A difficult diagnosis

Michael Sultan warns against the quick fix when patients are in pain.

Diagnosing and treating pain is not always as easy or as straightforward as it may seem. Very often we find ourselves confronted by patients who may be sleep deprived, or who may have poor communication skills; both of which can be a hindrance to diagnosing the precise cause of the pain.

Another problem that we face is that pain is very emotional issue for all those concerned. When a patient presents with pain, clearly we want to relieve their suffering and help in any way we can. The problem is, as dentists we are often inclined to look for dental causes. Though fairly rare, problems can arise in cases when we intervene with the very best intentions, but are then faced with an issue that was never dental at all.

Do no harm

This topic reminds me of a feature posted on the BBC towards the end of last year. In the article we met a patient, Ann Eastman, who unfortunately lost two teeth through misdiagnosis of her trigeminal neuralgia. This condition, which often mimics the symptoms of dental pain, is thankfully relatively rare, however this article showed it can be misdiagnosed – often with serious consequences for the patient.

As dentists, the first step with any treatment should always be to 'do no harm'. As long as we are unsure of the diagnosis, we should avoid intervening for as long as possible, especially when intervention involves something as drastic as removing teeth. However, having said that, sometimes you just have to make a call. It is a fine balancing act, and only with experience and understanding can we make a decision that is truly in the best interests of the patient long-term.

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Difficult diagnosis

When any patient presents with pain, there are a number of key questions we need to answer. Firstly, is the pain dental, or non-dental? If it is non-dental it may pain associated with the TMJ, the sinus, or something more sinister. If the pain is dental, is it pulpal or periodontal? If it is pulpal, is it reversible or irreversible? Is it vital or non-vital? Of course all of these things sound fairly straightforward until we are faced with a patient who is convinced that they have a toothache, but can't tell you whether it's a top tooth or a bottom tooth. Even worse when on inspection you are faced with 24 crowns!

Clearly, communication is a key factor in determining the true cause of dental pain, though from our own experience, we know that pain is rarely easy to put into words. Descriptors such as 'sharp stabbing pain' could be pulpitic, but alarm bells should go off when the patient uses terms such as 'electric shocks', or if the burning pain is so severe they have to hold their face, or brings them to tears.

However even then things aren't always black and white. There are a lot of grey areas, and a lot of different factors that we need to take into account. Though the temptation may be to ask the patient to 'come back in a few days' to eliminate some of the possible causes, this isn't always practical. After all, the patient is suffering and wants an immediate solution to their problem.

No easy solution

So what do we do? As we have seen, the general problem with pain is that it can be very difficult to diagnose. Sinus pain can easily mimic a toothache – as can bruxing, or even a high restoration. The worst is atypical pain, and one of the most distressing is trigeminal neuralgia, especially if it appears to be a toothache. With a distressed patient who is at their wits end we really want to help, but we should not be hasty to act.

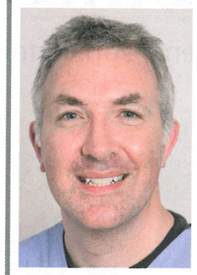
If unsure, first and foremost, we should always try and avoid intervening when the diagnosis is unclear. It is soul destroying to see radiographs where a dentist has gone from root canal to root canal, or worse still, extraction to extraction. We should also be on the look out for 'non-classical' descriptors, and pain shifting around the mouth should make us particularly cautious. Better here to prescribe antibiotics to rule out infection, or cabamezipine if there is a possibility that it might be trigeminal neuralgia. After all, a diagnosis through medication is preferable to reaching for the drill (or the extraction forceps).

Seek advice

As we know, great diagnosis is paramount to great practise, and it does a lot to enhance our standing in the general community and to patients. Though the temptation will always be to act quickly, we need to be sure that we are always acting in the patient's best interests. Treating pain is no easy matter, and while in most cases, the cause will be dental, if you are not sure it is always a good idea to ask a second opinion of a colleague. Then if you are still in doubt, for patient's sake, refer.

References available on request.

Implant Case Notes



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GDP sees patient's delight

A 31 year old professional lady was referred by her general dentist. A hit and run accident had left her with an unrestorable root fracture in her UR2 and several displaced teeth.

Dr Ian Bellamy explains, "*Following the trauma, the UR2 needed to be extracted and the adjacent teeth were displaced. As the patient was an academic with a public-facing role, leaving a gap was not an option for her, so the ideal treatment was an implant and orthodontics.*"

The orthodontic realignment was started a few weeks ahead of the implant treatment. Then the UR2 was carefully extracted and an ASTRA TECH Implant System™ 3.5 x 13mm Osseospeed TX implant was immediately placed. A fixture head impression was taken at the time of surgery to allow fabrication of the abutment and temporary crown. The coronal part of the extracted tooth was carefully manipulated and used as a temporary pontic, held in place using the orthodontic wires.

The implant was allowed to integrate for three months. It was then exposed and an Atlantis zirconium custom abutment was attached. A temporary acrylic crown was cemented in place. This allowed good soft tissue development while the orthodontic treatment was completed.

The referring GDP began the final restoration using a ceramic coping over the abutment. A pick-up silicone impression was taken without the need for retraction cord, due to the coping's exact fit. An EMAX crown was then placed.

Ian concludes, "*The patient was amazed and delighted with the seamless treatment process. What started with a devastating accident and loss of a front tooth, ended with a near perfect smile. The task of providing the definitive crown was relatively straightforward for the referring dentist. Best of all, he had the joy of witnessing the patient's reaction to the finished smile.*"