Mandibular Dislocation in a Patient Diagnosed with Bell's Palsy: A Case Report and Literature Review

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Abstract: Mandibular dislocation is a musculoskeletal disorder often associated with trauma and anatomical predispositions, which can result in severe pain and difficulty moving the mandible. Some conditions, such as Bell's palsy, can mimic signs and symptoms of mandibular dislocation, confusing some professionals during diagnosis. For this reason, a detailed anamnesis and clinical examination, combined with complementary tests such as computed tomography (CT) and magnetic resonance imaging (MRI), are necessary for a reliable diagnosis. The aim of this case report was to explore the management of mandibular dislocation, highlighting the importance of a detailed anamnesis and the use of complementary tests in the differential diagnosis of complications associated with temporomandibular disorders. Patient, 66-years-old, was referred to by her neurologist with a suspected relapse of Bell's palsy. After initial assessment, the suspicion was ruled out and a left-sided mandibular dislocation was hypothesized. A CT scan was requested, which confirmed the diagnosis. The treatment adopted was a maneuver to reposition the mandibular condyle in the articular fossa and the use of an anterior partial plate to stabilize mouth opening and closing. The patient received counselling therapy on more stable mandibular movement and was monitored to prevent recurrences. Confirmation of mandibular dislocation requires careful assessment, combined with complementary tests for an accurate diagnosis that excludes other conditions such as Bell's palsy. Conservative treatment, with reduction maneuvers, counselling therapy and the use of the Front Plateau, were effective in recovering mandibular function.

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Prague Medical Report / Vol. 127 (2026) No. 1, p. 55–63

Introduction

Temporomandibular disorders (TMD) are disturbances that can affect the temporomandibular joint (TMJ), the muscles of mastication and their adjacent structures (de Leeuw and Klasser, 2018; Melchior et al., 2019). They have a multifactorial etiology and may be associated with structural, neuromuscular, occlusal, psychological factors, parafunctional habits and trauma (Da-Cas et al., 2024). Among the main signs and symptoms related to TMD are pain on palpation, joint noises, headaches, otalgia, facial pain, muscle fatigue, spasms and mandibular deviations (List and Jensen, 2017).

Due to its multifactorial characteristics and complex diagnosis, the identification of TMD involves clinical examinations, such as muscle palpation, functional manipulation and, in some cases, it requires complementary tests such as computed tomography (CT) and magnetic resonance imaging (MRI) (Ferreira et al., 2016; Maulén-Yáñez et al., 2019; Małgorzata et al., 2020). MRI is the method of choice for visualizing changes involving the soft tissues of the TMJ. CT allows the visualization of articular bone structures in different planes, as well as their possible manipulation at different depths and three-dimensional reconstruction, indicated to precisely determine the location of bone components and their changes (Silveira et al., 2014).

Among TMD, mandibular dislocation can confuse some professionals, making it difficult to diagnose correctly. It is a condition that can be bilateral or unilateral, and as for its frequency, habitual or recurrent. Mandibular dislocation can occur when the condyle of the mandible extends beyond the articular eminence of the temporal bone, exceeding the articular eminence. Depending on which side it occurs on, it can be anterior, superior or lateral (Hillam and Isom, 2023). This dysfunction can occur because of atraumatic etiologies or trauma to the mandible. Factors leading to atraumatic dislocation can include anything that results in forced and excessive opening of the mandible, such as yawning, seizures or repeated chewing, as well as underlying anatomical causes, such as ligament laxity or connective tissue disorders (Cardoso et al., 2005; Liddell and Perez, 2015; Sharma et al., 2015).

