

Errata for Dilemma 30

The number of the dilemma in the black bar on page 115 is incorrect. The black bar should be labeled “Ethical Dilemma #30,” not “Ethical Dilemma #29.”



Important Notice

This is one of a series of ethical dilemmas published in the *Texas Dental Journal* between 1993 and 2005. The lead author of these dilemmas, Dr. Thomas K. Hasegawa, died tragically in 2005. The dilemmas remain an important legacy for dentistry.

Format

Each ethical dilemma was originally introduced in one issue of the *Texas Dental Journal* with the question, “What would you do?” The more expansive analysis of the dilemma was presented in a subsequent issue. The second page of this file depicts the cover of the issue containing the analysis of the dilemma, not the issue containing the briefer introduction to the dilemma. The ethical dilemmas were compiled for digital use by the American College of Dentists in 2008.

Purpose

This ethical dilemma and the other dilemmas in the series are only meant to further your knowledge and understanding of dental ethics by presenting, discussing, and analyzing hypothetical ethical dilemmas that may occur in dental settings. The dilemmas are not intended to: a) provide legal advice; b) provide advice or assistance in the diagnosis or treatment of dental diseases or conditions; or c) provide advice or assistance in the management of dental patients, practices, or personnel.

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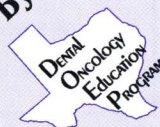
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What Would You Do?

Ethical Dilemma #29

Rebecca Martin is a new patient in your office who has been referred to you by a classmate in another state. Rebecca moved to your community four months ago due to a job relocation. She is a 46-year-old, single mother with two teenage daughters and a complex, painful history.

Your first question — “What brings you to the office?” — opens a tortuous monologue of her three-year struggle with recalcitrant acute pain in her left maxillary sinus area. Until that time, her medical history was unremarkable, as she was generally healthy with some history of allergies. Her vital signs and yearly physicals revealed a person who generally cares for herself with regular exercise and a reasonable diet. About three years ago, she gradually developed headaches, restricted to the left side. Her physician diagnosed her condition as migraine headaches, but was unable to resolve her condition with medications. The headache gradually became worse, with the pain radiating around the left eye and left maxillary sinus. She saw an ENT specialist who diagnosed her condition as sinusitis. He treated her with antibiotics for a prolonged period, and while there were brief periods of improvement, the pain persisted. Subsequently, Rebecca began to complain of pain in the upper left molars and she saw her general dentist, your classmate.

Rebecca brought a letter from your classmate that outlined the treatment regimen until the patient moved. The patient was diagnosed as having a localized, moderate periodontitis with 4-6 mm pockets between the upper left first and second molars with no mobility. After conservative therapy, the gingival health was stabilized, but the pain persisted. Moderately sized amalgams were replaced with IRM, but the pain in the left maxilla persisted. Finally, he performed root canals on the upper left three molars with no appreciable relief. The plan before moving was to extract these molars.

Your assessment of the patient revealed that she was in a Class I occlusion with anterior disclusion and group function in left and right working. She had mild crowding and wear facets in the posterior teeth, except the lower left, where she was missing the lower left second and third molars. The first molar was mostly amalgam, with evidence of recurrent caries and under heavy function. Most restorations were placed 20 years ago. Her chief complaint was radiating pain from her sinuses to the molar teeth on the upper left. The panoramic radiograph that you exposed showed that both maxillary sinuses were clear, the general bone pattern of the mandible and maxilla were within normal limits, and the TMJ did not show any signs of gross condylar pathology. Your periapical radiographs of the area showed mild horizontal bone loss interproximal between first and second molars. The recent root canals were obturated acceptably, although there was some dilaceration on the first molar roots. Ms. Martin was obviously frustrated with the inability of anyone to help remove her pain. She was also concerned because the chronic use of Motrin 600, along with an occasional Vicodin, was affecting her work. There is more work and longer hours than she anticipated with the move. Totally frustrated, she asks you, “will you pull these teeth or do I go to an oral surgeon?”

You are now faced with an ethical dilemma. Check the following course(s) of action you would take in this case and mail, FAX this page, E-mail your recommendation, or send a note as instructed below:

1. _____ extract the upper left three molars and make maxillary and mandibular partial dentures;
2. _____ refer her to an ENT specialist, neurologist, or chronic pain clinic;
3. _____ refer her to an oral surgeon for extraction;
4. _____ further evaluate her condition (explain) _____;
5. _____ extract the upper left three molars and place implants and crowns; or
6. _____ other alternative (please describe): _____

SEND YOUR RESPONSE BY **May 8, 1996** ATTENTION:

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"Headache/Orofacial Pain Diagnostic Dilemma"

Response to Ethical Dilemma #30

Rebecca Martin is a new patient in your office who has been referred to you by a classmate in another state. Rebecca moved to your community four months ago due to a job relocation. She is a 46-year-old single mother with two teenage daughters and a complex, painful history.

