



EPISODE #187
 USING CHIROPRACTIC NEUROLOGY FOR PAIN
 WITH DR. JEFFREY JAMES

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Wendy Myers:

Hello, thank you so much for joining us the Live to 110 Podcast. My name is Wendy Myers. I am your host today.

Today, we're going to be having Dr. Jeffrey James on the podcast. He is an absolutely brilliant chiropractor who is my personal chiropractor. I wanted to have him on the show because I've been with a lot of chiropractors over the years. I've been going to chiropractors since I was in my teen years. And I have never had anyone like him as far as the thoroughness of his evaluation, the methods he used to treat me and the results that I got with seeing him over a few month period.

And I wanted to have him on because he is a chiropractic neurologist. And so he has a lot of training in pain and how our brain interprets pain. And I thought he'd give you some great tips on how to manage your pain and deal with your pain.

On the show today, you're going to be learning about some little known causes of pain and perhaps while your pain hasn't been addressed successfully. I know a lot of you guys are out there are dealing with pain. You go to physical therapists and chiropractors and doctors and orthopedic surgeons and do all these things much like I did when I was in pain. I was desperate to get out of pain and restore my functioning, get back to my life, exercising and what-not.

And so I've been there, so I want to just help you guys on your journey to relieve your pain. And I think I have a lot of very effective tools that I found on my desperate search. So, we talk about that today on the podcast.

And a lot of different cutting-edge techniques that Dr. James uses with his patients, we talk about upright MRI's and we talk about a lot of things that you can be doing, a lot of alternative treatments that you can do to address your pain.

But before we get into that, please keep in mind that this podcast is not intended to diagnose or treat any disease or health condition and is not a substitute for professional medical advice. This podcast is for informational and educational purposes only, so please consult your healthcare practitioner before engaging in anything that we suggest today on this show.

02:37 ABOUT DR. JEFFREY JAMES

Wendy Myers:

Our guest today, Dr. Jeffrey James, is a board certified chiropractic neurologist. He graduated from Los Angeles Chiropractic College, earning a Doctor of Chiropractic and a Bachelor of Science and Microbiology. He's board eligible as a fellow in neurochemistry and nutrition. He's also board eligible as a fellow in vestibular rehabilitation as well as traumatic brain injuries.

He completed a post-graduate program of Functional Neurological and Orthopedic Rehabilitation in 2015 and has appeared on numerous radio and TV programs such as Herald, Date Line, KLOS, KLSX and KFI and has appeared as the medical expert for the NBC investigative journalist, David Cruz.

Dr. James fills a unique and significant role in treating back, neck, spine, brain and nervous system disorders using safe and effective methods, producing lasting, long-term health benefits, many times having great success with patients for whom all other treatment methods have failed. I can attest to this.

He has inspired thousands with his knowledge, warmth and personal touch, and his passion for teaching others how to restore their health and regain their vitality.

In addition to his non-surgical back and neck pain treatment protocols, he has helped those who have fallen between the cracks of traditional allopathic and alternative treatments by caring for patients with type II diabetes, Hashimoto's and peripheral neuropathy, often helping those patients reverse their disease process, reduce and eliminate many medications and decrease pain while increasing energy levels.

You can learn more about Dr. Jeffrey James at IntegratedPhysicians.com.

Dr. James, thank you so much for coming on the podcast.

Dr. Jeffrey James: Thank you so much for having me. It's good to be here with you.

Wendy Myers: Yeah! So, you're my chiropractor. And I think you are so brilliant. And I've had a lot of chiropractors. I've been going to see chiropractors since I was a teenager. And you're very, very different in how you work with people. You're a neurological chiropractor, is that correct?

Dr. Jeffrey James: Yeah, the term is really chiropractic neurologist, but neurological chiropractor works.

Wendy Myers: So, tell us about that. Tell us a little bit about the work that you do and your background and what-not.

Dr. Jeffrey James: Great! Sure.

So, just like the medical profession has subsets, like you can go through your general training and you can become an orthopedist or a neurologist or a pediatrician, it's the same thing in chiropractics. We have our subset and our specialties in our profession.

Most people don't know about chiropractic neurologists because there are less than a thousand of us worldwide and probably only about—I don't know, probably about 700 of us or 500 of us who are actually continuing with our continued education, keeping that board certification alive. So, we're certainly a rare breed.

And the difference between how we approach things and how traditional chiropractors will or medical doctors will is simply that as we're dealing with you, what we're looking at is how is your nervous system communicating with itself. And so we look at those breakdowns in communication. How can we improve the function of that communication?

So, the difference between us and a medical neurologist would be medical neurologists are really great at diagnosing a disease or diagnosing a problem. And then, the only alternative they have is simply to give you drugs or surgery.

In the world of functional neurology, the gray area is what matters to us. So, we could diagnose with a tumor. Well then, that's out of our hands. But most of the problems that we see that humans are suffering from aren't tumors, aren't cancers. They're actually functional disorders.

Just like I know you're familiar with autoimmune disorders, a lot of people have subsets of autoimmune disorders. Before they have autoimmunity, they have sensitivities to things. That's not on the radar really of allopathic, of traditional medicine.

