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Opinion

What I've Seen in My TMJ/TMD Practice Personally Examined Over 3,500 TMD Patients Over the Last 25 Years and Treated Most of them

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The Comment Below was Part of an Introduction for an Advanced Course in "Bite Equilabration Technique" Offered to Orthodontists

"Important Connection Between TMD and Orthodontia"

Conventional and even functional orthodontics share the same diagnostic dilemma as psychiatry, that is, they both do not have a diagnostic protocol to assess the baseline of patients before, during, and after treatment. The treatment objectives of orthodontics are admirable: straight teeth, a pretty smile, and functional temporo-mandibular joints. The one key component missing from the treatment objective equation is an occlusal cranial balance. The reason for this is that the orthodontic and dental profession does not know that they do not know that this component even exists. The only saving grace is the cranium's ability to adapt to the distortions created by orthodontic treatment. Patients and dentists alike do not connect the dots between the occlusal cranial distortions they have created and the symptoms of trigeminal Neuralgia, atypical facial pain, migraine and tension headaches, cervical, low back pain, and more."

Pilar Views Follow....

1. Many Patients Share the Same Issue

A) A surprising number of my female patients between the age of 17 and 32 have had one thing in common.

B) All have had orthodontic treatment; and after treatment completed, some patients are still wearing their initial orthodontic retainer for years.

C) As part of our initial exam most patients questioned never experienced their dentist asking them if they ever had headaches.

D) Most migraine and headache patients have seen neurologist before coming to me. From my diagnostic experience, hardly ever does the neurologist examine the head and neck muscles, nor ask the patient about symptoms usually related to TMD. Their interest is strictly in having MRI of brain taken so as to rule out tumor or vascular involvement. When tumors are ruled out, only treatment given is muscle relaxant pills and hope for the best.

E) Most TMJ/migraine patients I have examined have seen at least three to six medical professionals before coming to me. Those visited are Neurologist's, ENT's (ear, nose and throat), Primary Physicians, Pain Management doctors, Chiropractic, Physical Therapy, Cranial-Sacral, Acupuncture, and Massage Therapy.

F) Physicians look at patient symptoms as a disease entity not singularly or collectively as part of a dysfunction entity. Medication is the choice of treatment; not investigation for source. Initially, health professionals treat the patient symptom

as possible tissue, nerve or bone disease. These patient TMD symptoms range from tension/stress, to headaches & brain fog & dizziness condition, to sinusitis, to visual disturbances, to ear pain, to jaw joint noises to throat / eye muscle issues / to neck & shoulder muscle contracture / to sleep deprivation & resulting daily yawning. These symptoms gyrate up and down over months to years before patients respond medically.

G) Jaw joint dysfunction can be the result of genetic inheritance or environmental mishap or combination of both. The discomfort usually afflicting one side of the head first before the other side.

H) Constant Jaw joint complex dysfunctional abuse leads to inflammation of bone and tissue that lead to eventual degeneration of muscle tissue and bone.

I) TMD leads to muscle contracture of head and neck, which leads to disuse atrophy and major restrictive head and neck muscle movements

J) The patient is usually not aware of the TMD teeth clenching of upper teeth to lower teeth during their restless sleep periods.

K) The patient or the doctor is usually not aware of the connection of night time teeth clenching with dizziness, imbalance, ear congestion, ringing in the ears with potential hearing loss, and visual disruption.

L) The patient and doctor many times fail to connect the migraine to erratic clenching of back teeth during sleep; in many cases the imbalance of upper to lower back teeth at 160 lbs to 300 lbs vertical/lateral abnormal movements being the causative agent…along with the accompanying condyle displacement / The elevator muscles of the head notably the Lateral pterygoids in spasm along with the Tensor veli palatini muscles in joint spasm closing off the eustachian tube and produce middle ear involvement, etc….

M) Imbalance of teeth (uppers to lowers) can originate via:

1) Genetic inheritance of bone structure dictating erratic tooth position; or…

2) Environmentally created impact of whiplash accidents; or…

3) Faulty orthodontic intervention being a causative agent, when considering vertical and lateral movements of jaw are pre-determined during bone growth stage but now interfered with by orthodontic tooth movement to create a more esthetic alignment of teeth creating imbalanced tooth position, rather than normal jaw muscle control functioning with proper tooth position. This pre-determined re-positioning of teeth would be acceptable if a manual balancing of the teeth between uppers to lowers in all excursions under acceptable muscle condition were to be instituted prior to a full arch retainer being fitted.

To emphasize, jaw joint movements are directed either by:

1) Proper muscle control with normal bite,

or…

2) Poorly related teeth in faulty position to each other controlling jaw positioning and promoting night-time jaw clenching.

3) Jaw-joint mal-development sometimes creating joint dysfunction, and muscle and bone inflammation leading to progressive degeneration.

For Migraine Prevention…

in my estimation, the only appliance that can effectively treat migraines and basic TMJ dysfunction is an anterior deprogramming orthotic device for the prophylactic treatment of medically diagnosed migraine pain and migraine associated tension headaches; and for the prevention of bruxism and TMJ syndrome by reducing trigeminally innervated muscular activity. Upper anterior orthotic is favored over lower orthotic based on greater surface area support.

With this appliance in place we also reduce the muscle stress that normally occurs with posterior clenching from the aggressive 160 pounds up to 300 pounds of pressure on posterior occlusion to 20 lbs of acceptable pressure on anterior occlusion, resulting in 50% reduced masseter muscle stress and 70% reduced Temporal muscle stress. No pills can accomplish that.

The Pilar orthotic is a deprograming stabilizing oral devise. It is fabricated chair-side with much detail resulting in a perfect fit controlling necessary joint movements in all directions. A laboratory processed orthotic will not have all the critical clinical refinements necessary for treatment success. For a dentist to refine a laboratory processed orthotic in "re-fitting and adjusting" is akin to you starting from scratch with border limitations that might not apply, it doesn't work.

The one-time belief that migraines are a primarily a vascular phenomenon is no longer viable. Today, most theories on the causes of migraines now include a trigeminal pathway, and cite the common peri-cranial muscular tenderness in migraine sufferers. There still exists a lack of objective evidence for a causative element for migraine pain, keeping the healthcare industry from isolating an acceptable means of prevention. I maintain along with my colleagues that Migraine/Tension Headache is not part of a disease entity as suggested by many of the health profession, unless we are dealing with a potential brain tumor or isolated vascular issue; it is a symptom of an underlying source. We address that source. Tension/stress & excess emotion is certainly part of the negative process along with the fact that 85% of the TMD affected population are woman.

TOO BAD… THEY SHOULD ALL KNOW ABOUT THE ANTERIOR DEPROGRAMING ORTHOTIC.

Acknowledgement

None.

Conflict of Interest

No conflict of interest.