Joints with a tendency to subluxation and/or dislocation itself can present a spontaneous manifestation, which occurs when the mouth is opened beyond its usual limit. In the case of subluxation, also referred to as hypermobility, this happens during a wide opening movement, where the condyle goes beyond the articular eminence. Clinically, it is possible to observe a "jump" of the mandibular condyle beyond the articular eminence, causing a depression in the preauricular region. Despite this, it is not a pathological condition, since in most cases the condyle returns to its original position when the mouth is closed (Okeson, 2013). In mandibular dislocation, the TMJ is forced beyond its maximum opening limit and the condyle exceeds the articular eminence in such a way that the depressors and elevators of the mandible are stimulated, making it difficult for the condyle to return to its original position. This can occur through the elevation of the mandible by the temporalis and masseter muscles before relaxation by the lateral pterygoid occurs (Okeson, 2013; Hillam and Isom, 2023).

This clinical situation can be underreported by some professionals, who may associate the clinical signs with other diseases such as Bell's palsy, a sudden and unilateral weakening of the facial nerve, which partially or totally affects one side of the face. Symptoms can include pain around the ear, facial numbness and altered sense of taste (Holland and Bernstein, 2014).

When the mandible dislocates, pain stimulates spasm or contraction of the masticatory muscles, which can cause the condyle to rise and lock anteriorly to the articular eminence (Cardoso et al., 2005). According to the literature, dislocations of more than 6 months usually require complicated surgical procedures such as condylectomy, myotomy and other methods to correct the occlusion and reduce the mandible to a normal relationship with the maxilla (Huang et al., 2011). As the time between the onset of dislocation and repositioning increases, the prognosis is less favourable (Wijmenga et al., 1986). In cases of subluxation and dislocation proper of the mandible, approaches can involve anything from manual reduction of the condyle to surgical procedures such as eminectomy (Cecílio, 2019). Failures of non-surgical methods are due to the resistance offered by spasm of the masticatory muscles, shortening and subsequent fibrosis of the temporal and pterygoid muscles, periarticular fibrosis, disc displacement and pseudoankylosis between the zygomatic arch and coronoid process (Debnath et al., 2006).

To avoid more invasive and irreversible treatments for the patient, non-invasive and reversible interventions are initially prioritized and, if they are not effective, more invasive procedures are used, aiming for the patient's functional, emotional and orthopedic balance (Almeida et al., 2016). Choosing the most appropriate course of action will depend on a detailed medical history, a well-constructed anamnesis and the help of complementary tests, when necessary (Reid and Greene, 2013). Therefore, the aim of this case report was to highlight the importance of a detailed anamnesis supported by complementary exams in the

differential diagnosis of TMD in a patient referred with a diagnosis of Bell's palsy, exploring the management of the mandibular dislocation found.

Diagnostic methods for TMD

The diagnosis of TMD is a complex process that involves a detailed assessment of the clinical history, physical examination and, when necessary, complementary tests (Sassi et al., 2018). For a good diagnosis, a detailed anamnesis is of paramount importance, where the health professional collects information about the patient's symptoms, including the nature of the pain, its location, duration and factors that can aggravate or alleviate it (Okeson, 2019). In addition, it is important to identify factors that may be contributing to the dysfunction, such as parafunctional habits like bruxism, stress or a history of trauma (Chan et al., 2022).

During the clinical examination, it is essential to assess mandibular function, observing mandibular movements when opening and closing the mouth, as well as checking for the presence of clicks or crackles in the TMJ. Palpation of the masticatory muscles and the TMJ region is essential to detect areas of muscle tension or tenderness (Schiffman et al., 2014).

In addition to the physical examination, complementary tests are often necessary to confirm the diagnosis and assess the extent of dysfunction. CT is one of the most useful tools, as it allows the bony structure of the TMJ to be visualized in detail, which is important for detecting alterations such as a shallow articular eminence, which can predispose to dislocations, or anatomical deviations in the mandibular fossa (Talmaceanu et al., 2018). CT is also useful for assessing the presence of bone lesions and other joint alterations that may be associated with TMD (Dhabale and Bhowate, 2022).

