Introduction and Dr. Shahu2019s Background

I try to avoid anything that had an ectopic pregnancy because we know that a lot of eectopic pregnancies or any pregnancy losses are due to some kind of chromosomal aberration.

That's the most common reason that you have that kind problem. So do you really want to use a cell that has potential chromosomo aberrations? I would not.

and I would have injected it to me or somebody else. And I always say that's my litmus test. Would I take this product and inject it into myself or my family member?

And if I wouldn't, then I'll do it for a patient. If I didn't I'm not injecting it in anybody. We're diving into the latest breakthroughs in telomeres activation, stem cell exosomes, and all the cutting edge science that's shaping the future of healing and longevity.

Let's get started. Hi everybody, this is Dr. Ed Park. Welcome to another Recharged Biomedical Podcast. Today we're very fortunate to be joined by Dr Shah and he's going to tell us all about what he does and it's gonna be very, very fascinating.

Thanks, Dr Shaw. How are you? Thank you, thank you. It was great to meet you in Vegas at the Stem Cell Conference and I'm glad we are still in touch and very honored to on your podcast.

Thank you so much. So let's get everybody caught up. Who is this gentleman, this handsome guy? He went to school at McGill for his medical degree and then was trained at Michigan interventional radiology fellowship, neuro intervention and pediatrics.

Anywhere you have a problem, he can get a catheter there and culturally help you, right? Yes, whatever needs to be kind of guided in with some imaging guidance.

Yes. Amazing. So the man wears an apron, it protects his thyroid. He's got fluoroscopy. Let's dumb it down a little bit for the lay person. Sure. In life, we have the body, heals itself most of the time it tries.

We have surgeons that cut you open and They can heal you that way. But then we got this third option for the last 30, 40 years where they can thread something usually through the groin and it gets to pretty much any end artery.

I guess sometimes you got to go through a heart, right? Yeah. So sometimes we've done, I've transseptal punctures myself actually going through, actually through wall of the heart.

And I remember when we started doing a TAVI, like I was working with some guys and they were not, the cardiologists were really not used to puncturing the muscle.

Us, we had done, We punch everything, including the brain. So we, had to train some of those guys and they had got some training and then we have to do some work with them.

But yes, going through the heart sometimes. Yeah. If we are, if we. We can do that too, especially going into the pulmonary vessel. so if I want to, do anything, pulinary arterial injection, I will go through.

The heart actually, what we call the right heart calf, go, through, the venous side, IVC, and, then thread through heart and get into pulmonary vessels.

You know how we used to float swans? So let me dumb it down further level. So the people who don't know, the

heart is in the middle and it pumps blood out through the arteries and receives deoxygenated blood from the veins.

Interventional Radiology and Catheter-Based Procedures

It's a roadmap. And so as the artery gets smaller and smaller out to your kidneys or your fingertips, they turn into capillaries and then they perfuse the organ.

and they come back as venules and bigger veins back to the heart. And that's somehow Dr. Shaw can get in there and he can to your end organ. So particularly useful in this day and age, they've got these stroke protocols.

If you're within a time window and you have what's determined to be an embolic clot, meaning there's a clot blocking the circulation in your carotid or your brain, your circle, He can get in there and either remove it or he can lice it.

Either way is good. So is that, that's one of the great applications of what you do. Yes. Change stroke therapy completely where people now present with a dense, we call it dense hemiplegia, where one part of their body is completely paralyzed.

And you see on the table as we remove the clot, and usually we have some kind of different graspers and different ways to remove a clot. As we do that you can see their, their bodies starts moving.

And they have feeling. And this is my assistant who just delivered me a coffee. Thank you. That's great. Okay. I mean, that's really a miracle. But you know, also, we talked about end organs like the kidney.

The kidney is not the easiest thing for a surgeon to get to. It's very traumatic. but I suppose in the future, if we have specific therapies, even directed bespoke cancer therapies with, let's say, microRNA or what have you, We can get to the pancreas, we can to get the kidneys.

What are the other home runs in interventional radiology in your mind? Yeah, exactly. So for tumors, even now, what we do is we ablate tumors with a wide variety.

We have something called nanonife, which is an electroporation, where it opens the cells up and the cell, a lot of all these electrolytes, the gradient is disturbed and electrolyte is flooded and cell bursts.

So we do that nanonife. We do, of course, radiofrequency ablation, which is a heating element. Microwave, also a healing element, we cryoablation for freezing tumors, and now, microwave ablations also, so these are the ways that we can destroy tumors.

And now because we have our regenerative capacities, We can actually deliver cells to regenerate. So for example, in the brain, so we've already done the animal studies.

We've done some human studies and we're now, we developed a prototype catheter where let's say a patient has a large hemorrhagic stroke, which is, um, if you know, uh, from the, there's a good studies in good data on the Austrian countries.

