

**Dr. Ralf Türk**

Zahnarzt  
Telefon (05281) 4597

3280 Bad Pyrmont, den  
Haus Hemmerich  
Brunnenstraße 47

S u m m a r y :

Preventive dental surgery

In the author's opinion, routine extractions in the dental practice are generally not satisfactory, as not enough attention is paid to the bone lesion produced. Methods are described by which surgical therapy can be far more successful - especially where patients with chronic conditions are concerned.

**Dr. Ralf Türk**

Zahnarzt  
Telefon (05281) 4597

3280 Bad Pyrmont, den  
Haus Hemmerich  
Brunnenstraße 47

American Academy  
of Biological Dentistry  
Carmel Valley, 6. - 9. May 1987

P R E V E N T I V E   D E N T I A L   S U R G E R Y

Whereas major maxillary surgery - practiced in hospitals and clinics - has made important progress and achieved considerable success, daily oral surgery in most dental practices, in my opinion, is still carried out as in the year one. Of course, this doesn't have to surprise us when we look at the so-called valid dental textbooks still in circulation today: they throw a poor light on the training of dental students at our universities. The fact that, even in what is called a 'simple' tooth extraction, a wound is produced in the bone tissue, simply seems to be neglected. When such a wound does not receive the proper care, this not only produces local damage but also constitutes a disturbance to the entire organism, which can, in the long run, lead to a chronic condition.

There is almost always a discrepancy between major and minor maxillary surgery - and it is our aim to eliminate or at least reduce this discrepancy.

As supporting evidence, I could cite thousands of cases in which I have proved, from measurement, tests and histological findings, that postsurgical residual processes in the maxilla, badly healed wounds or other neglected inflammatory processes in the bone have resulted in severe general disturbances which could be eliminated after cleaning up the maxillary areas concerned and specific subsequent treatment.

We must therefore revise our thinking in this field and conduct so-called simple extractions in taking great pains to prevent any pathological consequences, thus saving the patient much pain, trouble and expense.

For these reasons I take just as much care in performing so-called minor oral surgery as with major surgical interventions. I have worked out a special schedule, in which the healing of chronic conditions has been given a special place:

After obtaining the various clinical findings (patient history, radiography, vitality test, measurement of electric potentials, gland palpation, examination of nerve outlets and Adler's pressure points), my diagnosis is confirmed by regulation and localization tests.

Once all these facts are known, I establish a treatment plan. Here, the decisive factor is the regulation capacity - and thus the resistance - of the patient.

For this purpose I use in my practice the leucocyte test to obtain an insight into the reticuloendotheliase system (RES) and a decoder measurement to assess the electrolytic system. If these tests show restrictions indicating a paradox reaction or even a rigidity, intensive preliminary treatment with different therapy methods must be applied prior to actual surgery.

## LEUCOCYTE TEST

Normergic reaction

Change in no. of  
leucocytes (WBC)Individual  
initial valuestime  
h

No initial treatment required

## LEUCOCYTE TEST

Weakened resistance

Change in no. of  
leucocytes (WBC)Individual initial  
valuetime  
htime  
h

Paradox reaction

Regulatory rigidity

Preliminary treatment is **INDISPENSIBLE!**  
Otherwise more damage than use

Blood preparations by WALA

Antisensitization according to THEURER

Autohemotherapy (injection) with and without ozone

Thymus doses, Elpimed

Homeopathic nosode administration, neural therapy

Intestinal cleansing and, among other methods,

biological rehabilitation therapy

Once, following intensive preparatory therapy in teamwork with the relevant general practitioners and specialists, the regulatory mechanisms of the patient to receive surgery have regained normal values as far as possible, the date of the operation can then be determined in accordance with the most favorable biorhythmic factors.

The evening before the operation, the patients come to the clinic for a final assessment of their circulatory and Quick values. If the Quick values are unfavorable or there is a special propensity to hemorrhage, relevant medication is tested and administered the same evening.

As practised up to now, conventional dental surgery may here also be taken as a general prerequisite - however, as mentioned at the beginning, it is simply no longer sufficient for present-day patients suffering from stress and previous damage. This was clearly demonstrated to me already years ago when testing former extraction wounds. Macroscopic and microscopic examinations show that apical processes occur in the surrounding bone in every form of pulpitis or pulp degeneration, so that an independent process is produced which continues even after extraction of the tooth causing it, unless it is removed with great precision.

A clear survey of the area under surgery is a prerequisite for careful and thorough treatment. To avoid gum traumas as far as absolutely possible, I generally fold the tissue open prior to extraction. In fact, I apply the trapeze cut to compensate for tissue tension and to provide sufficient covering material for the final suture. In teeth affected by periodontitis and frequently with molars, the buccal flaps are not sufficient to guarantee a saliva-resistant suture. I then cut a slit in the periosteal area where the bone is still intact.

From my own experience, I recommend making the cut with an electrotome. The advantages of this are:

- coagulation of the cut edges;
- small blood vessels, when cut, are immediately closed to avoid extensive hemorrhage;
- in addition, the periosteum and gum tissue are welded together, which is a considerable advantage for a saliva-resistant suture.

As already mentioned, work on the bone should always be under observation. In the case of extractions, the buccal bone wall should always be folded down. The palatal and lingual sections of mucous membrane should remain untouched as far as possible and remain firmly attached to the bone, to maintain a supply of nutrition to the remaining bone after surgery.

To avoid iatrogenic opening of the maxillary cavity in the upper jaw and a nerve irritation in the lower jaw - which particularly in cases where wisdom teeth have to be chiseled out - I separate, if necessary, the crown and roots of the tooth to be extracted and then surgically remove the roots individually with great care.

