Dynamic Chiropractic

HEALTH & WELLNESS / LIFESTYLE

Silicone Breast Implants and Chronic Arthropathy of the Temporomandibular Joint

Breast implants have been associated with a broad spectrum of chronic arthroprathies, systemic illnesses and auto-immune phenomena. Despite the tremendous public attention devoted to this matter, few realize that the temporomandibular joint is one of the most commonly involved sites of chronic arthropthy.

What Do I Look for in My Patients?

First, always ask if a breast augmentation procedure has been performed. Then follow up by determining the type of material used. As most of the readers know, the silicone gel breast implant is the suspected offender.

Once this history is elicited, use a high degree of caution. There are numerous explanations other than silicone breast implants for the patient's complaint. Startling the patient and arousing fear when all the facts are not known is always an unwise course of action.

Next, elicit a careful and thorough history of the chief complaint, in this case complaints pertaining to the function of the jaw. Go back 10 or more years and slowly walk forward in time noting how all the changes in jaw function evolve.

After the History, What Examination Shall I Perform?

Hold on, not so fast. There is more work to do with the information obtained in the history. Once you are satisfied with the thoroughness of the history, compare the progression of the jaw symptoms to the time of the implant surgery.

If the jaw symptoms changed immediately after the surgery (within a year or less following the surgery) then you are going to take a course of action which is quite different that if the symptoms changed suddenly six or so years after the surgery.

Given these two scenarios, which one do you feel is the one most suspicious for temporomandibular joint arthropathy secondary to silicone gel breast augmentation? Is it the immediate onset scenario?

It is very important to understand why the answer to the above question is a strong no. As far as is known at this time, adverse reactions to silicone gel do not appear for many years. First, the gel sack has to break down, then the body has to go through the process of antibody reaction, all of which takes time. Therefore, it is understandable why various studies show that the mean time to the development of symptoms is 6.5 years or more.

Now that I clearly understand the circumstance of the patient, how do I follow up with an examination?

First, conduct a thorough temporomandibular joint examination such as we have discussed in numerous past articles. Do not jump to conclusions midway through the examination. Continue

collecting all the examination findings, looking always for the common etiologies of TM disorders.

Next, perform a thorough physical examination of the spine and extremities. Look for telltale signs of arthropathy. Also, carefully study the skin, eyes, mucous membranes, nails, and hair. Often telltale signs of connective tissue disease are readily apparent.

Okay, the Physical Examination of the Patient is Concluded. Now, Can I Make the Diagnosis?

Not yet. So far, all we have done is collect examination data and all this information is still in a rather raw state. One has to carefully sift through the data looking for clues which are pointing to silicone gel based arthropathy.

Suppose you find active synovitis involving one or both temporomandibular joints and left knee pain. Suppose also that the other findings are normal for the patient's lifestyle, work habits, age and sex. Here, proceed with the expectation that the synovitis is unrelated to the silicone gel implants. Keep in mind that synovitis is a very common complaint which arises from a wide variety of common causes. Initiate care based upon your findings no need to startle the patient with allegations of silicone gel reactions. Continue to monitor the patient over time.

On the other hand, suppose the patient reports with acute synovitis, multiple sites of extremity arthropathy and dry skin. If the patient also reports silicone gel augmentation surgery many years ago, then you have a rational basis to pursue arthropathy secondary to silicone exposure.

However, a word of caution is needed. Arousing the patient's fears prematurely is never a wise course of action. Get your ducks in a row. Raise your level of clinical suspicion well beyond the level of conjecture. Otherwise your patient may jump to a course of action which will do more harm than good. After all, remember the doctor's everlasting creed, "First, do no harm."

Next month we will discuss some of the clinical features of arthropathy secondary to silicone exposure.

With each article I encourage you to write the questions you may have, commentaries on patient care, or thoughts to share with your colleagues, to me at the following address:

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