Lake Pontchartrain Study Club 2025

John R Droter DDS
Annapolis, Maryland

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Hello. I am:

John R Droter DDS
Annapolis, Maryland

Milestones

Visiting Faculty LD Pankey Institute 2008-

Visiting Faculty Spear Education 2013-2020

Visiting Faculty Orthodontic Program
Washington Hospital Center 2000-2012

Past staff AAMC: Orthopedic Rounds
In OR for TMJ Surgeries

Devoted Facial Pain Practice 1996
(No Hygiene to Check!!)

CT and MRI Imaging Joints 1992
Guy Haddix, DDS: Mentor
(3,000+ images and rising)

Post Grad CE- GPR, LD Pankey Institute, Dawson, Mahan, Gremillion, Spear, Kois

Facial Pain Diagnosis

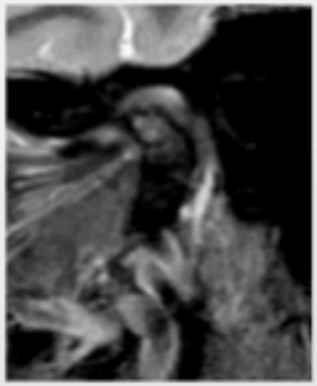
Diagnostic Tools

1 Written and Oral History
2 Observation
3 Physical Exam
- Muscle Palpation
- Joint Palpation
- Joint Auscultation
- Joint Motion

4 Anterior Stop Test
5 Sleep Airway Screening
6 CT Scan
MRI
Blood Tests

Occlusion: CR Mounted Study Models
Complete Dental Exam
Clinical Photographs
Dx Blocks
Dx Orthotics- Brux Checker, CR Orthotic

<u>Biometrics</u>
Joint Vibration
Jaw Tracker
Electromyography
T-Scan

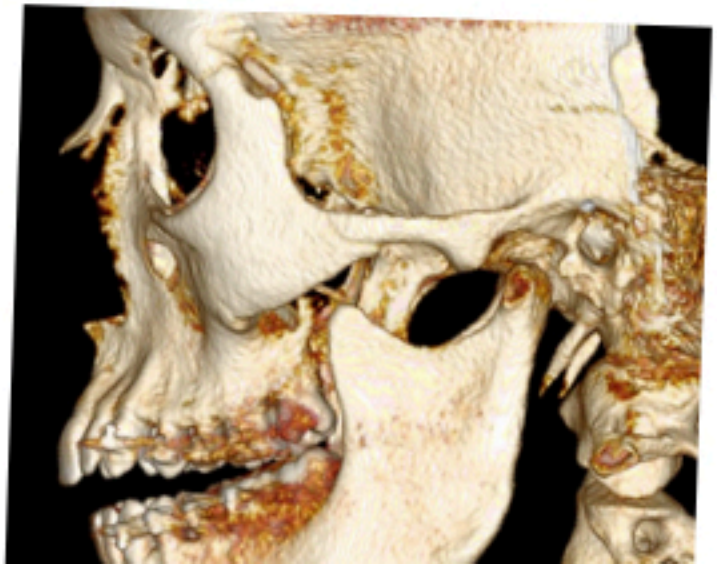


Lingual Light Wire- Crozat Arch Expansion

Age 29 Start

7 months LLW Age 30

Anterior Openbite Non Surgical Treatment: Moving the Maxilla



Restorative Dentistry

Pathological Occlusion

??Airway Related Bruxing?

Restore Function

Composite Trial Occlusion

AHI + 26 CPAP

Anterior guidance

or group function?

TMD Therapies: (70 therapies)

Physical

Ice
Hot Cold Hot
Cold Laser
TENS in office
TENS home use
Range of motion exercises
Active Stretching: Manual, Tongue Blades, Dynasplint
Refer to Physical Therapy: Rocabado mobilization
Refer to Physical Therapy: Postural Restoration Therapy
Refer to Physical Therapy: Various Muscle Therapies
Refer to Chiropractic: Atlas Orthogonist
Refer to Osteopathic MD: Body alignment
Breathe, Walk , Exercise

Brux Checker
Upper full coverage hard CR guard
BiArch Posterior Deprogrammer
Mandibular Advancement Device
Lateral Bruxing Device
Lingual Light Wire
Condylar Distraction

Medicinal

Anti Inflammatory:
NSAIDs,
Doxycycline low dose
CBD Topical
Glucosamine/Chondroitin MSM
Vitamins: Vit C, Vit D, Vit B12
Minerals: Magnesium, Electrolytes
Minerals: Iron
Refer to MD for Lyme therapies
Refer to MD Rheumatoid Arthritis therapies
Refer Botox Masseter injections
Refer Botox Lateral Pterygoid Injections
Food

Occlusal Orthopedic

Lingual Light Wire
Planas Tracks
Lower soft sectional orthotic
Sectional orthodontics
Expansion orthopedics/ orthodontics
Restorative Dentistry
Occlusal Adjustment with DTR, TekScan
Condylar distraction
Occlusal Adaptation

Tongue Parafunction

Refer for Cervical Alignment/ Stabilization
Myobrace
Upper Lingual light wire
Clear Brux Checker
Frenectomy
Myofunctional therapy

Dental Orthotics

In Office Trial Anterior Stop
Temporary home use anterior stop
Diagnostic Palatal Anterior Stop
Brux-PAS
Lower full coverage CR
Lower posterior deprogrammer
Lower TMJ Rehab flat plane
Lower Indexed
Brux Checker

Upper full coverage hard CR
Posterior Stop Night Guard
Mandibular Advancement Device
Anterior Stop Airway Bite
Lateral Bruxing Device
Condylar Distraction
Lingual Light Wire
Lower Soft Sectional

Athletic Mouthguard
Anterior Repositioning
Occlusal Adjust Assist
Aqualizer
Myobrace

Sleep/ Fatigue

Mouth taping
Diet Modification
Positional Therapy
Vitamins: Vitamin D, Vitamin B12, Vit C
Minerals: Magnesium, Iron
Lateral Bruxing Device guided plane
Lateral Bruxing Device Elastomeric
Mandibular Advancement Device
CPAP

Surgical

Refer: Arthrocentesis w/ PRP
Refer: Discectomy w/ Fat Graft
Refer: Total Joint Replacement
Refer: Orthognathic Surgery

TMDs- What are the choices? (190 Diagnoses, 7 Categories)

1. TMJ Damage

Adhesions and ankylosis of temporomandibular joint
Avascular Necrosis Mandibular Condyle
Cartilage Fibrillation, Mandibular Condyle, Fossa
Closed Lock, Jaw Cartilage, Acute
Closed Lock, Jaw Cartilage, Chronic
Closed Lock, Jaw Cartilage, Intermittent, Mechanically dysfunctional
Crush Injury Mandibular Condyle
Crystal arthropathy, unspecified, TMJ
Dislocation jaw cartilage due to Injury, Sequela
Dislocation jaw cartilage with reduction, favorable adaptation, TMJ
Dislocation jaw cartilage without reduction, favorable adaptation, TMJ
Effusion, TMJ
Impingement Retrodiscal Tissue
Inflammatory Tissue Bone Resorption, TMJ Condyle
Loose Body (Joint Mice), TMJ
Malignant neoplasm of bones of skull and face
Open Lock TMJ, Recurring
Osteoarthritis TMJ, active degeneration
Osteoarthrosis- Inactive
Osteochondritis Dissecans TMJ
Osteolysis Mandibular Condyle, Active
Perforation Meniscus, TMJ
Perforation Pseudodisc, TMJ
Psoriatic Arthritis TMJ
Rheumatoid Arthritis Sero Negative TMJ
Synovitis

2. Muscles of the TMJ

Dystonia
Habitual posture forward mandible
Hemifacial Muscle spasm
Inhibitory Reflex Dysfunction, Periodontal Ligament Masseter Muscle
Muscle Atrophy, TMJ
Muscle Bracing Neck Stabilization
Muscle Bracing Pain Avoidance
Muscle Bracing TMJ stabilization
Muscle Bracing Airway **Patency** (with Tongue)
Muscle Contracture Fibrosis Lateral Pterygoid
Muscle Contracture Fibrosis Masseter, Medial Pterygoid, Temporalis
Muscle Fatigue Overuse
Muscle Hypertrophy TMJ Muscles

3. Cranial Alignment/Occlusion

Cranial Distortion / Misalignment
Hemifacial Hypoplasia
Hyper Occlusal Awareness
Iatrogenic Orthotic Damage
Malocclusion Anterior Open Bite
Malocclusion Centric occlusion MaxIC discrepancy
Malocclusion Deep Bite
Malocclusion due to mouth breathing
Malocclusion due to TMJ bone loss
Malocclusion due to tongue, lip or finger habits
Malocclusion Insufficient anterior occlusal guidance
Malocclusion lack of posterior occlusal support
Malocclusion Posterior Openbite Bilateral
Malocclusion Posterior Openbite Unilateral
Malocclusion unspecified
Malposition /Misalignment: Maxilla, Temporal Bone, Mandible
Mandibular asymmetry
Mandibular hyperplasia
Mandibular hypoplasia
Mandibular Retrognathia
Maxillary asymmetry
Maxillary hyperplasia
Maxillary hypoplasia
Maxillary Retrognathia
Occlusal Adaptation, Favorable
Occlusal Dependency for Joint Stabilization/ Proprioception
Tooth Intrusion
Tooth Supereruption

4. Cervical Damage

Cervical Vertebrae Alignment Dysfunction
Craniocranial Syndrome
Muscle Guarding due Neck Instability
Trigger Point Neck Muscle with Referred Pain
Trigger Point Neck Muscle, Localized Pain

5. Parafunction

Excessive Tooth Wear, Damage
Hypersensitive Occlusion
Parafunctional Clenching Teeth, Awake
Parafunctional Clenching Teeth, Sleep
Parafunctional Grinding Teeth, Awake
Parafunctional Grinding Teeth, Sleep
Parafunctional Clench/Grind Wiggle
Parafunctional Tongue Bracing avoiding uncomfortable tooth contact
Parafunctional Tongue Bracing Neck stabilization
Parafunctional Tongue Bracing to maintain Airway
Parafunctional Tongue Bracing unknown cause

6. Whole Body / Systemic

Lyme Disease Arthritis
Magnesium Deficiency
Obstructive Sleep Apnea
Osteoporosis without current pathological fracture
Pathological Habitual Movement Pattern
Postural Disharmony Standing
Postural Disharmony Walking
Postural Forward Head Position
Upper Airway Resistance, UARS

7. Other

Nerve Entrapment Masseteric Nerve due to Masseteric hypertonicity
Neuroma Trigeminal Nerve
Obsessive-Compulsive Personality Disorder
Other
Otitis Ear Infection
Pain disorder exclusively related to psychological factors. Somatoform pain disorder
Pain disorder with related psychological factors
Peripheral Sensitization

Different Diagnoses have Different Therapies

Specific Diagnosis

TMDs- What are the choices? (190 Diagnoses, 7 Categories)

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3. Cranial Alignment/Occlusion
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70

Disclosures:

Atomic Skis- Sponsored.
I got stuff.

LD Pankey Institute TMD Course
Honorarium

Co-Owner of ArrowPath Sleep
Patent on sleep device: LatBrux

APS
ArrowPath Sleep

Living Tree Dental Lab
High Quality Dental Orthotics
License fee on my designs

LIVING TREE
DENTAL LAB

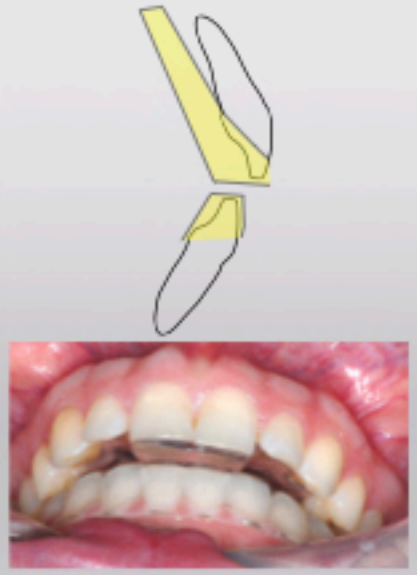
Ski Coach for National Ski Patrol
Level 3 Certified Professional Ski Instructors of America

Living Tree Dental Lab
(865) 509-4509
connect@livingtreelab.com

3D Printed Orthotics

D-PAS
Diagnostic-
Palatal Anterior Stop

Brux-PAS
with lower Essix



Hard Lower Posterior Stop
with upper essix

Hard Lower Full Coverage
Centric Relation Orthotic

TMJ/TMD Confusion

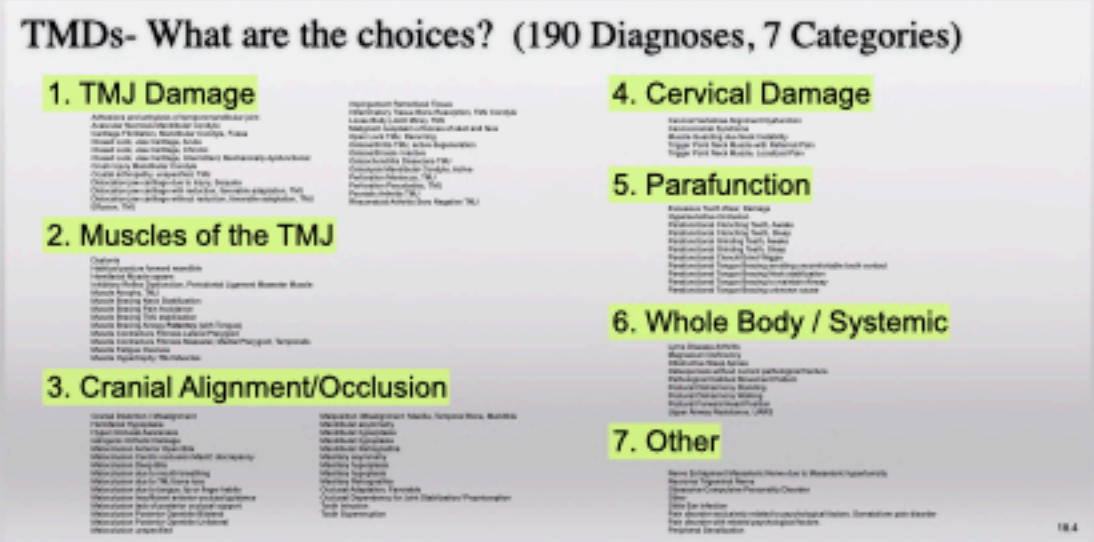
Dogmatic Arguments

Why Confusion?

Not One Disease

Temporomandibular Disorders (TMD) is an umbrella term covering any condition causing pain or dysfunction in the temporomandibular joint, muscles of mastication, trigeminal nerve, facial nerve, and associated head and neck musculoskeletal and neural structures.

190+ Different Diseases



The Diagnostic Process

When diagnosing and treating facial pain,
we have entered the world of medicine.

Think!!

Differential Diagnosis
All the choices

Diagnostic tests (Observations)
Narrow down the choices

Working Diagnosis
Treating as if

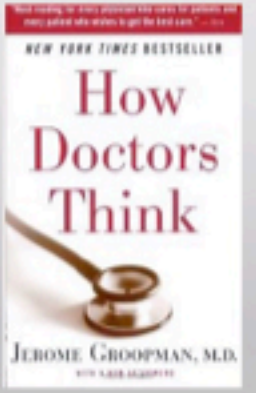
Not completely resolved

Final Diagnosis
Only after problem resolved

Always make a differential diagnostic list
Ask, " It appears to be this, but what else could it be?
Be aware you are blinded by your beliefs

Differential Diagnosis
Diagnostic Boxes: Pattern Recognition

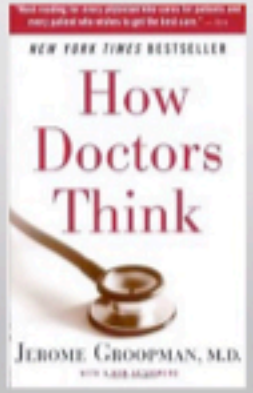
"My Tooth Hurts"



Differential Diagnosis
Diagnostic Boxes: Pattern Recognition

"My Tooth Hurts"

- Reversible Pulpitis secondary to caries
- Irreversible Pulpitis secondary to caries
- Pulpitis secondary to split tooth
- Pulpal necrosis
- Referred Pain from Muscle Trigger Point
- Sinus Infection
- Sympathetic Mediated Pain
- Neuroma
- Periodontal Infection
- Inflamed Tissue secondary to popcorn husk
- Aphthous Ulcer
- Periodontal ligament inflammation secondary to Occlusal Trauma
- Pulpits secondary to Occlusal Trauma
- Other

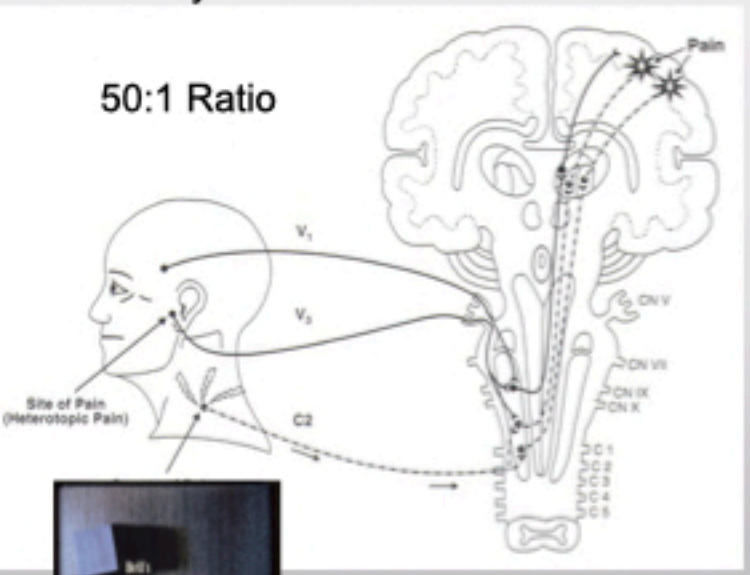


Referred Pain

Convergence

More primary sensory neurons than secondary neurons that travel to brain

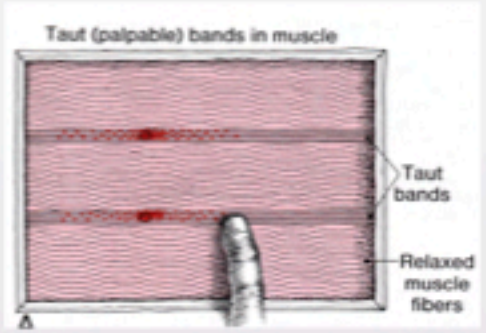
50:1 Ratio

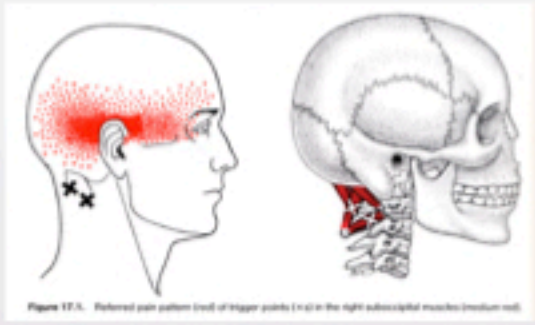


"Bells Orofacial Pain"
Jefery Okeson

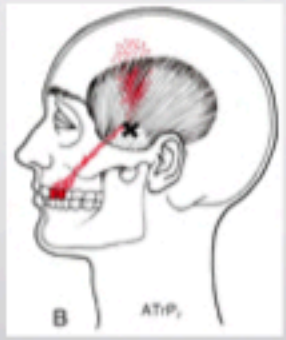
Trigger Points

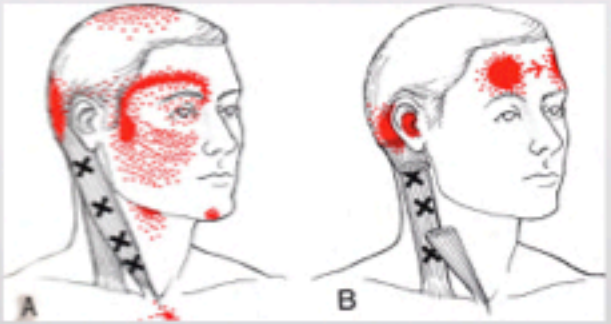
Contracted mass of actin, myosin and histamine

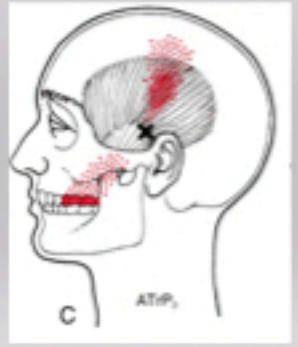


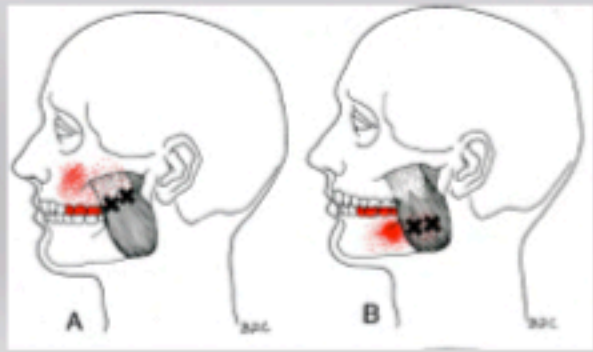


"The Trigger Point Manual"
Janet Travell, MD









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- Periodontal Infection
- Inflamed Tissue secondary to popcorn husk
- Aphthous Ulcer

- Periodontal ligament inflammation secondary to Occlusal Trauma
- Pulpits secondary to Occlusal Trauma
- Other

"How Doctors Think", by Jerome E. Groopman

Diagnose by Pattern Recognition
Tendency to make patients fit what we know
Ignore signs and symptoms that do not fit

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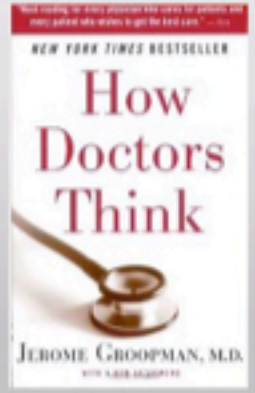

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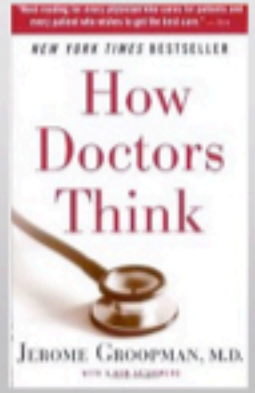

Different Diagnoses have Different Therapies

Specific Diagnosis

TMDs- What are the choices? (190 Diagnoses, 7 Categories)

1. TMJ Damage
2. Muscles of the TMJ
3. Cranial Alignment/Occlusion
4. Cervical Damage
5. Parafunction
6. Whole Body / Systemic
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Common TMDs

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6 Common TMDs

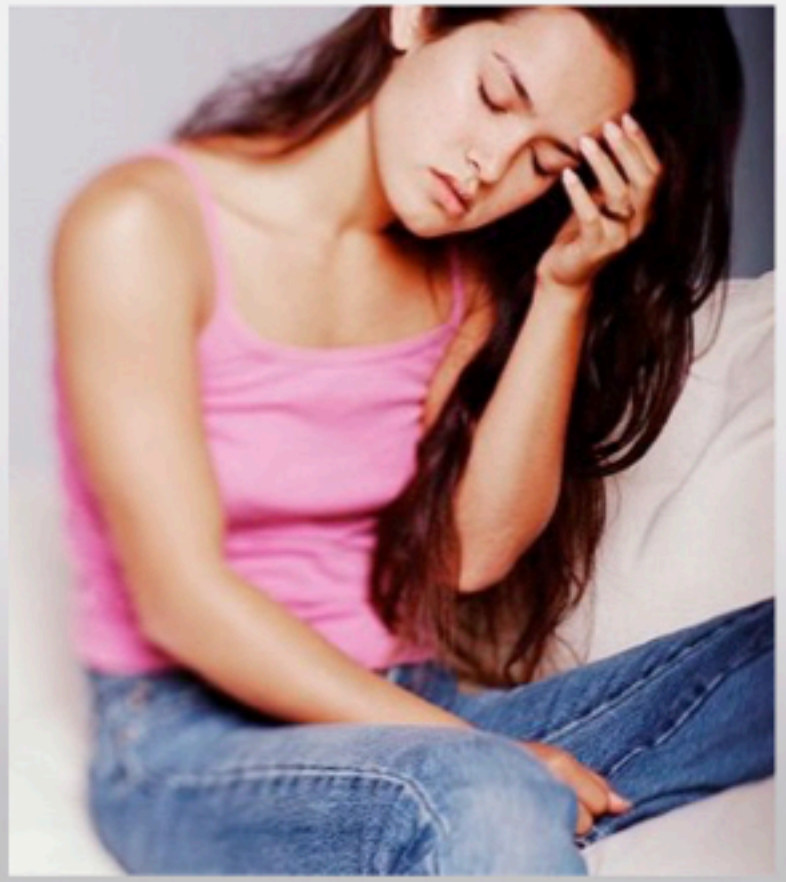
Parafunctional Clenching
Parafunctional Grinding
Occlusal Muscle Dysfunction
Osteoarthritis
Acute Sprain
Acute Closed lock of TMJ disc

5 Common Obstacles

Neck and Postural Instability
Wobbly TM Joint (Subluxation)
Compromised Breathing/Airway
Avascular Necrosis
Referred Pain Muscle Triggerpoints

1 TMD that **usually** does not need therapy

TMJ Clicking



6 Common TMDs

Diagnosis	Pattern	Treatment
Clenching	Patient is aware Masseters Ache Morning TMJ clicking that resolves	Occlusal Adjust D-PAS Night Guard (if inhibition) Magnesium and Vitamin C hs
Sleep Grinding	Worn Teeth	Protective night guard Airway night night guard
Occlusal Muscle Dysfunction	Sore muscles when chewing Sore Lateral Pterygoid, Headaches Day D-PAS Relieves Symptoms	Occlusal Adjustment
Osteoarthritis of TMJ	Arthralgia CBCT shows worn bone loss MRI T2, STIR ++	NSAID for 6-12 weeks Occlusal Adjustment Do not put in a night guard
Sprain Discal Ligament TMJ, Acute	Sudden onset pain TMJ, sore TMJ Limited opening Soft end point active stretch	Cold Laser, Ice 15 min 3x a day Rest, Soft diet, NSAID 7 days Anterior Reposition Orthotic 7 days
Acute Closed Lock TMJ	Sore TMJ Limited opening Hard end point active stretch	Arthrocentesis with PRP

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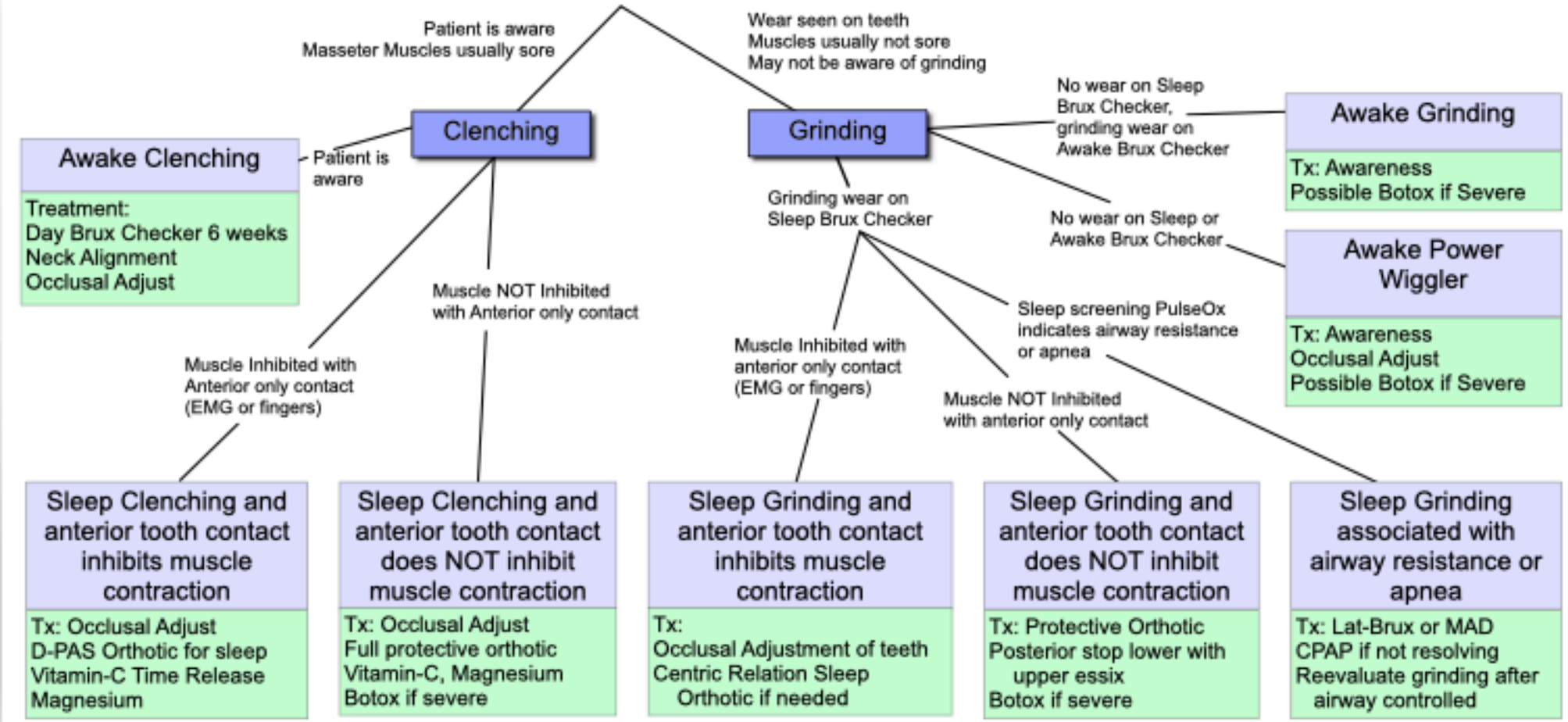
BRUXING: PARAFUNCTIONAL TOOTH CONTACT



Clenchers destroy the joint,
Grinders destroy the teeth

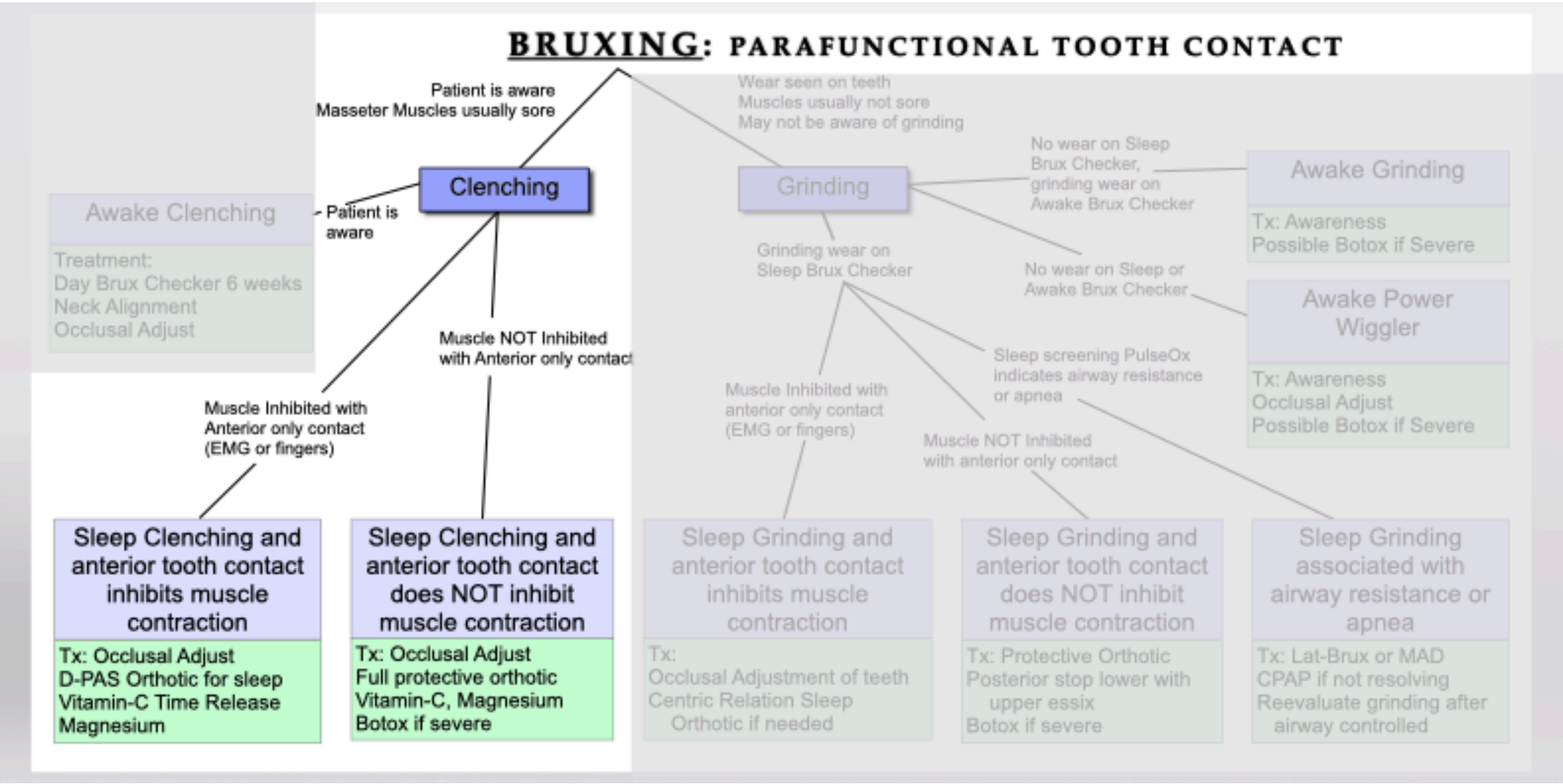
<u>Clenching</u>
Painful Muscles
Patient is usually aware of clenching
Fremitus
Strong Masseters
See slight wear around tooth contacts
Damage TMJ cartilage

If patient is unaware of clenching-
Plant seed at hygiene visit
Do you clench?

<u>Grinding</u>
See tooth wear
Patient is usually not aware
Buttressing bone if teeth are tight
If tooth mobility, on excursions
Strong Masseters
Slight if any soreness muscles
Usually no muscle pain

Parker Mahan-
"Women Hurt, Men destroy"

BRUXING: PARAFUNCTIONAL TOOTH CONTACT



Are the TMJ muscles inhibited from full contraction with anterior only tooth contact?

Detect with EMG or muscle palpation- Clench full power on posterior teeth and then with D-PAS orthotic.

