A Revolutionary Pain Solution That Most Practitioners Have Never Heard About Transcript

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Introduction to Pain and Imaging

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 based our surgery on the MRI and the CT scan and the X-ray.

And 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 and the other areas, you find out the pain's actually coming from a peripheral subcutaneous nerve that had nothing to do with the imaging that we're showing.

So is it all right to have something wrong in the x-ray and then I have to be treated? Of course. See, this is the problem. Our society has become one of treating tests, not people.

We gotta get back to treating people. This is what pops up. This is Dr. Talks. Today's episode was previously recorded on the Pain Solutions Summit that I hosted.

Hello, this is Dr. Pollock. 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 Dr. Ira Shandles. Dr. Shandles is a podiatrist in Tampa, Florida, and he's a very enthusiastic person.

So let's welcome Dr. Shandles. And Dr. Shandles, 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 of Podiatric 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 just weren't paying any attention. And so this is the laughable part of all this.

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

Dr. Shandles' Background and Early Research

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

I know that's what they preach at medical conferences, but I think my standards are a little bit higher than that. So in my research, mysteriously, in 1986, at a 20th high school reunion, up walks a classmate of mine who happens 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 diapulse.

Keith, don't ask any questions. Listen to me. You buy that machine. You will see sheer miracles. Now, 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 my classmates were all academic and not over 90% of them go on to college. It was that type of high school. So this was a big deal. And he had that to say, he was felt so strongly about it.

He almost twisted my arm. He didn't have to twist my arm. He convinced me by verbiage. In came the salesman a week later, no joke. And he sits down. He says, I want to tell you about a machine.

And I said, I'll take it. Pause, pause, pause that thought. Pause that thought. Let's go back to what you said. Seventy five percent cure rate, right?

Seventy. Seventy. Seventy. Seventy five percent cure rate of what kind of conditions of the feet, ankles and legs pain permanent. I didn't know completely was permanent yet.

I would have said at the time because I was on the course of performing a 10 year follow up of three hundred and seventeen cases. and I would not publish until the 10 years were up because I felt that anything shorter than that would be invalid.

So 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. But when you 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 your treatment, then you're cured.

It's a game, right? So you and I as clinicians know that the cure, well, it may take the rest of your life to, in quotes, have a cure, right? Okay. So you were dealing mostly with foot, ankle, and leg pain issues.

What kinds of problems caused 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.

You want me to jump ahead and Okay, I'm going to go ahead. 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'm 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.

I'm really sorry to interrupt because I'm sure there are people who say, okay, pain, 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 in school. So what we were taught in school was tendonitis, right?

Inflammation, fractures, neuropathy, right? Arthritis, a whole bunch of stuff that sounded good, looked good on x-ray, which was inadequate, but they didn't know that at the time.

And even the MRIs are inadequate. Oh, at least the entire line of them. 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 listened to the words they chose to describe their pain, I said, these are not bone and joint words. These are nerve words.

So I said, and I always wondered, by the way, after finishing residency and surgery and stuff, that these nerves are so close to the skin. How can you walk the full body weight on these structures and not injured these nerves?

It's impossible. But nobody was looking at it. Nobody. So the ultimate. Oh, all right. Diapause. All right. Diapause now. So the Dipulse rep walks into your office, gives you 300 references or at least a 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, That 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 I said, 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 what I did that was innovative, I guess, is incorporate a combination of technologies. I used the PEMF to make my therapeutic injection, which was already in use for 60 years by that.

Well, let's see, at that point in the 80s would have been in use for 20 years, 25 years, let's say. And Will discovered and well-familied by a very brilliant physician in New York.

So I combined not cortisone injections because they're just a band-aid. I combined the therapeutic injection with the PEMF and oh my God, my cure rate 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 data.

He said to me, Dr. Sheath, do you realize how much less surgery you're doing him? And the truth was, it was true. I had reduced my surgical load by over 90% and I was curing more people than I ever cured before.

What's wrong with this picture? 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 speeds they charge for the use of the room and the anesthesiologist who got his charge, each of the make four times what the surgeon makes.

It's pathetic. So my job is to cure people. And I'm just going to go ahead and cure people. And the truth is, My revenues went up because I didn't have to waste time taking a day off to do surgery.

I was seeing many more patients. They would have to stay curing every one of them that walked into the door. It was a very enjoyable way to practice. I think that's very unsatisfying, making everybody happy.

That's so incredible. Okay, well 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 then we'll go into the rest of 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, Diapulse.

