Introduction and Dr. Hindinu2019s Background

Hello, everyone, and welcome back to the reverse Alzheimer's Summit. It's my real honor today to have Dr. Howard Hindin here with us. And Howard is a practicing dentist for many years and is the head of the AARP, M. D., the American Academy of Physiological Medicine and Dentistry, and has hosts and organizes a remarkable conference for people all over the world who are interested in these various issues.

And I think, you know, you could argue that Alzheimer's disease is in large part a disease of oral systemic health because of the many different contributors, from inflammation to toxicity to airway issues.

So it's it's a real honor. Howard, welcome. Thanks so much for joining us. Oh, thank you for having me here. It's a pleasure. So let me just start by asking about how you got interested in this to begin with.

Well, even though I'm a dentist back in the 19, early 19, late 1970s, I became interested in acupuncture as my first licensed or certified dentist in acupuncture in New York State.

And I started looking at things beyond what I was taught in in dental school. And there there is a lot dentistry, mostly the way we're taught deals with repair problems.

Yeah. Why they're caused so early on. And I was always interested in nutrition, so and I love surgery so early on in my career, I took 23 patients, ten, I did surgery on and I just improved their nutrition at right after the surgery.

The surgery patients looked far better. After six months, you really couldn't tell the difference in after year one. So all we did was fix nutrition. We're doing better. Hmm. Interesting.

That led me down a path where I got involved in other things and beyond nutrition, looking at the airways, sleep and breathing and things related to something called heart rate variability where we measure the physiology.

Right. And which ultimately led me to starting this organization. Another dentist, Michael Gelman and I, we were sitting, having breakfast and we said we should never have to see the patients we see because the problems that we see existed decades before, which is basically the same thing you've been saying. No.

All right. That's very helpful. So, you know, we're very interested, of course, in actionable items. How can we get better outcomes in people who are either suffering from cognitive decline or at high risk for cognitive decline?

So let's just go right through because there are so many things related to oral, systemic health. So first issue I guess would be let's go back to the breathing issue.

You know, CPAP is everywhere. A lot of people don't like it. A lot of people won't stick with it. I see this all the time. And yet they end up living with with sleep apnea, which often is something that is an important contributor to cognitive decline.

So from your standpoint, what is what is the best way to approach this as far as, you know, airway, as far as sleep apnea? What is the best way that from from all the the wonderful studies you guys have looked at, what is what has emerged as the best way to deal with this.

The sleep apnea, by definition, is is a lack of breathing. And it's measured by something called a high number of times in the night. We either stop breathing or we have a 50% increased effort in breathing through our.

Right. And divided over the night. And that gives you a score. Yeah.

Sleep Apnea, Airway Health, and Cognitive Risk

The the effective ways to treat apnea are with the CPAP, as you mentioned, oral appliance, weight loss and surgery. Those are the only four ways in and in surgery.

I'm including something called Respire Inspire, which is the Hyperglycemia nerve stimulator, which is like a pacemaker for the the muscle under the tongue that would pull the tongue forward out of the airway.

Those are the only four ways. However, often if somebody has a score, let's say, of 30 and they get any treatment, it comes down to 15. What a great job we've done.

We've reduced it by 50%. Yeah, but they've shown that you do not see health benefits, whether it's blood pressure, diabetes, unless you get that number under five, right.

Yeah. So, so that one of the problems is, is it being effective and a lot of people getting the CPAP or getting oral appliance is the end of treatment, but it can't be at the end of treatment.

That patient has to be monitored. Things change over time. And there's a battle between the the school of CPAP and the School of of appliances. But there are instances where using both together may be the solution to the problem when the person who invented came up with the idea of a try at the end of his life, said what a disservice I did to the medical community by using that as as a guide, because maybe a better indication is the ODI, which is the oxygen saturation index.

Right. How many times during the night do we do we have a 3% or 4% D saturation so that if you think that a normal, healthy oxygen level is 96, 97%, 3%, a 4% reduction would be 94, 95%.

