

Original Contributions

Pain Update

The importance of the history and clinical examination

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“Listen to your patient, he is telling you the diagnosis.”

—Sir William Osler, Father of Modern Medicine, 1849-1919

The objective of this case series is to demonstrate to the general dentist the importance of obtaining a comprehensive patient history to arrive at an accurate diagnosis and determine appropriate treatment and the consequences of failing to do so. The cases described include medication-related osteonecrosis of the jaw (MRONJ), trigeminal neuralgia (TN), and myogenous pain involving the masticatory muscles.

A thorough and comprehensive patient history often guides the clinical examination to the appropriate diagnosis and helps in identifying the appropriate care. In dentistry, the emphasis on technical prowess and procedural skill often sidelines history taking and the clinical examination. Obtaining this information inclusively and thoroughly will help clinicians in the analysis of their patients' symptoms and formulation of the correct diagnosis and treatment. Often, patients erringly assume their medical history is noncontributory to their current oral health status and neglect to disclose information that can alter the entire course of treatment. Dentists must perform due diligence to collect all the necessary information before any treatment to avoid an expeditious yet inaccurate diagnosis and, ultimately, inappropriate treatment. We focused in this article on the indispensable patient history and clinical examination.

CASE REPORT 1

A 46-year-old woman sought oral health care at the University Hospital urgent care dental clinic, Newark, New Jersey, with pain in the left mandibular molar region for more than 6 months. Pain increased with chewing. Her medical history was clinically significant for breast cancer, diagnosed in 2000, which was treated with lumpectomy and radiation. She experienced a local recurrence in 2005 and underwent radical mastectomy. The patient received monthly zoledronate infusions over a 10-year period to address diffuse bone pain and osteopenia despite having had no bone metastases.

Results of a focused intraoral examination revealed that tooth no. 19 had been treated endodontically several years earlier; it was restored with a post, core, and crown and was tender to percussion. There was no evidence of recurrent caries in relation to the crown margins (Figure 1). There was a nonspecific increase in radiopacity in the region periapical to tooth no. 19.

The patient had been informed by the care provider at the urgent care dental clinic that she required extraction of tooth no. 19 because of failed endodontic therapy and a failing restoration. She also was advised of the risk of developing MRONJ as a complication.

One year later, she sought oral health care at Rutgers School of Dental Medicine's Oral Medicine clinic with symptoms of persistent pain, discomfort, and recurrent swelling at the extraction site of tooth no. 19. The patient reported no relief of her original symptoms despite extraction of tooth no. 19. Clinical evaluation results demonstrated no exposed necrotic bone; however, purulence was expressed via the sulcus of tooth no. 18 on palpation of the edentulous site of tooth no. 19 (Figure 2A). In addition, a panoramic radiograph demonstrated an unremodeled socket in the region of tooth no. 19 (Figure 2B). Shortly thereafter, she developed exposed necrotic bone along the retromylohyoid ridge (Figure 2C). We then diagnosed MRONJ secondary to recurring treatment with intravenous bisphosphonate, contrary to the original diagnosis of odontogenic pain after failed endodontic therapy.

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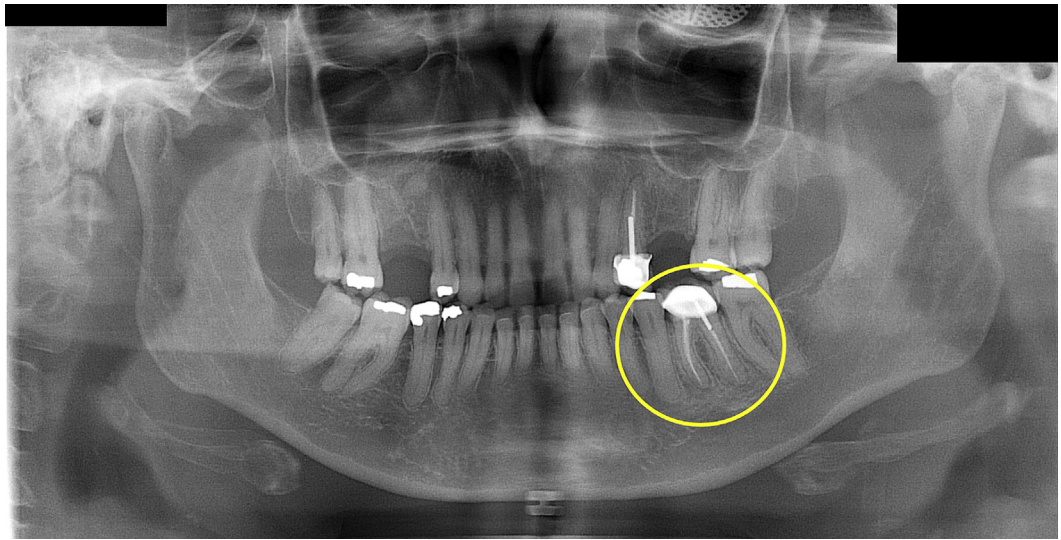


Figure 1. Case report 1. Panoramic radiograph at initial visit demonstrating nonspecific periapical changes in relation to endodontically treated and restored tooth no. 19 (outlined in yellow).

The patient subsequently had teeth nos. 18 and 20 extracted with minimal alveolectomy and primary wound closure with a membrane plasma-rich in growth factors. This strategy mitigates the risk of MRONJ developing in patients with a history of antiresorptive therapy who undergo subsequent dental extractions.¹ The patient's initial positive response to this intervention was complicated by ongoing zoledronate infusions for the next few months, resulting in renewed symptoms and minimally exposed bone. The patient continues to manage her symptoms with chlorhexidine mouthrinse and antibiotic therapy for episodes of infection. She continues with regular follow-up visits.

CASE REPORT 2

A 70-year-old woman sought oral health care at the University Hospital urgent care dental clinic with the chief complaint, "I need a tooth taken out immediately. I did not go back to my dentist who took out my other tooth because I do not trust him anymore." On questioning, she described severe pain that shot through her face from a mandibular tooth that was accompanied by a lingering throbbing sensation. She mentioned that she could no longer chew on that side. She also mentioned that she had had to discontinue the use of her maxillary complete denture. The patient had experienced this pain for the past 4 months but denied seeing any purulent discharge or swelling.

In an attempt to address her pain, the patient underwent endodontic treatment of the right mandibular first premolar. Her pain did not resolve. She consulted a second dentist who diagnosed that the "tooth behind this tooth was the problem and removed it." Her pain persisted.

The patient's medical history was unremarkable. The clinical examination included an evaluation of the masticatory musculature. The patient experienced severe pain on palpation of the right deep masseter and right temporalis muscles. In addition, gentle stroking of the area below the right angle of her lip precipitated severe pain followed by a brief refractory period. The patient confirmed both these manipulations reproduced her original pain symptoms.

The intraoral examination results revealed a well-healed extraction site of tooth no. 29 and a minimally restored and endodontically treated tooth no. 28 with no evidence of acute infection or tenderness to palpation or percussion. Lightly stroking the attached gingiva in the region of teeth nos. 28 and 29 reproduced the severe pain, which lasted for a few moments, followed by a refractory period. In addition, the panoramic radiograph demonstrated no periapical rarefaction suggestive of any ongoing disease (Figure 3).

On the basis of the patient's history, symptoms, and clinical and (negative) radiographic findings, we made the following provisional diagnoses:

- TN, key diagnostic clues being the pattern and quality of pain elicited and the ensuing refractory period;

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