Re: The Dr. K Book

Source: http://sci.tech–archive.net/Archive/sci.med.dentistry/2005–11/msg00591.html

- *From*: "Clinton" <clintonz@xxxxxxxxxxx>
- *Date*: 8 Nov 2005 23:08:26 –0800

Tony Bad wrote:
> "Clinton" <clintonz@xxxxxxxxxxx> wrote in message
> news:1131500449.270322.245960@xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
> >
> > Tony Bad wrote:
> The destruction of bone is usually visible on a radiograph...there can be
> cases where bony destruction will not be seen. I don't know what that OS
> told you...you are telling me what you heard...but I there have been many
> examples in our exchanges where you have distorted what I wrote. I find it
> hard to believe that the OS said "any infection", but if he did, I disagree.
>

Actually I think what he said was that an oral antral fistula which I
believe is a hole
through to the sinus or in the sinus would be visible if IIRC, with the
implication
that any hole from the maxilla through to the sinus could be detected
with a comparison
of panorexs. That premise proved to be false. It's also a fact that the
extent of many
types of jaw infection are not evident on CT, MRI or bonescans.

> As for being "Wrrroooonnnnggggggg"...looks like you get to wear the dunce cap
> again...osteomyelitis is an infection of the bone...like any other
> infection, there are many tests (the kind that...hmmm...maybe an infectious
> disease doctor might employ) that will show evidence of an active infection.

Ahha, But you are very wrong and I can prove it. For one thing the
tests
that an ID doc might employ such as a c–protein test or sedimentation
rate
test are frequently negative in chronic OM. I have read many papers on
chronic
OM as an example that state that x–rays and blood tests are not
definitive markers. Go to
the jaw infection group and a nurse with OM will be happy to discuss
why this
is the case!

> Once again...this is not a mystery.
>

Oh boy, you don't know about this stuff at all do you?

>
> > Ahhh, but it is! Because you can't find what you don't look for.
> > How do you find infection if you just go by x–ray and do no
> > exploratory surgery. I am guessing that in orthapedic surgery
> > the surgeon has special methods to look for and clean all
> > infection in the leg bone. Are similar methods used in dentistry?
> > A patient comes into your office with a pocket of infection near
> > the tooth but in the jaw with a skip area. How do you find it since
> > you state with supreme confidence that it is not a problem?
> >
>
> I have no idea what "Because you can't find what you don't look for." means.
> Are you suggesting that we look for infections when there is no evidence of
> a problem? Should we be wrestling random people to the ground and doing
> exploratory surgery just in case there is something going on? Attempts to
> diagnose are made when there is a reason. If there are no radiographic signs
> of pathology, no clinical signs of infection, no complaints do you still
> look for a problem?

If a patient comes through the door and say's I feel fine but I want
surgery
no. But let's suppose a patient became ill after an extraction has some
physical
complaints which could be related to jaw/tooth infection, but all
radiographs
are negative, and no local signs of infection, like inflammation of the
gum.
What do you do?

>
> I'll play along with your example...you say " A patient comes into your
> office with a pocket of infection near the tooth but in the jaw with a skip
> area. How do you find it since you state with supreme confidence that it is
> not a problem?"
>
> How do you know there is an infection? What are the symptoms? why did
> patient come in? any recent changes in general health?

You the dentist/OS are supposed to be able to tell where the infection
in and surgically
remove it without the patient giving you hints. What kind of a
professional are you?

>by skip area do you

> mean an area where tooth was lost?

Noo, read the book.

> I need to know why I would even suspect there was a problem.

Because bacteria have existed on earth for billions of years!

But Say a change in general health, and infection has eaten through
into the jaw
creating a large area of infection through a tunnel from a site of
infection near the tooth which wouldn't be clear from inspection or
necessarily x–ray, even if there were "indications" of erosion. This
happens all the time.

>
> > >
>> > The point is about the mechanics of infection detection and treatment.
> > Nowhere has Dr. Kulacz said he has discovered a new disease.
> >
>
> No, what he repeatedly suggests is that he has insight into this issue and
> others cannot or will not understand it.

