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CASE REPORT

The use of PEEK as an occlusal splint in a patient with histaminosis: A case report

Julien Delrieu^{1,2} | Sabine Joniot¹ | Thierry Vergé¹ | Florent Destruhaut^{1,3} | Karim Nasr¹ | Thibault Canceill^{1,4} 

¹Université Paul Sabatier, Faculté de Chirurgie Dentaire, Hôpitaux de Toulouse, Toulouse, France

²Université Toulouse 2 Jean-Jaurès, UMR Education, Formation, Travail, Savoirs, Toulouse, France

³URU EvolSan, Université Toulouse III Paul Sabatier, Toulouse, France

⁴CIRIMAT, Université Toulouse III Paul Sabatier, CNRS, INPT, Faculté de Pharmacie, Toulouse, France

Correspondence

Thibault Canceill, UFR Odontologie, 3 chemin des Maraîchers 31400 Toulouse, France.

Email: thibault.canceill@univ-tlse3.fr

Abstract

Poly-(etheretherketone) (PEEK) began to be used in the field of odontology more than 10 years ago, especially in relation to the creation of removable partial dentures. Here we report the case of a 62 years old woman diagnosed with histamine intolerance (or histaminosis), who presented a very particular set of oral symptoms. She described a certain tingling, burning, and swelling of the mucous membranes. These symptoms seem to be linked with the wearing of a resin occlusal splint which was initially prescribed to compensate for the absence of a meniscus in the left temporomandibular joint of the patient. After a multidisciplinary concertation, it was decided to create a new splint with a resin-free material. For this reason, the production of a PEEK prosthesis was considered. Following the installation of the occlusal splint in the patient, and after clinical adjustments, she described the occlusion positioning as correct and a disappearance of the symptomatology. Mechanically, PEEK seems to have higher mechanical resistance than PMMA. Despite these characteristics, the use of PEEK still presents some limitations, especially concerning the overall aesthetic. Additionally, the prescription of the occlusal splint seems to be limited to patients who need special care. The case presented here thus confirms a new perspective concerning the use of PEEK as an occlusal splint.

KEYWORDS

case report, dental materials, histaminosis, occlusal splint, PEEK, poly-(etheretherketone)

1 | INTRODUCTION

Histamine intolerance (or histaminosis) is characterized by the impossibility for patients to break down their intake of histamine, a molecule found in many foods,

including fruits, vegetables, several fish or even certain meat.¹ The main cause mentioned in the literature to explain histamine intolerance is a deficiency in Diamine Oxidase (DAO),² one of the enzymes responsible for the metabolism of histamine,^{3,4} which leads to an

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accumulation of histamine in the blood.¹ The symptoms of this pathology are very similar to those of an allergic reaction. They affect the respiratory, circulatory and nervous systems, the skin barrier and also the digestive system with major gastrointestinal symptoms.^{5,6}

The management of these patients with special needs is necessarily multidisciplinary in order to limit the occurrence of symptoms and to manage them when they develop. The purpose of this case report is to present the design of a specific occlusal splint in a patient with histaminosis.

2 | CASE DESCRIPTION

Here we report the case of a 62-year-old woman who had been directed to our specialized consultation in order to investigate the potential allergies she may have developed to various dental materials.

This patient followed a complex 15 years medical course to try to explain her atypical symptomatology. From a general point of view, she has food intolerances to many fruits and vegetables. Without any apparent relation to these intolerances, she also suffers from chronic anal pruritus—according to the doctors already consulted. The itching and irritation may be temporary or more persistent depending on the day. The patient did not report alcohol or tobacco consumption; she regularly drank tea during the day. After multiple medical consultations, internal medicine specialists diagnosed the patient with histamine intolerance (or histaminosis). This disease links all the various symptoms together she had presented for many years. In the mouth, the patient describes symptoms of tingling, burning and swelling of the mucous membranes that were initially localized on the tongue and now also extend to the lingual floor. This symptomatology has been evolving since 2005, when a resin occlusal splint was made that the patient still wears, continuously during the day and discontinuously at night. The wearing of this stabilization splint is accompanied by the appearance of the symptoms, whereas its removal makes them disappear. Clinically, no oral mucosa showed any apparent symptom of erythema nor swelling.

The splint was initially prescribed to compensate for the absence of a meniscus in the left temporomandibular joint, which, together with the patient's recurrent cervical hernias, caused significant chronic pain. The absence of the meniscus was detected by magnetic resonance imaging in 2005 and has obviously not changed since. Regardless of the mucosal signs triggered by wearing the splint, its adjustment in a myo-centric position with an average thickness of 2 mm has always helped the woman to relieve her joint pain.



FIGURE 1 Panoramic X-ray of the patient performed during her first consultation in our dental unit

The patient's dental history included caries treatments in adolescence on teeth #16 and #46 which were treated endodontically, as were #24 and #35 later (Figure 1). The #16 has since undergone apical resection due to the presence of a periapical granuloma. The tooth #46 was extracted in the 2000's and replaced with an implant. Composite resins, of different ages due to their different radiolucency, are present on the maxillary incisors.

