The Hidden Drivers of Chronic Illness: Mold Toxicity, Infections & Root-Cause Healing Transcript

(Transcripts are generated by AI and may contain errors)

Introduction and Dr. Latousu2019s Background

All right. Well, welcome to the Table Talk podcast. I'm here with Dr. Liam Latous and he is a naturopathic physician and so we've had a couple other naturopaths on the podcast as well. And so, um, they just really are able to see things from a different perspective. They do a lot of similar training to our conventional providers, but also get this expanded sort of functional holistic view um, that we all talk about all the time. So, thank you so much for joining us. And um he is also going to be a speaker in our program that's upcoming on March 2nd. So, this podcast may be out after that on the table talk platform, but we're going to share some of these tidbits prior to the program um on our social media as well. So, um so if you are looking for that, it's on our functional medicine CE website and we'll have recordings up there. So, even if you miss it on March 2nd, it'll be available. So why don't you just start by giving us a little bit of background on you know how um today our topic is chronic infections but how did you get to that point a little bit about you know what you were seeing in your practice? >> Absolutely and thanks for having me on this um >> I've always had a fascination for the unknown and so there you know from a very early age always kind of thinking about things in a you know through looking at things from a wide lens and trying to uncover things and putting my detective cap on. So, I think that was just inherently something I've always enjoyed. Um, I was on track to first pursue physiootherapy. That was a passion of mine. I've always been involved in fitness and and rehabilitation. And, um, as a kin undergrad, that's kind of standard issue. You look to get into physio. I had to take a uh hit pause after undergrad. My mom was dealing with a very unusual neurological presentation. It ended up being undiagnosed for three years. um she was working with countless neurologists here. We finally uh made a trip overseas and were able to receive a diagnosis, get her stabilized on the appropriate meds and come back kind of just navigating that. I started to think about moving into medicine and and conventional med and and started to put applications out. But through her healing journey, we were exposed to a host of of what we would consider complimentary and alternative med into way out into left field into wild energetic medicine and just very things that we were very open to and interested in, but were certainly broadening my horizons. And it was kind of wild. I mean, she had a spontaneous remission at one point following um an energetic medicine treatment. And I I just kind of stopped in my tracks and said, "There's so much more to this healing process, and I need to kind of just take stock of what's happening here." And I wouldn't say luck, but but it was very um serendipitous that a friend said, "You you need to look into naturopathic med." I had no idea what it was. Got into that. It was one of those situations where the doors just open. And I feel very, you know, grateful and blessed to have kind of been able to be oriented towards it because it's it it's allowed me to serve this demographic well. And so when looking at a situation like my mother's where she was undiagnosed and dealing with this very unusual complex chronic illness, I think that's what planted the seed. And then in my um naturopathic medical training, I did a specific focused internship in chronic fatigue syndrome, fibromyalgia, multiple chemical sensitivity, which really, you know, um uh reinforced the understanding that this is a very underserved patient population. There's so much we can do to offer and it's not these lightning cures, but there's so much we can do to help. and uh getting into practice, I just found that the universe brought all of these folks to my doorstep.

>> Yep. It was kind of destined at that point. >> Right. So, describe those people that are coming in. I mean, fibromyalgia is almost like a diagnosis of exclusion in a lot of ways for people if they don't have other autoimmune symptoms. So, what are they hearing from the conventional side? Like what is the person that walked in your door being told by their conventional provider about conditions like that?

>> I mean it's it's one of the upsides is that the stigma around it being just a psychological pathology and a psychosmatic presentation. We're finally able to shift away from that. Patients are seeing rheumatologists. They're doing >> you know investigations that don't typically like you said it's a diagnosis of exclusion. So, we're not looking at inflammatory markers or a key diagnostic marker on lab that will diagnose it.

Complex Chronic Illness Symptoms and Assessment Framework

But at least it's being more appropriately validated in a conventional medical setting, but generally speaking, it'll start with patients being told that they're stressed or that they're fine simply because lab markers are normal when they're working with their primary care providers.

>> Those primary care docs that are maybe a little bit more familiar with this presentation or recognize that no, there is in fact something going on here. um will be more proactive in getting them seen whether it's internal med or right to the rheatologist, neurology, wherever they need to go. But at the end of the day, um patients are still left with very few answers. They're often not validated. Um they're typically prescribed some form of an anti-depressant, >> obviously pain meds to try and manage the pain element, but there's so much that's missed. So, it's moving in the right direction from a validation perspective and a and a broader understanding, but it it's really disheartening to see how patients are either um you know just left stranded or inadequately managed.

>> Yeah, absolutely. So, when we do you want to talk like all together about like your approach as far as this person's complex illness or specifically like hone in on fibromyalgia and then the different ones? Um I would well in my practice under the umbrella of complex chronic illness you know fibro one you know one one segment of that so >> chunk of it >> right so I would say the >> there tends to be a lot of common threads when we're looking at complex chronic illness so what I would say is we can maybe look through that you know look at it through that framework and then maybe >> wiggle wherever we need to with these specific pathology >> sure yeah so when someone comes in I guess describe like the symptoms that someone might have that are, you know, in this complex chronic illness bucket. >> The so broad >> generally speaking, right? But generally speaking, we're going to see some degree of fatigue. I have patients that are bedbound. I have patients that are functional fatigued, right? Functionally fatigued where, you know, they get through their day, but they are not they're surviving. They're not thriving.

