

Unilateral Temporomandibular Joint Dislocation after Jaw Thrust Maneuver

Case Report

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Abstract

A 25-yr-old Iranian woman with incomplete abortion who was diagnosed and scheduled for dilatation and curettage procedures under general anesthesia. After premedication with Fentanyl 50µg and midazolam 2mg and enough pre-oxygenation, anesthesia was induced by sodium thiopental 250 mg and succinylcholine 60 mg with mask ventilation. After completion of procedure, the patient had a period of laryngospasm that we had to maneuvered head tilt and jaw thrust to insert an oral airway for effective ventilation. It was noted that the patient mouth was persistently open about 2 cm after removing of oral airway as the patients chin deviated to the left side. On palpation the right temporomandibular joint (TMJ) could be felt below the zygomatic arch and a diagnosis of unilateral mandibular dislocation was made. To confirm diagnosis plain radiography (anterior or posterior skull projection) was immediately taken.

TMJ dislocation was reduced by the anesthesiologist that placed his thumbs near the mandibular posterior teeth with his finger. Jaw dislocation after general anesthesia should be consider as an emergency situation that be harmful for the patients so everybody who work in the airway management must be alert to this complication. Actually, know to treat it.

Key words:

• *Temporomandibular* • *Joint dislocations*
• *General anesthesia* • *Jaw thrust.*

Case Report

A 25-yr-old Iranian woman, height 160 cm, weight 44 kg, gravid 1, parity 0, abortion 1, was admitted at 15 weeks gestation with abnormal vaginal bleeding for a week. Incomplete abortion was diagnosed and the patient was scheduled for dilatation and curettage procedure under general anesthesia. In preoperative evaluation that was taken by her, she revealed an ASA physical status II, malocclusion scoring was grade II. In addition, a history of mild anemia, but she was healthy otherwise. The patient had a previous appendectomy under general anesthesia, 14 months previously, without surgical or anesthetic complications. Her ability to open her mouth and flex/extend the neck was normal. She had a good dental healthy without any abnormality or history of surgery on oral cavity. After pre-oxygenation, anesthesia was induced with sodium thiopental 250 mg; fentanyl 50 μ g and midazolam 2 mg.

After establishing an adequate airway, succinylcholine 60 mg was administered.

The chin lift technique was performed to control the patient's ventilation with halothane through a facemask for 5 minutes. There were no problems during mask ventilation anesthesia. After completion of procedures, the patient had a period of laryngospasm that we had to maneuvered head tilt and jaw thrust to insert an oral airway for effective ventilation.

It was noted the patient mouth was persistently open about 2 cm after remove of oral airway as the patient's chin deviated to left. In the recovery room she was fully awaked and complained of jaw pain, and her mouth was remained slightly opened (approximately 2 cm). She had pain in the right temporomandibular joint (TMJ) and lost the ability to open and close her mouth (figure-1, 2). On palpation the right tm joint (TMJ) could be felt below the zygomatic arch and a diagnosis of mandibular dislocation was made. A radiography of skull –AP x ray was taken to examine TMJ dislocation, immediately (figure-3, 4). In addition, anterior dislocation of right mandibular condyle diagnosis was confirmed. In addition it should be noted that the degree of TMJ deviation in radiography was not measured. Since dislocation could not be readily reduced, in the manipulation of mandible it was necessary that

patient was sedated by 3mg IV midazolam. Anesthesiologist was placed his thumbs near the posterior teeth with his finger grasping lower edge of mandible. downward pressure on the posterior teeth (slightly more than in right side) and upward movement of the chin. Along with posterior displacement of the entire mandible, dislocation was readily reduced. The pain relief was quickly and she regains full jaw movement.