Discovering the Diapulse and Improving Outcomes

Are you tired of living with chronic pain? Medication only masks the symptoms, but real healing starts at the cellular level. I'm Dr. William Pollack, the leading expert on PMF therapy.

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There is no equal in the world, in my opinion. Well, we might have an argument about that, but let's live with your assertion. I mean, with my limited knowledge of the field, OK.

OK, so the diapulse, the phenomenal piece of equipment. So let's go from there. You started using the diapulse. Yes. And the patients were coming in with 50 to 70% relief of pain with just one treatment using the same technology I used before and the number of treatments went down to an average of one to three to get cured and maybe as high as one to five.

but they were cured. At that time, they had to come into your office to get treatment. Correct. Because this is a big machine and it's very expensive.

It has a great big head on it, right? It's got a big arm, and you have to apply it directly to the spot that you are treating. Only treat one zone at a time.

Right. All right. So you started using the Dipulse. When you started using the Dipulse, did you use it by itself? Or did you still combine it with your injections?

Always. Well, when it came to the therapeutics I'm referring to specifically, I was combining it. And we know that it can be applied to the injected area three hours before or up to three hours after and 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 it's such a bulky heavy machine, I had one room dedicated to the PEMF.

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

15 minutes. Now I do know from parameters it could be as little as 10 minutes but we always wait for the 15 and we know that beyond 15 was just building the loading based on the technology.

All right so you right off the get-go you started using the Dipulse with injections or did you try Dipulse 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 diapulse.

All I wanted to do was augment it so my cure rate would jump up to 100% if I could. Okay, so 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 last. They cause their own problems. So what was your injection?

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 either developed in New York or California.

I have no idea why it's always those two places, but one of the medical colleges in New York City was a Dr. Marvin

Steinberg. He was very bright in podiatric medicine, because of his depth of study into the relationships between Internal medicine and their presentation the lower extremities very interesting man very bright he Determined and I do not know how I don't think ever published He just taught that if you take a mixture of vitamin b12 liquid A tiny, and I'm telling you tiny, almost inconsequential to most clinicians, amount of long-acting soluble corticosteroid.

Well, he was using, actually, I can't really think you can get it anymore, but it was only two-tenths of a cc of steroid. But 90% of it was vitamin B12, and lastly, a little bit of lidocaine, whatever you choose, lidocaine.

So I figure you got a formula we know works, I'm just going to use what he used. Because all the students I've met in my travels that were using his formula were having tremendous success in their offices.

And I figured that's my job, cure patients. So I use Steinberg's formula, and later on reduce the corticosteroid to a tenth of a cc, because I realized I didn't even need two tenths.

It's almost an insult, but for electrochemical reasons, there's a good reason to use it based on what we know now. But in any case, B12 is the main ingredient.

So you were still using a tiny amount of steroid. I was insecure about taking away what Steinberg discovered completely. I'm insecure of it, but I have had cases where people were allergic to the corticosteroids, and I just used the straight B12, and I can't deny they also cured.

Why did you stop using the steroid altogether? I could. When? Or you're still using it? Never did. I hate to let's say contaminate an already good system by inserting my own.

All right, so we are using a tiny amount of long-acting steroid and a fairly substantial amount of B12. Yes. But the B12 you're using, which form of B12?

I know, I've been asked this before and the truth is always use the standard cyano cobala bean. I know there's a lot of people arguing about cobala beans.

Well, in my hands, this ad and cobala beans got me up to a 99.9% cure rate. So truthfully, it's the vitamin C or vitamin C produced by any manufacturer.

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, how much cyanocobalamin were you 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 a thousand milligrams per CC. So it's a little over a thousand milligrams a month supply.

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

Okay. Surgical residency did not 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 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 wasn't bone 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 elicit, if you will, the actual response from the nerve.

And my first tool that was published was the number two lead pencil with the eraser. Worked very well. But it's kind of fragile. It doesn't work when you go after a sciatic or some other nerve that's deeper, so to speak.

So I had to get a book. So later on, we developed our own 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 don't know where that phobia came from. I kind of do, but it's, it's wrong.

All right. So let me clarify just so I understand as well. So what you did is you took a lead pencil, you use the eraser side of the lead pencil. I'm glad we clarified that because people are going to say, well, you were jabbing the person with the lead pencil.

Sure. That's one of her. Okay. You use the eraser side and you were basically in a sense palpating or you're 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 gotta be the spot. Had no way to image it at the time.

