CASE REPORT LETTERS

Oral surgery

Bone exposure

Sir, we wish to present an interesting case of osteonecrosis of the jaw caused by a biopsy of the oral mucosa.

A 40-year-old female with an unremarkable medical history was examined at our department because of an asymptomatic mucosal alteration on the posterior, right side of the hard palate. The alteration was red/brown and located near the maxillary tuberosity (Fig. 1). A seemingly uncomplicated punch biopsy was performed, with oral melanin hyperpigmentation as the histological diagnosis.

However, at the follow-up 18 days after the biopsy, the patient complained of mild pain at the location of the biopsy. Examination revealed dehiscence of the mucosa and exposure of the osseous structures at the location of the biopsy. The circular bone exposure covered the entire area of the pigmentation and was not sensible to probing (Fig. 2).

Treatment consisted of use of chlorhexidine gel twice daily and paracetamol *per os*. Healing was confirmed one month later. It was noted that the patient had a bilateral prominent bony ridge, medial to the dental arch, extending posteriorly to the maxillary tuberosity. The mucosa at the site of the biopsy was very thin. In retrospect, we would have preferred a scalpel for a thinner and longer biopsy, instead of a circular biopsy punch with a diameter of 5 mm. Conservative treatment strategy as presented here should be regarded as the primary option. However, in cases with increasing pain or increasing bone exposure, surgery is required to reduce the amount of bone exposure and to facilitate faster mucosal coverage.

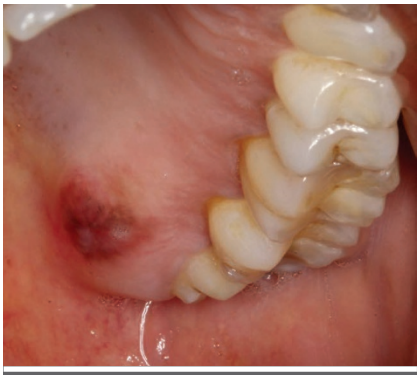

Fig. 1 Mucosal alteration on the posterior part of the hard palate

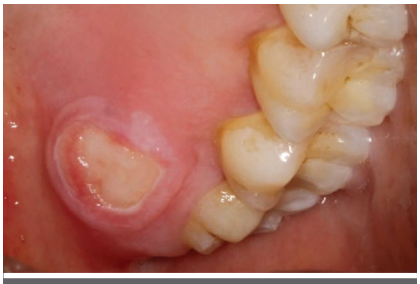

Fig. 2 Bone exposure at the site of mucosal alteration and biopsy. Note the prominent bony ridge medial to the dental arch

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Oral medicine

Diagnostic overshadowing

Sir, 'diagnostic overshadowing' is a term used by psychiatrists to describe a phenomenon that can be a potential barrier to healthcare provision. It is used to describe a situation where symptoms of a physical problem are attributed to a patient's mental illness, thus leading to under-diagnosis of the co-existing physical illness, treatment delay and increased complications.[1] This has also been noted by the WHO and NPSA as barriers in the treatment of patients with mental health issues. It is believed that lack of education and training in mental health along with stigmatisation may contribute to its occurrence.

Experience from our maxillofacial department has led us to believe that this term can be extended to include more aspects of medical, dental and surgical care. Stigmatisation by medical professionals has previously been reported.[2] However, when considered in the context of minimal exposure to dental/oral medicine amongst other health professionals, we are left in a situation where dental diagnostic overshadowing may be a reality.

A recent case that highlighted this issue was that of a 47-year-old man who was referred to the emergency department with history of a persistent dental infection. He was known to have learning difficulties and a compromised social situation led to his unkempt appearance at presentation. His main complaint was an increase in size of his facial swelling despite antibiotic therapy. He had poor oral hygiene, generalised periodontal disease and multiple retained roots. On further examination, he was found to have fixed cervical lymphadenopathy and a non-fluctuant painless swelling was noted arising from the retromolar trigone. When the history was revisited, the patient also reported a recent change in his voice.

In the preceding few months he had presented to various primary care settings. He was universally managed with antibiotics for a dental infection. Unfortunately, biopsy of the lesion confirmed a squamous cell carcinoma. Given the delay in presentation to secondary care, the disease was quite advanced and following multidisciplinary discussions, the patient was treated with palliative intent. Sadly, he passed away four months after his initial presentation to our department.

We feel this case highlights the difficulties that arise when treating those with mental health problems. As the majority of a diagnosis is based on history alone, diagnostic overshadowing would be more prevalent in those who are unable to communicate effectively. Communication was challenging for this patient and thus the red flag signs were not picked up promptly. The patient's appearance and neglect of personal hygiene meant dental infection was an obvious, if not simplistic, differential for his orofacial swelling.

However, thorough investigation revealed more sinister features. Irrespective of this, the definitive treatment for a dental abscess should be provided by a dentist. If antibiotics are to be prescribed in the interim, we recommend a timely review to be arranged. Failure to respond should trigger a referral to secondary care or a consideration of other potential diagnoses.

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