Letters to the Editor

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LETTERS

SMALL BUT REAL POSSIBILITY

Sir, the following case highlights the small but real possibility of temporomandibular joint dislocation into the middle cranial fossa.

A 12-year-old boy sustained a fall and injury to his jaw while playing indoor football. He experienced sudden acute left sided facial and jaw pain, and trismus. At examination, there was a significant malocclusion consisting of left sided premature posterior contact and a shifted dental centreline to the left (Figs 1 and 2).

Figs 1–2 Temporomandibular joint dislocation into the middle cranial fossa

Following presentation to the A&E department, he underwent an urgent CT investigation and was seen and admitted under the care of the maxillofacial team.

Open reduction and repair with a temporalis flap was planned under

general anaesthesia, however, subsequent manipulation and relocation under anaesthesia occurred as a closed procedure. He was placed in heavy elastic intermaxillary fixation for a period of approximately two weeks, and then a period of light elastics followed this.

To date, the patient has made an uneventful recovery and has commenced orthodontic therapy which had been planned for a pre-existing malocclusion. Functional and aesthetic outcomes are good.

C. J. Mannion, T. Teemul, R. Clarkson

By email

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FALSE NEGATIVE RESULT

Sir, I have been reading the very interesting ongoing series of articles in the *BDJ* discussing periodontal disease in relation to treatment planning and oral diagnosis.^{1,2} The point is clearly made that absence of bleeding on probing is a very significant indicator for periodontal stability.² Lack of gingival bleeding also suggests stability. Clinical attachment loss (CAL) is stated as a measure of periodontal disease history rather than current activity. Using this measure requires one to establish a baseline measurement and follow up regularly by probing measurements.¹ A detailed outline of smoking as a major risk factor for periodontal disease is outlined and the effect that this habit has on attachment loss and lessened response to periodontal therapy.¹

A senior periodontist colleague pointed out to me of late that smoking may mask periodontal bleeding and, therefore, can of itself be implied to produce a 'false negative' result in terms of scoring for disease activity via use of

this measure alone. The masking effect of smoking has been indicated from the literature.^{3,4} Further, a reduction in clinical signs of gingivitis is seen in smokers due to vasoconstrictor effects of nicotine and heavier keratinisation of the gingivae in smokers.⁴ In summary, as quoted from the literature:⁴ *'It is concluded that the validity of gingival bleeding as a sign and a symptom of inflammatory periodontal disease may be reduced as a consequence of smoking'*. This suggests that the utility of bleeding as a sign and symptom of periodontal disease activity may be masked due to smoking.

In summary, measures of periodontal disease such as bleeding may be different in smokers *vs.* non-smokers. The masking of selected periodontal disease signs/symptoms can be as a result of nicotine's vasoconstrictor effect. My advice now with patients who are smokers is not to directly trust the bleeding measure, rather, assess over time CAL after establishing a baseline, as suggested to me by my senior colleague. It was, therefore, quite surprising to me that the authors of the said articles in the *BDJ*,^{1,2} themselves periodontal specialists, had not indicated this connection between masked bleeding and the smoking risk factor. I feel it is very important for dentists in general practice to be quite aware that smoking may lead to underscoring for periodontal disease activity and, as mentioned, in these patients a thorough follow up of loss of CAL with baseline assessment is certainly a more worthy and reliable assessment of their disease status.

J. A. Loudon, NSW, Australia

1. Corbet E F. Oral diagnosis and treatment planning: part 3. Periodontal disease and assessment of risk. *Br Dent J* 2012; **213**: 111–121.