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PSYCHOSOMATIC DISORDERS OF ORO FACIAL REGION – AN UPDATED REVIEW

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ABSTRACT

The clinical course, development, and prognosis of any disease are all closely tied to psychological, social, behavioral, and environmental factors. About 30% of dental patients have psychopathological problems, which frequently go unnoticed and untreated. Hence, mental health promotes physical health and well-being through thorough history, diverse study, and reflection.

INTRODUCTION:

There were inevitable consequences on the psychological and mental well-being of the society, upsurging the anxiety and stress levels, also geopolitically and economically, due to the imminent lockdown in the spread of COVID-19. (1) The psychological, social, behavioral, and environmental factors are those that are deeply related to the complete course and outcome of the disease. Psychosomatic medication signifies "unification of mind and body" with an attention to mind-body coordination (psychosomatic relationship to treat specific mental disorders by the specialized psychiatrist in modern medicine) (2, 3). Psychological functioning to the point of distress is severely affected by psychological stress in a condition called psychophysiological disorder (psychosomatic disorder) (2). Oral cavity-specific psychosomatic disorders have significant psychological potential (4,5). About 30% of dental patients exhibit psychopathologic symptoms, which frequently go unnoticed and untreated. (6,7). In this context, the reader can get to know a vast range of psychosomatic disorders

PSYCHOSOMATIC DISORDERS AFFECTING ORAL CAVITY:

1. BURNING MOUTH SYNDROME:

In the absence of a local (or systemic) ailment, burning mouth syndrome is characterized by a burning or tingling feeling in the mouth (8, 9). It may be considered to be associated with anxiety, depression, which is of psychological origin, and cancerophobia (10, 11). The most frequent place is the oral mucosa, although it can also happen elsewhere, including the vulva or anogenital area. The beginning of pain, which is bilateral and symmetrically impacted and is chronic for at least 4-6 months, is spontaneous, bilateral, and without apparent inciting events (10, 12). The symptoms include loss of taste and changed flavor, such as a bitter or metallic taste, along with a burning, tingling, or numbing sensation in the oral cavity and a feeling of dry mouth without hyposalivation (8, 10, 13 and 14). It shows up as a variety of intra- and extraoral discomforts in addition to pain (15, 16).

2. MYOFACIAL PAIN DYSFUNCTION SYNDROME:

Regional pain that originates from hyperirritable areas inside taut bands of skeletal muscle, also known as myofascial trigger points (MTTPs), is the traditional diagnosis of myofascial pain

syndrome (MPS) (10, 17). The broad definition of this syndrome is "painful dysfunction of the masticatory and related muscles". Multifactorial etiology is evident in MPDS. The original theory put forth by Schwartz was that stress was a major contributor to the habits of clenching and grinding, which resulted in a spasm of the masticatory muscles. The clinical symptoms include unilateral (or dull aching) pain in the ear (or preauricular region) that usually gets worse when you wake up, tenderness in one or more masticatory muscles when you palpate them, limitation or deviation of the mandible when you open your mouth, and a clicking sound in your TMJ. The psychophysiological theory by Laskin stated that MPDS is primarily the result of emotional factors (10, 18).

3. ATYPICAL FACIAL PAIN:

In 1924, Frazier and Russell became the first to describe unusual facial pain (19). Atypical facial pain commonly manifests as burning, aching, or cramping on one side of the face, frequently in the trigeminal nerve region, and can radiate to the upper neck or the back of the scalp. It can also affect the second and third cervical nerves or the fifth and ninth cranial nerves (10, 12). While the psychological and biological causes of persistent idiopathic facial discomfort are acknowledged, there are no definitive diagnostic criteria or accepted treatments for this condition (4,20).