>> Um, we're going to see some degree of cognitive impairment. So brain fog, difficulty with word recall, memory issues, um with the fatigue, just to double back, it's generally not improved with sleep, right? So this is nonrestorative sleep plus the fatigue. >> And then we're also dealing with some degree of pain or inflammation. So I should say inflammation. So >> typically that'll come out as pain, aches and pains, general general muscle aches or or more, you know, specific joint pain. But that inflammation can really play out in any way, right? So where is that fire burning and that's what we're going to see. So is it coming out more in someone's skin? Is it affecting their digestive system? Is it coming out more from a neurological perspective? But it's kind of the fatigue, the the cognitive challenge and and the inflammation that can be so varied. And then you know we we'll say it's vague multi-system symptoms, right? Because >> Sure. Yeah. you know, my my intake form is about I think it's gone from 21 pages to over 30 pages now, but it's because we can capture so much, right? And >> most times I try to cap the the primary health complaints on the intake form to five, but usually there's an appendix that's like a laundry list of things because Yeah, it sucks. There's so many things that people can deal with, but it centers around those core three. >> Yeah. And I know a lot of functional medicine providers get some of these patients in our practices too. And your presentation that you're going to be giving um next weekend is all about like that roadmap to the assessment and figuring out you know where to focus for that patient. So talk to us about that roadmap picture. Yeah, it's um when you're dealing with a situation where there's so many moving parts, there's so much uncertainty, we often don't have definitive labs or or labs that will definitively diagnose this pathology, you really do have to start to think about either lenses or some kind of framework to to view this through. And so when I said there's common themes in the world of complex chronic illness um irrespective of the specific presentation you know two people have >> we're looking at a genetic predisposition.

So you know whether it's you know grossly reflected in the family history or not there's some degree of the genetic element that that may predispose someone to that presentation. We're looking at the environmental trigger or triggers that then, you know, shift the the the system into the state they're in or or kind of exploit that genetic susceptibility. That could be physical trauma, mental emotional trauma, um infections, toxicant exposure. Sometimes it's really clear. It's like one acute uh event and here we are. I had mono. I was never well since. There was a car accident. Never well since. Went through this nasty divorce. Never well since. Other times it's really insidious and and and subtle and you really have to to do some strong detective work to kind of put those pieces together. And then there are the modulators. What's turning the dial up or turning the dial down on the intensity of the symptoms and the disease state kind of dayto-day. And so we're starting to think about it in terms of what are what's fitting into those three kind of buckets to to start.

And then as far as going a little bit deeper in the process, what's really helpful is to start to think about in the world of functional med kind of physical, structural, biochemical, and mind body. And if we can start to think about it in in that way, we can start to extrapolate information about well, what's led to this point and what's driving this process of basically nonresolving inflammation. That's at the core of all of this. And when we think about, you know, physical, structural, mind, body, and and biochemical, we're able to start to structure the treatment strategy. And there's a lot of moving parts in between all of that, but overarching kind of concept, that's really where we can start to make sense of this.

>> Yeah. Um and then within like the conversation discussing like chronic infections, where do chronic infections in like micotoxins, pathogens sort of fit in the picture when you're assessing these patients? Are there does every patient that comes in with this complex chronic disease get that a workup for all of those or are there specific things that sort of tip your hat to like okay this is more likely a mold presentation or a um you know lime or something else like that? So basically everyone at least from the intake process as far as intake and and questionnaires there's going to be the same screening that will flag to that and then the history taking process generally cover those spaces but everyone is being asked about their early immune history and this goes back to you know whether it was vaginal or or C-section delivery were there any birth complications were they a sickly child recurrent throat ear infections frequent use of antibiotics so we'll start the conversation you know that far track just to start to get a pulse on >> what was going on from a an early immunological tone or burden perspective. Um we'll we'll certainly talk about the big players whether someone had known mono at some point in their life >> and how did that affect them if they did was there many individuals say that they were you know bedridden or or you know significantly affected for several weeks sometimes months that's that's that's going to you know >> peak uh get the ears up as well. Um have they had water damage in their home? Has there been some flooding? Do they have visible mold? Is there a musty or mildewy smell in any of the rooms? Do they feel really crummy when they're in a specific space in the home and feel better outdoors?

Screening for Chronic Infections and Mold Exposure

So there there are certain questions that would would be used to to kind of flag whether there's a chronic infection. And obviously, you know, where we are asking about tick bites and and time spent out camping or in the bush or or do their pets come home with ticks on them, that kind of thing to see if there could be a vectorbor illness component. though that can as you know can often be very can fly under the radar for so many people. >> Yeah.