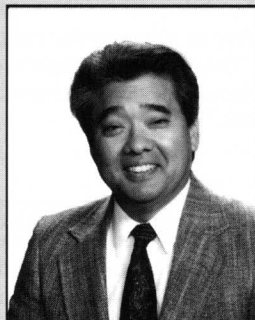
Your first question — "What brings you to the office?" — opens a tortuous monologue of her three-year struggle with recalcitrant acute pain in her left maxillary sinus area. Until that time, her medical history was unremarkable, as she was generally healthy with some history of allergies. Her vital signs and yearly physicals revealed a person who generally cares for herself with regular exercise and a reasonable diet. About three years ago, she gradually developed headaches restricted to the left side. Her physician diagnosed her condition as migraine headaches but was unable to resolve her condition with medications. The headache gradually became worse, with the pain radiating around the left eye and left maxillary sinus. She saw an ENT specialist who diagnosed her condition as sinusitis. He treated her with antibiotics for a prolonged period, and while there were brief periods of improvement, the pain persisted. Subsequently, Rebecca began to complain of pain in the upper left molars and she saw her general dentist, your classmate.

Rebecca brought a letter from your classmate that outlined the treatment regimen until the patient moved. The patient was diagnosed as having a localized, moderate periodontitis with 4-6 mm pockets between the upper left first and second molars with no mobility. After conservative therapy, the gingival health was stabilized, but the pain persisted. Moderately sized amalgams were replaced with IRM, but the pain in the left maxilla persisted. Finally, he performed root canals on the upper left three molars with no appreciable relief. The plan before moving was to extract these molars.

Your assessment of the patient revealed that she was in a Class I occlusion with anterior disclusion and group func-

TDA Council on Ethics and Judicial Affairs

By Thomas K. Hasegawa, Jr., D.D.S.
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tion in left and right working. She had mild crowding and wear facets in the posterior teeth, except the lower left, where she was missing the lower left second and third molars. The first molar was mostly amalgam, with evidence of recurrent caries and under heavy function. Most restorations were placed 20 years ago. Her chief complaint was radiating pain from her sinuses to the molar teeth on the upper left. The panoramic radiograph that you exposed showed that both maxillary sinuses were clear, the general bone pattern of the mandible and maxilla were within normal limits, and the TMJ did not show any signs of gross condylar pathology. Your periapical radiographs of the area showed mild horizontal bone loss interproximal between first and second molars. The recent root canals were obturated acceptably although there was some dilaceration on the first molar roots. Ms. Martin was obviously frustrated with the inability of anyone to help remove her pain. She was also concerned because the chronic use of Motrin 600, along with an occasional Vicodin, was affecting her work. There is more work and longer hours than she anticipated with the move. Totally frustrated, she asks you, "Will you pull these teeth or do I go to an oral surgeon?"

Dentists who responded to the case chose to: 1) refer to an ENT specialist, neurologist, or chronic pain clinic; 2) further evaluate her lower left first molar for root canal treatment; or 3) refer her to an oral surgeon or endodontist. None of the respondents chose to either: 1) extract the upper left three molars and make maxillary and mandibular partial dentures; or 2) extract the upper left three molars and place implants and crowns. Other options illustrated the complexity of the case.

Patients expect that the dentist will relieve their pain. However, painful conditions like Rebecca's headaches are complex and controversial regarding diagnosis and treatment recommendations. The response will briefly outline the diagnostic dilemma of the headache and its relationship to temporomandibular dysfunction (TMD) and will relate Rebecca's case to a hierarchy of central values of dental practice.

Headache/TMD Diagnostic Dilemma

There are no precise, objective diagnostic tests for headaches. Therefore, the diagnosis of headache is dependent on the patient's subjective description of his or her symptoms and a proper physical and neurological examination (1). Research in the area of headaches has increased significantly over the past ten years. The publication of the International Classification of Headaches Disorders by the International Headache Society (IHS) in 1988 has been useful in organizing research efforts (2). The Scandinavian University Press has given permission to reprint the Classification as an attachment to this response.