What issue? That RC may be unhealthy or proper methods for detecting
jaw infection? there is voluminous debate and controversy in both
areas.
This is not a new disease, and Dr. Kulacz speaks from clinical
experience
not "imagined insight".

> The reason I am reading this book
> is because he failed to prove this premise on his web site, failed to prove
> it in his exchanges on this NG, and failed to prove it in his "published"
> article.

Assuming your focus is on RC, i fail to see what he could do to prove
that bacteria
left in RC can be harmful other than document his case histories and
refer you to
the reasearch. Any picture of infection would be discounted by you as
"typical
bacteria", but its the clincal presentation that matters. Yes all
infection is caused
by some kind of bacteria.

> How are you going to find an area of infection, for
> > example a cavitation that doesn't show
> > on x–ray, or polymicrobial infection that has invaded the bone with
> > extremely subtle
> > signs on an MRI.

>
> What about other tests that show signs of infection? Why don't these work??

EXCELLENT QUESTION which 99% of dentists and oral surgeons would
not be able to answer.

Well Sue explained some of it. For one thing the bacteria create
biofilms
so it is hard to culture in the blood, even though they excrete toxins.
For
another in cases of chronic infection, the immune system eventually
relaxes
it's response so certain blood markers eventually come down. It is no
secret and well documented that is it difficult to test for some of
these
infections such as chronic OM. I assume that would also potentially
extended to certain kinds of colinizations of pathenogenic bacteria in
the Root canal.

>
> > You have to open the jaw up. Somehow you imagine that
> > you can do nothing to look for infection, even after you admit that
> > x–rays are limited and we know that even swabs taken DIRECTLY from the
> > infected are frequently fail to grow the infected bacteria. So how are
> > you going to find rot in the jaw or above the tooth if you can't see it
> > and you can't test for it?
>
> Do you have a clue how infections affect the body? Go look up the common
> tests used to find infections and explain to me why none of these will
> reveal these kinds of infections or explain why you "can't test for it"...I
> think this is nonsense.

For all you posturing about your extensive
education, you have no clue about the limitations in diagnosing chronic
infection. This is discussed all the time on the jaw infections groups.
The patients are better educated than the doctors. Unbelievable!

> > I'm still looking for the book, but does the section say that these are
> > caused by
> > most RC?
>
> Yes...but go find the book...you won't believe what I tell you anyway.

The person I gave it to lost it.

>
> > Secondly how do you know what is rare and what is not. Again
> > no
> > meaningful studies have been done by the ADA to investigate these
> > issues, or even
> > to meaningfully quantify non–severe effects on the immune system a RC

> > may have.
>
> Funny...How do YOU know what is rare and what is not? and where are the
> meaningful studies that shaped your opinion?

I'm the patient, your the doctor. You tell me. By the way I never had
any RC
or any recommendations for one so i have not formed an absolute opinion
on the safety of RC.

>
> > By the way many patients agree with Dr. Kulacz's views on RC
> >
>
> Which means what? Many patients agree with my views...shall we take a poll
> and decide on that basis?

That what Dr. K says makes sense and many patients have common sense.

> Maybe we can arm wrestle or size up to decide this
> issue. Let me know what you decide...until then, I will continue to
> disagree.

Hey I'm not the one treating patients, but I don't see any science from
you!

>
> > With what authority have you determined the scope of immune system
> > effects caused
> > by RC, or even the average level of infection that remains. You cannot
> > casually dismiss
> > any reference to that and try to imply that only "severe" effects
> > though "uncommon"
> > would be possible, then use that false premise to conclude that
> > therefore all discussion
> > on that topic is exaggerated.
> >
>
> Authority? Did I need to ask someone's permission to formulate an opinion??

Yes, if you pass that off to patients as science and then attack
dentists who
disagree with your opinion by law you have to provide evidence.

> I believe I have full authority to express my opinion, and it is just as I
> stated.

So you admit that you have no science. It is just group opinion!
That was the only point I wanted to make.

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- ***Follow−Ups***:
  - ***Re: The Dr. K Book***
    - *From:* Tony Bad
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    - *From:* Clinton
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    - *From:* Tony Bad
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  - ***Re: The Dr. K Book***
    - *From:* Tony Bad

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