>> Yeah. Absolutely. Um and then along with you know you mentioned the chemical sensitivities is a big part of your practice. How um how do you address that? I mean obviously there's like detoxification and liver support and things like that but I think a lot of these patients at least I know within my own team when they get these patients coming in they want to do everything in the kitchen sink. they want to do detox and they want to do their gut, you know, program and, you know, and I'm like, well, this person just needs to go to like trauma therapy first before we can do any of this. Like sometimes it's just like I don't know how this person that's had several traumatic experiences in their life is going to handle a big plan. So, how do you handle that with these complex patients and taking this like road map like one step at a time and sort of getting the patient to like be able to, you know, respond well to each thing? Such a good question and and you're so right just to bring up that that trauma element too. So >> yeah, >> when there's an individual that is hyper sensitive to really everything, you know, that could certainly be because, you know, physiology is bunged up, detox capacity is bunged up because of toxicant burden and and chronic infections and this chronic immune activation and that cell danger response that you know can can be propagated by that process. But so much of it can come from just completely like aberant activity in in nervous system response and and you know that that limbic system that fight orflight system activation.

>> So when I'm looking at someone and they say you know doesn't matter what I had a patient come in and say she can't sleep when she takes vitamin D and she gets constipated. I'm like what? Like it's it's vitamin D. What's the carrier or what's going on here? And it is one of those people that, you know, looks at a supplement and it can blow them up. And >> so if someone is hyper sensitive, >> the starting point is going to be that lyic system retraining. We're really not going to get anywhere. We're not going to push the needle unless we're able to start to to balance out that nervous system's hyperactivation that comes from >> really that that that >> hyperactivated stuck on on nervous system response and trauma response. Yeah. So, you know, that would be a situation where we pump the brakes and we really just focus our attention on something like that. Other than that, if and and that's

often going to be incorporated in some degree. It's just do we need to, you know, stop stop everything and focus >> off everything else. Yeah. If mold is an issue, I found this in practice certainly the the mentors I've worked with and the advanced CES that that we do in this space. The general consensus is that if there's a mold burden and if we're dealing with this um genetic hypersensitivity susceptibility and and kind of this culmination of toxicants, but mold is one of them. We generally need to deal with that first. It's not always feasible, realistic for someone to get out of the moldy space to do a full remediation. So sometimes we have to think about how we're managing the exposure versus kind of eliminating it.

And here >> where we are in Ontario, Canada, there's not going to be a house without mold. It's just how are we managing things? Um, but mold would be kind of one of the key things that would need to be addressed before we can get into other toxicants. And then there's different schools of thought, but usually we would look at kind of mold, then kind of parasites and fungus, bacteria, viruses. That order of operations often has to be modified based on the specific presentation of the person sitting in front of me. But I would say at the very least, if there is a limbic system hyperactivation from a trauma element, that's p primary order of business. And then if there's a mold element, I find we're not getting anywhere unless we somewhat to some degree get a handle on that. Then we can start chipping away at those chronic infections and whether it's mono first or the parasites or fungal burden. >> Again, there's a a general framework, but often we'll have to pivot >> and sorry and sorry heavy metals because I'll forget >> I find the heavy metal component can open up a can of worms if we start to hit that too early. I know there are other docs that'll just jump into keelation right away. Um I I tend to look at that as one of the latter pieces. It it can be tremendously disruptive to physiology, but I find that if we don't reduce the chronic immune activation and start to chip away at the other things first, I find at least the nature of the patients I see and I'm the end of the road doc so they're usually not doing well. >> They can't handle it very well.

>> Yeah. Yeah. Yeah, I think chilation too is such a very specific thing and like ex you know people need to be working with experts in that area to be able to do that. And so for the general functional medicine practitioner like working on all the other things to help your body properly detoxificate before you would you know do something heavy-hitting like that is definitely important. Um coming back to the mold piece how with are you doing specific lab testing to evaluate mold and if you find it like what is your how do you determine your treatment plan? It's um and so like I said, most folks that I work with will have some degree of mold exposure. So I kind of come into it with the assumption that okay, there's going to be something going on here. We try and get a gauge on whether we're seeing this kind of massie presentation or something that might flag that we need to be a little bit more focused on that evaluation and I will typically look to have some kind of microtoxin assessment done via lab testing. Um historically I've relied on urine testing. And I know there's a movement now shifting more towards kind of serum testing. Um because I've seen time and time again with colleagues where you know they'll use the same urine sample, run it through two separate labs using the same technology from a urine miccotoxin analysis perspective and we're getting different reports and I don't like that and I don't really know what to make of that. Obvious for obvious reasons. Yeah. Um and so I know there's you know even just in the past week I saw a forum discussion around amongst colleagues around you know who's shifted gears towards the serum testing and what are they getting from that and >> so on the one hand you know I like the laboratory testing to help guide and influence or to help provide insight as far as the burden and what specific micotoxins are we dealing with >> but at the same time often the history can tell you a lot right and so I would say the the bread and butter is always going to be the the history and and what that tells you and and you know the patient's story. Um but I will use the lab testing and then based on that start to have the discussion around okay what what evidence do we have that there is in fact a mold burden in the home again was there water damage or leaking. I have patients who have kind of seasonal flooding, right? Every every spring, >> you know, their their basement is is getting um water infiltrated in from from the through the uh foundation and things like that. So, sometimes it's very evident that that's what's going on. >> Other times, a little bit less, but then I might move into more of a like an air quality screening in the home, >> right? To start to get a pulse on what's going on. And we have one particular individual in in the area here who's kind of the go-to guy and I'll typically refer to him and he'll do an ex exceptionally detailed investigation and then we know kind of what's going on. And I had a patient a young um a young female patient maybe 16 17 couldn't get ahead of her case and it was really nasty just as far as how progressive it was.

