pause, pause that thought. Pause that thought. So let's go back to what you said. 75% cure rate. Right? So 70. So 70. 75% cure rate of what? Pain conditions of the feet, ankles and legs.

Pain in permanent work. I thought I, I didn't know completely was permanent yet. I would have said at the time because I was on the course of performing a ten year follow up of 317 cases, and I would not publish it until the ten years were up, because I felt that anything shorter than that would be invalid.

So I that's a very, very, very good point. We hear from many, many practitioners, many salespeople and so on that we can cure this problem. We ask them what their data is.

Well, the data is three months. And unfortunately, even the oncologists play this game that a cure is five years, right? If you go five years after you have treatment, then you're cured.

It's a game, right? So we, you and I as clinicians know that that cure. Well, it it may take the rest of your life to, of course, have a cure. Right. Okay, so you are dealing mostly with, foot, ankle and leg pain issues.

What caused the problems caused those those pain issues? Well, that was actually my discovery and not taught to me in school, because everything was the reverse of what I was taught.

And if it you want me to jump ahead and say, okay, well, I'm going ahead, go. No, no, no, we're going to go back. We're going to go back to the salesman walking into your office. But he looked at me and his jaw dropped and he said, you're kidding me.

I said, no, get the equipment. We're going to start to use it. And I knew exactly how I was going to use it. And then he provided me with copies of 300 national and internationally published papers on this one piece of equipment, which I had never seen any volume of research data like that.

And okay, I'm really sorry to interrupt that for the program. People. People were saying, okay, pain, but what's pain caused by? So let's go into some of the causes of the kinds of pain that you were seeing.

That's the surprise. There is only one cause this was my discovery and it was not what we were taught school. So what were what we were taught in school was tendonitis, right?

Inflammation, fractures and neuropathy. Right. And arthritis is a whole bunch of stuff that sounded good, look good on x ray, which was inadequate, but they didn't know that at the time.

And even the moralities are inadequate, that, oh, at least the tired line questioning. But the difference between me and the other clinicians in my field was I was actually listening to the patients and I was being a history major.

I was very verbal. And when I listen to the words they chose to describe their pain, I said, these are my bony joint words. These are nerve words. So I said, and I always wondered, by the way, after finishing residency and surgery, it's up to these nerves are so close to the skin.

How can you walk with full body weight on these structures and not injure these nerves? It's impossible, all right. But nobody was looking at it. Nobody.

So the ultimate. Oh. All right. Dipoles. All right. Dipoles. Now. So the dipole boss into your office gives you 300 references. And oh, or you know, this long list.

And instead of intimidating me, I thoroughly digested the papers because they covered a multitude of conditions. One technology curing or helping to cure conditions from otitis media or middle ear infections that we have in all of our kids.

Then down to let's say, oh, what the oh, head injury or up to a head injury, said study from India. Curing these people. No drugs, nothing. So did this is pretty powerful technology.

We may not understand it, but my job as a physician is to do no harm and use any harmless remedy that will heal my patients. So I b I what I did that was innovative, I guess is to incorporate a combination of technologies.

I use the PDM to make my therapeutic injection, which was already in use for 60 years by that. Wow. Let's see, at that point in the 80s would have been in use for 20 years.

At 25 years, I'd say. And, well discovered and well founded by very brilliant, physician, in New York. And so I combine cortisone injections because they're just a Band-Aid.

I combine distributed injection with the PMF and oh, my God, my curing jumped from 70% to 95%. I was doing as a resident. I was training at the VA hospital at the time who helped me with, collating that, said to me, doctor, do you realize how much less surgery you're doing in real and in truth, was this true?

I had reduced my surgical load by over 90%, and I was curing people that I ever cured before. What's wrong with this picture? Okay, I was making less money.

Well, theoretically. But the truth is, the public doesn't understand. The surgeon doesn't make a lot of money from the surgery. The surgical center for the fees they charge for the use of the room.

And the anesthesiologist who got his chart. Each of them make four times what the surgeon makes. It's pathetic. So, biology is a my job is to cure people, and I'm just going to go ahead and you're people.

Discovering the Injection Technique

The truth is, my revenues went up because I didn't have to waste time taking a day off to do surgery. I was saving money for patients. They want to say curing every one of them in the walked in the door.

It was a very enjoyable way to practice. I think that's very unsatisfying, making everybody happy. That's so incredible. So. Okay, well, hold, hold, hold that, hold that thought.

So let's. Okay, now you have this technology that has all these references and you said, okay, I'm going to start using it. So now we'll go into the rest of that, that story.

What was the technology. All right. The technology was the only major device, the one recommended to me by the graduate engineering student at Columbia University, my classmate diapers die.

