Chapter VIII
The Physiologic Dentist and the Mechanisms of Disease

Gradually, contemporary medicine has enlarged its concepts of pathogenic forces. Bacteriology is now included within a broader view, and other factors such as nutritional deficiency, physiologic imbalance, physiologic overstimulation, endocrine disturbance, and mental duress have been recognized as independent factors in the causation of disease. The Stress-Adaptation Syndrome offers us an explanation of the function of these factors in the origin of disease by developing the physiological and morphological changes which occur as a bodily reaction to any stressor. There are two general ways in which these various stressors affect the patient:

1. A pathogenic stressor such as infection or emotional strain causes the pituitary to secrete adrenocorticotropic hormone (and thus adrenal-corticoids) and somatotropic hormone. These adaptive hormones begin the process of, and determine the course of, the body’s reaction to the pathogen. If, however, the stressor continues its work indefinitely, the body passes through the stages of resistance and finally exhaustion. Thus, any pathologic influence can produce more or less extensive disease by continuance of the stress-factor.

2. A pathogen of any kind, topical or general, can act as a conditioning factor, i.e., it produces the GAS and/or LAS, and in addition, it can be the cause of a derailment of the adaptation syndrome when a new stressor is applied.

I. Mental or Emotional Stress as It Relates to the Adaptation Syndromes

The concept of psychosomatic disease was well established and accepted before the publication of the work of Selye, although he demonstrated to a great extent how psychic duress affects the patient. In the earliest stress experiments, it was found that emotional stress produced the same group of symptoms characteristic of the GAS as did physical stressors. It has long been recognized that emotional outlook is an important factor in the recovery of patients suffering from physical diseases, but until it is realized that emotional duress of itself can produce the stages of the GAS, the connection between psyche and soma is not appreciated.
Beyond the general stress produced by emotional strain, there are certain topical maladies due to emotion which complicate the problem. Certain cardiovascular difficulties, peptic ulcers, and other disorders result from prolonged or intense emotional duress. Such difficulties involve the patient in a cycle – these diseases are produced by emotional strain through independent channels and also through the action of the GAS. In turn, the diseases produced (such as peptic ulcer) act as further stressors.

In many areas which concern the medical doctor, the mechanisms of psychosomatic disorder have been elaborated, but less advancement has been made in those areas which concern the dentist. In one of the available examples, Campbell points out that experimental observations have demonstrated that the pH, the viscosity of saliva, and to some extent the mineral constituents may be altered under the influence of fear, rage, or pleasure. Calcium and other ionized salts of the body fluids are affected by emotional states as are the white and red cell counts of the blood. Excessive occlusal stress leads mechanically to paradentosis.2

The significance of psychosomatic disorder is especially evident in instances where emotional strain in the patient causes bruxism and hypertonic clamping. This of itself brings about a degeneration of muscle tonus, but when it is combined with malocclusion of the teeth, imbalance of all structures of the head related to the oral cavity takes place. Thus, hypertension not only produces the Adaptation Syndrome through the general stress exerted, but in the patient whose emotional problem causes him to indulge in hypertonic clamping the bruxism, the lack of physiologic balance and temporomandibular joint malarthrosis resulting from malocclusion, and the degeneration of muscle tonus (spasms) acts as a topical stressor as well. How functional disorders cause structural pathology has been well documented by the research of Whatmore and Kohli. Through signaling errors within the nervous system, functional pathology (physiopathology) causes aches and pains, depression and fatigue, insomnia and depression, GI and gynecological disturbances, and many other pathologies.17 18 This is an important connection between the work of the dentist and the general health of the patient.

