3 Miles I. *Adaptation to unemployment*. Science Policy Research Unit memo. Sussex: University of Sussex, 1983.
4 Warr P. Twelve questions about unemployment and health. In: Roberts B, Finnegan R, Gallie D, eds. *New approaches to economic life*. Manchester: Manchester University Press, 1985.
5 Jackson PR, Warr PB. Unemployment and psychological ill health: the moderating role of duration and age. *Psychol Med* 1984;14:605-14.
6 Fagin L, Little M. *The forsaken families*. Harmondsworth, Middlesex: Penguin, 1984.
7 Warr PB, Payne RL. Social class and reported changes in behaviour after job loss. *Journal of Applied Social Psychology* 1983;13:206-22.
8 Payne RL, Warr PB, Hartley J. Social class and the experience of unemployment. *Sociology of Health and Illness* 1984;6:152-74.
9 Stokes G. Work, unemployment, and leisure. *Leisure Studies* 1984;2:269-86.
10 Warr PB. A study of psychological well being. *Br J Psychol* 1978;69:111-21.
11 Daniel WW. *A national survey of the unemployed*. London: Political and Economic Planning Institute, 1974.
12 Brinkman C. Health problems and psychosocial strains of the unemployed. In: John J, Schwefel D, Zollner H, eds. *Influence of economic stability on health*. Berlin: Springer, 1983.
13 Warr PB, Parry G. Paid employment and women's psychological well being. *Psychol Bull* 1982;91:498-516.
14 Marsden D, Duff E. *Workless: some unemployed men and their families*. Harmondsworth, Middlesex: Penguin, 1975.
15 Salfield A, Durward L. "Coping but only just"—families' experience of pregnancy and childbearing on the dole. In: Durward L, ed. *Born unequal: perspectives on pregnancy and childbearing in unemployed families*. London: Maternity Alliance, 1985.
16 Fryer D, Payne R. Proactive behaviour in unemployment: findings and implications. *Leisure studies* 1984;3:273-95.
17 Warr P. Work, jobs, and unemployment. *Bulletin of the British Psychological Society* 1983;36:305-11.
18 Greenwood W. *Love on the dole*. London: Jonathan Cape, 1933.

Lesson of the Week

An unusual but easily treatable cause of dysphagia and dysarthria complicating stroke

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Dysphagia and dysarthria may complicate stroke and occur for various reasons. I report three patients being treated for stroke who developed dysarthria and dysphagia, the cause of which was misdiagnosed leading to delay in management in all and considerable morbidity in one.

Any patient with stroke who becomes dysarthric and dysphagic—particularly after receiving a muscle relaxant—should have the temporomandibular joints checked for possible dislocation

Case 1

A 33 year old woman who smoked 40 cigarettes a day developed left sided weakness of sudden onset. She had previously had two similar transient episodes, one affecting the right arm and speech, the other the left arm and leg. She denied any history of migraine and had never used oestrogen-containing preparations.

On examination she was agitated with a flaccid left hemiplegia. There was some increase in tone on the right with increased reflexes bilaterally, and both plantars were extensor. After sedation with parenteral diazepam computed tomography of the head showed bilateral cerebral infarctions with surrounding oedema. Next day she was dysarthric and having difficulty swallowing. Her mouth was held open and hypersalivation was noted. The tongue and palatal movements were thought abnormal, and in the presence of bilateral long tract signs pseudobulbar palsy was diagnosed. Her condition continued unchanged for four weeks, and despite enteral feeding she lost a considerable amount of weight.

Because of slow rehabilitation she was referred for long term care. Reassessment showed a thin woman with bilateral neurological signs and dysarthria and dysphagia. Movement of the tongue and palate was normal. Movement of the jaw was limited and the mouth was held open. *X* ray pictures of the temporomandibular joints showed bilateral dislocation. Reduction was achieved with parenteral diazepam and her swallowing and speech returned to normal. After three weeks' rehabilitation she was able to return home, still with evidence of bilateral cerebral damage but able to cope with activities required for daily living.