Diapers, diapers. Look, that pulse so lutely. That, to me, is the gold standard of PMS. There is no equal in the world, in my opinion. Well, we might have an argument about that, but let's live with your let's live with your assertion.

I mean, I mean, for with my limited knowledge of the field. Okay. Okay. So the diapers. Yeah. Phenomenal pieces of equipment. So, yeah, let's go from there.

You started using the diapers? Yes. And the patients were coming in with 50 to 70% relief of pain with just one treatment using the same technology used before.

And the number of treatments went down to an average of 1 to 3 to get cure and maybe as high as 1 to 5. But they were cured. So they had they had to come at that time.

They had to come into your office to get treatment. Correct. Because this is a big machine and it is very expensive, has a great big head on it. Right? Yeah.

I've got a big arm. Well, you have to apply it directly to the spot that you are treating. Only treat one zone at a time right. All right. So when you started using the diapers now you when you started using the diapers, did you use it by itself or did you still combine it with your injections.

Always got. Well when it came to the therapeutics I'm referring to specifically, I was combining it and we know that can be applied to the injected area three hours before, up to three hours after to have the same effect.

So, based on literature. So what I did was I would do the injection first and then they would go because was such a bulky, heavy machine. I had one room dedicated to the PMO.

They would go to that room and sit and read a magazine or something, take the diaper treatment and then leave. Like the diaper treatment is a how long does it take?

15 minutes, one, five, 15 minutes. Now, I do know from parameters it could be as less as little as ten minutes, but we always, wait for the 15. And we know that beyond 15 was just gilding the lily.

Okay. Based on the technology. Yeah. All right. So you right off the get go, you started using the diapers with injections or did you, did you try diapers for a while without anything else?

No, no, because I knew what the pathology was. And I already had a therapeutic injection that had a 70% cure rate with no dials, and I wasn't going to.

All I wanted to do was augment it so my cure rate would jump up to 100% if I could. Okay. So let's let's clarify that point. So you had already developed this injection technique and you told me about it.

And it's already different than what most doctors do. So you said already local anesthetics or local steroids don't do very much right. They don't like they and I cause their own problems.

So what was your injection? What? How did you discover this injection? I can't take credit for the original discovery. Like most of the great inventions we're dealing with, they were developed in New York or California.

I have no idea why. It's always those new places. But at Columbia and at, one of the medical colleges in New York City was a doctor, Marvin Steinberg.

He was very, very bright in pediatric medicine, because of his depth of study into the relationships between internal medicine and their presentation in the lower extremities.

Very interesting man, very bright. He determined. And I do not know how I he never I don't think he ever published, he just, taught that if you take a mixture of vitamin B12, liquid a tiny and I tell you, tiny, almost inconsequential to most clinicians, amount of long acting soluble corticosteroid, he ideas.

Yeah. Well, he was using, I think, you know, they think you can get any more, but it was only 2/10 of a CC of steroids, but 90% of it was vitamin B12.

And lastly, a little bit of lie to gain market, whatever you like. So I say you got a formula we know works. I'm not going to I, I'm just going to use what he used because all the students I read my travels were using this formula, were having tremendous success in their offices.

And I figured, that's my job, your patience. So I use Steinberg's formula and later on reduced the corticosteroid to a 10th of a CC, which I realize I didn't even need.

Duterte. It's it was almost an insult, but it but for electrochemical reasons, there's a good reason to use it based on what we know now. But in any case, that was the case.

So B12 is the main ingredient. That's what you are. So you were still using a tiny amount of, corticosteroid? I was I was insecure about taking away what Steinberg discovered completely.

I'm insecure about. But I have cases that were people were allergic to the corticosteroids, and I just used the straight B12. And I can't deny they also cured, but I, I why did you stop using the steroid altogether?

I could I or you're still using it. Never did. I'm, I hate to, let's say, contaminate an already good system. Okay. By inserting my own, All right, so you are using a tiny amount of long acting steroid and, a fairly substantial amount of B12.

Yes, but the B12 you're using which which which form of B12. I know I've been asked this before, and the truth is, always use the standard cyano Kabbalah beam.

I know there's a lot of people. Are we messed up with all the. Well, in my hands is ball. The beans got me up to a 99.9% cure rate. So truthfully, it's the that's what that's what vitamin C or vitamin C produced by any manufacturer, I think.

I think it's the same. The question is how do you get it absorbed? That's the key. All right. But before we go to that what how much cyano complement where you're using.

For every site I would use 1.3 ccs CCS, which amounts to how many milligrams, 1.2. How many milligrams? That would be 1000mg per ccs. So it's a little over 1000mg a month supply.

All right, so your injections were directly to the nerve. So you didn't inject into the pain area. You injected specific. So tell us more about how you discovered where to inject.

Okay. I really, surgical residency did not, did do me. Well, about one thing. It taught me the anatomy even better than I may have known it before. In three dimensions.