The oral manifestations presented by the patient during the wearing of her mouthpiece being evocative of a possible hypersensitivity reaction, complete skin prick-tests (SPT) were carried out in the allergology department of the hospital. These SPT, based on the injection of allergens extracts into the skin, constitute the most common and safe tests to determine a possible allergy⁷ but they did not reveal here any allergic-type reaction in the patient. As a result and after a multidisciplinary concertation with the internist, the allergologist and several odontologists, it was decided to make a new splint with a resin-free material. We wanted to use a biomaterial that would release as few monomers as possible and that would be totally different in nature from the resin used in the previous tray. Benli et al. showed that PEEK presented the best surface behavior in terms of wear and roughness, compared to materials considered hypoallergenic such as polyethyleneterephthalate or ethylene vinyl acetate.⁸ For this reason, and according to their recommendation in the conclusion, the production of a poly-(etheretherketone) (PEEK) prosthesis was considered. An impression of each arch and a recording of the patient's myocentric relationship were sufficient to prepare the design of the splint with the dental technician (Figure 2). We carried out registrations using irreversible hydrocolloids, but current CAD/CAM techniques would also have allowed for the recording of dental and mucosal surfaces for this type of treatment. The most common and easiest way for the prosthodontic lab to work with the material is to use digitized models and define the limits and shape of the future mouthpiece. This is then manufactured in a PEEK disc either in the laboratory or externally. Here, the settings chosen for the thickness of the splint

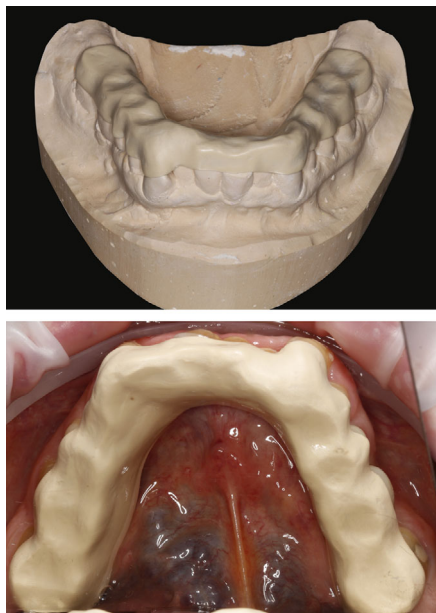


FIGURE 2 Photographs of the PEEK occlusal splint on the plaster cast (upper) and when placed in mouth (lower). It clearly appears that the PEEK splint is much more visible than one in transparent resin

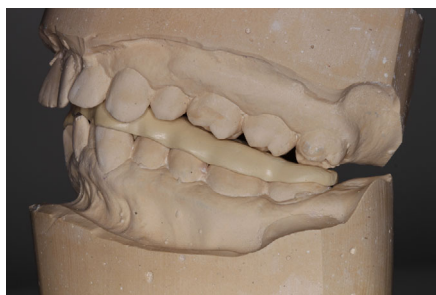


FIGURE 3 The high mechanical resistance of PEEK material enables to adapt its thickness in a patient with difficult occlusal context

(2 mm) were based on the one in resin that the patient was already wearing because it helped relieve her joint problems.

Following the installation of the occlusal splint in the patient, and after clinical adjustments, she described a good occlusion positioning (Figure 3) and a disappearance of the oral symptomatology that occurred when wearing the resin splint. We did not face any particular difficulties during the installation and modifications of the occlusal splint, the procedure being very similar to the installation of a resin one. The patient was seen again several times to modify the areas of contact between the splint and the mucosa. These were the only points that bothered her. During an exchange of medical documents with the patient by e-mail, she confirmed to us that she was able to wear her

mouthpiece every night and that she no longer had any oral symptoms, except for dietary reasons. To this day, the patient has been wearing the mouthpiece for more than a year and a half and her follow-up shows that her body has accepted it well. Further investigations on the treatment of her histaminosis are still underway.

3 | DISCUSSION

The case presented here confirms the perspective of using PEEK as an occlusal splint. This material is a semi-crystalline polyaromatic thermoplastic polymer which has been marketed in the industry since the early 1980's.⁹ Its first biomedical application was developed in the late 1990's¹⁰ as an alternative to metallic or ceramic medical devices in orthopedics or craniofacial reconstructive surgery. It has begun to be used in the field of odontology more than 10 years ago to create removable partial denture's basis, or several elements in implantology (fixtures abutments, healing screws).¹¹ This material is free of corrosion and radiolucent^{12,13} which offers an interesting perspective in comparison with metals.