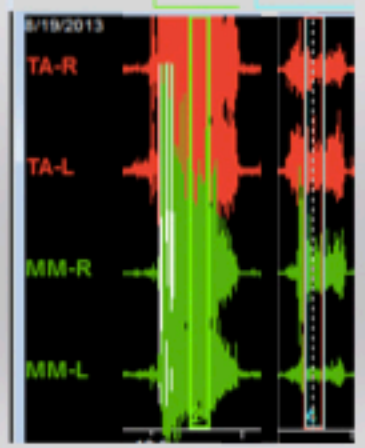
BioResearch EMG

BioResearch mScan

Diagnostic Palatal Anterior Stop

Patient with muscles inhibited by anterior only contact

	Clench MaxIC	Anterior Stop D-PAS
	µV	µV
TA-R	100.6	15.7
TA-L	108.9	25.3
MM-R	115.4	25.5
MM-L	70.5	6.8

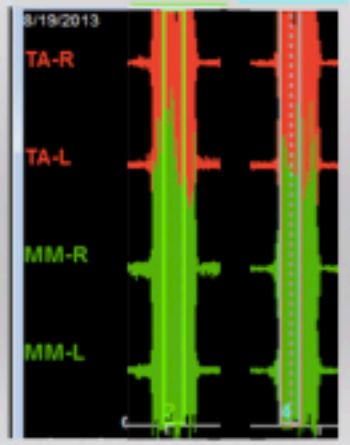


Major decrease in muscle power with D-PAS

BioResearch EMG

Another Patient with muscles NOT inhibited by anterior only contact

	Clench MaxIC	Anterior Stop D-PAS
	µV	µV
TA-R	82.2	77.9
TA-L	124.6	103.6
MM-R	185.0	169.0
MM-L	79.9	86.6



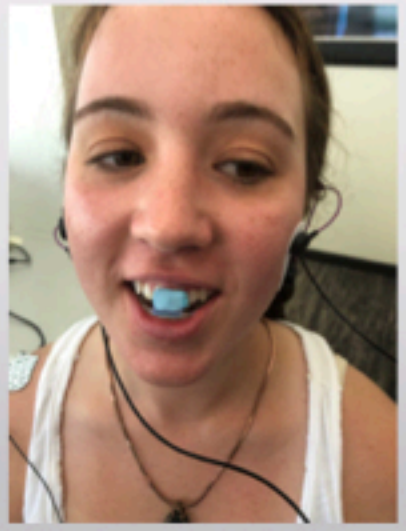
Muscle power same with D-PAS

Choosing the Correct Night Guard

M-Scan EMG
Electromyography

Clench back teeth

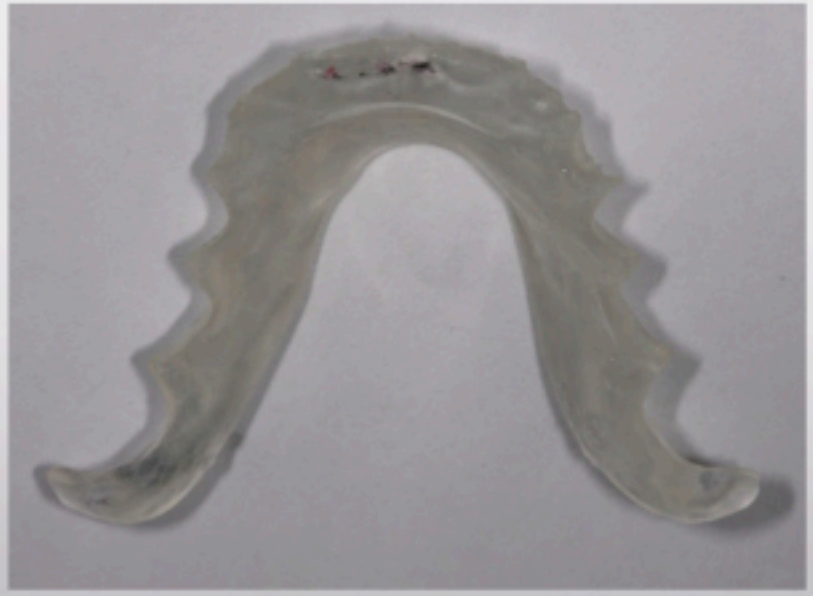
Clench
anterior stop

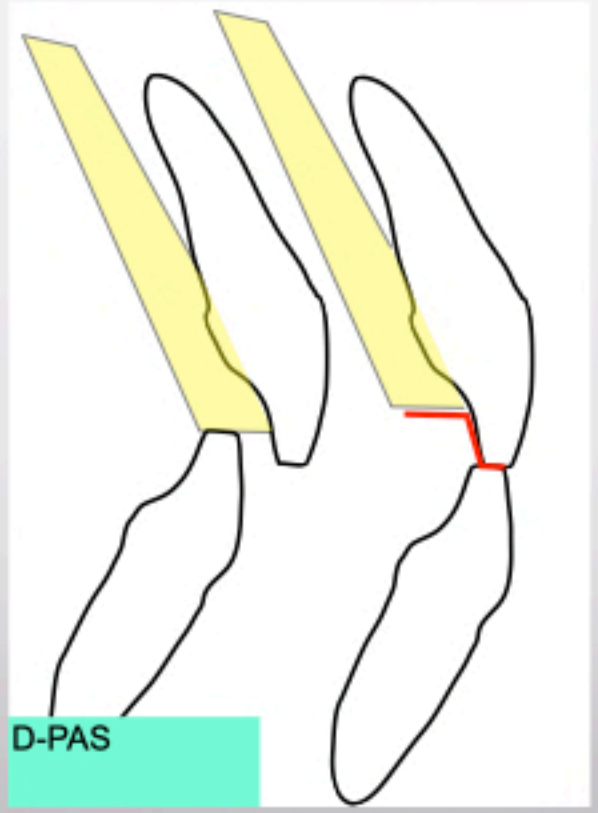


Can place moderate force on front teeth

<u>Clench</u>
Back teeth +250 µv
Front teeth +121 µv

Diagnostic Palatal Anterior Stop
D-PAS





Basically an upper Hawley with anterior stop without clasps or wire.
Simular Devices Kois Deprogrammer, Karl Hegyi DATA.

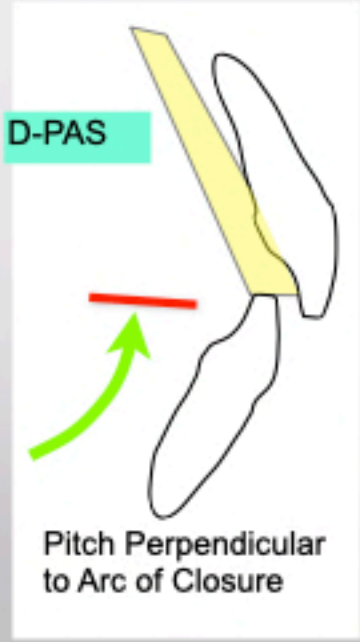
Diagnostic Palatal Anterior Stop

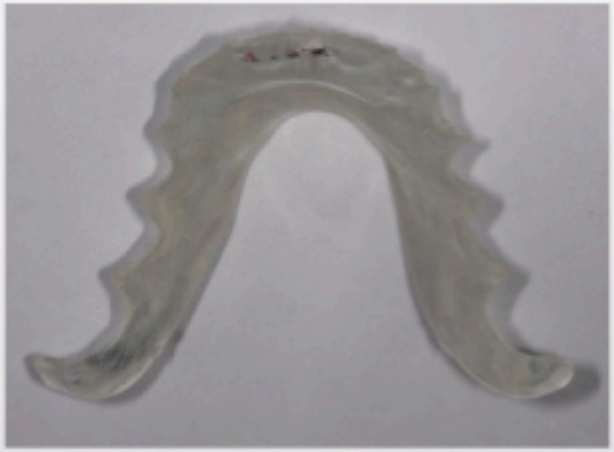
D-PAS Test: Wear 2 weeks for sleep, and occasional daytime

Better- Decrease in Symptoms
- Sleep Clenching Inhibited: Wear D-PAS as night guard
- Orthotic Improved Airway: D-PAS as night guard
- Occlusal Muscle Disharmony: Occlusal Adjust

Worse- Increase in Symptoms
- Mechanically Unstable TMJ, joint subluxation
- Intracapsular Problem TMJ
- Orthotic Made Sleep Airway Worse

Stays the Same- No Change in Symptoms
- Damaged TMJ are mechanically stable
- Pain not related to occlusion





Stapelmann H, Türp JC. The NTI-tss device for the therapy of bruxism, temporomandibular disorders, and headache…..BMC Oral Health. 2008 Jul PMID: 18662411

D-PAS Burs Shape and Polish

Brassler H351G.11.070 HP G-Cutter Carbide
Brassler 295E HP E cutter
Preat F-8 Silicon Polisher
Keystone Scotch-Brite Red Polisher, Fine

D-PAS Handout to patient

D-PAS Diagnostic Palatal Anterior Stop Test

Dr John R. Droter, DDS

This is a diagnostic test, not treatment.
D-PAS Instructions:

For next 2 weeks wear for sleeping and occasionally during the daytime.
Try wearing all day for 1 or 2 days.
Put D-PAS in if you are having sore muscles or a headache.
You will need to remove to eat.

Keep track of what changes you notice.
It is not unusual for your teeth to fit together differently in the morning as your jaw becomes better aligned.

When out of the mouth always put it in its case.
Top 3 ways appliance are lost or broken:
1. Placed in a paper towel while eating and thrown out.
2. Placed in pocket and sat on.
3. Your dog finds it and uses it as a chew toy.

Clean by scrubbing off with toothbrush and toothpaste.

If facial tightness or muscle soreness increases, stop wearing for 2 nights and try again. If still sore stop wearing and contact us.

Symptoms will either get better, get worse, or stay the same.
If symptoms become worse you may have a more serious problem that will require further tests.

Diagnostic Palatal Anterior Stop

D-PAS Test: Wear 2 weeks for sleep, and occasional daytime

Better- Decrease in Symptoms
Sleep Clenching Inhibited: Wear D-PAS as night guard
Orthotic Improved Airway: D-PAS as night guard
Occlusal Muscle Disharmony: Occlusal Adjust

Worse- Increase in Symptoms
Mechanically Unstable TMJ, joint subluxation
Intracapsular Problem TMJ
Orthotic Made Sleep Airway Worse

Stays the Same- No Change in Symptoms
Damaged TMJ are mechanically stable
Pain not related to occlusion

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Temporary Anterior Stop Test

This is a diagnostic test, not treatment

Wear for sleep for 2 weeks
Limited daytime wear if headache

Better- Decrease in Symptoms

Sleep Clenching Inhibited: Wear D-PAS as night guard
Orthotic Improved Airway: D-PAS as night guard
Occlusal Muscle Disharmony: Occlusal Adjust

Worse- Increase in Symptoms

Mechanically Unstable TMJ, joint subluxation
Intracapsular Problem TMJ
Orthotic Made Sleep Airway Worse

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Parafunctional Clenching

Signs

- Strong Masseters
- No major wear on teeth
- Slight wear around tooth contacts
- Fremitus
- Tori
- Slight scratch vibration doppler/ JVA

Diagnostic Tests

EMG M-scan
- Determine if muscle inhibition

D-PAS for sleep

Adhesive Click- "Sticky Disc"

Symptoms

- Aware of clenching
- Sore muscles on waking
- Clicking on waking that goes away
- Headaches

Causes

- Uneven occlusion, especially heavy anterior
- Neck stabilization
- SSRI

Treatments

Occlusal Adjustment
Neck alignment/ stabilization
D-PAS as night guard
Time Release Vitamin C
Angstrom Magnesium
Clear Brux Checker daytime for 6 weeks

TMD Therapies for Clenching

Medicinal

Vitamins: Vit C
Minerals: Magnesium
Glucosamine

Vit C 1,000 mg
before exercise
or clenching

Doctor's Best Vegan
Glucosamine/Chondroitin/MSM

Mother Earth Ionic Angstrom
Magnesium 2 oz bottle
0.5 teaspoon sublingual

www.meminerals.com

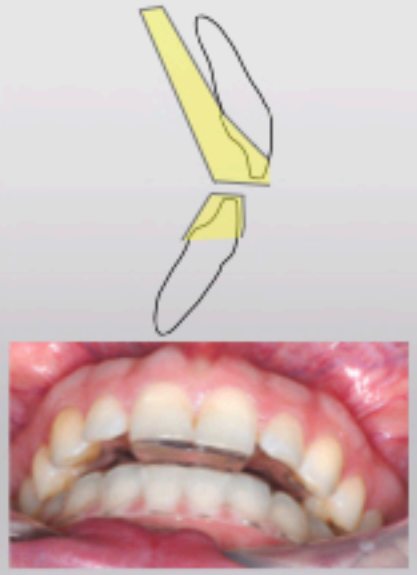
Natural Calm
Magnesium Citrate
1 teaspoon (162mg)

Living Tree Dental Lab
(865) 509-4509
connect@livingtreelab.com

3D Printed Orthotics

D-PAS
Diagnostic-
Palatal Anterior Stop

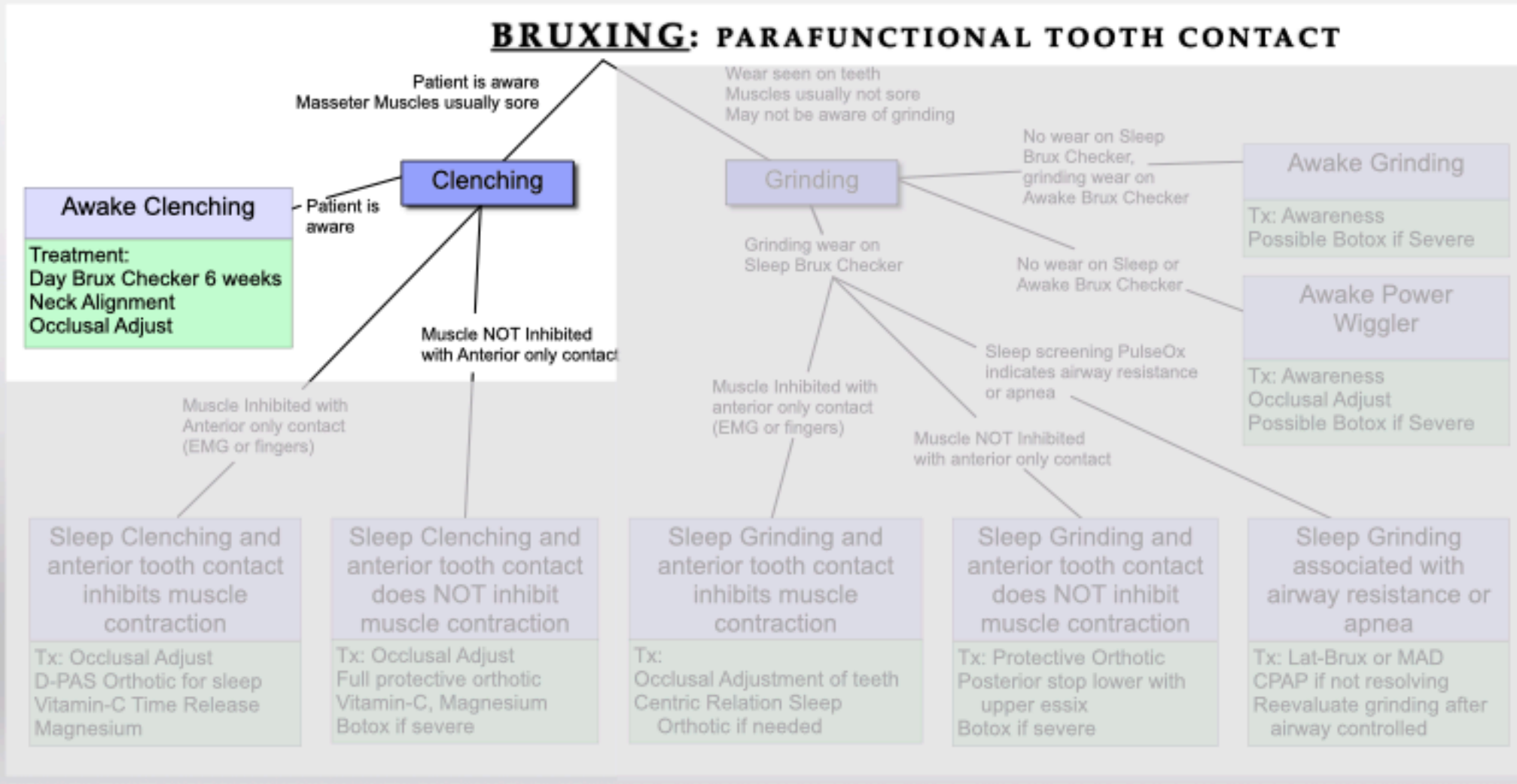
Brux-PAS
with lower Essix



Hard Lower Posterior Stop
with upper essix

Hard Lower Full Coverage
Centric Relation Orthotic

BRUXING: PARAFUNCTIONAL TOOTH CONTACT



Daytime Clenching- Clear Brux Checker

Increases awareness to break habit

Very thin: Similar to mylar used for composites

50 µm thick

Living Tree Dental Lab
(865) 509-4509
connect@livingtreelab.com

Material from:
Great Lakes Orthodontics
Platzhalterfolie by Scheu
Scheu Ref # 3202.1

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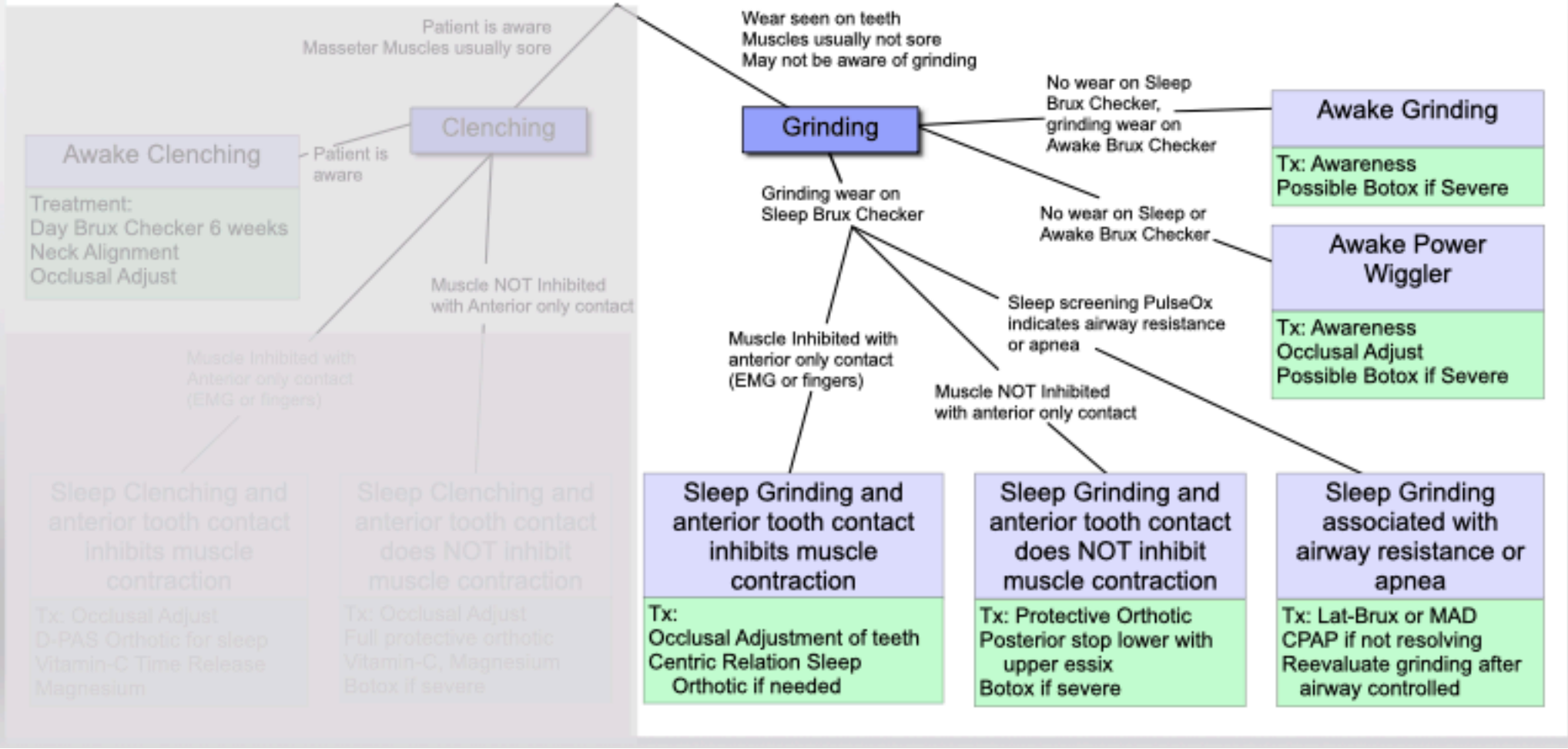

Clenchers destroy the joint,
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<u>Clenching</u>
Painful Muscles
Patient is usually aware of clenching
Fremitus
Strong Masseters
See slight wear around tooth contacts
Damage TMJ cartilage

If patient is unaware of clenching-
Plant seed at hygiene visit
Do you clench?

<u>Grinding</u>
See tooth wear
Patient is usually not aware
Buttressing bone if teeth are tight
If tooth mobility, on excursions
Strong Masseters
Slight if any soreness muscles
Usually no muscle pain

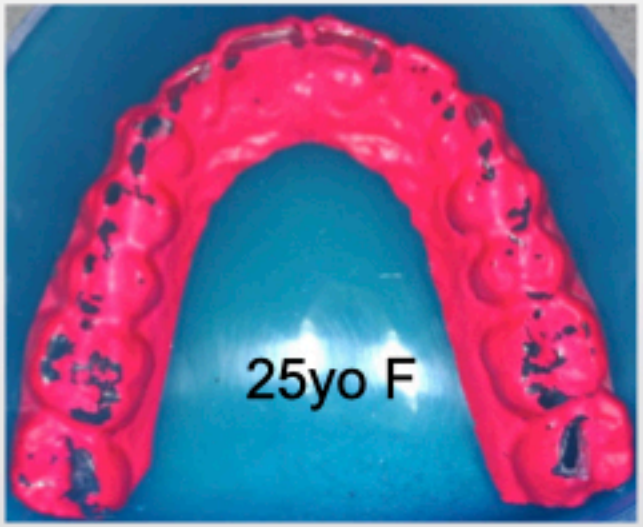
Parker Mahan-
"Women Hurt, Men destroy"

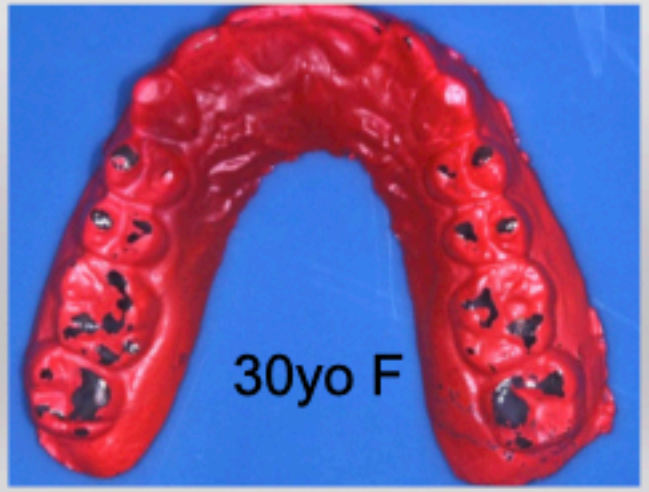
2. Does this occur awake or asleep?

Brux Checker
Great Lakes Orthodontics

0.1mm Mylar

Made on Biostar Machine

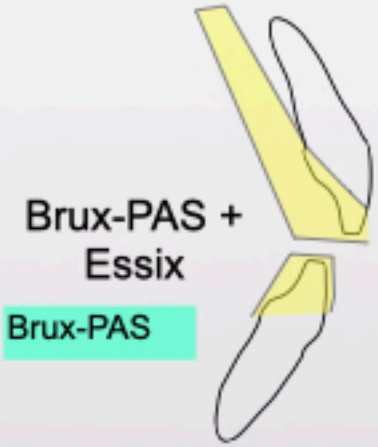




Which Occlusal Orthotic for Grinding?

Lower Posterior Stop with upper essix

Upper Hard CR Orthotic



Lat-Brux

Nylon Herbst
Great Lakes Ortho

APS
ArrowPath Sleep

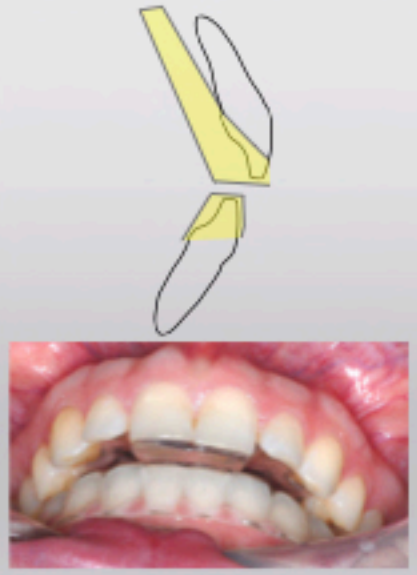
LIVING TREE DENTAL LAB

Nate Brock, CDT
(865) 509-4509
connect@livingtreelab.com

3D Printed Orthotics

D-PAS
Diagnostic-
Palatal Anterior Stop

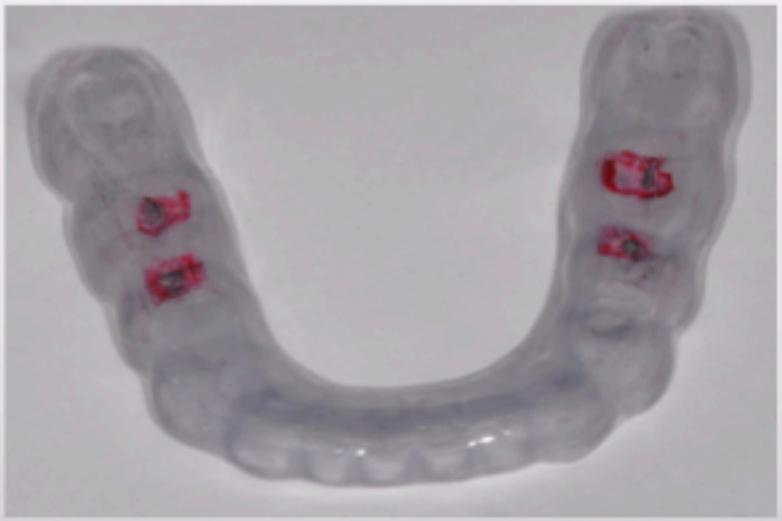
Brux-PAS
with lower Essix



Hard Lower Posterior Stop
with upper essix

Hard Lower Full Coverage
Centric Relation Orthotic

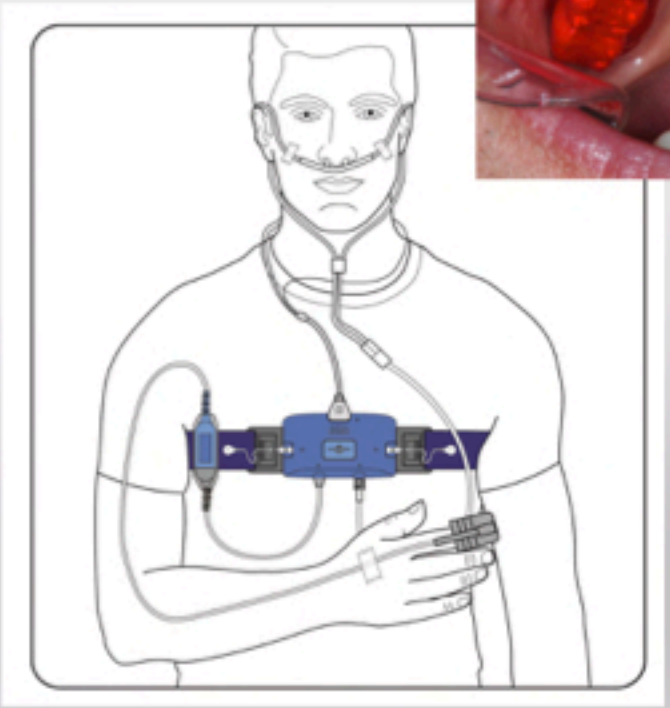
Lower Posterior Stop Night guard with upper Essix



zMachine

GENERAL sleep

zMachine + Brux Checker
+ Snore Lab



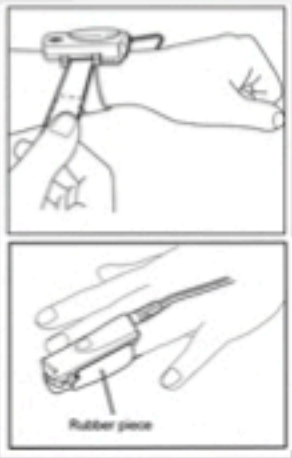
Call (888) 330-4424
Use Code: DROTER to receive special offer

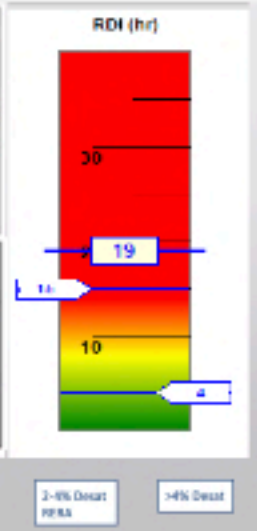
Also ask for access to Droter Modified Report

Treating Common TMDs in a General Practice

Management

Diagnosis	Pattern	Treatment
Sleep Grinding Airway Related	Worn Teeth Upper Airway Resistance	Mandibular Advancement Appliance (after MD approves)





Pulse Ox Screening

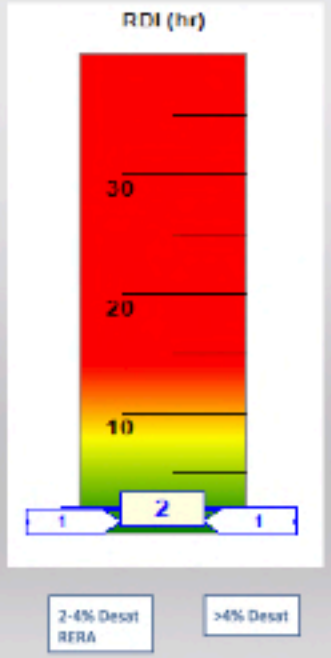
Refer to Medical Sleep Doctor

Get approval for Mandibular Advancement Appliance

Verify Airway Improves

19 events/hr before

2 events/hr with Orthotic



PULSOX 300i, Konica Minolta
with data analysis Patient Safety, Inc.

Nylon MAD
Great Lakes Ortho

D-SAD

PANTHERA

Restorative Dentistry

Pathological Occlusion

??Airway Related Bruxing?

Restore Function

Composite Trial Occlusion

AHI + 26 CPAP

Anterior guidance

or group function?

6 Common TMDs

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Occlusal Muscle Disharmony

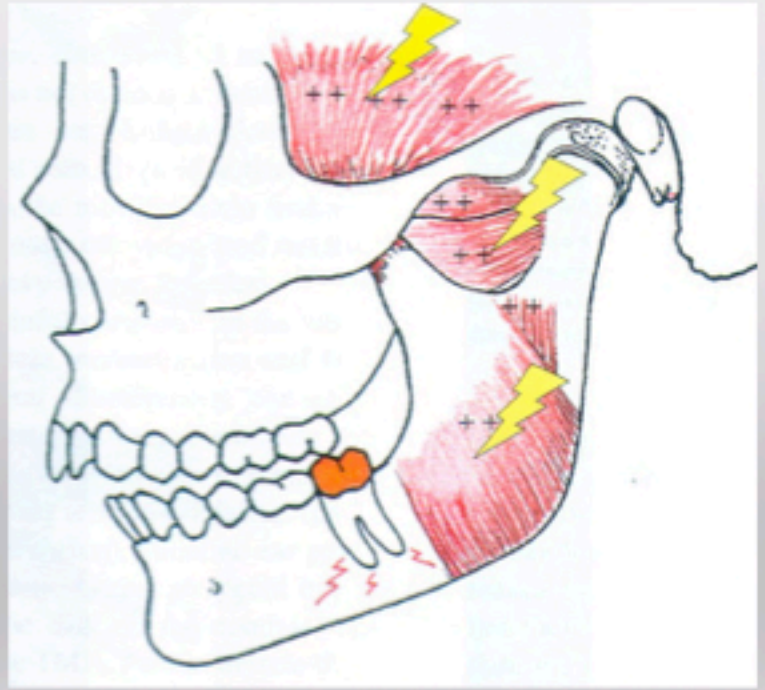
Uneven tooth contact with condyles fully seated triggers muscle activity

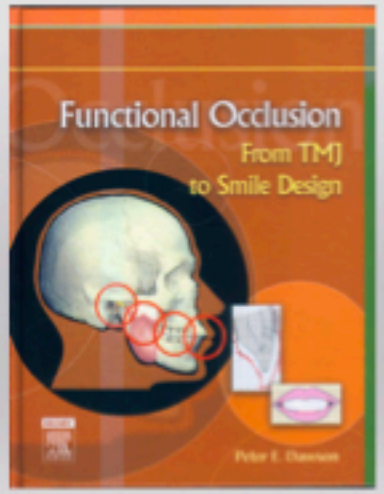
Lateral pterygoid fires out of sequence to create even tooth contact on closure

Disharmony in all muscles: Splinting/Bracing

Muscles sore from overuse

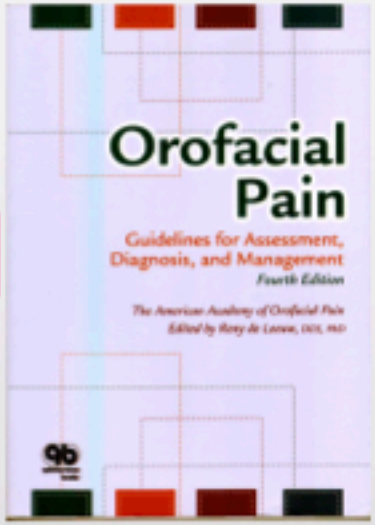
Muscles do not think- CNS input





from Dawson's Textbook, "Functional Occlusion"

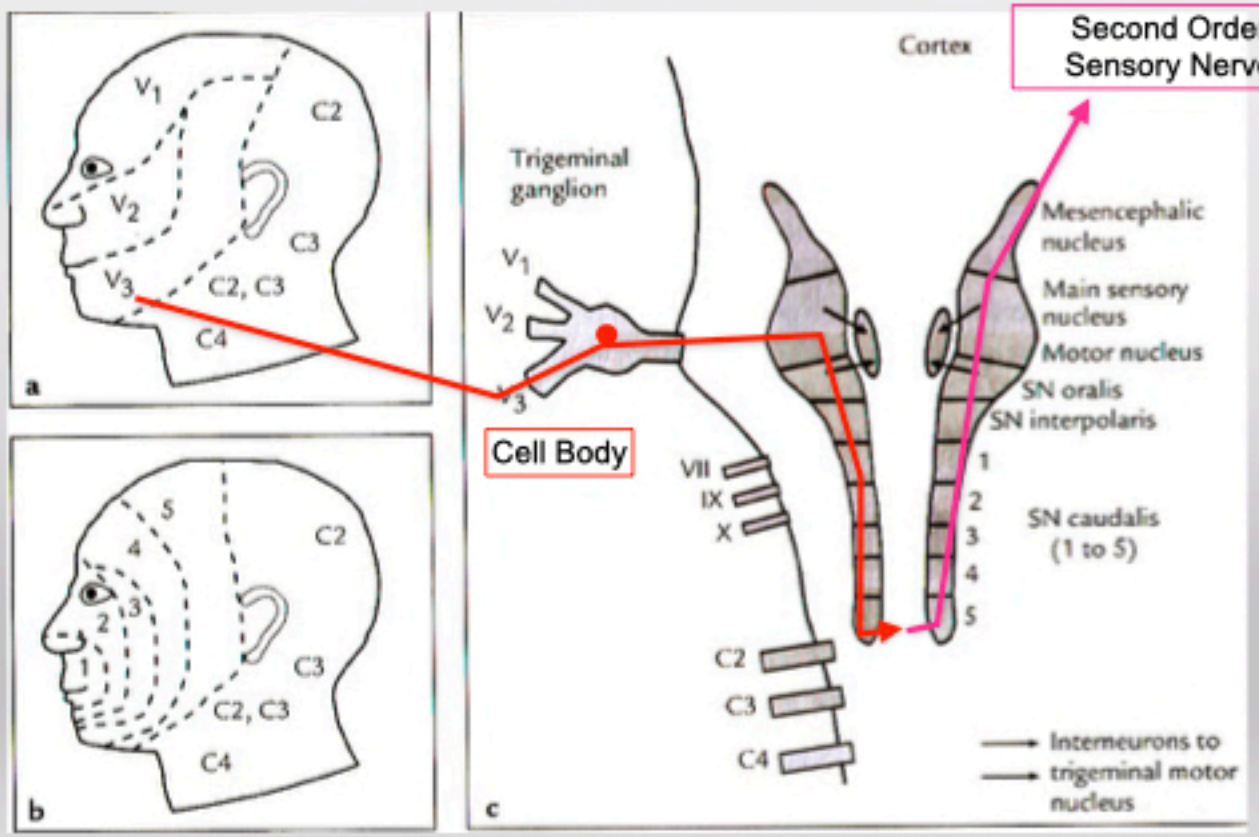
Trigeminal Ganglion-
Cell bodies of trigeminal primary sensory neurons
Trigeminal Nucleus
Connection of primary neurons with secondary neurons