Another widely used complementary test is MRI, which is very suitable for examining soft tissues associated with the TMJ, such as the articular disc, ligaments and masticatory muscles. According to Al-Saleh et al. (2016), MRI is extremely effective for assessing changes in the articular disc, which can be displaced or damaged in many cases of TMD, causing pain and compromising mandibular function. MRI can also identify inflammation in the soft tissues and the presence of altered anatomy that contributes to dysfunction (Balel et al., 2023).

Depending on the patient's condition, neurological examinations may be necessary, especially when there are symptoms that can be confused with other conditions, such as Bell's palsy, characterized by the inability to move the facial muscles. In these cases, the differential diagnosis between TMD and other neurological conditions, such as Bell's palsy, is made through the exclusion of neurological diseases and detailed analysis of joint and facial muscle function (Baugh et al., 2013).

Mandible dislocation

This condition occurs when the mandibular condyle dislocates from the mandibular fossa and can result in severe pain and the inability to close the mouth (Hillam and Isom, 2023). It can be caused by direct trauma, such as accidents or blows, or by an anatomical predisposition. Dislocation can be unilateral or bilateral, with the unilateral form being more common (Sharma et al., 2017).

The diagnostic hypothesis of mandibular dislocation can be raised from the clinical evaluation, based on mandibular movement (opening, closing, protrusion and laterality), which may be associated with severe pain (Hillam and Isom, 2023). Physical examination can reveal the abnormal position of the mandible, while complementary tests such as CT and MRI are used to confirm the diagnosis and assess the displacement of the condyle and joint changes (Okeson, 2019; Balel et al., 2023).

Initial treatment usually involves reduction maneuvers, which reposition the mandible (Liddell

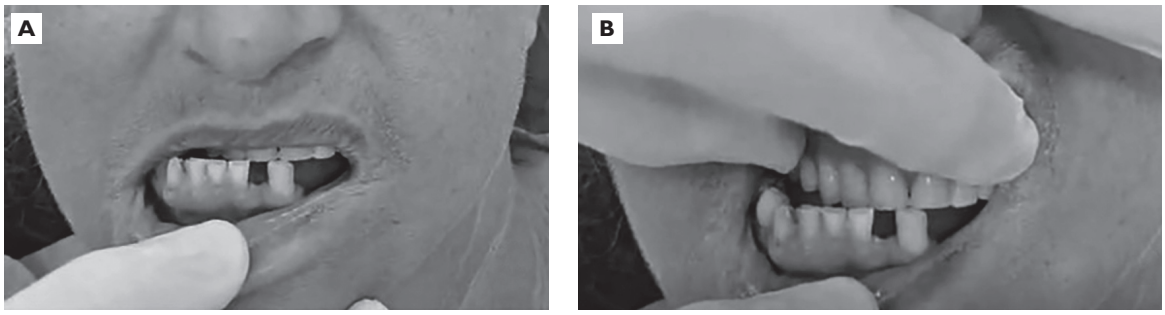

Figure 1: Initial appearance of the patient, revealing an anterior projection of the mandible (A) and deviation to the right side (B) even at rest.

Prague Medical Report / Vol. 127 (2026) No. 1, p. 55–63

and Perez, 2015). In recurrent or chronic cases, the use of devices such as full or partial occlusal splints, such as the Front Plateau, may be indicated to stabilize the condyle-joint relationship and prevent further dislocations (Okeson, 2019). If the maneuvers are not effective, surgical interventions such as eminectomy may be necessary to restore an anatomy compatible with a more stable joint function (Martins et al., 2014).

Case report

Study design

The case was conducted in a TMD School Clinic of the Department of Dentistry of a Federal University, by students of the Dentistry course under the supervision of two periodontics professors, one of whom was a TMD specialist and a professor in the area. In addition, the study followed the Helsinki Declaration of 1975, revised in 2013 (General Assembly of the World Medical Association, 2014), was approved by the Research Ethics Committee (7.263.258) and the patient signed an informed consent form. This case report was designed and written in accordance with the CARE Guidelines: Consensus-based Clinical Case Reporting Guideline Development (Gagnier et al., 2013).