So I knew exactly where the nerves ran when I was treating an area of the body. My challenge was to find out where the nerve is. Most of affected. Where is the sweet spot?

Where's the key to all the pain? And I discovered that all pain narrowed down to a one quarter inch diameter when it came to nerve pain. And, that all this bone and joint pain was, well, and joint pain.

It was nerve damage, and I was able to narrow it down. How did I do that? The only thing available to me at the time, I had to find an instrument that would not be injurious or create pain on its own, but solicit the actual or, if you will, the actual response from the nerve.

And my first tool that was published was the number two pencil with the eraser work very well, but it's kind of fragile.

Adding Pulsed Electromagnetic Therapy

It doesn't work when you go to after a sciatic or some other nerve deeper. So to speak. So I had to get about zero there later on. We developed around the instrument, but we started out with the number two pencil with an eraser, and that was my tool for locating the center of pain.

In other words, by touch, not running imaging by touch. God forbid we should put our hands on a patient. I never had that phobia. I did, kind of do, but it's it's wrong.

It's all right. So let me clarify. Just so I understand as well what you did is he took a lead pencil. You used the eraser side of the lead pencil. I'm glad we clarified that because people can say, well, you're jabbing the person with the lead pencil.

That's going to hurt, right? Okay. You use the eraser side and you are basically, in a sense, palpating are you probing, pushing on the various spots around where the pain was to find this sweet spot?

Correct. And it always narrowed down to one spot and they would jump or they would react. And I said, that's got to be the spot. I had no way to image it at the time.

It was all by touch and patient response. So, I marked it with the skin marker and later on that's where the injection would go. And the accuracy was formidable.

It was amazing. Easy to repeat, easy to teach, easy to show. And as the pain subsided, the center of pain would move. So you have to take a few seconds each time to find the part of the nerve that you hadn't reached yet.

Right? But that was the torture process. That's why I was. So that could take 2 to 3 injections. Yes. In order to get all the pain. That is absolutely correct. I.

Fantastic. Okay. So that's that's the part that you were doing before you got determined, before you got the diet pulse correct. You already had become skilled at doing that.

And you got a 75% improvement rate. Even then, 70%. Okay. I want to take back that five okay. All right. So now with I pulse. Yes. So you said 70% is not good enough I want I want more I want better.

If I were a patient going into a doctor's office, I want to hear him tell me if we do this procedure, your success of recovery complete recovery is 90% or better.

If they can't say that, they're not touching me because you should demand perfection. It's your body, it's your life. And so and we're going to medical conferences and I'm hearing 70 presenting.

They're happy and I'm laughing. So I after reading all the papers and listening to my classmate who swore by this technology, I started to incorporate 15 minute bio pulse after every injection case.

So you do your injection first and then you do the die pulse rate at right after that. Sometimes just because of scheduling, we would do it before 15 minutes because we knew the electrical charges were stored in the tissue for hours.

So that wasn't we weren't afraid. We weren't going to have the same effect as I had already been established. So that was it was great. So it was the dipoles was the workhorse.

Boy, it got a lot of work. And my so you never let up after that. It was the only ever combined. The two always absolutely. All right. Why. So why do you think the dipoles made such a big difference?

Peculiarly of all the reagents. No, no. Medical science. A study was done in New York. Again, using B12 is created to see how it would be absorbed with and without the dipoles.

Specifically, this was coincidental. I knew nothing about this study. I read it later. Well, they show that we inject B12 and we assume I want that word.

I'm going to use that a lot in future lectures. Like everything we were taught, so that we assume it's being absorbed into the bloodstream, into the body.

Well, they found out in New York it was it. It was sitting in the tissue using radioactive tag B12 and the gamma camera. They could trace the B12. It would sit in there on absorbed days, weeks, maybe longer.

And so where was the therapeutic value? As soon as they applied the type of equipment, the B12 was taken up by the tissue 100% in seconds, seconds. What's wrong with this picture?

Now that's that's neural tissue or regular tissue. What was the study? There was it was radiologist. Correct. They were using like you would do a B clove injection to a deltoid or, you know, thymus or something, right?

Yeah. So even so, from a regular tissue perspective, it was being absorbed much more rapidly and inclusively every time if you used the dipoles. All right.

So you said, well, if it does it for regular soft tissue, what about a nerve. Could have. Yeah that'll translate I figured the translation would be 100%.

Of course it was. And my data proves that. All right. So so then you started with 1 or 2 or 5 or 10 people, and then you, you went crazy. Okay. I wanted to cure these folks.

I mean, I thought I was the patient, I would I'd like that consideration. So why not cure them? All right, so then you you actually wrote a paper based on your experience with how many people using a nation of approach 317 followed for ten years because I didn't want to publish before.