It was all by touch and patient response. So I marked it with a 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 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 it. So it's a process. And that could take two to three injections in order to get all the pain. That is absolutely correct. Fantastic.

Okay. So that's the part that you were doing before you got diathermines, 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'll take back that. All right. So now the diet pulse. Yes. So you said 70% is not good enough. 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 we're going to medical conferences and I'm hearing 70% and they're happy and I'm laughing.

So after reading all the papers and listening to my classmate who swore by this technology, I started to incorporate 15 minute diapulse after every injection case.

So you do your injection first and then you do the diapulse right after. Now 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 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 a workhorse boy.

It got a lot of work in my office. So you never let up after that. It was only ever combined the two. Always. Absolutely. So why do you think the dipoles made such a big difference?

Finding Pain by Touch and Targeting Nerves

Peculiarly, of all the reagents known in the medical science, a study was done in New York, again, using B12 as a reagent to see how it would be absorbed with and without the dipole specifically.

This was coincidental. I knew nothing about this study. I read it later. Well, they showed that we inject B12 and we assume, I love that word, I'm gonna use that a lot in future lectures, like everything we were taught.

So then we assume it's being absorbed into the bloodstream, into the body. Well, they found out in New York, it wasn't. It was sitting in the tissue using radioactive tag B12 and a gamma camera.

They could trace the B12. It would sit in there unabsorbed days, weeks, maybe longer. And so where was the therapeutic value? As soon as they applied the diet pulse equipment, the B12 was taken up by the tissue 100% in seconds.

Seconds. What's wrong with this picture? Now, that's neural tissue or regular tissue? What was the study? It was regular tissue. Correct. They were using, like you would do a B12 injection to a deltoid or, you know, a thigh muscle or something.

Right. Yeah. So from a regular tissue perspective, it was being absorbed much more rapidly. And conclusively every time if you use the diapods. All right.

So you said, well, if it doesn't for regular soft tissue, what about a nerve? Yeah. I figured the translation would be a hundred percent. Of course it was.

And my dad approved that. All right, so then you started with one or two or five or 10 people, and then you went crazy. I wanted to cure these folks. I mean, I thought if I was the patient, I'd like that consideration, so why not cure them?

All right, so then you actually wrote a paper based on your experience with how many people using this combination of approach. 317. Followed for 10 years because I didn't want to publish before I knew that it was actually permanent And the paper the data was collated by us army research physicians along with by residents of the hospital and we had a cure rate of almost 95 without surgery the other uh, four point something percent went to surgery and were cured that way, but The truth is 95 were cured without surgery by combining the ejection and the diapulse.

Now this was for neuroma, right? Actually, put nerve damage because 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 neuroma of the metatarsal areas of the ball of foot.

And we were taught about tarsal tunnel syndrome, much like carpal tunnel and the rest. Unfortunately to the diapose in my injection, they don't care where the nerve is.

They cure it all. We cured carcel tonneau with it. We cured neuromas with it. And now I can image it and you see them just dissolve away. It's the most amazing thing.

The neuroma dissolves away. Completely dissolves away. You have a normal image once it's all done. Well, what's the cause of a neuroma? that involves the other cure that was developed that is non-PEMF.

We'll get that. The cost of the neuromas, this study did show that all this nerve damage, neuroma, tarsal tunnel syndrome, all of this stuff, feet, ankle, and legs is due to abnormal foot structure, which we've known about since 1960 from the work of Merton Root at the California College of Podiatric Medicine and the University of California College of Medicine, San Francisco, where they did the anatomic studies and it's cookbook.

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 who are my patients? The 80% that were born with 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 a durability because of the change fabricated materials available.

Now they last 10 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 it's true. Scientifically, yes, it is not an easy subject to understand. It's called biomechanics. And you have to be able to envision how the body moves in three dimensions.

And apparently a study was done, I was later told, And 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 it was cured.

I wanted to master it. So that's the other part of my practice is biomechanics. You did the biomechanics. Everybody gets biomechanics anyway. You took care of the pain problem, the sort of immediate need, right?

And how do you prevent it from coming back? And there it is. But it worked. It all works. Okay. Well, podiatrists are supposed to limit what they do, right?

By the bards, the regulations and so on. 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. Some conditions of the knee were actually allowed to treat when they're related to the foot, which we found out the University of Pennsylvania Sports Medicine Center is quite considerable.

But still, you're right. I'm not doing a menacectomy, and we're not working on internal parts of the knee. Correct. All right. Being the innovator and renegade that you are, you went astray.