Managing Sensitivities, Trauma, and Mold Burden

um her urine micotoxin test and we ran it twice was clear but finally we're like this is this is a mold case like I can't

no matter how I slice it looking at you everything about this I got colleagues to sit in and it's like this is a mold case >> finally we did had her do the the um air quality testing and her aspillus levels were higher than anyone had ever seen and in her case and then we did some other testing and found that yes it was in fact kind of colonizing her gut and some other things were going on but Okay.

>> So, it can be a little bit challenging to navigate when when you're dealing with this situation where you hope for a lab test to be definitive, give you the insight, let's treat it. >> But long story short, it's not in the world of mold. >> So, you may have to approach it in a multiffactorial manner. >> Um, and then at the end of the day, you you sometimes just move ahead with empirical trials, right? I had her we shipped her out, we got her to go to what we believed to be a safe space for two weeks. Symptoms improved. She came back symptoms worsened.

>> We used binder symptoms improved. Stop the binder symptoms worsen. So you know >> you may have to approach it in this kind of multi- multi-layered approach.

>> But yeah so so >> we are looking for testing to guide um knowing the the intensity of that micotoxin or what that can do to the body will sometimes influence how aggressively we treat. But >> for some of these sensitive folk, you know, micotoxins are micotoxins, mold allergies, mold allergy, and either way, we got to do something, >> right? >> I think that's a good point because I find there's this whole like test don't guess piece in functional medicine where everybody's like, you have to have a test. You have to have a test. Like a lot of times the person sitting in front of you telling that story is able to tell you more than this lab testing can confirm. just we have amazing tests and I think like so of you know I think the same situation with SIBO and yeast like you could send your SIBO test to multiple places and and depending on what substrate you use and what they use like you might get a different result.

So I know some companies even stopped doing SIBO testing for a while in the function medicine space because they were like we're not getting the same reproducible thing every time like you're talking about. And then um and not that I don't use SIBO testing because I think when it's positive like you know with glucose substrate like okay yes like we've got it here but like the lactulose you know positivity is like you know got more false positives.

So, it's like, well, but looking at the whole picture, like, am I going to treat this person anyways because of the digestive symptoms that they're experiencing? And if so, is it even necessary to do this breath test and pay this money? Um, so I totally hear you. And I feel like so often, like especially new practitioners to this space are often like, I have to have the data. I have to have the data. But so much of what we do in, you know, functional medicine, you can hear along that story of what they're telling you and their experience and how the symptoms line up with that. So, >> and I'll explain to patients, you know, we're thinking, is the test accurate? Is it specific to your case? And is it going to guide treatment, right? And if it's not going to change treatment, >> you know, you may still choose, we operate in a private system, you know, you may still choose to proceed with it if it's going to help validate, provide some some objective feedback versus me just telling you. But you're totally right. You know, there's there's a time and a place. >> Yeah. Yeah. And I see that a lot with like nutrient depletions. Like I could tell someone they need to take vitamin D and a multivitamin, but until they see it on the paper that their levels are low, like that helps to validate, yes, I need to take this. and you know seeing the numbers helps them to move forward with a treatment plan or people with diabetes. I take care a lot of metabolic people like an A1C number or watching their CGM rise like drastically after their carbs, then they're like, "Oh yeah, I do need to do something." But otherwise, they feel no different, right? So they're just like and and I think too like functional medicine interventions often take a long time to really see the results because they're so used to instant gratification. This antibiotic got rid of my, you know, sinocitis so quickly and it doesn't happen that quickly. So like keeping along with the process, sometimes the lab testing is really helpful for that purpose, but making sure we understand that it's not the end- all beall of our treatment plans for patients, I think, is really important.

>> That's right. And and just to maybe circle back to something you said before when we were talking about keation and just, you know, that being a more advanced um you know, intervention and that kind of thing, but but just to pull back thinking about that in terms of testing as well, there's so much foundational work to do, right? And I find we we often put the cart before the horse because we can, right? We've got these tests. We've we've we're searching for answers. We kind of know, you know, from our perspective as practitioners, we have >> a broader understanding of what we can do. But yeah, there's so much just foundational things to do to even get into a position where the data we get from those labs can then guide treatment in such a way that we get optimal

outcomes. Right. But >> there's just Yeah. If we can just take a step back, appreciate just getting those pieces in place, ducks in a row, and you said it right. It's it's a process this this this world of functional med and and the work that we can do from a root cause or rootbased medicine. So, yeah, there's >> Yeah, >> it's easy to just get caught up in other things. >> Yeah, absolutely. Well, talk to us about those foundational pieces for you. What is it for you that like has to be like working well for a patient before you can even move into any kind of detox or mold, you know, um reduction or lime, you know, antimicrobials.