Case description

Patient, 66-years-old female, living in a rural area, was referred to the University Clinic of Stomatology on June 26, 2024, by her neurologist, with a suspected recurrence of Bell's palsy diagnosed in January 2023. According to the patient, after the diagnosis, she underwent physiotherapy sessions with a slight improvement in her symptoms. Neurological examinations ruled out alterations in the spinal cord, spine and brain. The patient was systemically healthy.

The patient wore superior complete prostheses and had missing posterior inferior teeth on both sides. According to the patient's reports, she had received rehabilitative treatment for an inferior removable partial prosthesis (RPP), but due to the postural condition of her jaw she was unable to wear it.

When she was assessed by the stomatology team, no clinical signs compatible with Bell's palsy were found. The patient was therefore referred to the TMD clinic under the supervision of a specialist in the field. When mandibular movement tests (maximum opening, protrusion and laterality on both sides) and functional manipulation were carried out, the diagnostic hypothesis of left-sided mandibular dislocation was raised. Figure 1 shows the patient's initial facial appearance.

In this case, CT was requested to confirm the diagnosis. The CT scan revealed a change in the position of the mandibular condyle on the left during mouth opening (Figure 2A) and mouth closing, with no return to the articular fossa (Figure 2B), confirming mandibular dislocation. The right side showed no alteration, either during mouth opening (Figure 3A) or closed mouth (Figure 3B).

Treatment description

Jaw reduction maneuver

The bimanual method (Liddell and Perez, 2015) was used to reduce the mandibular dislocation identified on the left side. In this case, the patient was instructed to sit in a chair while the operator stood directly in front of the patient. The operator then positioned both thumbs in the region of the patient's respective inferior molars. As the posterior teeth were missing in this case, the external oblique ridge can be used as a reference, occupying the most posterior region

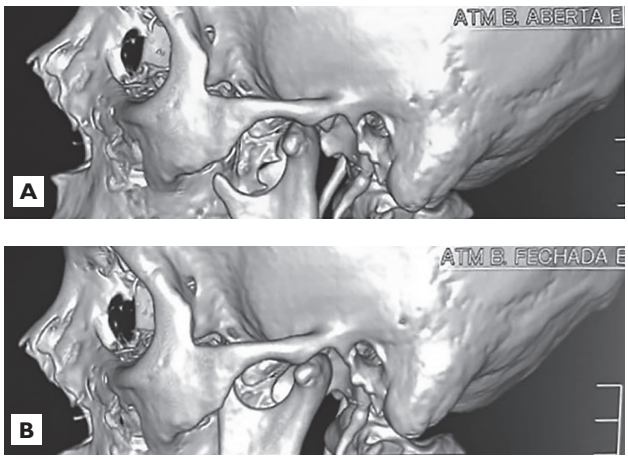

Figure 2: Computed tomography scan of the left side. (A) During mouth opening. (B) Mouth closed.

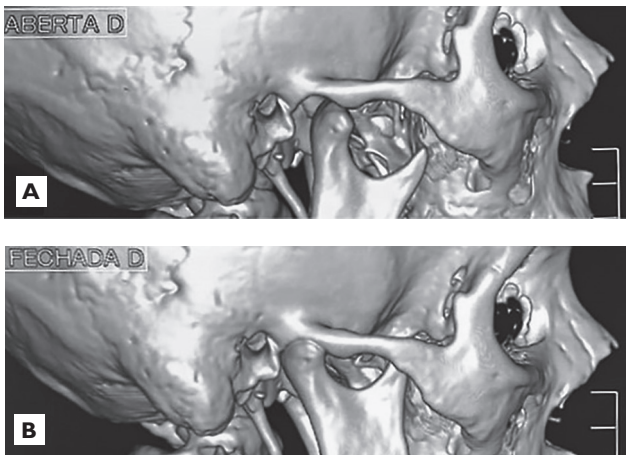

Figure 3: Computed tomography scan of the right side. (A) During mouth opening. (B) Mouth closed.