Little bit. Tell us about what you strayed into. Okay. Oh my goodness. Well, I figured 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, uh, I was able to continue my research on other kinds of cases and they truthfully, It's a breeze to cure anything above the waistband.

I'm going to tell you, they don't put body weight on their hands. So that could explain why I was curing carpal tunnel. Maybe one treatment cops too. I was curing so-called tennis elbow.

Is that a misdiagnosed condition? Maybe one or two 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 to cure. And then I had a five year follow up at five years, some kind of standard, but he couldn't believe he walked out of the office with no pain.

He couldn't believe it. 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 based our surgery on the MRI and the CT scan and the x-ray. And 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 and the other areas, you find out the pain's actually coming from a peripheral subcutaneous nerve that had nothing to do with the imaging that we're showing.

So is it all right to have something wrong in x-ray and then I have to be treated? Of course. See, this is the problem. Our society has become one of treating tests, not people.

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.

Absolutely. Right. They got the diapulse and the injection until I was able to replace the diapulse. Why did you replace the diapulse? There were two problems with the diapulse other than the bulkiness.

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 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 ABV. So that's. IVV, IV, IVI. Okay, so the IVV has the same signal. So the signal in the diapulse, let's explain that signal a little bit.

So the diapulse signal is 20, 21 point Hertz, what is it? 27.12 megahertz. 27.12 megahertz, that's the carrier signal. Correct. And then that carrier signal is then pulsed at a lower rate.

And that varies from equipment to equipment and study to study. But it can be upwards of, say, 300 to 600 cycles per second or pulses per second, right?

Correct. So the IVV came along. You had diet pulse people selling you IVV machines instead. Which shocked me. But I'm looking at this thing and say, now this could go.

The audience is going to want to see this. If it works. Now I'm a purist, I'm OCD, being a surgeon before being a 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. And I said to him, I mean, I know this is new technology. I know it's supposed to replace the dipoles in your eyes, but I 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 cure rate had jumped to 99.9%. So there's something different in the signal.

Same 15-minute treatment cycle, right? Correct. Now, the diet pulse, the IVV, the diet pulse is a big machine on a cabinet, on casters that you have to roll around, right?

Your IVV machine was the Roma. Right. Yes. That was a Roma that I'm still using today. Correct. How, what does that look like? Oh, that's about what the body of the machine is so lightweight.

It's a blue color about maybe a foot in diameter, maybe two, two and a half inches thick. It has three external male 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, eight inches of width in signal.

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

And so I said, this thing I could sell. This one I can lecture about and say, hey, look, this is the newer version of the old technology and has adjusted applications in cure as was the old.

So I have no reason to go backwards. I will go forwards with a 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 diapulse when I got it was $10,000 in that time.

By taking my diapulse in trade prospectively with the proviso, well, if it doesn't work, we will give you back your

diapulse machine. We respect your work that much.

Biomechanics, Orthotics, and Preventing Recurrence

And so they discounted 10,000 off of the Avivi at the time. So it could be fine. And I said, well, that sounds like a fair deal. If it works, I'll get a couple of them.

I'll get more than one. And as the story goes, it did. And I tried to acquire his name as I could over time. As you know, the Roma, there were several other IVV 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 a Torino. Yes, that is, that's interesting. That's true. That was the word they used for the original disposable version of the IVV.

Yes. Well, what's happened with IVV? Well, even though in 1990 I met with their chief scientific officer at IVV and I explained to her that what she had in the Roma was so incredible that they need to really market it.

In 1990, of course, my article wasn't published yet, but I have clinical results that would be useful for them in marketing that would be helpful. Apparently, they didn't believe enough in the Roma that they actually discontinued manufacturing 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 your machine, the Roma was also used a lot, was marketed a lot for nursing homes, for wound management or skin management. Which is the way diapulse was going, but you know, it's awfully bulky.

But the VV was portable and each you have a clip so it 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 the Roma, and you're lucky enough to have the older machines available. Yes. And now you said that the technology shifted to disposables, right?

Correct. And they would cost how much? At the time the Torino came out to a doctor, it would be $180. Now they created a new generation of the same exact equipment maybe a little bit better material and just about doubled the price on it.

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

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

Your body was designed to heal, but illness, chronic disease, stress, injury, and time can slow that process down. What if you could restore your body's natural ability to recover, recharge, and feel its best?

The key to healing is giving your body the energy to repair itself. PEMF therapy does exactly that. recharging your cells, improving circulation, reducing inflammation, and helping you function at your best.