It is necessary to consider the reverse situation also. The balance of the bodily organism, and particularly the endocrine balance, affects the emotional life of the person. Again a vicious circle is possible – physical malady can produce emotional stress which in turn produces further physical disturbance. “Derailments” of the adaptive processes through the influence of conditioning agents have important effects upon the emotional state of the patient.
II. Focal Infection as It Relates to the Adaptive Process

The Focal Infection as outlined by Selye has already been discussed, but it will be useful here to summarize its role in the health of the patient:

1. Any focus of infection elicits the Local Adaptation Syndrome.

2. Because focus of infection is a stressor, it can have two effects on or within the body:
   a. It can bring about the processes of the GAS. If such an infection is constant or of long duration, it is capable of producing the derailment of the adaptive processes observed in the diseases of adaptation. Furthermore, chronic foci of infection are quite capable of bringing about the stage of exhaustion – the last stage of the adaptation syndrome – directly in the locale of the focus and indirectly in the locale as a whole, if the focus is of sufficient strength and duration.
   b. It can act as a conditioner. Since a focus is a stressor, when it is present in the body, it is an agent of conditioning the body to further stress in an adverse manner. A new stressor, acting on the system which is already in a condition of stress, due to the focus, is capable of producing the diseases of adaptation.

III. The Relationship of Functional Pathology of the Stomatognathical Structures to Stress-Adaptation

The mouth is the only part of the body which contains so much symbolism, performs so many functions, or contains so many specialized structures. Frequently, however, its importance is only superficially understood by the dentist and by the physician. Neither seems to realize fully the relation which the condition of the mouth bears to the total well-being of the patient. The mouth is related by complex, delicate structures to the head, and through the head to other parts of the body. Disturbance of the relationships between the oral cavity and the remainder of the head and the soma results in a number of pathologies which have been inadequately developed by either medicine or dentistry.

Shore says the crucial structure for the dentist, the bridge between the oral cavity and the rest of the body, is the mandible and the structures contiguous to it. Of these structures, four are of primary concern: the teeth, the periodontium, the musculature controlling the mandible, and the temporomandibular joint. When the balance of function between these structures is upset, pathologic conditions develop which, because they are dependent upon basically dental structures, are the concern of the dentist, even though they are quite removed from the oral cavity.
The four compensating parts of the stomatognathic system are the teeth, the periodontium, the temporomandibular joint, and the neuromuscular system. These make up a quartet of compensation. When all the parts function in complete harmony, physiologic aging of all component parts results. Should any one part function improperly, then the normal stresses and strains of function become greater or lesser on the remaining parts. \(^3\)

Years of research have led the author to a conclusion shared by many: the proper occlusion of the teeth is an extremely important influence in the health of the person. \(^4\)\(^6\)

The principal pathologic sequelae of malocclusion are neuromuscular dysfunction of the mandibular musculature and malarthrosis of the temporomandibular joint. Dysponesis plays a role in the resultant neurophysiologic sequelae. \(^19\) Two “foci” of infection, otitis media and sinusitis, are commonly found concurrently with these conditions, and they are routinely mitigated or cured by correcting the malocclusion. These conditions of low grade infection in the head, along with the disturbance in the physiologic balance of the structures which results from malocclusion, are the point of contact through which the dentist can influence the entire health of the patient. He must consider these possibilities:

b. Dysfunctional disorders produce neuropathologic signaling errors within the circuitry. This dysponesis causes physio-pathologic diseases in various sites within the body. \(^17\)\(^18\)\(^19\) Malocclusion and its resultant imbalance of structures causes the focal infections in turn to act as stressors.

c. Malocclusion and its resultant imbalance of structures causes the focal infections in turn to act as stressors.

d. Malocclusion and its resultant imbalance of structures, by causing these localized difficulties, produces the General Adaptation Syndrome and thus sets up a number of conditioning factors permitting the development of diseases of adaptation. Continuation of the stresses of imbalance, bruxism, and dysarthrosis heightens the process.