So, the world that I live in is looking at—not just if I'm looking at somebody's eyes, do they move

from side to side, but how smooth and coordinated is that movement as it relates to the spine.

So, my training allows me to basically evaluate your nervous system probably more effectively than somebody who doesn't have my training and determine exactly where the breakout in your nervous system is.

So, do you have a problem with a nerve that's in your toe? Is it in your ankle? Is it behind your knee? Is it in your hip? Is it in your back? Is it in your neck? Or is it that your brain is perceiving the information inaccurately?

Wendy Myers:

Yeah. And so, I came to you when I was having lower back pain. I've been to a couple of other chiropractors and it really hadn't resolved my issues. And I had a bulging disc in my S1, so in my lower back, the very lowest vertebra.

You did a number of things with me that I have never encountered before, I've never experienced before. And just the way that you do adjustments and what-not are very, very different. And I, over time, was able to relieve my back pain.

I did a number of things, massage and other things that were very helpful to me. And I did some energy medicine. And over the course of a few months, I was able to finally get relief from my back pain. But it's so important to do that physical work.

Dr. Jeffrey James:

Absolutely!

07:45 WHY TREATING PAIN IS SO ELUSIVE

Wendy Myers:

So, we're going to be talking about pain. So why can treating pain be so elusive?

Dr. Jeffrey James:

Great question! There's pain that occurs as a consequence of, say, trauma or tissue breaking down or you injured yourself. But there's also neurological pain.

So, we don't have receptors in our body that transmits pain. Pain lives up here.

So we have special receptors, neural receptors, that transmit information related to pressure, that transmit information related to temperature, that transmit information related to light touch, to vibration, all of these things.

So, what we experience is something that we, in our world, call nociception. But the interpretation of that is what is pain.

So, many people will have an injury, let's say, and they can have a genetic susceptibility to sensitizing to that pain. What I mean by that is you have a trauma, and now the nervous system and your brain becomes so fired up and so plastic, if you will, so efficient, at transmitting that information relating to the suffering and the pain that you experience that even if you take away the actual insult or the tissue injury, the person is still experiencing pain.

Wendy Myers:

Is that why it's so important to treat these things for pain as soon as you have an injury rather than a few years down the road, because then you get that permanent loop, that plasticity in your brain, that permanent connection there that's transmitting pain?

Dr. Jeffrey James:

Yeah, that can be. But there are people who have drawn the unlucky genetic straw where they can sensitize immediately. They have a trauma, and they are just immediately sensitized and their system gets very efficient.

So, for listeners, we both use big words, "plasticity." That may not mean a lot to them. What it really means is that when you fire a nerve pathway over and over and over again—well, let's say you fire a neural pathway once, it may release five neurotransmitters. But as you continue to push that pathway, maybe it starts to release 10 or 15 for every time that that pathway gets hit.

And then, eventually, it gets so efficient that you create another bud that starts to release more and more neurotransmitters—more and more neurotransmitters.

So, essentially, what you're seeing is—and this is what we saw actually and was evaluated first with pain syndromes. The system, the pain nerve fibers became so efficient that you could take away the source, but these people were already wound up. Their brains are winding up.

So, think of it this way. Somebody who has phantom limb pain where somebody has their arm amputated, their arms still hurts them in their brain. That's the essence of a central wind-up phenomena. It can happen to any of us. And it's not fun when it does.

So, a lot of times, also, why it's so elusive is we tend to look at a structure and think the structure is causing the pain. I could see that on an MRI. So, I could see you have a disc bulge on an MRI, but it doesn't necessarily mean that is what's causing the pain or that the disc pushing down on the nerve was causing the pain, it could be the disc itself.

So, until you evaluate somebody, until you look at them, until you get a really complete picture of them, you don't know. People can have sub-clinical inflammatory processes going on—I know you deal with that in your practice, people are inflamed all over the place. That's going to impact your pain level for some people.

If people have a brainstem that's wonky—so this is probably starting to get a little heavy and deep right away. But there's an area in our brain and our brainstem called the locus coeruleus. And it produces epinephrine and norepinephrine. And centrally, meaning in the spinal cord, it actually inhibits pain. Outside of the spinal cord, when you start to secrete epinephrine and cortisol, it actually causes an increase in sensitivity to pain.

So, drinking coffee can sensitize you to pain. So if somebody's drinking four to five cups of coffee a day, that may be one of the reasons why it's difficult to get their pain level down.

Let's say they had a trauma when they were a kid, and they whacked their brainstem a little bit, they didn't even know it, now they're not producing that epinephrine that would normally suppress pain at the spinal cord level or serotonin at the spinal cord level.

So, unless you understand these mechanisms, it can get really tricky. And quite frankly, it's tricky even when you know the mechanisms to get somebody to follow through and allow you to work with them long enough to actually get that under control.

11:45 TREATMENT TIMELINE FOR PAIN

Wendy Myers:

So, how long does it take to get someone's pain under control? I know that everyone's a little bit different. But when you're working with them, what does that timeline look like?

