

# Letters to the Editor

## Dentist or Detective?

During dental school, we are taught to take a thorough history, assess appropriately, carry out special investigations before considering differential diagnoses and formulating a treatment plan. However, there are cases where the history does not correlate with the clinical symptoms, or when special investigations reveal nothing abnormal, and it is a struggle to decide where to refer.

I witnessed such a case unfold. A 17-year-old female patient presented with a 10-day history of a locked jaw and frequent episodes described as seizures. This was a particular point of interest as the 'seizures' were described as sudden jerking movements of the limbs with no loss of consciousness, incontinence or loss of reflexes. In fact, the patient would remain conscious and responsive throughout. The patient's past medical history revealed an eating disorder and multiple hospital admissions, while the social history provided by the family described a stress-free teenager embarking on a highly sought-after first job. The patient had undergone a wide range of special investigations to rule out neurological disorders, tetanus and the possibility of a stroke, while the use of muscle relaxant was unsuccessful in releasing the clenched jaw. Our assessment revealed no signs of an anterior disc displacement without reduction of the temporomandibular joint, which may cause a locked jaw.

After a bold suggestion that the symptoms may be voluntary, the patient underwent psychological analysis to reveal the likelihood of a subconscious functional disorder and a differential diagnosis of Munchausen's syndrome. Munchausen's syndrome is a psychiatric factitious disorder wherein those affected feign disease, illness, or psychological trauma to draw attention, sympathy, or comfort to themselves.<sup>1</sup>

This case demonstrates that, in some rare scenarios, reaching a diagnosis may require a health professional to think laterally (once all logical and likely diagnoses have been considered). As dentists, we may be exposed to similar

patients complaining of atypical facial pain, TMJ issues and even toothache. Without suggesting that we become sceptical, it is important to consider psychological contributors and the use of Cognitive Behavioural Therapy.<sup>1</sup>

## References

1. Scully C, Felix DH. Oral Medicine – update for the dental practitioner orofacial pain. *Br Dent J* 2006; **200**: 75–83.

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## Case report: atypical eruption of lower third molar in a patient who declined surgery

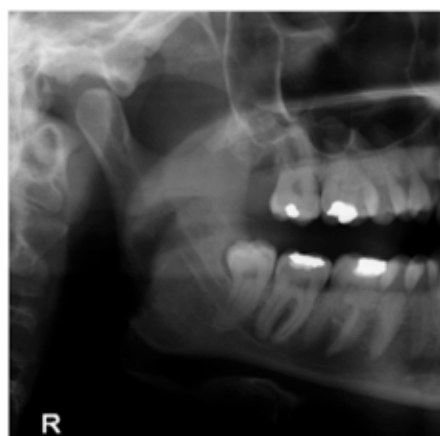
Approaches to management of third molars in the UK has changed since the introduction of the NICE guidelines in 2000<sup>1</sup> and prophylactic removal of third molars has been mostly discontinued. Where removal is indicated, the risk of morbidity with the procedure, notably ID nerve damage, can be of concern to clinicians and patients alike.<sup>2</sup>

A 43-year-old female patient attended following a referral from her general dental practitioner for re-assessment of both lower third molars. The patient was previously seen in early 2012 regarding discomfort associated with these teeth which had both developed multiple episodes of pericoronitis.

Figure 1 shows the position of LR8 and the high degree of risk of ID nerve damage which could have been present with extraction of this tooth. Coronectomy was proposed for LR8, however, owing to the absence of symptoms, the patient declined treatment.

At repeat presentation in late 2015, the patient reported that the lower right third molar had changed position and had 'grown' to be in an 'awkward' position. Clinical examination at repeat assessment identified that the lower right third molar had erupted considerably, to the extent that it was now an occlusal interference. Radiographs taken to assess the position of the tooth (Figure 2) in relation to the ID canal showed a considerable change from initial presentation (Figure 1); the tooth had moved to become a routine extraction with a reduced risk to the inferior dental nerve. The LR8 was removed with forceps and no alteration of sensation to the area supplied by the inferior dental nerve was reported.

Though multiple indications could lead a clinician to propose surgical intervention, this case suggests that, when risk of ID nerve damage is high, retention and monitoring over a longer period of time could be entirely appropriate, if the patient's oral hygiene is optimized and the tooth is not mesio-angular in orientation. In this scenario, caries development around the second molar is less likely and the potential morbidity associated with



**Figure 1.** Tooth at initial presentation (2012).



**Figure 2.** Tooth following re-referral (2015).