Phantom Bite - A Case Report of a Rare Entity

Shraddha Shetti1, Kishor Chougule2

Abstract
A case report of a patient suffering from a relatively uncommon condition called 'Phantom Bite' is presented with the aim to provide the fellow orthodontists & general dentists with an overview of potential diagnostic & treatment challenges posed by patients who present with occlusal dysesthesia. A clinical case illustrating the nature of this condition is presented & the problems associated with the management of affected patient are discussed. The patients suffering from Phantom bite syndrome have one symptom in common; that is, they feel that their bite is not correct & their iterative belief in the need for dental treatment to accomplish correction. Since this condition is associated with an underlying psychological problem, treatment of such patients poses a greater challenge to the operator. Thus, it can be concluded that 'Phantom Bite' or 'Occlusal Dysesthesia' is seen as a form of somatoform disorder where dental treatments should be avoided & instead the focus must be on addressing the somatoform disorder through behavior change.

Key words: Phantom Bite, Occlusal dysesthesia.

Introduction
Phantom bite or occlusal dysesthesia although a relatively uncommon condition, is at times encountered in the routine orthodontic practice. The patient's hyperawareness about the bite is almost always associated with some underlying psychological problem. Hence, treating such patients poses a greater challenge to the orthodontist. A great deal of patience is required while treating these patients.

A case report is presented with the purpose of making the dentists aware of the condition & the management of patients suffering from this condition which will enable them to render an appropriate care to such patients.

Case Report
A male patient A. M. aged 30 years, reported to the Department of Orthodontics & Dentofacial Orthopedics, Tatyasaheb Kore Dental College, New Pargaon, Kolhapur with the chief complaint of an uneven bite. On detailed case-history, the Patient gave a history of discontinued Orthodontic treatment. Later, in the due course of time, the patient visited 3 to 4 dentists for the problem of 'uncomfortable' bite & felt that his chief complaint was not addressed by the dentists. Various restorative procedures were tried on him but not to his satisfaction. The patient tended to elaborate & interpret the etiologies. The symptoms were said to have started two years ago following the treatment of a fractured silver amalgam restoration with a molar. Another dentist had replaced the restoration with a metal crown, which provided the patient a considerable improvement of the occlusal discomfort for some time. Unfortunately, the patient was still not convinced about the treatment rendered to him. The patient was also extremely resentful of the dentists' inability to treat his occlusion. The dentist finally referred the patient to the dental college for further opinion & needful treatment.

During examination, the patient was restless & reparative in his demand that he wanted a perfect bite. There was a slight tenderness on percussion with lower right first molar and occasional bilateral masseter muscle tenderness to palpation. The dental occlusion was intact with no significant interferences. It was considered that the patient experienced dental pain due to pulpitis of lower right first molar. The facial pain was thought to be due to TMD (facial arthromyalgia). The history, signs and symptoms of occlusal unevenness were consistent.

Differential diagnosis
Differential diagnoses of Myofacial pain, masticatory muscle disorders & Phantom bite were made.

After thorough convincing, the patient was ready for the psychiatric consultation. The psychiatrist opined that the patient had an underlying personality disorder with marked obsessiosity.

Intraoral and extraoral examinations did not reveal any abnormality and there were no pathological findings. Orthopantomogram and Lateral Cephalogram did not show any significant findings. Palpatory examination did not reveal any TMJ pain or tenderness to muscle palpation. (Fig 1,2,3)

Diagnosis
The possibility of myofacial pain was ruled out as there were no trigger points as typically seen in this condition. Even the
masticatory muscle disorders were not confirmed as the clinical characteristics such as increased pain on function was absent & also there was no sudden knotting up (tightening) of muscles as seen in myospasms. There was no evident discrepancy. Thus, based on the patient's symptoms & a detailed discussion with the staff, the patient was diagnosed to have phantom bite syndrome. He was suggested to take a psychiatric opinion.

**Treatment Objectives**

To relieve the occlusal prematurities, if any. To achieve a near normal functional occlusion & to advocate patient's complaint of improper bite.

**Treatment Plan**

Checking high points with articulating paper & taking care of the occlusal prematurities. A maxillary occlusal splint made of thermoplastic material & psychiatric consultation.

**Management**

1. **Orthodontic Management**

The patient was given a 1.5 mm thick, soft occlusal splint made of clear Biocryl (Scheu Dental co. Germany). The elastic modulus of which was 3100 mpa with a tensile strength of 70 mpa & an impact resistance of 11KJ/m². This material was thought of as it was considered that this material would withstand the occlusal forces in this patient. The patient was advised to wear the splint only at night initially & then gradually increase the hours of wear. Initially the patient showed great zeal of enthusiasm in wearing the appliance but gradually declined the wear. He felt slightly better than before in terms of reduction of pain but still was not convinced fully about his bite.

Since the patient exhibited a bizarre behavior pattern & was repetitive in his demand that he wanted a perfect bite, we were alarmed by the situation. After detailed discussion with the staff members of department of Orthodontics, it was decided to seek a psychiatric consultation for the patient. Initially the patient was not ready for the psychiatric consultation but after convincing him that it was a part of the treatment, somewhat unwillingly he was ready for the same. (Fig. 4,5)

2. **Psychiatric Treatment**

The Psychiatrist diagnosed the condition as Monosymptomatic Hypochondriacal Psychosis. The patient was kept on Tab. Monozide (Group pharma) and was taught the relaxation techniques to help himself reduce the stress. The patient was also advised deep breathing techniques in Yoga, along with the medication.

**Treatment Progress**

After 4 weeks of treatment, the patient responded to drug with significant improvement in his occlusal discomfort. This suggested that the drug was effective & well tolerated. Thus it proved to be useful in his treatment of underlying oral psychosomatic disorder. The patient was followed up over a much longer time.
Discussion
Although it is usually stated that phantom bite is a rare condition and the actual prevalence of the disorder is not known, it would appear to be much more common than documented and most Orthodontists will have seen patients with the disorder. Marbach first described the condition Phantom bite syndrome as a patient's perception of an irregular bite when the clinician could identify no evidence of a discrepancy. This often begins during adolescence after a significant dental or orthodontic treatment. Treatment of such patient is challenging task. Despite the official recognition of phantom bite, many professionals may not see or recognize this condition in the routine practice .Not all the patients respond to treatment & the prognosis is poor because of underlying psychological problems. Emphasis should be placed on building adaptive coping skills. General dental practitioners should refer patients for specialist opinion and management.

Conclusion
Phantom bite can be a disabling disorder which is difficult to treat on account of the patients unrealistic obsession with the occlusion. Further research is needed to elucidase the nature of condition to improve treatment.

Acknowledgment
We acknowledge the support & help of members of Department of Orthodontics and Dentofacial Orthopedics, Tatyasaheb Kore Dental College and Research Centre, in preparing the manuscript.

References