possible. The thumbs can be wrapped in gauze for protection. The operator's other fingers were placed outside the mouth at the angle of the mandible to elevate the mandibular body and chin. Pressure was applied by the thumbs to push the mandible downwards and then backwards, keeping the mouth slightly open. In this case, the left side was pressed down and back more, as this was the side with the condyle trapped in front of the articular eminence. The aim was to release the condyle from the articular eminence and push the mandible back into the articular fossa of the temporal bone.

Counselling therapy for the patient

Due to the postural condition developed by the patient, counselling therapy was given to re-educate the mandibular posture during the opening and closing of the mouth. The aim of these exercises was to induce a more comfortable and stable mandibular position without pain (Simões et al., 2023). The guidelines adopted can be found in Table 1.

Adjustment of the inferior RPP

To provide the patient with complete rehabilitation treatment, attempts were made to adjust the inferior RPP during the appointments. However, due to the length of time the patient had not worn the prosthesis, it was not possible to achieve a satisfactory fit. In addition, the superior complete prostheses were also poorly adapted. The team therefore decided to refer the patient to the Integrated Clinic of the Department of Dentistry at the same institution to have new complete prostheses and an inferior RPP made.

Front Plateau manufacturing

To facilitate the patient's adaptation to the new mandibular position, a rigid occlusal splint with partial coverage was made, called a Front Plateau. In the case of this patient in particular, the Front Plateau involved the inferior anterior teeth (Gomes et al., 2018; Belchior et al., 2021; Leonan-Silva et al., 2025).

The following materials were used to make the Front Plateau: self-curing colourless acrylic resin liquid and powder, dosing cup, kit of cutters and polishing tips, carbon paper, Muller tweezers, No. 31 spatula, brush, paladon pot, water tank and procedure gloves.

After organizing the materials, the acrylic resin powder was mixed with the liquid in the paladon jar for manipulation. This was done until a homogeneous mixture was obtained. The paladon jar was then closed and we waited until the acrylic resin lost its shine and reached its plastic phase.

After isolating the patient's teeth and the operator's fingers with liquid petroleum jelly (to prevent the resin from sticking during manipulation), the resin was manipulated with the operator's fingers until it was shaped like a stick and adapted to the patient's inferior anterior teeth (33 to 43).

Table 1: Counselling therapy

1) Relax your jaw muscles	Try not to clench your teeth. Practice keeping your tongue on the roof of your mouth, behind your front teeth, your lips together and your teeth apart.
	Maintain good head, neck and back posture. This will help relax your jaw muscles.
	Avoid sleeping on your stomach or in other positions that strain your jaw and neck muscles.
2) Try not to open your mouth too widely	Avoid opening your mouth wide when yawning, avoid shouting and singing and avoid long sessions at the dentist.
	When yawning, place the palm of your hand under your chin to avoid opening it too much, keeping your tongue up.

Figure 4: Front Plateau after finishing and polishing.

Figure 5: Patient assessment after 1 month.