Discussion

Temporomandibular joint (TMJ) instability, while not always symptomatic, has a prevalence of up to 25–50% in the general population, and is most common in middle aged females.^(1,2) Such instability may have important implications for airway management during anesthesia. Temporomandibular joint dislocation occurs when the condyle is displaced anterior to the auricular eminence and the patient unable to reduce itself back into the glenoid fossa.⁽³⁻⁶⁾



Figure 1. TMJ dislocation

A lot of factors causing TMJ dislocation. hyperextension, yawning, wide mouth opening during mastication, vomiting, trauma, seizure, flexion – extension of mandible, dental procedure, Use of the laryngeal mask airway anesthesia or diagnostic procedures, direct laryngoscopy for intubation, Parkinson disease, drug such as phenothiazine can cause extra pyramidal movement that affect the mandible.⁽⁶⁻⁹⁾ Dislocation of TM joint can occur either in awake patient that experience forced voluntary opening of mouth during yawning, bronchoscopy even in patient under general anesthesia, several studies have reported that yawning after induction by Thiopental or Propofol can lead to dislocation of TM joint, particularly in association with muscle relaxation.^(9, 10)



Figure2. After TMJ dislocation reduction

TMJ dislocation may be happened unilaterally or bilaterally. A dislocated condyle will usually created a concave facial appearance just anterior to the tragus.⁽⁷⁻⁹⁾ In unilateral dislocation the chin deviate to contralateral side of the dislocation. Bilateral dislocation cause anterior open bite in case of mandibular fractures and TMJ dislocation patient have periauricular edema and tenderness.^(5, 6, 8) Rather than the typical concave appearance of a patient with a dislocation, panoramic radiographic examination is used to confirm the diagnosis.⁽¹¹⁾ The degree of displacement or damage of articular soft tissue can be determined by MRI.⁽¹²⁻¹⁴⁾

Once TMJ dislocation is occurred, the treatment must be done as soon as possible by local anesthetic blocks of the TM joint, auriculotemporal nerve, and lateral petrygoid muscle that provide the patient comfort during reduction.

For reduction of TM joint dislocation the surgeon or anesthesiologist must standing in front of the patient and it is better the patient head supported by chair or table. The surgeons thumbs, which are placed over the occlusal surfaces of the mandibular molar teeth or the posterior portion of residual alveolar ridge in edentulous patient, and the remaining fingers are place under inferior border of mandible, the patient instructed to relax the jaw and then downward and backward movement. (figure-5). If reduction is unsuccessful after two attempt, muscle relaxation and sedation (rarely general anesthesia) must be performed. After reduction of dislocated condyle, limitation of jaw movement must be prescribed for several days and external dressing over the chin and head may be useful.^(5, 6) If dislocation is not obvious, then consider other conditions, such as fracture, hemothrosis, closed lock of the joint

meniscus, and myofascial pain. After reducing the dislocation it will be comforting to apply a soft cervical collar to reduce the range of motion at the temporomandibular joint (TMJ). Recommend a soft diet and instruct the patient to refrain from opening his mouth too widely. Prescribe analgesics if needed.⁽¹⁵⁾

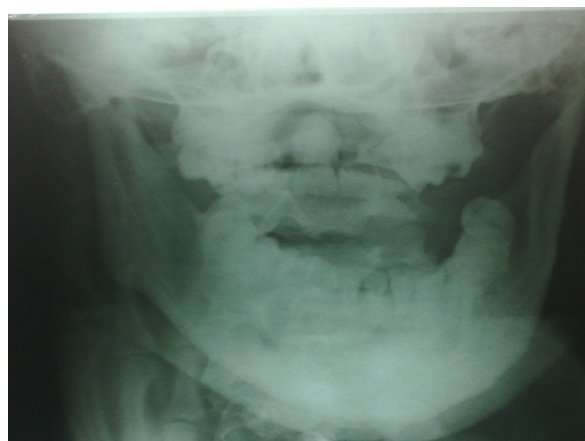


Figure3. Anteroposterior x-ray view



Figure4. technique of reduction of jaw dislocation

Conclusion

Jaw dislocation is not a common clinical syndrome after general anesthesia, but every changes in the face morphology should be rouled out as mandibular dislocation. Especially, in the mandibular patient zone.

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