I know a lot of people are very quick fix, they want to feel better immediately. And if they don't, they get that shiny object syndrome and then they look for the next practitioner.

And I deal with that myself in my practice. A lot of people don't want to spend two years detoxing.

So, how long does it take usually for people to get relief?

Dr. Jeffrey James:

I'm an in-patient practitioner, so I like to get results fairly quickly. That said, people who have chronic pain and have had it for a long time, and have a poor diet, and haven't worked out, and haven't exercised and they're de-conditioned, and they're coming in with back pain, sometimes, it can take months.

Normally, we see people reduce their pain probably fairly significantly over the course of two or three months. Again, depending on what I'm working with, I like to see a 25% to 30% reduction in pain. People who their pain is an 8 to a 10, pain is shooting down their leg, let's say, or into their arm, in four weeks, I'd like to see at least a 30% reduction to know that I'm on the right path. Otherwise, I have to change tactics.

But it's a little hard to predict. It's so individual. And our perception of pain, as I've said, it lives up here. So, the suffering component of pain is something that's both learned, but it's also something that's genetic.

I tell the story of like, let's say, two kids. They're five years old. They're running down a gravel driveway and they fall down. One kid is pulling gravel out of his knee and laughing at it, and the next kid is running to mommy saying, "This is killing me." What is that? It's a different perception of what occurred for those people and they're going to grow with a different perception of pain.

So, I might do the exact same thing for the exact same diagnosis. And one person's pain is relieved in two visits, and the next person takes four weeks.

Wendy Myers:

When I came into you, I had an injury on my shoulder. I had this weightlifting injury when I was 25. I literally just lifted a weight up like this. It was just the most ridiculous injury that you could get. But it's plagued me for 20 years almost.

And I've been to numerous physical therapists, chiropractors, but I never really got relief. And you did one move, and it was gone. This is like six months ago. You did one move, and its total functioning and my pain has improved.

I need to come and do it again, get another adjustment because it's been bugging me just a tiny little bit. You have to keep up with these things.

14:10 CHIROPRACTIC ADJUSTMENTS

Wendy Myers:

But I was really impressed with just the different ways that you adjust people. And a lot of times, when you go to chiropractor, they only adjust your back. But you're doing all kinds. You're doing the arms and the elbows and the toes and all kinds of things.

Dr. Jeffrey James:

So, the reason for that for me is that I'm adjusting you for where I see your brain not functioning well as opposed to just looking at it as a structural thing. "Oh, your back. I feel your back. Oh, your pelvis is out." I tend to look at you and look at your eyes, and it gives me a window into, "Is the left side of your brain not functioning as well as the right side or vice versa? Or is there an area of your brain, the cerebellum, not working? How do I want to fire that up?"

So, I can use adjustments. They're very powerful.

Adjustments, look, all therapies in the world are receptor-based. So, whether it's nutrition or it's drugs or it's massage or it's acupuncture or chiropractic, at the end of the day, we're stimulating

receptors. And those receptors fire up eventually into your brain.

So, if we can narrow down what area of the brain we want to work with and fire it up, we can do a little bit more effectively with our therapies. So, for me, when I'm adjusting somebody, I'm usually looking at, well, what's bothering you of course because that will tell me potentially were there structural abnormalities. But oftentimes, it's the brain that's driving the structural abnormality.

So, if I can adjust you to release something in your shoulder, but it also has an impact in your brain in the way that I want, I'll probably have a more effective outcome.

Or as my neurology instructor likes to say, "You just had a temporary lapse in clinical incompetence" to keep us all humble.

15:37 CHIROPRACTIC EXAMINATION

Wendy Myers:

Yeah. I mean, I was really impressed when I came into your office. And just the evaluation that you did, I'd never really had that before with any chiropractor that I've been to over 20 to 25 years. You really do this very thorough examination on many different levels.

I mean, it took like an hour. Most guys, they come in, and they just start adjusting you. There really isn't that much of a health history or evaluation involved.

Dr. Jeffrey James:

So, again, that's just a training thing for us. Again, we're looking at what part of your system is breaking down.

Most of the people who come to me have been to half a dozen other really competent doctors. And the story that I hear over and over again is they don't really get examined. So it's not just the chiropractors, I'm probably examining more thoroughly than most medical doctors.

I was diagnosed with Lyme a few months ago. I went to a very well-known Lyme doctor in Los Angeles. Her examination was listen to my heart for two or three seconds, and kind of looked in my eyes, and that was it! It was just a conversation.

So, most doctors don't. But again, because my wheel house is to look at where's function breaking down, how do I restore function, I've got to look at everything to go, "If I hit you up here, would that effect everything else down here?" I don't want to just go boom, boom, boom, and then go, "Okay, come back and see me three times a week." I really don't want to do that when I'm adjusting somebody.

I've done that early on in my career, but as a functional neurologist now, we want to see if we can hit the top part of the nervous system and have that take care of everything else. So, if you hit the apex of the pyramid, then you've handled everything else below it.

In your case though, when you have somebody that has a disc problem, non-surgical decompression, I have found to be just miraculous for some people. Really, truly, just people come up to me and say, "Wow! I've been to chiropractic, I've got physical therapy, I've done so many different things, I've had surgery..."