This, briefly, is the argument for physiologic dentistry. It is an established fact that dental infection (i.e., intra-oral infection) is a disturbing pathogen. However, the disturbance of physiologic structures resulting from malocclusion (which is the concern of the dentist) is a disturbing pathogen. However, the disturbance of physiologic structures resulting from malocclusion (which is the concern of the dentist) has far more widespread implications. It is our belief that the GAS perpetrated through neuropathologic dysponesis is the principal explanation of the systemic disorder which one observes in connection with physiologic imbalance of the structures related to the oral cavity. The scope of these disorders,
which is presented here in a general way, may at first seem quite extensive. As the dentist and physician work together on patients suffering from dental stress due to neuromuscular imbalance of the muscles controlling the mandible, they will soon understand that the scope of disorders may in fact be expanded.

IV. Malocclusion as It Relates to General Health

The following controlled study[11] will serve to indicate the possible role of malocclusion and its attendant neuromuscular imbalance. It is the outcome of four decades of research in dental rehabilitation. During the past three decades a few thousand temporomandibular joint malarthrosis cases were observed or treated.

The reader would misinterpret our intent if he were to draw the conclusion that the dental stress resulting from malocclusion was the only stress operable in the total person, or that we are proposing that proper occlusion is the panacea for all ills – or even as the sole treatment for the disorders outlined herein. Experience from combined medical and dental treatment, however, has demonstrated that dental stress can be the root or cause of many disorders in the body because it is a constant, unrelenting stress, always operable until the dentist intervenes.

During the course of this research, the patients were divided into four groups.

**Group 1:** These patients were interested in thorough dental care. They were asked no questions and were given no information. Months after the dental treatment was completed, a thorough medical history was taken.

**Group 2:** A routine medical history was taken on these patients before dental care was begin, but they were given no information, and no prognosis was made.

**Group 3:** A routine history was taken and our treatment procedure was fully explained to these patients. They were also informed fully on what results we expected to achieve.

**Group 4:** This was strictly a control group. No work was done on these patients for one reason or another.

Two hundred and forty seven patients were involved in this report. The four groups were numerically comparable: the smallest group totaled fifty-seven and the largest numbered sixty-six. All patients had a temporomandibular joint problem with crepitation, subluxation, and a disturbance in opening and closing movements of the mandible. Every case was an easily recognizable condition of malocclusion. No questionable cases were used in this study. There was a severe overbite; or several missing, overerupted, or tilted teeth, often accompanied by periodontal destruction; or a severe crossbite with missing and drifted teeth; or an excessive freeway space with an irregular occlusal place.

Treatment varied with the individual, but all cases were handled
by altering the maxillo-mandibular relationship to free the mandible so that it could assume its most relaxed position at rest and in occlusion. If an acrylic treatment template was placed, the occluding surface was kept as flat as possible to allow the mandible to gradually reorient as physiologic muscle function returned. Teeth in extreme supraocclusion or badly involved periodontally were removed and partial denture splints were placed, taking care to avoid confining intercuspation during the treatment period. When deemed necessary, full dentures were constructed. Where freeway space was inadequate to place a template, occlusal fillings were placed in the posterior teeth to gain dominant molar support and to free the intercuspation of the teeth. In no case did the treatment infringe beyond the freeway space, and an attempt was made to leave no more than 2 mm. interocclusal space as the starting treatment relationship.

Usually the patient was seen at subsequent intervals of two days to a week, gradually lengthening the interval between visits to a month. Necessary adjustments usually involved eliminating premolar prematurities, which were more unilateral in nature. The controlling musculature normalized as the mandible, head, neck and body assumed a more normal and stress-free posture. Usually crepitation and the accompanying head pains had subsided before the second appointment. Often this happened before the patient left the office or within an hour or two after the treatment was initiated.

The scope of the syndrome of temporomandibular malarthrosis is considerable. It should be noted that the area of the difficulties broadened as research progressed and more and more patients were successfully treated. The following list is quite complete. The disorders listed were observed to be coexisting with this dental stress condition and routinely disappeared once the malocclusion was corrected and the dental stress problem of temporomandibular joint malfunction and neuromuscular imbalance was eliminated.