I knew that it was actually permanent. And, the paper, the data was collated by U. S. Army research physicians, along with my resident at the hospital.

And, we had, cure rate of almost 95% without surgery. The other, four point something percent, went to surgery and were cured that way. But the truth is, 95% were cured without surgery.

By combining the injection and the pulse. Now, this was for neuroma, right? No, actually, left foot nerve damage because you're you're. Wait. You made a very good point.

Up to that point, the only kind of nerve damage we were taught in school had to be the erosion of the metatarsal areas of the ball, the foot. And we were taught about tarsal tunnel syndrome, much like carpal tunnel.

The rest, unfortunately to the thigh, opposed to my injection. They don't care where the nerve is. They curable? We cured Castle tunnel, whether it be cured in aromas with you.

And now I can image it and you see them just dissolve away. It's the most amazing thing. Beautiful. The neuroma dissolves away, weakly dissolves away.

Then you have a normal image. Once it's all done. Well, what's the cause of an aroma? That that involves the other cure that was developed. That is non PMF.

We'll get. We'll get that going through the aromas. This study did show that all this nerve damage neuroma charge O'Connell syndrome, all of this stuff feet and legs is due to abnormal foot structure, which we've known about since 1960 from the work of Merten Root at the California College Body Atrophy medicine and the University of California College of Medicine, San Francisco, where they did the anatomic studies.

And, it's it's they tell you, they show that the world's broken up to three foot structures. You're born with one of two abnormal structures and only 20% of people are born with normal feet.

And, the who who were my patients? The 80% that was abnormal foot structure, which means it's an inherent factor for which they developed a cure in 1960, which was a simple, custom made insert that went into the shoes for both sports and regular day to day activity, with the durability, with.

Because of the change, fabricated materials available now the they last ten more years or more. All you're doing is you're with the orthotic. You're basically just maintaining the, natural angles of the arches of the foot.

That is correct. And, and, it it's true. It scientifically, yes. It is. Not subject understand. It's called biomechanics. And you have to be able to envision how the body moves in three dimensions and that apparently a study was done, I was later told, had only about 25% of physicians have that capability.

It's not easy, but I spent 400 hours in training under the people that wrote the textbooks, in California, on my own dime, because I wanted to, I knew was cured.

I wanted to master it. And that's so that's the other part of my practice is biomechanics. And and so after you did the biomechanics, everybody gets biomechanics anyway, you took care of the pain problem.

The immediate need. Right. How do you prevent it from coming back. And there it is. But it where it all works. Okay. Well podiatrists are supposed to limit what they do, right by by the bards, the regulations and so on.

Say you're you're limiting your practice to the foot, the ankle and the leg. And that's the leg from the hip from below the knee. Right. Not above the knee. Yeah. Correct.

Biomechanics, Orthotics, and Preventing Recurrence

Some conditions of the knee we're actually allowed to treat when they're related to the foot, which is why which we found out the Pennsylvania sport bends etc.

is quite considerable. But still you're right I'm not doing it better to be in that. We're not working on it. Correct. All right. Well being the being the innovator and renegade that you are, you, you went astray a little bit.

Tell us about what you strayed into. Okay. Oh my goodness. Well, I figured if the works on nerves in the lower extremity, it would work on nerves in the upper extremity.

And I was working in the office of an orthopedic surgeon whose license was bigger. So what happened was, I was able to continue my research on other kinds of cases, and they truthfully, it's a it's a breeze to cure anything above the waist.

Man, I'm going to tell you why they don't put body weight on their hands. Yeah. So that could explain why I was curing carpal tunnel. Maybe one treatment tops to.

I was curing so called tennis elbow. Oh, is that a miss? Diagnose condition, maybe 1 or 2 treatments. There was, a guy with the neck pain. That was two years post, rear end collision scheduled for surgical intervention.

And he was a great subject that took just one injection. Secure. And that. And I had a five year follow up at five years. So I've got a standard. But he was he still he could be walked out of the office with no pain.

He couldn't believe how you and, I also found out with my, research and using good imaging system that all this crazy back pain that we're all worried about, they, they base our surgery on the MRI and the CT scan and the X-ray and.

But you. So what do you do? You assume that the pain is coming from what the studies are showing wrong. If you use the touch principle and an instrument that can work on the back in the other areas, you find out the pain is actually coming from a peripheral subcutaneous nerve that had nothing to do with the imaging that were showing.

So is there all right, have something wrong, an x ray. And then I have to be treated. Of course. Whereas this is the problem. Our society has become one of treating tests, not people.

All right. We got to get back to treating people. This is what bothers me. So in that orthopedic office, you were still doing the same treatment. You'd find the nerve so lutely. Right?

Everything got the VA, the diet and the injection until I was able to replace the dipoles. Why did you replace the dipoles? There were two problems with the dipoles other than the bulkiness.

