

Letters to the Editor

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LETTERS

TMJ DYSFUNCTION

Sir, the general dental practitioner may be the first point of contact for patients with TMJ problems. Presenting complaints may include pain, limitation in mouth opening, clicking and dislocation with occlusal changes. There may also be associated tooth wear. Often the symptoms may be related to functional habits such as bruxism.

However, various medications may also result in TMJ dysfunction, due to side effects such as bruxism and TMJ dislocation. There have been several reported incidents of iatrogenic bruxism involving diurnal bruxism¹ thought to be associated with dopaminergic blockade, and nocturnal bruxism. Nocturnal bruxism has been reported with venlafaxine, a serotonin/noradrenaline reuptake inhibitor, which responded to gabapentin,² as well as three selective serotonin reuptake inhibitors (SSRIs), paroxetine, fluoxetine and setraline. In both reports the SSRI-associated bruxism was treated with buspirone. Nocturnal bruxism may also be secondary to the SSRI citalopram.³

Phenothiazines are widely used for their antipsychotic, antiemetic and sedative properties. They are known to block the dopamine receptors in the brain, which may account for their extrapyramidal side effects. These side effects cause various movement disorders including oral bucco-lingual dyskinesia (continual side to side or circular chewing movements of the jaw) and oromandibular dystonia (OMD). OMD is a focal dystonia manifested by involuntary muscle contractions producing repetitive, patterned mouth, jaw, and tongue movements.⁴ This is often referred to as primary (idiopathic) or secondary dystonia. The latter most commonly develops

as a side effect of long-term treatment with antipsychotic drugs and approximately 10% of patients exposed to these will experience a dystonic reaction.⁴ It is important that GPs are aware of this condition for successful management. Such dislocation of the TMJ is usually unilateral, although reports have shown that the mechanical energy derived from the oromandibular dystonia can occasionally cause bilateral dislocations.

Classic signs of TMJ dislocation include pain, inability to completely close the mouth, deviation of the jaw to the side, forward protrusion of the mandible, difficulty swallowing, drooling from the mouth, difficulty chewing and difficulty articulating. Treatment of the dislocation requires manual manipulation of the joint, aided with the use of analgesics and benzodiazepines. Botulinum toxin A (BTA) injection therapy is indicated where conservative treatment has failed, and surgery carries an unacceptable risk. BTA is also beneficial in patients who suffer recurrent dislocation of the TMJ as a result of impaired muscle coordination secondary to mandibular dystonia, early and late dyskinesias, epilepsy and brain stem syndromes of various origins.

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TRAUMA BY IPAD

Sir, an 11-year-old boy attended the emergency clinic at Glasgow Dental Hospital and School's paediatric department in March 2012 following a second incident of trauma to his upper right central incisor. The first incident, a skateboarding accident in May 2011, resulted in a middle third comminuted root fracture, which healed with connective tissue union after a period of splinting and the tooth remained vital. The second traumatic incident resulted in an oblique crown fracture at the level of the cervical margin (see accompanying radiograph, Fig. 1). The coronal fragment was subsequently removed, the exposed pulp extirpated and an overdenture provided to restore aesthetics in the short term. Ideally, the root will be obturated and retained in order to facilitate placement of a single osseointegrated implant at an appropriate age.



Fig. 1 Oblique crown fracture at the cervical margin