>> Absolutely. And you brought some of these points up earlier, but thinking about it in terms of again physical biochemical mind body starting with the physical or structural element in in Ontario and in Canada, we have osteopaths that are manual providers versus dos that operate in a slightly different setting. in the US, but you know, the vast majority of my patients will automatically get a referral to see a manual therapist of some kind that works. Yeah. >> Not just on, you know, stick it where it hurts kind of medicine. Really looking at what can we do globally to support >> fascial tone recognizing that no sception pain signaling in the fascia is multiplefold greater than what we would experience elsewhere in the body. And no wonder everything hurts cuz your fascia is stuck from all of these scars and this physical trauma and dehydration and not enough fruits and veggies and flavonoids in your diet. And so looking at a manual therapist that can help kind of support >> just mobility and and and and flow within kind of the fascial body. A manual therapist also has the ability to support that autonomic nervous system regulation whether it's craniosacral or something gentle that can start to get the vagus nerve balanced out a bit.

>> Um basically thinking about the body you know starting out >> normal and coiling up over time and we want to provide messages to the body to gradually uncoil it. you know, >> yes, >> the body remembers the original blueprint and we can work with manual providers to help facilitate that work. So, >> yeah, >> that's somewhat handsoff in the sense that, you know, you're seeing a provider to support that, but >> passing it on to somebody else. >> There'll be some homework.

>> Yeah, I I love that because I actually have an OMT appointment this afternoon after this call. Um, I have been a big fan of osteopathic manipulation. I worked in a clinic um with DO providers and it was actually a residency training program. So they were teaching the other the residents how to do proper osteopaths and they would always need practice subjects. So I was a practice subject for several years but it's so important. And I mean, even in babies that are coming out of, you know, the uterus and they're all coiled up because they've been in there so tight, like, you know, we have these collicky babies, they do so well with OMT and just being able to help relax their body and get their spine back in alignment and the muscle structures. So yeah, it can help with feeding and I mean even from the early days of life. So yeah, from I always am referring to whether it's some kind of physical manipulation, you know, whether it's OMT or chiropractic um in the US getting >> getting people's bodies in balance because you definitely see I mean it's crazy like even certain points in the spine like if that is out you have heartburn, right? >> Like and I know exactly like all of a sudden I have heartburn. I never have heartburn. I go in and she's like, "Yep, this I can't even remember which thoracic one it is, but yep, you're out there.

Foundational Support: Detox, Structural Care, and Lymphatics

" And I'm like, "Oh, it's so crazy how the body like that piece like influences your nervous system enough to affect your digestion and but like all throughout your body like that that's happening um in different places and certainly our postures and everything that we have sitting front words like this and you know so anyways I interrupted your foundations but I am just echoing the physical manipulation. >> Yeah, let's put an asterisk beside it." And the way I think about it is, you know, we can we can try to fix the the flickering light in the kitchen, but if the electrical supply to the house is not >> is not working, what are we really doing, right? So, let's work with someone that's going to get that neurology and and >> communication pathways in the body supported. So, I think we're certainly on the same page when it comes to that.

>> Um, so there's a physical structural element from the mind body perspective. I'll typically do um some form of assessment in office, usually a heart rate variability assessment and start to give them some feedback as far as you know where their body is in terms of that fluidity between kind of fight or flight and rest and digest state using a basic practice whether it's breathing, visualization, gratitude to see how we can shift that um you know that that that rigidity in in the nervous system's regulation and then sending them home with some degree of homework whether it's as simple as just, you know, splashing cold water in their face to get that vagus nerve awake if that's where

they're at right now or whether we can move into some form of a more formal and and and consistent practice. We're certainly going to be looking at some degree of of kind of um stress system regulation, veagal tone balancing work.

And then from the biochemical perspective, there's so many different ways we can approach it. So, it's going to be individualized to some degree, but I try to get everyone oriented towards at least the basic foundations of an anti-inflammatory type diet. >> And for some folks, it's a bit much to ask them to cut things out. So, we'll talk about what can we do to just get some berries in. Let's get some of the brassasica, the broccoli family, you know, veggies in. Let's get some more omega-3s in.

>> Something along the lines of some basic anti-inflammatory diet work. For some folks, we have to go right into like autoimmune paleo or or something else that because of the nature of their presentation. But >> thinking about something along that vein that we can start with.

>> Um, and another thing that I try to emphasize in the biochemical space, and I'm not a dental health professional, but trying to get their oral health in check, right? Because for so many folks, that's going to be a major barrier to healing. Um, you know, we're not talking about yanking out metal amalgams and getting root canals investigated to see if there's cavitations. Like, we're not going there yet, but just basic stuff because if we're not, >> we always forget that, you know, digestion and the digestive tract starts up here in the mouth, right? And if we're working on the gut with kind of a weed, seed, feed approach, but we're not working on the mouth and the oral the oral health, we we we stop short of what we can do. So, going a little bit, you know, off off center here, but those are some of the things that might come up um that we've got to think about. >> Yeah. Yeah. And how do you for people that I mean, you said you have some people that are bed bound, but how does movement like factor into this and like getting lymphatics and things like that to be foundationally a little bit in a better place?