So, you, know the far Eastern countries where stroke hemorragic, stroke can be up to a 70% mortality rate. and a 90% morbidity rate. So that's a devastating illness.

And what we can do now is we actually, we could drill a hole into the brain, into skull first, do a durotomy where we cut through the dura, that leathery covering layer, and then we'll put a catheter in and through that catheters will drain the blood out.

That saves their life, number one, but then there's some damaged brain there. So what we do is we will actually through that same catheter, we have other side ports, will inject stem cells and we'll also do photobiomodulation.

And so what were doing is as we're coming and taking the catheters out, were actually healing that part of the brain. So that's, you know, especially for me, a big focus of mine is brain health.

and as you can extend lifespan and longevity guys are doing that and extending people's lifespans. But if you don't have the neurocognitive abilities with that lifespan, there's no use of being a nine year old if can't think and you cant be productive.

So let's explain what you just explained in a little more obvious way. So if you have like say a clot in your lungs or, I mean, in, your heart, like people have AFib or you.

A clot. In your neck. Yes. Occlusion or a downstream thromboembolism that is a stroke protocol with TPA might be sufficient to open that up. But if it's deemed that.

interventional radiology gets called, you can go in there with baskets and rotorouters and actually remove the clot hopefully without any fragmentation.

Correct. But the scenario you just described is like a subdural hematoma where the compression from let's say an AVM bursting or something will actually cause the brainstem to herniate And then you can die from that very quickly.

So you'll go and suck out the blood and then do some photobiomodulation and put some stem cells, no exosomes. Yeah, of course. No exo-zones. My protocol is always stem-cells, exozomes, and secretome.

Okay. You're not concerned about the allogeneic issue as much? Yes. Yeah, so no, I am concerned, and that's why we try to use placental exosomes, or other exasomes which are from a umbilical cord.

Because I think that the, you know, as you and I know the MHC compatibility antigens are usually not well expressed initially early on. That way, that why the female body doesn't reject the fetus, otherwise it would.

So by using those kind of early, early cells, there's not a high rejection rate. I don't worry about that much of an antigenic response, but that being said, Despite that, and despite there being very, you know, immature cells and even exosomes, there still can be a response.

And I see that response when I inject intrathecally. So when we do an injection into the CSF space, because as you and I know that's not a really intracellular space.

It's only a cellular space when it becomes pathological. And so when we do intrathecal, you always see people have a meningitic type picture and they have headache and you know, typical occipital pain and it may even get febrile.

And we know that's just a reaction to the body not accepting too many cells being in that space. Yeah, that's why when I do intrathecal, I only use exosomes because they have less variables, right, with the NHG, but also the micro secretome, anything can go with immunogenicity.

So typically, intratecal I don't usually get a reaction.

Stroke, Hemorrhage, and Tumor Interventions

But all right, so let's talk about what you do now, just to contextualize your US brains, but you practice in Dubai in the UAE and also in Las Vegas, correct?

Yeah, and Malta. Oh, Malto, okay. And Mexico, sorry. My God, you got everywhere. So you had to go through licensure for all those places? Yeah. So, yeah.

The Maltese license, it was a European license. Took a little while for American. They're not very friendly to

Americans, unfortunately. That took a long time.

Dubai license is very quick. If you're American boarded, you get it's an automatic almost licensure. Then Mexico, initially what we did was we would operate under a Mexican doctor's license and we had to, of course, show them all the protocol, what were doing and make sure they agreed with it.

Because I speak Spanish, so I got a Mexico license as well. Oh, great. So you're at the forefront. You're in a very good time in your career. I see you publishing a lot and there's demand.

How are people finding you? Is this just word of mouth? I know there is a street in Dubai where they have all these clinics. What's been your way to acquire new patients?

Yeah, so I would say everything you mentioned, all of the above. So we get patients, a lot of patients through word of mouth because patients have had good outcomes and they let somebody else know.

I could tell you for our Hollywood community, there's a friends of mine that, that deal with a lots of celebrities or, or celebrity known doctors. And if, if they find there something that I can help with, they will then contact me.

We do have Instagram. we have all our social media. LinkedIn, Instagram, Facebook, and TikTok social medial channel. And we try to, you know, try and give good information to people and kind of science information so they understand what they're choosing, what their getting into.

And then podcasts like this, and then meeting other doctors at meetings. I get a lot of referrals from other docs just because some of the stuff that I do is a little bit more rare and there's not a lof of people that are doing it.

So that, I mean, then we, general advertising. It's mostly social media and podcasts and word of mouth. You have a sort of thing I didn't really fully understand, but it's sort like a concierge service in aging.