For decades, I've studied this technology, worked with hundreds of medical professionals, and helped thousands of people reduce pain, regain energy, and take control of their health.

However, not all PMF devices are created equal. No one size fits all. We offer personalized consultations so you can find the right device for your needs, backed by real science and trusted results.

If you're ready for a real solution, let's talk. Schedule a consultation at drpauluk.com. That's P-R-P-A-W-L-U-K dot com, because real healing starts at the cellular level.

All right. So unfortunately, what happened to Ivy? Out of business, as far as I know. Out of business. Yeah, they stopped business. They did a lot of studies.

A friend of mine, a colleague of mine was actually one of their researchers, Dr. Arthur Pilla. Oh yeah, I remember him. You remember him? Yes, yes. He was in the literature.

God, his name was bandied about a lot, I guess. Yeah, he did a lot of the basic science research on the signal. Interesting. So I've even went belly up or basic stock production.

They were actually 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.

And so the soft pulse has 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. And one of the principles of the IDD ended up developing another company called the Assisi.

So the Assisi, like Francis of Assisi. The Assisi is a pet device. It's marketed as a pet machine. That's what I saw on the day. That's what I saw on the day.

Now, the coil is smaller because it's really for smaller animals. What I don't know is whether the intensity in this case is not just the peak PMF intensity, which we talk about in terms of Gauss or milli Tesla.

You often talk about wattage. So the wattage of the the dipulse was pretty high because it was plugged into the wall, right? It used current to power it.

And the Avivi, the new Avivi, the soft pulse and the Assisi are powered by batteries. Interesting. They're small little batteries. 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 treatments. I'm sorry, 50 to 70 treatments.

And then the battery basically dies and then you have to replace it. It costs like 300 plus dollars as well.

Expanding PEMF Use Beyond the Foot

Like spare parts. That's the legacy of that technology. So people are interested in trying this technology. You could try the Assisi, although they do ask you for the name of your veterinarian.

Oh my gosh. So right now, I think that we are kind of in a hiatus, unfortunately, with this technology, which is, I think, tremendous technology. So people can still buy the loop coil from Softpulse.

So it's S-O-F-P-U-L-S-E. And it's still available, although the company, again, has shrunk down substantially with their investments. And they spent a lot of money and have not been able to really grow the company.

establish a good product so 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 podiatric device this is not just a nerve device right this technology has been shown to the wounds right as you said brain treatment sprained ankles so swollen sprained ankles it's fantastic against the diva yes True.

And that's one of the, it is actually, it is FDA approved. So the soft pulse does require a prescription. The FDA has

classified it as a schedule two, not drugged, 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 soft pulse. Interesting. So because it is 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 other clinicians, non-podiatric clinicians? Well, let's talk about podiatric clinicians. Obviously, if people want to come to Tampa, you're still seeing patients.

Yes. Right. So give us your website, please. Oh, yes. It's Dr. I. Shambles, Dr. So Shandles, spell Shandles. S-H-A-N-D-L-E-S, drishandles.com. Do you know other clinicians, other doctors, orthopedic doctors who are using this signal?

Oh, absolutely not. This is the problem, which is something I think you talked to me about. I've lectured to the orthopedics department at Tampa General Hospital on this 20 years ago.

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.

My discoveries are converse to what I was taught, where the damage really was. I was taught to shoot the X-rays, I was taught that. 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 one of the few they don't train us on, I had to take my own training, get my own training, get a certified course up in New York, interestingly, by one of the medical colleges up there.

And then when I left the courses, was that all there is? He said, yeah, now you got to do them. And it's true. 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 creating now the first atlas for ultrasound in the foot, ankle, and leg ever published, because there are no images.

There's nothing standard to these people. The only thing, neuromas, yeah. But what I've seen, carcel tunnel and the cyst that grows, it's amazing. Just amazing.

Now, not everybody has access to Dr. Shandles, not everybody has a podiatric 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 to you, 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 all bents what i'm doing But let's say like you say if you just had pain or swelling or something like that was not like threatening Why not?

use it. Why not try? The beautiful part, it can do no harm. So if it works, what have you found? A cure without drugs and without dangerous treatments.

Now, unfortunately, in looking at the science myself on the IVV, well, that's not so much the IVV, but the science on the diapulse and that particular signal, 27.12 Hertz.

You know, I asked you at the beginning, what's special about this 27.12 Hertz? you said it's the FCC 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 That's not to say that there may not be other megahertz signals or other signals.

