

AADR TMD Policy Statement Revision
Approved by AADR Council 3/3/2010.

For citation: <http://www.aadronline.org/i4a/pages/index.cfm?pageid=3465> followed by date.

The AADR recognizes that temporomandibular disorders (TMDs) encompass a group of musculoskeletal and neuromuscular conditions that involve the temporomandibular joints (TMJs), the masticatory muscles, and all associated tissues. The signs and symptoms associated with these disorders are diverse, and may include difficulties with chewing, speaking, and other orofacial functions. They also are frequently associated with acute or persistent pain, and the patients often suffer from other painful disorders (comorbidities). The chronic forms of TMD pain may lead to absence from or impairment of work or social interactions, resulting in an overall reduction in the quality of life.

Based on the evidence from clinical trials as well as experimental and epidemiologic studies:

- 1) It is recommended that the differential diagnosis of TMDs or related orofacial pain conditions should be based primarily on information obtained from the patient's history, clinical examination, and when indicated TMJ radiology or other imaging procedures. The choice of adjunctive diagnostic procedures should be based upon published, peer-reviewed data showing diagnostic efficacy and safety. However, the consensus of recent scientific literature about currently available technological diagnostic devices for TMDs is that, except for various imaging modalities, none of them shows the sensitivity and specificity required to separate normal subjects from TMD patients or to distinguish among TMD subgroups. Currently, standard medical diagnostic or laboratory tests that are used for evaluating similar orthopedic, rheumatological and neurological disorders may also be utilized when indicated with TMD patients. In addition, various standardized and validated psychometric tests may be used to assess the psychosocial dimensions of each patient's TMD problem.
- 2) It is strongly recommended that, unless there are specific and justifiable indications to the contrary, treatment of TMD patients initially should be based on the use of conservative, reversible and evidence-based therapeutic modalities. Studies of the natural history of many TMDs suggest that they tend to improve or resolve over time. While no specific therapies have been proven to be uniformly effective, many of the conservative modalities have proven to be at least as effective in providing symptomatic relief as most forms of invasive treatment. Because those modalities do not produce irreversible changes, they present much less risk of producing harm. Professional treatment should be augmented with a home care program, in which patients are taught about their disorder and how to manage their symptoms.

References

- 1) de Leeuw R, Klasser GD, Albuquerque RJ. Are female patients with orofacial pain medically compromised? *J Am Dent Assoc* 2005;136(4):459-68.
- 2) Diatchenko L, Nackley AG, Tchivileva IE, Shabalina SA, Maixner W. Genetic architecture of human pain perception. *Trends Genet* 2007;23(12):605-13.
- 3) Sessle BJ. Sensory and motor neurophysiology of the TMJ. In: Laskin DM, Greene CS, Hylander WL, eds. *Temporomandibular Disorders: An Evidence-Based Approach to Diagnosis and Treatment*. Chicago: Quintessence; 2006. p. 69-88.
- 4) Reissmann DR, John MT, Schierz O, Wassell RW. Functional and psychosocial impact related to specific temporomandibular disorder diagnoses. *J Dent* 2007 Aug;35(8):643-50.
- 5) Klasser GD, Okeson JP. The clinical usefulness of surface electromyography in the diagnosis and treatment of temporomandibular disorders. *J Am Dent Assoc*. 2006;137(6):763-71.
- 6) Suvinen TI, Kempainen P. Review of clinical EMG studies related to muscle and occlusal factors in healthy and TMD subjects. *J Oral Rehabil* 2007;34(9):631-44.
- 7) Greene CS. The Role of Technology in TMD Diagnosis. In Laskin DM, Greene CS, Hylander WL (Eds). *TMDs - An Evidence-Based Approach to Diagnosis and Treatment*. Chicago, Quintessence Publishing Co, 2006, pp 193-202.
- 8) Greene CS, Laskin DM. Temporomandibular disorders: moving from a dentally based to a medically based model. *J Dent Res* 2000;79(10):1736-9.
- 9) Truelove E. Role of oral medicine in the teaching of temporomandibular disorders and orofacial pain. *J Orofac Pain* 2002;16(3):185-90.
- 10) Dworkin SF, Massoth DL. Temporomandibular disorders and chronic pain: disease or illness? *J Prosthet Dent* 1994;72(1):29-38.
- 11) Carlson CR. Psychological considerations for chronic orofacial pain. *Oral Maxillofac Surg Clin North Am* 2008;20(2):185-95.
- 12) Lindroth JE, Schmidt JE, Carlson CR. A comparison between masticatory muscle pain patients and intracapsular pain patients on behavioral and psychosocial domains. *J Orofac Pain* 2002;16(4):277-83.
- 13) American Academy of Orofacial Pain. *Temporomandibular Disorders*. In: de Leeuw R, ed. *Orofacial Pain: Guidelines for Assessment, Diagnosis and Management*. Chicago: Quintessence; 2008.

- 14) Stohler CS, Zarb GA. On the management of temporomandibular disorders: a plea for a low-tech, high-prudence therapeutic approach. *J Orofac Pain* 1999;13(4):255-61.
- 15) Fricton J. Myogenous temporomandibular disorders: diagnostic and management considerations. *Dent Clin North Am* 2007;51(1):61-83.
- 16) Okeson JP. Joint intracapsular disorders: diagnostic and nonsurgical management considerations. *Dent Clin North Am* 2007;51(1):85-103.
- 17) Carlson CR, Bertrand PM, Ehrlich AD, Maxwell AW, Burton RG. Physical self-regulation training for the management of temporomandibular disorders. *J Orofac Pain* 2001;15(1):47-55.
- 18) Dworkin SF, Huggins KH, Wilson L, Mancl L, Turner J, Massoth D, LeResche L, Truelove E. A randomized clinical trial using research diagnostic criteria for temporomandibular disorders-axis II to target clinic cases for a tailored self-care TMD treatment program. *J Orofac Pain* 2002;16(1):48-63.