>> It's Yeah. at the very least. So, if if someone were to do a head and neck lymphatic drainage, this is a it's a pretty long write up that they get when they leave the office. Um, >> yeah, >> if they're to do a head and neck drainage practice, which could be done with kind of the homeopathic, you know, drainage creams, good old castor oil, or just >> use your hands.

>> And we'll get them to do some pumping at the termini of the of the uh, you know, lymphatic channels just underneath the collar bones on both sides. start to get them doing some work at the the head and neck to to just get the lymph flowing.

And this would be the person that, you know, we we we're not able to necessarily do too much more, but I forget the research, but you can increase systemic lymph flow by like 30% just by doing head and neck work, right?

Like that's such an important piece just because again that's where it all drains into. >> Yeah. So, you know, for most folk that that are able to, we'll we'll start on that. And if they find that challenging, then I'll get them just to use castor oil or one of the homeopathic drainage creams just to start to get things moving. But we'll start with that.

Otherwise, there's the pin technique, P R I N technique. And if people can dedicate like five minutes to the short technique, that's the next step because now we're going to really get everything moving lymphatic wise. And then if they are in a position where they can physically move, we're getting them moving, right? Is it Tai Chi, Chiang? Is it um yoga? Or is it more of a formal standard or conventional form of exercise or walking just to get things moving? But >> my background is in fitness and rehab.

And so I tend to emphasize that as much as I can and you know pass the baton and see what they can do with that. >> Yeah, that's awesome. Yeah. >> And then from a bowel standpoint, um, are you doing like, you know, if they're coming in, they're not pooping for a week or I mean, I see a lot of these people that are so sick and they're just like, "Yeah, I go bathroom once a week." And I'm like, "What?" Like, how is that possible?

So, what are you doing there from a foundational standpoint at the beginning? >> That's really important and I appreciate you bringing that up. So, on the one hand, you know, we want to try and facilitate daily bowel movements in in some circumstances, we'll actually I'll send them off. uh we don't have the scope to but I'll you

know connect them with practitioners that can do a KUB kidney url bladder X-ray to see if there's fecal loading in the ascending colon.

>> Yeah. And if there is, sometimes this is one of those hit pause, nothing else. We got to deal with this. And we'll do like a magnesium flush protocol where we're basically inducing watery stool one or two days a week for an extended period of time. And between those flushes on the weekends, we're basically inducing loose stool with magnesium oxide would be the tool here. Um, and we're doing nothing else, right? And the reason for that is one, you know, you're we're all going to be cognizant of the fact that if if someone's backed up, what are we really going to be able to do to get the digestive tract in check first? You would never use a clogged toilet. Let's kind of get things flowing.

>> Um, >> yeah, >> but if there's a significant amount of fecal loading and fecal matter just caked onto the intestines, especially that ascending colon, which has to go up against gravity, >> there's going to be so much biofilm there. There's going to be so much Australia and other disbiotic bacteria that are going to be throwing off their neuroendocrine activity >> that we're going to be spinning our wheels. The the antimicrobial herbs or or pharmaceuticals if that's what someone's using, it's not going to touch it. >> You're going to, you know, hit them with anti or anti or bofilm disrupting agents. It's not going to do it because it's caked. And I always, one of my patients said, you know, they started to see the aliens coming out in their stool in their in their bowel movements. So now I call it the aliens. But when people start to see the aliens coming out, the the the fibroid the muccoid plaques and you know fibrootic bofilm, >> we know we're starting to get there, right? You know where for some people it could be one month, like four weeks before we start to see it. There are patients where it's like 6 months to 12 months before the aliens are coming out.

And um depending on the severity of the constipation, the chronicity of the constipation, it might be one of those stop all hands on deck. Let's get this dealt with. But at the very least, getting them having regular bowel movements with the support of magnesium oxide and then obviously diet and lifestyle strategies. Otherwise, we may need to just that's it. This is what we got to do. And in some of the neurode divergent cases, it's kind of wild to see how much can shift simply by getting that bofilm out of that ascending colon.

Right? It's it's it can be lifechanging for these families. >> Wow. Um, specifically on the biofilms, are you adding any biofilm disruptors other than just the magnesium? >> Not when we're doing magnesium oxide in the right Yeah. in the right >> dosing. As long as someone's compliant because it sucks. It's not a fun protocol. um it's a big ask, but when they get into it and when they start to feel the difference, it's a big win.

>> Um so often I won't lead with that. They have to have some kind of trust, >> right? >> Some rapport with them, >> get some small wins before we get into that. But um >> generally not. You don't need to generally worry about antimicrobials or biohilm disruptors in that setting. >> If we're having to do somewhat of a hybrid approach, I have some folk that are like, I can do this maybe once a month or something, then I'm like, okay, we got to fill in the gaps. But if they're fully committed, the nice thing is it's no, it's just that and we're managing their hydration status and electrolytes and >> yeah, >> otherwise very low burden with other supplements and pills. Like it's really a very impactful monotherapy.

