COMMENT

Letters to the editor

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OMFS

TMJ dislocation: late presentation

Sir, a 51-year-old gentleman attended our unit with a history of six-day difficulty eating and an altered bite. On questioning, he gave a history of biting into a hard sweet and then felt a sudden pain in the right side of his face. The pain settled and he thought nothing more of it.

He was medically fit and well.

On examination the patient was comfortable at rest and not in pain. Figure 1 shows the patient at rest.

Further examination demonstrated a deviated chin point to the left and an anterior open bite. There was some limited mouth opening and restriction of movement. Intra-oral examination was unremarkable apart from gross caries in posterior segment teeth. No active infection was noted.

An OPG was taken which showed the patient to be partially dentate with gross caries.

Fig. 1 Patient at rest showing chin point off centre to the left and an anterior open bite

Fig. 2 Right TMJ dislocation. OPG x-ray demonstrating unilateral right TMJ dislocation (arrow). Contrast to normal position of left condyle which is in the glenoid fossa

On further inspection of the OPG it became apparent that the right mandible condyle was dislocated and completely out of the glenoid fossa. A diagnosis of unilateral mandibular TMJ dislocation was made (Fig. 2).

After discussion with the patient, he gave consent to having manipulation of the dislocation. This was achieved by pushing down on his right posterior mandible ridge intra-orally and in a backwards direction. The patient regained full movement of the mandible and mouth opening.

We would like to highlight that patients with TMJ dislocation may present late and not necessarily on the day of dislocation.¹ If available an OPG will confirm the diagnosis. Importantly, the OPG x-ray should include both condyles as a dislocation will be easy to miss.²

General dental practitioners are in an excellent position to diagnose TMJ dislocations by simple clinical examination looking for chin point asymmetry and the presence of a malocclusion. Good OPG imaging will confirm the diagnosis. Where the dental surgeon is unable to reduce the dislocation, referral to their local maxillofacial unit is required.

J. Watson, S. Rai, A. Ujam, London, UK

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radiographs for trauma cases: a retrospective audit at a regional maxillofacial unit. *Br J Oral Maxillofac Surg* 2016; **54**: e68.

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Passion, pride, professionalism and partnership

Sir, we would like to draw readers' attention to a case which provided an opportunity through partnership to reconcile our professional views, with reference to recent *BDJ* content on appropriate referring.^{1,2}

A cheerful 86-year-old lady outpatient with no medical history or constitutional symptoms requested the removal of her bothersome, over erupted and wobbly left maxillary second molar. Taking a few minutes with topical anaesthetic, the extraction was simple enough, but the patient returned two weeks later with a necrotic ulcer spreading 2 cm palatally from the socket and onto the floor of the maxillary sinus. Referring her into the suspected cancer pathway and after one month, we were relieved to learn the patient did not have oral cancer but not reassured, as the ulcer continued to spread. A diagnostically challenging histology revealed a non-dysplastic oral mucosa, scattered atypical lymphocytes and the presence of Hodgkin/Reed-Sternberg cells which pointed to a lympho-proliferative disorder. Further tests excluded lymphoma.

Dentist-doctor discussions continued and a negative galactomannan test ruled out invasive aspergillosis and microbiology eliminated bacterial species. The presence of the ubiquitous Epstein Barr Virus (EBV) was revealed with histochemistry providing a definitive diagnosis of EBV positive mucocutaneous ulceration (EBV-MCU). Treatment started with intravenous administration of a monoclonal antibody (Rituximab) targeted to control B-cell

proliferation. The patient, now recovering, is under review and in our care.

