

site that has allowed commercially damaging comments attached to many practices.

I'm keen to hear from anyone who may have similar stories to Dr Hussain and would value their assistance if they could contact me at [ecrouch9@btinternet.com](mailto:ecrouch9@btinternet.com).

E. Crouch, Birmingham  
DOI: 10.1038/sj.bdj.2012.940

## DISLOCATED JAW

Sir, I am a newly qualified dentist and recently experienced a patient dislocating their jaw whilst treating them in practice. This incident has compelled me to write to share my experience to highlight that this unexpected incidence can easily happen when you least expect it.

At university we were taught only briefly about TMJ dislocations with the main emphasis being that it was somewhat a rarity and most likely to occur when extracting wisdom teeth or if using excessive force. The reality of my situation was far from this. I was extirpating a lower premolar, using no force at all, my patient did not have his mouth open wide or for very long, he had no history of dislocating his TMJ and there were no other associated risk factors.

Having not previously seen or managed any TMJ dislocations I felt under-prepared for managing this incident. At university we were simply told to 'push back and down' and to be careful that you don't get your thumbs bitten. This sounds rather straightforward but the reality of my situation was not so. Even my experienced VT trainer and an associate – who has previously worked as a MaxFax SHO – were not able to relocate my patient's TMJ.

Although I am sure that this scenario is straightforward for someone with experience in this area, I found managing this incident was not as simple as I had been led to believe in my training at university.

My patient attended our local hospital and successfully had his TMJ relocated by the MaxFax team and has had no subsequent problems. I felt compelled to write to draw the attention to how a seemingly low risk patient can dis-

locate their TMJ during routine dental procedures, when one may least expect it, and how recent dental graduates have limited experience in this field.

K. Parker, London  
DOI: 10.1038/sj.bdj.2012.941

## NARROWER SKULLS

Sir, just as autism is being called autistic spectrum disorder, I believe the issue with crowded teeth and a narrow skull should be called 'narrow skull spectrum disorder'. It is indeed multifactorial: chronic inflammation, changing breathing patterns and all the issues with tongue weakness, as well as improper development of the jaw due to lack of 'tough' food which was more stimulating to the growth of the mandible when chewing.

There are also many less talked about issues that relate to chronic inflammatory conditions that lead to poor breathing patterns. Lack of development of the brain due to lack of physicality in youth affects the development of the autonomic system that drives digestion, which then leads to these inflammatory conditions.

The poor vagal tone described above in essence leads to poor blood supply to the gut which leads to poor gut function as it relates to acid and enzyme production from the gut. This then often leads to chronic gut-associated issues such as dysbiosis, and leaky gut syndrome which can then lead to food sensitivities and autoimmune disorders.

There are also issues associated with this mechanism related to processed foods and even environmental chemicals. Since mouth breathing seems to be the common relationship to a narrower skull and teeth crowding then these mechanisms might be the primary epigenetic triggers.

J. Lieurance, Florida  
DOI: 10.1038/sj.bdj.942

The *BDJ* website now includes a facility enabling readers to immediately comment on letters. All comments must comply with the *nature.com* Terms and Conditions and Community Guidelines – visit the *BDJ* website to find out more and to post your comment now.