Afferent
First Order
Sensory Nerve

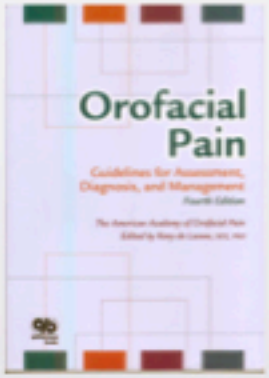
Second Order
Sensory Nerve

Cell Body

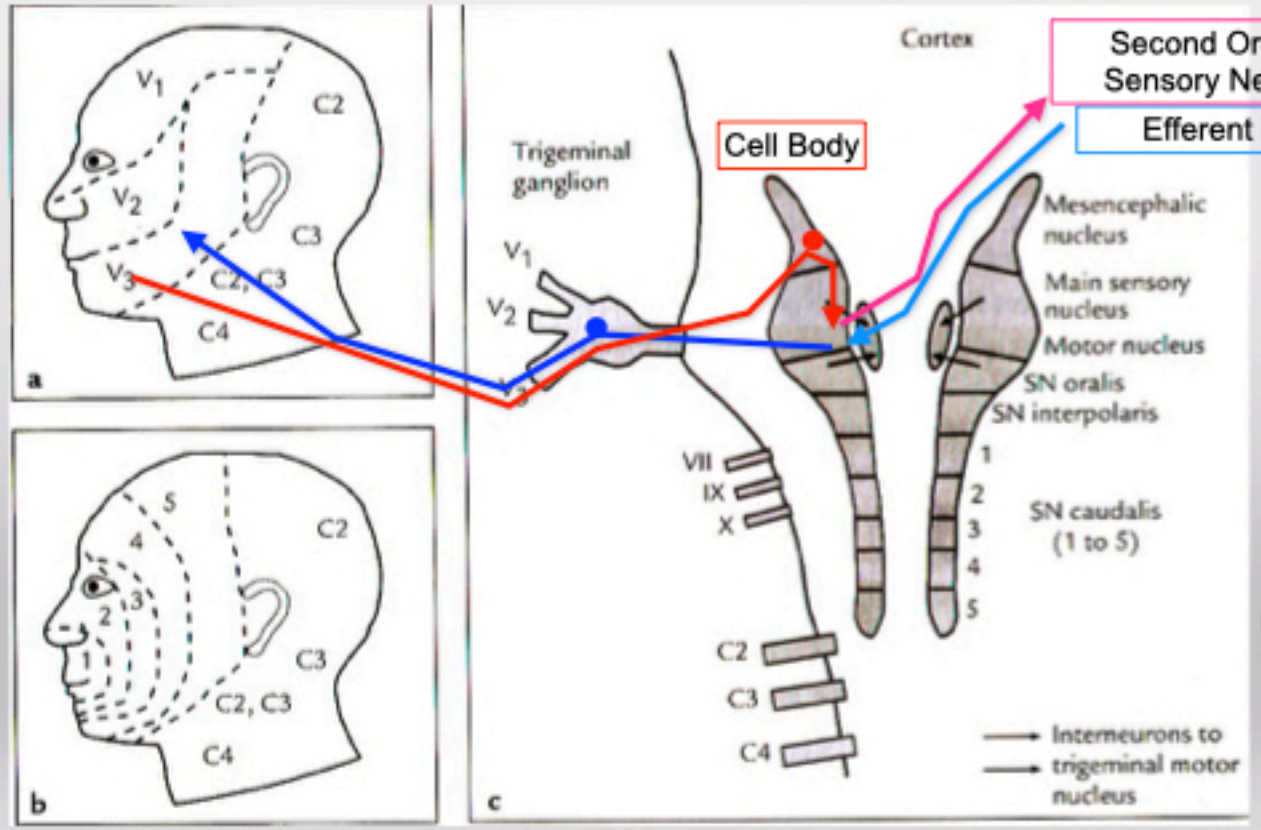


First Order PDL sensory neurons and proprioception neurons of TMJ closing muscles have their cell bodies in the upper section of the Trigeminal Nucleus and synapse with their second order neurons in the Motor nucleus

Efferent motor neurons to the TMJ muscles also synapse in the motor Nucleus

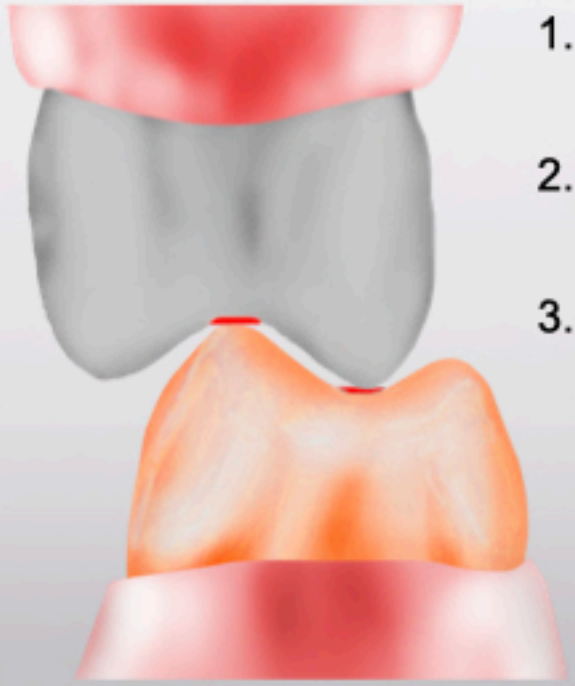


PDL Afferent
First Order
Sensory Nerve

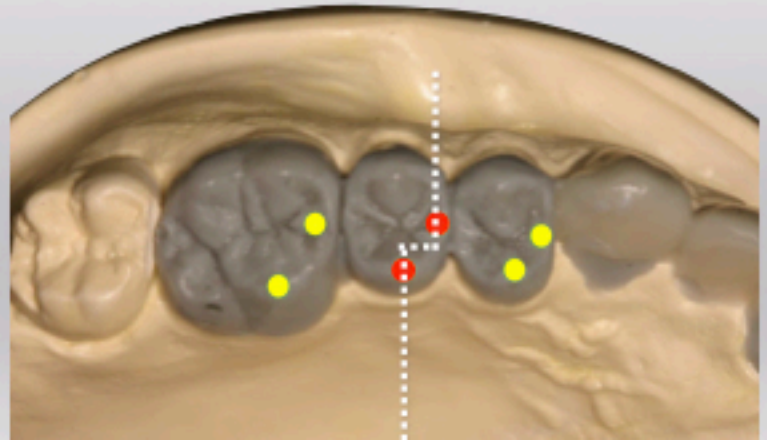


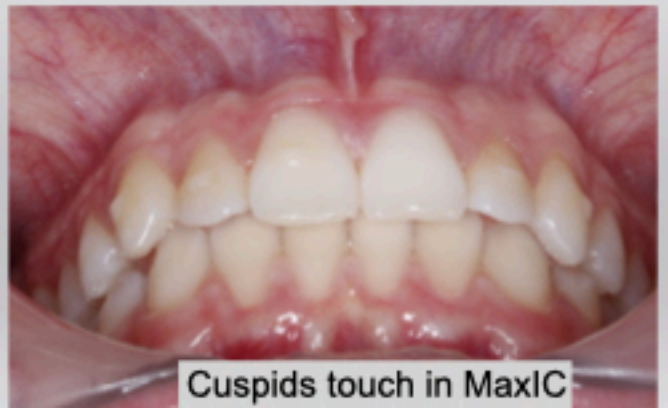
Blink and PDL only peripheral nerves with cell bodies in CNS

LD Pankey's Rules of Occlusion for Comfort and Function (Clyde Schuyler)



1. With the condyles fully seated in the fossa, all the posterior teeth touch simultaneously and even, with the anterior teeth touching lightly.
2. When you squeeze, neither a tooth nor the mandible moves (in a lateral direction).
3. When you move the mandible in any excursion, no back tooth hits before, harder than, or after a front tooth.

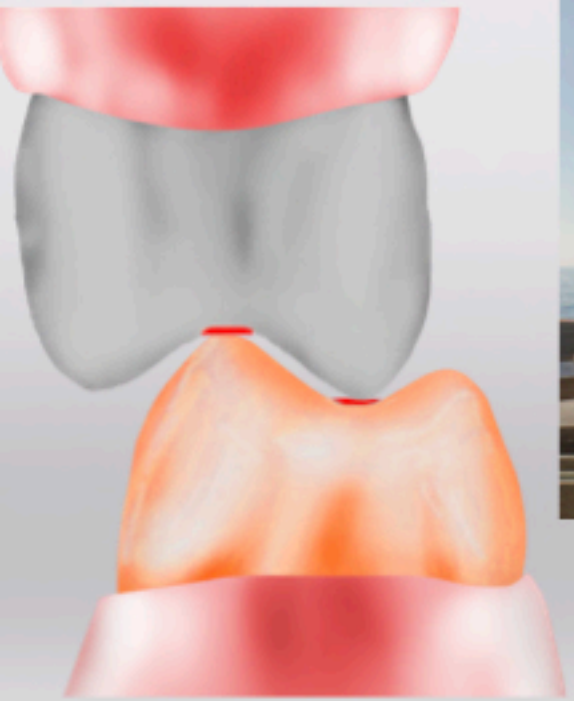




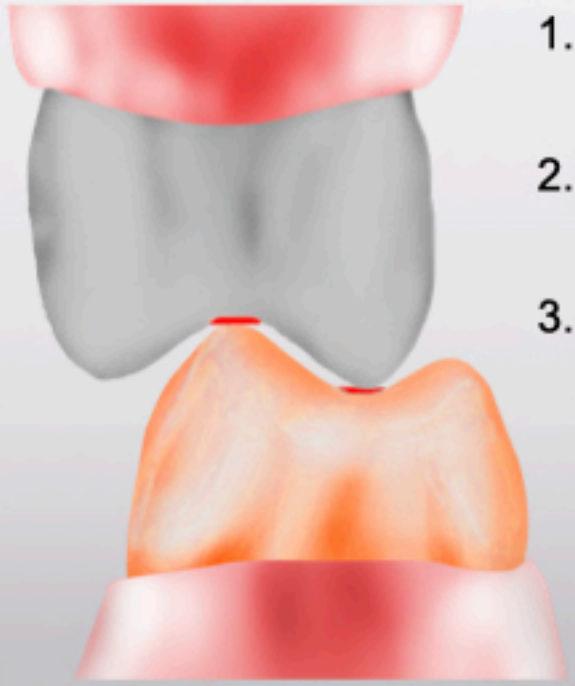
Slide by Dr John Droter
Drawing by Dr Jim Kessler

2. When you squeeze, neither a tooth nor the mandible moves (in a lateral direction).

Rule #2 = Flat Landing Area



LD Pankey's Rules of Occlusion for Comfort and Function (Clyde Schuyler)



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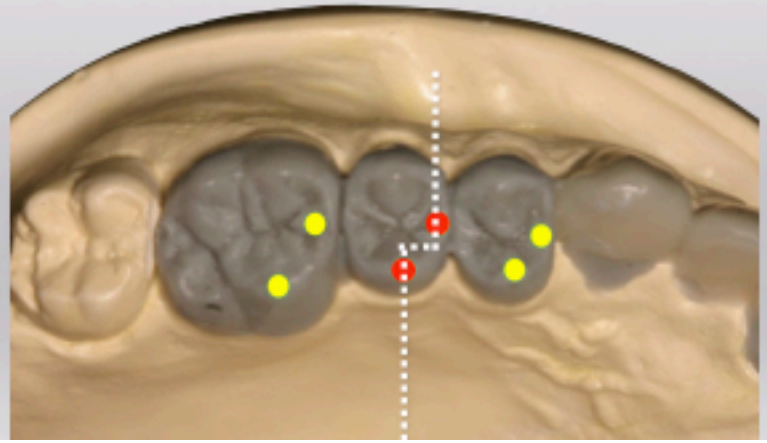
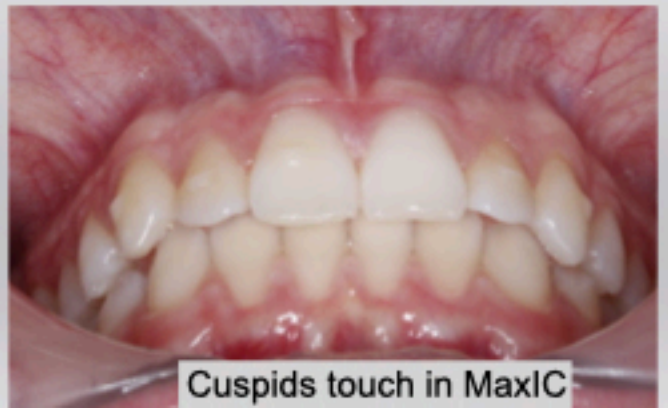


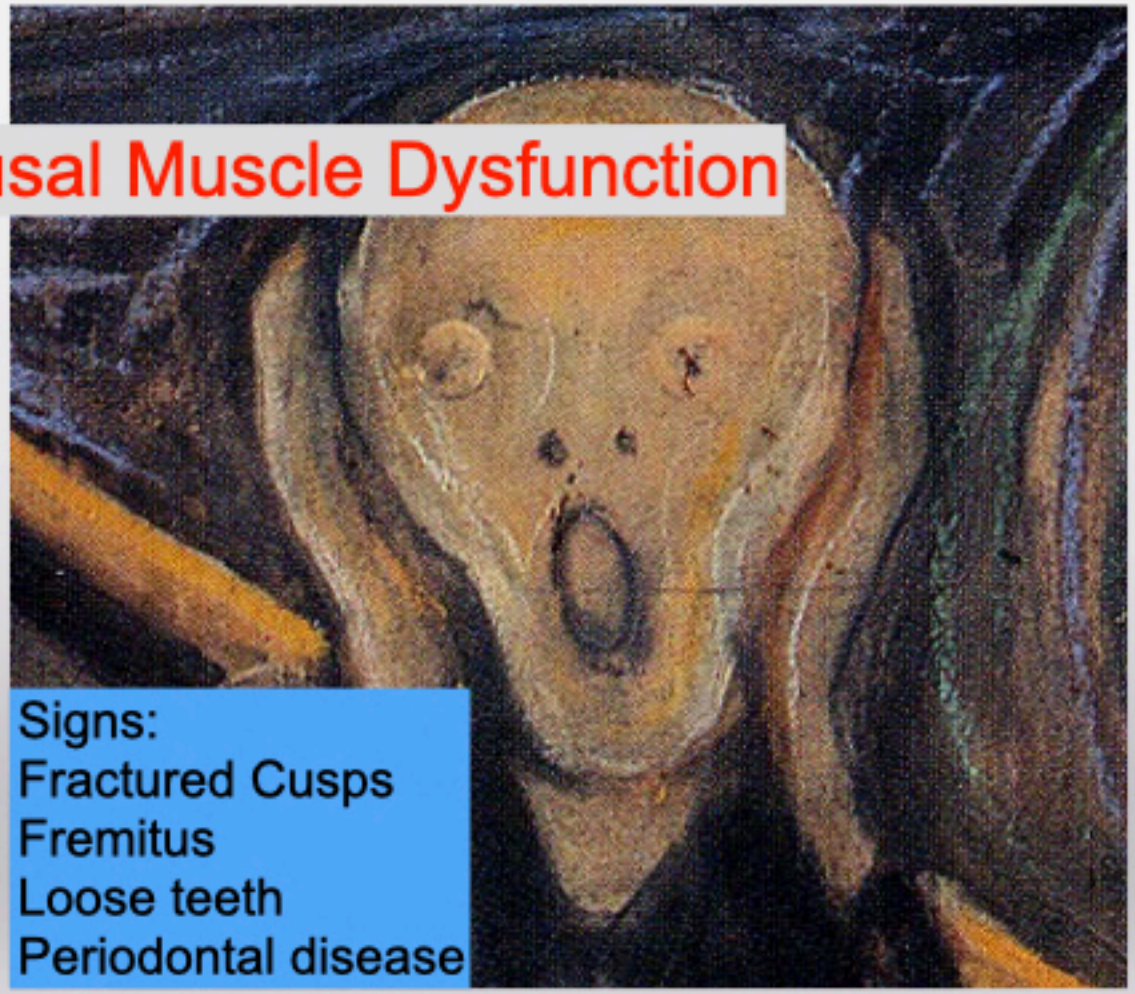


Slide by Dr John Droter
Drawing by Dr Jim Kessler

TMD Symptoms

Sore TM Joint
Sore TMJ muscles
Difficulty chewing
Headaches
Eye pain
Ear pain
TMJ clicking
Jaw locking
Limited opening
Difficulty open jaw
Difficulty closing jaw
Anterior Open Bite

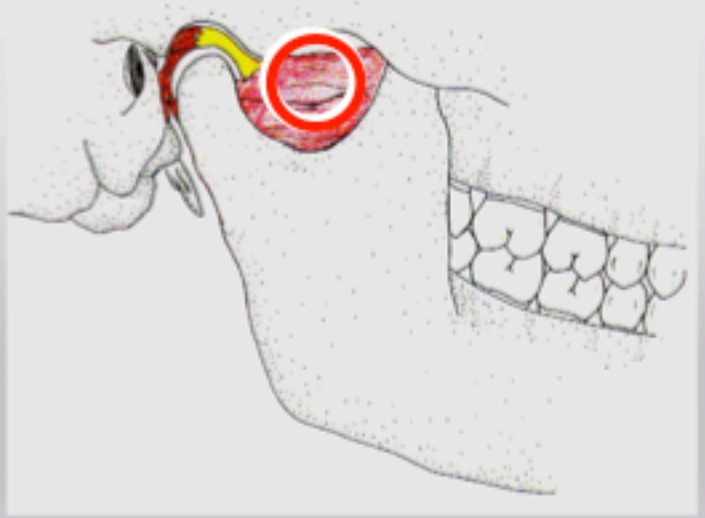
Occlusal Muscle Dysfunction

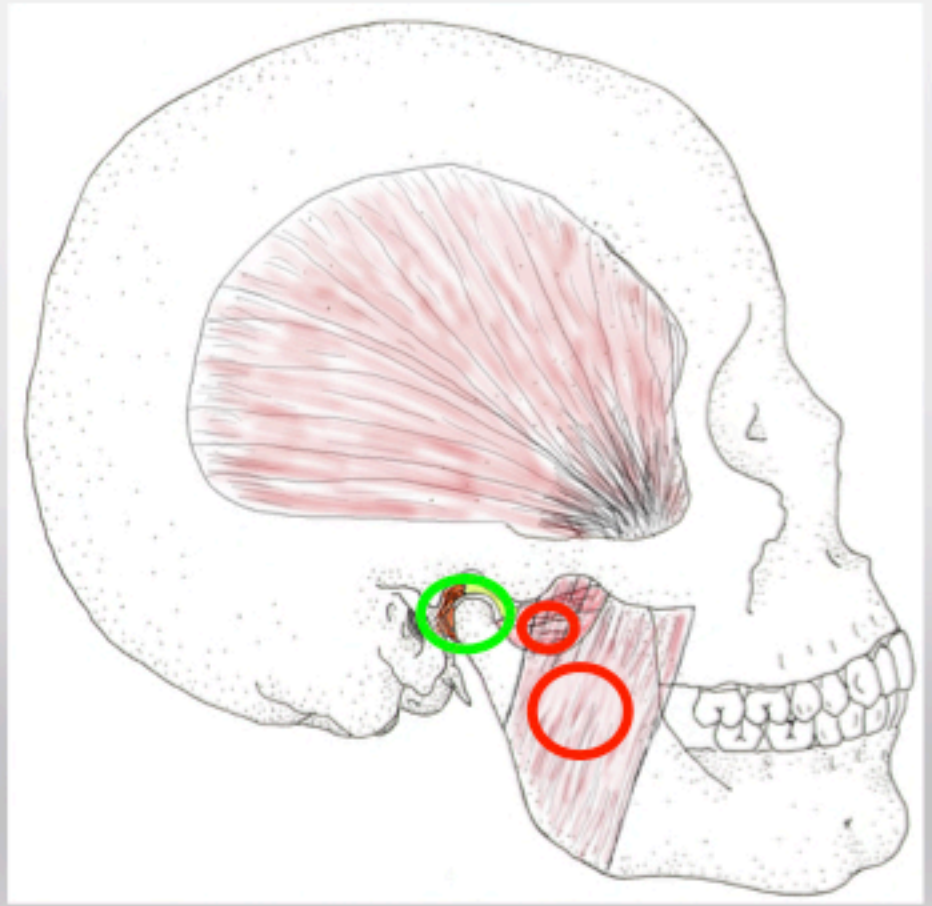


Signs:
Fractured Cusps
Fremitus
Loose teeth
Periodontal disease

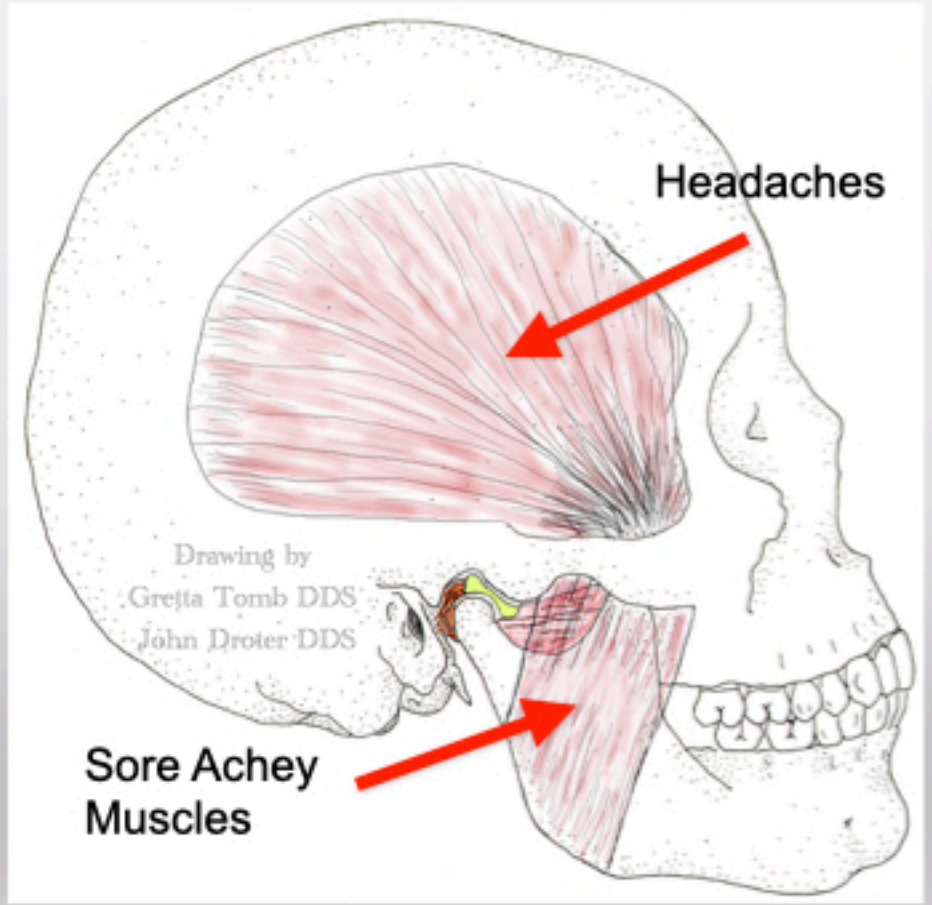
Occlusal Muscle Dysfunction Pattern

Sore muscles when chewing
Sore Lateral Pterygoid
TMJ is not sore
Day orthotic relieves symptoms





Drawings by Gretta Tomb DDS and John Droter DDS


Headaches
Drawing by
Gretta Tomb DDS
John Droter DDS
Sore Achey
Muscles

Occlusal Muscle Dysfunction Diagnostic Tests

Occlusal Muscle Dysfunction is a daytime problem

Clenching can be both a daytime and nighttime problem

>30% of headaches have an occlusal component

D-PAS 2 week trial

OR

3-6 week lower CR orthotic

Occlusal adjustment in patients with craniomandibular disorders including headaches. A 3- and 6-month follow-up. Vallon D, Ekberg E, Nilner M. Acta Odontol Scand. 1995

Response to occlusal treatment in headache patients previously treated by mock occlusal adjustment. Forssell H, Kirveskari P, Kangasniemi P. Acta Odontol Scand. 1987

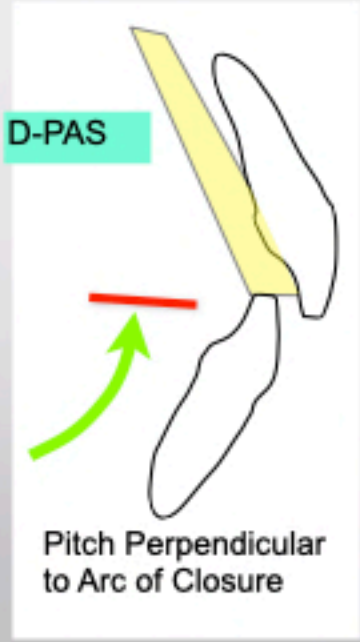
Diagnostic Palatal Anterior Stop

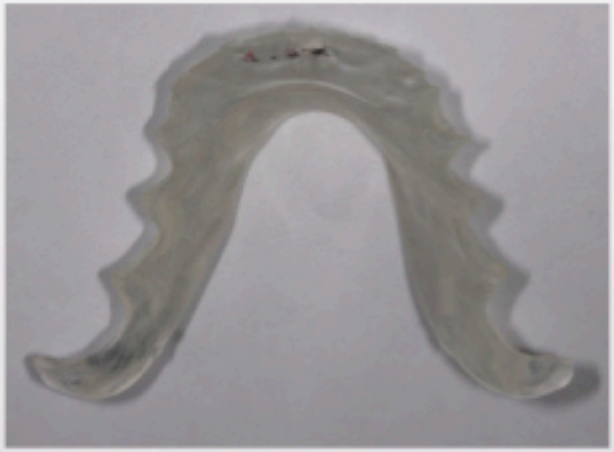
D-PAS Test: Wear 2 weeks for sleep, and occasional daytime

Better- Decrease in Symptoms
- Sleep Clenching Inhibited: Wear D-PAS as night guard
- Orthotic Improved Airway: D-PAS as night guard
- Occlusal Muscle Disharmony: Occlusal Adjust

Worse- Increase in Symptoms
- Mechanically Unstable TMJ, joint subluxation
- Intracapsular Problem TMJ
- Orthotic Made Sleep Airway Worse

Stays the Same- No Change in Symptoms
- Damaged TMJ are mechanically stable
- Pain not related to occlusion

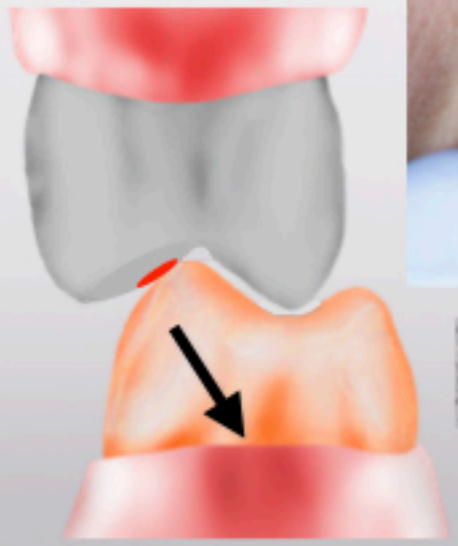




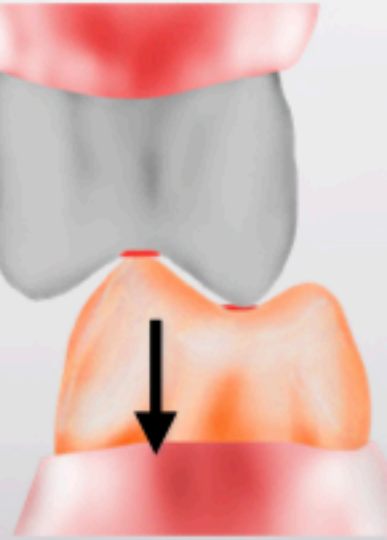
Stapelmann H, Türp JC. The NTI-tss device for the therapy of bruxism, temporomandibular disorders, and headache…..BMC Oral Health. 2008 Jul PMID: 18662411

Occlusal Sculpting

Reshape so no sideways forces on back teeth

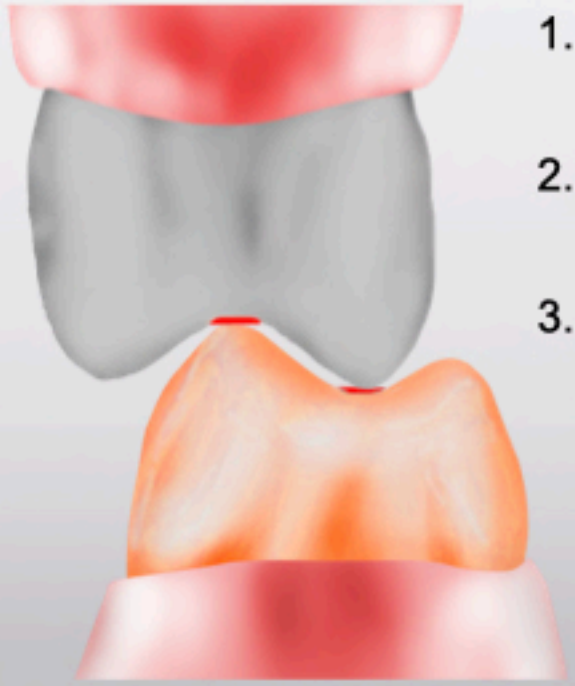


Polish



Sideways forces belong on cuspids

LD Pankey's Rules of Occlusion for Comfort and Function (Clyde Schuyler)



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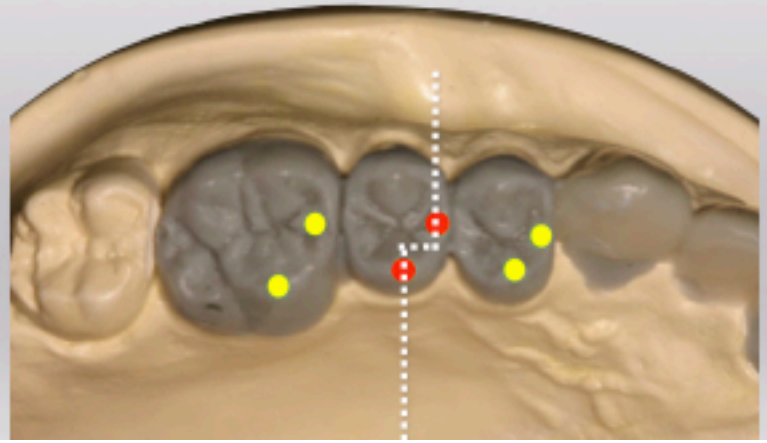
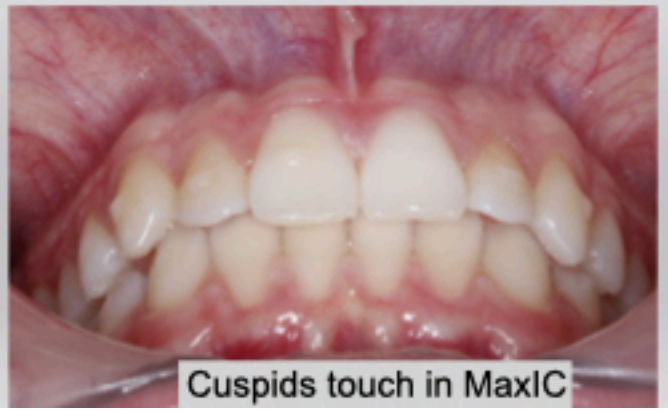




Slide by Dr John Droter
Drawing by Dr Jim Kessler

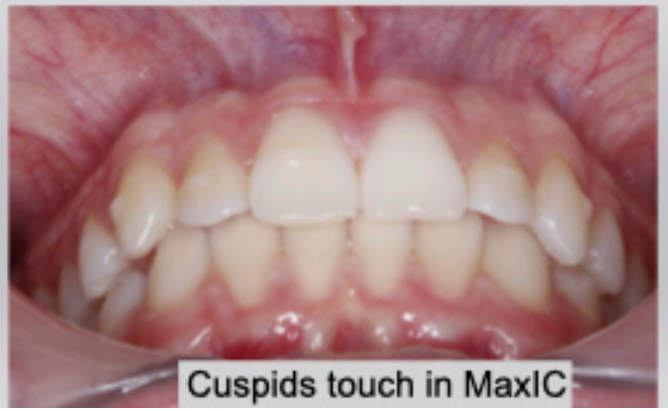
LD Pankey's Rules of Occlusion for Comfort and Function

Simply

No sideways forces on back teeth.

Sideways forces are on cuspids.

Cuspids need to touch



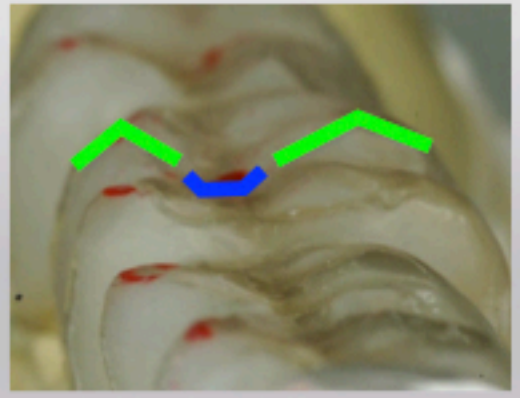
Cuspids touch in MaxIC

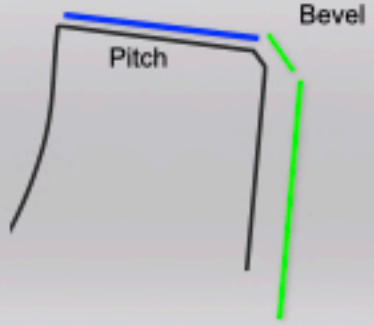
Occlusal Sculpting Tools, including Zirconia

Wheel
- Create Cusp Landing Zone
- Flatten Incisal edges
- Bulk reduction of inclines

Move and Shape Cusps, Inclines, Facial Surfaces

Brassler Brio Shine
FLBCER-1
FLBF-2

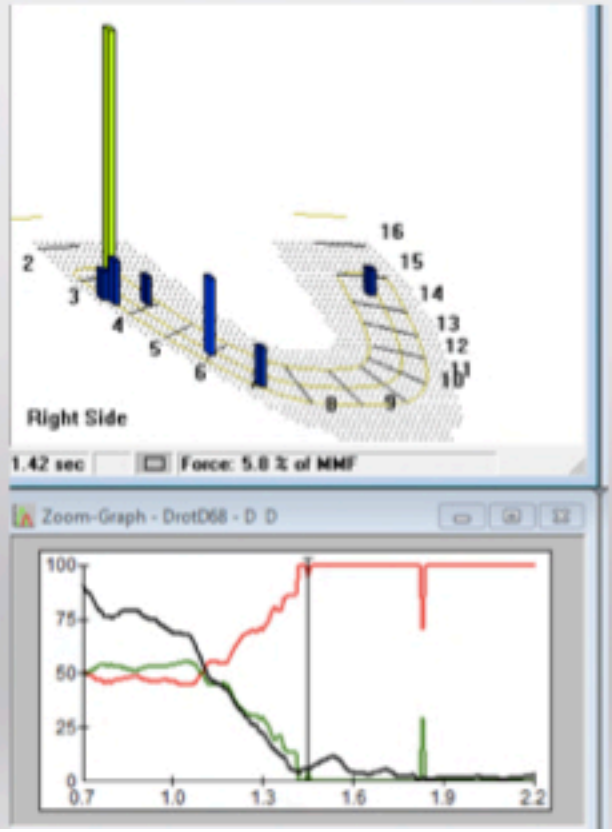




Premier 860.9 F Wheel Diamond
Premier 230 F Barrel Diamond
Neodiamond 1118.7F Roundend taper
Dedco Green Stone
White Arkansas stone
Filtek Supreme- B1B, Albond

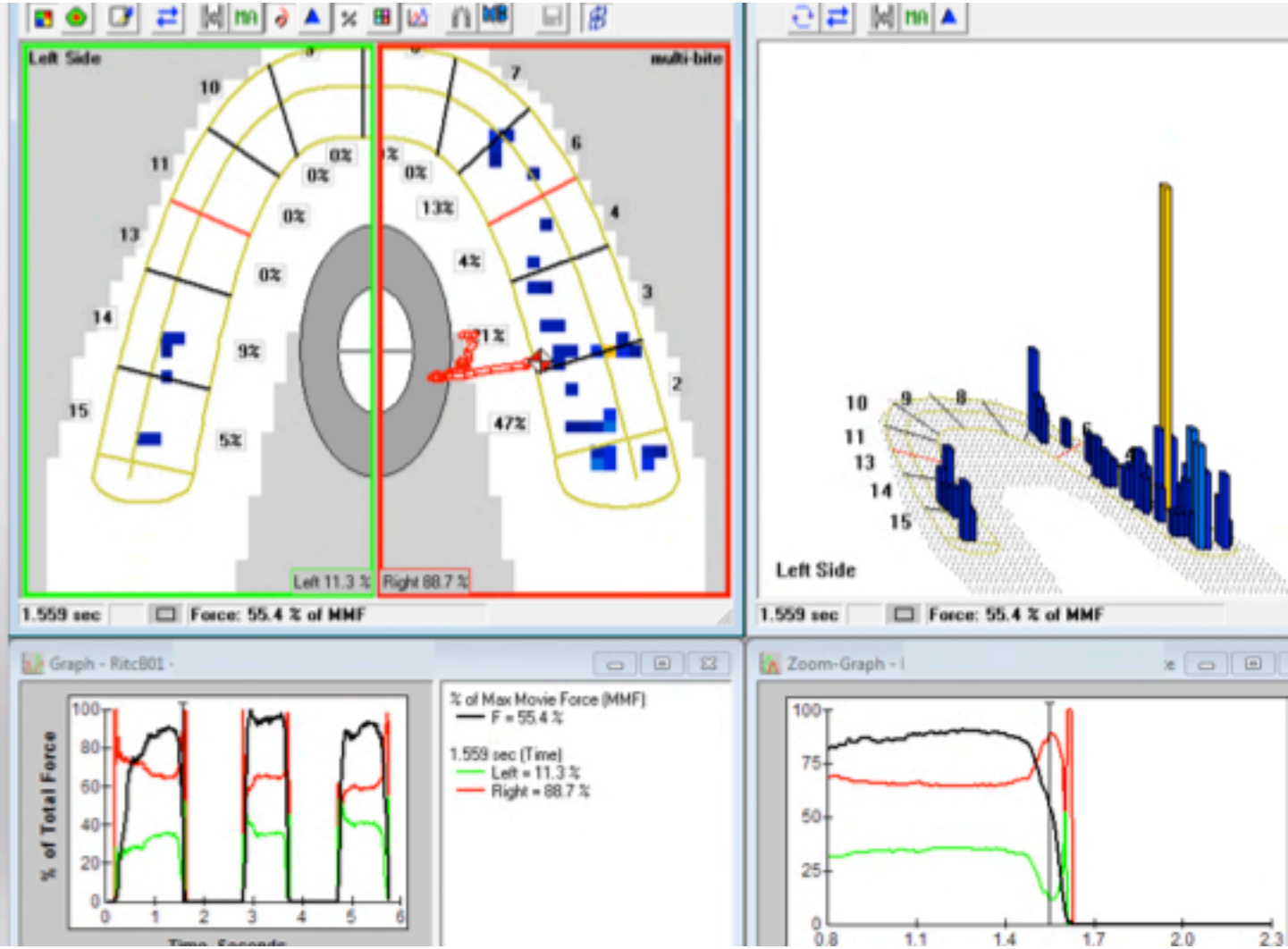
The indispensable value of T-Scan is not in finding heavy CR contacts, but working and nonworking contacts.

