



Huntington Village Implant & Oral Surgeons
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Don't Miss out
on our Next
Seminar

Thursday

Please note:

March 6th,
2014

3 CE Credits

“CDC Recommended Infection Control Practices for Dentistry”

Presenter:
Harold Edelman, D.D.S.

Registration
Dinner 5:30
pm

Lecture
6:00 - 9:00 pm

Dolan Family
Health Center

284 Pulaski
Road,
Greenlawn, NY

This course is
sponsored by
the Suffolk
County Dental
Society, an
ADA-CERP
recognized
provider of
Continuing
Education
(CE)

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the New York
State Dental
Association
and a design-
ated PACE
Program Pro-
vider for the
Academy of
General
Dentistry.

Mark Your Calendars For Our Thursday, May 22nd, 2014 CE Lecture on :

**Removable Partial Overdentures
An Underutilized Modality Let Wax Be Your Guide:
Avoiding Clinical Complications**

Presented By: Kenneth S. Kurtz, DDS

Craniofacial Pain Of Cardiac Origin

Danesh-Sani SH, Danesh-Sani SA, Zia R, ET al: Incidence of craniofacial pain of cardiac origin: Results from a prospective multicenter study. Austral Dent J 57:355-358,2012

Clinical Significance— When patients do not experience chest pain associated with cardiac event, craniofacial structures were the most commonly reported sites of pain associated with an ischemic episode. Dental practitioners should be aware of the possibility that craniofacial pain is referred from cardiac source and manage patients accordingly. During history taking, it is useful to ask whether the patient's pain is associated with exertion and relieved by rest, which tends to indicate pain of cardiac origin. Early differential diagnosis of craniofacial pain of cardiac origin is an important task that dentists can perform for their patients.

Background— Craniofacial pain, a common complaint in the dental practice, may not originate from dental sources. Non-odontogenic craniofacial pain or heterotopic pain presents a significant diagnostic challenge. A cardiac source is possible, with craniofacial pain being the only symptom of cardiac ischemia experienced by about 6% of patients. The misdiagnosis of referred cardiac pain has potentially lethal implications for patients. Patients who never developed chest pain have a significantly higher cardiac mortality rate than those for whom chest pain was their chief complaint. The incidence and distribution patterns of craniofacial pain of cardiac origin were evaluated.

Methods— The 248 consecutive patients (age 26 to 88 years) had been hospitalized with confirmed cardiac ischemic periods. Digital orthopantomogram (OPG) analysis was performed on all patients' jaws and dentition and all underwent clinical and radiographic examinations. Their symptoms were analyzed to determine the prevalence and distribution patterns of their craniofacial pain of cardiac origin.

Results— Craniofacial pain during a period of ischemia was reported by 34.2% of the patients, with significantly higher incidence among women and men. Pain in the craniofacial region, chest, shoulders, and arms was also reported by 84.7% of patients. In 13 patients (15.3%) no other symptoms accompanied the craniofacial pain.

The 85 patients who had craniofacial pain during ischemia reported the pain affected various regions, but the left mandible was the most often cited, found in 42.4% of patients. Two patients had bilateral toothache pain in the mandible teeth. Fifty-two percent of patients had an acute myocardial pain in various distributions (Fig 2). Among those who experienced AMI, the right mandible was most often involved. For two men, craniofacial pain was the only symptom experienced. Nine percent of patients had no chest pain. Patients who had no chest pain were the most likely to experience craniofacial pain.

Discussion— Cardiac nociceptive input can stimulate nervous system neurons to produce referred pain in the craniofacial area. Various patterns of pain are experienced, with some patients having no chest pain and no symptoms other than the craniofacial pain. The mandible, TMJ, and ears are affected most often.

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