The, The problem was, I realized when I'm lecturing and I'm trying to present this around the world, I've got a 200 pound machine on casters that looks like it came out of, the early days of radio and and I'm trying to impress younger minds that are used to seeing sleek machines, space age type technology.

And I said, we just got to make a solid state version of this thing. So that's when I met the AVP. So that's I've, I've, I've, I. Okay. So the RV has the same signal.

So the signal in the dipoles. But let's explain that signal a little bit. So the dipole signal is 20 21 point hertz. What is

it, 27.12MHz, 27.12MHz. That's the carrier signal. Correct.

And then that carrier signal is then pulsed at a lower rate. And that varies from equipment and equipment to equipment. It's funny to study, but it can be upwards of, say 300 to 600 cycles per second or pulses per second, right?

Correct. So the I've, came along, you had dial pulse people selling you give me machines instead. Yeah. Which shocked me. But I'm looking at this thing.

Is it now this could go this the audience going to want to see that if it worked. Now, I'm a purist. I'm OCD being a surgeon for before being, clinician like I happened.

So you want to put things back the right way? Well, my idea was I've got to see if this works. I said to him, I mean, I know this new technology. I know it's supposed to replace the dipoles in your eyes, but I don't want to see the clinical results.

And I was shocked. Not only did I get the 95% cure rate when we actually tabulated the results at the end of a year, our curated junk to 99.9%, so there's something different in the sink, something different in the signal, say same 15 minute treatment cycle, right?

Correct. Now, the diet pulse, the I. V., the diet pulses is a big machine on a on a on a cabinet on casters that you have to roll around. Right? Yeah. What was that?

Your idea machine? Was the aroma, right? Yes. That was a aroma that I'm still using to that right now. But what does that look like? That's about, What?

The body of the machine is so lightweight. It's, blue color, about maybe a foot diameter, maybe two, 2.5in thick. It has three external male coupler couplings for, using three separate electrodes.

So instead of being relegated to only one treatment head, I had three heads I could use simultaneously with eight inches of penetration and eight inches of width in signal.

Right. So I was even close to where my mark was. This thing was going to work, as far as absorption and penetration and so forth. Well, yeah, my study showed that it worked, actually, as well.

We're better. And, so I said this thing, I could sell this one, I could do a lecture about and say, hey, look, this is it. This is the, the that's a the newer version of the old technology and has is just as efficacious in cure as was the old.

So I have no reason to go backwards. I will go forwards with the solid state circuitry. So if you can share what was the price of the, Roma? The room at the time was marketed at $15,000.

The, dial pulse when I got it, was $10,000, at that in that time, by taking my diet pills in trade prospectively with the provide, provide proviso proviso of, well, if it doesn't work, we will give you back your diet pulse machine.

We we respect your work that much. And so they discount discounted 10,000 off of the heavy at the time. So they sold to be five. And I said well, that sounds like a fair deal.

If it works, I'll be I'll get a couple of I'll get more of them. And, it just the story goes again, I tried to acquire names I could over time, but as you know, the the Roma, there were several other Ivy models, right?

Apparently I was not aware of them at the time, but I found out later, from looking on eBay that some of these things were being sold. It was interesting. Well, there was the, Roma, there was the Torino.

Yes. That is, that's interesting. That's true. That was the word they used for your original disposable version of the TV, right? Yes. Well, what's happened with the company that what's happened with Ivy?

Even though in 1990 I met with their chief scientific officer, Adam Levine, and I explained to that what she had in the Roma was so incredible that they need to really market it.

And they. And, in 1998, of course, my article was published yet, but I have clinical results that would be useful for them in marketing. That would be helpful.

And, they didn't believe the paper.

Expanding Treatment Beyond the Foot and Ankle

Apparently they didn't believe enough in the Roma that they actually discontinue manufacture during it so they could focus on the Torino and its, later heirs in order to deal with the disposable economics of medicine and sell more equipment over and over and over again.

So, yeah. So I know that the, your machine, the Roma, was also used, a lot was marketed a lot for nursing homes, for wound management or skin skin management, which is the way Diet Pulse was going.

But, you know, it's awfully bulky, but the body was portable, and you have a clip so we can hook onto the back of a chair. And you could treat multiple patients in either direction with their coils.

So it could be very practical from that standpoint. So then so the Roma and you, you're lucky enough to have the older machines available. Yes. And now you said that the technology shifted to disposables or.

Right. Correct. And they would, they would the cost how much the at the, in the torino's at the time the Torino came out, to a doctor, it would be $180.

That right. They they created a new generation of the same exact equipment, maybe a little bit better material. And, just about doubled the price of it.