THE DENTAL STRESS SYNDROME

<table>
<thead>
<tr>
<th>% of incidence among the adults studied.</th>
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<tr>
<td>1. AURICULOTEMPORAL SYSTEMS</td>
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<tr>
<td>A. Symptoms of the TMJ area and masticatory manifestations</td>
</tr>
<tr>
<td>1. Crepitation</td>
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<tr>
<td>2. Subluxation</td>
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<tr>
<td>3. Pain or tenderness</td>
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<tr>
<td>4. Disturbance in opening and closing movements of the mandible.</td>
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<tr>
<td>(These four symptoms are 100% mandatory for that was the basis for the study.)</td>
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<tr>
<td>Oral Subgroup</td>
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This table summarizes the symptoms and their incidence in the study.
a) Numbness of and around the teeth 13%
b) Aura of toothache 14%
c) Facets 89%
d) Periodontitis 68%
e) Dry mouth 18%
f) Burning sensation 14%
g) Puffy and distended lips 9%
h) Ropey saliva (6% had extremely ropey saliva) 64%
i) Calculus deposits (Increased with severity of the case in the adults and observed in occasional children.)
(Symptoms c, f, and g were observed in the more advanced problem cases.)

B. Pathology of the ear (in one form or another.) 100%
1. Otitis media (Frequent among children with malocclusion. An occasional acute problem among adults.)
2. Excessive cerumen 86%
3. Itching-occasional 74%
4. Tinnitus 92%
5. Earaches-occasional 23%
6. Vertigo 74%
7. Falling (Sudden loss of static sense.) 7%
8. Hearing loss (gradually progressive in a typical pattern of hearing acuity. Severe hearing loss is less frequent.)

C. Pain in the head and neck 96%
1. Headache
   a) Women (Migraine-frequent, sinus-frequent.) 99%
   b) Men (Migraine-infrequent, sinus-fairly common.) 47%
2. Sensitive scalp (A frequent female complaint.)
3. Neuralgic pains (Constant or intermittent.) 82%
4. Nape of neck and shoulders (Dull ache and tiredness.) 94%

II. RESPIRATORY SYMPTOMS

A. Sinus and throat (Constant, except for fresh-air addicts.)
1. Post nasal drip 93%
2. Habitual clearing of throat 84%
3. Sinusitis-chronic with acute flare-ups 86%
4. Chronic colds 58%
5. Laryngitis-constant or chronic 17%
6. Chronic sore throat or tonsillitis (Very frequent among children but less frequent among adults.)
   Allergy Subgroup
   a) Sneezing (Occasional or sneezing spells.) 57%
   b) Hayfever 21%
   c) Asthma 7%

III. OCULAR SYMPTOMS

Some symptomatology of the eye is routinely found. 84%
1. Injection (Very common.)
2. Iritis (Occasional.)
3. Scleritis (Occasional.)
4. Photophobia (The most frequent symptom found in this area.)
5. Blurred vision (Common in advanced cases.)
6. Itching (Frequent.)
7. Burning (Fairly common.)
8. Tearing (Fairly common.)
9. Muscle twitching below the eye. (Common but periodic.)
IV. SKIN AND HAIR SYMPTOMS
1. Dry skin (Hands and scalp predominantly, face and upper torso common but less frequent.) 93%
2. Skin rashes as a chronic problem 9%
3. Dermatitis 6%
4. Acne (Frequent among juveniles and occasional in adults.)
5. Dry and brittle hair (Common complaint of most women.)
6. Diffuse hair loss (Common complaint among women.)