And if you have that many, many times a night with or without apnea, then there could be little micro insults to the brain, which over a period of a decades will be a precursor to to any kind of dementia or a brain trauma, number one.

And then the other thing is, every time that happens, it sends a message to the brain, we have a problem and it alters it keeps us in a sympathetic right state, which is a state where we can heal.

We have increased inflammation and all the wonderful things that happen at night while we're sleeping. Our brain is cleansed. We we balance our metabolism.

We balance our immune system. We reduce our bacterial load. It doesn't happen unless we can get in that restful, relaxing, parasympathetic state. Very interesting.

So what about these devices that actually increase airway size is a little bit like a retainer, but not for your teeth. More for your airway. Have you used those devices and what do you think about those?

So so our tongue is really the front wall of our airway. Anything mouth is too small, too narrow, or we've worn our teeth down or we've lost teeth. Then there'll be less room for our tongue.

And then it only has one place to go back. Okay. And when and when that happens, it'll make our airway smaller. So any of these devices, what they can do, they can give you more height and they can bring your jaw forward, can't make your jaw whiter, so that if your deficiency is in one of those two dimensions, it will be more it would be more beneficial than if basically your your deficit is it is a narrow arch that's and so a CPAP works by blowing air an increasing amount of velocity down this airway to prevent the soft tissue of the airway from collapsing while an oral appliance will bring it forward and keep it open.

And sometimes the two of them work well together because the upper appliance will keep the tongue forward and you can reduce the amount of velocity you need for a CPAP because a lot of people a lot of reason people don't wear it.

They feel they're drowning on air. Yeah. And and so the two together often are the best solution. Excellent. All right, let's move over then to the microbiome for a moment of such so much coming out.

Of course, there's been a lot in the last decade plus on the gut microbiome, but of course, it's turning out that the oral microbiome and the sinus microbiome as well and other skin microbiome, etc.

are turning out to be important players and especially the oral microbiome. With all the attention given to PE gingivalis in the brain, you find it in the brain, you find it's Ginger Payne.

And of course, one biotech company has put a lot of time and effort into inhibiting that one specific Syrian protease ginger pain in in the brain, in patients with Alzheimer's.

And although, though the initial trial failed, there were some good takeaway lessons. And so, as I understand it, they're now going to do another trial focused on people who had PE gingivalis.

So tell me a little bit about what's what's your favorite test for evaluating the oral microbiome? Okay. So there's salivary testing that's done by different company.

There's oral oral diagnostics, right? But there's a new company that's just come out called Biome is familiar with that company, but they they use a RNA testing as opposed to DNA testing and they get a lot more detail.

I just did a call with them and one of the things that they can tell is whether a certain bacteria is present or present and active. Just because something is there doesn't mean it's causing a problem.

And as you you know that as a result of a conference we've created this group of 24 dentists who are going through your protocol together. And one of the things I'm looking at is to have everybody do that testing with Brian to see if there's active pathogens precedent and see where they're doing something else, like just improving the sleep or diet will change active pathogens to non active pathogens because in in dentistry the traditional method of, of dealing with this is to scrape them away and get rid of them.

Oral Microbiome Testing and Pathogens

And if that doesn't work, you, you give antibiotics and sometimes anti spy Riki medications like fragile in order to do that but they found that after you finish treatment bacteria will grow back in the same exact proportion that it was before.

So now they were looking at probiotics, right? But in periodontal disease, having no disease is considered an autoimmune disease. And what often happens, it's as much the response of the patient as it is the bacteria that's present and being able to calm down the inflammatory process by an anti-inflammatory diet or better sleep, which reduces inflammation or was dressed into a control because college students around exam time would always come in with rampant gingivitis.

And then once, once the exam season was over without any other treatment, it got better. So stress can have an effect. So the question is, you know, like we talk about these risk factors, but you can't separate them out.