Is that a smudge or a muscle activating interference?



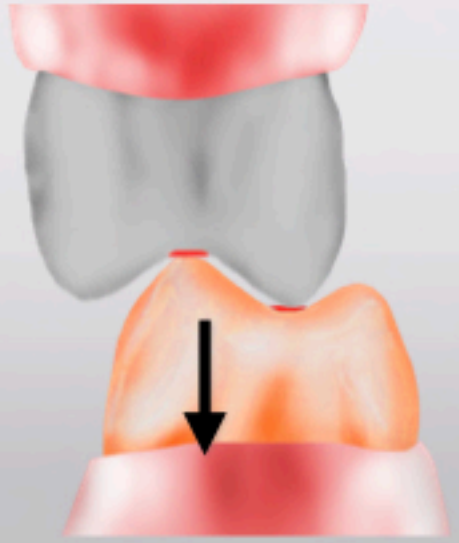
Remove too much and you decrease the ability to chew, especially lettuce. Chewing lettuce requires posterior inclines coming close enough to chew, but far enough apart to not touch and activate muscle.

T-Scan is excellent for Patient Education of Occlusal Pathology

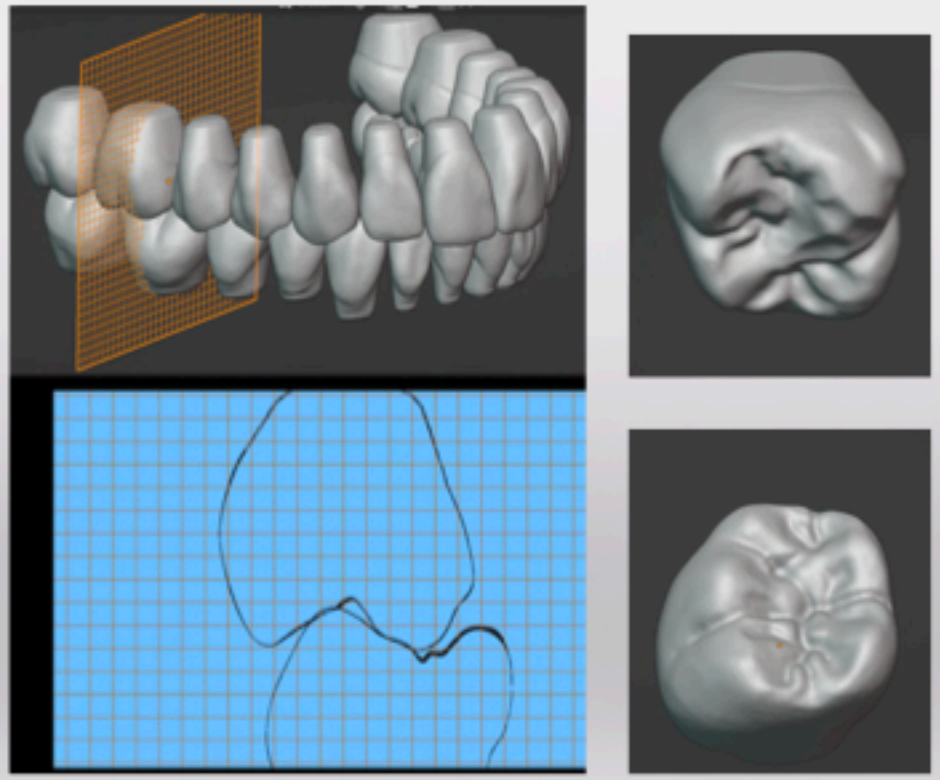


Ideal Occlusion

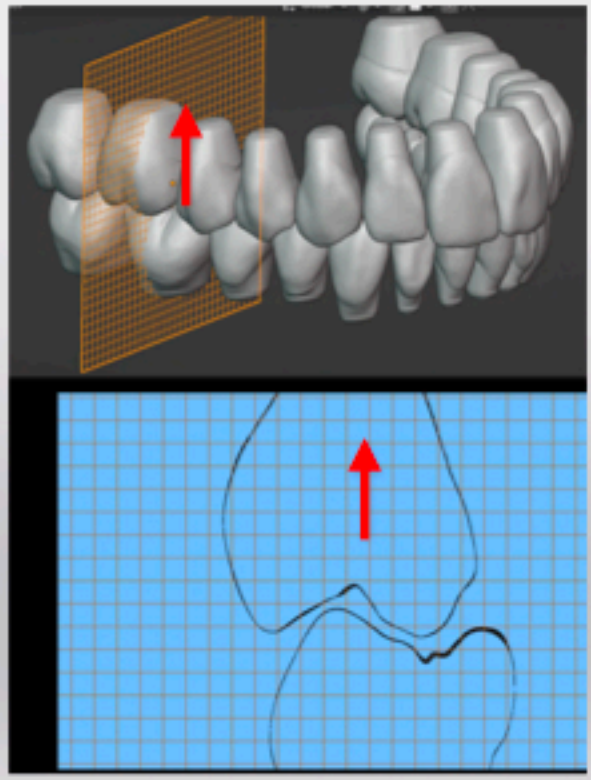
No sideways forces on back teeth.
Comfortable Muscles.



Digital Tooth Libraries
Occlusal Contacts on Inclines



Presets on how far out of occlusion to make crown



www.Despair.com

MEDIOCRITY

It Takes a Lot Less Time
and Most People Won't Notice the Difference
Until It's Too Late.

Dr. Glenn Kidder 2015

90 Consecutive New Patients

84 / 100 crowns done in past year were out of occlusion, did not hold 12µ shim stock

Bonding Zirconia, E.max, Porcelain, Gold

Roughen with Diamond

Microtech

Katana Cleaner, Kuraray
Removes phosphates, saliva

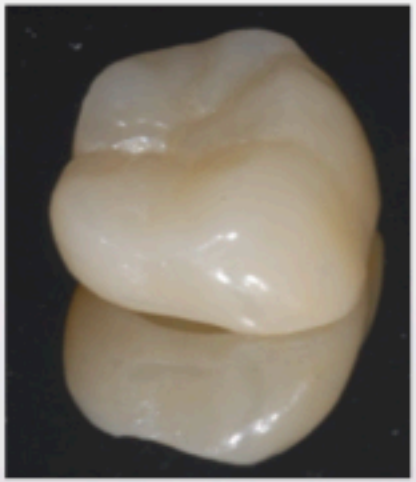
Clearfil Ceramic Primer Plus, Kuraray
3 coats: 30 sec each

All Bond, Bisco

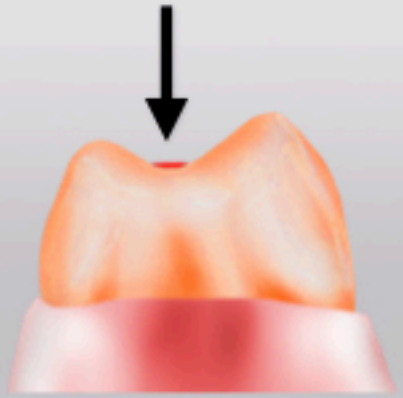
Light Cure
Critical step for stronger bond

Filtek Composite shade B1B

Challenge yourself to create perfect
form and function on a single tooth.
Occlusal contact holds 12µm Almore shimstock.

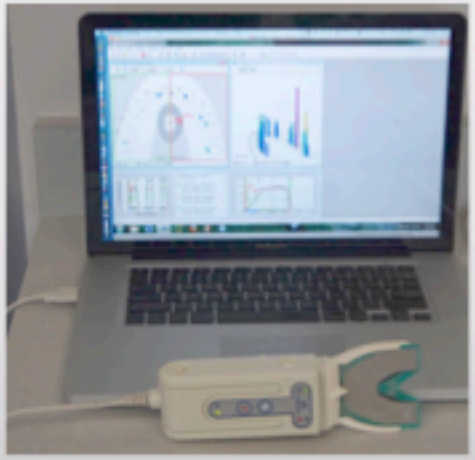


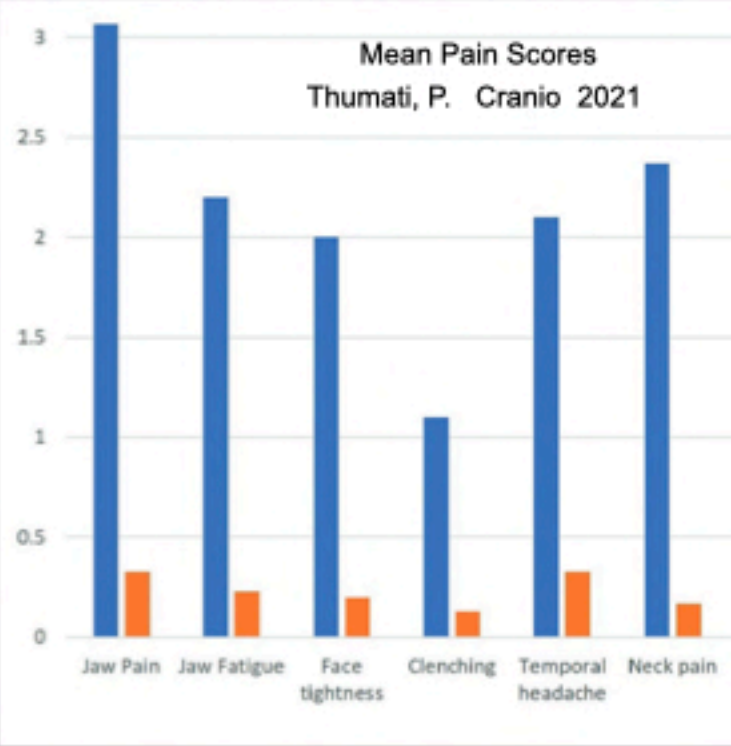
Flat landing area



Note: Insurance reimbursement is not enough to
make functional crowns

The best orthotic is no orthotic with teeth adjusted to a disclusion time of less than 400 mSec with T-Scan





Kerstein, RB. Cranio 1995
Treatment of myofascial pain dysfunction syndrome with occlusal therapy to reduce lengthy disclusion time—a recall evaluation.
Thumati ,P. J Indian Prosthodont 2016
The effect of disocclusion time-reduction therapy to treat chronic myofascial pain: A single group interventional study with 3 year follow-up of 100 cases.
Thumati, P. Cranio 2021
A retrospective five-year survey on the treatment outcome of disclusion time reduction (DTR) therapy in treating temporomandibular dysfunction patients.

The best orthotic is no orthotic with teeth adjusted to a disclusion time of less than 400 mSec with T-Scan

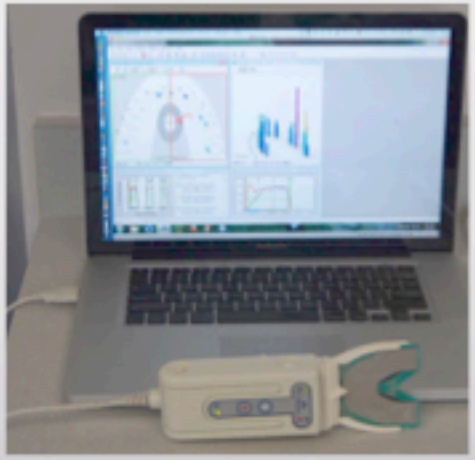


Table of Signs and Symptoms Associated with Bruxing

Patient Report with Bruxism None = 0, occasional = 1, often = 2, always = 3	Pre-treatment	Day 1 post	1 Week post	1 month post	12 months post
Aware of nighttime tooth grinding	88	38	21	20	11
Morning facial muscle soreness	89	38	2	2	0
Morning headache	94	31	23	20	3
Afternoon or evening headache	55	35	1	1	0
Teeth sensitive to cold	74	33	0	0	0
Daytime tooth clenching or grinding	48	36	9	7	1
Clinical examination never = 0, minor = 1, moderate = 2, severe = 3	p =	0.00078		0.00715	
	0.00408		0.02275		
Current Tooth Wear	57	57	57	57	57
Masseter muscle hypertrophy	49	49	15	15	15
Muscles tender to palpation	44	37	1	1	1
Wear facets	46	46	46	46	46
Indentations on the tongue	45	45	10	6	0
Linear Alba on inner cheek	15	15	4	4	0

Thumati, Kerstein, Radke. Advanced Dental Technologies & Techniques. December 2021
Bruxism Improvements After Disclusion Time Reduction (DTR) – A Pilot Study.

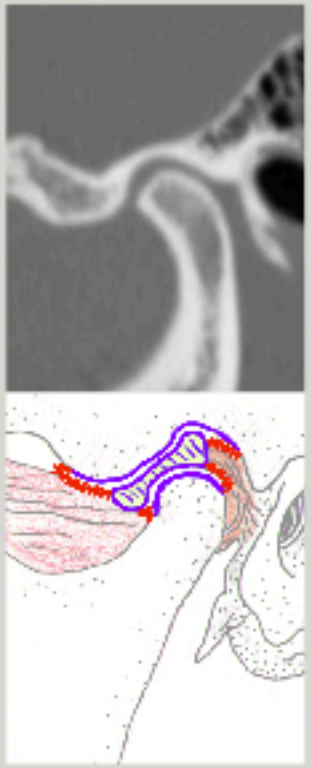
6 Common TMDs

Diagnosis	Pattern	Treatment
Clenching	Patient is aware Masseters Ache Morning TMJ clicking that resolves	Occlusal Adjust D-PAS Night Guard (if inhibition) Magnesium and Vitamin C hs
Sleep Grinding	Worn Teeth	Protective night guard Airway night night guard
Occlusal Muscle Dysfunction	Sore muscles when chewing Sore Lateral Pterygoid, Headaches Day D-PAS Relieves Symptoms	Occlusal Adjustment
Osteoarthritis of TMJ	**Arthralgia** **CBCT shows worn bone loss** **MRI T2, STIR ++**	**NSAID for 6-12 weeks** **Occlusal Adjustment** **Do not put in a night guard**
Sprain Discal Ligament TMJ, Acute	Sudden onset pain TMJ, sore TMJ Limited opening Soft end point active stretch	Cold Laser, Ice 15 min 3x a day Rest, Soft diet, NSAID 7 days Anterior Reposition Orthotic 7 days
Acute Closed Lock TMJ	Sore TMJ Limited opening Hard end point active stretch	Arthrocentesis with PRP

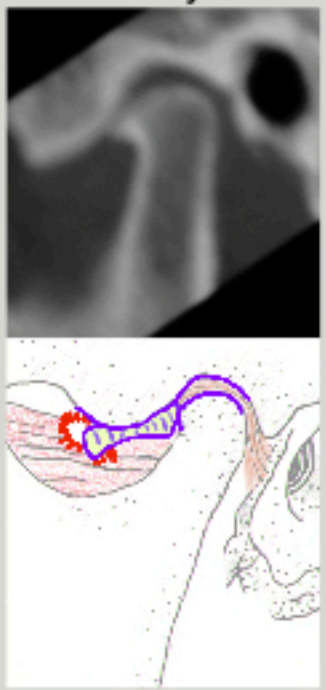
Osteoarthrosis/Osteoarthritis

Healthy joints have no friction or wear.
Damaged joints have Friction. Friction causes wear.
OA is a wearing out of a joint which starts in cartilage.
Parafunction increases wear.

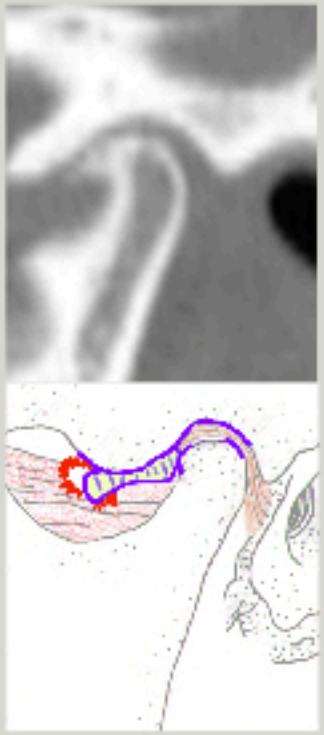
Normal



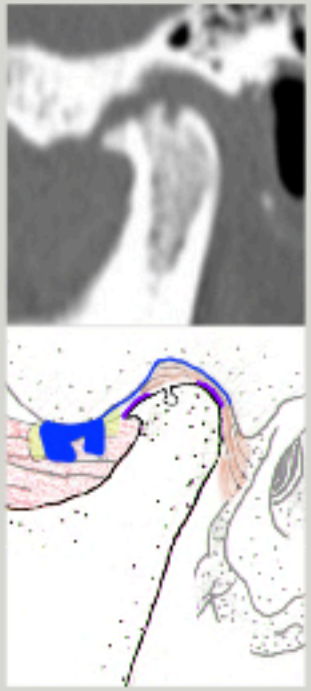
Early



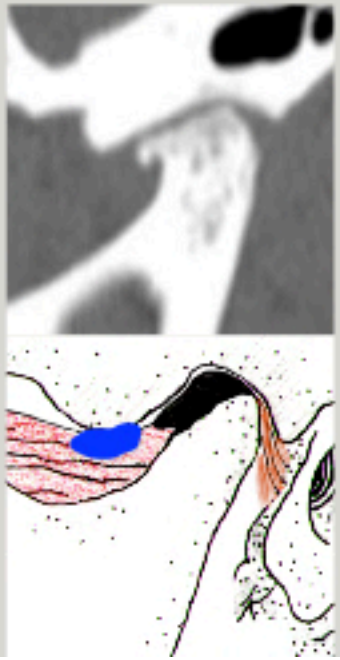
Early/ Moderate



Moderate



Severe OA, Eburnation

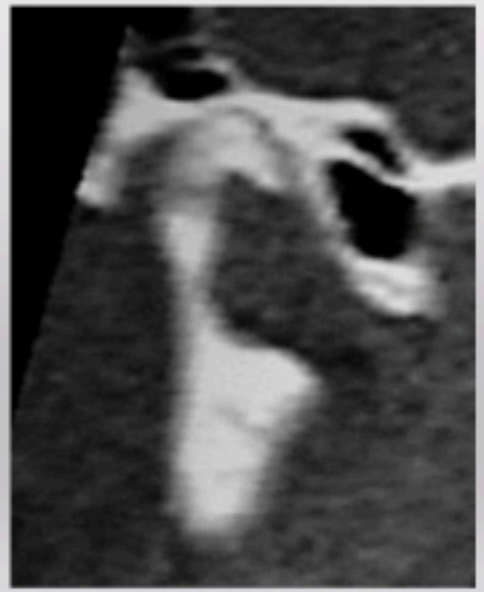


Representative examples of OA
in different patients

Drawings by Gretta Tomb DDS and John Droter DDS

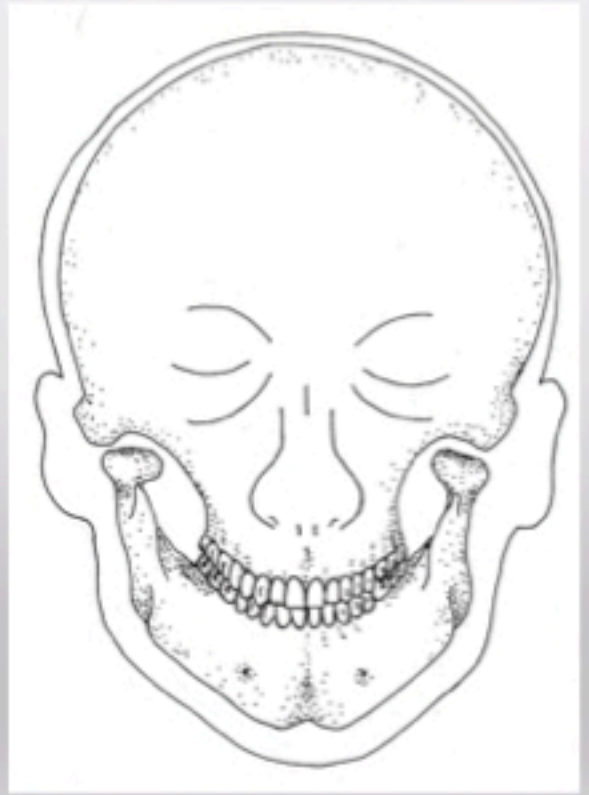
Adaptation Chronic Bilateral Osteoarthrosis

Mandible recedes Slowly
Teeth Move/ Adapt
Anterior Guidance gets steeper as Condylar Guidance get shallower

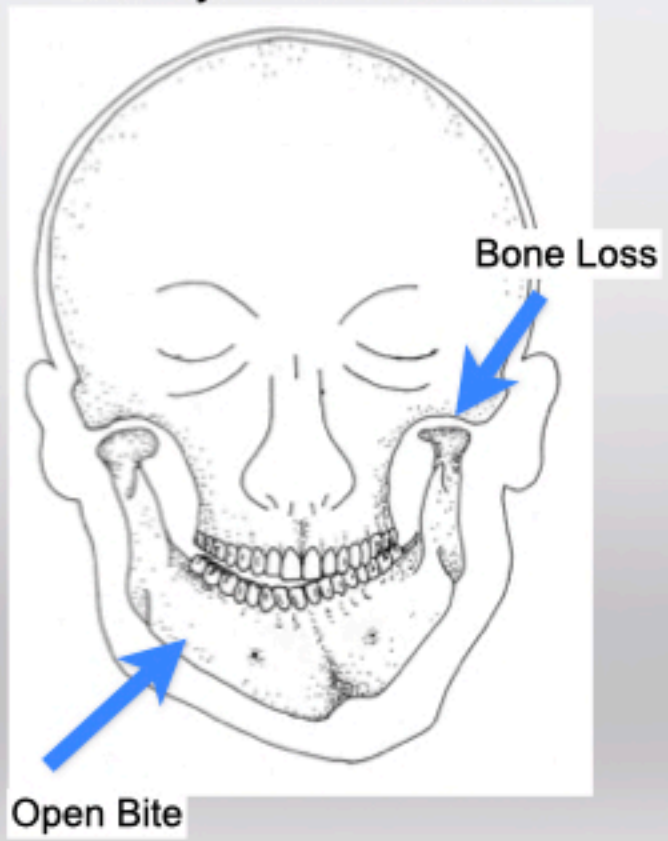


OA Right and Left Bone Loss
#8 Ankylosed

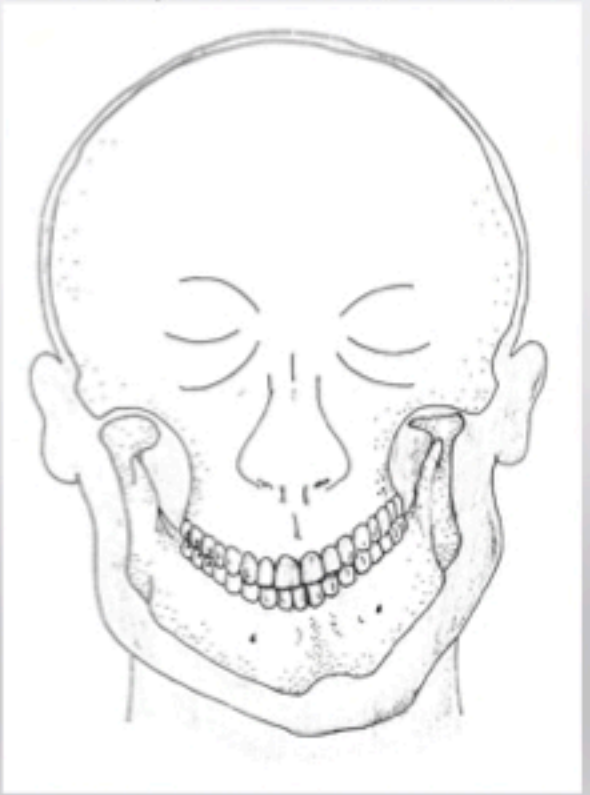
Diseases that cause bone loss in the TMJ alter the Occlusion



Condylar Bone Loss



Adaptation Over Time



Drawings by Gretta Tomb, DDS

Treatment OA

Osteoarthr**osis**

- Glucosamine 1500mg /Chondroitin 600 mg per day
- Minimize parafunction:
  - D-PAS
  - Brux Pas
  - Posterior stop night guard

Shea Brand CBD

Osteoarthr**itis**

- All of the above plus eliminate inflammation……
  - NSAIDs for 6+ weeks
  - Cold Laser

If still inflamed arthrocentesis with Platelet Rich Plasma (PRP)

MLS Laser
9 sessions over 4 weeks

MLS Laser: BioResearch

808 nm Continuous, 905 nm Pulsed

Multiwave Locked System Laser

Diode Laser

Stimulates metabolic processes in cells
Increase release NO from cells
Decrease inflammation
Pain Reduction
Faster Healing
Eliminates Trigger Points
Much better than Dry Needling

Chung, H., Dai, T., Sharma, S. K., Huang, Y.-Y., Carroll, J. D., & Hamblin, M. R. (2012). The nuts and bolts of low-level laser (light) therapy. Annals of Biomedical Engineering, 40(2), 516–533.

Ilbuldu E, Cakmak A, Disci R, Aydin R. Comparison of laser, dry needling, and placebo laser treatments in myofascial pain syndrome. Photomed Laser Surg. 2004 Aug;22(4):306-11.

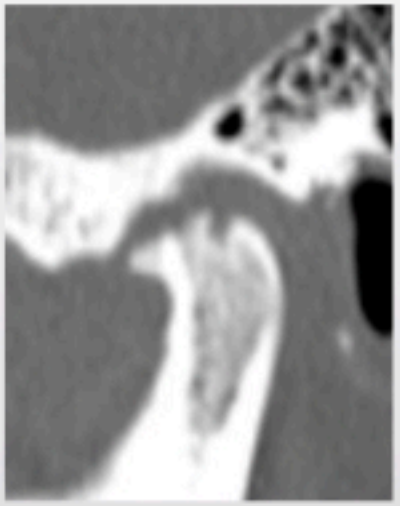
Treatment OA

Osteoarthr**osis**

- Minimize parafunction:
  - If sleep grinding due to airway:
  - CPAP or Dental Airway Device
- Glucosamine 1500mg /Chondroitin 600 mg per day

If still pain in 6 -12 weeks of NSAID:

- Arthrocentesis
- Platelet Rich Plasma



Osteoarthr**itis**

All of the above plus eliminate inflammation……

- NSAIDs
- Cold Laser

If still inflamed arthrocentesis with:

- Platelet Rich Plasma (PRP)
- Anterior stop
- Jaw Movement Exercises

6 Common TMDs

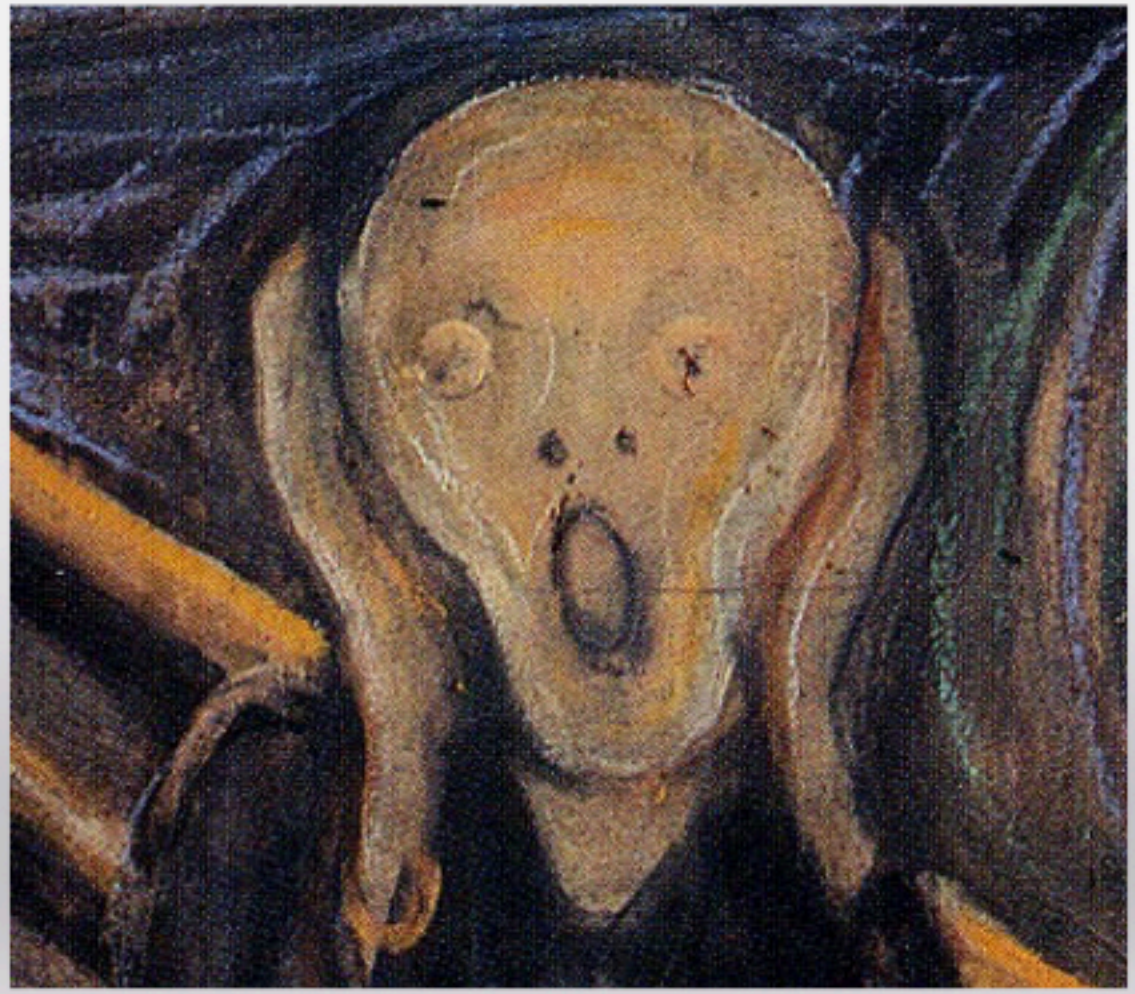
Diagnosis	Pattern	Treatment
Clenching	Patient is aware Masseters Ache Morning TMJ clicking that resolves	Occlusal Adjust D-PAS Night Guard (if inhibition) Magnesium and Vitamin C hs
Sleep Grinding	Worn Teeth	Protective night guard Airway night night guard
Occlusal Muscle Dysfunction	Sore muscles when chewing Sore Lateral Pterygoid, Headaches Day D-PAS Relieves Symptoms	Occlusal Adjustment
Osteoarthritis of TMJ	Arthralgia CBCT shows worn bone loss MRI T2, STIR ++	NSAID for 6-12 weeks Occlusal Adjustment Do not put in a night guard
Sprain Discal Ligament TMJ, Acute	Sudden onset pain TMJ, sore TMJ Limited opening Soft end point active stretch	Cold Laser, Ice 15 min 3x a day Rest, Soft diet, NSAID 7 days Anterior Reposition Orthotic 7 days
Acute Closed Lock TMJ	Sore TMJ Limited opening Hard end point active stretch	Arthrocentesis with PRP

TMD Symptoms

Limited Opening

Diseases to consider and rule out:

- Pain Avoidance Sore Joint
- Pain Avoidance Sore Muscle
- Hematoma
- Muscle Spasm
- Masseteric Space Infection
- Nonreducing Disc (4b,3b Acute)
- Joint Fibrosis, Muscle Fibrosis
- Other



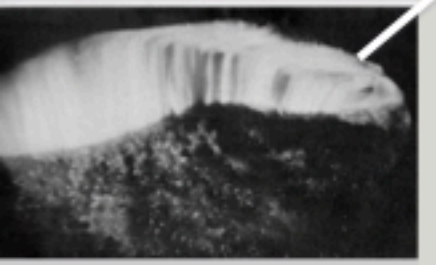
Differential Diagnosis: Limited Joint Motion

Muscle Spasm

Painful to Move
- Joint Pain
- Muscle Pain

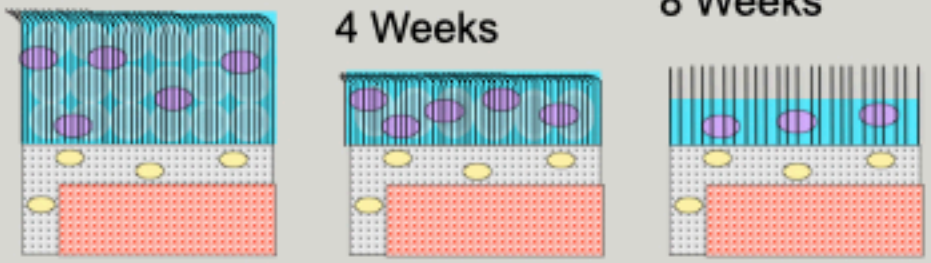
Mechanically Blocked
- 4b Acute
- Adhesion

Masseteric Space
- Infection
- Hematoma



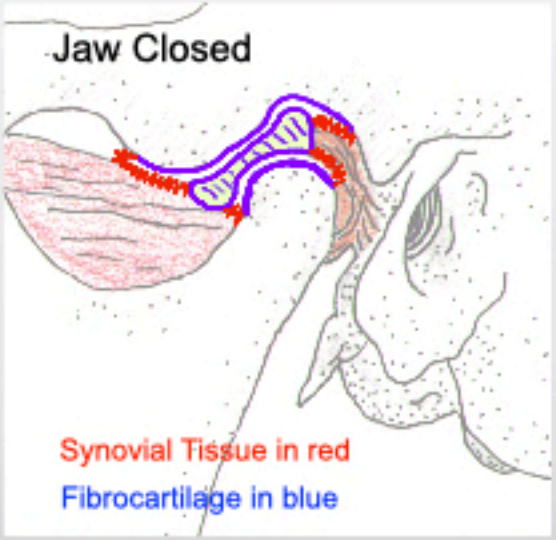
Lose 50% height of cartilage
Proteoglycans not being produced by Chondrocytes
Loss of 50% proteoglycans and water
Collagen still intact
Process is reversible
Move joint with light force/repetitive motion next 30 days

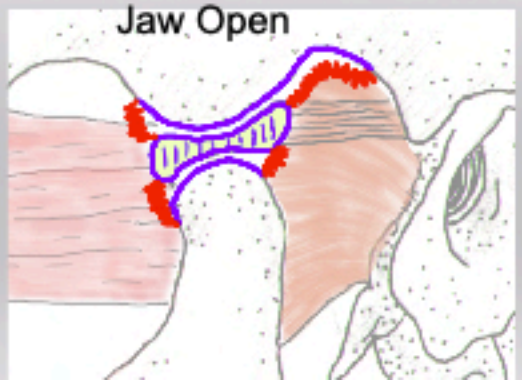
You have 6-8 weeks to get jaw moving before cartilage is irreversibly damaged, independent of the cause of the immobilization



E.B. Evans, GWN Eggers, J.K. Butler, and J. Blumel, Experimental immobilization and remobilization of rat knee joints, J Bone Joint Surg Am, 1960 vol. 42 (5) pp. 737-758
Enneking WF, Horowitz M. The intra-articular effects of immobilization on the human knee. J Bone Joint Surg Am. 1972 Jul;54(5):973-85. PMID: 5068717