V. VISCERAL SYMPTOMS
1. Upset stomach 59%
2. Heart burn 27%
3. Gas and/or puritis 29%
4. Nausea 13%
5. Constipation (Chronic-ranging from an occasional to a severe problem.) 92%
6. Diarrhea (Chronic or an occasional problem.) 4%
7. Bladder infections (Chronic problems.) 26%
8. Frequent micturation (Requiring getting up nights.) 29%
9. Kidney infections (Bed wetting is a frequent problem in malocclusion children.) 17%

VI. GYNECOLOGICAL PROBLEMS 99%
1. Irregular menstrual cycle 99%
2. Premenstrual tension 96%
3. Premenstrual or midmenstrual cramps and pain 97%
4. Menstrual flow excessive-in amount and duration 94%
5. Amenorrhea 4%
6. Frigidity (Onset usually occurring after two or three children.) 85%
7. History of miscarriages and/or inability to conceive 51%

VII. GENERAL SYMPTOMS 89%
1. Chronically tired (Blood tests usually show lowered hemoglobin.)
2. Increased nervous tension 80%
3. Malaise 61%
4. Restless sleep (Awakens tired.) 76%
5. Numbness of hands (Often awakens with hands numb.) 12%
6. Cold hands and feet (Poor circulation.) 67%
7. Back and leg aches (Ache-all-over feeling in some cases.) 47%
8. Thirsty (Much water doesn’t satisfy.) 43%
9. Restless nibbling at food (Yet, unsatisfied and uncomfortable.)
10. Blood (Variations in count and quality are not rare findings.)
11. Lowered Hemoglobin is a constant finding.
12. Lowered thyroid activity is also a constant finding.

VIII. MENTAL SYMPTOMS 97%
1. Depression (Routine among females.)...Females
2. Irritated (Temper loss is common among males.)...Males
3. Worrying (Routine among women.)...Females
4. Melancholia (Not uncommon.)
5. Hypochondria (Frequent, especially among females.)
6. Excessive dreaming (Disturbing dreams, rarely pleasant.)
7. Forgetfulness (A common complaint.)

IX. BODY POSTURE PROBLEMS 84%
1. Scoliosis is a constant finding
2. Kyphosis is often observed
3. Lordosis is demonstratable with full spine x-rays
4. Uneven shoulder height is almost constant
5. Head tilted toward elevated shoulder is almost constant
6. Rotation of the pelvis is almost constant
7. Uneven leg length is almost constant
8. Rounding of the shoulders is frequently noticed
9. Disturbed posture of the atlas and axis is constant

(It is exciting to note the close correlation between the vertebrogenic-somatic dysfunction reported by Nobel laureate Tinbergen and the Dental
Distress Syndrome. The reporting of Alexander's muscle therapy to reposture the body and the subsequent correction of a host of somatic and psychic illnesses was delivered to the Nobel Dignitaries when Tinbergen accepted the 1973 Nobel prize for medicine and physiology. Dentistry should take note that these reports coincide with the normalization of spinal posture, resolution of the upper respiratory problems etc., herein described by physiologically repositioning the jaws and teeth. It is interesting to note the routine interplay of the autonomic nervous system in the symptomatology throughout the total person when analyzing the data on each patient. Also of interest is the routine picture of endocrine gland disturbance that Selye so ably depicted in the GAS brought on by any stress to the body.

After definitive dental care to eliminate the malocclusion and the resultant dental stress factors, the results in the three treatment groups were:

- **The first group**: Asymptomatic in 92% of the cases.
- **The second group**: Asymptomatic in 91% of the cases.
- **The third group**: Asymptomatic in 92% of the cases.
- **The fourth group**: The control group improved in 6% of the cases but were not asymptomatic. The condition worsened in 94% of the cases.

The following observations will be of interest: In group four, each case of improved health was accompanied by the removal of stress of some kind. Two patients changed residence areas and were no longer unhappy. One patient resolved the family problem that was a constant source of worry. Another married happily. The results were so comparable in the three treatment groups that the possibility of psychology playing a part in the convalescence must be ruled out. The final picture of the results of the treatment groups and the control group offers such diversity that it is impossible to ignore the role of the dental care in removing the dental stress factors. Statistics on the 247 patients in the study are enlightening, as 42% had sought relief from more than five different physicians, while 26% had visited at least three major medical centers in the country seeking relief to no avail. The remaining 32% had made less of an effort to seek relief but this may have been conditioned by the fact that most of them were in an income bracket where they could ill afford such an expense.