You have to look at what else is is happening and in relation to what you said before, p gingivalis is one of the bacteria that's been indicted as a component of of heart disease and in of and of dementia.

Yeah, but when there's a predator on the condition this bacteria can also get into the, into the gut and then it will alter the gut microbiome and allow species that don't belong there to grow.

So, so, so that even though we think of these gut dry skin microbiome, the oral microbiome and the gut microbiome being separate, it really not that they can you know, it's sort of the opposite of Las Vegas.

We see what happens in Vegas stays there. What happens the mouth doesn't doesn't stay there, not very well. So

in what we try to do is try to look at what else is going on in the body that could could be a factor, you know, that there are certain bacteria that cannot exist well in an alkaline environment.

And it's a we always measure the age of the saliva. We do salivary testing. We would like to get somebody to be slightly alkaline, yet people in alkaline mouth you can't get the K because the bacteria that cause tooth decay strep mutants cannot live in that environment.

So so yes oral pathogens are important but you need to really take a really broad shotgun spectrum approach to the problem. So how do you then accomplish this to keep things slightly alkaline?

And does it have any negative impact on enamel? And no, actually, it actually doesn't have a negative any negative action. But the way we try to get people to change the diet, vegetables, vegetables are alkaline, everything else is basically acid.

So you want to have a more a diet either higher in in vegetables, which, you know, when you think about it, it's really the diet that's recommended in your protocol.

Yeah. Yeah. So we want to have a diet. There's a way of of taking equalizing drops. Yeah. You can take a half a teaspoon of baking soda in water, which will also help neutralize it.

And people can get paper, intestine cells at home test himself in the morning. Now, if you find that you're doing well, but in the morning, you tend to be more acid that could be related to a sleep problem because you're not sleeping well and more in a in an acid sympathetic upregulated state.

Interesting. Okay. And by giving helping people with their diet, you really giving them control of their health. Yeah. You know, most of traditional Donald Trump treatment scraping, removing the plaque, doing surgery, you sort of take away control of the health from the patient, which which I think that's a big disservice that we've done over the years to as we become more specialized.

Yeah. So then, you know in our first clinical trial we published a year and a half ago, we used dental and for people I know at your conference, one of the points made was that these probiotics seem to be even superior.

So my question is, number one, do you ever use first a dental side? And two, to kind of get rid of some of the pathogens and then come in with probiotics?

And secondly, what are your favorite probiotics? Oral probiotics? I think that that's a good approach. And because anyone you never going to have a sterile mouth, you always want to you there's always going to be bacteria.

You want to reduce the the bad bacteria and encourage growth of the good bacteria. The different ones work better for different patients. Recently I met a I research who has a company called Phyto Dental Solutions who is making products based on cannabinoid cannabinoids.

Yeah. And they're taking out some of the trendy products. And he claims and he just sent me a sample to test that his products can reduce the bad bacteria without reducing the good bacteria, which I think that that'll be great because most of most of the products you use today kill everything.

And then you try to it with with good, good probiotics. And then when they're looking at that, the most favorable traditionally is the lactobacillus trying to put.

So the probiotics that contain that, that seems to be the most favorable one that has that's been showing the best benefit today. Interesting. Okay. So for the the ones that you don't want to see, of course, we tend to think of you mentioned P gingivalis they're t identical.

The f nucleosome revital the intermedia. Are there others that concern you? Well, that any any kind of this breakage would be a concern. You know, that they they did a study where they showed that when somebody loses

an implant and they do a testing around that, there's always parakeets are interesting around that we that in our practice we've had treated a lot of people with chronic Lyme disease.

Yeah and Lyme disease can mask a TMJ problem or something else because it it seems that that whenever there is an injury or problem somewhere then the the dormant Lyme spider Keith will go to that site now. So I think that that's a factor too.

Okay. Now in our trial also we did we sent everyone to dentists and actually did a cone beam analysis because some people, of course, have these undiagnosed abscesses.