Tell me about that. Yes. So we try to focus on longevity, everybody does longevity right now and all these functional integrative and other kind of doctors with all of these different initials behind their name are doing longevity.

But it is mostly measuring biomarkers and then giving some kind pharmaceutical product. You know, I think that's medicine 1.0. We need to go to medicine 3. or 4. I say, you know Peter Ahti already talks about medicine, 3, so I said, we'll make it medicine 4 point.

So that where you have interventional regenerative practices to regenerate and restore organs and function. And I, think as you, and I know cause we're in the field, this is the future that we are not just, making people live longer, but we want, if they're going to live long, or we went their heart to be younger.

If they're going to live long, we want their brain to be younger. If we're gonna live longer, want the bones and the musculoskeletal system to younger so that they are capable, functional individuals and not just, you know, they have a long lifespan.

That's not really great. We talk about health span and healthspan, I think, has to do with using the tools that we have for regenerating organs and cellular tissue.

Yeah. So you, you're doing fine. You have multiple places where you practice. And one thing that we kind of touched upon was the Muse cell that's become popular in the last couple of years.

Yes. For those who don't understand myself being one of them, I guess Muse was discovered in Japan and then it's licensed. It's a subtype of the MSCs or mesenchymal stem cells that have.

a certain marker on them so they can be identified SSEA-3 and then they have this resistance, but more importantly to stress, they could be trilineal or because they express the Yamanaka factors they become any cell

line.

The thing that's not clear to me and I wish you could you know, explain it to me is number one, it seems like these are a normal subpopulation, like queen bees are to the bee colony.

So I'm wondering if it's something that people can actually enhance or provoke. Because that's what they're selling for, you know, 30, $40,000. And as far as my patients coming back and give me feedback, I don't think it's been materially that different, at least in the clinic, from just stem cells or exosomes.

So you can take the position that this is a breakthrough. explain to me how it is that you're really making more mucels for the client from their own cells.

Yeah, so that's a great question and as you correctly said, you know, the stem cell lines are multiple and muce cells are just a small cell population and depending on where you where you sample from bone marrow or fat or other parts of the body, the dental pulp, for example, there are a higher subpopulation of mu cells.

And as you correctly pointed out, they do have that ability to form any of three main lineages, your endoderm, mesoderma, ectoderem, and they can. The difference between them and MSCs is we believe and there's good anecdotal evidence and some experimental and scientific evidence that they also engraft.

And, you know, we used to think that MSC is engrafted and then we realized, no, they're more like construction managers. It might be in the middle, like a sub-population may actually do the engravement.

Yeah. Yes. And so, and what I want to say, one thing, I'm not loyal to any specific mucel company. Now, Dezawa cells are a brand, DMC, right? They're specific, their cells.

I think, that they have a market and they do charge a lot. Some of the patients I know, I have to explain to them sometimes they're like, Dr. Shaw, why is it going to be $30,000 or $40,00 and you have do three treatments?

And I'm like this is why and here and this. But I think the future of mucels, because we know that they work and I, think again, they, work again because of exosomes, right?

I mean, the muce cell also, yes, and the ones that can engraft, but again they are also giving signaling. and their signaling, again, is always through the exosomes.

And so what I find is the mucous exo zones actually create a bigger effect because we did some initial trials with just muce cells themselves. As Yous correctly pointed out, we didn't always see the greatest effect.

But when we had mousse exotomes, and sometimes we also added, sometimes, you know, placental exozones. Placental excosones, as I always tell patients, and other practitioners, the placenta is the source of all life.

When you get that initial one cell zygote, that's when the spermatozoa and the oocyte combine, and that cell has all the information, it has the DNA, but it doesn't have any of the structural growth factors nor structure to build more.

And where does all that nutrition and regenerative support and signaling proteins and transduction proteins come from? Comes from the placenta. And it comes from placental blood.

That's why you have two veins in an artery, because you're delivering a lot of cells to that growing fetus. So I always believe that, you know, as I said, I'm not loyal to any specific company.

And I think what you're going to see, and you might have talked to some of the guys at the meeting, there's, at least two Chinese companies and I know three American companies that are now developing autologous mu cells.

That's what I was really driving at. Like how can you do that in the course of an afternoon? Like, or even without clonal expansion, but even with clonal expansion.

You know, if we just go forget all this stuff, whether it works or not, like just, go back to sort of principles, right? So we'll talk about stem cells and you know the nineties, and they were using embryonic stem.

Cells have that potency that rhymes with new cells, then the problem. is teratoma formation because they have that ability. So I had a friend of mine who was pitching me and I know a colleague at the conference was using these brand of ectopic derived, eptopic primacy being of course a non-viable fetus, that line of exosomes.

But I'm thinking if it's not really an embryonic development, it retains too much potentiality. So intuitively it makes sense. Mu cell axons would be strong, but perhaps it is too early in, you know, ontogeny to sort of use those.