We just took care of somebody in the last four months who is a 37-year old yoga instructor that had surgery. It had left her with nerve damage. She is better now, but it took a few months.

Without that technology, there's not much I could do even with my hands.

17:35 ORTHOPEDIC SURGERIES AS A LAST RESORT

Wendy Myers:

And I think people have to really be careful. When you have a back injury and you go to an orthopedic surgeon, they do surgery, they're going to recommend surgery for you.

And so what are your thoughts on that as doing surgery as a last resort before exhausting all the other treatment options available out there.

Dr. Jeffrey James:

That is my thought, right? To me, this seems like common sense. Why would you ever have anybody cut on you before you've exhausted all the possibilities?

But I'll give you another personal example that humbled me.

About three years ago, I woke up at 2 o'clock in the morning, and it felt like Chucky was in bed with me, stabbing my shoulder blade. My pain on a scale of 1 to 10 was like a 12 to a 15. I just woke up like, "Oh, my gosh!" My finger was [lit] up on one side, and my finger was [lit] up on the other side. I tried to get one step out of the bed, and as soon as my foot hit the floor, I got an electric shock up and down my whole body.

I know what that is. That's damage to my spinal cord, that this is not good.

I had an MRI done, and I had two enormous herniations up against my cord in my neck. The radiologist actually called me back on the way out of the place and said, "I'm looking at your film. Congratulations, Dr. James, you got the real thing." He said, "If I were you, I would try to avoid surgery because I don't really get to see such great outcomes I guess. I'm looking at MRI's."

I had a laugh, saying, "You know who I am, right? I send you guys 20 cases a month for upright MRI's." He kind of laughed.

But I did have a moment where I thought, "Now, I see why people want surgery" because in that moment, I had such excruciating pain. You just want relief. You want it, you need it to stop.

But I was fortunate. I literally drove back to my office. I got out my tables. And I did it twice a day for three weeks, and I was 85% pain-free in three weeks.

Wendy Myers:

Yeah, yeah. The decompression is amazing. I was utilizing that in your office.

19:17 SPINAL DECOMPRESSION

Wendy Myers:

Can you talk a little bit about decompression and what injuries people have that are appropriate for using decompression and what decompression is exactly?

Dr. Jeffrey James:

Yes. So spinal decompression is a way for us to reduce the pressure in the disc. So, we have discs on our spine from C2, the second vertebra in our neck, all the way down to our sacrum.

And its job is several-fold. Number one is to give us flexibility, one is to act as a cushion, to act as a shock absorber and give us mobility.

So, we have a blood supply to our disc until we're around 14 years of age. And then, that whole blood supply disappears. And yet the disc is supposed to be 85% to 87% water. And that's important because our whole spine pivots over that. And that water content gives it its flexibility.

So, the only way that that disc can stay flexible and stay full of water and work the way that it's supposed to is through osmosis and imbibition. In other words, the great architect in the sky, He put us together thinking that as we bend and move through our daily activities of living, what would happen would be that we would squeeze out acidic waste products to bring water back in.

So, all of us have more sedentary lives than we've ever had. We're sitting in computers all day like this, right? And even if not, we've had multiple traumas going through life whether it's [...] et cetera. And now the spine doesn't move as well.

Let's say you're sitting in a chair and certain muscles get shortened that shouldn't be shortened, now we get abnormal movement patterns. Guess what? We're not creating that osmosis and imbibitions. It just begins to break down and dry out.

When it breaks down and dries out, it can't distribute weight the way that it's supposed to. And so now we end up with compensations and/or disc herniation or disc bulge.

The beauty of non-surgical spine decompression is that it gets to that source. In other words, it can create a negative pressure into the disc. So it's reducing pressure in the disc, drawing new water and nutrients back into the disc. It's not regenerating disc tissue, but essentially bringing the water back in that makes it more soft and pliable.

Think of a dried up riverbed, having water run through it. It gets [silty] again, right?

So, it's great for people who have degenerative disc disease, who have disc bulges, disc herniations, who have sciatica, pinched nerves, spinal stenosis. All of those things are really amenable to non-surgical decompression.

But that's one component of it. The really critical component is, yes, if you have a disc problem, we've got to handle the disc problem.

This is also where surgeons fail, right? We don't want to just do the decompression. What you want to do is you want to re-calibrate and reset the way that person's muscles are firing.

There is a sequence that your muscle should fire in order for you to resist gravity properly and be able to move and have stability. And probably 99% of the time, that's missing for people.

So, we have to do things in a certain order. We want to reduce the pain, so your body isn't getting abnormal pain signals, which would then cause it to basically fire muscles aberrantly to support you. So we want to get rid of that. But then we want to start putting you on the path to teaching you how to do specific exercises to train your body to fire muscles in specific patterns, so that you don't re-injure yourself.

If people are recalcitrant to care, they're not responding even to that, then usually, that means I've got to do some brain-based work with them. This usually means that basically the brain isn't firing right, they're not getting the right information, the output isn't right, and there are some simple things that we can often do that stabilizes people and gets them out of pain.

