Letters to the Editor

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LETTERS

TMJ DYSFUNCTION

Sir, the general dental practitioner may be the first point of contact for patients with TMJ problems. Presenting complaints may include pain, limitation in mouth opening, clicking and dislocation with occlusal changes. There may also be associated tooth wear. Often the symptoms may be related to functional habits such as bruxism.

However, various medications may also result in TMJ dysfunction, due to side effects such as bruxism and TMJ dislocation. There have been several reported incidents of iatrogenic bruxism involving diurnal bruxism¹ thought to be associated with dopaminergic blockade, and nocturnal bruxism. Nocturnal bruxism has been reported with venlafaxine, a serotonin/noradrenaline reuptake inhibitor, which responded to gabapentin,² as well as three selective serotonin reuptake inhibitors (SSRIs), paroxetine, fluoxetine and setra-line. In both reports the SSRI-associated bruxism was treated with buspirone. Nocturnal bruxism may also be secondary to the SSRI citalopram.³

Phenothiazines are widely used for their antipsychotic, antiemetic and sedative properties. They are known to block the dopamine receptors in the brain, which may account for their extrapyramidal side effects. These side effects cause various movement disorders including oral bucco-lingual dyskinesia (continual side to side or circular chewing movements of the jaw) and oromandibular dystonia (OMD). OMD is a focal dystonia manifested by involuntary muscle contractions producing repetitive, patterned mouth, jaw, and tongue movements.⁴ This is often referred to as primary (idiopathic) or secondary dystonia. The latter most commonly develops

as a side effect of long-term treatment with antipsychotic drugs and approximately 10% of patients exposed to these will experience a dystonic reaction.⁴ It is important that GPs are aware of this condition for successful management. Such dislocation of the TMJ is usually unilateral, although reports have shown that the mechanical energy derived from the oromandibular dystonia can occasionally cause bilateral dislocations.

Classic signs of TMJ dislocation include pain, inability to completely close the mouth, deviation of the jaw to the side, forward protrusion of the mandible, difficulty swallowing, drooling from the mouth, difficulty chewing and difficulty articulating. Treatment of the dislocation requires manual manipulation of the joint, aided with the use of analgesics and benzodiazepines. Botulinum toxin A (BTA) injection therapy is indicated where conservative treatment has failed, and surgery carries an unacceptable risk. BTA is also beneficial in patients who suffer recurrent dislocation of the TMJ as a result of impaired muscle coordination secondary to mandibular dystonia, early and late dyskinesias, epilepsy and brain stem syndromes of various origins.

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TRAUMA BY IPAD

Sir, an 11-year-old boy attended the emergency clinic at Glasgow Dental Hospital and School's paediatric department in March 2012 following a second incident of trauma to his upper right central incisor. The first incident, a skateboarding accident in May 2011, resulted in a middle third comminuted root fracture, which healed with connective tissue union after a period of splinting and the tooth remained vital. The second traumatic incident resulted in an oblique crown fracture at the level of the cervical margin (see accompanying radiograph, Fig. 1). The coronal fragment was subsequently removed, the exposed pulp extirpated and an overdenture provided to restore aesthetics in the short term. Ideally, the root will be obturated and retained in order to facilitate placement of a single osseointegrated implant at an appropriate age.

Fig. 1 Oblique crown fracture at the cervical margin

A second traumatic incident is not uncommon in active young boys. However, in this particular instance he had been relaxing, or slouching as his mother put it, at home on the sofa playing a game on his iPad 2. Such was his excitement or absorption in the game that he dropped the iPad 2, hitting his tooth and decoronating it. We believe that this may well be the first incident of dental trauma by iPad 2 and wish to bring it to the attention of the profession so that the dangers of ownership may be taken into consideration when treating and advising patients!

We prescribe a mouthguard for those who play contact sports. Should we now consider doing the same when we know that our patients own an iPad 2 and in the knowledge that an obvious danger to the developing dentition exists? Perhaps we should consider referral for lessons in deportment as injury is surely less likely when slouching is removed from the equation? Can we take any positives from the incident? Is there now a potential gap in the market for mouthguard provision to the iPad 2 owning population? And significantly, it is surely another point in favour of encouraging an active lifestyle in our patients given the obvious danger to the developing dentition when sedentary in one's own sitting room.

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SYSTEMIC HEALTH SCREENING

Sir, reviewing the literature reveals an abundance of suggestions as to how the dental professional can investigate issues related to patients' systemic health.

Screening for hypertension, diabetes, HIV, obesity and excessive alcohol consumption are but a few that have been discussed.¹⁻⁵ The mindset underpinning these ideas is noble, as the dental profession is in an ideal situation to interact with patients who may not visit any other primary health care provider.^{4,6} Systemic considerations by dentists can be valuable additions to improving the nations' health, particularly in detecting asymptomatic conditions.⁷ One example is Engström *et al.*,⁸ who excellently demonstrated the value of screening

for hypertension in Sweden, and there seems to be no real reason why this effect could not be duplicated in the UK.

We are aware of referral letters contacting general practitioners and where necessary facilitating pathology requests, however, the dental professional in the UK seems reluctant to participate in these potential interventions.^{1,3} Sproat *et al.*⁹ list possible limitations to hypertension screening, though many of these can be applied to other similar interventions. Reviewing the literature in the UK and abroad outlines barriers, mainly related to referral and lack of guidelines related to screening in dentistry. Guidance is surely needed to ensure our role doesn't expand exponentially and impractically to consider factors far beyond our resources.

We can exercise individual discretion, of course, possibly relating to conditions affecting the provision of oral health foremost.² Examples include checking blood sugars of a patient with refractory chronic periodontitis for example, or measuring the blood pressure of an obese 50-year-old who has admitted to not taking their prescribed antihypertensives. Modern clinical practice strives to be evidence-based and using our discretion is insufficient to fully facilitate optimum patient care beyond the oral cavity. In the UK, we should strive to echo the efforts implemented internationally.

With even basic guidelines in place, we could be assured of the value of referrals we may generate whilst being sure we are appropriately using our limited clinical time. Does anybody else feel the need for clear guidance to ensure we can optimise our patient care beyond their dental health, whilst not venturing beyond our traditional role?

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DOUBLY IMPOSSIBLE

Sir, I wish to endorse wholeheartedly the views of Varley, Kanatas and Carter (*An impossible position*; *BDJ* 2012; **212**: 153-154) in their wish to improve access of appropriate care for those patients on bisphosphonates. I would like to add to this 'impossible position' from my perspective for those patients who are on or about to commence high dose intravenous/oral bisphosphonates as part of their oncology care for their multiple myeloma or for their metastatic bony lesions from breast, prostate or renal carcinoma.

Where I work as a consultant in special care dentistry (SCD), the SCD and oncology teams have worked very hard and closely to be proactive in the care of this cohort of patients. We now have a streamlined/fast-tracked referral system which endeavours to see these patients as an absolute priority *before* commencing their bisphosphonate treatment, as they are at an even higher risk of developing bisphosphonate related osteonecrosis of the jaws (BRONJ) following exodontias, or, spontaneously.

Although they are being referred from an oncology consultant to a SCD consultant, and 50% of the time are seen in a hospital location, there is a catch. I am employed as a consultant in primary care and as such these patients are subject to the normal NHS patient charges as they would be on the high street (other than normal exemption). For many of these patients these charges come at a time when they are not receiving their usual salary, when they are already having to come to terms with their diagnosis, difficult treatment and prognosis, on top of the