Maybe they're too powerful. I don't know. What do you think? Correct. No, so I agree with you. Number one, I try to avoid anything that had an ectopic pregnancy because we know that a lot of eectopic pregnancies or any pregnancy losses are due to some kind of chromosomal aberration.

That's the most common reason that you have that kind problem. So do you really want to use a cell that has potential chromosomo aberrations? I would not.

and I would have injected it to me or somebody else. And I always say that's my litmus test. Would I take this product and inject it into myself or my family member?

Stem Cells, Exosomes, and Immune Reactions

And if I wouldn't, then I'll do it for a patient. If I didn't I'm not injecting it in anybody. I've seen complications with mucels. We had some cells which were called muce cells and we used them and at that time I had to babysit eight patients in a Mexican ICU.

because they all got a little bit of a complication. It was not, luckily it was, not a serious compliction and everybody did well. But, you know, it, was an inflammatory picture where the Mexican ICU docs started with sepsis because there's a septic marker called procalcitonin C and, and that's one of the very, very sensitive markers to sebsis.

And so these patients pro-calcitonine C started like just shooting up and the mexican ICU critical docs were all like, Hey, Dr. Shaw, this is a, sepcis, we're going to start antibiotics.

and I'm like wait, stop. It's not sepsis and I can't prove it yet. I'll prove to you guys later that it's no sepis. But understand this is just an inflammatory reaction.

It happens with certain types of cell lines. Mu cells are one of the cell line where you can still get inflammation. And so I had to stop them from giving antibiotics because they wanted to give broad spectrum antibiotics.

Well guess what? That's going to kill the whole gut. And the gut microbiome, as you know and I know, and Dr. Sabin talked about at the conference, the guts microbiomes and the brain axis, cardiac axis and gut immune axis is a very strong part of hormesis in the body.

And once you upset it, you can cause a lot of bad complications, one. Two, You will not allow the stem cells to do their job. So I had to stop them from giving the antibiotic.

Then slowly the procalcitonin C started going down, but some of the other inflammatory markers like CRP and ESR were still up. And they're like, okay, now we have to give steroids.

I'm like no, don't give the steroids because that's always going to mess up the stem cells that people have paid a lot of money for and they are expecting a result and an outcome from it.

So please don' do that. And I can tell you it was a big tug of war. Yeah, that's tough. I mean, ethically, if I was with a Mexican ICU attending, I would be like, yeah, not so sure about this.

But yeah. Exactly. Luckily, all's well that ends well. You know, the thing of it is you brought up some interesting points, one of which, you know is that immune competency or at least some kind of regulation is part and parcel of how these regenerative therapies work.

Correct. So when I look back and people ask me why are 20% not happy. A lot of that, they have too much stress, too many adrenal fatigue. They are on biologics for some autoimmune condition or they're on steroids.

So having an intact immune system to play along is important. But, you know, when you only have a hammer, everything looks like a nail. Although I'm trained to do stem cells and I've done them, I kind of stopped.

I had one patient with chronic renal disease and gave her because the son-in-law had bought 30 million allogeneic stem cell. And I combined them with exosomes and the poor thing got COVID at a family gathering and then got C.

diff colitis from the antibiotics. Yes. So in that case where she was chronic kidney failure, she's so immune suppressed that I don't think they have to tell them to do any good and they actually push it into an untoward complication.

Yes. So I a hundred percent agree with you because what we do and I have very well-developed protocols and it's over 12, you know, I've been doing stem cells and regenerative medicine for over 15 years and our protocols have developed over that time.

And so what always do is, as you've correctly surmised, You have to prepare the patient. You'll have prepare to the ground. you're not going to plant a seed.

I always tell people that, these are seeds that we're planting. The stem cell are seed, the exosomes are a seeds and the secretome is seeds. And if you haven't properly watered the ground, it's not properly fertilized before, you can throw a seed.

It's, not going to grow. Uh, and there's no point in doing that and you're wasting your money. So we, we have protocols where we do photobiomodulation to the patient, to, uh, product and we prepare them with peptides.

We prepare that with nutrition, sleep. And we told them, listen, your sleep has to be improved. Cause remember sleep is when you regenerate, right? That's when your recuperate and regenerates.

in repair. Melatonin, we think of it as a sleep hormone. It's not a sleeping hormone, it happens to do that, but it's really a regenerative hormone or regenerate product.

So it makes you go into sleep mode and sleep a lot and repair yourself. And if you've ever seen a wild animal, because I like watching those wild animals documentaries, when a animal gets injured, what does it do?

It doesn't have access to an emergency room or a clinician to help them. They go to a water source They lie down in a quiet, secluded area of the water source, they keep drinking water, and they just sleep.