22:31 BRAIN RETRAINING

Wendy Myers: What does that look like, the brain retraining?

Dr. Jeffrey James: It depends for everybody. It's as creative as you want to be. Often, it's eye movement stuff. For

me, it's a simple thing to do for people.

So, if you were to look at me, and don't take your eyes off of me—I know it's hard not to—and turn your head to the right—so turn your head to the right now...

Wendy Myers:

I know! You did those to me on our first consult. I'm like, "What the hell is he doing?"

Dr. Jeffrey James:

You have to understand, there's a relationship between our eyes and our spine. And there's an integration in our brainstem, between our brain and our cerebellum and our brainstem, to make all these things work well.

Walking is a series of coordinated falls. So, walking is an incredibly difficult neurological task to accomplish. And it requires spinal stability, what we call "shunt stability." And that requires your brain to be working right.

So, there are things that we can do above the spine to get your brain working well or do things like adjusting you in specific patterns to get certain areas of the brain to fire up or give you certain exercises to do that will help your brain fire up and work better for you that will also give you stability to your neck and to your back.

23:37 UPRIGHT MRI'S

Wendy Myers:

So, you use upright MRI's as part of your evaluation.

Dr. Jeffrey James:

I do.

Wendy Myers:

And a lot of people—I came in, and I had an MRI where I was just lying down. And that's the kind of MRI's that most people are getting when they're getting an evaluation with their physician to figure out what's wrong.

So, what is the problem with the MRI's where you're lying down, the difference between that and an upright MRI?

Dr. Jeffrey James:

There's not a problem. I mean, if you have a liver problem, it's not a problem to do it lying down versus seated.

Here's what I'll tell you. UCLA did a study a few years ago. And they said that they missed between 38% to 40% of disc herniations and spinal instabilities when they did the MRI with the person lying down versus seated.

And guess what UCLA still does? MRI 's lying down.

Their own research says, "Hey, we're missing 30% to 40% of the problems we see in the spine," yet they still haven't converted to it.

So, the technology is fairly expensive, but it's been around for about 10 years. I like it because the job of our spine, our discs, is to help us resist our body weight and gravity. Most people have problems when they're seated or standing. There are some people who say, "God! I can't lie down on my back. It kills me." But for the most part, most people are having problems with gravity.

In addition, when we have you in the seated position, in a weight-bearing position, we can bend your spine forward and we can bend it back. So that gives us more information. We can see if there's an instability—in other words, if there's a vertebra that slipped forward or backward. That would create a problem maybe for us to rehabilitate to you or it's not a problem, but it would give us a window into how we would have to rehabilitate you.

A herniation can get a lot worse or better in one position over another. That's also beneficial for us .

So, when we put you on a decompression table, we have some really cool new technology with decompression. I mean, a lot of it didn't really move along until the last few years. It was just a static pole, if you will, lying down the table. But now, [...] the table itself moves, we're flexing your spine. So, we can target a disc more effectively. We can find out where a person has the most relief and move the table in that kind of a direction.

So, having an upright MRI gives us a lot more clinical information. And when we can match that, and it matches to our thorough neurological evaluation, now we know more specifically how we have to address the patient.

25:42 DR. JAMES' DECOMPRESSION PROTOCOL AND EQUIPMENT

Wendy Myers:

And so when you're doing a decompression, how many sessions do people typically need? And what's the difference between the decompression machine that you're using compared to other ones?

I've been to some chiropractors. They have some ancient decompression machines. I went to one guy that his decompression machine was from the 90s. He was actually still trying to get people to do this.

Dr. Jeffrey James: He's getting his money's worth, wasn't he?

Wendy Myers: He's getting his money's worth. So, I ran out of his office as fast as I could.

So, you have obviously a very newer high-tech decompression machine. What are the benefits of the one that you use compared to others?

Dr. Jeffrey James: So, let's actually give you a little history on this. Back in 1989, the very first decompression table was created by Dr. Dyer who was the Minister of Health in Ontario, Canada.

He had a herniated disc. And the research showed, "Hey, traction really didn't work." He theorized it was a consequence of when we pull, basically, the muscles react and they start to spasm. And that's why you can't do anything to the disc.

So, he thought, "Well, if I could bypass that mechanism, I might be able to fix the disc."

And so he created the first table. It's called the Vax-D.

Wendy Myers: That's the one that was at the chiropractor's office. it was the first one!

Dr. Jeffrey James: The first one. That's funny. That's funny.

You would lie on your stomach and hold on like this for dear life as it pulled you.

So, he fixed himself. And actually, it was a really good table, and it helped a lot of people. But there were a couple of problems to it. Number one is he created a lot of shoulder problems and neck problems because people couldn't hold on. Right away, holding on caused problems.

A lot of people who had tons of pain can't lie on their stomach. So that's another issue.

And then, it was dependent upon, hey, how strong are you feeling that day where you could actually hold on because if you let go, then the table is pulling, but you're getting no decompression.

So then, a whole bunch of engineers looked at this. A guy named Norman Shealy who's considered the Father of Pain Medicine came up with his own version of what his engineers called the DRX System. And then, there was—oh, my gosh, there were three or four big manufacturers.