>> Impactful, no pun intended. Um, as far as like the dosing on that, are you using like a magnesium oxide powder or capsules? >> Powder. And then um >> yeah, you can kind of go anywhere from like 500 to 1,500 milligrams once or twice a day, you know, in the >> in the leadup. Um we kind of start low, go slow a bit just to not really mess with people. >> The you know, the worst side effect we might see would be some some cramping, some abdominal discomfort, cramping, and you know, we pull back. >> Um it's interesting though, the amount of patients I've had on super high doses that don't have any response, right? And it's just like either you're dehydrated because we're not getting that osmotic effect or >> um you know we're just we're we have so much >> to do just to get to the starting line.

Constipation, Biofilms, and Detox Support

But uh yeah, magnesium powder really nothing else and kind of going from there. Um, as far as So, circling back to sort of like recap what we've talked about, um, what do you feel like for the majority of patients that are coming to

your practice, like what are either what are like the big things that you find the most impactful or I don't know if you want to walk us through like a case example of like someone and then sort of what you did along the way, whatever you feel. I know you're going to present some cases next weekend. So, >> yeah, >> whatever you want to close with. I would say the these standards and again I tend to operate more in the world of the biochemical >> you know pillar of both of those three um right so >> the main things that we're looking at one would be if there's constipation I'm so glad you brought that up kind of dealing with that first because nothing's going to move otherwise >> um I didn't really talk about this within the the comment on the foundational support but the liver detox element is going to be big because again there's going to be if there's a backlog or a bottleneck someone's going to feel horrible and we start to do things and mobilize toxicants.

>> So, we're typically incorporating some degree of a detox support intervention. >> Um, you know, some people we may need to think about genetics in terms of figuring out where in that process they're backed up or is this someone where if we're supporting phase one of detox with B vitamins or dark leafy greens or that kind of thing, they feel really bad because their phase two is really slow. So generally just trying to do everything through that process with you know B vitamin support that intermediary stage i.e. supporting anti-inflammatory antioxidant capacity. We're supporting that phase two of detox with glutathione amino acids. So, constipation support >> um some degree of detox support with some core neutrauticals, B vitamins, antioxidants, uh amino acids, including glutathione.

>> Glutathione can push mold a bit hard for some people. So, that may not be the thing we lead with. The other thing that I'll typically bring in and this is after that first visit between the first and second visit while we're doing completing the more thorough assessment. This is some of what we have in place right >> the other thing that tends to be a big one would be redux support right thinking about that glutathione system capacity and oxidant proxidant antioxidant balance. So we're typically thinking about things like vitamin C, vitamin E to just get the antioxidant recycling pathways supported. We're then coming in with something like an acetylcysteine to help you know with that glutathione production and then thinking about again core glutathione whether that's you know liposomaal or IV or however else we might kind of go about um intervening with that but that would be another kind of key element and then that's all balanced out with some degree of symptomatic support right are they coming in with a histamine dominant >> histamine intolerant MCCAST presentation in which case we're trying weather that storm. Um whether it's your mass cell stabilizers or the B vitamins to help with histamine metabolism, DAO. Um recently, the amount of POTS and dishonomia that I'm seeing is horrendous and it's in these young >> predominantly female patients and it's completely debilitating and there are reason, you know, there's reason to believe there's a postviral element to it and and other factors.

um you know if that's the case then we're doing a fairly focused kind of conventional but blended you know intervention there so yeah then putting out fires and symptomatic support but I could go in a million directions >> yeah right I know that's complex thing yeah I mean are you seeing specific viruses like is COVID the trigger for a lot of the POTS patients or are there other viruses that are you're noticing are also >> Yeah I mean certainly I've seen a ton of it post co natural infection and post in post vaccine in susceptible individuals >> it can take quite a long time to resolve but the way and a colleague said this you know he looks at CO as the great revealer right and I was listening to Heather Ziki the immunologist recently and she said you know what's fascinating is where autoimmunity would normally take you know anywhere from like 5 to 18 years I forget what she quoted exactly from the study to to manifest from that acute onset virus or pathogen we're seeing it postcoid in like 3 to 15 months >> right and so what would normally be a slow burn is just fast and furious. So most of these folks would have some underlying factors, right? And we know that COVID is a great um reactivator of the herpes family viruses, whether it's, you know, EBV, CMU or HHV or whatever it might be.

>> So there's usually something else that's smoldering and then CO comes along and throws the mule on it, right? But CO's a big one, whether it's the inflammatory burden in and of itself or some kind of other viral reactivation. Um, but I I mean in the in the world of pandemic post-pandemic setting, I would say that's one of the biggest drivers I'm seeing in this massive uptick of dysotonomia largely in POTS. >> Yeah. Yeah. And it's interesting because I feel like in the last five years or so, like you didn't really hear about datonomia. You didn't talk about POTS and like it was very like one person I knew like had it from that I went to pharmacy school with. And then all of a sudden it's like, you know, mainstream people are talking about this. This is occurring all the time. So for those patients, what are like the biggest wins that you're seeing for them as far as addressing the dishonomia piece?