4. RECURRENT APTHOUS STOMATITIS:

RAS is a self-limiting, recurrent illness that primarily affects non-keratinized mucosa and manifests as numerous recurrent clusters of tiny ulcers. Psychological stress is regarded as a trigger or moderating factor rather than a disease cause (4, 10). Major RAS, which is more severe and widespread than mild RAS, affects 20% of the general population. The prodromal burning sensation lasts for 24 to 48 hours before being noticed to be dispersed throughout the oral mucosa. These ulcerations then grow larger and heal more slowly, frequently leaving scarring behind (17). More than 80% of RAS cases are minor RAS, which manifests as a small, shallow, painful, well-circumscribed, spherical ulcer covered by a yellowish-grayish pseudomembrane with an erythematous halo and cures in 10 to 14 days without leaving any scars (17). Several repeated clusters of tiny ulcers are the hallmark of herpetiform ulcers. These ulcers are dispersed throughout the body and could grow to be significant ulcers (10). RAS is

regarded as one of the significant manifestations of serious medical illnesses such as autoimmune disorders, hematologic (or oncologic) disorders, and human immunodeficiency virus infection (4, 5). Anxiety and psychological stress, meanwhile, contribute to the development and recurrence of RAS lesions (10).

5. ATOPIC DERMATITIS:

Itching and anxiety about itching are the main signs of atopic dermatitis. The unpleasant body sensation known as pruritus (or "itch") is frequently accompanied by scratching behavior. When an itch lasts more than six weeks, it is said to be chronic and is a common sign of atopic dermatitis (21, 22, 23). The biopsychosocial model of itch suggests that there is an increase in physiological response (e.g., activation of certain brain areas) regarding the internal and external factors leading to illness, cognition, social reaction, and behavioral change causing itch (21). Shenefelt described that mindfulness measures would help via psychoneuroimmunological pathway to reduce mindfulness itch (21).

6. ATYPICAL ODONTALGIA:

Tooth pain with no obvious cause is regarded as atypical odontalgia (10). 50% of the elderly population and 10% of adults are thought to be impacted by AO. Psychological causes are most common among AO, despite deafferentiation, vascular, and neurovascular causes (10). Many articles stated atypical odontalgia as phantom pain as a deafferentiation pain disorder of persistent tooth ache in teeth that have been denervated (8, 24). It can also be regarded as "phantom bite syndrome," "occlusal discomfort," and "occlusal dysesthesia" (4).

7. IDIOPATHIC XEROSTOMIA:

Idiopathic xerostomia is characterized generally as salivary hypofunction (dry mouth) (4, 10). The etiology may be considered because of the following:

A number of systemic illnesses, including Sjogren syndrome;
The anticholinergic effects of numerous drugs;
Emotions, fear, excitement, stress, and depression;
Physiological changes (10)

8. IDIOPATHIC DYSGEUSIA:

Dysgeusia is characterized by a continuous gustatory sensation in the absence of a gustatory stimulus or by a distorted gustatory perception. The increased activation of numerous neural pathways that are involved in controlling hunger and stress demonstrates the close relationship between stress and taste as a potential key mechanism.

9. GLOSSODYNIA:

Glossodynia is a condition involving an intraoral burning sensation or chronic pain in the absence of the tongue (4, 25). The condition associated with glossodynia is candida-associated lesion (CAL), BMS, or a combination of CAL and BMS (4).

10. GLOSSOPYROSIS:

Glossopyrosis is the medical term for tongue burning. It may have occurred as a result of gastrointestinal, immunological, neurological, mental, and dermatologic disorders and demonstrates a relationship with BMS. The patient may have gone through a protracted depressive phase prior to the emergence of the full clinical picture of glossopyrosis (4, 26).

11. DENTAL AND PERIODONTAL DISEASE CAUSED BY BRUXISM:

Due to the biomechanical pressures, bruxism, which is the unconscious or conscious clenching of the teeth, can cause a number of dental issues, including hypersensitivity, periodontal distraction, TMJ dysfunction, and fraction. Children's behavioral and probable emotional issues could

be the main risk factors for bruxism (4). Breakdown of dental rehabilitation or repair, aggravation of mandibular abnormalities, the beginning of a temporal tension headache, and the production of grinding noises that may interfere with family members' or partners' sleep are the stages of bruxism (10).

12. ORAL CENESTHOPATHY:

The patient with oral cenesthopathy might complain of unusual sensations such as increased mucus secretion, a glossy feeling in the mouth, or the sensation of a foreign body in the mouth without connecting them to the pathologic findings in the oral cavity. Strategic compartmentalization among medical professionals and regional cooperation platforms for medicine may be beneficial (8).