What triggers you if you've got someone who's, you know, who's got problems and typically, you know, cognitive problems, what what triggers you to want to get cone beam analysis.

So we have a coming in our office. Okay. And every new patient we see gets crumby regardless because we don't we don't know what's not that, you know, like before that there are things that we have uncovered with a cone beam that that we would have never seen.

Yeah, exactly. We've, we've, we've seen calcification calcification in the carotid arteries on its own being.

Root Canals and Dental Decision-Making

Yeah. We've picked up cancer, we picked up other, other things. And if it's a new patient, we think that they may not have had as much of an in-depth, in-depth exam before.

I don't want to go back two or three years later and find there was something there that I could I could have found before, and especially if you take somebody's health history, you know, what what chronic diseases they're fighting, you know what medications they're on.

You really want that that information and what that what's amazing with new patients we find that some patients are being treated by multiple physicians who don't know everything that they're taking.

Yeah, there's not good communication. Right. All right. And then let's talk for a minute about root canals. Here's another concern. People who've had root canals, what do you have an algorithm or do you have a feeling about, you know, when should these come out?

Are you concerned about them? Can they be sterilized? Are these a problem? What is your how do you analyze people who have root canals? Well, that's it's a very interesting question or that there are people who have symptom.

They will say that I've never felt the same. That never feel it. It always feels funny. Yeah. Ever since I've had the root canal. And then then a normal regular x ray is taken and everything looks fine.

Then you do a cone beam and it doesn't look fine. Yeah. So. So that would be something that. That would be considered if somebody says and we like to do is do a medical history and I'm one column and a dental history and the other column.

If there's been a change in the history when somebody has had a root canal, then then that's suspect. And then there were root canals. They just don't look good.

Like that could be a problem. You know, that that if somebody is having major restorative dentistry done and one of those root canal teeth is going to be the the foundation for a bridge or something that we may consider removing it and replacing it with an implant before.

On the other hand, there are people that believe there is no root canal that's good and should be taken out. So. But then removing all those teeth also can present a problem for people.

Yeah, but if somebody has no health issues, then I will leave. And the root canals look okay. They would be okay. I wouldn't do I. I don't have any root canals in my mouth.

I've been fortunate. But if I had to lose a tooth or have a root canal, then I would probably think long and hard before I. Which they take out the truth instead of doing the work now.

Yeah. Okay. Very young to be 83 without any root canal. So so far, so good. So far. Yeah, you're doing great for 83. I'm really impressed. All right. So, I mean, this is obviously a big issue for people because you're talking about, you know, losing a tooth and at the same time, when you're talking about someone with cognitive decline, you've got to identify what's driving it or you're going to lose the person.

So this becomes a really, really important issue when you when to leave it when I'm out. There, somebody is is looking to find the root causes. It's a sort of a pun for their dementia.

I would look at the root canals very, very carefully. Yeah. And the ultimate decision is, is up to the patient what they want to do. You know, if they've improved their diet, they're exercising more in managing their their stress.

And then things are improving, their market scores are improving. You may you may say, well, let's watch it. But, you know, if if if it's not, I would rather sacrifice the tooth if it was suspicious and protect the brain.

Yeah, it's a great point. If you're going to sacrifice the brain to keep the tooth, that doesn't make a lot of sense. So. All right, that's really helpful.

So let's now move to toxicity. And of course, we the it has been striking for years that you can actually get what looks identical Alzheimer pathology simply by giving someone mercury of of all the metals it's the one that really gives you more than anything else.

True Alzheimer pathology. Well, of course others can contribute things like lead and in arsenic and cadmium and things like that.

Mercury Amalgams and Toxicity

And of course, a lot has been written about aluminum, but mercury is the one that is that is really gives you a pathology of Alzheimer's, most strikingly.

And so this this comes up all the time. People say, do I really need to get my amalgams out? So I guess the first question is, what is the current feeling about putting in amalgams?