There was a company called Axiom that came out with a DRX9000. And that was big for a while. I had three of those tables. I think I was the first person to bring it into LA. We had three of those tables for many years. And they were good.

But here are their limitations. It's a linear pole. You're putting a harness around your torso, a torso around your pelvis. And then, it will be attached to a tower where it would raise and lower the angle to target a disc.

So, we got really good results with it, but there are people who I couldn't get the results for them, people who needed it to be on a different position. You're limited to being on your back, and it's being pulled like that.

In addition, they had presets in there like, "Oh, we want to target L5, we push the button." Well, that always sounded absurd to me. My L5 disc is going to be different for somebody's who's 5'8, who maybe has a big belly and he's got a hyper-extended back versus somebody who's 6'2 and slender. So, we had to play with that a lot.

Also, it didn't give you a lot of variability of how long you wanted to pull somebody, how long you wanted them to rest, what was the speed that you bring them up.

So, in that fashion, it was limited. But we had three tables and treated an awful lot of people very successfully with that.

In the last few years, neurotechnology has come around where it's just more sophisticated. So, instead of a belt pulling you, you're literally strapped to the table, and we flex the table. So now, we're bending your spine—either extending it or flexing it—and that's much more specific to targeting a disc for a person.

We can also laterally bend and we can rotate it. So there are ways in which, for instance, somebody comes in with pain shooting down their legs, if I can get them in a position in the exam where I can decrease that pain in their leg, that's the position I want to put them on the table.

And there have been at least a half a dozen people who I've put on the table now face down where I've gotten better results when I did face up.

So, that's the mechanical part. The sophistication of the computer has also advanced light years. Now, I can determine how fast do I want to bring up that ramp speed. So, let's say we started zero, and I wanted to pull you at 40 lbs., well, do I want to get that to 40 lbs. in 30 seconds or do I want to take 90 seconds to get there? How long do I want to hold it? How long do I want to rest? All those things.

We treat different types of these conditions differently. So somebody who comes in with a herniation from last week, they get treated with a different protocol than somebody, for instance, who has just degenerative disc disease where we want to pump that disc.

So, the new tables of decompression allows us to be more specific, if you will, with people. And we just love it.

And when I made the transition, I was a little nervous. I mean, you get used to what you get used to. And I knew this was the right move, but I was still a little bit nervous about how the patients are going to feel. But every single patient who went through the transition said, "I love this table so much more. It's more comfortable. It feels better. I'm getting better relief" and all that.

Wendy Myers:

Yeah! I had to say an experience. I was going to another chiropractor before you. They were using a table. And they were using way too much pounds. They were doing a hundred pounds of pressure on me. I've had a couple of times where I kind of pulled my muscles and I'd have more back pain afterwards. I just intuitively knew that it wasn't right.

And then, I came to you and the tables are much more sophisticated and computerized. It's just a whole other ballpark. I ended up getting relief from that. So thank you for that.

Dr. Jeffrey James:

Yeah, my pleasure. We love helping.

The funny thing is there are people who come in and they're like, "Pull me more. I want to be pulled more." And we know from the literature and the research that more is not better with that, that there's a sweet spot where you actually decompress the disc better, that more is not better.

But sometimes, you just got to give people what they want. We experienced bull-headed, hard-headed plumber guys. They're big. They're like, "Pull me more. I want to be pulled to 150 lbs."

"You won't walk when you get off the table."

"I don't care."

"Alright! So, you'll sign this release, and I'll make you not walk for a day."

Wendy Myers:

Yeah. Yeah, that's what I was having. I was getting to the point where I'd get off the table, and I couldn't walk, I had to lay down for a few minutes first. It just felt very un-stabilizing.

Dr. Jeffrey James:

That's a good point to make, and it's a funny thing to talk about. People talk about stretching is making you looser. But stretching does not make us looser. Stretching increases muscle tone.

So, everybody who's listening to this right now, you can do it to yourself. You can stretch out your arm. Well, it's hard to do it to yourself. But let's say you just feel the tone of your arm here, and then you stretch the muscle, you can feel that that muscle actually got tighter.

So, why do we think that we're actually stretching out a muscle? We're not. When you're doing yoga, you're actually increasing tone.

When you hold something long enough, you can actually start to maybe break up the adhesions and the white tissue and the connective tissue and the tendons and the fascia. But the muscle itself is not getting lengthened.

So, when you're pulling like that, if you're not doing and cycling properly, you're going to cause more muscle contraction.

When I was a really young man, when I was 17 years old, I went to my first chiropractor. He used to hang me upside-down on these inverted rod things. And for the first 15 seconds, it was heaven. Even at 17, it was just, "Oh, out of gravity. It feels so good." I spasmed every single time I came off that.

And I didn't know until I studied neurology. "Oh, that's the mechanism. The muscles are actually tightening. It doesn't like being like that."

Wendy Myers:

Yeah, yeah. I had a machine like that too. It was the machine you kind of sit on and then you spin over and you hang upside-down and it stretches your back or you can do sit-ups on it. It's the same thing, you go into a spasm where it starts tightening up.