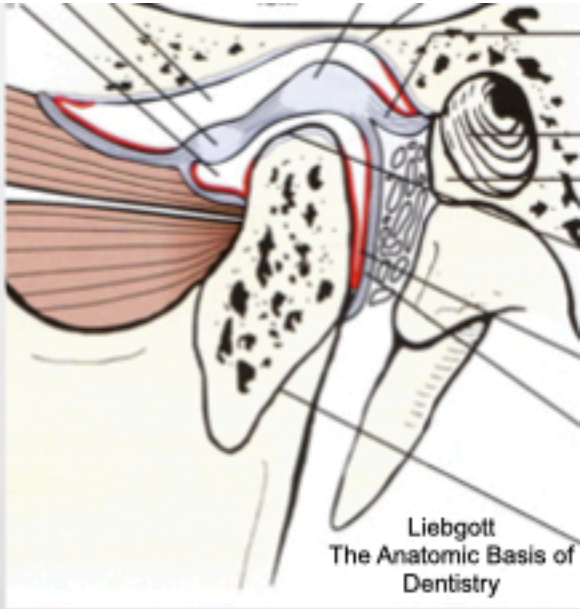
Normal TMJ- Synovium, Cartilage

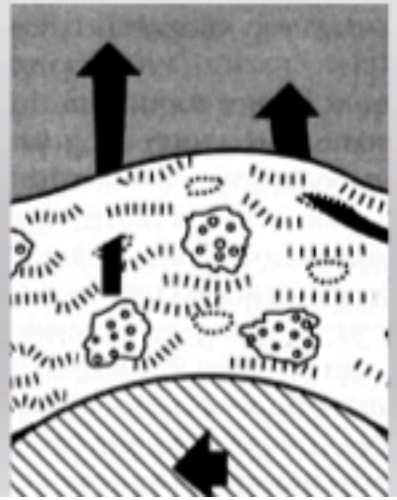




Fibrocartilage-
- Slope of Eminence
- Disc
- Top of Condyle

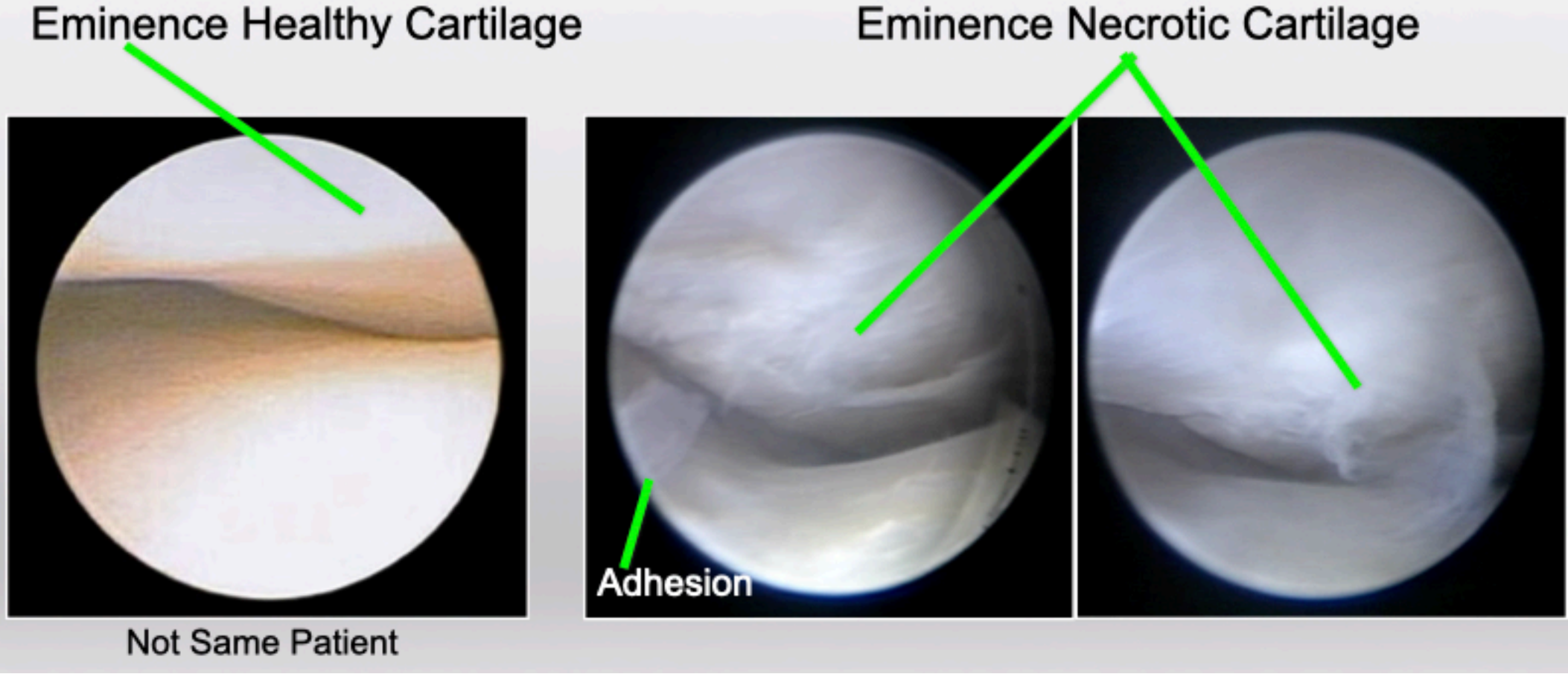
Synovial Tissue makes Synovial Fluid
- No blood vessels in a health joint
- Nutrition to the cartilage cells
- Lubrication- Hyaluronic Acid and Lubricin

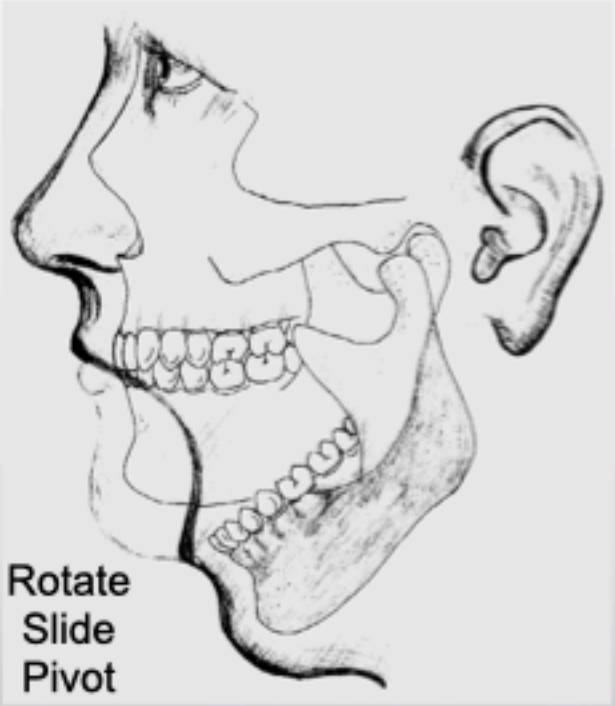




Fibrocartilage surface covered in fluid
- Cartilage is hydrophilic
- Proteoglycan negative charge
- Surface Active Phospholipids
- Fluid slides against fluid
- 5x slipperier than ice

Arthroscopic View Left TMJ



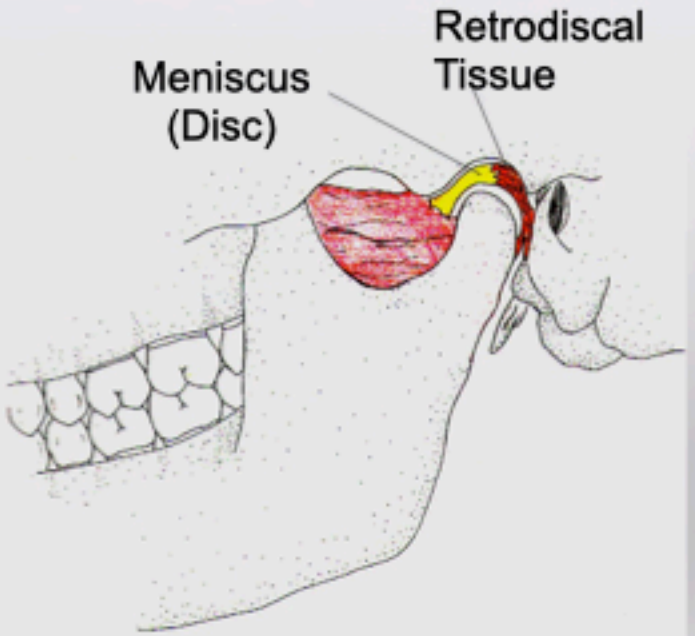


Rotation only 25mm

Max Open	40-55mm
Right Lateral	10-12mm
Left Lateral	10-12mm
Protrusive	10-12mm

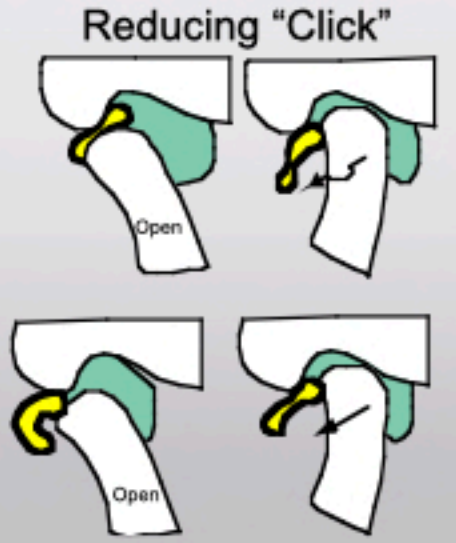
TMJ has 2 Joint Compartments:

Upper- Translation
Lower- Rotation



Acute non-Reducing Disc Limits Translation.

"Old Adapted" may have full range of motion.



Limited Opening Algorithm

Differential Diagnosis Limited Opening:

- Pain Avoidance Sore Joint
- Pain Avoidance Sore Muscle
- Hematoma
- Muscle Spasm
- Masseteric Space Infection
- Nonreducing Disc (4b,3b Acute)
- Joint Fibrosis, Muscle Fibrosis
- Other

Diagnostic Tests:

- History: How long limited
- Body Temperature
- Caries Exam, Perio exam
- ROM open, side to side
- Gentle Active stretch
  - Point to area of pain
- Anterior Stop
- If needed CBCT, MRI

Dr Droter's Limited Opening Algorithm

Differential Diagnosis Limited Opening (Less than 38mm): Pain Avoidance Sore Joint, Pain Avoidance Sore Muscle, Hemtoma, Muscle Spasm, Masseteric Space Infection, Nonreducing Disc (4b,3b Acute), Joint Fibrosis, Muscle Fibrosis, other.

Palpate First

How long with limited opening?
Can move fully side to side?
Measure Max Opening <38mm

8+Weeks **and**
Limited side movement
Verify hard end point

Less than 6 weeks
Or Can move jaw fully left and right

Permanent joint damage
Regardless of original cause now have:
- Permanent cartilage damage
- Muscle fibrosis

MRI and CBCT of the TMJ to assess damage
Anti-inflammatory medication if pain
Physical therapy: active stretching
- Tongue blade stretch or Dynasplint

Rule out Masseteric Space Infection
Temperature
Palpate Medial Pterygoid, Submandibular
Palpate Salivary Glands
Look for decay
Perio probe distal to molars
Take CBCT or other RG if suspect

Elevated Body Temp
Painful, medial pterygoid area
Caries or Perio pocket distal molars

No Signs Infection

Masseteric Space Infection
Refer to Oral Surgeon or ER immediately
Risk of airway closure, May need to be intubated
Will need CBCT and antibiotics

Rule out Hematoma Dental injection

No Signs Hematoma

Body Temp Normal
Painful medial pterygoid area
Recent Dental Injection

Hematoma
Cold Laser Intraoral

Maximal Opening Active Stretch
Range of Motion side to side
History of jaw clicking

Hard end point active stretch
Limited jaw move to one side
Past history of clicking

Soft end point w/ active stretch
May or may not have hx clicking

Anterior disc displacement non reducing
Easy ROM exercises, especially lateral
Refer oral surgeon: CBCT, Arthrocentesis, MRI

Palpate TMJ, Load TMJ
Palpate Masseter, Temporalis
Active Stretch and point to pain
If no TMJ pain do Anterior Stop

Soft end point
TMJ Pain
Active stretch points to joint

No TMJ Pain
Soft end point,
Active stretch points to muscle

Pain Avoidance, TMJ Arthralgia

Joint Pain Diff Dx: Acute Sprain, Chronic Sprain, Osteoarthritis, Perforation of Pseudodisc, Discal perforation, Retrodiscal tissue impingement, Acute 4a, Fracture, Crush Injury other.

Pain Avoidance, Muscle Pain

Diff Dx: Muscle Bracing Fatigue, Trigger point, Muscle Spasm, other.

CBCT full field of view of head. MRI of TMJ if not resolved 2 weeks.

Acute Sprain TMJ Ligaments
Side to side may be limited. Possible posterior open bite
Soft Diet, Ice 15 min for 3-5x/day, NSAIDs 7 days.
Possible Anterior Stop or Anterior Posturing Orthotic 24/7 1 week.

Pull Accufilm

Anterior Stop

Muscle Bracing Fatigue
Anterior Stop Relieves
Cold laser, Hot cold hot as palliative.
Possible Anterior Stop prn
Possible Valium 5mg hs for 3 days
Eval for OMD, Sleep Clenching: DPA8 test

Chronic Sprain: Sprain not resolving, evaluate for sleep bruxing

Osteoarthritis TMJ
OA on CBCT, NSAIDs 6-12 weeks, Cold Laser 3x week for 3w

Trigger Point
Can palpate Trigger Point, Cold Laser Relieves.
Cold laser, Hot cold hot as palliative.
Need to find cause TrP: OMD, neck damage

Note: Acute Sprain is much more common than non reducing disc displacement as a cause of limited opening.

Subjective:

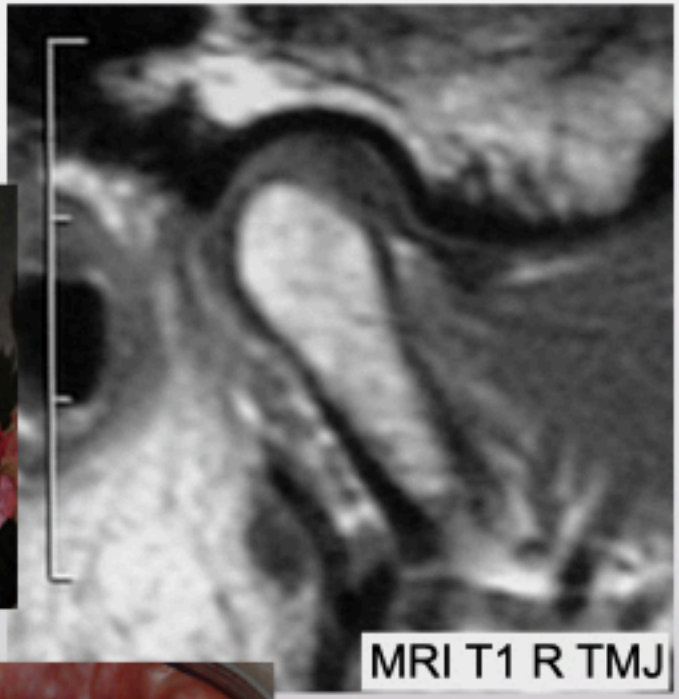
- Dentist doing crown prep #30 1 week ago
- Severe pain Right TMJ after moving jaw at end of appt
- Constant deep pain Right TMJ
- Limited opening

Objective:

- Limited opening 32mm, Mandible shifts Left
- Normal side to side motion
- 98 temp, normal perio probe 2nd molars, no caries
- No pain palpation RL Medial Pterygoid
- Soft end point on active stretch, 45mm, R TMJ pain
- Right TMJ pain to palpation, Left TMJ normal
- Posterior openbite Right, does not hold Accufilm

Assessment:

- Limited opening due to Right TMJ pain avoidance
- Acute Sprain Right TMJ Ligaments

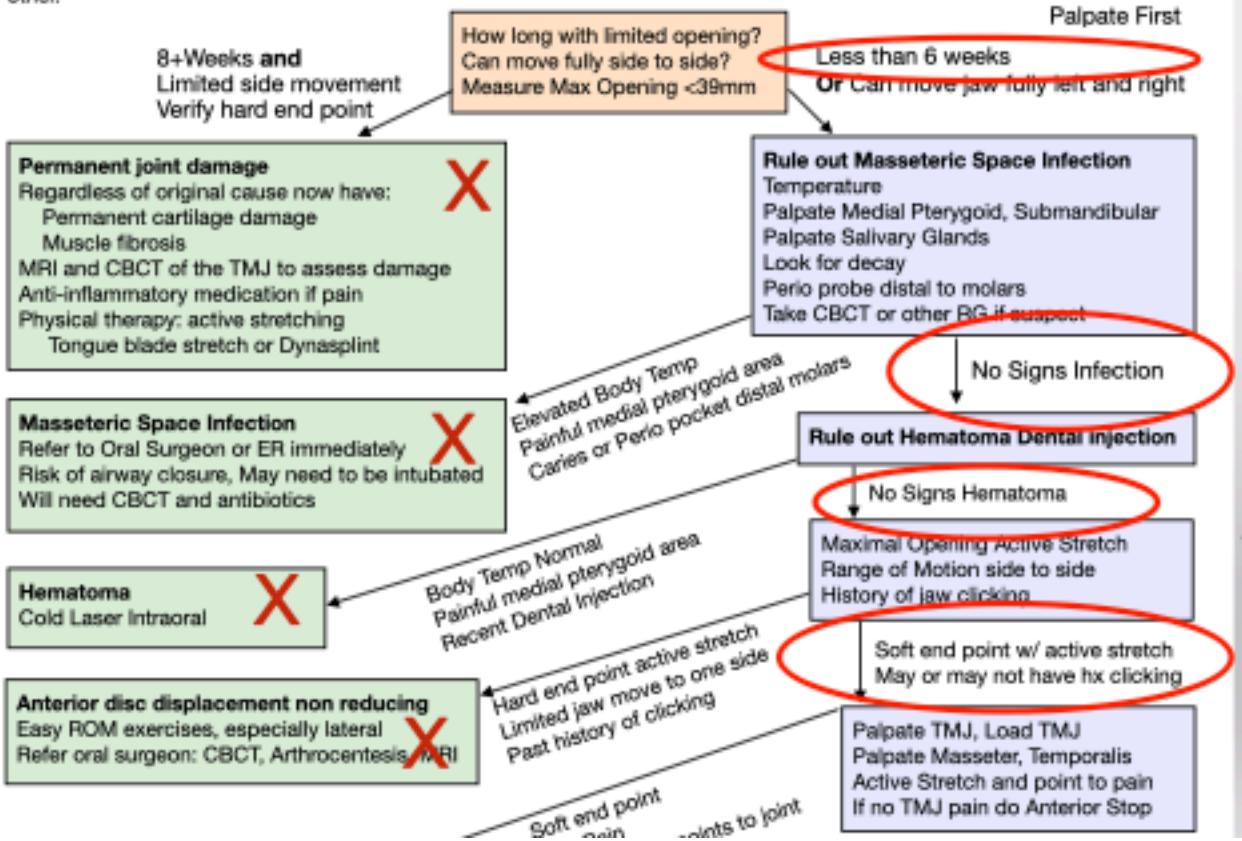


MRI T1 R TMJ

Dr Droter's Limited Opening Algorithm

22.3

Differential Diagnosis Limited Opening (Less than 39mm): Pain Avoidance Sore Joint, Pain Avoidance Sore Muscle, Hemtoma, Muscle Spasm, Masseteric Space Infection, Nonreducing Disc (4b,3b Acute), Joint Fibrosis, Muscle Fibrosis, other.



Objective:

Limited opening 32mm, Mandible shifts Left

Normal side to side motion

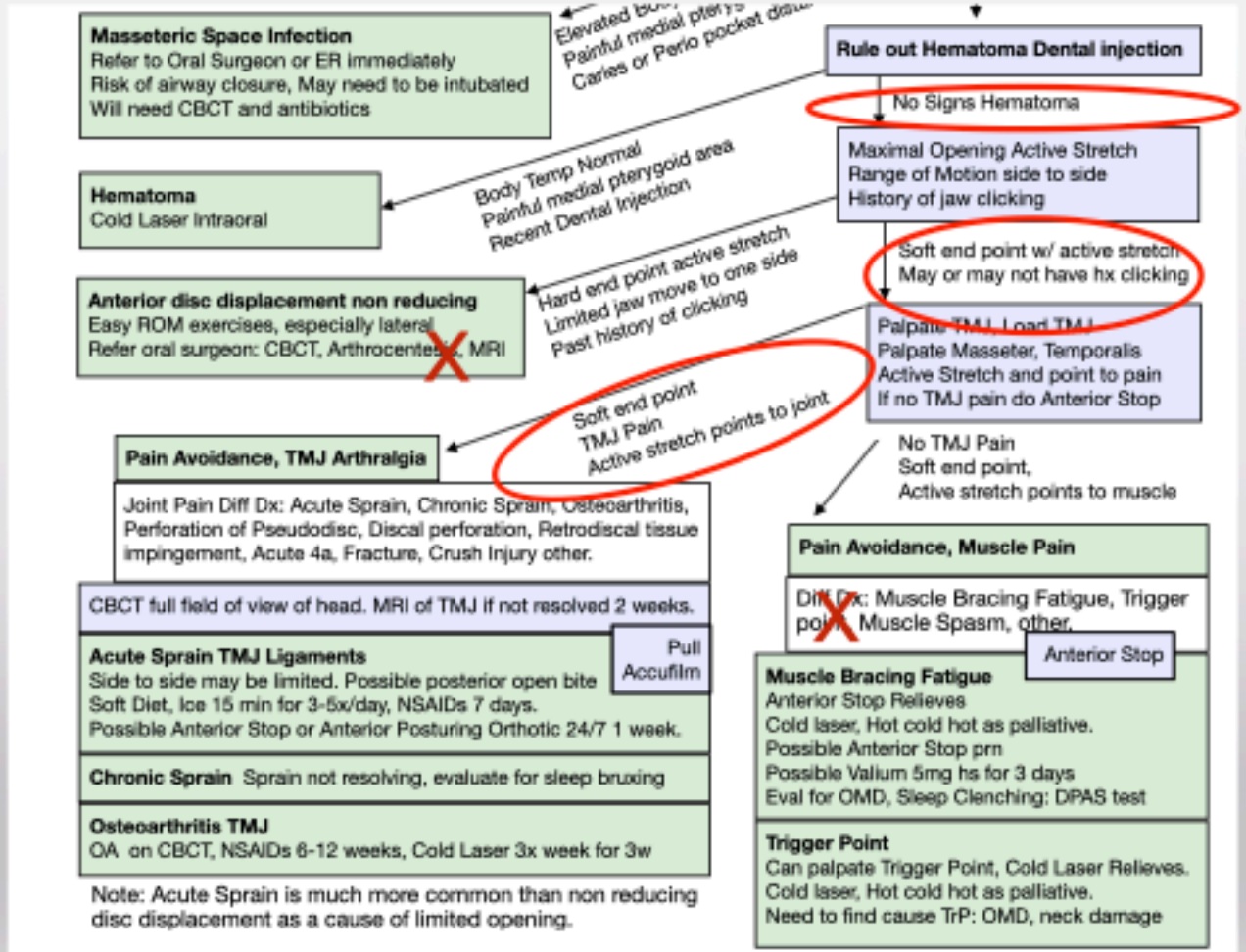
98 temp, normal perio probe 2nd molars, no caries

No pain palpation RL Medial Pterygoid

Soft end point on active stretch, 45mm, R TMJ pain

Right TMJ pain to palpation, Left TMJ normal

Posterior openbite Right, does not hold Accufilm



Objective:

Limited opening 32mm, Mandible shifts Left

Normal side to side motion

98 temp, normal perio probe 2nd molars, no caries

No pain palpation RL Medial Pterygoid

Soft end point on active stretch, 45mm, R TMJ pain

Right TMJ pain to palpation, Left TMJ normal

Posterior openbite Right, does not hold Accufilm

Working Diagnosis: Sprain Discal Ligament TMJ, acute with joint edema.
Pain Avoidance Sore Joint. Muscle bracing painful joint.

Treatment:
Ice 15-20 minutes for 3-5x 2 days only
Anterior repositioning orthotic 24/7 one week
NSAID for 5 days- 800mg Advil Liquid gel caps, q8h
Soft chew diet
At 1 week Anterior repositioning orthotic sleep only for second week
Week 3, no orthotic, reintroduce harder foods

At 4 weeks patient had full ROM
No clicking

Another Case Limited Opening :

Subjective:

Finished Invisalign 1 year ago
Has been clenching her teeth
Months ago jaw started locking in the morning on waking
8 weeks ago pain right jaw joint, could not open all the way
Motrin 800 mg upset stomach

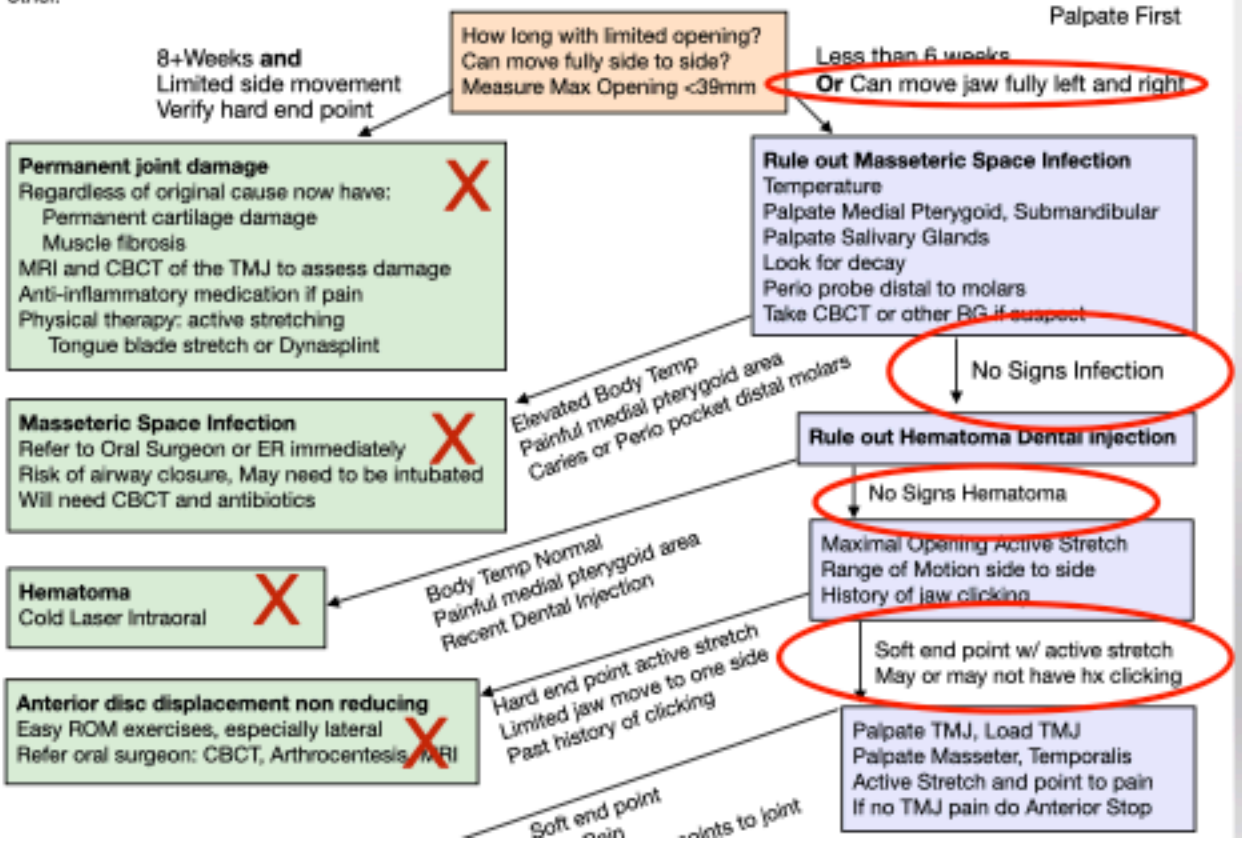
Objective:

Limited opening 25, Mandible shifts right
Normal side to side motion
98 temp, normal perio probe 2nd molars, no caries
No pain palpation RL Medial Pterygoid
Soft end point on active stretch, 35mm, R TMJ pain
Right TMJ pain to palpation, Left TMJ normal
Posterior cross bite on left

Dr Droter's Limited Opening Algorithm

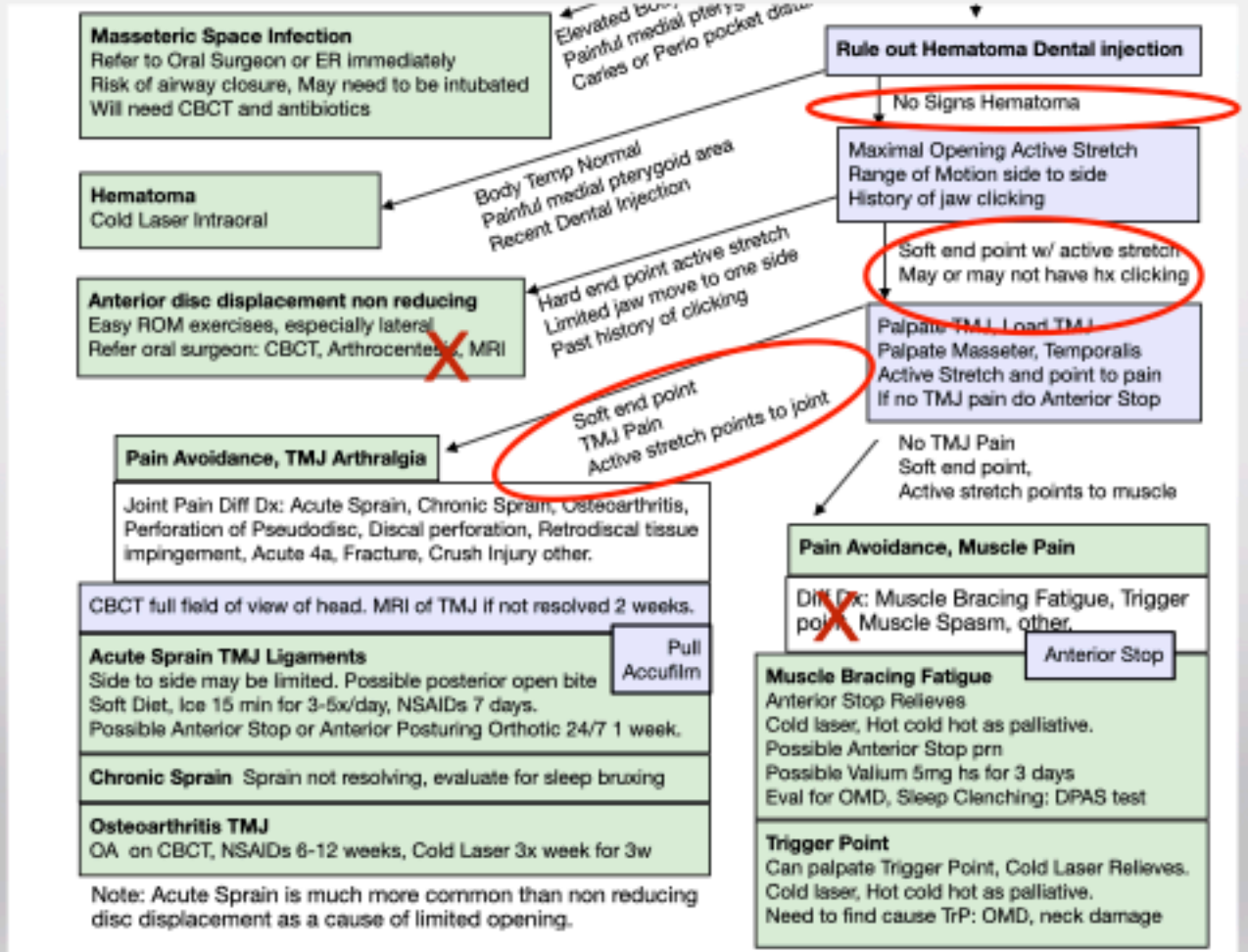
22.3

Differential Diagnosis Limited Opening (Less than 39mm): Pain Avoidance Sore Joint, Pain Avoidance Sore Muscle, Hemtoma, Muscle Spasm, Masseteric Space Infection, Nonreducing Disc (4b,3b Acute), Joint Fibrosis, Muscle Fibrosis, other.