Measuring the prevalence of headaches is hindered by several methodological problems including: the frequency and time between headache disorders, coexisting headaches, lack of objective diagnostic tests, and problems in experimental design (2). Headache pain is common in the North American adult population, with surveys showing an incidence of up to 73% in the preceding 12 months (3). Recurrent headaches afflict 20% (4,5) of the general population, with 5% to 10% seeking medical advice (6). While studies have found that headaches are associated

with TMD, from 70% to 85% (7), establishing a causal relationship will require further epidemiological studies (8).

Rebecca's history provides a glimpse of the complexity of diagnosing a painful condition associated with headaches and possible TMD. Her history is also a reminder for dentists to consider the array of disease entities not associated with the masticatory system when forming a differential diagnosis. It is also a reminder for physicians to include TMD and odontogenic pain in their differential diagnosis of craniofacial pain (9).

Her headaches began three years ago and her physician diagnosed them as migraine and treated her with medications. The prevalence of migraine headaches for one year is estimated at 10% (10). Treatment of migraine headaches by medication was not successful for Rebecca, however, and her headaches became worse, with pain radiating around her left eye and left maxillary sinus.

An ENT specialist diagnosed her condition as sinusitis and prescribed antibiotics for a prolonged period. The site of the pain is important in identifying the source of the pain. The physician may have diagnosed Rebecca's condition as acute maxillary sinusitis because the associated pain is usually localized below the eye, in the gingiva and the teeth of the maxilla. Pain in ethmoid sinusitis is felt in the nasion, and the eyeball may be tender and painful. Frontal sinusitis pain is located in the forehead and in the vertex or sometimes behind the eye and ear. There is also the possibility of pain due to malignant changes. A purulent discharge from the nose and opacity or fluids in the sinus on radiographs are common findings in the acute sinus headache (11). Rebecca's pain continued after the antibiotics, and when the pain spread to her upper left molars, she saw her dentist.

The general dentist treated her periodontal condition, and when the radiating pain to her teeth did not improve, replaced the large amalgams on the upper left molars with IRM. The pain in the left maxilla persisted and finally he performed root canals on the molars again, with no improvement. The plan was to extract the molars that the patient deferred, since she was preparing to move.

Differentiating the true source of pain

from the site of pain is central to Rebecca's case. For example, the previous dentist proceeded on the assumption that one or all of the molars were the source of primary pain — because the source and the site of pain were the same. An endodontist observed that Rebecca's case was, "a good example of treating a patient without evaluating the patient's history, performing an adequate oral examination and arriving at a reasonable diagnosis," and that, "the endodontic treatment of the three molars seems to have been done in desperation."

Since there are no objective tests for headaches, the patient history is the key to diagnosis. Information about Rebecca's history, vitality tests, and the nature of the her pain was missing. The essential features of headache pain include: pain — site, quality and severity; time factors — onset, duration, and frequency, and precipitating or aggravating and ameliorating factors (12). The progress of treatment for Rebecca after her periodontal care became more aggressive with the removal of amalgams, then the root canals, and finally the recommendation to

TABLE 1. Classification of headache disorders, cranial neuralgias, and facial pain (4)

