

Metastatic melanoma misdiagnosed as a temporomandibular disorder

A case report and review of the literature

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The differential diagnosis of the various temporomandibular disorders (TMDs) often is complicated by the fact that the most frequent symptoms associated with these conditions (facial pain and limited mouth opening) are common to most of them. Moreover, these symptoms, particularly unilateral facial pain, also can be related to odontogenic, traumatic, vascular, sinus-associated and neoplastic etiologies.¹ Thus, a misdiagnosis of TMD frequently is made initially and the correct diagnosis is overlooked. In this case report, we describe a patient with a metastatic neoplasm that was misdiagnosed initially and treated as a temporomandibular joint (TMJ) disorder.

CASE REPORT

A 75-year-old woman with a history of right-sided orofacial pain of approximately 18 months' duration was referred by her dentist to the oral medicine clinic at Virginia Commonwealth University, Richmond, for evaluation and management of TMD. The onset of her symptoms occurred shortly after she underwent extensive dental treatment that included restorations and fixed prosthodontics. The dentist attributed the pain to para-

ABSTRACT

Background. Malignancies in the head and neck region are difficult to diagnose because of their deep location and presence of symptoms mimicking those of temporomandibular disorders or other orofacial pain disorders.

Case Description. A 75-year-old woman reported experiencing right-sided jaw pain, temporal discomfort and paresthesia. She had undergone conservative therapy for temporomandibular joint disorder, which was unsuccessful. A magnetic resonance image of the midface revealed a mass on the base of the tongue along with possible metastatic lesions to the brain. Further investigation of the lesions revealed them to be metastatic melanoma.

Practical Implications. Patients with atypical symptoms of facial pain, including neurological signs, should undergo further investigation with advanced imaging to determine the source of the symptoms, which could include neoplasms.

Key Words. Oral medicine; temporomandibular joint disorders; pain; orofacial; neoplasms; metastatic melanoma.

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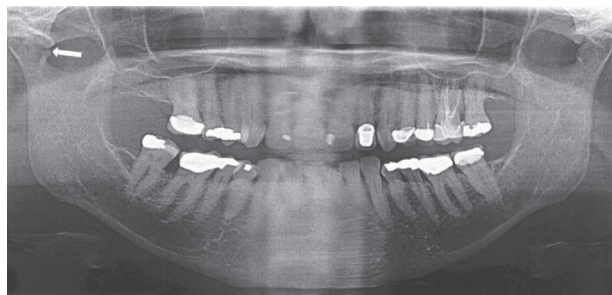


Figure 1. Panoramic radiograph reveals the presence of degenerative joint disease on the right mandibular condyle (arrow), with no other remarkable pathological findings.

functional tooth clenching and grinding and suggested trial use of an orthotic appliance to alleviate her symptoms. Failure to achieve adequate relief of symptoms resulted in the patient's seeking the advice of her primary care physician, who referred her to an otolaryngologist. After the otolaryngologist ruled out any auditory or sinus-related pathology as the source of her pain, the patient returned to her dentist, who referred her to the oral medicine clinic.

On evaluation, the patient's chief complaint was a constant dull ache on the right side of her face in the preauricular region that was aggravated by movement of her jaw and by mastication. The pain radiated occasionally to the right side of the neck and temple regions. She reported crepitation in both TMJs on mandibular movement. In addition, the patient reported a mildly altered sensation in the right masseter region that she described as a feeling of "fullness to mild numbness," as well as mild discomfort when swallowing.

The patient's medical history was significant for migraine headaches, hypertension and hyperlipidemia. Her surgical history was significant for a cholecystectomy and removal, by a dermatologist, of a basal cell carcinoma from her right arm. The patient's current medications included acetaminophen, amlodipine, rosuvastatin and an over-the-counter formulation of acetaminophen, aspirin and caffeine used as needed for her migraine headaches. She reported having an allergy to penicillin, with an unknown reaction. Her social history was positive for occasional alcohol consumption and negative for tobacco use, as well as for illicit substance use. A review of systems was significant for frequent headaches, loss of appetite, unexpected weight loss and fatigue of one month's duration. The review also was significant for otalgia in the right ear (without changes in hearing) and tinnitus, as well as occasional odynophagia.

On examination, the patient's vital signs were within normal limits, and she appeared to be in no acute distress. Extraorally, the clinician (B.D.) found no significant palpable masses, lymphadenopathy or tenderness in the head and neck region. A cranial nerve examination revealed mild paresthesia in the right-side V3 trigeminal nerve distribution. Examination of the TMJ revealed

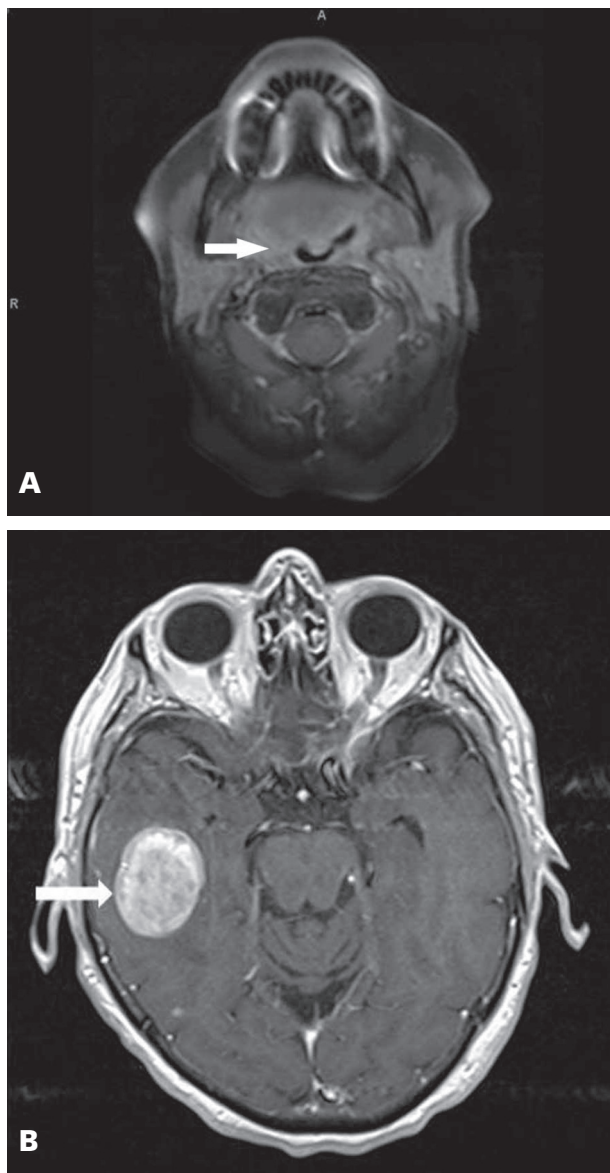


Figure 2. Magnetic resonance images (MRIs). A. T1-weighted MRI shows obliteration of the right piriform sinus, suggestive of a mass effect by a tumor at the base of the tongue (arrow). B. T2-weighted MRI of the brain reveals an enhancing lesion (arrow) in the right temporal lobe.

an adequate range of motion, with an unassisted mouth opening of 41 millimeters and symmetrical right- and left-sided mandibular excursive movements of 11 and 12 mm, respectively. Palpation of the joints revealed tenderness of the right TMJ. Auscultation revealed crepitation in both joints. Results of the myofascial examination were significant for mild to moderate tenderness of the

ABBREVIATION KEY. MRI: Magnetic resonance image/imaging. PET: Positron emission tomographic/tomography. TMD: Temporomandibular disorder. TMJ: Temporomandibular joint.

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