

PREPARING FOR TOOTH LOSS FROM CAVITATION SURGERY

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Since publishing *Beyond Amalgam* in 1998, I've received a steady stream of inquiries from readers, most of whom are dental patients trying to make decision about treatment of suspected jawbone cavitations. In those early years, I had more questions than answers myself despite being the person who "wrote the book about cavitations."



A turning point in my understanding of jawbone necrosis (dead bone), both personally and professionally (as a writer/teacher in the holistic health field), came last year (2001) when I spent the better part of the year working for CAVITAT Medical Technologies in Colorado. Here I got to see the Generation 4 CAVITAT in action on numerous occasions and was able to come to an understanding of how this new technology works. I also had the opportunity to listen to and speak with some of the great pioneers in the cavitation arena. I got to watch as dentists across the country were introduced to bone sonography, a technology that is very different than the x-rays they're accustomed to routinely using. While most caught on readily to the technique of scanning the jaw and understood how to interpret the scans, all were

faced with the dilemma of coming to terms with what they saw in them — invariably a good deal more necrosis than they suspected. While the dominant response could probably be termed 'cautious acceptance' of the technology, there were a minority who went into denial, refusing to believe what they saw. On the other side of the spectrum was another minority — those who dared to believe what they were looking at and act upon it. These were people like Wes Shankland, Columbus OH dentist who did surgery on my maxilla (upper jaw) in March of 2001 and surgery on my mandible (lower jaw) 4 months later. What I experienced in his office during my first appointment that March would make an indelible impression on both of us and lay the groundwork for a deeper understanding of the disease process with which we'd so long dealt — he as a dentist, and I as a patient. It would also mark my initiation into the world of dentures.

When I first saw Dr. Shankland, I knew (from recent panorex evaluation by another dentist) I had a root tip from an old wisdom tooth extraction at site #1 that had migrated into my sinus cavity. I also knew I would need to lose the adjacent tooth and probably a few others due to spreading necrosis, based upon our previous discussion of my panorex. However, neither Dr. Shankland nor I were prepared for what we saw on the CAVITAT scan of my maxilla — every tooth site on the left side of the upper jaw was showing an abundance of red (necrosis) on the CAVITAT scan, as were most on the right side. Since Dr. Shankland had just purchased his CAVITAT, and I was the first patient with whom he used it, he was shocked to find necrosis that was much more widespread than he'd determined based on panorex analysis. To his credit, he dared to act upon what he saw. Over the next two days, he removed 13 of my maxillary teeth, along with the root tip from site #1. Any doubt that he may have had initially about the accuracy of the CAVITAT scan was dispelled soon after he cut into the jawbone. Biopsy reports and analysis of the pulp chambers of the extracted teeth also later confirmed the accuracy of the scans and the necessity for removal of the teeth. The bone healing from that surgery was rapid and complete. Four months later, the scan of my maxilla was showing green (healthy bone) at all sites. This taught me that a thorough removal of necrosis (sometimes necessitating extraction of seemingly 'good' teeth) is the key to successful surgery and good bone healing. It gave Dr. Shankland the confidence to repeatedly act upon what he saw in CAVITAT scans. Now, over a year later, he says he'll never again practice without a CAVITAT, and credits bone sonography with greatly improving his surgical outcomes.

Before flying from Denver to Columbus in March of 2001, I had the foresight to consult with a local dentist

and have an impression made of both upper and lower jaws since I knew I'd be losing some teeth but wasn't sure exactly which ones or how many. After the surgery, Dr. Shankland phoned the Colorado dentist to tell him which teeth had been extracted so that the work on my denture could be initiated immediately. I knew since I'd only be in Columbus for three days, there was no way Dr. Shankland could do anything about fitting me with a dental appliance. Since that time, I've spoken to numerous patients who are flying out of town or out of state for surgery and have fielded their questions regarding what to do about filling the space left when teeth are removed.