Prague Medical Report / Vol. 127 (2026) No. 1, p. 55–63

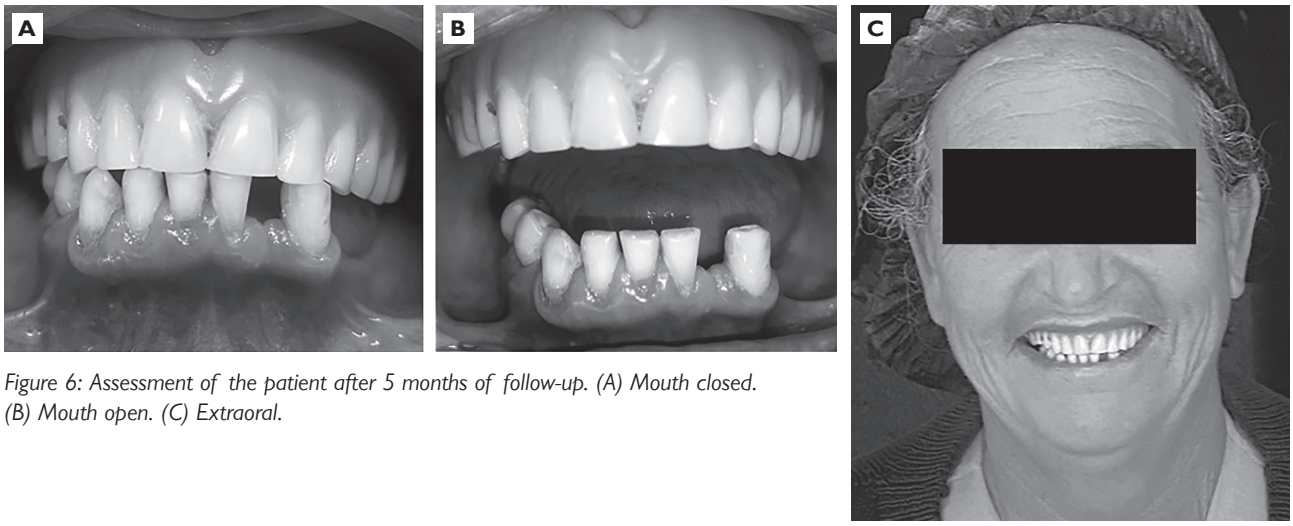

Figure 6: Assessment of the patient after 5 months of follow-up. (A) Mouth closed. (B) Mouth open. (C) Extraoral.

The patient was instructed to always bite down with her tongue on the palate to ensure that the Front Plateau acted in centric relation. During the setting time, due to the acrylic resin heating up, the Front Plateau was removed from the patient's mouth and placed to rest in a tub of water. The material was then returned to the patient's mouth. After the setting time, occlusal adjustments were made, ensuring that all the anterior teeth were touching, and with a small step with slight marks on the antagonist teeth so that occlusion only occurred in that position.

At the end, the Front Plateau was finished and polished with a set of cutters and abrasive tips for delivery to the patient (Figure 4).

Patient follow-up

The patient has been followed up for 5 months, since the first assessment at the TMD Clinic and the interventions. After 1 month of using the Front Plateau and following the instructions, it was already possible to see a considerable improvement in the patient's mandibular posture (Figure 5).

The last appointment was made in November 2024, when it was possible to see a considerable improvement in the patient's initial condition (Figure 6A–C).

The need for restorative treatment was identified in teeth 42, 43, 44 and 45, so restorations in Vittra APS Unique monochromatic composite resin (FGM, Joinville, SC, Brazil) were made in teeth 42 (Class IV Distal), 43 (Class IV Mesial), 44 (Class II Distal), 45 (Class II Distal).

Subsequently, the patient will receive rehabilitative treatment with the manufacture of new: superior complete prostheses and a new inferior RPP. The treatment will be carried out by students in the Integrated Clinic of the Department of Dentistry under the supervision of teachers in prosthodontics.

Discussion

The patient in this study lives in a rural area in the Jequitinhonha Valley, located in the state of Minas Gerais in Brazil. Historically, the region has faced major challenges in terms of access to basic health services, especially specialized dental care (Bernardes, 2017; Andrade and Andrade, 2021). This contributes to late diagnosis and inadequate treatment of specific conditions, such as TMD. The scarcity of specialized professionals, the lack of health information, as well as restricted access to imaging tests such as CT and MRI in large urban centers, make it difficult to establish definitive diagnoses and specific treatment for each condition (Balel et al., 2023).