>> Yeah, I I realize I left a massive gap in in discussing this. So this kind of ties into that.

POTS, Dysautonomia, and Connective Tissue Support

>> I would say in my practice, again, being an end of the road doc, I tend to see folks that really even with with and this is not a knock to anyone. It's just you know the the somewhat standard approaches even within the world of naturopathic med don't serve some of these patients simply because of the underlying factors. The biggest missed piece for the vast majority of patients that come to me and this is upwards of 80 plus percent would be some degree of connective tissue disorder within the specifically joint hypermobility >> not necessarily like full-on EDS Ellers down syndrome but but some >> some iteration or some variation of that presentation. >> So what I find is that the most stubborn cases tend to fall under that umbrella. I would say the vast majority of the POTS cases I see recently seem to be again that that's the predisposition and this virus is just completely >> decimated that that that kind of system.

>> Yeah. >> So what I find is you know yeah we end up using high dose high high amounts of salt we end up doing you know lots of hydration we end up doing compression uh uh uh uh what's it called? Clothing >> support. Yes. >> Right. Right. Right. and um you know the usual things try to get them on a recumbent bike and get things moving usual things and then naturopathically you know things like like uh licorice and and uh go and bilbury and I kind of put together a specific picture for them >> but the other thing is um if we don't address the if we don't adequately support the underlying connective tissue abnormalities we can really fall short in supporting them and so that comes in the context of brick and mortar things like vitamin C, glucosamine, manganese, copper to help support the actual >> give them the building materials, but you can have the best building material in the world. If you don't have workers, what are we doing? So, mitochondrial support, >> CoQ10, carnitine, da da da. >> So, we're thinking about that neutrautically. Um there's a modality called frequency specific microcurrent which can be really helpful in supporting the vagus nerve trauma that happens because of the ligament laxity in these individuals. So their nervous system is out of whack. They can do HRV training all day but every time they move and are faced with gravity the vagus nerve gets traumatized and that's going to be a problem >> for obvious reasons. How are we healing?

And in situations like this, I know I'm going a bit far down the rabbit hole, but I think this is pretty important. >> That's okay. >> If there's cranioervical instability, CCI, the upper cervical, the the ligaments that connect the skull and the neck, if those are lax, that's a major proprioceptive center. That means that communicates to your brain where we are in space. Much like the jaw and the talis, where our ankle and leg meet. if there are ankle injuries, jaw issues, andor this upper cranial instability.

What that's going to do is instead of us having this conversation like this, it's as if I'm speaking to you through a megaphone cranked up to 10 that's crackly. >> Your the brain goes on fire. And so there's a very >> potent neurological dis autonomic neurological dysregulation that comes from a a physical structural abnormality. So, we do the, you know, we do the neutrutical support. We have to work extra hard to get the gut in check because they're going to have leaky gut because their connective tissue is wonky.

>> Um, so we do all of the things, but that one is where we really have to double down on the connective tissue and and structural support. So, >> for those POTS folk, especially if they're not responding to conventional or functional approaches, >> that's often where we need to shine the lens. So, ask them, you know, are they hyper mobile? Were they that kid that could pull their thumb all the way back or do they have poor wound healing, atrophic scars? >> Sure.

>> That kind of thing. >> So, sorry I digress. >> No, that's great information. But yeah, it's so important. It's so important because there's so much of this going on right now and so many people that don't have answers. Um, and yeah, so I think that's a great place to end and you know, be able to have people, you know, listen to this and share with their friends and family because I mean I think everyone knows someone right now that's dealing with some aspect of datonomia. So hopefully this message I was just going to think say that you should come up with like a supplement like line for datonomia based on your experience in this connective tissue piece. You could really um >> it's where focus the attention, you know, based on this. Yeah. >> And what I would say is maybe to to kind of close on this, the silver lining through the pandemic is that finally postviral squalle, postviral fatigue, pardon me,

postviral pots, immune dysregulation is finally going to start getting the research and attention it deserves. >> And so, you know, for 30 plus years, we've known that these things are happening, but people have not got the validation they needed. They certainly not got the they needed. There's been no integration amongst >> specialists and and other allied healthcare professionals. So finally >> there's a glimmer that we're moving in the right direction. So you know a rough time and people are really suffering >> but there will be you know there there should be some some light at the end of the tunnel here. >> Yeah. Well thank you so much for joining the podcast and um we're looking forward to your CE presentation next week.

>> My pleasure. Thanks so much. And yeah, and again for those of you who are listening, if you're looking for the CE presentation, um it is going to be at functional medicine.com. And you can also find our team at farmtotableteam.life. And where can they find you?

>> Uh liamush.com is kind of my website. It needs an upgrade, but that's that's where you'll be able to jump up. Otherwise, Instagram, Dr. Liam, or on uh Facebook, same kind of handle, but you can certainly stay in touch. And I welcome questions, comments. I love to stay engaged with people. and education's big and we need this information to get out there. So happy to connect. >> Awesome.

>> Yeah. Thank you. >> Thanks so much.