1. Migraine 1.1 Migraine without aura 1.2 Migraine with aura 1.2.1 Migraine with typical aura 1.2.2 Migraine with prolonged aura 1.2.3 Familial hemiplegic migraine 1.2.4 Basilar migraine 1.2.5 Migraine aura without headache 1.2.6 Migraine with acute onset aura 1.3 Ophthalmoplegic migraine 1.4 Retinal migraine 1.5 Childhood periodic syndromes that may be precursors to or associated with migraine 1.5.1 Benign paroxysmal vertigo of childhood 1.5.2 Alternating hemiplegia of childhood 1.6 Complications of migraine 1.6.1 Status migrainosus 1.6.2 Migrainous infarction 1.7 Migrainous disorder not fulfilling above criteria 2. Tension-type headache 2.1 Episodic tension-type headache 2.1.1 Episodic tension-type headache associated with disorder of pericranial muscles 2.1.2 Episodic tension-type headache unassociated with disorder of pericranial muscles 2.2 Chronic tension-type headache 2.2.1 Chronic tension-type headache associated with disorder of pericranial muscles 2.2.2 Chronic tension-type headache unassociated with disorder of pericranial muscles 2.3 Headache of the tension-type not fulfilling above criteria 3. Cluster headache and chronic paroxysmal hemicrania 3.1 Cluster headache 3.1.1 Cluster headache periodicity undetermined 3.1.2 Episodic cluster headache 3.1.3 Chronic cluster headache 3.1.3.1 Unrelenting from onset 3.1.3.2 Evolved from episodic 3.2 Chronic paroxysmal hemicrania 3.3 Cluster headache-like disorder not fulfilling above criteria 4. Miscellaneous headaches unassociated with structural lesion 4.1 Idiopathic stabbing headache 4.2 External compression headache 4.3 Cold stimulus headache 4.3.1 External application of a cold stimulus 4.3.2 Ingestion of a cold stimulus 4.4 Benign cough headache 4.5 Benign exertional headache 4.6 Headaches associated with sexual activity 4.6.1 Dull type 4.6.2 Explosive type 4.6.3 Postural type 5. Headache associated with head trauma 5.1 Acute posttraumatic headache 5.1.1 With significant head trauma and/or confirmatory signs 5.1.2 With minor head trauma and no confirmatory signs	5.2 Chronic posttraumatic headache 5.2.1 With significant head trauma and/or confirmatory signs 5.2.2 With minor head trauma and no confirmatory signs 6. Headache associated with vascular disorders 6.1 Acute ischemic cerebrovascular disease 6.1.1 Transient ischemic attack (TIA) 6.1.2 Thromboembolic stroke 6.2 Intracranial hematoma 6.2.1 Intracerebral hematoma 6.2.2 Subdural hematoma 6.2.3 Epidural hematoma 6.3 Subarachnoid hemorrhage 6.4 Unruptured vascular malformation 6.4.1 Arteriovenous malformation 6.4.2 Sacular aneurysm 6.5 Arteritis 6.5.1 Giant cell arteritis 6.5.2 Other systemic arteritides 6.5.3 Primary intracranial arteritis 6.6 Carotid or vertebral artery pain 6.6.1 Carotid or vertebral dissection 6.6.2 Carotidynia (idiopathic) 6.6.3 Post endarterectomy headache 6.7 Venous thrombosis 6.8 Arterial hypertension 6.8.1 Acute pressor response to exogenous agent 6.8.2 Pheochromocytoma 6.8.3 Malignant (accelerated) hypertension 6.8.4 Preeclampsia and eclampsia 6.9 Headache associated with other vascular disorder 7. Headache associated with non-vascular intracranial disorder 7.1 High cerebrospinal fluid pressure 7.1.1 Benign intracranial hypertension 7.1.2 High pressure hydrocephalus 7.2 Low cerebrospinal fluid pressure 7.2.1 Postlumbar puncture headache 7.2.2 Cerebrospinal fluid fistula headache 7.3 Intracranial infection 7.4 Intracranial sarcoidosis and other non-infectious inflammatory diseases 7.5 Headache related to intrathecal injections 7.5.1 Direct effect 7.5.2 Due to chemical meningitis 7.6 Intracranial neoplasm 7.7 Headache associated with other intracranial disorder 8. Headache associated with substances or their withdrawal 8.1 Headache induced by acute substance use or exposure 8.1.1 Nitrate/nitrite induced headache 8.1.2 Monosodium glutamate induced headache 8.1.3 Carbon monoxide induced headache 8.1.4 Alcohol induced headache 8.1.5 Other substances 8.2 Headache induced by chronic substance use or exposure 8.2.1 Ergotamine induced headache 8.2.2 Analgesics abuse headache 8.2.3 Other substances
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Ethical Dilemma

extract the molars. **None** of the respondents chose to extract the upper left molars, as per the previous dentist's recommendation, and some noted that they did not believe the extractions would resolve her pain. If TMD is the source of pain, the extraction of Rebecca's molars could exacerbate her symptoms through further loss of occlusal stability.

Most dentists chose to investigate the lower left first molar as a possible source of referred pain. Referred pain is one type of heterotopic pain where the true source of pain and the painful site are separate (6). Locating the true source of pain was clearly a priority, as some dentists chose to refer Rebecca to an endodontist, oral surgeon, ENT specialist or neurologist for a second opinion. There was also some concern that the painful condition was psychogenic or idiopathic.