Experience has taught me that, in the case of focally infected teeth, the inter- and intraradicular septa are always affected by additional inflammation.

After careful initial milling (I principally cut bone at 8 - 12,000 rpm only), I rinse out the operational area with a fairly powerful jet of ozonized water, thus obtaining not only a relative freedom of blood, but I am also able to distinguish the affected from the healthy spongiosa. This means that I can work very carefully, being able to retain a good bed for a later prosthesis.

During the entire milling/cutting procedure, the drill and the area under surgery receive rinsing with ozonized water. This means that, both when cutting and blowing out the spongiosa, the whole area is kept sterile to a maximum extent as ozone is a known bactericide, fungicide and viricide agent.

To prevent hematomas, venous and arterial hemorrhage should be stopped before suturing and the whole time when working with the electrotome.

However paradox it may sound, I always carry out hemostasis during rinsing with ozonized water; at the same time I avoid heat necrosis in bone tissue.

Finally, before the suture, the bone edges should be rounded off. Only in this way am I able to obtain a bed thoroughly capable of supporting a denture.

Cleaning up the mucous membrane is an important factor in good wound healing. Granulation tissue and deep inward epithelial growth must be removed accurately and with great care before being able to start closing the wound.

Care should be taken that the edges of the wound be sewn together layer for layer; only in this way are the edges capable of holding well together.

The stitches should not be spaced further apart from each other than 2 - 3 mm. In my case, colored acetate silk has proved itself to be the best material, as it is least capable of producing allergic reactions and can be removed with the least trouble. I remove the stitches between the 6th and 8th days.

Surgery on residual foci in toothless jaws is carried out taking the same precautions, i.e.:

- Jaw ridge-to-center section with vertical trapezoid cuts.
- Folding down of the buccal mucosal flaps,
- Folding up of the cortical tissue at a sufficient distance from the ridge of the jaw to obtain the best possible base for a denture, and
- Rinsing with ozonized water under pressure.

If the inflammation in the lower jaw has penetrated to below the mandibular nerve or has even affected the bony section osteolytically, the ozonized water in the fundus must remove the sequestered spongiosal sections.

In the lower jaw, the most frequent osteolytic processes are found in the retromolar area and very often in the rising branch. In this case, I cut open the buccal cortical tissue until I reach more deeply situated healthy spongiosa, continuously rinsing with ozonized water.

In the upper jaw, there is a site which has a predilection for chronic inflammations involving osteolysis of the maxillary tuber (tuberosity). Particularly the tuber is neglected in many cases when surgery is performed, although it is frequently subject to osteolytic damage to such an extent that it can be ablated with a sharp spoon excavator.

In the treatment of residual ostitic processes in the upper jaw, the inflammation has often progressed in many cases to include an infection of the cortical section of the maxillary sinus floor, which then has to be included in surgery to a considerable extent. In doing so, however, one must work very carefully indeed to avoid arrosion of the mucous membrane of the maxillary sinus.



If, before surgical treatment of an upper jaw quadrant, there is a suspicion, confirmed by radiography and testing, of dentogenous participation of the maxillary sinuses in the focal processes, I carry out antroscopy at the same sitting.

For this purpose, I make an opening into the maxillary sinus at the canine fossa with the trapanation drill. If the findings are positive, I operate on the maxillary sinus under local anesthetics during the same sitting, and apply a nasal window. I remove only the affected mucous membrane and save healthy tissue as far as absolutely possible.

After termination of the operation and application of a saliva-resistant suture, an intraoral wound dressing is applied for every oral intervention.

This dressing consists of an approximately 2 - 4 mm thick layer of beeswax over the wound surface: this then receives a layer of covering material which may consist of plastic plates or the already available prosthesis. In the case of small surgical areas, a 'Peripac' or self-hardening dressing has proved its value. It is important that the edges of the covering material be coated with sufficient beeswax to avoid pressure necrosis, as the wax is moldable at body temperature, thus compensating any pressure easily.

This dressing has a number of functions:

- it prevents subperiosteal hematoma,
- it protects the wound from mechanical loading through tongue pressure and low pressure from swallowing,
- it prevents direct soiling from food mush,
- and - very important! - the chance of a hematoma through pressure of the periosteum on the bone is kept as low as possible, and a basis for a later denture/prosthesis is prepared.

The dressing remains at least for 2 - 3 days after initial application.

But naturally, a healing process free of complications is not entirely possible without the cooperation of the patient!

In my clinic, the patients are under observation following major surgery. For this reason, our schedule is easily adhered to, i.e. 3 days confinement to bed, 2 days liquid food only, with additional, previously tested, therapy administered on a daily basis. Treatment with a relaxation (sweep circuit) oscillator, acupuncture, short-wave irradiation sessions and ozone injection autohemotherapy etc.

In the case of out-patients, it is necessary to inform them about the dangers of infection or destruction of coagulated blood. This is why such patients should stay in bed for at least one day, eat nothing for one day, i.e. take only liquids, and only consume soups or soft foods for the following 3 days. In particular, smoking is strictly forbidden for 8 - 10 days.

In my experience, if all these measures are adhered to conscientiously, a good and rapid healing of the wound may be assumed as being certain.

The post-extractional pains, which are justly feared in most cases, are an extreme rarity in my case due to the accuracy and diligence with which I operate. In addition, a wound healing free of complications is the surest protection from future residual ostitis.

The surgical prevention thus obtained can be viewed as a safe guarantee against focal conditions in the future.