Screening Techniques for the TMJ/D Patient

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PART one of this TMJ/D series (AUSTRALASIAN DENTIST: Nov-Dec 2016), included discussion regarding evidence that the medical profession was aware of issues caused by disturbed function of the temporomandibular joint in the mid-20th century. In fact, in an Australian Dental Journal article published in 1959, Dr G. Wing wrote:

“As is well known, Costen’s Syndrome is a set of symptoms associated with disturbed function of the temporomandibular joint.

This syndrome which received formal status in 1934, following observations made by Costen, has as its basis a disturbed function of the temporomandibular joint, following the loss of molar support with an associated increased overbite and decreased vertical dimension, producing abnormal ear and head conditions.

Whether or not there is a specific syndrome as described by Costen is being debated. Nevertheless, it is inarguable that detangements in the oral cavity, especially in the occlusion, may lead to mechanical and neurologic symptoms and signs. It is the recognition of the relationship, rather than the specific terminology which is of cardinal importance.”

Unfortunately for suffering patients, physicians Costen and Sicher spent years engaged in academic debate, which rather than shed light on the syndrome, only succeeded in shrouding it in more mystery and resulted in treatment limitations still evident today. During this debate, Sicher came closest to demystifying the TMJ/D issue in a 1955 article published in the Journal of the American Dental Association.

According to Dr Wing:

“Sicher regards most of the extra-articular pain as being due to pain caused by muscle spasms. This is in accordance with the work of Schwartz who regards muscles as being the main source of pain and he considers that temporomandibular joint pain may be due to a painful, self-perpetuating spasm of the muscles of mastication.”

The conclusion drawn by Wing in his 1959 ADA article was that “the important thing is our ability as dentists to be able...
to correctly recognise and treat, but above all prevent the symptoms associated with dysfunction of the temporomandibular joint.2,3

This was later confirmed by Dr Janet Travell, who mapped the pain referral patterns of the crano-mandibular musculature and illustrated the perpetuating pain produced by the “trigger points” (TrP) in chronically “overloaded” or over stimulated muscles.

In her textbook, titled Myofascial Pain and Dysfunction – The Trigger Point Manual, she wrote:

“When an acute myofascial TrP syndrome is neglected and allowed to become chronic, it becomes unnecessarily complicated, more painful, and becomes increasingly time-consuming, frustrating, and expensive to treat.”

Dr Travell concludes; “Diagnosis and treatment of acute single-muscle myofascial pain syndromes can be simple and easy.” 4

While debate still smolders regarding the cause and prevalence of TMJ Disorder, as well as sleep disorders, with claims ranging from 25-60%, there is no argument that there is a lack of attention given to the screening and evaluation of patients suffering daily from pain associated with TMJ/D. In fact, very few medical or dental practitioners are equipped with effective screening methods that can efficiently fit into daily practice routine.

Dysfunction of the jaw joints affects a large proportion of the population globally. Furthermore, because the wide range of symptoms can make it difficult to establish a correct diagnosis and therefore, an appropriate treatment plan. Most suffering patients go un-diagnosed or are treated incorrectly. Often, in search of relief, these patients will visit one health care professional after another without ever obtaining treatment from their symptoms, until they eventually learn to live with their painful problems. Thus, due to the prevalence of jaw joint problems in the general population today, there is a need for effective screening protocols to be included in every dental practice and become a regular component of routine dental check-ups for all patients. To ensure our patients’ pain free future, the onus is on health care providers to start screening early, before the symptoms become harder to treat.

The first step in an effective screening and evaluation procedure is the recognition of the prevalence of TMJ/D in your practice. This can be put to the test in your own practice during an efficient screening process, by completing the following steps:

1: Understanding how a TMJ patient might present themselves in the dental practice

Most patients attending a dental practice do not associate their symptoms with the dental profession. Therefore, as a routine examination just ask:

a. Do you suffer from the GROUP of symptoms?
   - Headaches
   - Neck pain
   - Jaw clicking or pain
   - Ear symptoms
   - Snoring or disturbed sleep

If the patient answers yes to each of these questions, there is a possibility they experience a TMJ/D.

b. How long have you experienced these symptoms?
   - 1 year
   - 5 years
   - More than 10 years.

If the symptoms have persisted long-term there is a strong likelihood the patient suffers from TMJ/D.

c. What treatments have you had?

d. Have any been successful?

If treatments have not been successful, you have a positive for TMJ/D and should proceed to STEP 2

2: Myofunctional Research Co.

Visual TMJ/D questionnaire.
(request PDF from info@myoresearch.com)

It is important to remember, you are looking for a multiple symptom pattern, not just a clicking joint that requires fixing. Additionally, while often easier, it is insufficient to attribute or dismiss all the symptoms as the result of bruxing.

If the cause of the pain is indeed TMJ dysfunction, many of the groups of symptoms below will be present. The following visual questionnaire will help to decide if TMJ treatment will alleviate the patient’s painful situation.

 Undertaking just these two steps, which require very little time, will provide...
a strong indication of how many patients in your practice are suffering the symptoms of TMJ/D. Many of these patients will have experienced chronic severe symptoms for years and sought relief from multiple medical practitioners. Understandably, they will not be interested in answering lengthy questionnaires nor in complex explanations for their multiple symptoms.

Because symptoms tend to vary between patients and may present in varying forms, establishing an official diagnosis can be difficult when looking at TMJ Disorders.

3: Diagnosing TMJ Disorders
The following information will facilitate a practitioner in correctly diagnosing a patient for TMJ Disorders:

a. Detailed medical history (much of this you will have already)
b. Previous health practitioners consulted
c. Three main complaints – Ask the patient which issues are the most distressing (i.e. what irritates you the most of these complaints)
d. How long the symptoms have been apparent?
e. Are these symptoms triggered by anything?

4: Muscle Palpation
In the text, Myofascial Pain and Dysfunction, The Trigger Point Manual, Dr. Janet Travell identifies the basic muscles that form the primary source of pain.4 Pressing on various parts of these craniomandibular muscles is useful to identify pain, as well as painful trigger points.

Palpate the following muscles (see video on myoresearch.com for palpation guide):

a. Temporalis Masseter Lateral Pterygoids Sternoclidomastoid
b. Trapezius Posterior Cervicals (checking for clicking or pain in the TM joint)

The questions and patient examination procedures outlined above provide an effective and efficient backbone of the protocols required to screen, identify and diagnose the patients in your practice who experience symptoms caused by TMJ/D. Implementing these protocols into the practice provides a means of helping our patients become pain free and, as we all know, a patient in pain is generally a pain for everyone. Therefore, with the tools at hand, there is no reason not to start screening all your patients today.

The next part in this TMJ/D series will focus on education and record taking for the patient with TMJ and SRB disorder.

REFERENCES