Dr. Jeffrey James:

Exactly!

This is the beauty of decompression where the computer has a tensometer on it. So it's monitoring as it's pulling you. It doesn't completely let go. But if it starts to feel that your body is resisting, it starts to back off.

So, your body's alarm system, the warning systems says, "Oh, I've got to protect the joint. It starts to relax when it realizes there's no threat there."

And then, the cycling pattern starts to basically cause water to get sucked back into the disc. We've seen this a lot. And it's the only thing I've ever seen in 30 years in practice where you can do a post-MRI and you see more water back in the disc. That's a pretty cool thing to do. There's no surgeon that's going to do that. There's no chiropractic treatment that's going to do that. There's no acupuncture. There's nothing I've ever seen do that.

Wendy Myers:

You also have to actually drink water, right, to keep the body and the disc hydrated? I was guzzling water the whole time we're talking.

Dr. Jeffrey James: That's good. I see you're drinking out of a glass bottle, good for you. It's not a problem .

Wendy Myers: Oh, yeah. Yeah, I am.

33:22 CONDITIONS APPROPRIATE FOR DECOMPRESSION TREATMENT

Wendy Myers: And so, what kind of conditions you typically have success with in your practice?

Dr. Jeffrey James: All sorts of different stuff. Somehow, we've sort of fallen into this thing of I tend to treat a lot of discs and a lot of spines. So, people who have disc herniations, disc bulges, degenerative disc disease sciatica, whether these degenerative diseases are on the neck or on the lower back. We're quite successful with that.

Spinal stenosis. So let's talk about that for—I don't know what the age range of your audience is, but a lot of folks, when they get into their 70s, they're diagnosed with stenosis.

And I love this because I say to patients, "Well, okay, what's causing the stenosis?" They look at me like I'm a three-headed horse or something like, "What do you mean? The stenosis is causing the stenosis." I was like, "Well, no, stenosis is a narrowing down of an opening." So if we're talking about stenosis, it's either a narrowing down of the opening where the spinal cord lives in the spinal canal or where the nerves exit, neuroforaminal stenosis. There are lots of things that can cause that.

So, it can be a disc bulge. It can be a disc herniation. It can be degenerative disease. It could be a facet hypertrophy [...]. That can be something called an epidural lipoma that lives inside there. It can be one vertebra slipping over the other. It can be a combination of all those things. It can be bone spurs.

Normally, what we see is, frequently, it's a combination of things that are soft tissue-related, not bone-related. And that can be really, really [...] probably more investigative tests to figure out what's going on in with the person if it's warranted.

I have a naturopath in the office. He does bio-energetic medicine (I suppose is what he calls it). I don't know too much about it. He lives in his own world and universe. There's only so much I can know. I start to dip into it, then it's like it's going to be a wormhole that I can't deal with, a neurology wormhole.

Wendy Myers: Yeah, that's Rex Wilson.

Dr. Jeffrey James:

It is, it's Rex Wilson.

I've got a terrific chiropractor in the office who really helps a lot of athlete, a crossfit trainer. I taught him a lot of neurology, so he's really adept at handling people with any kind of physical issue. We do ozone therapy in the office.

So, we have quite a few different things going on there. And we're always evolving and changing. I'm also looking at [...] before getting on the call with you about having an office on the East Coast. So, my primary office is in Los Angeles, but I'm looking to have an office on the East Coast and North Carolina in Interim Chapel Hill, Raleigh area. So, that's soon coming.

So, for the most part, my role in the practice, most of it is doing triage, that guy that evaluates somebody, have them come in and go, "Okay, what's really going on here? What components of your health are—first of all, what does the person want? What's their primary goal? What do they need?"

And then, based upon that, what I'm seeing in the eval and maybe what their [...], I'll determine, "Well, this is somebody who could use some decompression. This is somebody who actually would go to Rex. This is somebody who my nutritionist should see or I should work with. This is somebody who needs ozone therapy to handle a chronic infection or something."

So, that's how I saw myself, as sort of the triage back in the office. When somebody has got a brain-based problem that I clearly need to work with, I can fix that and help them.

Wendy Myers:

Is that why you saw me primarily?

Dr. Jeffrey James:

Because you were brain damaged?

Wendy Myers:

Exactly!

Dr. Jeffrey James:

No, there wasn't actually. You came in because you had a disc problem and a minor shoulder thing that, apparently, I was able to handle differently.

Wendy Myers:

Just checking, just checking.

36:31 THE MOST PRESSING HEALTH ISSUE IN THE WORLD TODAY

Wendy Myers:

So, I have a question I like to ask all of my guests. What do you think is the most pressing health issue in the world today just to put you on the hotseat?

Dr. Jeffrey James: I don't think it's one, I think it's potentially two.

I think we are unbelievably inundated with chemicals that are just completely unnecessary in our environment. I think glyphosate is probably going to be one of the greater evils that we'll deal with. It's spread everywhere and I think it's causing a lot of problems. And it may be at the heart of why there's so much gluten sensitivity and gluten intolerance.

So chemicals, whether that's in the vaccines that everybody is going to be inoculated with and in our environment, I think we're just inundated with chemical toxicity at a level that we have never dealt with before.