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Case 2

An 82 year old woman was found comatose with pinpoint pupils, neck stiffness, absent reflexes, and bilateral extensor plantar responses. A diagnosis of brain stem infarction was made. Twenty four hours later she had improved but was unable to speak or swallow and admission was therefore arranged. On arrival she was unable to speak or swallow and her mouth was persistently open. A diagnosis of brain stem infarct was made and she was observed overnight. We then noted that not only was her mouth held open but it could not be closed either passively or actively. Radiography of the temporomandibular joints showed bilateral dislocation and after reduction she was able to speak and swallow normally and returned home.

Case 3

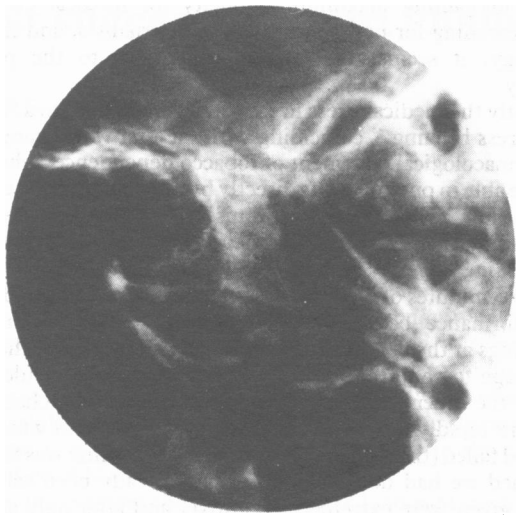
A 75 year old woman with a history of cerebral infarction and dementia was in hospital for continuing care. Five days after starting baclofen 5 mg three times a day she developed dysarthria and dysphasia. This in association with bilateral long tract signs led to a diagnosis of pseudobulbar palsy. When seen 48 hours later, however, it was apparent that movement of the jaw was limited and that she could not close her mouth and that her problems related to dislocation of the temporomandibular joints. This was confirmed radiologically and after treatment she regained her speech and swallowing abilities.

Discussion

Dysarthria and dysphagia after stroke are usually transient, being related to upper motor neurone face and tongue weakness associated with infarction of middle cerebral artery territory. If the brain stem is directly affected the dysarthria and dysphagia may be permanent.

Pseudobulbar palsy is uncommon after stroke unless superimposed on previous cerebral infarction.[1] Two of our patients had clinical evidence of bilateral cerebral infarction, and in one this was confirmed by computed tomography. The third patient had sustained a transient ischaemic attack in the posterior circulation territory with no evidence of diffuse cerebral damage.

Acute dislocation of the temporomandibular joint (figure) is not uncommon[2] and is managed relatively easily.[3-6] Longstanding dislocation is uncommon, since the associated disability usually leads to patients seeking early treatment. Cases are occasionally seen in the presence of communication difficulties or abnormal mental states.[7] The unsatisfactory nature of management of longstanding dislocation is reflected in the many different methods of management reported.[6]



Radiograph of a right temporomandibular joint showing complete dislocation.

Two of our patients sustained acute dislocations with delays of 12 and 24 hours before diagnosis and treatment. In case 1 the joints were dislocated for more than four weeks, but fortunately the dislocation was reduced without difficulty. There is no doubt that rehabilitation was considerably delayed. It may be important that days or hours before joint dislocation occurred two of the three patients had received agents used to control muscle spasticity. All three patients were misdiagnosed, and in two (cases 1 and 3) this related to an erroneous diagnosis of pseudobulbar palsy.

Careful assessment of temporomandibular joint function must be made in all patients with the combination of dysarthria and dysphagia after stroke to exclude dislocation, particularly when antispasticity agents have been used.

