

Thesi 1& 2 .

Blog at strivetospin.com

February 15th 1981 to November 17th 2018

THE METHOD OF INJURY(MOI)

Please, consider a 10 tonne engine hauling a 200 tonne load on rails at 20mph . The air brakes fail on the 10 tonne engine, meaning an immediate stop. The inertial force then exerted by the 200T load behind it, means that the engine will then be damaged in some way.

Now consider the 10 tonne engine as my 6 year old(15/2/81) head and the 200 tonne load as my body, when playing being a battering ram! I impacted a friends stomach and abruptly stopped!

We now have inertia exerted, which is then transmitted through my brain stem , and meaning contact was then made with the Diencephalon area.

The start of the >condition< known as MS, has a beginning , that many have lived.

This is likely the injury for many conditions.

THE RESULT OF THE MOI

From my own learnings as a Marine Engineer and the Method of Injury above, I've armed myself with an Anatomy book and some idea of the MOI. The Diencephalon area took an impact by, and the Hypothalamus is part of this by body temperature function.

The impact has resulted in reduced flow of the Thalamus. The flow would lessen even more over time via 'furring up' of blood equalling a decades later diagnosis. A temporary lock between the over extended Brainstem and the Brain itself is also a consideration, as I struggled to stand up straight afterwards.

In addition the Brain is displaced due to the Method of Injury(MOI) then pushing hard onto the Occipital Bone(OB) of me .. The creaking then FAILURE of it, then a drop of Brain, or Pons, has closed or reduced flow to Thalamus and Hypothalamus This left me in crazy pain at my cervical spine.

The External Occipital Crest has opened up, midseam. Pons pushed the cerebellum through it , reducing flow to Thalamus and Hypothalamus. Whatever the damage, there are friction points thereafter, once it heals. This area will be calcified and apparent with MRI. The resulting friction marks are what you see on MRI, which is easily proven.

Nature doesn't work in straight lines, yet friction does!

I actually "read" my image to then surmise, the protrusions of the internal skull are leaving their mark on my brain.

However, speaking with others says there was enough force, to burst the seam EOC:ExternalOccipitalCrest(ie it was from above) and without an impact to their Diencephalon. I realised

this when other MSers weren't too bothered with heat, meaning Hypothalamus wasn't impacted like I was.

The Cerebellum is now in contact with the skull after the burst of OB, causing friction seen on MRI. This damaged area would heal and calcify but friction would persist, once it heals.

The severity of an individuals journey with MS is down to the magnitude of the Occipital Bone damage and Diencephalon mess, if any.

*le If the force from above was enough to open up between OB and Magnum Foramen, **angling** the bent seam possibly (both sides) ,then more mass can fall downwards. The calcified area would be bigger and more easily identified in Primary patients. This is due to a bigger force,deflating Thalamus, and has then made contact with the Spinal Chord, or doorstep friction point, over time. The magnum ,or the formed doorstep, is the only direction a massive blow would leave for the Cerebellum to head towards.*

I know my Cervical Spine(CS) was pained by the initial impact. Shunted likely.

The very act of lying down equates to the head leaning forward 30 degrees or so, lifting the Brain out of way of the Occipital damage. . Maybe this is why horizontal MRI hasn't allowed this to be realised?

>if a vertical scanner were used, I'm completely sure,for me at least, you'd find BM touching a healed EOC!<

More work on the container of Brain Matter is required as there are friction points acting on BM.

*I recently upped Methotrexate from 15 to 17.5 mgs. There was a pronounced definite ability to walk better. I am now of the opinion that this is how the "walking drug" is working for some and not others... .From my perspective it's **down to increased flow through Thalamus**. Some have impacted their Thalamus in such a way, that the flow doesn't change much via reduction of swelling, meaning they aren't suitable for "Fampyra".*

Perhaps the view plane of an MRI is hiding the burst too?Surely that can be altered to show the damaged area?100%, there was, and still is, damage.

Is the Diencephalon area damaged beyond repair?Mines looked normal. Think of a bit of scrunched up bit of paper. It can be repaired by unfurling of the impacted mess. That "mess" is partly what defines the state of a person's MS.

I took the inertial force impact, at the top of my head, while staring at floor. I think the flow improvement may be possible with different methods other than TKMS, but way slower. A frame with MSers upside down for a period is one of several. Vibration at the head may give temporary relief for example to aid decompression that TKMS would undoubtedly do.

The opposing force of static laddies lowest rib contacting my skull, when being a battering ram for the day, forced the Cerebellum to burst my OB, and BM to head downwards , giving us the telling friction.

We have friction and compression too. I have expectations of the entire brain mass movement being downward into CSF. Namely, everything is compressed.

I believe the majority of the compression marks will be around the Brain Stem.

In my previous job, we used centrifuges which were used to clean oils. This principle is used by TKMS. Different, but the same concept.