**V. Research and Conclusions**

These results indicate that in removing the condition of malocclusion and the resultant dental distress factors, we are dealing with a biologic whole and not with just teeth and the adjacent tissues. It demonstrates the impossibility of dividing the patient up into neat little specialty areas to be treated without consideration of the resultant effects upon the total person, psyche and soma. It further indicates that there is a need for more cooperation between medical and dental science in research.
to better understand the human body and the interrelationships of medicine and dentistry.

**Case #103**

*Mental Problems*

Male laborer, age 48. He was a patient in the *Third* mental institution. He had undergone shock treatments and every possible medication and psychotherapy at two previous institutions with a gradual worsening of his condition. When the doctors were again planning to resort to shock treatment the wife protested. The patient’s brother, a psychologist, had been gently advising dental therapy since he had referred many DDS patients for successful treatment. Now the wife was ready to listen to any possible solution. Six days after proper molar support was provided and “normal” circulation had been restored to the head and extremities, the patient was discharged from the institution. For the next five weeks he drove sixty miles *Alone* for his follow-up dental adjustment care. On the sixth week the wife accompanied him. Her remark was, “I watched him deteriorate over a period of many years. It is a miracle. He is now as normal as he ever was.”

**Case #104**

Male business executive, age 56. He had committed himself to a mental institution in search of help for his mental health problems. He had a long-standing malocclusion problem, a full upper denture against a free-end saddle lower partial denture, where the lower six anterior teeth had been retained to insure stability of the removable mandibular prosthesis. Due to a history of relining the free-end saddles providing occlusal support accompanied by a temporary remission of the sinusitis headaches and mental aberrations and the author’s conviction that free-end saddles are a “no no” that will never provide dominant molar support when premolar and anterior root supported teeth are present, the lower anterior teeth were removed and full (upper and lower) dentures were placed. The headaches, sinusitis and mental problems dramatically ceased. This patient was at the author’s office on the day that the above 48 year old laborer came for follow-up care. The executive’s comments were significant. “The patient that just left your office was at the same institution to which I committed myself. He was the worst case in the hospital. He sat all day staring into space and never moved. To see him walking and talking normally is shocking. I can hardly believe what I saw.”

**Case #105**

*Headache*

Housewife, age 28. The wife of a chiropractor presented with a full compliment of teeth and a history of intense headaches and sinusitis.
Chiropractic treatment was helpful but the adjustments would not hold and the headache problem would immediately return. A bionator was placed to allow molar eruption and mesial repositioning of the mandible. The patient has now been free of headaches for six months. She said on the last visit, “I haven’t had a chiropractic adjustment in months. The adjustments held after I started wearing the bionator faithfully.”

**Case #106**

Mononucleosis

School girl, age 12. The child presented with a toothache. A diagnosis of mononucleosis had been made two days earlier following tests. She was rather listless and had no appetite. Complete bedrest for a few weeks had been ordered by her physician. The hypersensitive tooth was apparently caused by clamping and bruxing. All teeth were present. There was no decay in any teeth and no periodontal problems. Tonsilar swelling was extensive. Two occlusal fillings were replaced with new amalgam fillings 1/4 mm. higher to eliminate the premolar prematurities and to provide balanced bilateral molar support.

The following day the mother reported the tooth no longer hurt and that the child had a ravenous appetite and was up and around with no fever or any signs of illness, when she had been listless for days. Two days later the tonsils that were the size of a small crabapple had been reduced to normal. She returned to the family physician for further tests that indicated no signs of mononucleosis.