First identified in 2010, EBV-MCU was provisionally classified by the WHO in 2016 as a mature B-cell lymphoid neoplasm.³ Although relatively rare, perhaps due to under reporting, by 2018, some 100 cases have already been documented, 27% being associated with the immuno-senescence of old age alone.⁴ Disease progression can be anything from indolent and self-resolving, to aggressive and requiring surgical excision and radiotherapy.⁵ Regardless of the EBV-MCU profile, once detected, multi-disciplinary surveillance should always follow due to the increased risk of neoplastic transformation in the oral and sinus cavities, the nasopharynx and the GI tract.⁵

On reflection, due to the ubiquitous nature of EBV and the ageing patient population globally, we believe EBV-MCU could be under-reported in the UK and it should be considered within differential diagnoses when referring. A definitive diagnosis and treatment depends on an approach that is inter-professional and the work of the perceptive dentist and supportive doctor might continue even after referring their patient. Certainly passion and pride enhance such outcomes, but perhaps even more so if they proceed in partnership with other professionals.

*J. Laszlo, A. Azher Anwer,
London, UK*

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Prosthodontic dentistry

Self-repaired denture

Sir, a 55-year-old edentulous male reported to our Institute for the fabrication of a new denture. He was using an old denture which he had had for five years. Intra-oral examination revealed a maxillary denture innovatively repaired by the patient himself

Fig. 1 The denture repaired by a patient

Fig. 2 The broken denture joined with soldering wire

as he was frustrated by its frequent breaking and recurring cost of repair (Fig. 1).

He therefore developed an ingenious technique of repairing his denture by joining the broken halves using solder wire with a soldering gun, which had been functional for the previous eight months (Fig. 2). The case proves true the old idiom 'necessity is the mother of invention'.

*P. M. Shirsat, P. Prasad, S. Bansal, R. S. Desai,
Mumbai, India*

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General dental practice

Mental health confidences

Sir, during my first year in general dental practice one of the things that has shocked me most is the number of patients who have confided in me regarding their mental health. On several occasions I have found myself to be the first healthcare professional from whom a patient has sought help.

Very early on in my foundation year I found myself with a patient in crisis, with very little idea of how to help or refer them. I felt strongly that I should have been able to do more than simply contact their GP and hope they intervened swiftly. As GDPs we, in many cases, see our patients on a more regular basis than most other healthcare professionals and naturally build a strong rapport with them. So it is not

surprising that our patients feel comfortable confiding in and seeking help from us.

However, I was surprised to find that in my area there was no mental health pathway in place for dentists to refer or signpost their patients who reached out for help. After discussing this matter with fellow GDPs and foundation dentists, I realised that I was not in isolation. Everyone had multiple similar instances, yet not one of us was aware of any local mental health pathway.

After a discussion with my local mental health coordinator, I found that they were more than happy to integrate our services. I was able to create a document with the contact details of the relevant organisations in the area, something I wish I had to hand in those first few weeks when I encountered the patient in crisis. It is so easy in the busy world of the GDP to brush over a small comment which may be a big cry for help. I believe that mental health is an area in which GDPs require additional training and further integration with local mental health teams.

L. Long, Lancaster, UK

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Burnout and stress

Can we do more?

Sir, there is increasing awareness of burnout in healthcare professionals. Little is known regarding oral and maxillofacial (OMFS) dental core trainees (DCTs) who find themselves challenged being expected to bear the responsibilities, and display the knowledge and skills of a junior doctor, but without the benefit of a medical degree. We conducted a questionnaire which aimed to measure the risk of burnout among OMFS DCTs, and identify factors which may influence this.

An online questionnaire was sent to OMFS DCTs in the South West, Essex, and London Deaneries in 2018, which included the validated Oldenburg Burnout Inventory. We received responses from 34 OMFS DCTs (an estimated 50% response rate). Figure 1 highlights sources of stress with 97% (33/34) feeling their job was stressful, and 32% identifying a 'lack of correct equipment' as a source of stress. Applying a standard of care for dental procedures that is comparable to general dental practice (eg splinting an avulsed tooth) may be unachievable due to the lack of specialist equipment and assistance. This may cause dissatisfaction with the care provided, and induce a feeling of vulnerability