Objective:

- Limited opening 25mm, Mandible shifts Left
- Normal side to side motion
- Normal temp, normal perio probe 2nd molars
- No caries
- No pain palpation RL Medial Pterygoid
- Soft end point on active stretch, 35mm, with R TMJ pain
- Right TMJ pain to palpation, Left TMJ normal



Working Diagnosis:

Acute Sprain Right TMJ Ligaments

Limited opening due to muscle bracing Right TMJ pain

Current Sprain Protocol

We used Advil gel caps
600mg tid with food

Soft chew diet
Ice over TMJ 15 minutes 3-5 times a day for 3-5 days,
Ice 2-3x a day for additional 3 days if needed
NSAID: Advil Liquid Gel Caps 200mg, 3 caps 3x a day
or Aleve Liquid Gel Caps 220mg, 1 cap twice a day for 5 days or
Temporary upper Anterior Stop for sleep
Cold Laser 350 hz both joints: 30 seconds open, 30 seconds closed
If still sore in 1 week will need TMJ imaging: CBCT and MRI

MLS Cold Laser
BioResearch

Temporary Anterior Stop
ArrowPath Sleep

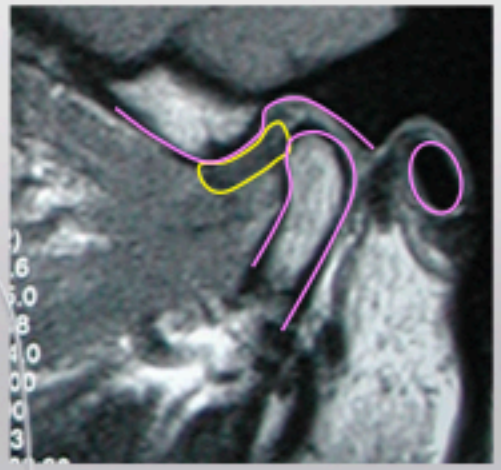
Ms MY

Treatment Acute Closed Lock

Anterior Stop or D-PAS for 3 weeks

Jaw Movement Exercises 5x day
- Left Right 20 reps
- Open Close 2 reps
- Front Back 2 reps
- Left Right 4 reps

Ice 10-15 min 3-5x a day
NSAID
Cold Laser



Verify with MRI

If still locked arthrocentesis with:
- Platelet Rich Plasma (PRP)
- Anterior stop
- Jaw Movement Exercises

6 Common TMDs

Diagnosis	Pattern	Treatment
Clenching	Patient is aware Masseters Ache Morning TMJ clicking that resolves	Occlusal Adjust D-PAS Night Guard (if inhibition) Magnesium and Vitamin C hs
Sleep Grinding	Worn Teeth	Protective night guard Airway night night guard
Occlusal Muscle Dysfunction	Sore muscles when chewing Sore Lateral Pterygoid, Headaches Day D-PAS Relieves Symptoms	Occlusal Adjustment
Osteoarthritis of TMJ	Arthralgia CBCT shows worn bone loss MRI T2, STIR ++	NSAID for 6-12 weeks Occlusal Adjustment Do not put in a night guard
Sprain Discal Ligament TMJ, Acute	Sudden onset pain TMJ, sore TMJ Limited opening Soft end point active stretch	Cold Laser, Ice 15 min 3x a day Rest, Soft diet, NSAID 7 days Anterior Reposition Orthotic 7 days
Acute Closed Lock TMJ	Sore TMJ Limited opening Hard end point active stretch	Arthrocentesis with PRP

John R. Droter, DDS
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6 Common TMDs

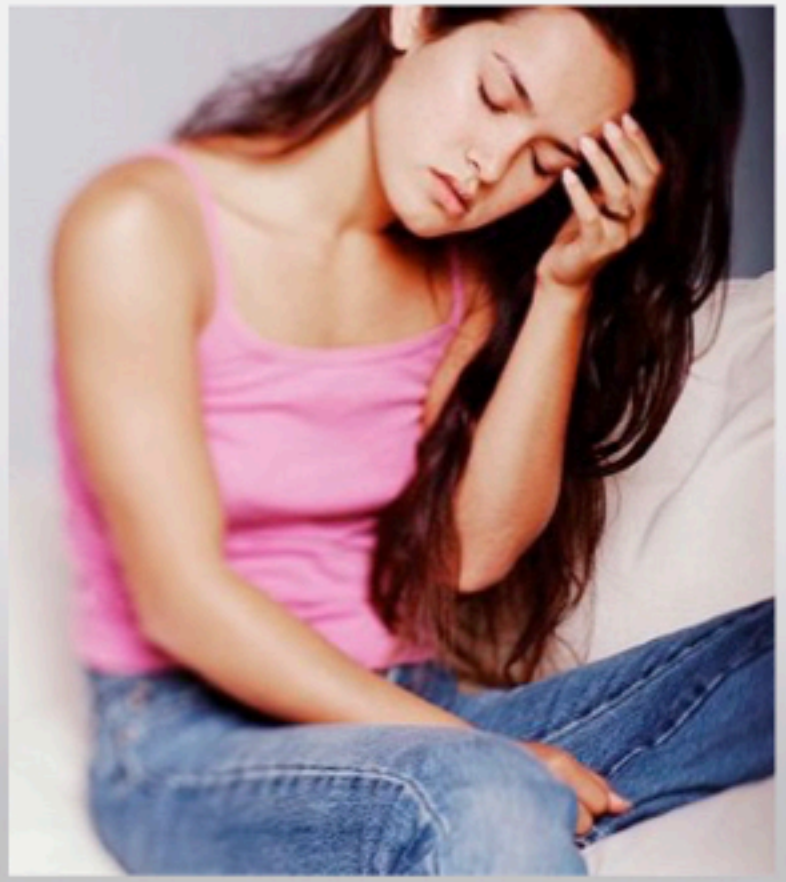
Parafunctional Clenching
Parafunctional Grinding
Occlusal Muscle Dysfunction
Osteoarthritis
Acute Sprain
Acute Closed lock of TMJ disc

5 Common Obstacles

Neck and Postural Instability
Wobbly TM Joint (Subluxation)
Compromised Breathing/Airway
Avascular Necrosis
Referred Pain Muscle Triggerpoints

1 TMD that **usually** does not need therapy

TMJ Clicking



mid detail

The Click

John R Droter DDS
Annapolis, Maryland

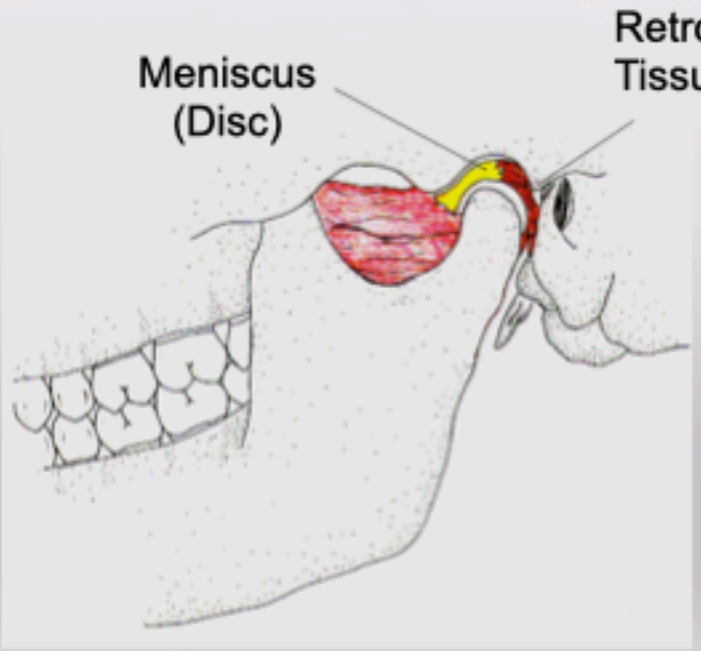
A joint joins two bones that allows movement between the two bones

TMJ has 2 Joint Compartments:

Upper- Translation
Lower- Rotation

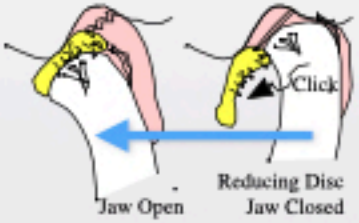
Rotate
Slide
Pivot

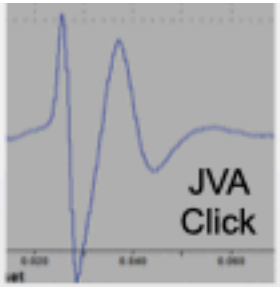
Solid end point closing
Ligamentous end point opening



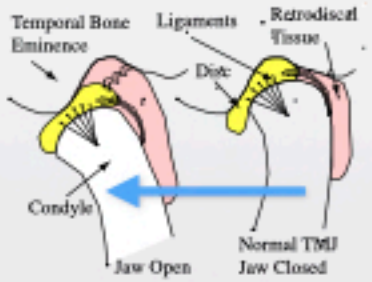
Differential Diagnosis of TMJ Clicking

Disc Reduction





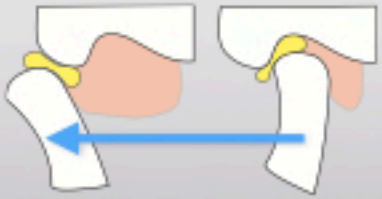
Normal



Adhesive Click

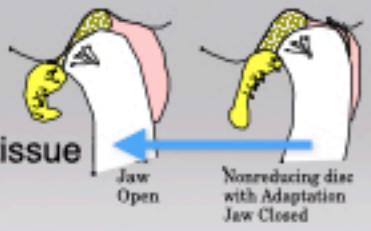
"Sticky Disc" - Disc sticks after prolonged clenching, then releases

Eminence Thud



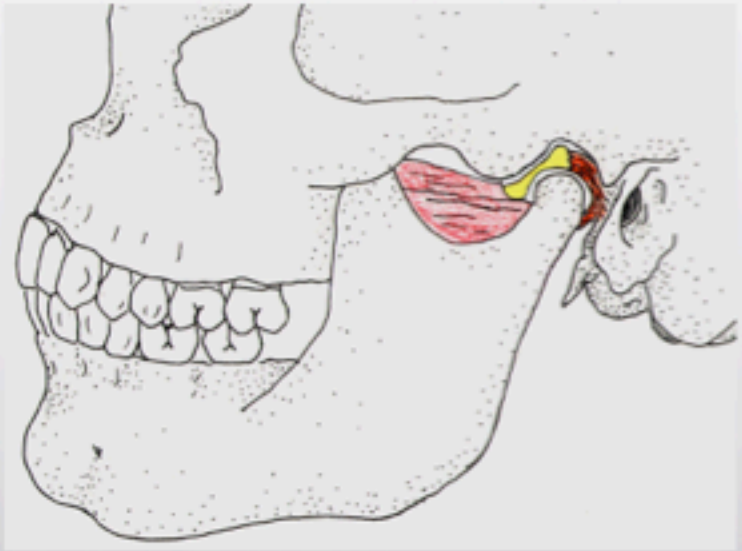
A hypermobile condyle moves past the crest of the eminence and makes a thud sound

Adhesion Crackle

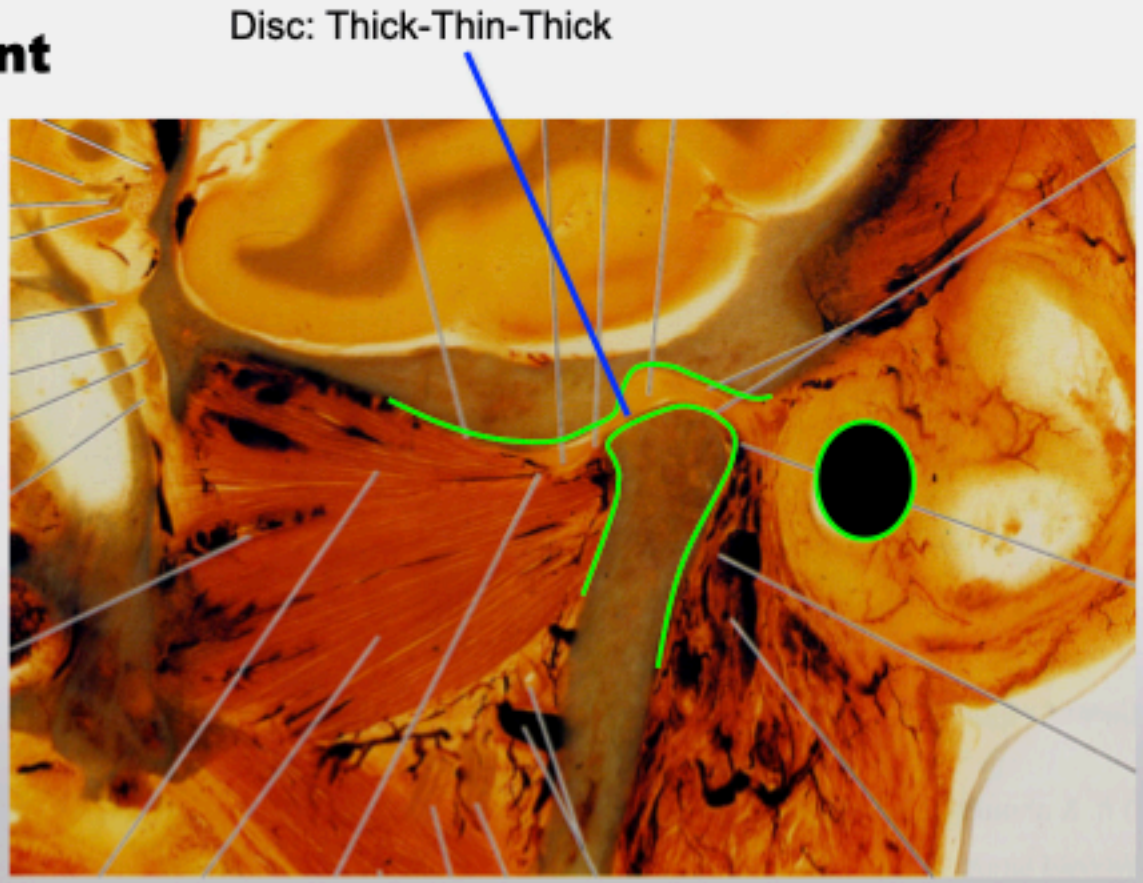


A small piece of fibrous tissue
4b joint is moved across

The Temporomandibular Joint

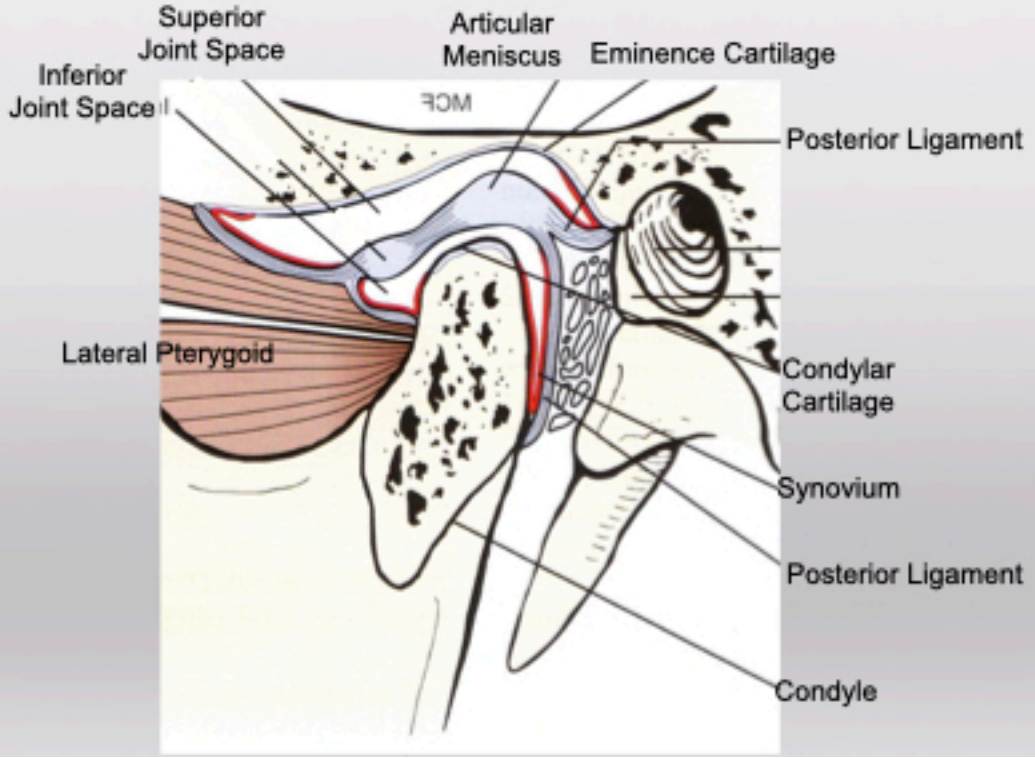


Ear
Sideways “S” Fossa
Condyle
Disc- Thick Thin Thick

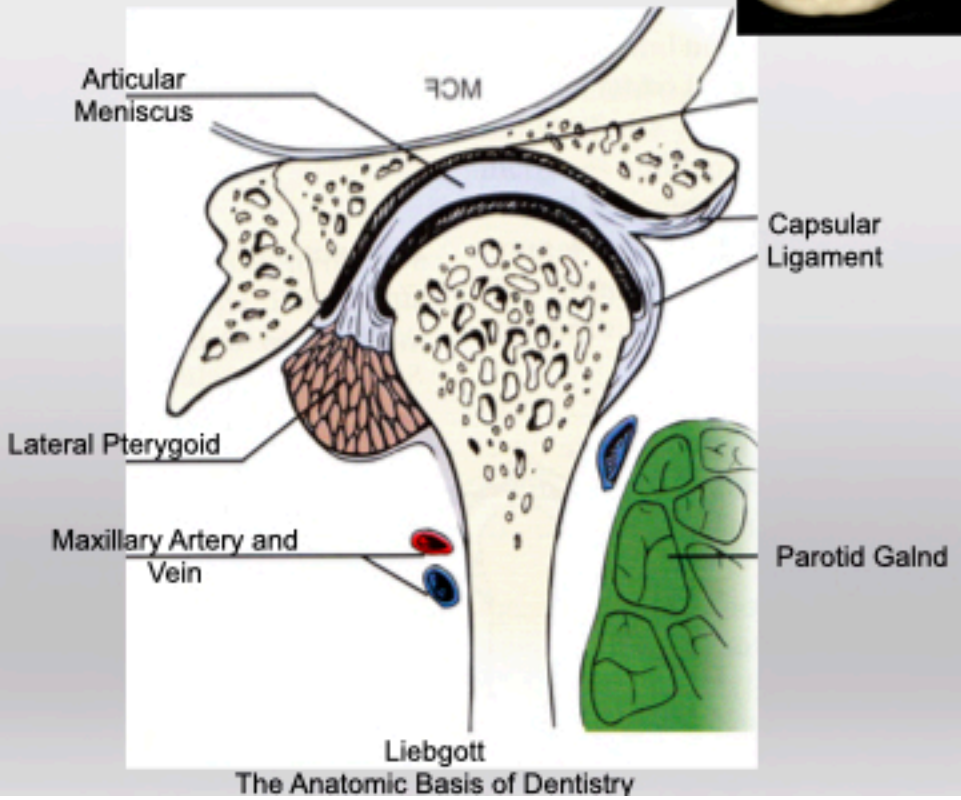


Oblique Sagittal View
Romrell, Mahan

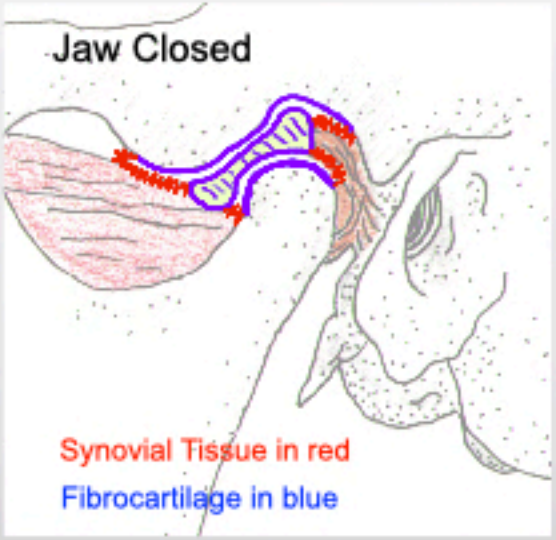
Left TMJ Sagittal View

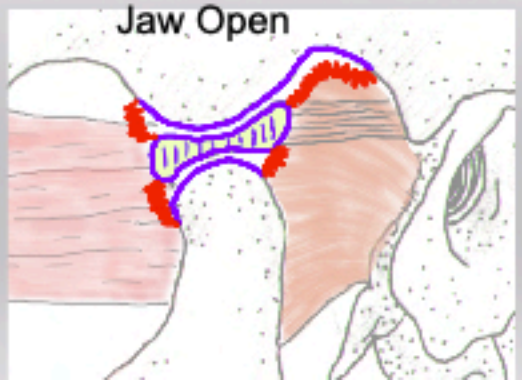


Left TMJ Coronal View



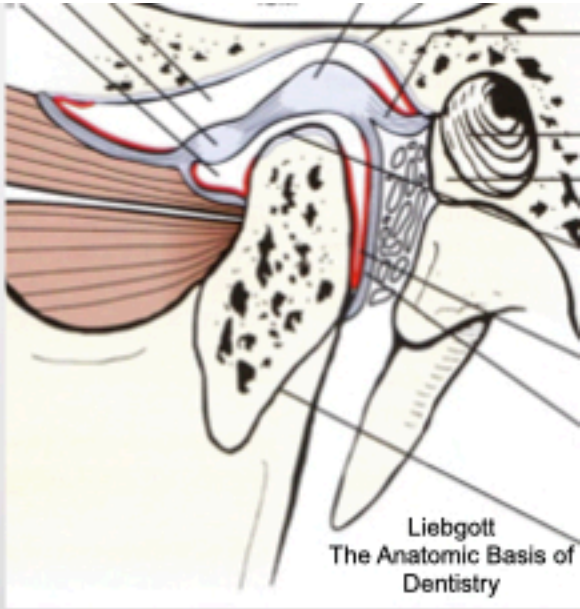
Normal TMJ- Synovium, Cartilage

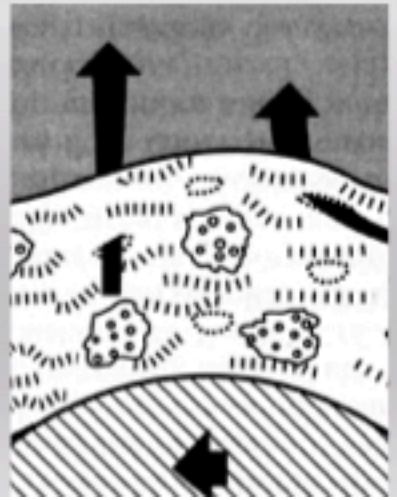




Fibrocartilage-
- Slope of Eminence
- Disc
- Top of Condyle

Synovial Tissue makes Synovial Fluid
- No blood vessels in a health joint
- Nutrition to the cartilage cells
- Lubrication- Hyaluronic Acid and Lubricin





Fibrocartilage surface covered in fluid
- Cartilage is hydrophilic
- Proteoglycan negative charge
- Surface Active Phospholipids
- Fluid slides against fluid
- 5x slipperier than ice

Normal TMJ

Discal Ligaments attach Disc to Condyle

Synovial Tissue
- Covers Front , Back and Sides
- Collapsed due to negative joint pressure

Disc viewed from above

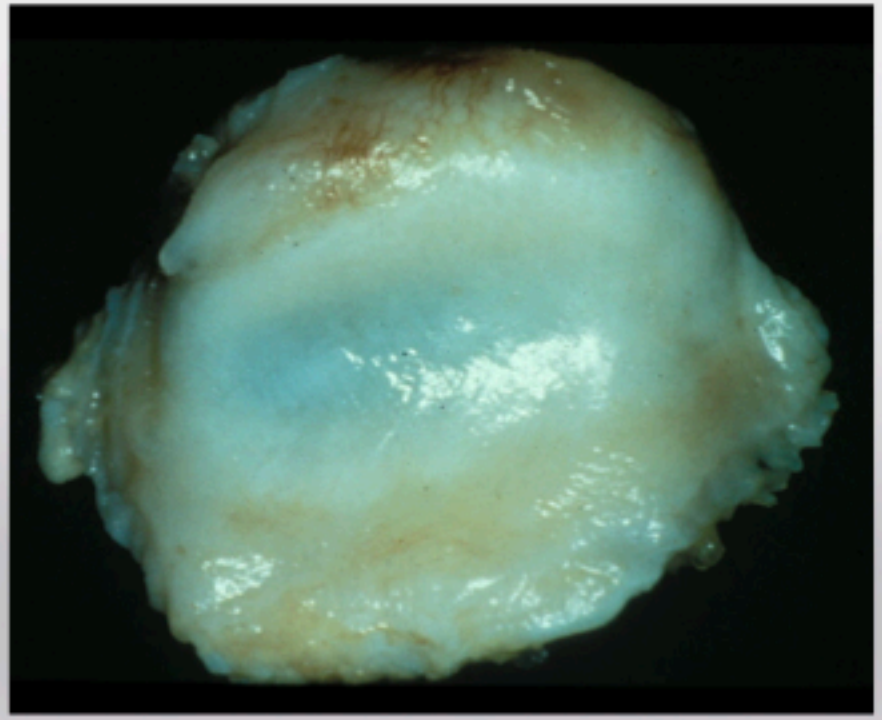
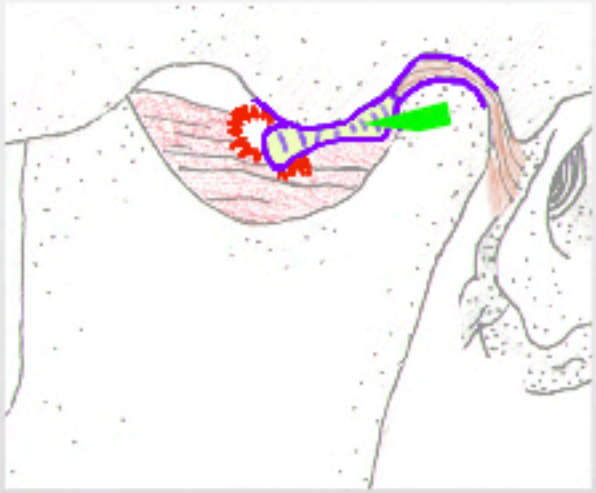


Photo Courtesy of Dr Henry Gremillion

Damaged TMJ- Anteriorly Dislocated Disc



Torn or stretched Meniscal ligaments

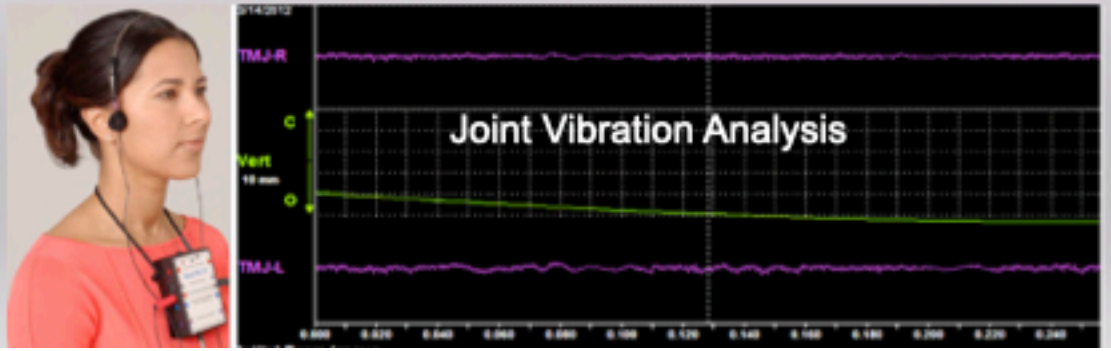
Anterior Dislocated Disc

Damaged Synovium

Retrodiscal Tissue pulled up and over the condyle
- Retrodiscal tissue in direct contact with fibrocartilage
- Major Increase in friction
- Retrodiscal tissue adapts into fibrous “pseudodisc”

85% of all damaged joints adapt favorably without treatment

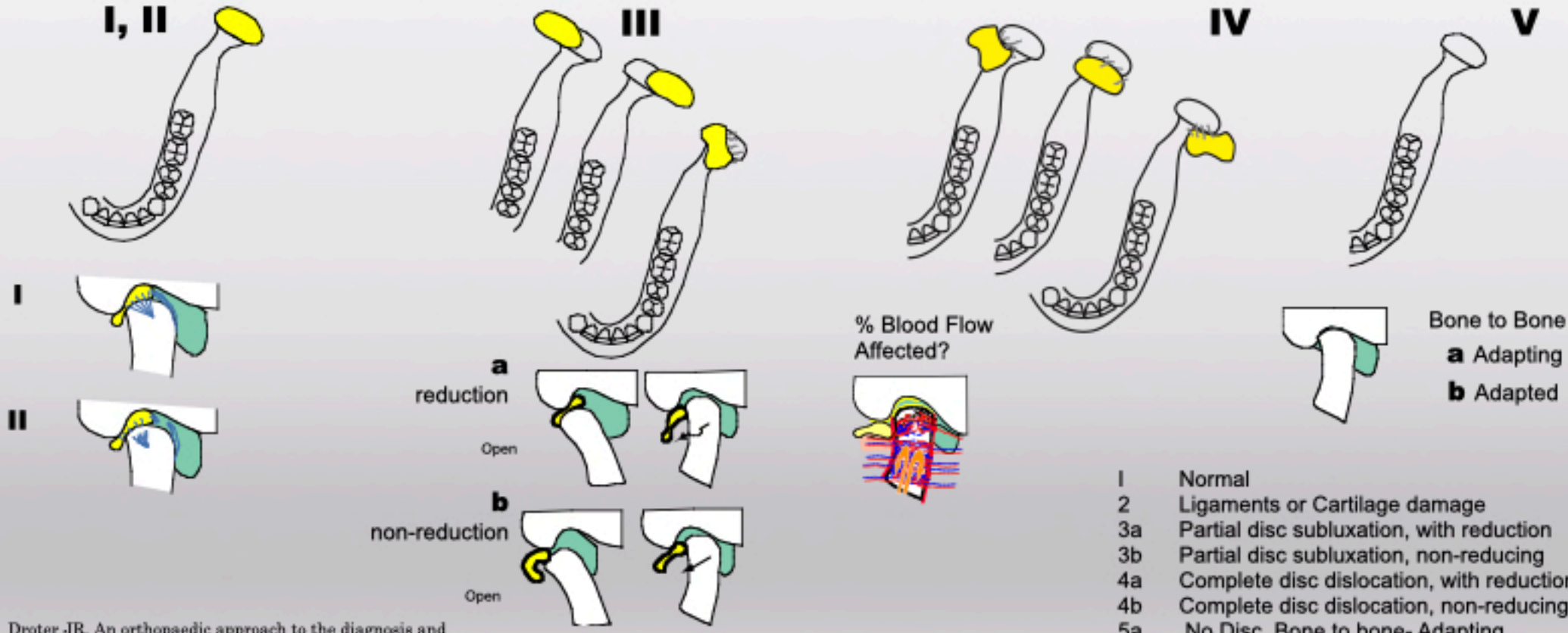
Cartilage sliding on tissue creates vibrations that can be detected




Condylar and Disk
Movements in Dissected
TMJ Autopsy Specimens

Dr. Mark Piper's Classification

Left TMJ



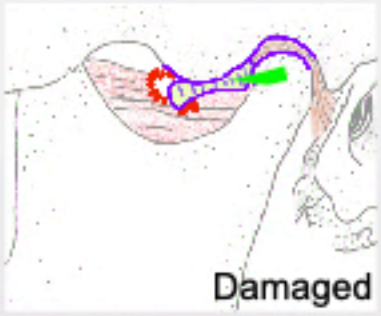
I	Normal
2	Ligaments or Cartilage damage
3a	Partial disc subluxation, with reduction
3b	Partial disc subluxation, non-reducing
4a	Complete disc dislocation, with reduction
4b	Complete disc dislocation, non-reducing
5a	No Disc, Bone to bone- Adapting
5b	No Disc, Bone to bone- Adapted

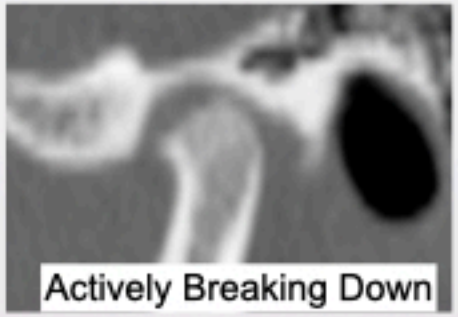
Droter JR, An orthopaedic approach to the diagnosis and treatment of disorders of the temporomandibular joint. Dent Today 2005 Nov;24(11):82, 84-8

Basic Orthopedics

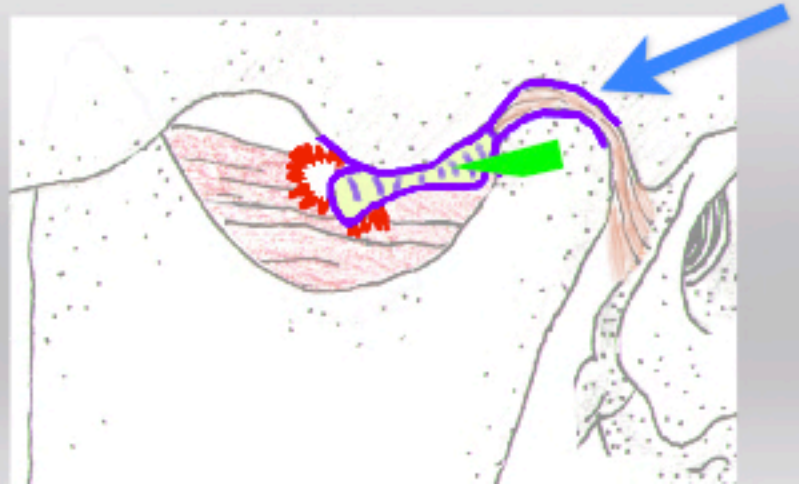
Joints are either
- Healthy or
- Damaged

If damaged, joints will be either:
- Actively Breaking Down
- Adapting
- Adapted
  - Structurally, Mechanically
  - Favorably, Unfavorably





Majority of damaged TMJs adapt favorably

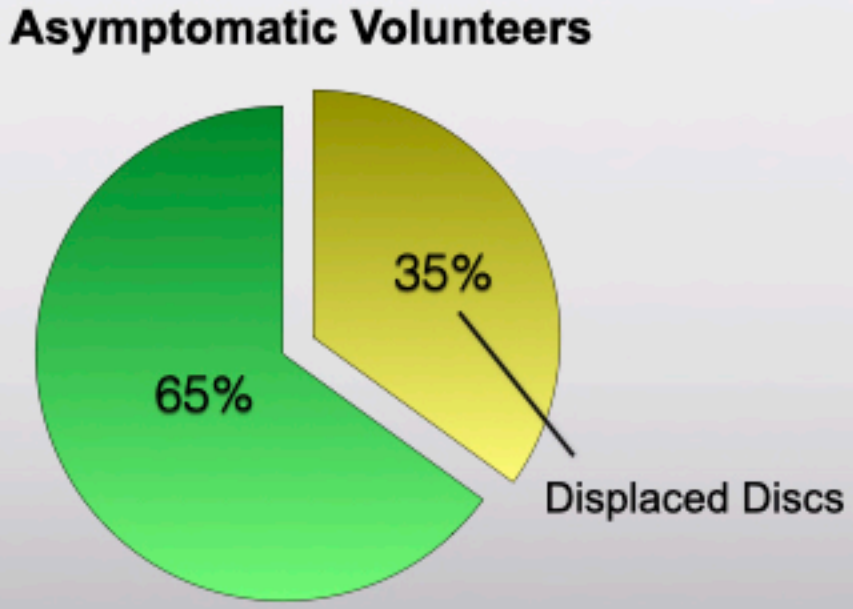


Posterior ligament, synovium, and retrodiscal tissue adapt to form a

Pseudo-disc

Tissue Fibrosis

Prevalence Displaced Discs on MRI



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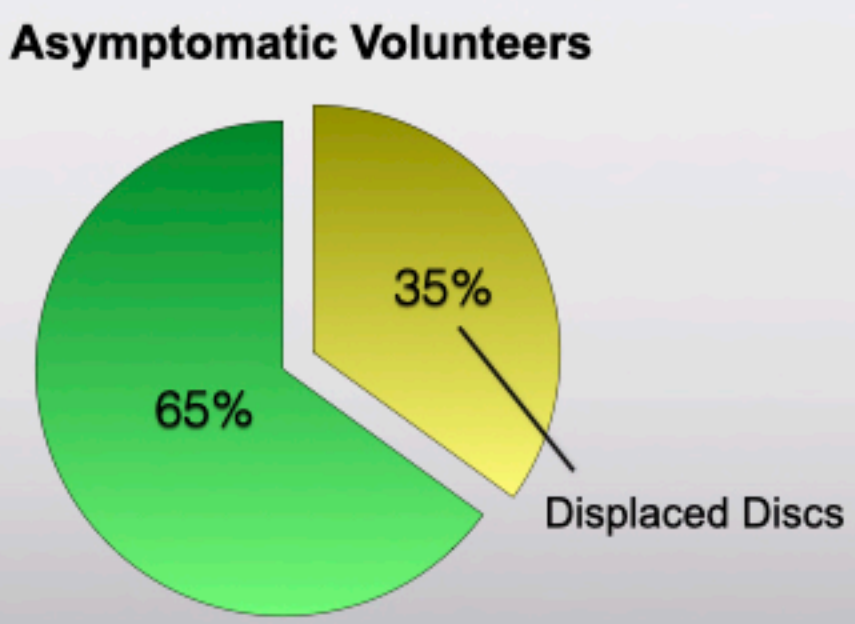

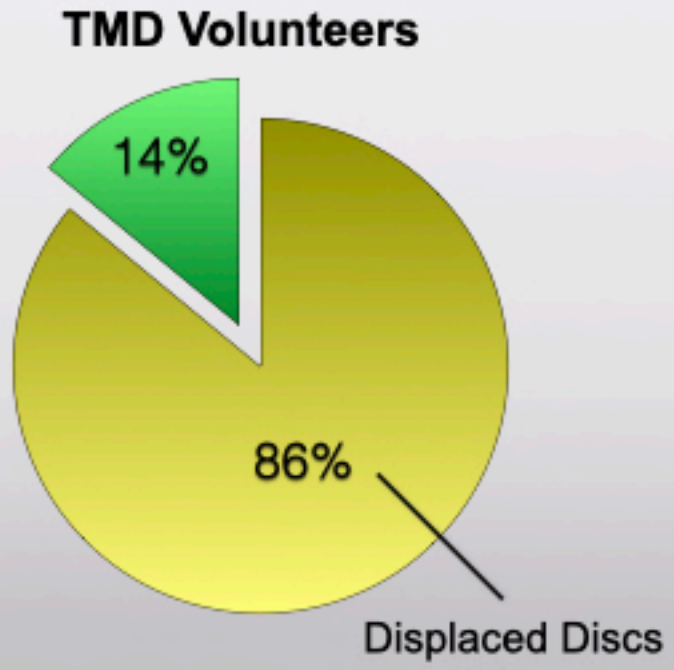

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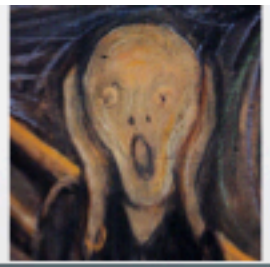
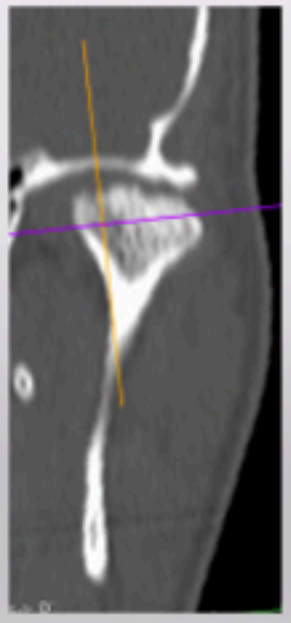
MRI of 237 volunteers

What is the Clinical Relevance of TMJ Damage Post-Puberty?

John R Droter DDS
Annapolis, Maryland



Damaged TMJs



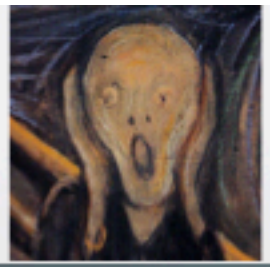
Adapt Favorably **85%**
Adapt Fairly **14%**
Adapt Poorly **<1%**

→ Occlusal Muscle Dysfunction
Osteoarthritis
Mechanically Dysfunctional

→ Avascular Necrosis

Progressive Condylar Resorption

*These are my guesses on %, no research to back up to backup



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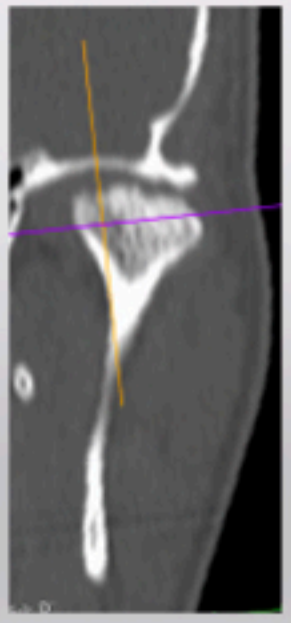

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Symptoms of Temporomandibular Joint Osteoarthrosis and Internal Derangement 30 years after Non-Surgical Treatment.