Okay. And you said that you found that work just as well, correct. Technically speaking, if you were, let's say, reticent about investing thousands of the BMF devices, you could get one of those and use it in your practice.

If you were a doctor or a doctor prescribed it for a patient. And, it could be used for several months at a much less your cost. And if it worked, then you'd have your evidence that maybe would work.

All right. So unfortunately, what happened to IBD? Out of business, as far as I know. Out of business? Yeah. They I think for. Yeah, they stopped. They stopped business.

They did a lot of studies. A friend of mine, a colleague of mine was actually one of their researchers went back to Arthur Piller. Oh, yeah. Separate.

You remember him? Yes. Yes, he was in the literature. I and, his name was bandied about a lot. Yes. Yeah, he did a lot of the basic science research on on the signal.

Interesting. So I maybe went belly up, or they stopped production. They were actually re, reformulated into another company, which is now called Soft Pulse.

And the soft pulse, one of the original soft pulses was actually being used in the nursing homes. So the soft pulse is gone through some of the same sort of, rejiggering, if you will, of the corporation of the company.

And they're really not doing almost anything. They're really not doing any marketing. You don't hear any salespeople coming by, right? No, not at all.

No, not at all. And one of the principals of the IB, ended up selling developing another company called the SEC. So the SEC, like Francis, Saint Francis of Assisi, right during the CC, is a pet device.

It's marketed as a pet machine. That's what I saw on eBay. That's what I saw on eBay. Now, the coil is smaller because it's really for at for smaller animals. Yes.

What I don't know is whether the, intensity or an intensity in this case is not just the peak EMF intensity, which we talk about in terms of Gauss or Milli Tesla, you often talk about wattage.

So the wattage of the, the dipoles was pretty high because it was plugged into the wall, right? It used current. It's correct to power it. And the, the Aviva of the new IDB, the soft pulse and the AC are powered by batteries.

Interesting. They're small little batteries. Yeah. And like their model, as you said, had switched over from a, professional model to a disposable model.

So now you have you buy this ring, and it's sealed and you use it for something like seven 70 minutes of total treatment time or 70, 70 treatments. I'm sorry, 50 to 70 treatments.

And then the battery basically dies. And then you have to replace it. So it costs like 300 plus dollars as well. Like spare parts. Oh that's so that's the that's the legacy of that technology.

So people are interested in trying this technology. You could try the SEC. Although they do ask you for the name of your veterinarian. Oh, yeah. So right now we I think we're kind of in a hiatus, unfortunately, with this technology, which is, I think, tremendous technology.

So people can still buy the loop coil from soft pulse. So it's soft. Policy. Correct. All right. It's still available. Although the company, again, has a shrink shrunk down substantially, with their investments, and they spent a lot of money and have not been able to really grow the company and establish a good product.

So we there's a there's a gap and there's an opportunity here for us to do a lot more with this. Because as you said, this is not just a podia device.

This is not just a nerve device. Oh no. Right. This technology has been shown to you wounds. Right. As you said, brain treatment, sprained ankles. Ho swollen sprained ankles.

It's a tastic against edema. Yes. It's true. And that's one of the is actually it is FDA approved. So the soft box does require a prescription. The FDA has classified it as a schedule two, not drug, but device, which means that it requires a prescription, which is unfortunate.

The SEC doesn't, but I think that the SEC is probably weaker. I'm sure that it's weaker than the softballs. Interesting. So because of this, FDA approved for pain, post-operative pain and for edema.

Which is why you were getting the kinds of results you were getting with what you were doing as well. Now, do you know, do you know clinicians, other clinicians non clinicians.

Well, let's talk about pediatric clinicians. Obviously if people want to come to Tampa you're still seeing patients. Yes. Right. So give us give us your website please.

Oh yes. It's, doctor, I shambles.com. So channels, bell channels, shambles.com for life and less doctor eye shadow.com. All right. If you do you know other clinicians other doctors or orthopedic doctors who are using, this signal. Oh.

Absolutely not. No. This is the this is the problem, which is something I think you talk to me about. And I've lectured to the orthopedics department at Tampa General Hospital on this 20 years ago.

I know no one comprehends the fact that one machine has the latitude to cure or help cure so many different disorders. They just don't understand because they're not teaching this in the medical schools. They're not they're blindsided by discoveries or converse to what I was taught, where the damage really was.

I was taught to shoot the x rays. I was taught there's only one imaging system, by the way I'm down to, and that's the only one that shows the damage all the time.

And that's ultrasound. The one thing that the one of the few they don't train us on. I take my own train to get my training at a certified expert, of course, again in New York, interestingly, by one of the medical colleges up there and, and then I when I left the course, it was that all there is said.

Yeah. Now you got to do it. And it's true. You once you've done hundreds of tens of thousands like I have, you come very proficient with it and you know how to see.