Other recommendations related to more TMD-specific evaluations, including a thorough evaluation of the occlusion, the use of Dawson's technique for checking for muscle spasms, and fabricating an anterior disengagement splint

for Rebecca. TMD is defined as: "a cluster of joint and muscle disorders in the orofacial area characterized primarily by pain, joint sounds and irregular or deviating jaw function. The pain is not of neurogenic, psychogenic or visceral origin, and periodontal, dental or cutaneous pain also have to be excluded from this definition (13)." The true dilemma for this case is that the previous diagnosis of migraine headache and sinusitis may have been TMD-related. For example, anatomically, myofascial tenderness of the anterior belly of the temporalis could be the source of pain that mimics migraine symptoms. Also, myofascial pain of the lateral and medial pterygoids, particularly at the origins of these muscles on the pterygoid plate behind the maxillary sinus and molar dentition, could be the source of radiating pain that mimics sinusitis. The dentist could assist the diagnosis of headache by ruling out TMD as a source of pain. This may prevent harm to the patient by eliminating unnecessary treatment for migraine headache and sinusitis, root canal therapy and extraction, as in Rebecca's

case. As one respondent noted, an occlusal splint is a diagnostic device to determine if the source of pain is Rebecca's molars or TMD. Since there are no objective tests for headaches, the diagnostic occlusal splint is one non-invasive strategy for identifying muscle trismus as a source of pain.

Central Values of the Profession

The philosopher David Ozar proposes a hierarchy for understanding the central values of dental practice. Central values are those to which a profession and its members are committed. The six identified by Ozar include: 1) the patient's life and health; 2) the patient's oral health; 3) the patient's autonomy; 4) the dentist's preferred patterns of practice; 5) esthetic values; and 6) efficiency in the use of resources (14). Rebecca's case will illustrate the key concepts of the first four central values.

1. The patient's life and health—every patient and every treatment must be evaluated against this basic value. The dentist would not recommend or perform surgery if, for example, that would threaten a patient's life without the possibility of benefit. For example, in Rebecca's case her headaches were affecting her quality of life but not her life. One respondent expressed a concern that a tumor may be causing her pain.

2. Oral health — appropriate and pain-free oral function are goals of daily practice. Protecting Rebecca's oral health includes addressing the recalcitrant acute pain that is causing her frustration by identifying the source of pain and by ruling out referred or TMD-related pain. Also, an improper diagnosis may exacerbate Rebecca's painful condition. For example, she would be worse off if her molars were extracted and she received no relief of her painful symptoms.

3. Patient autonomy—Rebecca is expressing her autonomous choice by requesting that you "pull these teeth" or she will "go to an oral surgeon." Patients have their own values, goals and purposes. This is a critical element in Rebecca's case, because her request to have the molars extracted may be detrimental to her general and oral health if the extractions do not relieve her headaches. In this values hierarchy, the dentist is not obliged

TABLE 1. Continued.

8.3 Headache from substance withdrawal (acute use)	11.3.2 Refractive errors
8.3.1 Alcohol withdrawal headache (hangover)	11.3.3 Heterophoria or heterotropia
8.3.2 Other substances	11.4 Ears
8.4 Headache from substance withdrawal (chronic use)	11.5 Nose and sinuses
8.4.1 Ergotamine withdrawal headache	11.5.1 Acute sinus headache
8.4.2 Caffeine withdrawal headache	11.5.2 Other diseases of nose or sinuses
8.4.3 Narcotics abstinence headache	11.6 Teeth, jaws and related structures
8.4.4 Other substances	11.7 Temporomandibular joint disease (functional disorders are coded to group 2)
8.5 Headache associated with substances but with uncertain mechanism	
8.5.1 Birth control pills or estrogens	
8.5.2 Other substances	
9. Headache associated with noncephalic infection	12. Cranial neuralgias, nerve trunk pain and deafferentation pain
9.1 Viral infection	12.1 Persistent (in contrast to tic-like) pain of cranial nerve origin
9.1.1 Focal noncephalic	12.1.1 Compression or distortion of cranial nerves and second or third cervical roots
9.1.2 Systemic	12.1.2 Demyelination of cranial nerves
9.2 Bacterial infection	12.1.2.1 Optic neuritis (retrobulbar neuritis)
9.2.1 Focal noncephalic	12.1.3 Interruption of cranial nerves
9.2.2 Systemic (septicemia)	12.1.3.1 Diabetic neuritis
9.3 Headache related to other infection	12.1.4 Inflammation of cranial nerves
	12.1.4.1 Herpes zoster
	12.1.4.2 Chronic postherpetic neuralgia
10. Headache associated with metabolic disorder	12.1.5 Tolosa-Hunt syndrome
10.1 Hypoxia	12.1.6 Neck-tongue syndrome
10.1.1 High altitude headache	12.1.7 Other causes of persistent pain of cranial nerve origin
10.1.2 Hypoxic headache (low-pressure environment, pulmonary disease causing hypoxia)	12.2 Trigeminal neuralgia
10.1.3 Sleep apnoea headache	12.2.1 Idiopathic trigeminal neuralgia
10.2 Hypercapnia	12.2.2 Symptomatic trigeminal neuralgia
10.3 Mixed hypoxia and hypercapnia	12.2.2.1 Compression of trigeminal root or ganglion
10.4 Hypoglycemia	12.2.2.2 Central lesions
10.5 Dialysis	12.3 Glossopharyngeal neuralgia
10.6 Headache related to other metabolic abnormality	12.3.1 Idiopathic glossopharyngeal neuralgia
	12.3.2 Symptomatic glossopharyngeal neuralgia
11. Headache or facial pain associated with disorder of cranium, neck, eyes, ears, nose, sinuses, teeth, mouth or other facial or cranial structures	12.4 Nervus intermedius neuralgia
11.1 Cranial bone	12.5 Superior laryngeal neuralgia
11.2 Neck	12.6 Occipital neuralgia
11.2.1 Cervical spine	12.7 Central causes of head and facial pain other than tic douloureux
11.2.2 Retropharyngeal tendinitis	12.7.1 Anaesthesia dolorosa
11.3 Eyes	12.7.2 Thalamic pain
11.3.1 Acute glaucoma	12.8 Facial pain not fulfilling criteria in groups 11 and 12
	13. Headache not classifiable

