Psychology

Psychiatric dimension to oral pain

Sir, we read the case report 'The woman who found worms in her mouth' (*BDJ* 2018; **224:** 918), diagnosed as having delusional parasitosis (DP) with interest.

The detailed description of the patient's medical history and examination is indicative of another condition called oral cenesthopathy (OC), characterised by unusual, strange bodily sensations within the oral region without corresponding abnormal extra-intra orofacial findings.[1,2]

While some patients can clearly describe the sensation as having 'worms', 'fingers', or 'coins' in the mouth, some patients cannot describe this unusual sensation.

Different from the concept of DP that is usually reported by dermatologists, OC is mostly observed in dental clinics, with or without the presence of a dental treatment trigger. Both can be primary or secondary in origin, relating to other mental disorders.

A recent study found the asymmetric regional cerebral blood flow in the broad brain region in OC patients was attenuated following improvement of the symptoms, suggesting that brain dysfunction may be involved in the pathology of OC, especially in the 'primary' origin.[3]

Many case reports of both conditions described significant effectiveness of anti-depressants or antipsychotics on symptom improvement. Instead of arguing which diagnosis is more reasonable, we discuss what a dentist should do to manage patients.

All these patients tried to convince the dentist with their own evidence. Their belief in a dental-related/somatic nature of symptoms made them seek help from a dentist.

In addition, psychiatrists find it difficult to understand the oral complaint. Consequently, a mere psychiatric referral is usually not helpful. In such a situation, explaining and discussing the unknown origin of the symptoms is necessary.

In Japan, in an effort to provide better treatment to patients, dentists and psychiatrists worked together to develop Oral Dysesthesia Rating Scale, a tool to assess psychosomatic symptoms in oral regions.

We suggest that except for patients with mental disorders who need obvious help from a specialist, a collaborative approach between a dentist and psychiatrist should be more actively considered rather than just a direct referral.

T. T. H. Tu, A. Uezato, A. Toyofuku,
Graduate Tokyo Medical and
Dental University, Japan

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CASE REPORT LETTERS

Oral surgery

Transplantation success

Sir, a 36-year-old male attended as a new patient to my practice in 2012, complaining that he had a fractured tooth on the lower right side.

After clinical and radiographic examination it became clear that there was a large carious lesion in the distal of the lower right second molar tooth and also a mesially impacted lower right third molar (Fig. 1).

After much discussion we planned to extract the carious second molar and also the poorly positioned third molar tooth.

I saw the patient the following week and the second molar tooth was extracted with curettage of the socket.

The third molar was then extracted and on removal, the socket of second molar tooth 'begged me' to try the third molar in for fit.

It seated very nicely, so I stopped the procedure with the tooth still in the socket and discussed the pros and cons of attempting a transplantation procedure.

The patient was keen to give it a go and I bonded the third molar to the distal of the first molar with composite resin. The patient was advised not to load the teeth on that side (Fig. 2).

I saw him for review some two months later and removed the composite splint. There was some slight mobility of the tooth, but no discomfort.

A radiograph showed some bony infill. I advised him that the tooth required root canal treatment but we decided to leave the tooth for a further couple of months before attempting this procedure.

At his next visit, the tooth was much more firm. The root canal treatment was performed and the tooth settled uneventfully (Fig. 3).

I saw him for examination in May this year (five years post-operatively) and the tooth is still doing well. The radiograph shows complete bony infill and no signs of resorption.

He is delighted that he has his own tooth there and not a dental implant!

S. Simpson, by email

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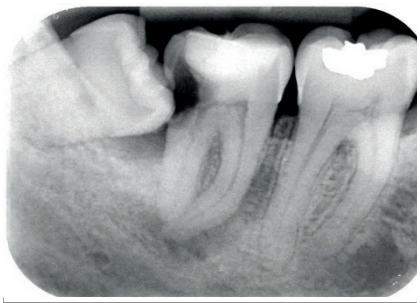

Fig. 1 Mesially impacted lower right third molar

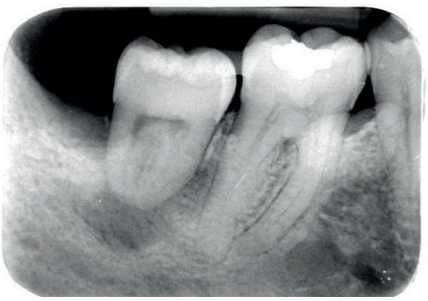

Fig. 2 Third molar transplant to second molar pocket

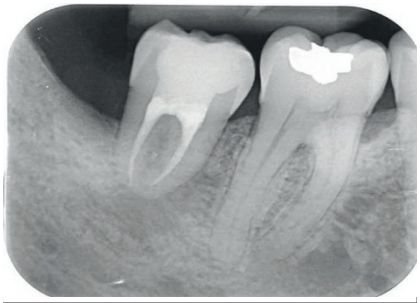

Fig. 3 Settled transplanted third molar post RCT

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