I mean, I'm actually doing a great now the first atlas for ultrasound in the foot ankle leg ever ever published. They, they because there are no images.

There's nothing standards for these people. They the Romans. Yeah.

Device Evolution and Clinical Results

But what I've seen tarsal Tunnel and the stuff that grows up to be just amazing. Now not everybody has access to the doctor channels. Not everybody has a particular pain problem.

So in the absence of people in the community who are able to do this, what would you say about using this signal? Directly on a pain area itself without using the injection?

I mentioned you and I understood real as a result of this technology. I've come to believe something. I believe you believe? And that is that everything we need to heal ourselves is already in our body.

The issue is, how do you get it to work? And I believe this signal does that. So yes, it augments what I'm doing. But let's say you you say if you just had pain or swelling or something like that, that was not like threatening, why not use it?

Why not try it? Can't the beautiful part, it can do no harm. So it works. What have you found? A cure without drugs and without dangerous treatments. Now, unfortunately, and looking at the science myself, on the I. V., that's not so much the idea, but the science on the pulse and that particular signal, 27.12Hz.

You know, I asked you at the beginning, what's special about this 27.1Hz? And you said it's the FCC. They they created that as the, as you say, carrier signal.

Pardon me, that was medically approved for all medical devices. We're allowed to broadcast on that frequency. Isn't that interesting? I mean, we're routing.

That's not to say that there may not be other megahertz signals or other signals. Absolutely. And of course, my experience with Pmfs is most PDA maps will help with pain.

And where I found that the issue is a lot of the time, the issue is, the depth of the pain problem and having the right magnetic field intensity. Now, it's possible that you don't need as much intensity with this megahertz signal than you do with other other PMF signals interest.

But I have never seen studies comparing other pmfs to the dipole signal. True. Right. So we don't know what the comparison might be. Now, when you treated superficial issues like the foot, the ankle and the and I consider them relatively superficial compared to the liver or the lungs or the brain.

Would you like an interesting liver story? By all means, please. This is one medical miracle that has I have documented, it is documented. And, I the punchline I may leave out, but the truth is, I was treating a patient.

Referred to me that at the time I did not know was at the top of the liver transplant list from Lakeland, Florida. In

that one of my said what I had a satellite office was the branded.

So they drove from Lakeland to Brand, and he was referred to me by a liver specialist, and he was being tested regularly for his liver levels because they really tried to keep him out of the death bed.

But the point is referred to me for, metatarsal fracture, one of his feet. So I, I said it, I did what I supposed to do, and of course, I had the old guy machine at the time, so this for you might be of interest.

So I treated his foot. But I was always told, you treat the liver the same time. Because the liver can act as a storage battery. It will bind the electronic charges.

You negative electrical charges, just like a battery would. And when the heart beats worse, the red corpuscles go through there. And we do that. And I guess guys must have had this because I knew this, that each red corpuscle had a capacity to carry two extra electrons.

So they thought that you create you can create a therapeutic battery circuit by charging the liver. And then the charge will be dropped off where, where the positive charges were, which is any side of injury or disease.

So I did that that day. One treatment 15 lift 11ft. The liver specialist called me from Lakeland one week later he said, what do you do? And I said, I want it is fractured and I put the dipoles here.

The man no longer has liver disease. He is totally healthy. What did you do? So he made me send him copy of the 300 published papers on this technology.

He goes through them for 2 to 3 weeks. He calls me back. I don't understand, I don't know how this did, but. I do the punchline. Probably a little humiliating, but the point is, no, he didn't want a machine.

And no, he didn't want experts patients, sadly. But there you go. That's the punchline. But the point is, it cured this one man. Why? Because the liver already had the capacity to heal itself.

But it was inspired to do this by a 1934 discovery. I guess we don't really need a better mass trap. We already have. That's my. That's what I see. Well, I think liver disease.

You're obviously correct. I think liver diseases, the liver is very it's the most regenerative organ in the body. Right. Yes, absolutely. So you give it a fighting chance and amazing things happen after one treatment.

I do don't any more livers beyond that. Oh never never. And nobody else in that company either. It's it's you know, the public isn't surprised when I talk to the public about some of this stuff.

The because they understand the profit motive. They understand that everybody needs to eat, but that doesn't mean they like it, but they understand it.

That doesn't mean they're happy about it. And as a doctor, I'm not happy about it because I think that we're not doing our job well. I know that, one of the reasons pmfs are not more widely accepted in general and certainly in the medical community, and I've talked to several orthopedics, doctors I and also pain management specialists.

And they think it's a threat and it's a threat to their business. Oh, I absolutely agree. I absolutely agree, it's sad as it may be, but so the public doesn't benefit or the public's being harmed by the lack of the use of the technology that upsets me.