And they sleep for hours and days sometimes. Guess what? Their body, because they're animals, probably because of natural evolutionary mechanisms, can repair much faster than us.

They do. It's amazing. I come from a religious background, we believe that for every illness, God has created some kind of cure. And we believe that scriptural saying.

And I believe it exists. I think 90% of our antibiotics come from some type of plant or fungus or other compound. They're naturally derived. Why do nine pharmaceutical companies have labs in the Amazon?

Because the amazon is a great pharmacy. And they discover things all the time. But, you know, more importantly, we know that within ourselves, We have the ability to, as you mentioned, and you said at the beginning of the podcast, the body always tries to repair itself.

You know scarring, whatever, things that happen in the, body that look like they look, like their negative healing mechanisms are not necessarily negative.

When the scar develops over in his laceration afterwards, fibroblasts come in and they start repairing it. Start repairing underneath the scars. The scar is protective actually.

So the scar will protect, and then the skin can actually come together. And guess what? It becomes very strong at that point. Yeah, I think you're right.

I was watching a stem cell podcast yesterday about this digit regeneration, right? So in the humans, the tips of the fingers can, to an extent, if it's not below the nail, regenerate.

Whereas if you cut off the tail of a salamander, it can regrow that. So all these kind of latent programs of development. But you know, I'm not a smart guy.

I've never read or done a Western blot, but my intuition often guides me to a very efficient answer. So I think that a lot of what we're doing with these exosomes and You know, by proxy, the stem cells is transiently allowing for de-differentiation of local stem cell niches.

And whether that becomes a true blastema, like they said, you know. Or this, I wrote about, and I forgot what it even means, but this epi. Epithelial mesenchymal transition goes back and forth.

There's like secret switches that can trick the cartilage cells, the nerve, swan cells. It's being primitive, but only for a time. And so the Balxian bargain, as with senolysis, is always, you want these things to turn off.

You don't want to just unregulatedly turn them on, right? So that's why, despite not really understanding how exomes work, I have a great confidence in them.

And that's like, when my friend tried to twist my arm and use her ectopic exosomes, I'm like I, just scared, you know? Do you agree that it's doing a transient de-differentiation?

And maybe even the mule cells, like a cell population will go in and graft, but I am not sure that anybody I go to these exome conferences, stem cell conferences.

I don't think anybody is really fluent in the language of cell biology yet. No, a hundred percent. I think that the inner mechanisms of what happens at the cellular level, because we don't do a lot of intercellular testing, right?

We test blood. We're basically testing plasma. So we use those very indirect signals to try to make some grand sweeping assumptions. And we know the whole thing about assuming.

As you said and correctly said, the body has these intense, Simple things like the hormone axis and women's having a menstrual cycle. You know how highly regulated that cycle is?

It's amazing. you have a master gland in the hypothalamus and thalamis and pituitary and that axis so that the thalamo pitutary axis is working and then give signals to other endocrine organs which then decide and there's your genetic organs and your ovaries and it all comes to be a very regular, in most women, a fairly regular period.

And it's all very carefully balanced. And that hormone axis we've at least studied. But I think, you know, we're going to keep on discovering things about cellular biology in the future, as you're correctly mentioning that, there's on and off switches, even Yamanaka factors, and guess what?

The body prevents those becoming tumors, right? We're not good at it, but the body's excellent at, right? The body knows how much long, so how long exactly to let the chondrocytes produce the exact amount of cartilage you need for the joint.

I mean, you know, we're talking tolerances of one millimeter or sub-millimeter tolerences, Right? You know engineers don't use that kind of tolerance that the It makes perfect and then it's balanced on both, both joints, right?

Two separately complex systems that form the same amount of bone, the similar amount cartilage, same amounts of laboratory. I don't understand, like there's full other meta theories about electrical fields and stuff.

Muse Cells, Placental Products, and Safety Concerns

It's probably way truer than what we, because why would people have similar, you know, Symmetry, why would you have symmetry unless it was predetermined in some way by the morphogenic field or whatever?

Yes, I believe that. So I use electric medicine. I used electro medicine a lot. You've probably heard of the Reif machine, but now there are much more.

And you know, the right machine was seized by FBI. Well, it's interesting. I was at the Asprey conference a few weeks ago, and I turned to this newbie and said, you know, most of this stuff is kind of not that effective.

But in 15 or 20 years, maybe the photo modulation, the frequency will be understood better for specific instances. I just got a frequency generator. We'll see what it does.

And I bought a PEMF machine based on my experience of it. Now let me ask you, I, just, my mom has had a slipped disc for the last three weeks. So I helped her somewhat with the epidural exosome injection.

Yeah. On the Pemf machine 10 days ago and it, it caused a gout flare or it happened the night before the gougt flare. But if you're running a cramped machine at low power, can that cause untoward effects?