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to set aside his or her standards of care when the outcome of treatment may be harmful to the patient's general or oral health. For example, the dentist is not obligated to treat a patient who refuses to take antibiotics to prevent infective endocarditis, simply because the patient exerts his/her autonomy. The central values of the profession and standards of care are violated if the dentist relinquishes all decision-making to the patient.

4. The dentist's preferred pattern of practice — dentists develop their own individual manner of practice. This includes, for example, the office environment, the type of dental materials, techniques and treatment philosophies. In Rebecca's case, dentists responding to the case did not support the extraction of her molars as a viable option. Respondents addressed her case from a referred pain or TMD perspective, while others selected to refer her to specialists to aid in identifying the source of her pain. Each drew upon his or her knowledge gained in training and experience to make choices to competently care for Rebecca.

Rebecca Martin's (fictitious name) case profile is based on an actual case history. The hypothesis that TMD was a contributing factor to this patient's symptomatology was tested using a diagnostic occlusal splint. The splint incorporated basic, functional principles of occlusion; anterior guidance, cuspid disclusion, posterior vertical support and the absence of interferences in lateral excursions. The patient responded with a resolution of headache and elimination of any left-sided sinus or molar pain within a three-month period of wearing the splint full-time. She remained stable for an additional three months and subsequently underwent balanced occlusal reconstruction. The patient has remained stable one year past occlusal reconstruction.

It is important to emphasize that each patient must be assessed thoroughly on an individual basis. All causes of headache are not TMD-related and all TMD-related headache may not respond to occlusal treatment. Further, once a diagnosis is formulated, a hypothesis is developed with regard to treatment options. If possible, that hypothesis should be tested prior to initiation of definitive treatment.

Conclusion

Headaches and TMD-related symptoms present one of dentistry's most difficult and controversial diagnostic challenges. The reliance on the patient's subjective history of pain, lack of objective tests and scientific research, and the convergence of medical and dental diagnostics, increases the potential for misdiagnosis and mistreatment of the patient. Ozar's hierarchy of central values reminds clinicians that the patient's general and oral health should not be set aside by patient demands. Also, the preferred pattern of practice requires clinicians to be lifelong learners to maintain competence in such areas as headaches and TMD. The general dentist is obligated to search for the source of Rebecca's pain (e.g., referred or TMD) and to refer as needed to dental and medical specialists.

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EDITOR'S COMMENT: Responses to the ethical dilemmas are views of the contributors and consultants and not Baylor College of Dentistry, the National Center for Policy Analysis or the Texas Dental Association. Dr. Richard Harper is an Assistant Professor in the Department of Oral and Maxillofacial Surgery and Pharmacology at Baylor. Address your comments to Dr. Thomas K. Hasegawa, Jr. Department of General Dentistry, Baylor College of Dentistry, P.O. Box 660677, Dallas, TX 75266-0677, fax to (214)828-8952, or E-mail to: tk.hasegawa@baylordallas.edu