Absolutely. And of course, my experience with PEMFs is most PEMFs 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 PMF signals. But I have never seen studies comparing other PMFs to the dipole signal.

So we don't know what the comparison might be. Now, when you treat your superficial issues like the foot, the ankle, 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 I have documented, is documented, and the punch line 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 one of my, when I had a satellite office, it was in Brandon. So they drove from Lakeland to Brandon. He was referred to me by a liver specialist. And he was being tested regularly for his liver levels because they really want to try to keep him out of the deathbed.

But the point is referred to me for a metatarsal fracture on one of his feet. So I asked, I said it, I did what I'm supposed to do. And of course I had the old diapulse machine at the time.

So this for you might be of interest. So I treated his foot, but diatmos always told you, treat the liver at the same time, because the liver can act as a storage battery.

It will bind the electronic charges, the negative electrical charges, just like a battery would. And when the heart beats, of course, the red corpuscles go through there, and we do know I guess Guyton must have had this because I knew this, that each red corpuscle had a capacity to carry two extra electrons.

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

So I did that that day. One treatment, 15 minutes, lift the liver and foot. The liver specialist calls me from Lakeland one week later. He said, what did you do?

I said, I did his fracture and I put the diapulse here. The man no longer has liver disease. He is totally healthy. What did you do? So he made me send him copies of the 300 published papers on this technology.

He goes through them for two to three weeks. He calls me back and understands. I don't know how this did it. But the punchline is probably a little humiliating.

But the point is, no, he didn't want a machine. And no, he didn't want a service agent.

Roma, SoftPulse, and the Future of PEMF Devices

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 absolutely 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.

One treatment? Have you done any more livers beyond that? Oh, never. Never. And nobody else from that company either. It's no, the public isn't surprised when I talk to the public about some of this stuff.

Cause they understand the profit motives. They understand that way 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. Cause I think we're not doing our job. Well, I know that one of the reasons PMFs are not more widely accepted in general, certainly in the medical community, and I've talked to several orthopedics doctors and also pain management specialists, and they think 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, is to educate people in general who are not going to hear it from their doctors so that they can make their own decisions.

Unfortunately, the technology is available without a prescription most of the time. right? And 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 Assisi or an Avivi or a soft pulse, the doctor is going to say, what are you talking about?

True. Right? Generally speaking, they're not going to, they're not, and that's probably one of the reasons these companies have failed because 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 the 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 a study too with swelling, people have reconstructed procedures up 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 We'll take away the swelling and the bruising very quickly within a day or two, you're back to normal.

You don't have to hide in people for a few weeks. But we're told that you shouldn't be using the dive pulse around the eyes. Have you had any experience that way?

Well, it's funny because every night I could, before I go to bed, I use the ABV three 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. This is very bizarre. I think this is the type of energy field that actually maintains the health of tissue. If it's not there, it 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 Sweden, Dr. Sweden in the eighties, and he was shut down too. Even though he was very world renowned, they wouldn't publish his work.

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

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.

The cover of the battery is the skin. That's a good image. I like it. I think one of the reasons that they talked about the eyes is contraindication for the diapulse.

was largely because at that time, diapulse was considered shortwave diathermy. 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 diapulse and the 27.12 megahertz signals as athermics. They don't create heating. They don't produce, they don't have their effects through the heating action, just like true diathermy does.

So it's not really considered diathermy anymore. And I'm 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 its own code. It's electric. It's electrical medicine. Call it what you will, but 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 curing their patients. Maybe they would switch.

Well, again, that's one of the reasons we, drpawlik.com 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 referral or even for guidance to a great extent.

Closing Thoughts on Healing and Access

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

That is true. Dr. Shandles. I can't tell you how much I appreciate a chance to chat with you and get more of your history and what you've been able to accomplish at a 95% cure rate 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?

I think the original article on the website and all the references and so forth. It's on your website, right? Yeah. Actually, yes. The website purveyor was able to download the entire article with all the illustrations, references, 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 actually is if you think about it.

But works better than all the garbage I was taught. It's sad. I mean, oh, by the way, after publishing this work in 2002 with the highest published curate and the longest poll for anyone on heel pain in the world, do you think they're teaching this anywhere?

Do you think that I laugh at it? I just so laugh. No, podiatrists, because again, like most other doctors, many podiatrists like their surgery. So 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 am causing more problems.

Yeah. Potentially. Absolutely. Nobody ever talks about the significance of all the complications. Again, 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. Thank you for tuning in to Doctor Talks. We hope today's episode has enlightened and inspired you on your path to optimal health.

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