Like, you know, the person who sells it to you doesn't really say that. No, but so understand, we, and you and I know we often have to interpret what our salespeople are telling us.

And there's things they're not going to mention. So any type of electromagnetic energy spectrum machine is carefully balanced, even photobiomodulation.

We know that if we give too much photo, and I do intravascular photobio-modulation with the endo laser, where I actually put an optical fiber into the vein, within two minutes I have most of the blood circulation irradiated.

But again, you can overdose. So just like we know everything is dosing. And dosing is very, very important. Even with, even with exosomes, you put too many exasomes in a, in, uh, joint, or you've put to many exit zones in certain place, You will get a…

you may get bad reaction. And that happens. The body… Well, I mean, it helps her gout. You know, her Gout is like five days later, 80% gone. For me, It was pretty much hours for another patient.

his husband, it was pretty immediate. But everyone, yeah, everyone's on a different spectrum. So the PAMF, maybe I shouldn't have thrown that variable in there, but I think your point is well taken.

It's also a dose response thing too. Yes. No, and the doses, remember, we can't use a stupid pharmaceutical model with their pharmacokinetics for cellular medicine.

it's just not the same. Like, they need dosing models and they have first or second or third or pharmacogenetics where they can see how much the dosage is going to affect a large population.

Well, as you were talking about cellular machinery is much more variable. And each person's cellular machine is more valuable. I always say you have to keep on making micro adjustments.

Like the Japanese talk about Kaizen Engineering, where they do small microscopic improvements until they get a

final product which they're happy with.

I agree with you, but you know, when we're at the conference, they talk about photobiomodulation on stem cells to make the exosomes more productive. I think cells are truly, we are alive.

They have all the machinery and the intelligence. So I really think that not only the known conditions of the medium and oxygen and CO2, also vibrations, light, I'm sure they respond.

Why wouldn't they? They're living things. When I was in Mexico, my colleague got her bone marrow aspirate from her iliac crest and then she took the SVF or whatever it was, the extract and put it to a Korean machine that was like red, yellow, green.

Is this hoka? Is it bullshit? But apparently everyone doing it says it's not. So do you also access the light technology post-extraction and pre-reintroduction?

I do, yes. And I'm a big believer in photo medicine. I think medicine 4.0 is going to be involving photomedicine, regenerative and cellular medicine, electro-tome, right?

So the electro medicine which is many different things, whether it's resonance, PEMF or some other type of electrical stimulation. And I think it is a combination of understanding all those factors.

Those factors occur naturally, you've heard of grounding and people taking their shoes off and walking on ground and there's changes and we know and it has been measured that those patients have a different electrical charge now.

And wearing clothing like linen and sleeping in linen has an effect, a positive body effect and this has been measured. And so what we're learning more and more about our environment is there are all these environmental factors.

To me, light is the big one, right? Because understand, the Greeks and Romans had solariums, The Incas, Aztecs, Mayans, Sumerians, Chinese, whatever culture you want to go back to and see, Light was often used as medicine.

Before we had antibiotics, Even in World War I, they were using photo medicine to help treat patients. And the 1905 Nobel Prize was won by a guy named, just forget his name, I think it's Christensen, but he discovered that he could use light therapy for non-pulmonary TB.

So, you know, in manifestations, lymph node manifestations and using light therapy, he could actually cure those patients or at least treat those patience with active mycobacterium that are dividing in their body.

And guess what? The light would work. I think obviously what I've seen light has many different effects, very immune, so immune regulatory and usually in a positive way.

Then of course, working on all the other secreting factors in the body, including nitric oxide. reactive oxygen species, all those things that we know that there's a balance between inflammation and treatment.

And you know, that's how prolotherapy worked, right? They would create a very focused injury, with the dextrose. That dexrose would then call in the immune cells to repair it.

I'm sure, of course, mucels were part of that subpopulation of the cells that would come in and do the repairs. By doing proliferative therapy, they got amazing results with dexterose.

Dexterous in a joint. It's really, it's amazing. But yeah, I remember a year ago I had a fellow tell me his story how he was a paratrooper in Vietnam and he really badly hurt his hip.

It wasn't until he fell off a roof in New England. 20 years later that it healed. And the only thing that he injured again,

and he did his own prolotherapy, right?

He bled. He had a hemarthrosis, which caused stem cells and exosomes and regeneration. So I thought that was funny. That was something I would recommend to somebody to do, but happenstance seemed to just go.

Look at that. There's two of the Olympic swimmers. I think Michael Phelps might've been one of those other guy and they were using hijama. Hijama is cupping and cuping therapy has been used all over the world for many years, right?