We haven't we haven't done I haven't done a mercury filling since 1970. Wow. I was one of the first dentists to eliminate mercury from my practice, accused of being the communist in all sorts of things.

But I came to the belief from what I knew at that time, I couldn't put it in a family member or somebody I liked. My partner at that time said, Well, can't we just use up what we have?

And I said, I hope so. So so we didn't I don't think there's any place for it in practice. When I started in practice over 95% of restorations were mercury fillings.

Now it's less than 20%. Yeah. Which really it's usually in the people in the underserved communities who are who are, who have this done. And there are, there are so many equally or better materials today.

The question is, if you have them, who should have them taken out? Right. And how quickly you know, one or two at a time. All of them. So so this is one of the concerns.

We had a case that we heard about, unfortunately for a woman just taking wonderful care of her mother, but took her to have many amalgams taken out all at once.

The next day, she had a cardiac arrhythmia and passed away. And now it's not clear that that had anything to do with having all these things taken out, but it raised the concern.

Do you like to take out one or two at a time and then wait a few months? Or do you like to take out all of them at a time? If someone's got say let's say they've got six or eight of them back.

So number one is if you're taking out all of them, that's a traumatic procedure. Forgetting about that, it's mercury. Somebody in the chair, how many injections of an anesthetic are you going to give them?

So somebody like this patient may have had five, six copies. Was of anesthetic with epinephrine with preserved in that which might have been the cause of the problem we have.

We move them a quadrant at a time or or more and without any any problems like that. As long as you, you know, the patient you're treating, what is their condition now? Are they able to tolerate being in a dental chair for 2 hours?

Are you using a rubber dam? Oxygen. We have them rinse with with Lorella. Hmm. Even so that anything that gets around them rubber dam can the corella will just act like a like a mop picking up any leftover over of the mercury and then and then if some we also want to know whether they're an employee for those people they don't detoxify.

Well right. And so you might need to do some preparatory work to prepare them for for the removal. Yeah. And the other thing that that we found I found personally is that we had people that we we and I've been doing this for many, many years, we removed all the feelings.

Some people remarkable change in their health. I have miracle stories and we tried out our miracle stories and our people I thought would do better, wouldn't do better.

These same people who remain patients. And then we later treated their sleep. All of a sudden they got even. They got better improvement. And so now we look at what their sleep is before we would consider what we would consider removing their fillings, that that's part of the preparatory work and we want them to be alkaline because people don't detoxify well if they're in an acid state.

Yeah. So removing them isn't and this is the big, the big problem I believe is that somebody says, yeah, you want your fillings removed, will remove them and they don't do a complete assessment of the of the patient.

This is if somebody is being has negative impact from mercury fillings you have to treat it as a really an important problem, not just yeah sure we'll take them out and replace them with, you know, because after ten or 15 years there's very little mercury leaking out of the fillings.

The biggest exposure is going to come when you drill them out and you create this vapor that could be a problem. So so if you're going to do that, you want to make sure that's going to be okay.

You want to make sure that can they be replaced with other fillings or are the teeth going to need crowns? Is that going to threaten the tooth might end up needing a root canal on one or more of those teeth.

So there's a lot to be considered. And everything that we talked about, airway, periodontal pathogens, toxicity, they're all related. You can't separate them.

There's no there's no fence between them. And if you go back to your you know, you mentioned the big success stories, the miracle stories. Did those people have high blood levels of mercury or does that really not helpful to us to look at?

Because I know people I hear from frequently will say, look, I've got a bunch of amalgams, but look, my my mercury level is normal. Do I really have to have these out?

So that if you're exposed to mercury, it gets transported through the blood and it's dropped off somewhat? Yeah.

And so once the mercury exposure has been you've had the exposure and it's been shipped and dropped off into tissue somewhere, the mercury isn't going to show high levels.

