

Letters

acceptance. Dr. King seems to be talking about denial of symptoms before the diagnosis has been made as a way of hiding signs or symptoms. The best antidotes for this are multiple observations by family and caregivers gathered at different points in time and multiple interviews of both patient alone and patient with family. This accounts for our team approach, without which any single clinician will be considerably less effective. There are also some specific interview techniques that work better than others when interviewing alcoholic patients, but I will leave that topic for another forum.

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Exacerbation of Mental Illness by Dental Disease

*"...of the viscera responsible for the more obscure cases of nervous and mental degeneration I have no hesitation in designating the teeth as the most important."*¹

SIR: This statement stimulated the discovery of four cases in which dental disease was a significant contributor in exacerbating preexisting psychopathology.

Case Reports

Case 1. Mr. A, a 33-year-old male, was admitted from a group home after 2 weeks of throwing food,

striking attendants, and sleeping poorly. Mr. A was profoundly mentally retarded and lacked development of speech. He had been taking a constant dose of chlorpromazine. Mr. A appeared frightened and vocalized nonverbal sounds of distress. Examination of his mouth revealed that all his teeth were severely carious or abscessed. Dental consultation suggested that the abscesses were new and causing great pain. A full-mouth extraction was completed, followed by immediate improvement in behavior.

Case 2. Mr. B, a 38-year-old male, was admitted from a group home after 2 days of destroying furniture and striking staff. Mr. B was profoundly mentally retarded, as manifest by lack of development of speech and stereotypic movements. The patient's residence and medication regimen had not changed in 6 years. On physical exam, the patient had a single abscessed left lower molar. This impression was confirmed by dental consultation and radiograph. The fresh abscess was believed to correlate with the sudden deterioration in the patient's behavior. The patient underwent a tooth extraction with subsequent behavioral improvement.

Case 3. Mr. C, a 27-year-old male, was admitted after a self-inflicted superficial cutting of his wrist while intoxicated with alcohol. The patient's drinking had escalated in his attempt to relieve dental pain of new onset. He was noted to have poor dentition corresponding with his pain complaint. Dental consultation resulted in the extraction of several teeth with good pain relief.

Case 4. Mr. D, a 30-year-old male, was admitted for confused thought processes and hostility of 2 days duration. The patient had a history of schizophrenia but had not been hospitalized in 4 years. During the week prior to the admission, the patient developed jaw pain. He discontinued his neuroleptic and began to drink alcohol to relieve the pain. The patient began to deteriorate and was admitted. Dental consultation confirmed the impression of a single abscessed tooth, and an extraction was performed. The patient was restarted on neuroleptic and symptomatically improved within the week.

Each of these four cases demonstrates the exacerbation of preexisting psychiatric disorder by acute dental pain. Each patient had poor judgment or lack of cognitive skills preventing an adaptive response to the stress of pain. This position is in contrast to the claim at the turn of the century that dental disease causes psychiatric illness de novo.

A variety of mechanisms were invoked to

explain how dental pain caused mental illness. Dickinson suggested that afferent dental pain became derailed in the medulla oblongata and redirected mistakenly into motor efferents resulting in behavioral change.² Van Doorn believed that abscessed teeth release toxins into the systemic circulation, resulting in distant nervous effects and psychopathology.³ Levinson emphasized the developmental antecedents of distress occurring in infants cutting their first teeth.⁴ Finally, Mummery reported that even healthy teeth could result in mental disorder if the tooth had roots sufficiently elaborate to cause local pressure on the nervous system.⁵

Dental pain is not more likely to exacerbate a psychiatric disorder than any other type of pain, but, because dental health is relatively neglected in medical school curricula, it is more likely to be overlooked by psychiatrists. Therefore, patients must have their dental status and all other aspects of their physical and mental functioning evaluated if assessment is to be adequate and treatment appropriate.

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On "Stress and the Heart: Biobehavioral Aspects of Sudden Cardiac Death"

SIR: The role of the right frontal cortex in the development and progression of coronary heart

disease (CHD) manifested by lower galvanic skin responses associated with right-hemisphere damage, discussed by Cathrine Frank, M.D., and Stephen Smith, M.D.,¹ is supported by a number of studies. Pronounced blood pressure changes have been noted in women during lateralized presentation of an emotionally laden film,² and right-sided activation has been observed in the frontal and anterior temporal regions associated with facial behavior of women indicating disgust.³ Disgust and glare have been correlated with hostile components of speech associated with CHD incidence,⁴ and the "traditional" Type A components of impatience and a sense of hurry have been correlated with somatic risk factors of CHD in adolescent girls.⁵ The latter correlation may have been mediated by dopamine lateralized to the right hemisphere, in which the metabolic rate is higher in females.⁶

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In Reply

SIR: We wish to thank Dr. Friedman for his comments on our review article, "Stress and the Heart: Biobehavioral Aspects of Sudden Cardiac Death." Our review deals primarily with sudden