Well, and this is one of the reasons for this summit as well. It's to educate people in general who are not going to hear it from their doctors so that they can make their own decisions.

And fortunately, the technology is available without a prescription. Most of the time. All right. So we're going to have to bypass that hurdle of requiring a prescription because, if you go to a doctor and you ask for an a CC or an a

baby or, soft pulse, the doctors say, what are you talking about?

True. Right. Josh? Because they're not going to they're not.

Broader Applications, Access, and Closing Thoughts

And that's probably one of the reasons these companies have failed, because they're one of their big marketing campaigns, because some of the studies were done on this was post-operative pain and swelling following, reconstructive, plastic surgery procedures, primarily on their breasts.

So women have reconstructive surgery to their breasts. If they do magnetic field therapy after the surgery, they recover much better, much faster. And I've done the study, too, with, swelling.

People have reconstructive procedures to their faces. So if you have, bruising in your face after reconstruction or after plastic surgery to your face, PMF therapy around the face will take away the swelling and the bruising very quickly.

Within a day or two, it's you're back. You're back to normal. You don't have to hide it. Right? Yeah. Right. And for a few weeks, for that. But we're told that you shouldn't be using the dipoles around the eyes.

Have you had any experience that way? No. Well, I did, I it's funny because every night I go to bed, I use every coils all over my body at sites that I think are especially as you age, let's say fragile.

And one of them is I wear it as a crown on my head, which is well within the eight inch range of the field. And it's over my eyes. And my vision's never been better.

I don't know, it's it's very bizarre. I, I think this is the type of energy field that actually maintains the health of tissue if it's not there, corrects it because we're not treating the body as an electrical factory, which it is.

And that's because our physiology courses don't teach that the main conductor of electricity must be not the nervous system, but the blood vascular system.

And this was discovered by a very brilliant man in Sweet Doctor Sweden in the 80s. And he was shot them too, even though he was very world renowned. They would publish his work.

But for my technology to work the way it's working, he had to be right that we're that we're conducting electricity through bones and, muscles and blood and gore gases through ionic exchange.

We're we're just loaded with minerals and they are great electrical conductors. We don't need a wire. It's really interesting. I totally agree with you that the body is basically a battery inside skin right now that the cover of the battery is that.

Yeah, that's a good image I like. All right. So, I think one of the reasons that they talked about the eyes is a contraindication for the, for the dire pulse was largely because at that time, GI pulse was considered shortwave diaphragm.

Okay. And it was considered thermal. So therefore it could the risk is it would create thermal damage to the eye cloud. The lens and so on. Well, the FDA has now reclassified the diet pulse and the the 27.12MHz signals as a thermic know they don't create heating, they don't produce, they don't have their effects through the heating, action.

Just like true, dietary dyes. So it's not really considered dietary anymore. I am glad because we have to get away from thinking of it as physical therapy.

It's not. It's a whole nother field. It's something that deserves so code. It's, It's a lecture. It's an electrical medicine. Call it what you will, but it nobody's giving it the respect.

And, identification that it requires. And that's one of the reasons more doctors started. They knew that there was revenue that could be gained by during their patients.

Maybe they would switch. Well, again, that's one of the reasons we Doctor Polycom exists as well as it educate people that they have access to this technology on their own without having to rely on a doctor for a referral or even for guidance to a great extent.

And that's another reason why I wrote the book Supercharge Your Health with therapy. Right? Because now we have we have some we have some guidance on how to use it properly through it through.

That is true. Doctor channels. I can't tell you how much I appreciated, a chance to chat with you and get more of your history and what you've been able to accomplish at it.

95% cure rate for for pain. I wish we could all, experience that. And, so people I'm sure people will be going to your website. Do you have any other, references or any other information you could provide people?

The I think the original article on the website and all references and so forth. It's on your website. Is that. Yeah. They are actually the, the website purveyor was able to download the entire article with all the illustrations, graphics and so forth, which I love, because then you can understand and visually appreciate the magnitude of what we're doing and how simplistic it is, actually is.

If you think about. But, works better than all the garbage. Obvious. Got it said I be. But but oh, by the way, after publishing this work in 2002 with the highest publish cure rate and the longest of anyone on your plate in the world, do you think they're teaching this anywhere?

Do you think, that, I have I, I laugh at it, so level it's no podiatrist because, again, like most other doctors, many podiatrists, like their surgery.

So, you know, the the old aphorism to cut is to cure, right? Oh, God help us. Well, that's what I realized, that I was doing all the surgery, but I wasn't curing anybody.

I was treating a symptom. That's when I. I it causes more problems. Yeah. Yeah, potentially. Absolutely. Nobody ever talks about the significance of all the complications.

So yeah it's crazy. Well, again, thank you very much for taking the time to, teach us what you, took so many years to learn. Thank you. My pleasure.