If you do red blood cell mercury, it might, you might show a bit better level. They look at urine mercury also and and they do a provocative test where you give somebody chelating agent like the DMCA DPS and you look at the difference between no and no chelating agent.

And with that, that might show something. But then again, somebody might have been eliminating mercury through their stool more than the urine. And they you know, there are a couple of labs that do that.

And even if you do urine, mercury, the urine may not the mercury may not be high in some other metal might be higher. So being curious, back in the early days when I was doing this, I took a couple of patients and I had them do a urine mercury every week after we finished.

And it was amazing that one week the mercury would be high and next week arsenic would be high and something next week something else would be high. Then another week and the mercury would be high again.

And what would happen is the whatever is the most available to come out comes out, you know, when we use things like a ruler or, you know, sulfur containing foods, eggs.

Yeah, these, these. And I have people start on a diet before we even begin the process. Okay. Protect them. All right. Well, let's talk a little bit about gingivitis.

I know that, you know, people will get period feel on Titus, as you talked about earlier. But what about the person who says, look, I don't have any root canals, I don't have any major problems, but when I brush my teeth each night or each day or whatever, I see blood in the sink when I spit.

Gingivitis, Home Care, and Prevention

What do you what do you recommend for this person who kind of has a chronic, mild gingivitis? Okay. So first of all, I always to people, is there any other part of your body that would bleed when you touched it that you would accept?

Yeah. Yeah. Uh, because bleeding gums are not normal. So, again, what's what's the root cause? Is it that they're home care? Is it good? Is it that their mouth is unclean?

Maybe they're a mouth breather and and a night and breathe through it. Mouth tissues dry out and it makes them more susceptible to bleeding. Yeah. But if. If you have gingivitis and you don't get the cause of it, it will become something else and it won't stay.

Gingivitis. Gingivitis. It's so wonderful that somebody has gingivitis because it gives you something that's easily treatable and reversible and an early warning sign.

But yeah, it's so much of medicine today. We ignored the early warning signs that it's not it's no big deal. You know. And so what are your favorite treatments or what is your favorite treatment for gingivitis in general?

In general, it's improved home care, flossing, brushing. Check your mouth, are going and check your sleep wear to see whether you're you're sleeping well or maybe you're just become a habitual mouth breather.

Try taping your mouth at night. Yeah. In a very light silicone on tape. Do you have a favorite water flosser and do you, do you suggest that people should get water flossers?

Yeah, something like a water pick, that sort of thing. Does that help. If somebody has trouble manipulating the floss, they can get like a water picker.

There are so many different companies are all I think the only caveat I would say is you never want to use it at full force and you always want to direct it parallel to horizontally.

Don't push it into pockets because you have any pockets. It's just going to it's going to it's going to be you're going to cause more bleeding. So there are some uses one of these devices and they think that I get a lot of bleeding when I do it.

That's a good thing. It's not a good thing. I say very good point. Okay. All right. Anything else we should talk about with respect to oral systemic care and cognitive decline?

I think one of the one of the problems is there aren't enough practitioners doing it and and doing it well, which is what we're trying to teach. Right.

I don't know who was going to be viewing this, but often changes occur because the public demands the changes. And so my message would be that if you think that this is any value, make sure that when you go to your dentist, you you ask for all these things.

You ask them to check these things. And because I believe that dentists play a very important role, not only in the looking at the risk factors for dementia, but all the other chronic diseases.

And more and more dentists are doing that. You know, we were a one of our keynote speakers last year and at our Collaboration Cures conference, it's called Collaboration Cures because no one practitioner has the answers right or health care.

The medicine in the future is going to be where treatment is personalized for the patient. And you bring in the team members from different practice practice parameters that will deal with them ideally.

Yeah. Fantastic. Thank you very much, Dr. Hindin. It's I think it's become very clear that a better oral care means better cognitive outcomes. So this is a such a critical area.

Thanks very much. Great to have you here at the reverse Alzheimer's Summit and look forward to talking to you next time. Thank you, Dale.