The Occipital Bone, splayed at External Occipital Crest near Magnum Fornam, is one source of friction when the injury heals and calcifies.

TKMS:TheKineticMomentialSystem

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The impact has left flow altered in Thalamus. . This is why there's a variation in MSers, as there were different methods allowing BM to head towards SC, or doorstep Friction Point(FP)

The friction points established after the collapse, and then healing, of OB, is rubbing the brain equalling further variation, too!

~~The Kinetic Momential System is a must build. ~~

This would refill Thalamus and Hypothalamus.

We need construction of a machine to harness Centrifugal Force. with frame adjustments placed at a distance from COR? This will improve Thalamus flow. A spin with their head near centre of rotation prior to the head outwards spin, may aid other parts of Diencephalon to unfurl.

Surely, we only need to visit a Theme Park, or aeronautical college, to circumvent construction of anything, of course.

In essence, I want to reverse the impact many have experienced. Refilling our traits, owned by Thalamus and Hypothalamus, would be the aim.

I know millions of us have been unwell from childhood. The forces I have experienced it's plain to surmise that something had to give way.

Step up Occipital region...

It was my personal duty to share this. It is then in our abilities to help make TKMS happen. Different scans will give us the info needed as to where cerebellum(is parked, when upright.

Prove this man wrong...

Check my previous mri results for Occipital bone and Magnum details, please. Then a scan of Occipital Bone to Magnum seam, where there will be calcification. There shouldn't be anything but you will be surprised.

There are friction points.

Friction pt 1 is the healed OB burst

Friction pt 2 is the formed doorstep, for Secondary, or Magnum Foramen, for Primary .

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🚩Thesis 2🚩

February 15th 1981 to ??/2019/20/21/22/23/24.

Thesis part 1:"The reason/the repair with TKMS:TheKineticMomentialSystem, leaves many questions, unrealised yet.

The healed Occipital burst, from childhood, has left, FP:Friction Points, in contact with the brain.

+

Thalamus, and Hypothalamus,flow has been altered by the initial drop of BM, meaning flow changes,then flow restriction, at dx time.

The friction, which is viewed on my Mri image, and I believe it to be the same for all, was caused by the calcified area, of that damaged OB:Occipital Bone, at childhood.

In addition, the change to blood flow, of Thalamus and Hypothalamus,means that flow would worsen due to it "furring up", over time.

These two are what you have issues with, leading to DX time, decades later.

We had an increasingly injured brain, as a child , waiting on the 'furring up' to happen. My TBI day was 15/2/81.

I was 6yr 11mth old. 🤔😞😫🧑

I forgot it, as you have.

Till I then injected 17.5 MTX:Methotrexate.

Then, a memorised day appeared, after 3 injection.

I say this after being dx @ 29. This is bang on the average age.

A REPAIR is possible.

The MOI means the body eventually has sensory confusion(Thalamus blog) and Hypothalamus can't deal with heat, and others, too. .

Thalamus and Hypothalamus had flow altered, regardless of the MOI, by the BM drop of Pons anyways, when Occipital leak/.burst/healed gap(?) happened.The need to improve flow, of blood, to Thalamus, while lifting BM off of the Diencephalon, can be achieved by using CF:Centrifugal Force.

HT is underneath it, but smaller. Filling HT is going to happen prior, to Thalamus being filled, and lifting BM. (neurologist opinion need)

The Dangers

The danger here is aperture length ,and revs,of TKMS. A causative injury may result if an MSer were subjected to CF at the wrong aperture distance, revs and angle.

However, if Thalamus were to be functioning, then cerebellum can't reach these friction points!

What I'm not sure of, is, will Thalamus stay inflated, and will the furred up loosened debris cause vein blockage or heart issues?

(I know we've all been unwell for years. This means our Thalamus and Hypothalamus have grown-up flattened. Therefore, with the pressure rise to unfurl them, removed, they may want to return to the "memory" shape)

However

There's been mention of Asprin being a possibility to treat MSers. They don't know why from thing I've seen.

I know. 🤔 😊 😄

Asprin thins the blood. This equals better flow of a flattened Thalamus. 😊

Better flow, means less chance of a Thalamus , secondary collapse, when it's filled with blood.

It would therefore be a really good idea to take Asprin an hour prior to TKMS.

The Methodology of Repair, using TKMS:THEKINETICMOMENTIALSYSTEM.

The COR:Centre Of Rotation has zero Centrifugal Force, potential.
le if an MSer were stood on it spinning, they'd get dizzy. No CF would occur.

If they stood less than 1 metre away from COR, and then rotated, they'd be thrown to the outer edge, ala "Sticky Wall" fairground ride.