13. SELF MUTILATION:

The tongue's lateral surface, buccal and labial mucosa, and labial mucosa are the unintended injuries that occur most frequently (10). Those with a psychogenic background and those who are under stress can best understand self-mutilation (4).

14. ORAL LICHEN PLANUS:

A prevalent chronic immunologic inflammatory skin and mucosal condition is lichen planus (4, 10). Interlocking keratotic lines (Wickham's striae), which appear bilaterally on the buccal mucosa, are one of OLP's defining characteristics (4, 27). Although the actual cause is unknown, mental health issues brought on by stress, worry, and depression may be taken into account. Chaudhary has noted increased levels of anxiety, depression, and stress in patients with OLP compared to the healthy control group in previous investigations (10).

15. PSORIASIS:

As a papulosquamous exfoliative dermatitis with discrete flat-topped papules or plaques coated in thin, white, loosely adherent scales, psoriasis is classified as a skin condition (4, 28). As a common dermatological disorder, it shows an association with psychological factors and, in addition, oral lesions such as geographic or fissured tongue and pustular psoriasis (4).

16. MUCOUS MEMBRANE PEMPFIGOID:

MMP is regarded as a heterogeneous group of autoimmune blistering diseases since it primarily affects the oral mucous membrane and ocular mucosa and exhibits a stress relationship (4, 29).

17. ERYTHEMA MULTIFORME:

Erythema multiforme which is a red lesion without manifesting as a target lesion of the skin, presents as oral and lip ulceration with bleeding and cramping of the lips. It is thought to be occurring secondary to herpetic infections. The pathophysiology may be deregulation of T-lymphocytic activity with evident stress factor (4).

18. RECURRENT HERPES LABIALIS:

RHL is a mucocutaneous infection brought on by herpes simplex virus type 1 (HSV I), which causes discomfort and blistering on the lips and perioral area (4, 5). Physical trauma or emotional stress may have caused the lesions, according to their origin. Sun exposure, psychological stress, and the onset of menses are the triggering factors (10). The role of stress is evident in the modulation of T-lymphocyte function (4, 5). Primary gingivostomatitis, which is the manifestation of HSV I infection, does not recur in the same form. Preschoolers or kindergarteners, adolescents, and young adults are the typical populations affected.

19. NECROTISING ULCERATIVE GINGIVOSTOMATITIS:

a fusospirochetal infection, an unusual illness characterized

by bleeding, discomfort, ulceration, and gingival necrosis. The pathophysiology is determined by the induction of increased cortisol form, function, and catecholamine levels. Due to these local and systemic risk factors, emotional stress seems to be the most prevalent in causing NUG, whereas debilitating disease, nutritional deficiency, and neurological disease also play an important role (4).

20. DELUSIONAL HALITOSIS:

Person complaints of a falsely offensive mouth odor sometimes occur, depending on the response to a few initial treatments. It is also referred to as "pesudo-halitosi" (or "halitophobia"). These patients must be advised to consult a psychiatrist (4).

21. CANCEROPHOBIA:

The pervasiveness of cancer fear is called cancerophobia. This disorder would fall under the category of hypochondriasis. The exact pathogenesis is not clear, but psychological factors such as anxiety and depression might be causes (12,30).

22. MEDICALLY UNEXPLAINED ORAL SYMPTOMS:

In clinical medical practice, MUOS is taken into consideration when patients frequently complain of physical problems without clear etiologies. When the issue is psychogenic yet patients are hesitant to accept the diagnosis, the term "medically unexplained mouth symptom" is taken into consideration.

CONCLUSION:

Mind and body are co-adjustors. On a daily basis, dentists come across patients with psychosomatic disorders frequently since stress is increasing in every field for everyone. The clinician should develop knowledge about the psychiatric problem inducing the oral disorder and be aware of taking a detailed history for better understanding and diagnosing. So it is on the dental and psychiatric professionals to unite for the various approaches of investigation for their lifelong happiness by managing them in the right way through meditation and medication.

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