Detailed anamnesis is essential in the diagnosis of TMD (List and Jensen, 2017). Collecting data on medical history, such as previous episodes of mandibular dislocation or neurological diseases such as Bell's palsy, is fundamental to identifying risk factors and establishing an appropriate treatment plan. In the case of the patient in question, medical history ruled out possible neurological disorders resulting from the condition detected in 2023. In the literature, three cases of patients with confirmed Bell's palsy and TMD involvement were found, one of them with mandibular dislocation (Santos et al., 2009; Alfaya et al., 2012; Ascenço et al., 2012). However, in all cases, a sign was identified which is a differential of true Bell's palsy, namely the impossibility of voluntary eyelid closure on the paralyzed side (Hungria, 2000). This manifestation was not observed in the patient in question.

From then on, the diagnosis was directed towards the stomatognathic system and TMD. After assessing mandibular movement based on opening, closing, protrusion and laterality (Schiffman et al., 2014), signs and symptoms suggestive of mandibular dislocation were detected, such as difficulty closing the mouth, joint instability, muscle pain and the impossibility of performing functional movement (Hillam and Isom, 2023). These clinical findings are in line with other studies in which mandibular dislocation was confirmed (Man et al., 2011; Vasconcelos et al., 2014; Sharma et al., 2017).

Imaging tests play a fundamental role in confirming the diagnosis of mandibular dislocation and other TMDs. As discussed by Balel et al. (2023), CT and MRI are crucial for detailed visualization of the TMJ and surrounding tissues. With the CT scan, it was possible to obtain a conclusive diagnosis, revealing that the patient had a slightly shallow articular eminence, which made it easier for the mandibular condyle to escape from the mandibular fossa during the dislocation. CT is considered the imaging method of choice for assessing TMJ bone conditions and is superior to conventional radiography in visualizing structural lesions, even in cases without obvious bone lesions. The relevance of using CT was also highlighted by Talmaceanu et al. (2018), who state that CT allows detailed visualization of subtle anatomical features, such as the formation of the articular eminence, which may not be adequately detected by other imaging modalities.

The initial treatment of mandibular dislocation was carried out using the bimanual reduction maneuver, an effective conservative technique, especially in cases of acute dislocation (Liddell and Perez, 2015). Although the technique has proved effective in repositioning the mandible and relieving the pain associated with the dislocation, some authors report that, depending on the time and factors associated with the dislocation, such as those caused by macrotraumas, surgical interventions such as eminectomy and eminoplasty are necessary (Martins et al., 2014; Vasconcelos et al., 2014; Santos et al., 2022). Most cases reported were the result of car accidents and the condition had existed for at least 6 months. Another surgical approach also mentioned in the literature is the installation of mini bone plates, especially in cases of recurrent dislocation (Cardoso et al., 2005; Vasconcelos et al., 2009).

The use of auxiliary devices to stabilize the closing and opening arch after the reduction maneuver, such as occlusal splints, full and partial coverage, such as the Front Plateau, can be used (Okeson, 2019). Occlusal splints can be a good alternative for patients who have undergone treatment for chronic dislocations, as they allow the mandible to acquire an anatomically and physiologically correct position, stabilizing the temporomandibular joint and preventing recurrences (Al-Moraissi et al., 2020).

As noted in this report, a careful approach to cases of mandibular dislocation is necessary, because as described in the literature, minimally invasive treatment, such as the one adopted, is not always successful (Vasconcelos et al., 2014). In addition, it is essential to combine these approaches with counselling therapy on TMD and constant monitoring of the patient to assess the effectiveness of the treatment.

Conclusion

In this case, an anamnesis and detailed clinical examinations were essential in establishing the diagnostic hypothesis of mandibular dislocation and excluding recurrence of Bell's palsy. The use of CT was fundamental in confirming the diagnosis and establishing a specific treatment plan for the case. The bimanual mandibular dislocation reduction technique, followed using the Front Plateau and counselling therapy, contributed to greater mandibular stability, preventing recurrences of the condition. In addition, according to the patient's reports, there was a reduction in the pain that existed before treatment and an improvement in her self-esteem.

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