The patient who travels to consult a dentist about possible cavitations should be prepared to lose teeth. The *possibility*, of course, exists that extractions will not be necessary; however, if the patient has a history of root canals, large restorations, chronically sensitive teeth, implants, periodontal disease and/or surgery or other jaw trauma, it is likely that necrosis can be found under treated and adjacent teeth — and possibly elsewhere. A point that I want to make very strongly is that we need to be prepared for extractions in the event that they are found to be necessary. If it is just one or two posterior (back) teeth that are lost, there will be no hurry to have a partial denture made, and the patient can wait several months to have impressions made of the jaw so that an appliance can be fabricated. I should say here that I believe a partial denture to be the safest choice where restorations are concerned. Crowns, bridges, implants — these all subject the jaw to further trauma which can give rise to development of cavitations or spreading of existing ones. A partial denture, on the other hand, provided that it is made of biocompatible material, does not cause any trauma to the jaw. Such a prosthesis, since it is removable and generally taken out at night, has limited extremely limited potential to cause harm.

If more than a few teeth need to be extracted, or if critical anterior (front) teeth are removed, it is advisable to have an appliance made as soon as possible after surgery. (It can even be made beforehand, if it is known which teeth are to be removed.) I found that placing a denture (with a soft lining) in my maxilla early on served as a sort of bandage for the fresh wound. As the jaw heals and the gums shrink, the soft lining of the appliance is replaced to accommodate the shift until maximal healing has occurred, at which time a 'hard' relin can be done.

It is important for the cavitation patient to select his partial/denture material beforehand. This selection should be based upon biocompatibility testing. Serum antibody (blood) tests are available which will rule out incompatible materials. Those materials testing as compatible should be further screened through bioenergetic testing or applied kinesiology (muscle testing) to assure compatibility. See my separate article on Serum antibody testing for more information on this subject.

There are two further considerations with regard to complete and partial dentures — these have to do with aesthetics and fit. I had worn a bottom partial for several years before being fitted for an upper denture and found it quite difficult to get a good fit. Apparently some people (those with wide dental arches) are easier to fit than others (with narrow arches). I have also found that the prosthetics skills of some dentists leave something to be desired. Again and again I would experience the same scenario: A partial denture would be fabricated by an out of town lab. It would be too tight, so the dentist would adjust it. It would then be too loose and have to be sent back to the lab to be relined. Each time I'd lose a tooth, the attempt to add a tooth to the existing denture failed, necessitating an entirely new plate.

I have largely solved the problems of aesthetics and fit by finding a prosthodontist who is willing to work with biocompatible materials. Prosthodontists are dentists who specialize in making partial (where some, but not all, teeth are missing), and complete dentures (for a totally edentulous arch) and other dental appliances, both fixed and removable. They can be expected to have a higher skill level in this regard than the average dentist. However, it is rare to find a prosthodontist with both an understanding of the concept of

biocompatibility and experience with fabrication of biocompatible non-metallic materials. Finding such a dentist can be difficult and may require that the patient once again travel for the best results – OR educate a local prosthodontist about biocompatible materials.



Aesthetics is a subject that took on importance for me when I got my first complete denture, the denture I now refer to as my “horse teeth.” Here a picture is worth a thousand words. Note the difference in my appearance with this denture (far left) and a new smaller, more contoured one. The first denture showed way too

much pink when I smiled, with the teeth set down too low. It also took up a lot of space in my mouth so that I found it difficult to talk and eat.

My experience with cavitations and tooth loss has taught me that we need a revolution in dentistry to undo the iatrogenic (physician-induced or dentist-induced) harm that has been done. The new ‘army’ in that revolution will be the front line guys, the cavitation surgeons, flanked by dentists with a general practice and other practitioners who screen for cavitations, and holistic prosthodontists who can skillfully fabricate functional, aesthetic partials and dentures using biocompatible materials. I envision a day when every cavitation surgeon shares office space with a prosthodontist who has his own lab on the premises so that safe, good-fitting, attractive dental appliances can be fabricated without delay for the cavitation patient.

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