If they were positioned and secured, on a Racer like frame midforce, near to COR, making a 90° bend with the head outermost, their blood would fill both hemisphere, Thalamus and Hypothalamus. This is in effect pumping the BM, or the top slice of bread in the sandwich analogy, off of it. [blogged previously]

This filling has to be done cumulatively. This would avoid a causative injury.

If they were to stand, a full 1 metre away from COR, and make the same 90°, more CF would occur.

If it were 2mtrs distance, even more so again!

Its finding the safe pressure of veins, with Diencephalon awareness(a check)
*(need vascular dr opinion+heart Dr+Neurologist)

Think of Thalamus as a mini shape brain. It's a chamber filled with blood. It has 4 blood inputs stemming flow to effect their output functions.

- Once impacted, all Thalamus results are different, have individual variance, greatly impact the TBI:Traumatic Brain Injury sufferer life and its all downwards, in the main, for the rest of their days. (done 5th May).

This is literally true.

Progression

Progression, is down to gravity. The cerebellum makes its way over the calcified burst, made so as a kid, then each head motion takes a tiny part of their BM.

Over time, more brain is impacted.

Thalamus is furring up after your OB burst, as is Hypothalamus, until dx, decade's later.

Reasoning

I know the difference of the big 2, is down to the magnitude of the bursting force, that separated Occipital Bone, as a kid, at EOC.

This means for PP, a larger force opening the midseam of OB, so then BM drops, equalling a harder compression of Thalamus and which is then meaning more healed FPs, due to that wider OB burst.

This, would need a larger aperture distance, to repair it, by filling Hypothalamus first, then a cumulative filling of Thalamus.

The brain, for all, was RR to start with. Depending on the MOI, means how hard BM is then rubbed off, by the skull, plus the FP burst of course.

MSer day

2 primary, 2 secondary and 2 RR....on Racer like frames, mounted, and secured, on TKMS, in an opposing weight adjusted, hexagonal shape.

Hexagon shape around the COR, with they 6 MSers, would be, OMFG!

They completely secured MSers, WOULD KEEP THEIR FOREHEAD ON HANDLEBARS, MAKING THEIR SPINE PARALLEL TO THE DECK OF TKMS . Adjustments if needed, as this is Important.

Varying aperture. Varied revs, would equal learning the ideal distance, and they all important revs.

I believe each TBI will be the same. Its the damage done to Occipital Bone, and the resultant impact force to Thalamus,, due to pons drop, that decides how to repair it, by aperture distance.

. ie: That impact to OB, will be proportional to the Thalamus, flattening, force.

Perhaps, a Primary greater aperture and Secondary lesser, to give you my pre assumed gameplan. This equates to my thinking a Primary Patient had a bigger Occipital burst than eventual Secondary. This bigger initial impact has likely, really flattened Thalamus and would need a bigger, initially at least, force, hence the bigger distance from COR, to start with.

Woopdiddlydo.

Ma grief is now true.

"Gonnae gies a shot".

"Is ma name in the pot?"

When will Keith learn.

The results we yearn?

The forces, to enable filling of both Thalamus and Hypothalamus(same forces lifting BM at both sides), have to be equal.

I also think, the direction of rotation, changing midway of the time frame, would have to happen, too.

Eventually momentum via CF, would make you form this tall shape. It is at they revs, we are close to the inertia needed to START to lift BM off Diencephalon and filling Thalamus, with

blood.

This is where times comes in. If you were kept at higher revs "Rx" for too long, you'd cause a causative injury .

For sure. 🙏

The speed and aperture distance? I need to find CF percentage against distance from COR.

This is revision. I know such a diagram exists, as I seen it at Nautical College! 👍

Must Avoid causative. Must not pong.

Research needed. (done 12th May)

Perhaps, the top slice of BM has to be lifted by inertia, to enable Thalamus/Hypothalamus to inflate?

TESTING

The ability to deal with heat, would be first to show an improvement via Hypothalamus.

Hypothalamus, is a guide here.ie its max pressure, or revs, is the overall max, when Thalamus is filled, with blood.

Hot bath monitoring at R revs, then R1, then R2 and so on.

Cover that wae, when the MSer gets worse, in the hot bath, or the temperature even. Then after several, you'd get a change, THAT says Hypothalamus is WORKING.

We would then have "Rx", which becomes the cumulative filling revs for Thalamus.

Testing, is going to be an exciting, wet drama.

I'd bet my life, on this.

I probably will! 😄👍🙏☎️🤔👏👏👏....

Conclusion

.

My thinking is something positive would be damn quick,but if its ridiculously easy, then a causative injury is close, too. (19 may)

I have lived this. All MSers have, in some guise.

Honest. Learned. Lived. Loved
+ Shared.

Ma Mate Is nearing,
I can hear him cheering.

" TKMS TKMS TKMS TKMS"

Thanks for your time,

Keith "MS is 3rd" Campbell, on the 23rd May, 2019 and edits aplenty.