References

1 Walton JN. *Brain diseases of the nervous system*. Oxford: Oxford Medical Publications, 1979.
2 Fordyce GL. Long standing bilateral dislocation of the jaw. *Br J Oral Surg* 1965;2:222-5.
3 Stimson L. *Fractures and dislocations*. New York: Lea Bros, 1899.
4 Johnson WB. New method for reduction of acute dislocation of the temporo-mandibular joint. *Journal of Oral Surgery* 1958;6:501-4.
5 Hogan N, Nally F. Prolonged bilateral temporo-mandibular joint dislocation. *Irish Dental Review* 1964;10:40.
6 Littler BO. The role of local anaesthesia in the reduction of long standing dislocation of the temporo-mandibular joint. *Br J Oral Surg* 1980;18:81-5.
7 Rowe NL, Killey HC. *Fractures of the facial skeleton*. Edinburgh and London: Livingstone, 1968.

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Medicine and the Media

I FIRST welcomed the *Times Health Supplement* in 1982 and advised all doctors to read this weekly because "give the *THS* a couple of years, and 1984 will make you a barefooted doctor in its collectivist utopia" (*BMJ* 30 January 1982, p 342). After five months the *THS* was bought by Pergamon Press, to come out fortnightly as *The Health Services* from May 1982 to November 1983. It was reborn in September 1984 as *THS Health Summary*, a monthly briefing paper (annual subscription £49·50 to 32 King Henry's Road, London NW3). Each of the three *THS*'s has been edited brilliantly by Jill Turner. Although I have yet to meet a single clinician who has ever seen a copy of any *THS*, I shall try again to suggest why doctors should read it.

THS has columnists who put the several points of view of a general practitioner, a nurse, the private sector, alternative medicine, the Department of Health and Social Security, Mrs Renée Short, an administrator, and an authority chairman. Doctors are asked to change their attitudes and accountability (1983;**43**:20). The medical model is increasingly outdated and inappropriate for many health needs (1983;**31**:8). Healing happens despite medicine, whose role is to take the credit (1985;**31**:5). British medicine is ruled by arrogant (1985;II(V):1) middleaged men (1982;**27**:5) of particular class background and political inclinations (1985;II(VI):3). Women doctors have been indoctrinated into a subservient role from childhood onwards (1982;**27**:5). Nurses are still encouraged to be subservient and passive—docile and doting handmaidens of the doctors (1982;**31**:12-3), strictly ancillary ministering angels (1982; **25**:16)—reinforcing medical domination of health care (1982;**31**: 12-3).

Feelings of insecurity make doctors possessive about health (1985;**31**:5), act politically in their own professional interests (1982;**25**:14 and 1982;**27**:10), fear new perspectives (1982;**25**:14), test experimental drugs on patients without telling them they are guinea pigs (1982;**29**:2), refuse to give evidence after medical accidents (1982;**27**:5), and concentrate on high technology (1982; **38**:4), instead of the needs of the community (1982;**27**:10). Doctors are unwilling or unable to communicate with their patients: if people believe their doctors have not talked to them properly, then their doctors have not (1983;**47**:19).

Psychiatry is the happy hunting ground for the eccentric theorist (1982;**27**:8), who gives electroconvulsive therapy without a patient's consent (1982;**27**:4): medical freedom is a fine thing provided you are not a victim (1982;**27**:8). In the antenatal interview one partner is supine, pregnant, and half undressed, and the other is upright, male, and white coated (1982;**37**:19). Pathology laboratories are run by medical laboratory scientific officers (1982;**23**:21), consultants are non-persons. The old are told their difficulties are to be expected (1982;**23**:17). Yes, one country has a health care system deserving a panegyric—Hungary (1982;**27**:14-5).

In each issue over the years the goodies and baddies are the same. The goodies are still the leaders in primary care and community medicine, holists who understand the patient as a person, full of empathy and maintaining their patients' independence. The next level of sanctity includes health visitors, district nurses, and social workers, all of whom are well ahead of GPs in holism—perhaps because GPs still look up to the hospital doctor. The baddies are still the hospital doctors, reductionists who make the patients surrender