**Case #107**

Epilepsy

Housewife, age 45. She wanted new dentures made because the old ones were so loose that it was difficult chewing. The dentures were 16 years old, with fractured teeth and in disrepair. Her major complaints were tiredness, headache, aching muscles in the neck and shoulders and lower back. She had been having epileptic seizures for a period of four years. New dentures were constructed according to the principles of the American Academy for Functional Prosthodontics utilizing the lateral palatal walls of the maxilla and the buccal plates of the mandible for support.

Two weeks later she reported that she awakened rested, was free of headaches, neck, shoulder and backaches, and had not had a seizure since the dentures were placed. Two years later she reported continued freedom from seizures.

**Case #108**

Student, age 22. She presented with a full compliment of teeth and premolar prematurities. A complete physical with a battery of tests had
just been completed at a neighboring university medical center. The diagnosis was epilepsy along with multiple health problems. She was placed on 14 different medications and referred to me because of a TMJ problem.

Two occlusal amalgam fillings were replaced on the mandibular second molars sufficiently high to eliminate the premolar prematurities. She returned one year later and reported that soon after her first visit to the author her health was so improved that she had returned to the medical center and insisted on having all of the tests redone. They took her off of 13 of the medications but left her on the dilantin fearing she might still have seizures in spite of normal brain wave tests and normalcy in the other areas where formerly problems had been found.

When asked why she had returned she responded, “I have stuttered all my life. But after you corrected my occlusion the stuttering stopped. The past two weeks I have started to stutter again, so I felt it was time to see you.”

The same fillings were replaced with slightly higher restorations. The stuttering again ceased. No epileptic seizures have occurred since her first dental visit.

**COMMENT:** All musculature in chewing, swallowing, breathing, etc., work in balanced harmony in normal occlusion. Maloccluded teeth disrupts this harmony. Choking on food, fluid or solids getting into the air passages, etc., quite routinely occur when synchronized muscle balance is lacking.

**Case #99**

*Numbness (one-half of the body)*

Housewife, age 43. The wife of a professor at the University of Illinois School of Medicine had a history of numbness of one entire side of the body for a period of fifteen years. Medical science had been unable to help her. The patient was missing all six mandibular molars, three maxillary molars and three maxillary premolars. A mandibular splint was placed to provide bilateral mandibular, pivotal support slightly distal to the mandibular second premolars. The feeling returned to the numb side of the body within 24 hours. Several weeks later a maxillary removable bridge fractured and balanced occlusal support was lost. The numbness returned to half of the body within a matter of hours. After the bridge was repaired and the occlusion was balanced, normal feeling returned. Four years later the numbness has not returned.

**Case #100**

*Open sores of long duration*

Housewife, age 63. The patient reported being hospitalized at least once a year over a period of 14 years due to open sores on the right ankle. Her nurse daughter had been changing the dressings twice a day. She
walked with difficulty.

After an unsuccessful attempt by a “renowned clinic” to heal the sores, she came to the author for new full upper and lower dentures. There had been considerable loss of vertical and the mandibular ridge was almost entirely destroyed. New dentures were constructed at the proper vertical providing dominant-balanced molar support. Circulation immediately improved.

Two weeks later the daughter thought the sores looked like they were healing. After six weeks there was complete healing. Upon returning to the “famous clinic” for a “check-up” she was congratulated on the beautiful plastic surgery done on her ankles.

**COMMENT:** If circulation to the extremities was so poor that sores would not heal, no plastic surgery could ever succeed.

She said, “Now my husband has a difficult time keeping up with me when we go for walks.”

**Case #101**

Retired male, age 71. An open sore of four years duration on the scalp healed within a period of three weeks following proper dental care to provide balanced molar support at the proper vertical. Circulation improved throughout the body. It was especially apparent in the extremities.