Leeuw, Boering, Stegenga, Bont,
Journal of Craniomandibular Practice, April 1995, vol. 13, No. 2

- University Hospital, Netherlands: 134 TMD patients, 30 year follow up
- Patients received good clinical work up and diagnosis 30 years ago, but basically no treatment
  - (Reassurance, PT, exercise, limited occlusal adjust)
- 70% satisfied with results
- 25% still had pain on movement
- 15% not able to eat hard foods
- 35 control patients had no apparent symptoms

6 Common TMDs

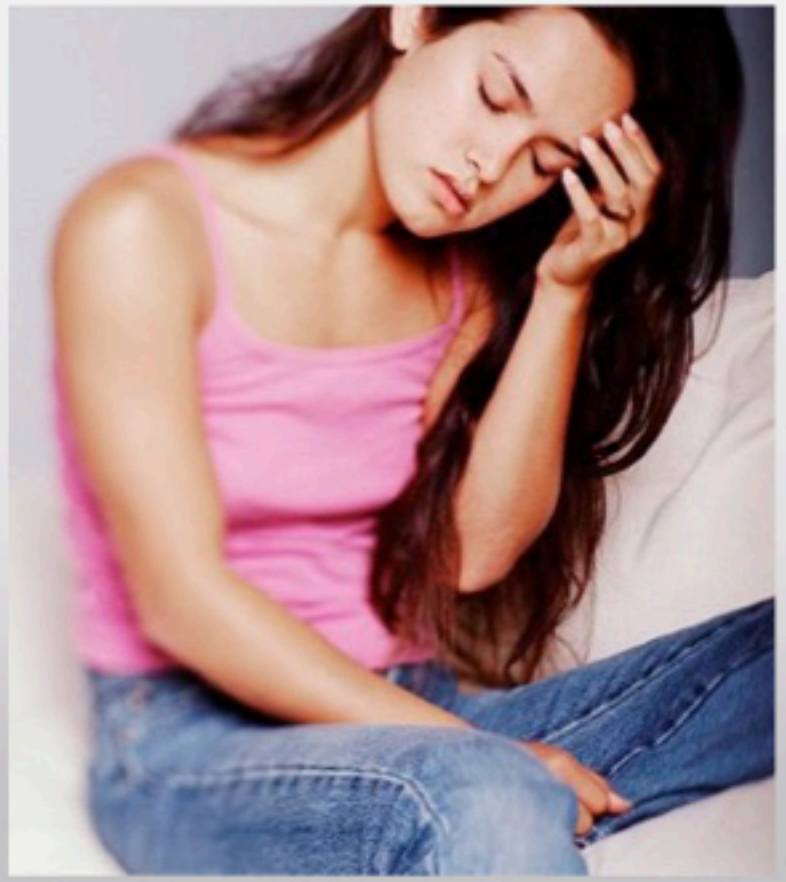
Parafunctional Clenching
Parafunctional Grinding
Occlusal Muscle Dysfunction
Osteoarthritis
Acute Sprain
Acute Closed lock of TMJ disc

5 Common Obstacles

Neck and Postural Instability
Wobbly TM Joint (Subluxation)
Compromised Breathing/Airway
Avascular Necrosis
Referred Pain Muscle Triggerpoints

1 TMD that **usually** does not need therapy

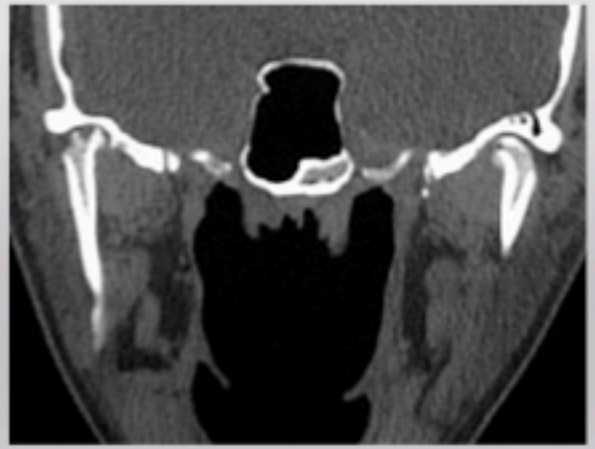
TMJ Clicking

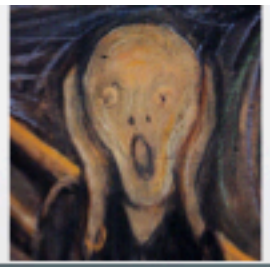


If you have a disease that is one in a thousand, it is 100% for you

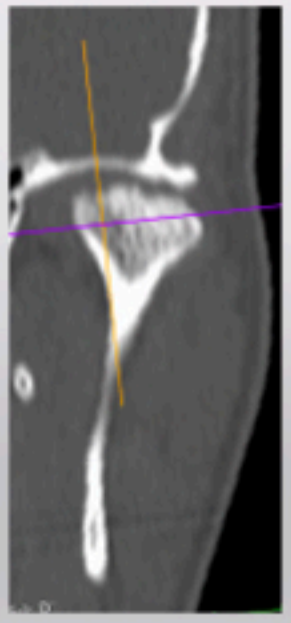
There is no love sincerer than the love of food.

G. B. Shaw





Damaged TMJs



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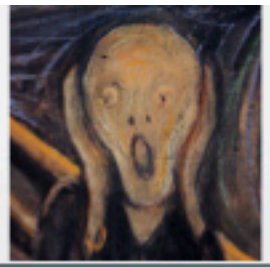

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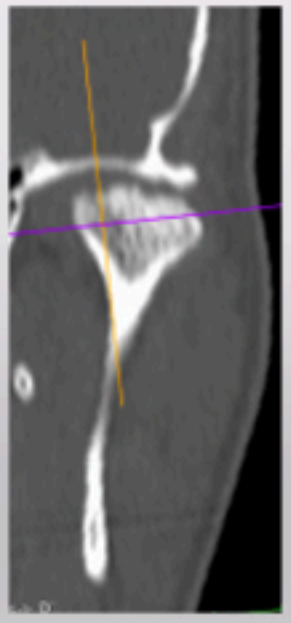

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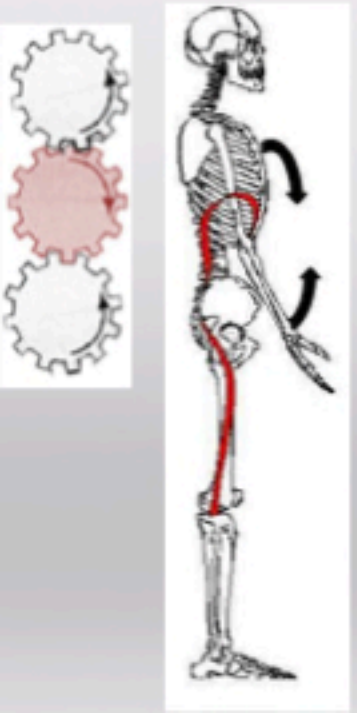
Neck and Postural Instability

This is a **dynamic** orthopedic System



A change in any one area will affect the others

CNS/PNS

Skull

TMJ

Teeth

Mandible

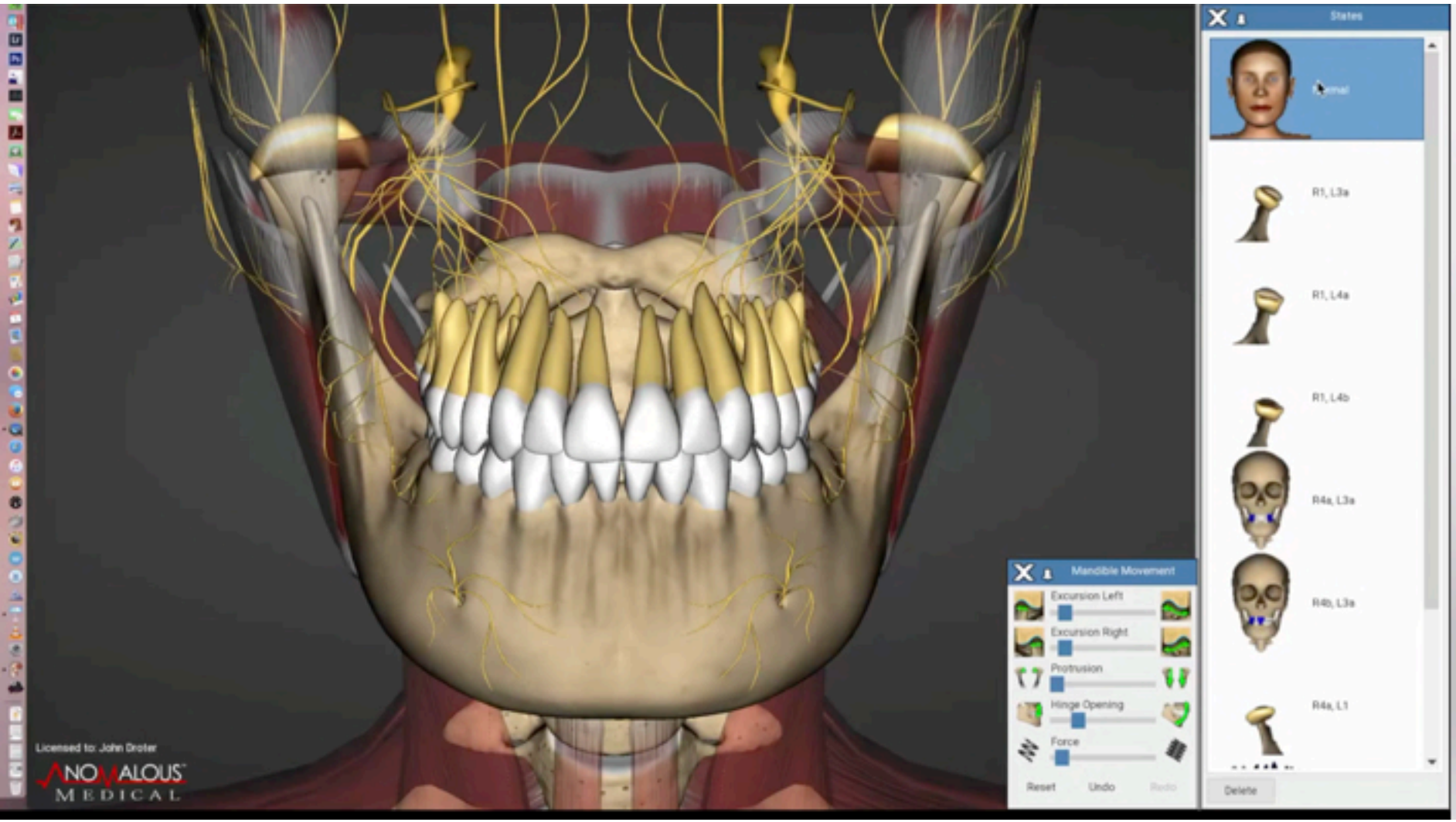
Teeth

Neck

Muscle Neck

Muscle TMJ

venn diagram

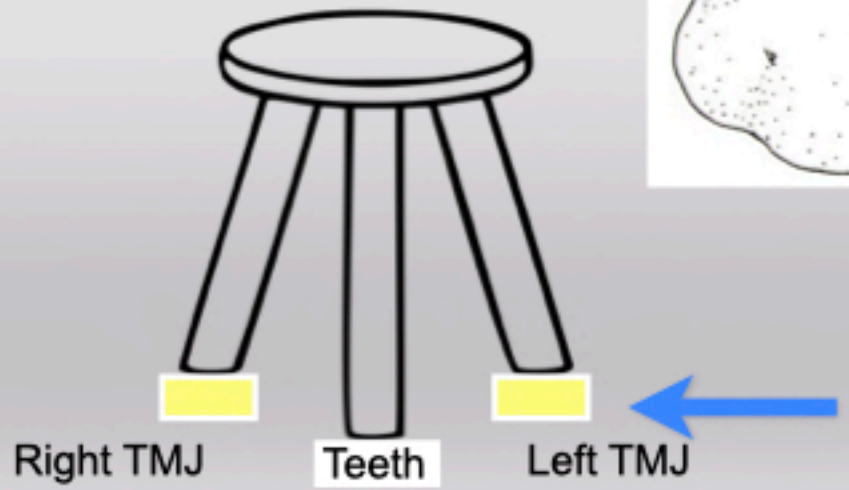


Occlusal Shift Short

Normal Joint with Normal Occlusion

All teeth touch evenly with condyles seated in fossa

What happens to the occlusion if the disc is dislocated?



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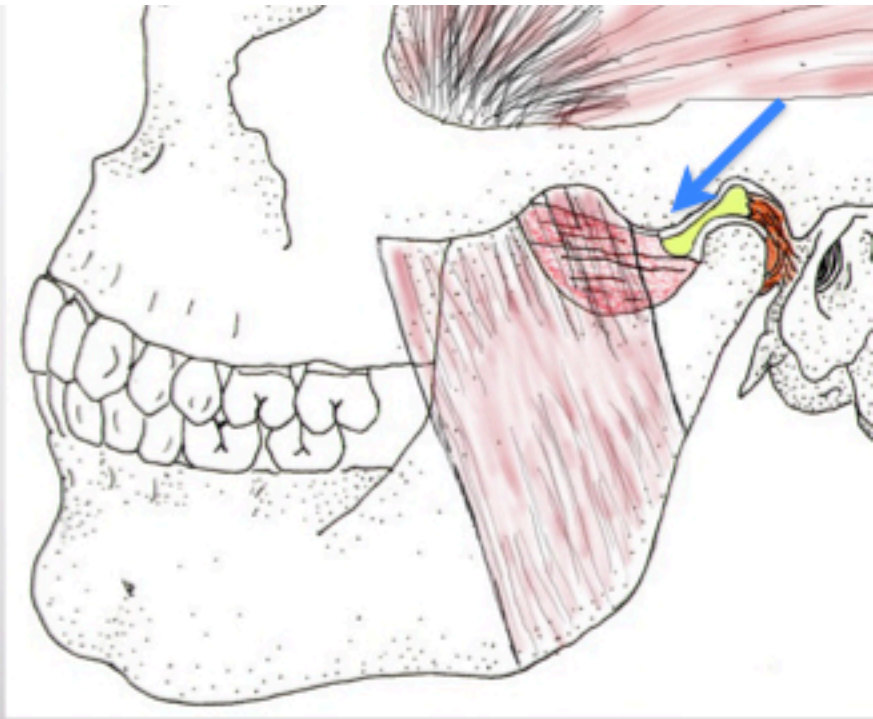
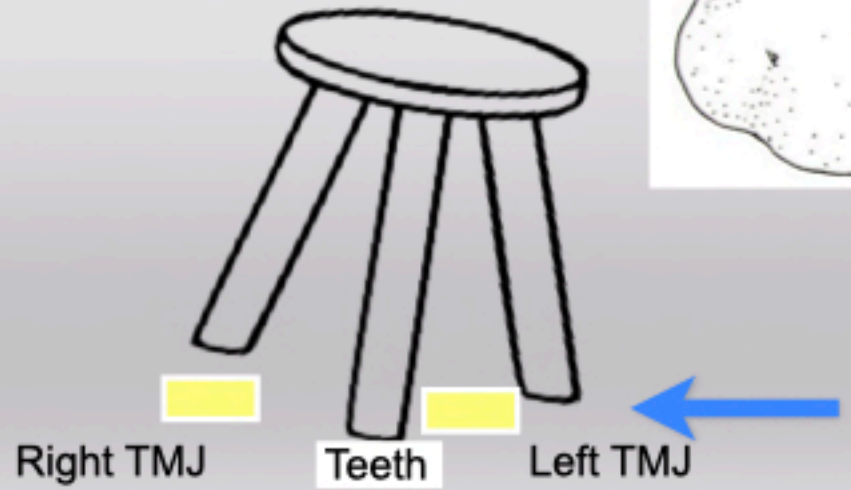




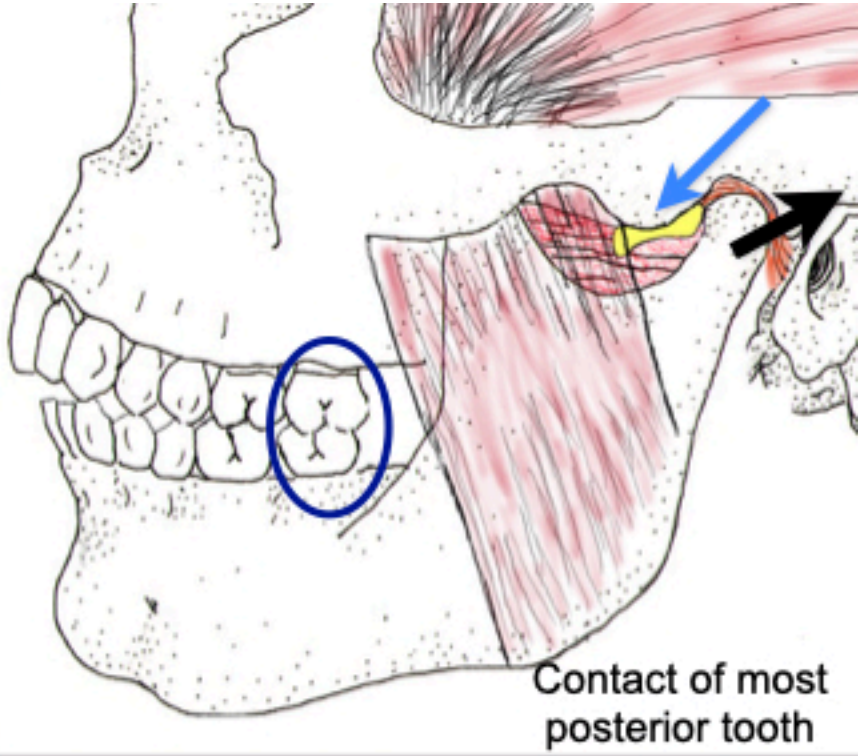
Damaged Joint with Malocclusion

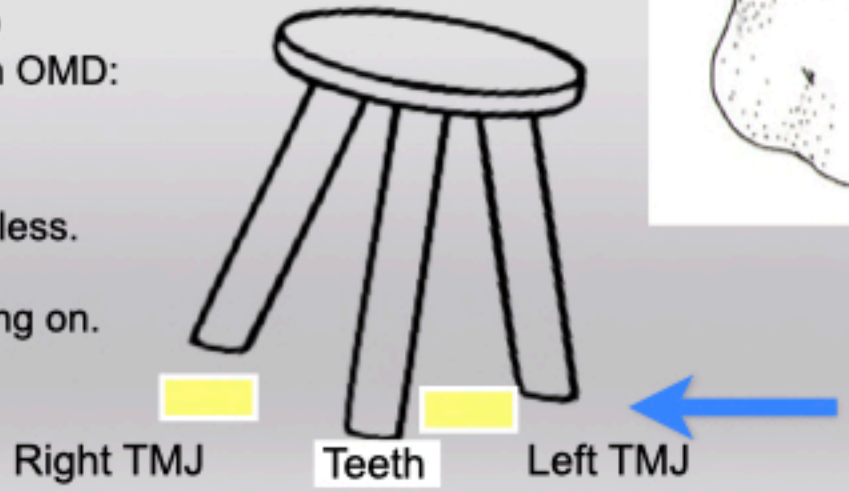
85% damaged joints adapt favorably with respect to the TMJ.

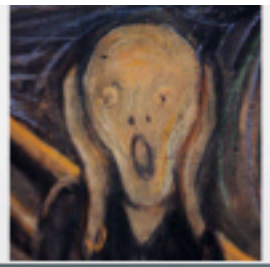
Anteriorly Dislocated Disc, Mandible shifts:
- Inadequate Anterior Guidance, Posterior Disclusion
- Uneven Occlusion,
- CR≠MaxIC
- Occlusal Muscle Disharmony develops.

Treat Adapted joints with OMD
the same as healthy joints with OMD:
Occlusal Adjustment

CR≠MaxIC should be 2mm or less.
(Horizontal 2mm)
If >2mm something else is going on.







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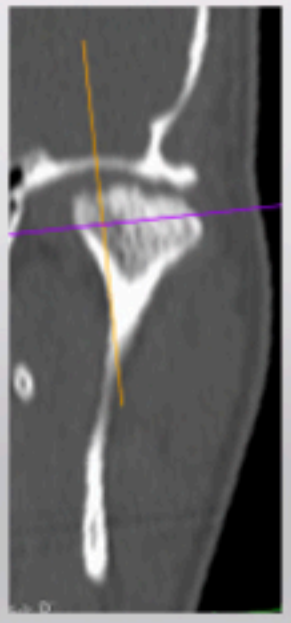

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→ Osteoarthritis
→ Mechanically Dysfunctional

→ Avascular Necrosis
→ Progressive Condylar Resorption

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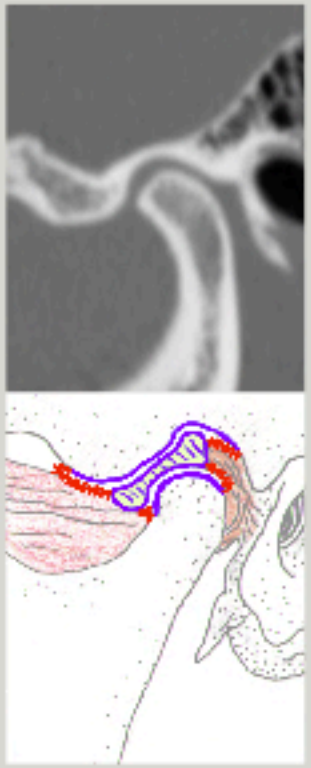
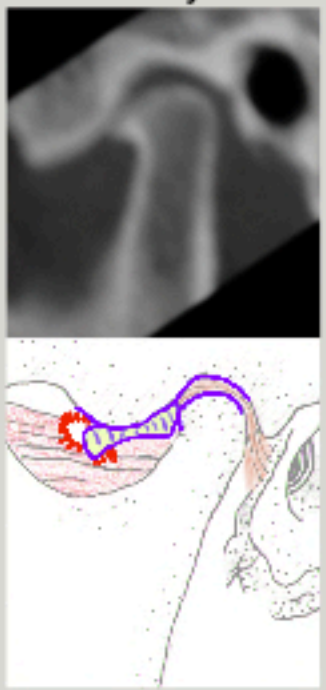
Osteoarthrosis/Osteoarthritis

Healthy joints have no friction or wear.
Damaged joints have Friction. Friction causes wear.
OA is a wearing out of a joint which starts in cartilage.
Parafunction increases wear.

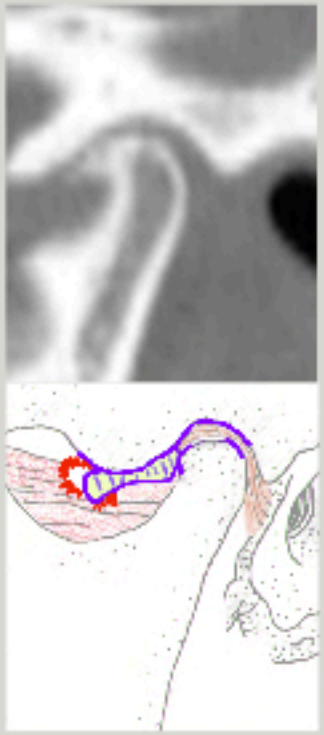
Normal



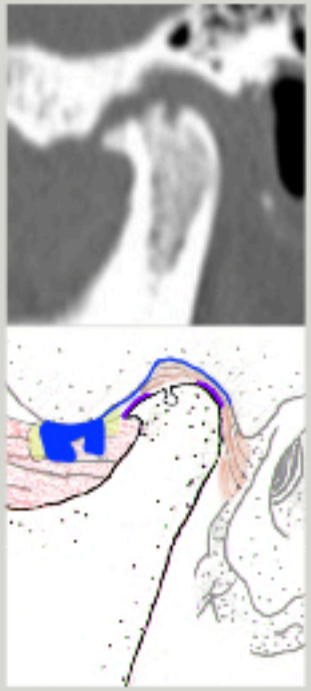
Early



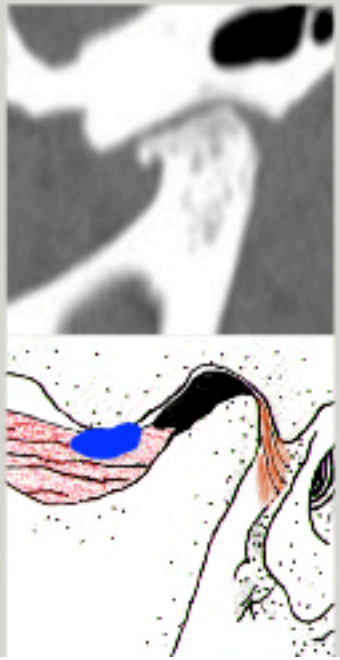
Early/ Moderate



Moderate



Severe OA, Eburnation



Representative examples of OA
in different patients

Drawings by Gretta Tomb DDS and John Droter DDS

Treatment OA

Osteoarthr**osis**

Minimize parafunction: Night guard D-PAS, Brux-PAS
Glucosamine 1500mg /Chondroitin 600 mg per day

Osteoarthr**itis**

All of the above plus eliminate inflammation……
- NSAIDs
- CBD Topical Balm
- Cold Laser

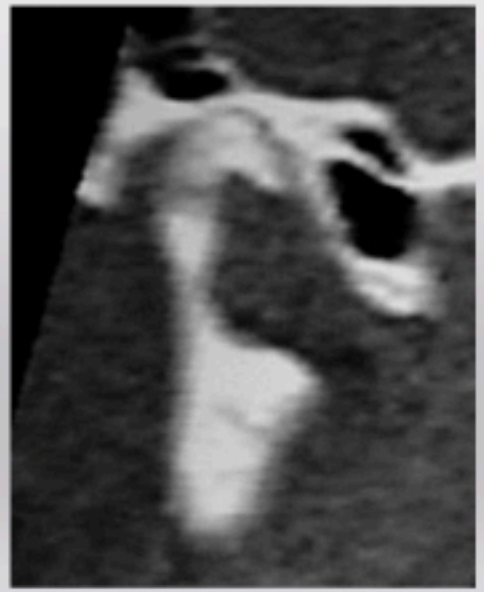
If still inflamed arthrocentesis with
Platelet Rich Plasma (PRP)

Shea Brand CBD

MLS Laser
3x week for 3 weeks

Adaptation Chronic Bilateral Osteoarthrosis

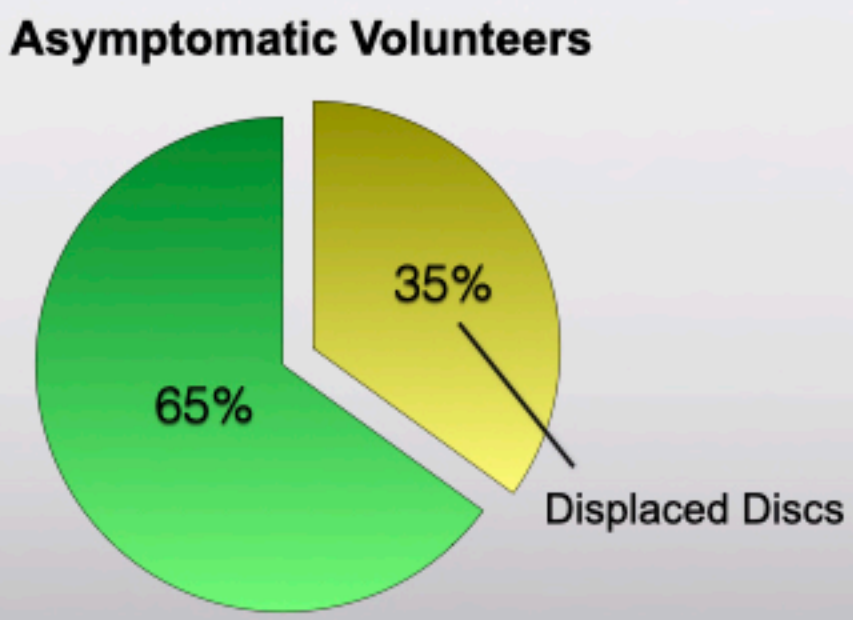
Mandible recedes Slowly
Teeth Move/ Adapt
Anterior Guidance gets steeper as Condylar Guidance get shallower

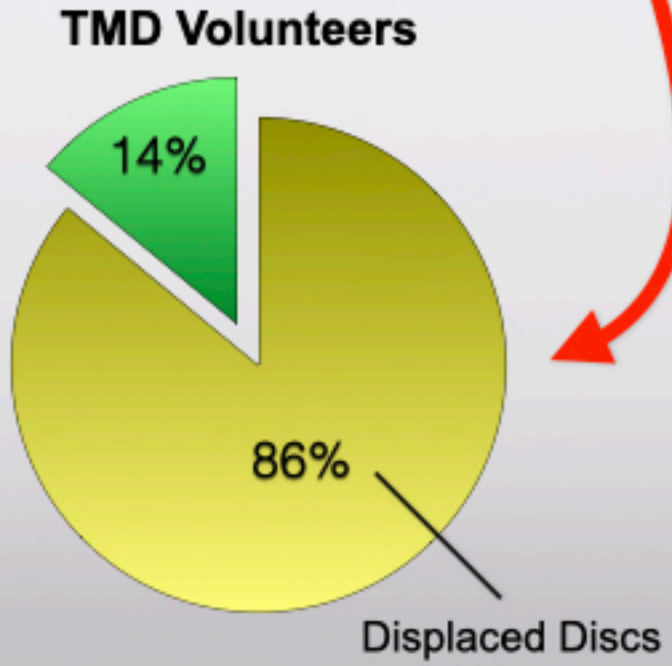


OA Right and Left Bone Loss
#8 Ankylosed

Prevalence Displaced Discs on MRI

Occlusal Muscle Disharmony
Osteoarthritis





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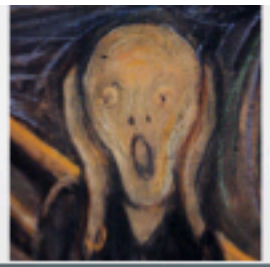
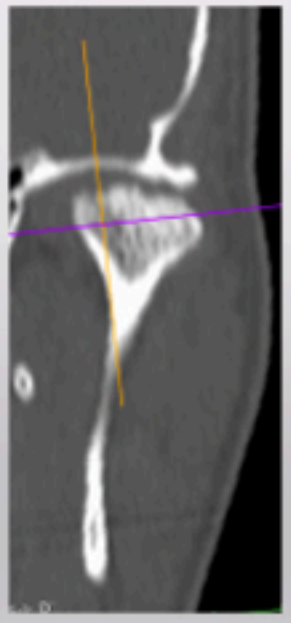


Damaged TMJs



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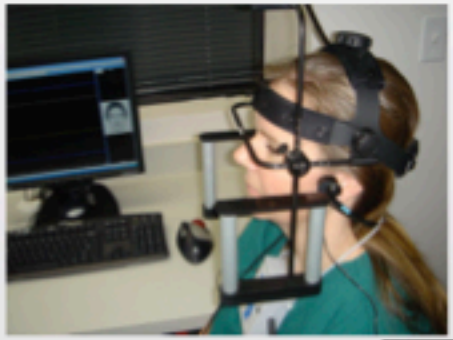
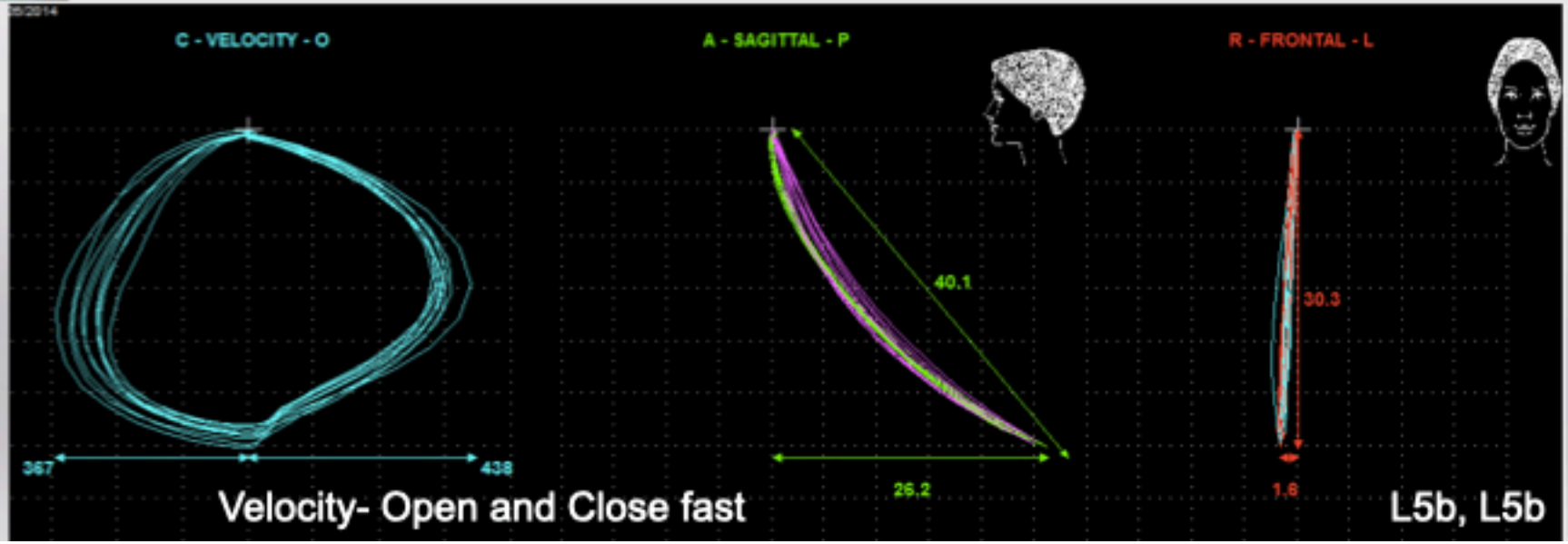
BioResearch Jaw Tracker



Normal TMJ- Motion

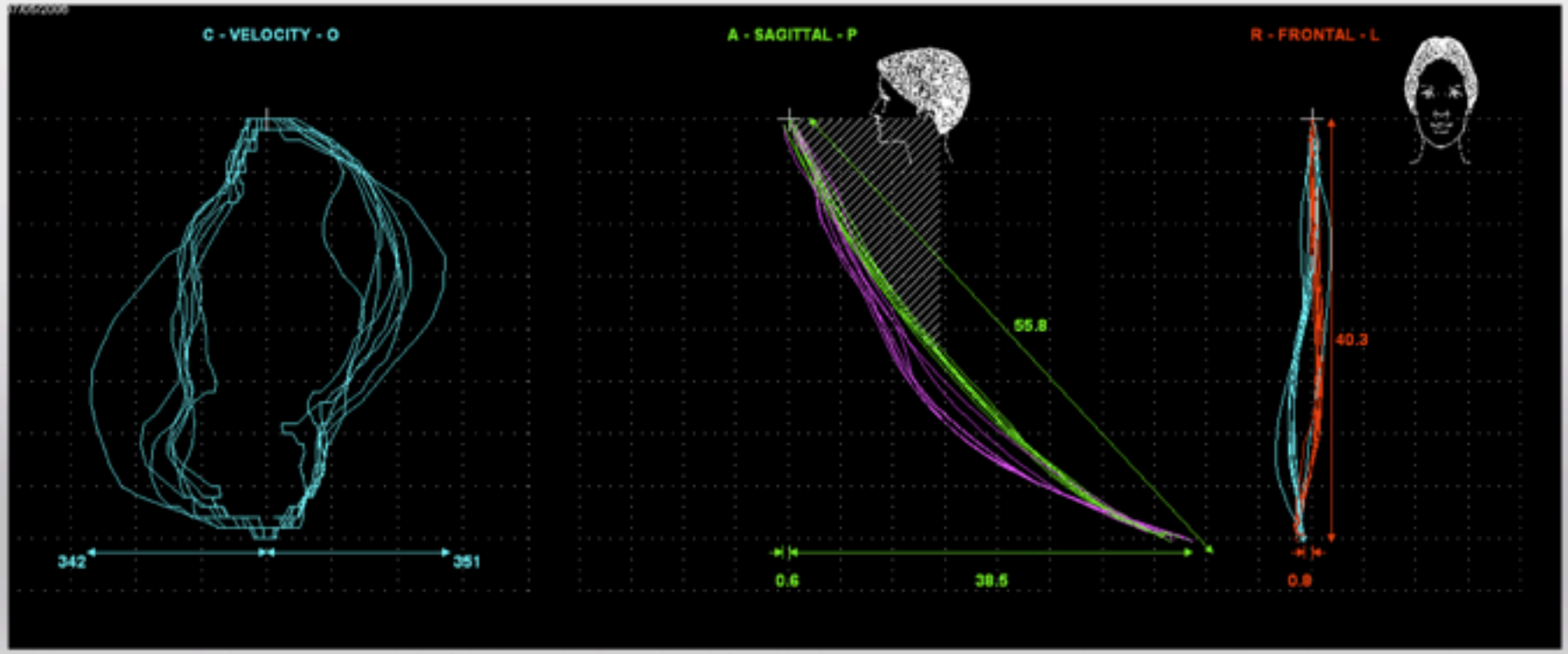
ROM- 40-55mm
Velocity 300+mm/sec
Consistent arc open/close
sagittal path
Straight frontal path



