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Dental Implantology and Radionics

Implantation in cases of significant bone deficit with radionic support

In dental implant procedures, we often encounter horizontal or vertical bone deficits. Depending on the extent, the use of autologous blocks as well as autologous and/or alloplastic bone replacement materials is indicated, which are fixed with collagen membranes or similar and protected from ingrowing epithelium and connective tissue. These measures are complex, expensive, partly associated with risks (infectivity, antigenicity) and stressful for the patient, so there is a desire for methods that are closer to biology and allow avoiding the use of too many foreign substances and materials.

As an approach in this direction, we have been using the techniques of the PRGF process (Plasma Rich in Growth Factors) for some time, which enables the collection and processing of the body's own growth factors and fibrin from the patient's own blood. This practically excludes any antigenicity, allergization, or risk of infection, as we know, for example, when using bovine or porcine materials.

Depending on the case, 20-80 ml of blood are taken from the patient and separated into their different fractions by gentle centrifugation. The plasma layer directly above the erythrocytes and leukocytes is rich in platelets with growth factors for the healing of hard and soft tissues. Therefore, it is destined to be introduced into extraction sockets or as a carrier medium for autologous or alloplastic materials for defect filling. The other two fractions are used to produce autologous fibrin membranes.

> The technique of this procedure ideally allows for radionic treatment.

For this, the corresponding test tubes are positioned on the diode (Fig. 1) and informed with special affirmations.

In the case of the patient presented (hereinafter referred to as Pat. A. B.), the teeth 13, 11, 21, and 23 were not conservable due to large substance defects in combination with extensive periodontal destruction (Fig. 2). Especially the teeth 11 and 21 showed a partial or complete loss of the buccal lamella. To achieve optimal regeneration of these structures, the extraction sockets were filled with PRGF and autologous fibrin, which had been treated as follows:

Healingsheet objective phrase: Bioenergetic support of the upper jaw growth for A. B.

Affirmation: Optimal acceptance of the growth preparation and implants for A. B.

Then, database entries from the areas Mineral, Alphabet of Success, Detoxification, Homeopathy, Bach Flowers, ICD10, Affirmations according to Louise L. Hay were selected. The potentiation was set to Optimum for the treatment.

The test tubes with the different plasma fractions were placed directly on the diode and informed for five minutes. Post-operatively, the patient was treated with the aforementioned Healingsheet, which contained both these case- and treatment-specific information and also the general personal harmonization affirmations.

The wound healing process was uncomplicated, and after three months, the implantation could be set.

In the selection of the pillar locations, 13 and 23 were mandatory; in the mesial area, the combination of 22 and 12 would have been possible. As the patient valued avoiding a connection across the body meridians, we planned the mesial pillars as locations 11 and 21 despite the previously deficient bone structures in these areas.

Upon opening the operation area with a crestal incision slightly displaced towards the palate, it was observed that at 11 a nearly complete regeneration of the bone had occurred, while at 21 a larger defect still persisted, which normally would not have allowed for immediate implantation (Fig. 3).

The method of choice according to conventional medical criteria would have been, in such a case, a two-stage approach with defect augmentation using an autologous bone block, which

Fig. 1: Irradiation of the plasma fractions (here: with the Quantec®5.1 device)

Fig. 2: Clinical initial situation

Fig. 3: Bone deficit at 21

Fig. 4: Irradiation of the implants

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could be taken from the retromolar region or the chin. Autogenous, xenogenous, or alloplastic block materials were not available at that time or had not been sufficiently tested.

Due to the morbidity of the donor site, the associated risks and burdens, and the significantly longer treatment duration, we agreed with the patient on an alternative approach to avoid these inconveniences. We decided to proceed with immediate implantation despite the large bone deficit, with simultaneous augmentation with radionic support.

As preparation for the implantation operation, the patient was treated as follows:

Healingsheet objective phrase: The implants of patient A. B. integrate perfectly.

Affirmations: The implants of the upper jaw of A. B. integrate perfectly and remain stable for life in the reconstructed bone; additionally, entries from ICD10 and affirmations according to Weber.

At the beginning of the implant operation, the growth factor concentrate was again prepared according to the protocol described above and treated. Additionally, this time, the implants in question were also treated with the same information (Fig. 4).

The excavation of the implant cavities was carried out by creating an initial hole with the Lindemann bur (high speed, cooled) and the shaping with slowly rotating instruments without water cooling (50 rpm), which allowed the collection of large amounts of very high-quality bone chips. These were immediately placed in the treated growth factor-rich plasma fraction.

Figures 5 and 6 show the state after placing the implants; the huge bone deficit at 21 is very visible. The implant is almost exposed for half of its length and in horizontal over the greatest diameter.As figuras 5 e 6 mostram o estado após a colocação dos implantes; o enorme déficit ósseo em 21 é muito visível. O implante está quase à metade do comprimento e em horizontal sobre o diâmetro maior exposto.

This goes beyond what is achievable with a lateral augmentation according to usual judgment; but due to the possibility of supporting integration radionically, we decided to risk this method.

From the cavities of 13, 23, and 11, we were able to collect almost 1 cm³ of bone chips, which were mixed with the treated plasma. After making multiple perforations in the peri-implant cortex for the nutrition of the augmentation, a thick layer was introduced into the defect (Fig. 7).

The coverage was also performed exclusively with autologous fibrin obtained from the procedure described above and treated radionically, which was cultured in appropriate vessels as a membrane.

Through a submucosal vestibuloplasty after periosteal incision with tunneling split-skin preparation, a tension-free suture closure was ensured.

During the post-operative phase, the patient continued to be treated with both Healingsheets. The wound healing process was uncomplicated, and after four months, the implants could be opened and exposed. Sufficient and secure hard and soft tissue defect coverage was observed (Fig. 8), allowing the abutments and bridges from 11 to 13 and 21 to 23 to be manufactured and integrated as planned (Fig. 9, 10).

Fig. 5: State after placing the implants

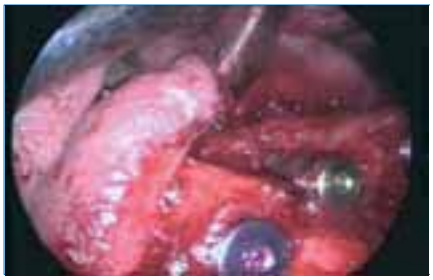

Fig. 6: Bone deficit at 21

Fig. 7: Augmentation with autologous bone in radionically treated plasma.

Fig. 8: Impression posts placed

Fig. 9: Definitive abutments

To maintain this result, the following Healingsheet was included in the patient's general continuous treatment (which was also always included in

Fig. 10: Completion

the Healingsheets mentioned above):

The peri-implant hard and soft tissue situation of A. B. is now immediately and always perfectly preserved in terms of type, quality, height, and volume.

Database areas: Organ preparations, Bach Flowers, Burdens, Affirmations according to Tepperwein Colors, Australian Bush Flowers, Kabbalah, and general affirmations.

Summary

Despite a very strong bone deficit after a very problematic initial situation, it was possible, thanks to radionic support, to treat the patient completely biologically with the body's own substances without any additional foreign materials (excluding titanium implants). This guarantees maximum biointegration; any incompatibilities or antigenicities and allergizations are absolutely excluded.

Furthermore, the method is much more economical for the patient and represents for this reason an alternative to conventional practices.

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