Unilateral Hysterical Mandibular Dislocation

Dr. Muralee Mohan
Professor
Dept. of Oral & Maxillofacial Surgery
A.B.S.M.I.D.S., Mangalore

Dr. Ritesh K.B.
Asst. Professor
Dept. of Oral & Maxillofacial Surgery
A.J.I.D.S., Mangalore

Dr. Shyam S. Bhat
Asst. Professor
Dept. of Oral & Maxillofacial Surgery
C.I.D.S., Virajpet

Abstract

Acute mandibular dislocation is defined as displacement of the condyle anterior to the articular eminence with complete separation of the articulating surfaces and fixation in that position[1]. A case of unilateral dislocation is presented in this article.

Key Words : Mandibular dislocation; unilateral dislocation; hysterical dislocation

Case Report

A 16 years old female patient came to our department with a chief complaint of pain and deviation of the jaw towards right side since 2 days. She had a history of an unintentional blow to the left side of her face 2 days ago, following which her mandible deviated to the right side. She was unable to bring it back into position. She complains of mild pain in right side of her jaw. She reports of a similar incident 5 years back, when, as a result of a blow to the left side of her face, her jaw was deviated to the right side. She was then diagnosed with TMJ dislocation, and was subsequently treated with reduction of the dislocation and intermaxillary fixation for 1 week.

She had no relevant medical history, the general condition of the patient was moderately good, and she appeared to be well nourished. However, she seemed to be too anxious, and her responses to our history taking and examination felt exaggerated.

On examination, facial asymmetry was apparent, and deviation of the mandible was evident on mouth opening to right side. Intraorally, she had posterior cross-bite, which was also evident in the Orthopantomogram (OPG) and transcranial TMJ radiograph. Her history, coupled with clinical examination and emotional behavior led us to the diagnosis of Unilateral Hysterical Dislocation of the Left Mandibular Condyle.

Treatment options ranged from simple manual reduction of the condyle to condylectomy. However, on account of her volatile emotional nature, we decided to go ahead with a conservative treatment with manual reduction of the condyle using Yurino's method under local anesthesia followed by intermaxillary fixation with eyelet wiring for 2weeks. She was given a psychiatric reference for treatment of her emotional problems.

Discussion

The displacement of the condyle out of the glenoid fossa and anteriopposterior to the articular eminence is termed as Subluxation, and Incomplete Subluxation is defined by the term Dislocation. Predisposing factors may be laxity of ligaments, capsule and ligament injury, degenerative joint diseases, non-synchronized muscle function and morphologic abnormalities of condyle and articular eminence. Hypermobility of temporomandibular joint is characterized by excessive anterior movement of the condyle at maximum mouth opening without strain or symptoms. Hypermobility, subluxation, and dislocation of the temporomandibular joint are interrelated conditions and hypermobility is likely a predisposing factor for the latter two. Long term overclosure and loss of physiologic vertical dimension secondary to loss of dentition can also contribute to subluxation & dislocation.

Recurrent mandibular dislocation is relatively uncommon. It is found more frequently in people with general ligamentous and capsular laxity, eminential erosion and flattening.[2]

Incidence of dislocation is more in people with general joint laxity and internal derangement of the TMJ or people with occlusal disturbances, such as those associated with loss of teeth and vertical height.[3] It has also been associated with neurologic diseases with increased muscular activity as well as in patients with extrapyramidal symptoms who are under neuroleptic therapy.[4]

Surgical techniques employed to treat Chronic recurrent dislocations were partial or complete myotomy[5], capsular plication[6], scarification of the temporalis tendon[7], open condylotomy[8], insertion of implants into the articular eminence[9,10], down-fracturing of the zygomatic arches (Leclerc and Girard, 1943), augmentation of the eminence by allografts[11, 12] and eminectomy.[13,1] Manual reduction of dislocated condyle has been described first by Hippocrates. An alternative method for the same has described by Yurino.[14]

References

References are available on request at editor@healtalkht.com

Legends

Fig. 1: Initial presentation- Extraoral
Fig. 2: Initial presentation-Intraoral
Fig. 3: Initial presentation- OPG
Fig. 4: Administering LA
Fig. 5: Yurino's method of reduction
Fig. 6: Eyelet wiring for immobilization
Fig. 7: 2weeks follow up extraoral
Fig. 8: 2weeks follow up OPG

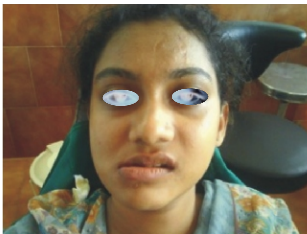
Fig. 1

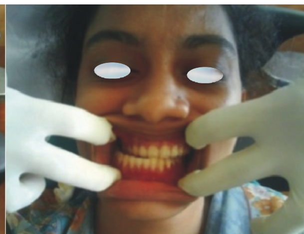
Fig. 2

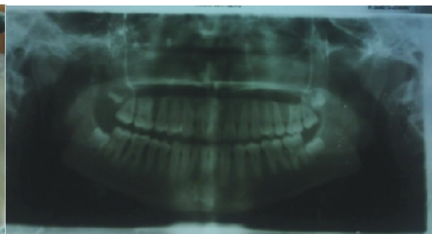
Fig. 3

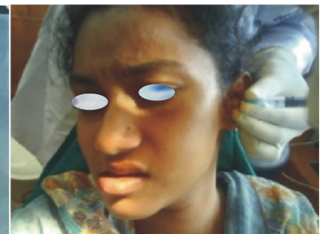
Fig. 4

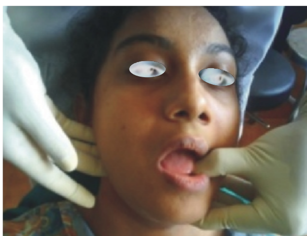
Fig. 5

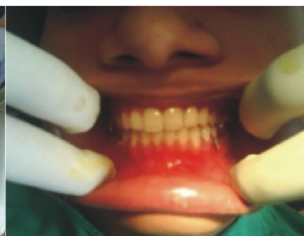
Fig. 6

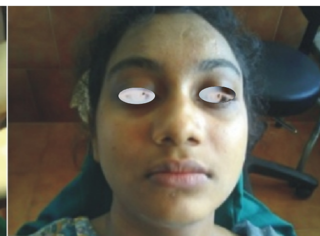
Fig. 7

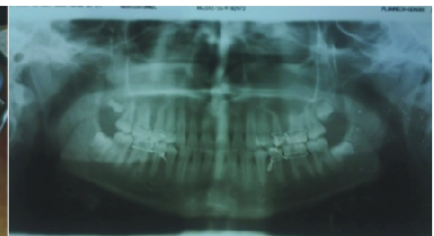
Fig. 8

Address for Correspondence: Dr. Shyam S. Bhat; Asst. Professor, Dept. of Oral & Maxillofacial Surgery, CIDS, Virajpet.
drshyambhat87@gmail.com