



CLINICAL PRACTICE

ABSTRACT

A patient received treatment for temporomandibular joint dysfunction, but it was later discovered that his facial pain resulted from a brain tumor.

**A CASE REPORT:
ACOUSTIC NEUROMA
CONFUSED WITH TMD**

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Young adults can suffer from temporomandibular joint dysfunction, and many patients have facial pain, particularly in the preauricular region. They also have altered sensations within the ear or frank pain in the ear. In this case, many treatments were tried before arriving at the correct diagnosis of a brain tumor.

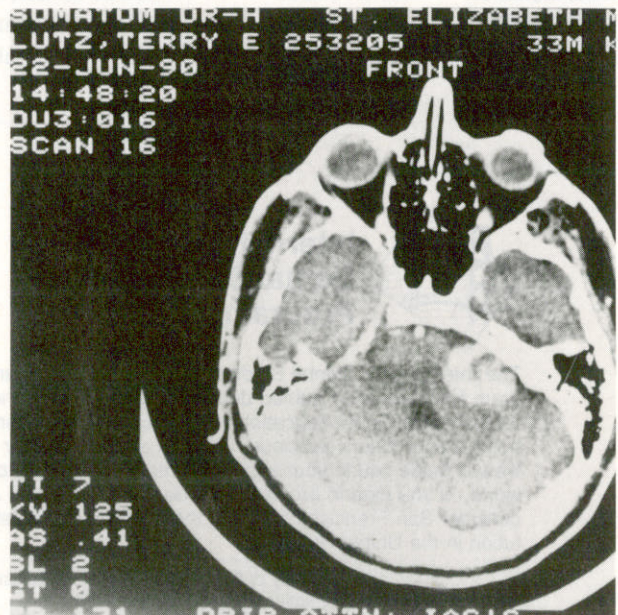
REPORT OF CASE

A 33-year-old man was referred to an orthodontist in April 1989 as an emergency referral from his general dentist. He was in severe pain and was placed in an "aqualizer" instant TMJ splint to reduce the pain. He also had complete orthodontic records made.

The orthodontist referred him back to the general dentist for removal of his mandibular third molars and maxillary right first molar.

The patient returned to the original orthodontist in August 1989 when he again experienced severe pain. A conventional full-coverage splint was placed, and the patient returned for one follow-up visit in October 1989.

The patient still had left TMJ pain and saw an oral and maxillofacial surgeon in January of 1990. The patient requested surgical correction of the TMJ. The oral surgeon prescribed hydrocodone bitartrate and acetamin-

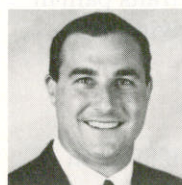


The CT scan revealed a large acoustic neuroma in the left cerebellar pontine angle.

open (Vicodin, Knoll) to help control the pain and referred the patient to my office for non-surgical treatment of the pain.

The patient complained he had experienced left TMJ pain for about 10 months. He stated that the previous 10 days had been the worst days of his life, that he was unable to eat or sleep and had not been to work for approximately one week.

His medical history revealed a transient Bell's palsy three years earlier, which was treated by a neurologist. A chiropractor had treated his spinal alignment at that time. He had a Class III malocclusion with multiple missing teeth, an anterior open bite, ante-



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rior and bilateral posterior cross-bites and advanced periodontal disease. His maximum opening was 50 millimeters, with right and left lateral excursions of 7 mm. I made complete orthodontic

records as well as corrected lateral tomographic views of both TMJs.

The corrected tomograph of the left TMJ showed good mandibular mobility. However, both condyles revealed some flattening on the superior aspect of the condylar head. The patient reported a long history of clicking and popping in both TMJs, and he wanted surgical correction of the joints plus orthodontic treatment to correct his severe malocclusion.

TREATMENT

I placed a full-coverage mandibular orthopedic repositioning appliance, prescribed triazolam (Halcion, UpJohn) to assist the patient in sleeping for three days and a two-months' supply of proxicam (Feldene, Pfizer) to control any inflammation within the joints. I applied a vapocoolant, dichlorodifluoromethane and trichloromonofluoromethane (Fluori-Methane, Gebauer) to the masticatory muscles to reduce some of the facial pain.

A week later, the patient was still in pain. Some areas on his face were so sensitive that it was difficult for him to shave and wash.

I gave the patient two injections

of bupivacaine and hydrochloride (Marcaine without epinephrine, Winthrop) in his left masticatory muscles, which relieved all of his pain. A day later, his pain returned, and at that point, I referred him to an ear, nose and throat specialist for further evaluation of his atypical facial pain.

The specialist's report stated that the patient's pain had been increasing in various different trigger points in the left anterior facial region. In addition, the patient described hearing loss in his left ear caused by exposure to motorcycle noise.

The patient returned to my office on June 20, 1990, after seeing the ENT specialist. He had significant preauricular pain, and his maximum opening was decreased to 34 mm.

An audiogram was obtained revealing a left-sided neurosensory hearing loss. The ENT specialist referred the patient for a CT scan of the internal auditory canals. The CT scan showed an enhancing lesion in the left cerebellar pontine angle region that measured 2.7 x 2.2 centimeters.

A neurosurgeon immediately removed the brain tumor. The patient survived the removal of the acoustic neuroma, but he had some left-side facial paralysis. Additional surgery was performed to help restore some of the neurosensory function in the left side of the face.

Currently, the patient still suffers from TMJ dysfunction. The severe facial pain was reduced by removing the neuroma. The motor function on the left side of his face is mildly compromised.

CONCLUSION

This case report illustrates the importance of recognizing patients who do not respond to treatment and to evaluate them for other conditions that may mimic TMJ dysfunction. ■



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