I mean, the Chinese are experts in ancient cuppying where they do it with, you know, lit candles and all kinds of… Yeah, but understand what you do is you create a focal localized inflammatory reaction.

And then guess what? The body responds. How does it respond? Through the immune system. My big thing is always try to use the body's innate mechanisms for healing because they're much better than whatever you and I could create in a laboratory.

on every level. Another big focus of mine and a passion of mind is oncology. And I can tell you the number one best chemotherapy agent in the world hands down beats everybody else is your immune surveillance system.

Right? It picks up on mutations in minutes. Like, you know, like you and I both have 8 to 10, this is measured, 8-10 circulating tumor cells, right? Mutated cells which could eventually become a tumor.

They're circulating in our body.

Photobiomodulation, PEMF, and Regenerative Prep

And guess what? The immune system recognizes them. The antigen presenting system recognize them, says this an abnormal cell. I think people didn't really get that message the first time around in the 80s where AIDS presented as Kaposi's sarcoma, right?

AIDS itself is immune suppression. And they're from so many different cancers. Yeah. Oh yeah, and the COVID vaccine may have unearthed some. I had one guy with a retinal Melanoma that came back after 15 years and took his life.

You know, so the immune system is your number one or two. I, for me, it's, you know cell suicide via P 53 and, yeah, I mean, cells are always killing themselves.

That's the number. But the new system was a close second. Yes. They're the natural killers of cytotoxic T cells, but they have also an anesthetic response to previous tumor loads.

That's why a thousand years now, people will consider destroying stem cells with chemo to be somewhat barbaric, like bloodletting. Anyway, I think if we had the wherewithal, if I go to the stem cell conference and They've already cured diabetes with IPS pancreatic cells into the rectus sheath.

I mean, the things they can do now, they play God quite literally, de-differentiate and create any cell type they want. So I'm going to clue your audience into something that's going, it will hopefully blow your mind also.

You told me this story about the billionaire clone kids. Yeah, I already know. We would not get in trouble because Zoom is owned by a Chinese company.

But even more so the Japanese, what Dr. Shao was saying that he heard of a guy who cloned himself and has like five copies, which is a good plug for my graphic novel, Maximum Life Spent, where these scientists did the same thing.

There you go. 1200 scientists. And it was a pitch, a study out of Kyoto. Would it be okay to do IPS sperm, IPS egg?

we'd be okay to fertilize them, we would be ok to gestate them we'll be OK to birth them and the public opinion was 25 25, 25. 25 and it was their country that was xenophobic and why Japan for Japanese yeah make Japan great again that's yeah Right?

So we'll see. I mean, I'm on the internet, they're feeding me like mansions in the countryside for $20,000. They have a real demographic collapse, along with South Korea too.

Yeah. No, and I understand, just like we know, so this is a known fact, right? If a billionaire wants to create a nuclear weapon, then they can do it with the required resources.

The same way, if a millionaire wants a cloned body to get a new kidney or a heart or new lungs, It can be done. We know it can. No, in my graphic novel, that's what the future billionaires do.

They have cloned copies and they lobotomize them, but they're not fully lobotomized. So the zombies rise up. Anyway, fascinating conversation as I knew it would be.

Tell me why it's pro-vastin. Is that something you kept? Yeah, so that was when I was involved. I used to work for a pharmaceutical company long when i was on the dark side.

As a young college graduate, I was just working for them. But at that time, there was a drug that we were trying to develop. It was not a statin, it was actually a erectile dysfunction drug and it called Provastin.

And so everybody else, you know, the project got abandoned because it didn't work as well as we wanted it to. So it got defunded, but I kept the name Provestin so I use it for my emails.

And it reminds me of my failure, right? So, you know, we failed on this thing and it's a continual reminder to me that, just like we talk about dextrose and causing a little bit of reaction.

So I see that name for us and I'm like, You know what? We didn't do it and why did we do that? I always think, what were the things that we could have done to improve and maybe and gone?

Absolutely. I mean, success has many mothers, but failure is an orphan. I think we don't learn so much as when we bail and that's whenever I go to these conferences, I'm astounded by it.

You know, when I went to a Google ventures thing, they were saying, well, You're judged by your failure. Tell them about your failures. But not everyone really takes that seriously.

They always flex by saying, oh, I was publishing papers for five years and I totally wrong about this one thing. That's their flex. The other thing now they're saying oh we're using AI to create hypotheses, which is really scary.

Who knows? My nephew is going to computer programming school. They say even the programmers at Berkeley can't get a passing grade because they use too much AI.

Right. And we're becoming, and understand we were becoming dependent on it and even our phones, you know, before me and you, we remember seven digit number.

When you were kids, We knew we could do it. We could rattle off 20 numbers that we memorized. Nowadays, most people can remember their phone number themselves.

