UNILATERAL IDIOPATHIC MASSETER ATROPHY A RARE ENTITY

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ABSTRACT
Unilateral atrophy of massager is rare as compared to masseter hypertrophy. We describe a patient who had asymptomatic thinning of left cheek. Magnetic resonance imaging (MRI) brain ruled out structural lesions, as well as confirmed the wasting of the masseter and pterygoids muscles. Bony changes of mandible associated with it indicate long standing pathology. Trigeminal neuropathy should be ruled out in isolated masseter atrophy.

Keywords: Maseter, Atrophy, Pterygoid, MRI

INTRODUCTION
Commonly facial hemiatrophy is seen in epilepsy, encephalitis or trigeminal neuropathy. This may be associated with atrophy of the skin, muscles and bone of one side of the face depending on the severity of the condition (Imarhiageoti, 2011). Unilateral isolated atrophy of massager, temporalis and medial pterygoids muscles comparatively are rare (Takamasa, 2000).

CASES

Figure 1: Profile of patient showing prominent masseter and temporalis wasting on left side

Figure 2: Coronal T2WI image at the level of ramus of mandible showing severe atrophy of the left masseter (black arrow) and pterygoid muscles (white arrow) with mild deformity of the left mandibular ramus as compared to right side.
We report a 25 year male who noticed progressive thinning of left cheek for last 5 yrs. Recently this thinning has become more obvious with some difficulty in chewing especially from left side. No sensory symptoms were present on the face. No history of birth injury/ dental malocclusion/ trauma/neurological illness/previous radiation received. Examination showed weakness and wasting of left temporalis, masseter and pterygoid muscles (Figure 1). Facial sensations were intact. Routine biochemistry blood tests are unremarkable. Serum creatinine phosphokinase was in normal range. Blink reflex test and the brainstem auditory evoked responses were normal. Electromyography showed no denervation changes in left masseter and left temporalis muscles but the motor unit potential were small. Magnetic resonance imaging (MRI) confirmed atrophy of masseter (black arrow) and pterygoid muscles (white arrow) as depicted in coronal T2WI (Figure 2), axial T1WI (Figure 3) and axial T2WI (Figure 4).
structural pathology. We assume this masseter atrophy in our patient seems to be congenital as the patient symptoms and wasting were noticed incidentally and of longstanding duration. Associated bony deformity of the mandibular ramus also supports congenital hypothesis. Management of masseteric atrophy is predominantly by rehabilitative techniques. In conditions where atrophy is secondary to temporomandibular joint ankylosis low dose corticosteroids may be given for short period. All efforts should be done to detect underling trigeminal neuropathy in a unexplained masseter atrophy (Chiba, 2012).

REFERENCES


