

Oral and maxillofacial

A quick scale and fracture

Sir, a patient was referred to the Oral and Maxillofacial Surgery Dept. at Hull Royal Infirmary by their GDP. He had attended for a routine restorative procedure by a dental therapist when, following the administration of an inferior dental nerve block he attempted to close his mouth followed by a loud 'cracking' sound. He immediately suffered a left cheek swelling and an inability to fully close his mouth.

After a requested review by the GDP, an attempt was made to reduce a suspected unilateral TMJ dislocation. As this was unsuccessful the patient was referred to the secondary care environment. After an initial history and exam it was noted that the patient was almost able to close his mouth but was unable to close the last few millimetres due to pain. The clinical position of the mandible did not seem in keeping with a unilateral dislocation and an OPT was requested. This showed that the mandibular condyles were both in the glenoid fossa and that there was a mal-positioned (suspected fracture) to the left coronoid process. Figure 1 shows the normal coronoid on the right side.

As it was not possible to discern the position (medial or lateral displacement) of the left coronoid process further from the OPT, a CT scan of the TMJ region was requested. This showed a laterally displaced coronoid process contacting the underside (inferior aspect) of the zygomatic arch and preventing full mouth closure. The patient was then requested to open their mouth fully and under direct external digital pressure the author (PB) manipulated the coronoid process back into position with both an audible and palpable crepitus detected.

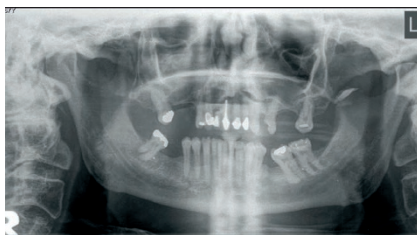


Fig. 1 Normal coronoid as seen on the right side

Immediately following this reduction, the left sided extra oral swelling was gone, discomfort eliminated, and the patient was able to close their mouth normally.

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DOI: 10.1038/sj.bdj.2018.490

Diagnostics

The woman who found worms in her mouth

Sir, I would like to share an interesting case of a 58-year-old lady who presented with the complaint of a crawling sensation in her mouth for the previous six months. She believed that the sensation was caused by numerous small worms inhabiting her complete denture and feeding on her oral tissues. The crawling sensation persisted even if the denture was removed because the patient believed 'the worms had penetrated into the oral mucosa'. Her medical history was unremarkable and she didn't smoke tobacco, drink alcohol, or use recreational drugs. Extra-oral examination was unremarkable and the patient denied any similar sensation elsewhere in her body. Intra-oral examination revealed healthy oral tissues with no evidence of mucosal infection or inflammation (Fig. 1a). Her complete denture was overly clean as she reported washing it with a denture cleanser more than ten times per day in an attempt to kill the worms (Fig. 1b). The patient reported that she had three different sets of complete dentures since the onset of her symptoms, but all were inhabited by worms. Relevant investigations, including complete blood count, hepatitis serology, vitamin B12, thyroid function, blood sugar, brain MRI, and allergy tests, were within normal range. One week after the initial assessment the patient brought a small envelope containing cloth fibres believing these fibres to be the worms inhabiting her denture and eating her oral tissues (Fig. 1c). The patient was referred to psychiatry where a diagnosis of delusional parasitosis was confirmed.

Delusional parasitosis, also known as Ekbom's disease, is a rare psychiatric disorder characterised by the firm belief of having been infected by parasites, worms, insects or other living organisms when one is not.¹ The condition may exist as an isolated phenomenon

(ie primary delusional disorder) or in association with other psychiatric or organic diseases (ie secondary delusional disorder).² The diagnosis of delusional parasitosis can be made on the basis of history alone, but when the mouth is involved the dentist should perform proper examination to make sure that the patient doesn't have an organic oral disorder. Close collaboration with psychiatry is essential because patients with delusional parasitosis often reject psychiatric referrals.

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DOI: 10.1038/sj.bdj.2018.491

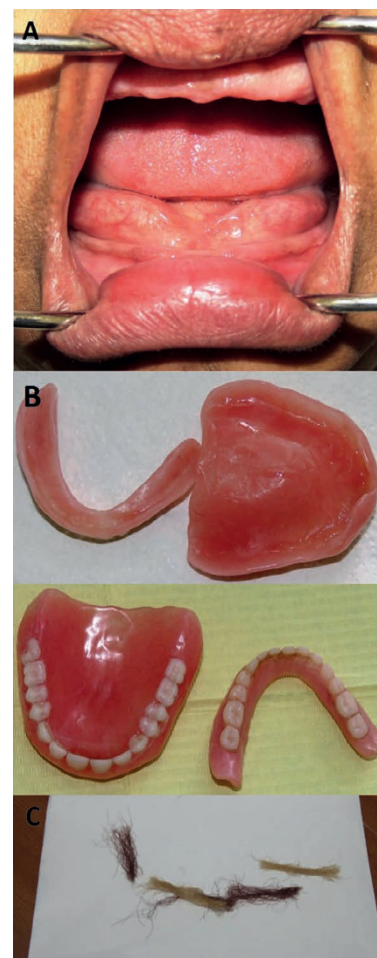


Fig. 1 (a) Healthy oral tissues; (b) Two sets of overly cleaned dentures; (c) Cloth fibres brought by the patient and believed to be 'evidence' of worm infection