Sometimes they can. Remember their own phone numbers. I'd like to get to copy. What is your graphic novel already? Yeah, yeah, it's called maximum lifespan.

It was translated into 11 languages, but I think my Hindi translator didn't do a good job with the article adjectives and I had two of them. So, by the way, It's kind of, a funny story because the guy, if it was just like 20 years ago, I tried to think how are you going to cheat death?

So the one, he invents a commercial telomerase actuary, which I told you I've been taking for 18 years. Right. Secret spoiler, because nobody has ever, I can't literally give it away.

He cloned his two sons, one into a pure protozoan mitochondria transfer. And the other one did half human, half proto zoan. Couldn't receive the death suicide thing.

So basically gave him infinite lifespan. Spoiler alert, because no one's ever going to read it. He used brain-computer interface to transfer his consciousness and swap them.

Wow. It's kind of a fun story.

Longevity, Cloning, and Philosophy of Consciousness

Anyway, I'll leave one interesting story, so I work with this billionaire and I cannot talk about him because he's very ultra, ultra secretive. But he said, you know, these guys have access to knowledge and sometimes scientists that we don't always have to.

And he says, in the future, we're going have a choice. as human beings, we'll have these kind of avatars, body avatar, fully created, and we can just implant all our thoughts, memories, ideas, experiences into that avatar and then live in that new avatar.

The problem is, as the cyberpunk genre has already explored, the problem that there's a ghost in the machine, right? And not just epigenetics. Right. It's just the host never gets fully erased.

That's a good thing and it's about things. Koreans are on my top and going down this path too. But yeah, it is a very interesting thing. So it really comes down to a philosophical question of where you think the spirit and the soul lie.

Yes, where do the souls lie? Do you localize and do you thing it material? Because those are really quite limited world views, I think. No, I think there's a, like you, there is a community consciousness and our souls are connected into that community conscious.

And then I believe it connects to a higher power and that higher powerful communicates to us with dreams and intuitions and coincidences, which I don't believe in the word coincidence.

So we get messages all the time from that high consciousness, and from our community conciousness. When you and I see It doesn't have to do with—there's a visceral reaction.

When we see a child getting hurt by war or famine or whatever, there's viscereaction inside of us that I think is part of that community consciousness.

And that's why me and you kind of went into medicine, because we want to help people. That's our goals. Well, that's a great note to end on. I knew it was going to be a fun talk and you did not disappoint.

So again, thank you so much, Dr. Shah. We appreciate you and your wisdom. And really, congratulations on a very interesting career. You're a pretty wildly distributed, so you may need to clone yourself to Mexico and Malta.

Yeah, I'm going have, you, and me, we'll have to cone each other for sure. Yeah, well, I know you have a lot of family responsibilities, so you'll have to be in multiple places.

So all respect to you. I will let you go. Thank you so much. If they are in UAE, or traveling through, how can they connect with your practice? Yeah. So our main kind of header is Brockwell Healthcare.

There's a Brock well healthcare group. And so we have all the affiliated clinics. Anybody who looks at Brock Well Healthcare, they can find the Instagram, TikTok, Facebook, all our social media is there.

May I ask what brand of Exosomes you've been trying or using or? So I've used, and I'll tell you, because in Dubai, the field was relatively open as far as the regulatory pathways initially.

So, I have used everything. And so I use placental exosomes. I used musexosome. All the, all the major, uh, RegenBio, or Regenscel, Xcel. You know, you know I, don't even remember all of the names now anymore.

Yeah. It's sort of a prejudice against lyophilized. Because I think the viability is good, but not great. But even more so stem cells, like people don't routinely check the viability of thawed cells.

So you never know how good the quality is. There was a great article on LinkedIn recently where they showed what a lyophilized cell or lysosome or exosomes looks like.

All the signal transduction proteins on the outside, some of them are deformed through the lyphilization process. Right, so that less sufficient docking and incorporation.

Correct. Yeah, correct. That makes sense. All right. Well, we can get more nerdy with it, but I think we've hit our limit. So again, thank you so much.

And Rockwell Health, rockwellhealth.com. Okay, great. Yes. Alright, Dr. Shah. Thank you. Many clinicians are getting interested in exosome therapy and they hesitate for good reason.

Questions like, does this work? What forms do I need? How much should I charge? how do i stay out of trouble? All these questions are addressed in my online course.

That's why I created it to help you get started. The online Course is your permanent turnkey resource to get start either treating yourself, friends and family or to expand your practice and help more people as well as increase your revenue.

Thanks for tuning in to the Recharged Biomedical Podcast. If today's episode got you thinking, you'll love my book, Exosomes, Songs of Healing. It's packed with cool analogies, full color illustrations, and all the science you need to understand how exosome are changing the game in aging and regenerative medicine.

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