Eminectomy Versus Eminoplasty in Treatment of Chronic Recurrent Temporomandibular Joint Dislocation.

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بِسْمِ ٱللَّهِ ٱلرَّحْمَٰنِ ٱلرَّحِيمِ

" وعلمك ما لم تكن تعلم وكان فضل الله عليك عظيماً"

صدق الله العظيم

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Introduction

Temporomandibular joint is classified as a ginglymoarthrodial joint which combines both a hinge action and gliding action. Embryologically it is derived from two blastomas: temporal blastomas, which forms the glenoid fossa and articular eminance, and the condylar, which forms the condyle of the mandible. The articular surface of the temporal bone consists of the articular tubercle anteriorly and mandibular fossa. The condyle of the mandible is rounded in an anteroposterior dimension, but resembles a narrow ellipsoid in its larger transverse dimension[1].

Temporomandibular joint (TMJ) dislocation is defined as an excessive forward movement of the condyle beyond the articular eminence with complete separation of the articular surfaces and fixation in that position[2,3].

The dislocation of mandibular condyle can be occurring in different positions: anterior, posterior, lateral, and superior according to the direction of the movement. Anterior dislocation occurs when the mandibular condyle moves anterior to the eminence. This is the most common situation, representing a pathologic forward extension of the normal translational movement of the condylar head. The posterior dislocation is mainly associated with a fracture of the anterior wall of the bony meatus of the ear or the base of the skull. Lateral dislocation of the condyle association mainly with fracture of the angle or body of the mandibule and it can be divided into two types the first one is, lateral subluxation and the second is a complete dislocation in which the condyle is forced laterally and then superiorly to enter the temporal space. Superior dislocation is associated with a fracture of the glenoid fossa, with displacement of the condyle into the middle cranial fossa[1].