

## Hysterical Trismus: Review & A Case Report

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### **ABSTRACT**

Hysteria may be responsible for a variety of conditions. However, when hysteria is suspected as the cause of entity, careful investigation is necessary to rule out the underlying organic disease. The present case describes a patient attending emergency clinic having complete trismus with conversion hysteria probably of psychogenic origin. She got relieved of her symptoms spontaneously.

### **KEYWORDS**

Trismus; Lock jaw; Hysteria; Tetanus

### **INTRODUCTION**

Trismus commonly called lock-jaw, is muscle spasm of the mandibular elevators resulting in the clenching of the teeth, is due to several causes: Myofascial pain dysfunction syndrome, infection, trauma, neoplasia, drugs (e.g., phenothiazines) tetanus, neurological lesions and hysteria. Myofascial pain dysfunction syndrome being the most common and hysteria probably the most difficult to diagnose. Hysteria is derived from the Greek word for uterus. Some ancient Greeks believed that the disease was restricted to women and was caused by the wondering of a frustrated uterus to various parts of the body because it was pinning for children [1,2].

Freud used the term conversion hysteria to indicate that the hysterical symptoms were an expression of repressed or deviated sexual energy. It is now recognized that psychologic conflicts other than sex may also be important etiologic factors [2].

The various presentations include paralysis, blindness, anesthesia, anorexia, vomiting and in fact, this condition may mimic practically any disease. Through the mechanism of conversion, the emotional conflict is converted into a physical symptom thus releasing the patient from the emotional conflict and producing the typical, although not invariable "labella in difference". The patient, now having resolved the inner conflicts, denies all stress believing simply that the symptoms are of a purely physical nature. However, when hysteria is suspected as the cause of an entity, careful investigation is necessary to rule out organic disease [2].

The onset of hysteria is usually before the age of 35, mainly occurring in women and in those with a suggestible and parent-dependent personality.

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This paper presents a case of hysterical trismus and highlights the difficulties encountered in diagnosis and management.

### **CASE REPORT**

The patient a 35-year-old female, Indonesian was referred to the emergency department of oral and maxillo-facial surgery. She complained of inability to open mouth during the previous five days (Figure 1 & Figure 2). The patient was a housemaid and accompanied by her sponsor.

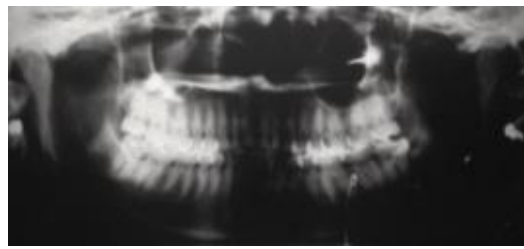
There was no previous history of joint pain or similar complaints. She did not have any cut wounds. Medical and dental history obtained at this time was non-contributory.



**Figure 1 & Figure 2:** Photograph showing complete trismus.

Extra oral clinical examination revealed no facial asymmetry. There was no palpable cervical lymphadenopathy. Palpation of masticatory and cervical muscle revealed mild tenderness over the masseter, temporalis, and sternomastoid muscles. No area of muscle spasm was clinically evident. She was not able to open her mouth for even a few millimetres.

Intra oral examination revealed poor oral hygiene, multiple carious teeth, complete trismus, no soft tissue abnormalities and there was no sign of acute illness which could be suggestive of causing trismus. Her voice was normal. There was no difficulty in swallowing or deglutition. The vital signs were within normal limits An orthopantomogram and lateral skull x-rays including neck were non-contributory (Figure 3 & Figure 4).



**Figure 3:** Orthopantomogram at the time of presentation.



**Figure 4:** Radiograph of lateral skull and neck showing no pathology.

She was started with intravenous fluids (dextrose/saline) and blood was collected for complete blood count and biochemical analysis. Blood results showed no leucocytosis or increased erythrocyte sedimentation rate which ruled out any underlying infection.

After examination, the following differential diagnosis was considered: Hysterical trismus, Myofascial pain dysfunction syndrome, Peritonsillar abscess, Torticollis, Tetanus, extrapyramidal tract syndrome and Meningitis.

Meningitis was considered because the patient complaint of headache and stiff neck in her past history. Negative Kerning's and Brudzinski's signs ruled out this entity. Extrapyramidal tract involvement was a remote possibility to exclude any drug abuse. Use of phenothiazine and its derivatives was denied by the patient. Since the trismus was so pronounced, it was thought that we still had to account for it. Peritonsillar abscess was another consideration, Quinsy is usually manifested by fever, pharyngitis and dysphagia which may lead to trismus. Traumatic arthritis secondary to recent mandibular trauma could account for trismus although usually minimal opening is possible.

Hysterical trismus was our prime consideration, mainly because of the 'belle indifference' of the patient. She was given a dose of intravenous diazepam 10 mg to make her relax and see if trismus can be relieved but it was not fruitful. It was then decided to examine her under sedation either under general anesthesia or intravenous sedation to rule out any hidden pathology. Before transferring to theatre she opened her mouth dramatically and no organic cause for her trismus could be substantiated. On the following day she was discharged in good spirits, completely asymptomatic and with a complete range of mandibular movements (Figure 5 & Figure 6). She was referred for further psychiatric examination arrangement. The patient did not come for further follow up.



**Figure 5:** Photograph after opening of the mouth.



**Figure 6:** Orthopantomogram after opening of the mouth.

## **DISCUSSION**

Trismus is a problem commonly encountered by the dental practitioner. It has number of potential causes, and its management is driven by its cause. Each case of trismus requires an accurate diagnosis to determine the specific causative factors. Diagnosis of hysterical trismus should be made on the basis of positive findings and not simply by ruling out other possible etiological factors. Causes such as local trauma, inflammation, infection, tumour and tetanus must be considered.

Long-standing trismus, regardless of the cause, may result in atrophy of the associated structures, with the formation of fibrous or even bony adhesions or ankylosis. The conditions compound the problem and mask the diagnosis. Physiotherapy is useful in correcting these secondary changes [6,7].

## **CONCLUSION**

Hysterical trismus is a conversion type of reaction. A case has been presented in which this psychogenic defence mechanism involved the stomatognathic system, resulting in complete trismus. The immediate symptom was cured spontaneously, and the patient was then referred for psychiatric assessment.

## **CONFLICT OF INTEREST & FINANCIAL SUPPORT**

None

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