



Obstacles to Dental Healing

Part I Overview

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Except for the teeth, hardly any other part of the body is damaged so early, so intensively and with such lasting effect: acid attacks by diet, bruxism (teeth clenching or grinding), iatrogenic (physician induced) influences from fillings, thermal and mechanical forces, and much more.

Except for the teeth, hardly any other part of the body has a vertical connection via acupuncture meridians to all the other organs of the body.

Except for the teeth, hardly any other part of the body has - as a result of neural switching - a horizontal connection via the trigeminal nerve (*N. trigeminus*) to the other cerebral nerves in the body and thus to the area of the brain that deals with sensation.

Furthermore, dental ivory (dentine) is in fact connective tissue, and thus everything that is used as filling directly into the dental ivory is in direct contact with the connective tissue and also with the regulatory system according to PISCHINGER.

Hardly any other part of the body is so frequently amputated, extracted and mutilated as the teeth.

It is inevitable that disorders occur in the maxillofacial region more frequently than in other organ systems.

Disruptive fields

About 70% of all disruptive fields are found in the maxillofacial region (including the tonsils and retromolar area). 70% of the disruptive fields are on the upper jaw and 30% on the lower jaw.

The following disruptive fields or obstacles to healing in the maxillofacial region should be considered:

1. vital teeth with reduced vitality and beginning root resorption
2. vital teeth with chronic inflammation of the dental pulp or pulpal necrosis (decomposition of the protein)
3. teeth with dead nerves
4. retained or dislocated teeth
5. residual osteitis
6. enclosed foreign bodies of all types
7. pathogalvanism as a result of various oral metals
8. chronically inflamed tonsils
9. the bite between the upper and lower jaw
10. The faulty occlusion of both jaws is a disruptive field in the wider sense.

It is the responsibility of dentists to recognise and eliminate the foci and disruptive fields which are the most important causes of dysregulation in the maxillofacial region. The treatment must be arranged in such a way as to prevent any additional strain on the patient's body and to support the body's ability to regulate itself.

But how do these disruptive fields arise? One thing that encourages them is caries in milk teeth which can lead to early gaps between the teeth or total loss of teeth. If the gaps are not dealt with using space maintainers, the result is mesial migration (i.e. the position of the

milk teeth changes, relative to the centre of the face), with the result that the permanent tooth does not have enough space to erupt. Even at this very early stage, dysregulations can occur which favour the development of disruptive fields.

Caries

Premature caries in the permanent teeth – in particular the 1st permanent molar (also called the “six-year molar“) can lead to destruction of the morphological surface of the chewing surface and thus to the indifferent setting of the fine adjustment of the mandibular joint, which in turn leads to premature failure of the stomatognathic apparatus (occlusion of the dental arches).

If the caries continues to the point of infection of the dental nerve, which frequently can only be treated by a root filling, this is yet another opportunity for a disruptive field to occur.

Caries which progresses slowly can also lead to decreased vitality and resorption of the root; furthermore it can lead to chronic pulpitis with necrosis of the root – in other words, decomposition of the protein. This frequently occurs without the patient noticing these changes.

Once the dental nerve has become infected, far-reaching problems can start. The pulp is no single-track canal, but instead there are several – even a large number of – lateral canals. It is impossible to reach these adequately by using conventional endodontics. The result is decomposition of the protein

in the remaining part of the nerve with corresponding negative consequences for the organism.

If there are further symptoms of pain and inflammation involving a tooth with a root filling, this tooth is often extracted. In case of any residual inflammation in the bones, this can lead to persistent osteitis of the jaw. At first this is hardly noticeable but later it may become a focus.

Teeth which have been retained or moved

For various reasons retained or dislocated teeth – in particular the wisdom teeth – do not have sufficient room in the jaw and within the rows of teeth. As these teeth are continually stimulated to grow, compressions of the third division of the trigeminal nerve are possible. This can result in a neural disruptive field.

Under certain circumstances the gaps between the teeth are closed off with prosthetic appliances. Often more than one metal is used (in dental medicine we speak of alloys – that is, combinations of metals), which can soon lead to pathogalvanism involving various oral metals.

Occlusion

The prosthetic appliances can show deficiencies in the restoration of the morphology of the surfaces of the teeth, resulting in the disruptive field of occlusion. This hardly ever leads to immediate problems, but they

build up over a period of years and can become acute after 5 – 7 years. The lower jaw is not linked by bone to the upper jaw: only the tendons, muscles and fasciae link the lower jaw to the skull. The exact positioning is determined by the upper surfaces of the teeth. If these are restored in a non-physiological manner or if any teeth are missing, this leads to faulty positioning with a shifting of the lower jaw. This can be associated with compressions of the jaw joint and its neighbouring structures.

From the dentist's point of view, this type of shift or faulty positioning encourages the clinical characteristics of neuralgia (in particular trigeminal neuralgia), head, jaw and facial pain, together with tinnitus and Menière's disease.

Summary

In dental medicine the probability of finding obstacles to healing is great. The mechanisms which lead to these are both many and long-term, so that each tooth can theoretically develop an obstacle to healing in a patient's lifetime. The problems are intensified by the current standard of prophylaxis of the population, which still can and must be improved significantly.

These obstacles to healing can primarily be found by means of an x-ray examination at an early stage. A panoramic radiograph (abbreviated to OPG or OPAN) is particularly suitable for this purpose, or – even better – radiovisiography. From these x-rays it is possible for

the dental surgeon to see beginning or already established changes in the teeth, periodontic regions and jawbone.

The first choice of therapy is surgical revision of inflammation, apical processes and dislocated teeth. Furthermore it is necessary to carry out absolutely clean dental treatment which is supported by complementary individual procedures.

Naturopathic physicians and therapists should ensure that they cooperate with dentists who employ natural healing methods. Frequently this can prevent treatment failures.

Part 2 of this short series, which will appear in one of the next editions of SANUM Post, will deal with root-filled teeth and their cause, consequences, prevention and attempts to revise them; Part 3 of this short series will present the holistic point of view and periodontal treatment (creation of an ecological oral milieu); Part 4 will deal with the necessity of recognising and treating functional disorders and with the treatments necessary when replacing lost teeth (prosthetics); finally Part 5 will deal with chronic pain of the jaw and face, trigeminal neuralgia, tinnitus and Menière's disease.

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