And on top of that, the level of communication and the level of things that are coming at us is creating a stress level for everybody (and I know myself included) that you haven't had to deal with in the past. We're in a brave, new world of so much communication coming at us and so many things we feel like we need to learn.

Technology is keeping us up 24 hours a day, and we're not sleeping enough. And I think we're becoming very sympathetic dominant as a world society which means we're on the edge like this.

So, I think those are the pressing concerns which is why I try to meditate for half an hour to an hour every day. Without that, I feel like a crazy person.

Wendy Myers: How do you have time to do that?

Dr. Jeffrey James: It's funny that you asked that. I was in a yoga class—in a gym of all places in LA. I get my yoga class at gym. Their teacher is fantastic! She started the class up with a 5-minute meditation. And then, she said that "everybody should meditate for an hour every day." And she paused. And there were giggles in the room of course.

People were thinking, "I don't have an hour." And he also said that if you're really busy, you should be meditating four hours a day.

Wendy Myers: Yeah, exactly. And it's hard. We make choices. And people find that when they do meditate, that they're much more productive and functional the rest of that whatever—10 or 12, I have a 12-hour day. But they're much more productive over that day. They get more work done and they're more productive.

Dr. Jeffrey James: It's a discipline to be sure.

I mean, you have to look at where it fits in your life. There are days where I feel like I'm better. I

like to wake up at 4:30 in the morning to get an hour of meditation in. I'll interrupt my sleep to do it. There are days where I [...] meditate for half an hour.

I'm actually teaching—it still blows me away. I have an eight-year-old daughter, and she can't sit still for a minute. I just started meditating with her. Before she went to sleep the other day, she meditated for 35 minutes with me. It blew me away, an eight-year-old. Oh, it's going to be so good for her to have that, what that does to her nervous system and all of us.

So, I think it's just a matter of the discipline of saying, "This is going to be more important to me than anything that occurs in the course of my day. My connection to myself, my connection to peace and calming myself down, my connection to that inner spirit and God is more important than making money, working, cooking, doing the shopping, whatever craziness we get caught up in." It just has to be that important.

I'm lucky that I was introduced to meditation 30 years ago. I got to spend some time in India. And the time I spent in an ashram in India, I was meditating four to five hours a day. That's life-changing. When you walk out of that, you don't really realize it at the moment, but when I got back out into the world, not much affected me—not from a dispassionate place, but more like it was just fascinating to watch my mind and not get caught up in all the drama.

But unfortunately, I fell out of that practice. And the savings account that I had built up from meditating four or five hours a day kind of dwindled. But if you do that practice regularly, it does help you make different choices. You know, and we all know from doing that.

Wendy Myers: I'm sure moving to LA really helped calm me down.

Dr. Jeffrey James: LA is such a deceiving city, isn't it? People think, "Oh, it's so laid back and casual." I never found it that way. It's casual because of the way people dress, but it's a dog-eat-dog city. It's a very high stress city.

Here on [...], it's a whole different thing. People wave and go hi. They don't look at you like they want something from you. They're actually just saying, "Hi!"

Wendy Myers: Yeah, yeah, I know. I had the same experience in Texas. I go back and I'm like, "Why is this person sayin' hi to me?" It's not so literally, but it's just kind of funny. It's just very different.

Dr. Jeffrey James: "What's he looking at?" That's the thing you get in LA, "What are you looking at?" They're very edgy.

So, that speaks to again the question you asked me about, which is what are our most pressing

concerns. That level of stress isn't good for us. We're not designed for chronic stress.

There's a book I'm reading right now. It's been around for a long time. It's called Zebras Don't Get Ulcers. Have you read it?

Wendy Myers: I haven't, but I've heard of it.

Dr. Jeffrey James: It's about that very subject of just the amount of stress, the chronic stress, it creates an inflammatory process and it starts to destroy our cardiovascular system and our endocrine system and our nervous system. It starts to break us down. None of us can survive these. It's like, "Oh, my God! Forget Sta. Monica. I'm moving to West LA." It makes a difference. No, we're actually in West LA, right just at the 405 and the 10th.

Wendy Myers: Okay, good. Okay, great. But you're technically Sta. Monica, but east, east, east Sta. Monica, right?

Dr. Jeffrey James: Oh, actually no. It's actually west LA. I think Sta. Monica ends like a half a mile west of us.

Wendy Myers: You would think I would know that because I live in Sta. Monica a long time. So, anything west of 405, it's all Sta. Monica to me.

Dr. Jeffrey James: Ah, I see, I see.

Wendy Myers: Well, thank you so much for coming on the show. And everyone, if you want to learn more about me, you can go to Liveto110.com. You can learn more about my healing and detox program, MineralPower.com. Thank you so much for listening. And have a wonderful—

I hope you guys had a wonderful New Year and a wonderful holiday. I know that I did. I spent some time with my daughter. I took about 10 days off of work which is great. Our office was seeing clients. I was still working a little bit. But I hope you guys had a wonderful vacation.

Thank you so much for listening to the Live to 110 Podcast.