**Case #102**

*Asthma*

Building contractor, age 43 (asthmatic on 40 mg. prednisone daily). History as written by the patient: I was bothered by severe respiratory problems with profuse nasal drainage and congestion, allergy problems especially severe during pollen season, and frontal sinus headaches from childhood on with constant use of much aspirin. A diagnosis of high blood pressure and malaria was made in 1968. This required quinine and medication for blood pressure. After six years the malaria symptoms disappeared. Polyps on the vocal cords were removed in 1971. I stopped smoking. The postsurgical problems were post nasal drip and repeated head colds, followed by a morning cough and much increased nasal discharge.

Rounds of doctors and clinics for diagnostic work followed. Then skin tests and allergy shots with no relief. The problems worsened and headaches were extremely severe. More rounds of medical specialists, increased asthma attacks and no relief. During all these bouts with illness I was on and off of prednisone with temporary relief. It was impossible to sleep lying down due to drainage and congestion so I slept in a chair, was able to do no physical work and was barely able to manage my business.

August 1977, I went to a “major medical clinic” for thorough
testing and diagnostic work. They removed a dead 3rd kidney and performed a complete polypectomy of the nose and sinus areas. This gave almost total relief for two to three months. I could taste, smell and breathe with less asthma and tolerable allergies. After this brief reprieve all symptoms returned, as well as the nasal polyps.

Kidney “shots” and prednisone were administered “on and off” until September 1978 when I almost died from an asthma attack. I returned to the “medical clinic” for hospitalization, for theophyllin and preparation for more polyp surgery. There was some postsurgical relief but I have never regained the sense of taste or smell. I was also told that I must stay on at least 20 mg. prednisone daily for the remainder of my life.

I returned home extremely depressed. Sometime thereafter a friend recommended seeing Dr. Fonder. This made some sense since I had worn a “dental splint” that afforded brief relief.

**DENTAL FINDINGS:** A severe caries problem with several crowns completely decayed away and a moderate periodontal problem but no abscessed teeth. The freeway space measured 11 mm..

**TEMPORARY TREATMENT:** Quite unexpectedly, caries control preserved all 32 teeth without an exposure and a treatment acrylic splint was placed.

Now, when the “shim” is correctly adjusted I am completely free of headaches. When the occlusion needs adjustment a slight headache problem occurs. The nasal discharge is much reduced and I manage my business, do some physical labor, exercise and play tennis. I am very careful about what I eat or drink and have fewer allergy attacks. The asthma is always a constant threat but now I feel I can manage that problem.

When I came to Dr. Fonder for treatment I was on 40 mg. prednisone a day. I was told that this dosage may need to be increased and in due time I must cease using the drug or it would cause my demise. As I became convinced that my health was improving I began to cut back on the prednisone dosage. After three months of care I was down to 30 mg. of prednisone every other day (approximately 2/3 reduction in dosage). After an additional three months I had complete stopped using prednisone. This was August 1, 1981 and I have never felt the need for any prednisone since then.

I returned to the “major medical clinic” in November of 1981. Upon examination they eliminated some medicines and reduced the others. Each year I return to the clinic for a physical.

**FINAL TREATMENT HISTORY:** Following the caries control and several months of splint therapy all maxillary and mandibular premolars and molars were covered with full cast gold crowns. A complicated “overdenture” was placed over all of the mandibular teeth and crowns to correct the 11 mm. freeway space leaving ½ mm. clearance in speech. Only minor occlusal adjustments were necessary during the next two years and no adjustments for the past year.
Case #103

Emphysema

Male office worker, age 47. The patient presented with ill-fitting dentures and extremely severe breathing problems. Temporary treatment consisted of quick office relines and a flat acrylic occlusal plane was established on the mandibular prosthesis for an “acrylic” pivot of the maxillary first molar to allow the mandible to seek its “muscular” balance. Periodic adjustments were made over a three month period before new dentures were constructed.

Three weeks after the initial treatment the patient said, “My boss can’t believe the change in my breathing. He said he could hear me through the door before I cam into the office in the morning. Now I can walk up and down the stairs without any shortness of breath and I have started jogging again.”

References

7. Shore, op. cit.