Its biocompatibility brings PEEK closer to the other materials that can be implanted for an extended period of time in a patient. Bacterial adhesion to PEEK is considered as low and appears to be comparable to that of Titanium, Zirconia or PMMA.^{9,11} It is hypo-allergenic in the absence of monomers in its structure,^{14,15} so it may trigger far fewer hypersensitivity reactions than other polymers. Only two cases have already been reported concerning allergic reactions to this material since it is used in medicine.^{16,17} However, even if the biocompatibility of PEEK may seem attractive, its use in oral implantology may be limited by its bioinertia and its osseointegration capacity.¹⁸ There are two mainstream techniques to improve the bioactivity of PEEK: by incorporation of bioactive materials in the matrix or by surface chemical modification.^{18,19} Production and characterization processes are developing quickly and thus promise a profitable future for the material.

Its mechanical properties are even more interesting because in its natural state, that is, when it is not modified, PEEK shows a behavior close to natural hard tissue such as cortical bone and dentin.²⁰ With an elastic modulus close to 3.5-4GPa according to the majority of the studies,⁹ strength transmission to natural tissues can be envisaged without harmful effects. Indeed, the use of materials (either metallic or ceramic) with mechanical properties far removed from living tissue can lead to pathogenic effects, such as stress shielding.²¹ The reinforced versions of PEEK increase the elasticity modulus to a level close to that of cortical bone. This is especially true when the



FIGURE 4 The lingual side of the splint is particularly deep in order to stabilize the structure

material is modified by carbon or hydroxyapatite adjunction for example.¹⁹

The conception of a PEEK occlusal splint has only been described once in the literature by Wang et al. who have performed occlusal splints to treat sleep bruxism in patients.²² They chose to position the prosthesis on the upper jaw with an anterior fenestration to limit the esthetic disturbance.²² Mechanically, PEEK seems to have higher mechanical resistance than PMMA, particularly in traction, flexion and resilience.²³ Its surface hardness is close to that of PMMA,²⁴ which is interesting for a use in contact with the occlusal surfaces of teeth. Inflexion, PEEK is more rigid and less flexible than PMMA resins,²³ a property which will greatly limit the deformations that the material may undergo during insertion and removal of the prosthesis (here the splint). This is the reason why it is necessary to take great care not to place the material below the retentive lines of the teeth (buccal and lingual) with the material, which could hinder the removal of the splint by the patient. To compensate for the lack of stability that may result, our dental technician has created a deeper lingual margin (Figure 4). Because the patient was uncomfortable with the contact of this flange on the tongue-floor, we had to carefully reduce this part of the splint in order to avoid compromising its stability.

Despite these characteristics, the use of PEEK still presents some limitations and its indication for occlusal splint seems to be limited for instance to patients who need special care due to a particular health status.

First of all, it is not possible to repair it and thus to modify it by any adjunction process. That means that the slightest fracture will compel the dentist and its technician to make a new splint entirely. This limitation is however relative, insofar as the precision of PMMA splints does not allow for reparation in case of fractures. Moreover, the use of CAD/CAM could make it possible to manufacture a second splint. Depending on this property, the practitioner has to limit to a minimum the oral modi-

fications he may perform on the splint because it may weaken it and an adjunction of material will not be possible thereafter.

Then, as the material is not widely used—mainly as a substitute to metallic armatures on removable partial dentures—only a few dental technicians are equipped to work on the PEEK in their own lab. When a special request is made for a patient, unequipped technicians will delocalize their production to specific laboratories through a digital process and the delivery time of the device is extended.

Finally, PEEK material presents really poor aesthetic properties. Even if different shades exist, they remain opaque and unnatural. In the case we have presented above, the splint has a milky shade that contrasts a lot with natural and ceramic teeth. It was however not a problem for the patient as the splint relieved its symptomatology, but the matter may be of concern to other patients more discerning of the appearance of their prosthesis despite the fact that most splints are worn during sleep.

This very white color makes it a material that stains very easily with food pigments, especially in patients who drink tea or coffee without removing their mouthpiece. Once ingrained, these stains are complex to remove. Thus, the hygiene maintenance of PEEK prostheses should be very clearly specified to patients at all appointments.

4 | CONCLUSION

This case report confirms the interesting new indication for PEEK as an occlusal splint beyond the best-known uses for framework for removable partial dentures and abutments on implants. Even though all dental technicians are not yet equipped to work on this material, it will still be possible to subcontract the process. The possibility of using PEEK as splints will allow the dentists to treat all their patients, whatever their allergies or other health issues. Many people turning to highly specialized occlusion specialists are effectively in a therapeutic limbo unable to treat their oro-cranial pain. Ruling out allergies by using a hypoallergenic material can often be perceived as a welcome option by the patient.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICS STATEMENT

The present article does not present any research performed on humans nor on animals. The patient consent

has been obtained for publication of information and photos.

ORCID

Thibault Canceill  [https://orcid.org/0000-0002-0049-](https://orcid.org/0000-0002-0049-7622)

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