may be a connection between patients with polymyalgia rheumatica (PMR) and GCA and a significant proportion of patients with PMR also get GCA. It may be that arteritis in blood vessels supplying muscles results in a diminished supply thereby giving rise to the symptoms of PMR. Where patients report a diagnosis of polymyalgia I will now ask them if there are any headaches or jaw pain, especially on eating.

T. Lynn, by email

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OMFS

Odontalgia and facial pain

Sir, an 83-year-old gentleman recently attended our OMFS department with intractable facial pain of presumed dental origin. He initially reported a 6-month history of gradually worsening pain in the upper left quadrant. This became increasingly severe and he eventually visited his dentist who assumed a dental causes and extracted 25, 26 and 27 (Fig 1.)

However, following these extractions, the pain became increasingly relentless and he attended the accident and emergency department with referral to OMFS. His pain was now severe left sided pain radiating from the upper lip to the left ear. The pain was scored 10/10 and described as a sharp, electric shock like, episodic pain with a trigger point around 23, 24 region. An MRI scan was ordered which demonstrated a solid, space occupying lesion in the left cerebellopontine angle (CPA). This was reported to be causing distortion on the left trigeminal nerve. The definitive diagnosis was a meningioma[1] which was impinging on the left V2 trigeminal nerve resulting in neuralgia.[2] Initial management was medical treatment with carbamazepine and a neurosurgical consult was also arranged.

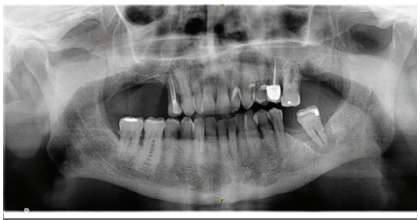

Fig. 1 An OPT showing 25 heavily filled, 26 distal radiolucent lesion and 37 apical radiolucent lesion

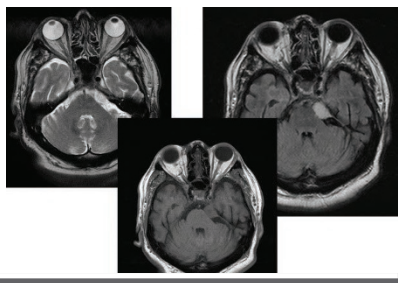

Fig. 2 Axial MRI images showing lesion in left CPA

This case serves to highlight the importance of a thorough history and clinical examination in all cases of facial pain, together with reassessment of those patients in whom clinical symptoms do not resolve following initial treatment. In these cases, a prompt referral to the appropriate specialist (in this case OMFS) is advised for further investigations and management.

M. Davies, C. J. Mannion, by email

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Osteonecrosis as a complication of GA

Sir, we wish to present an interesting case of osteonecrosis of the jaw.

A 41-year-old female underwent general anaesthesia for hysterectomy. She had no history of treatment with bisphosphonates or radiation to the head and neck region. After recovery from general anesthesia, she started to feel pain from her right mandible. Twenty-two days after the general anaesthesia she went to her dentist for examination due to persisting pain. Examination revealed a mucosal ulcer and local bone exposure at the right mylohyoid ridge close to a mandibular tori. The patient was referred to an oral surgeon due to suspected oral malignancy. Seventeen days later (39 days after anaesthesia) the patient had a spontaneous exfoliation of a bone sequestrum in her mouth, and her symptoms declined almost immediately. At the time of examination by the oral surgeon (three days after exfoliation of the sequestrum), the ulcer was healing (Fig. 1). A CT scan showed signs of an exfoliated bone sequestrum (Fig. 2). Complete healing and absence of symptoms were confirmed 50 days after anaesthesia.

To our knowledge, only six cases with the same complication of general anaesthesia as described here have previously been reported, and never in a dentistry journal.[1-2] We believe that this type of injury could either be caused by soft tissue necrosis due to local pressure from the endotracheal tube, or by soft tissue injury caused by the angulation and insertion of the laryngoscope, which could explain why patients are always affected on the lingual side of the right mandible.[2] The blade of the laryngoscope is sharp and usually held in the left hand of the operator while inserted into the oral cavity along the right side of the mandible. In almost all reported cases, symptoms emerge directly after recovery from general anaesthesia or within a day.

Patients with large mandibular tori are at particular risk. Careful oral manipulation and use of techniques to facilitate laryngoscopy could possibly reduce the risk of oral trauma.[3] Patients affected by this complication need to be followed until healing is confirmed (within 1-8 weeks). In selected cases, minimal surgical intervention may be needed to remove sequestered bone, to provide pain relief and to reduce the time required for healing.

M. Kharazmi, U. Nilsson, Västerås, Sweden
P. Hallberg, Uppsala, Sweden

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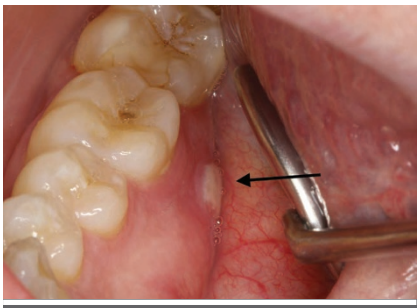

Fig. 1 A healing ulcer located at lingual shelf of the right mandible, on the posterior aspect of a mandibular tori

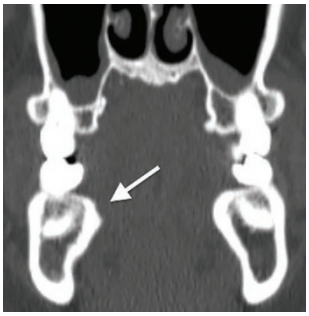

Fig. 2 CT scan showing reduced amount of bone after spontaneous exfoliation of a sequestrum on the lingual shelf of the right mandible

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