Velocity- Open and Close fast

L5b, L5b

Mechanically Dysfunctional: Intermittent Locking
Jaw “Gymnastics” to open and close



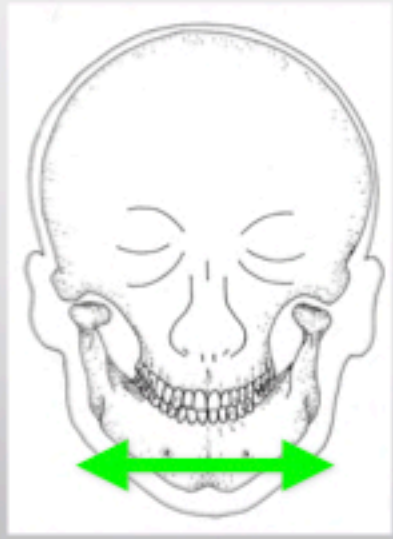
Jaw Tracker- Bioresearch

Mechanically Dysfunctional: Intermittent Locking
TMJ Home Therapy

Exercises 20 2 2 10

- ❑ 5-6x a day to rehabilitate damaged jaw joint
  - 20 reps Side to side
  - 2 reps Forward and back
  - 2 reps Open wide, but not too far
  - 10 reps Side to side

You can go to 2-3x a day to maintain once joint has adapted



- ❑ Doctor's Best Vegetarian Glucosamine Chondroitin & MSM
  Take 2/day

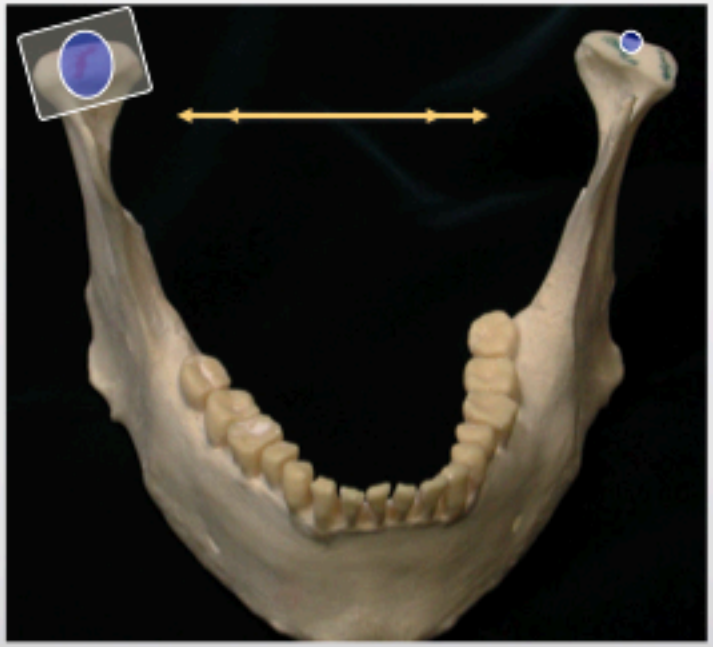
- ❑ Shaklee +C Boost- 500 Vitamin C Sustained Release.
  Take 1000mg before sleep

Non-Linear Joint Deformity- Mechanically Unstable TMJs- "Wobbly Joint"

TM Joint subluxates under load
- Adapted CR "wobbles"

TMJ Muscle hyperactivity
- Looks similar to OMD
- Muscles must stabilize the joint
- Deep temporalis especially sore

Clinically:
- Hypersensitive bite
- Increase muscle pain with anterior deprogrammer
- Continued muscle disharmony with flat plane orthotics
- CT Scan- CR load zone not medial
- JVA- after tooth tap see "wobble- 50hz vibration



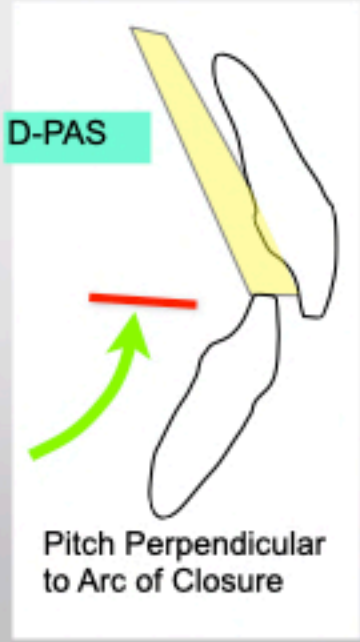
Diagnostic Palatal Anterior Stop

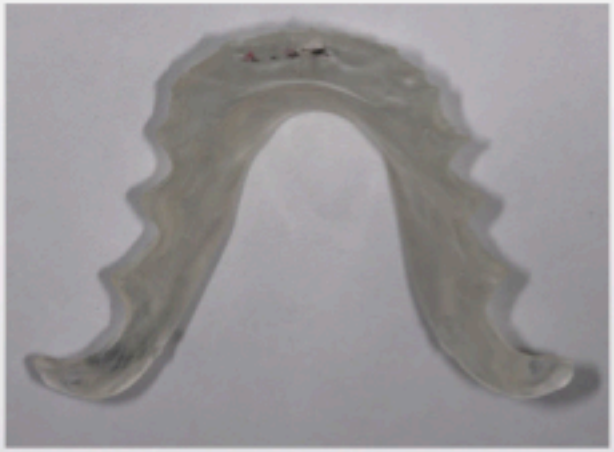
D-PAS Test: Wear 2 weeks for sleep, and occasional daytime

Better- Decrease in Symptoms
- Sleep Clenching Inhibited: Wear D-PAS as night guard
- Orthotic Improved Airway: D-PAS as night guard
- Occlusal Muscle Disharmony: Occlusal Adjust

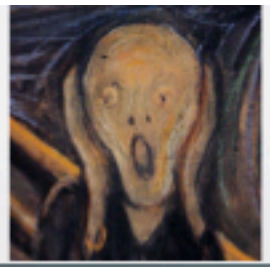
Worse- Increase in Symptoms
- Mechanically Unstable TMJ, joint subluxation
- Intracapsular Problem TMJ
- Orthotic Made Sleep Airway Worse

Stays the Same- No Change in Symptoms
- Damaged TMJ are mechanically stable
- Pain not related to occlusion

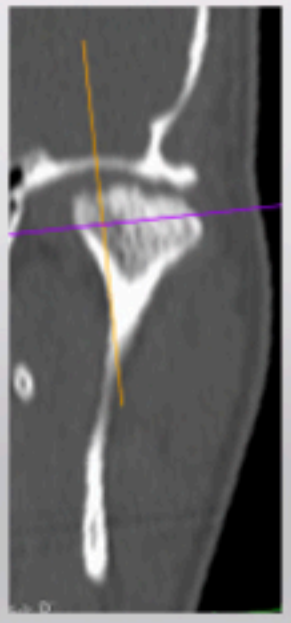




Stapelmann H, Türp JC. The NTI-tss device for the therapy of bruxism, temporomandibular disorders, and headache…..BMC Oral Health. 2008 Jul PMID: 18662411



Damaged TMJs

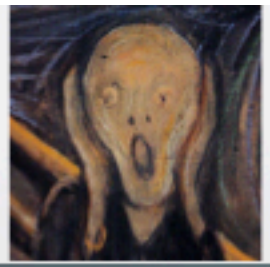


Adapt Favorably	85%
Adapt Fairly	**14%**
Adapt Poorly	<1%

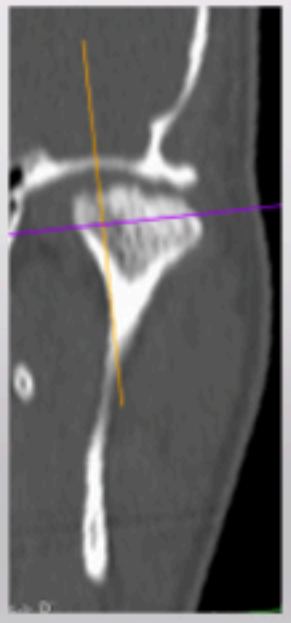
→ Occlusal Muscle Dysfunction
Osteoarthritis
Mechanically Dysfunctional

→ Avascular Necrosis
Progressive Condylar Resorption

*These are my guesses on %, no research to back up to backup



Damaged TMJs



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Osteoarthritis
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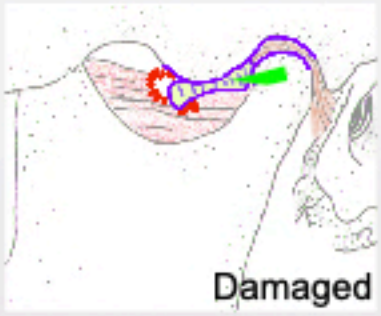
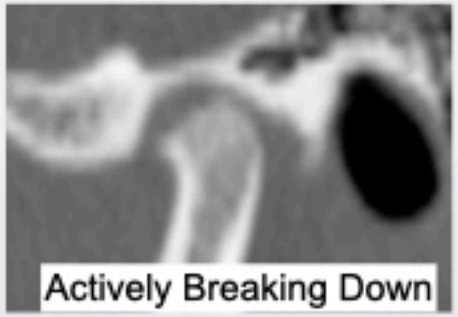
Basic Orthopedics

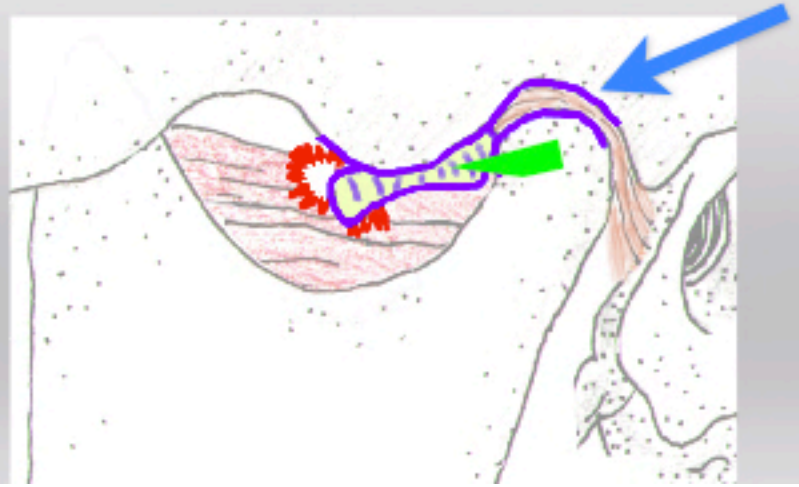
Joints are either
- Healthy or
- Damaged

If damaged, joints will be either:
- Actively Breaking Down
- Adapting
- Adapted
  - Structurally, Mechanically
  - Favorably, Unfavorably





Majority of damaged TMJs adapt favorably



Posterior ligament, synovium, and retrodiscal tissue adapt to form a

Pseudo-disc

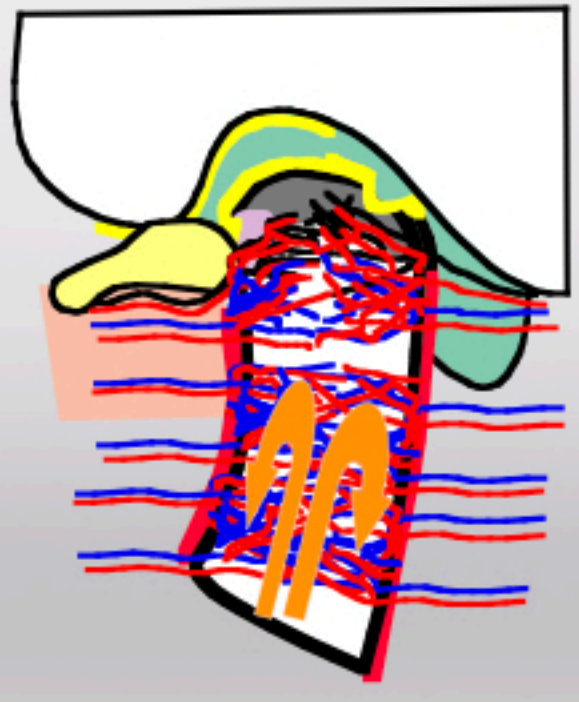
Tissue Fibrosis

Basic Orthopedics

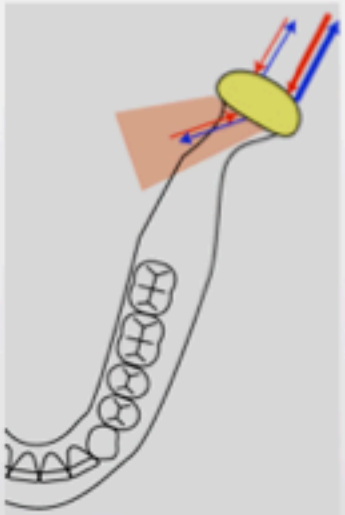
Joints are either
Healthy or
Damaged

Active
Structural
Breakdown

Osteolysis: Condylar Bone Loss



Axial View



Normal TMJ Blood Flow, Marrow

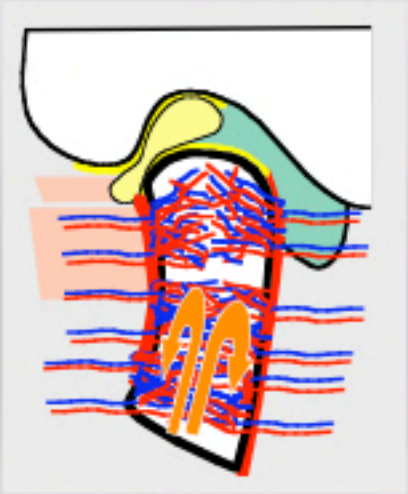
Condylar head limited collateral circulation

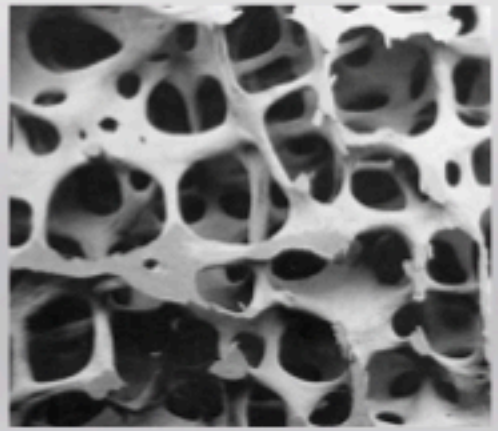
Epiphyseal growth center

Marrow is fatty tissue with blood vessels, containing the precursor for blood cells

No Blood vessel inside joint

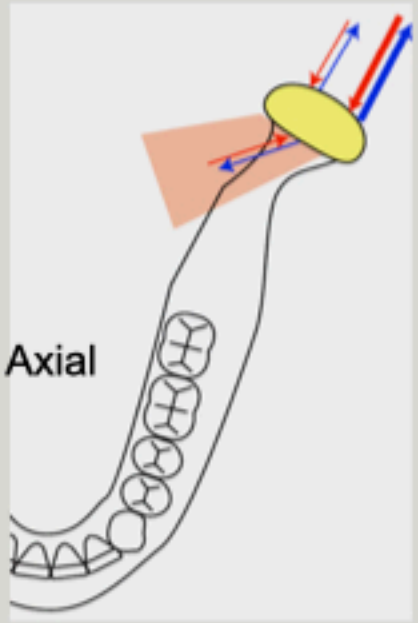
Closed Sagittal

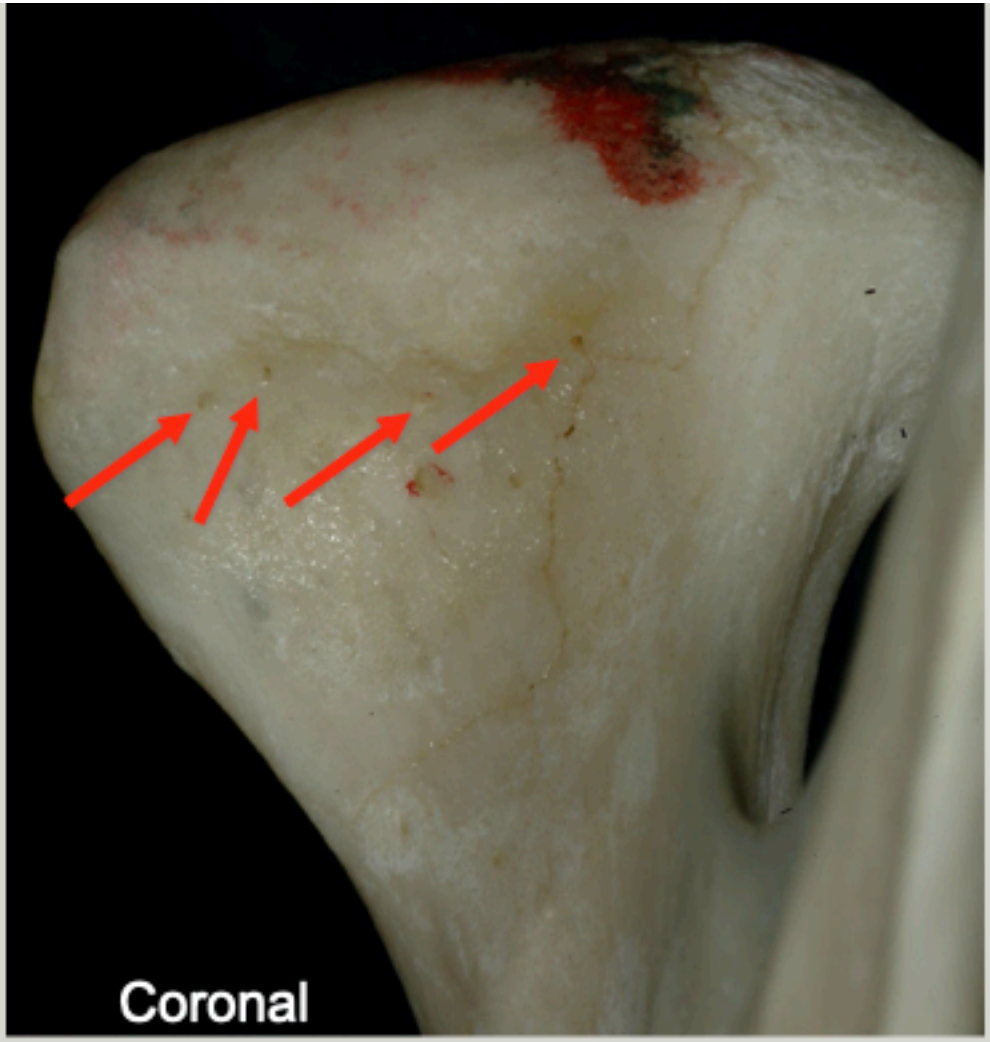




Condylar Perfusion

Blood flows in and out of the condylar head through vessels that pierce the cortex





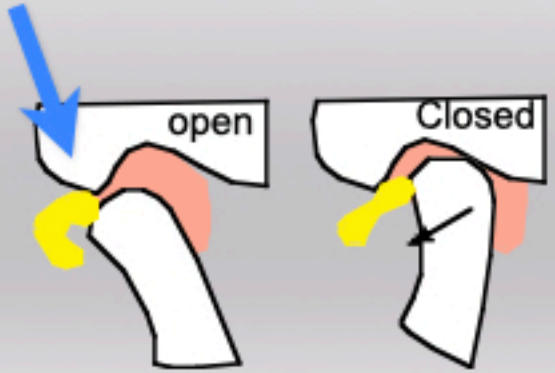
When the clicking stops (4a to 4b):

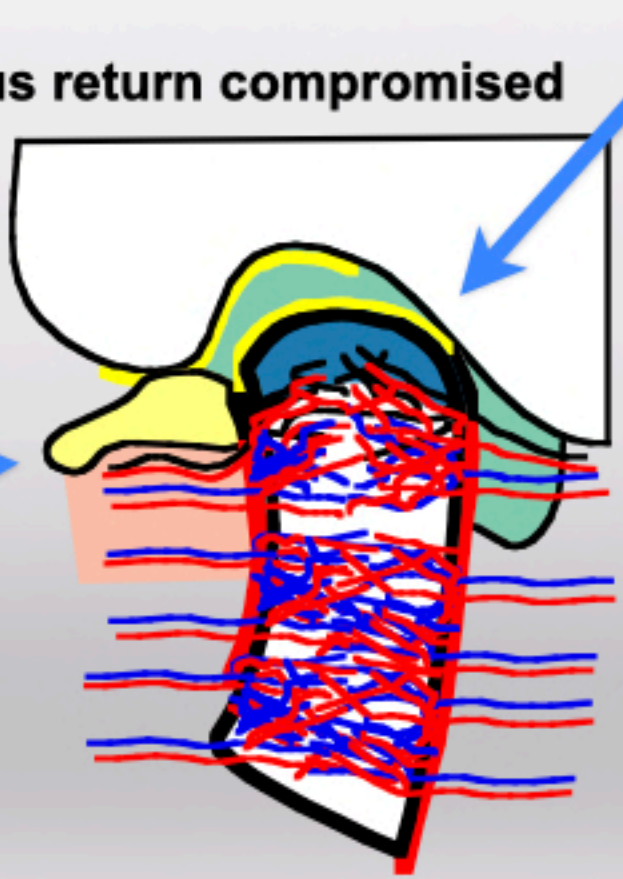
Condyle Distalized

Venous return compromised

Compromised Condylar Perfusion
Blood flow through condyle is decreased

Disc Anterior





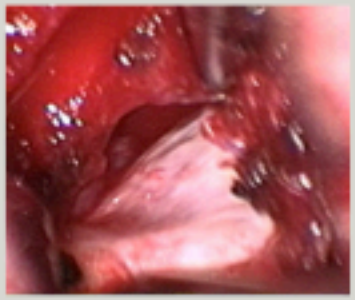
3 Outcomes of Compromised Condylar Perfusion

Bone cells die

Avascular Necrosis

One and Done

Condyle collapses 1y later.
Cartilage remans intact
Occlusion shifts once, AVN is finished.



or

Nothing

Compromised but adequate.
99% patients have no problems

Inflammatory Tissue Bone Resorption

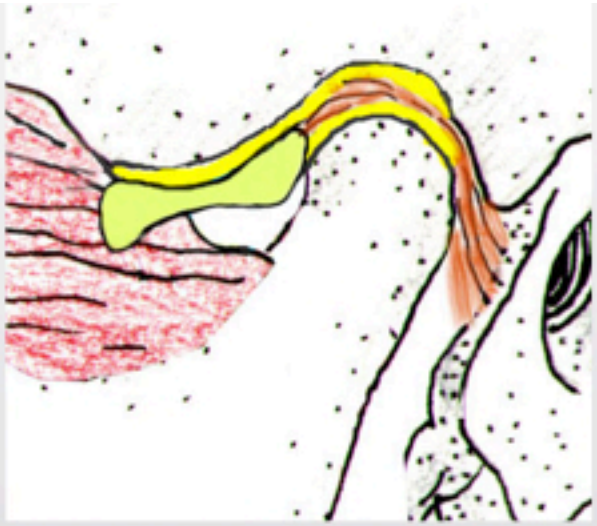
Cortex Collapses, Cartilage tears
Inflamed tissue contacting bone
Inflammatory cells activate Osteoclasts

Droter JR, An orthopaedic approach to the diagnosis and treatment of disorders of the temporomandibular joint. Dent Today 2005 Nov;24(11):82, 84-8

All Clicking Joints are Damaged

Not so Dangerous Clicks

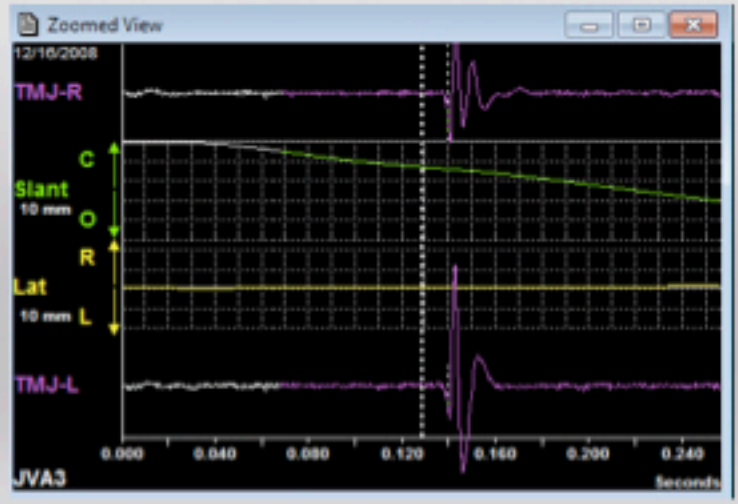
- Unchanging click for 2+ years
- Consistent, easy reduction of Disc
- Good range of motion with clicking
- Stable occlusion with clicking



Clicks that need further Evaluation/ Scans

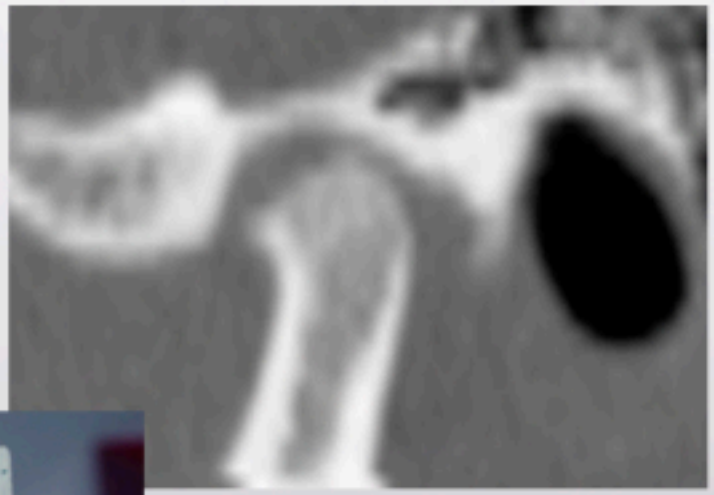
- Clicking that has stopped in the past year
- Clicking has changed in the last 2 years
- Wiggling jaw to open. Locking.
- Chronic Painful click
- Unstable Occlusion

Simple Click on JVA
Joint Vibration Analysis
BioResearch

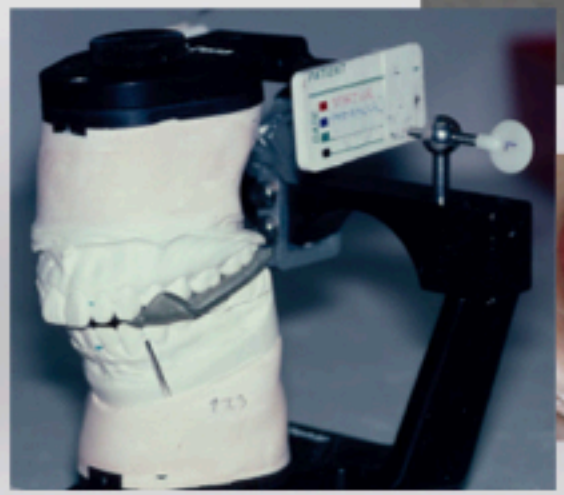


1 year after the clicking stops is the “Danger Zone”

Look for TMJ bone loss, anterior open bite developing
- Avascular Necrosis
- Hypoxia Induced Progressive Condylar Resorption



After clicking stops:
- Get CT or CBCT scan of the TMJ
- Maintain jaw motion: PT, exercises
- Get photos
- Mounted models
- Monitor occlusion over the next year
- Follow up CBCT scan 1 year later
- After 1 year “Adapted Favorably”



Age 30 Female
Start

Front teeth use to touch 1 year ago

Adult Onset Anterior Open Bite Differential Diagnosis

Developed Post-Puberty

What causes?
Only 2 choices.

The joint has changed

or

The teeth have moved

Adult Onset Anterior Open Bite Differential Diagnosis

Three different patients

Adult Onset Anterior Open Bite Differential Diagnosis

Three different patients

Teeth moved
Iatrogenic

TMJ Bone loss

Teeth moved
due to tongue

Why Tongue Bracing:
- Stabilize Neck
- Stabilize TMJ Subluxation
- Used as Occlusal Orthotic

$558,000 Malpractice Verdict

Failure to diagnose condylar resorption during orthodontic treatment

Dental Liability Alert, Vol 5, Issue 6, May 2002

Additional Dental Malpractice Verdicts

■ **$558,000 VERDICT - Failure to diagnose Condylar Resorption - Excessive use of cervical head-gear as part of orthodontic treatment - TMJ Syndrome - Occlusal deficiencies - Osteotomy recommended for minor plaintiff.**

This dental malpractice action was brought on behalf of the minor female plaintiff, age 11 at the time in question, against her treating orthodontist. The plaintiff alleged that the defendant failed to diagnose idiopathic condylar resorption (a condition similar to osteoarthritis) and excessively utilized cervical head gear in her orthodontic treatment, causing permanent mouth and jaw injuries.

The minor plaintiff treated with the defendant for approximately two years for a Class II malocclusion (secondary to crowding in the upper arch), a midline shift and a deep bite/overbite. The defendant prescribed cervical headgear, comprised of a wire which connects behind the head to pull the molars rearward and leave more room for the incisors. The plaintiff wore the headgear for approximately nine months.

The plaintiff's dental experts testified that the plaintiff suffered from condylar resorption of the jaw during the time period the plaintiff was under the defendant's care and that the condition would have been evidence on x-ray. The plaintiff contended that the standard of care required the defendant to stop all orthodontic treatment under these circumstances and allow the condylar resorption to run its course. The plaintiff contended that the defendant failed to recognize that the plaintiff's jaw was rotating open due to the loss of calcification of the teeth and jaw associated with condylar resorption and that the defendant negligently attempted to reverse the open bite by inappropriate methodology.

The plaintiff's dental expert testified that the methodology employed by the defendant worsened the plaintiff's open bite, causing her to develop TMJ syndrome and requiring a future LaFort I (lower jaw) osteotomy. The cost of the plaintiff's surgery was estimated as between $25,000 and $30,000, according to the plaintiff's oral surgeon. The plaintiff alleged that had the defendant performed a proper examination, treated the dental dysfunction adequately and referred her to the proper specialists, the plaintiff would have suffered no injury.

The defendant denied negligence and contended that the plaintiff's resorption process was not detectable with any routine diagnostic study normally used in orthodontic treatment. The defense expert opined that the treatment provided by the defendant comported with the standard. The defense expert additionally maintained that all injuries suffered by the plaintiff were the result of her idiopathic condition. The defendant asserted that he made a timely referral to an oral surgeon who diagnosed the bilateral condylar resorption, a rare condition which is not well understood by the medical community.

The jury found for the plaintiff and awarded $558,000.

EXPERTS:

Plaintiff's orthodontia expert: Ira Yerkes from Woburn, Ma. Plaintiff's expert oral surgeon: Charlotte White from Tallahassee, Fla. Defendant's dental experts: Charles S. Green from Skokie, Ill. and Daniel M. Laskin from Richmond, Va. Defendant's orthodontia expert: Cyril Sadowsky from Skokie, Ill.

REFERENCE:

Orange County, Fla. Haughey vs. Fravel. Case no. 96-1024; Judge Jeffords D. Miller. Attorney for plaintiff: Christopher M. Larmoyeux of Montgomery & Larmoyeux in West Palm Beach, Fla.; Attorney for defendant: Kenneth L. Baker and John S. Derr of Bush & Derr in Orlando, Fla. □

"DENTAL LIABILITY ALERT (USPS 015947 is published Bi-monthly for $150/year by Jury Verdict Review Publications, Inc., 45 Springfield Ave., Springfield, N.J. 07081. Periodical Postage Paid at Springfield, N.J. and additional mailing offices. Postmaster: Send Address Changes to Dental Liability Alert, 45 Springfield Ave., Springfield, N.J. 07081"

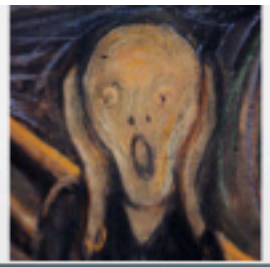
Volume 5, Issue 6 - May 2002

Anterior Openbite with Active Osteolysis due to Inflammatory Tissue Bone Resorption

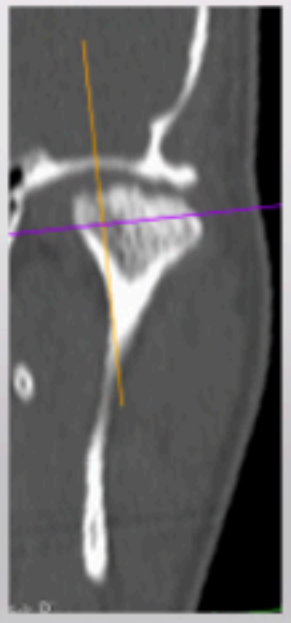
Non Surgical Therapies

Condylar Distraction

Anti Inflammatory Therapies



Damaged TMJs



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Adapt Fairly **14%**
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→ Occlusal Muscle Dysfunction
Osteoarthritis
Mechanically Dysfunctional

→ Avascular Necrosis

Progressive Condylar Resorption

*These are my guesses on %, no research to back up to backup

The TMJ: What You need to Know before you change an occlusion

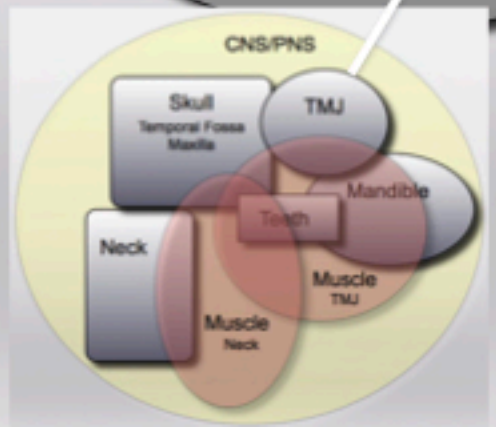
TMJ

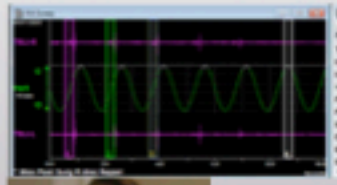
Does it Hurt?
Does it Move?
Does it Wobble?
Is it Structurallv Stable?

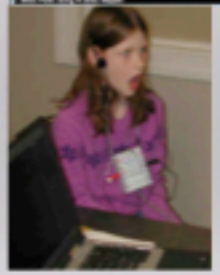
Palpate and Load the TMJ.
Measure Smoothness and Range of Motion (Quality and Quantity), Record JVA
Take CT scan- see intact cortex of condylar bone and fossa
CR ≠ Max IC less than 2mm (horizontal), not more than 3mm.

D-PAS test

History: No changes to the clicking.
Non-painful.
Can eat and chew what they want



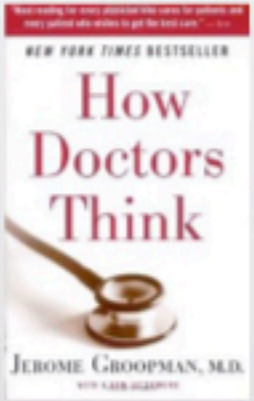




Palatal Anterior
Stop Orthotic

Blinded by the Click

There is no rule that says you only get one disease



Always make a differential diagnostic list
Ask, " It appears to be this, but what else could it be?
Be aware you are blinded by your beliefs

Jaw is clicking, ear pain

Jaw is clicking, sudden onset headache, 53 year old

Jaw is clicking, temple pain, pain increases with chewing, 62 year old

Jaw use to click, Jaw stopped clicking and can not open wide

History is key, physical exam is next most important, palpate the muscles and joint.
Notice the age group does not fit OMD for the second and third patient.

John R. Droter, DDS
drdroter@mac.com
301-805-9400

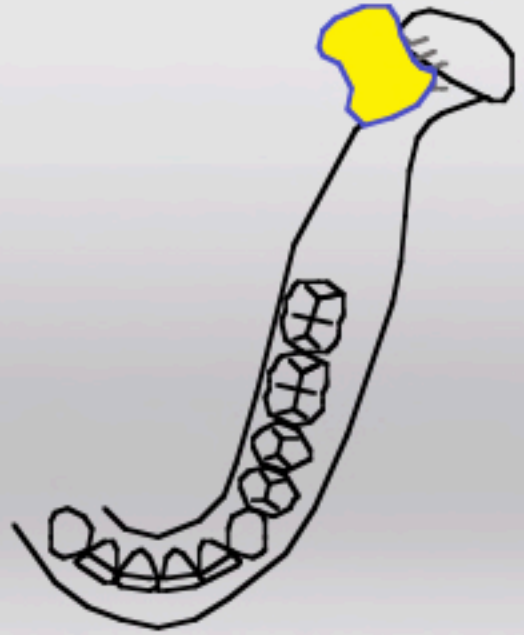
What is the Clinical Relevance of TMJ Damage Pre-Puberty?

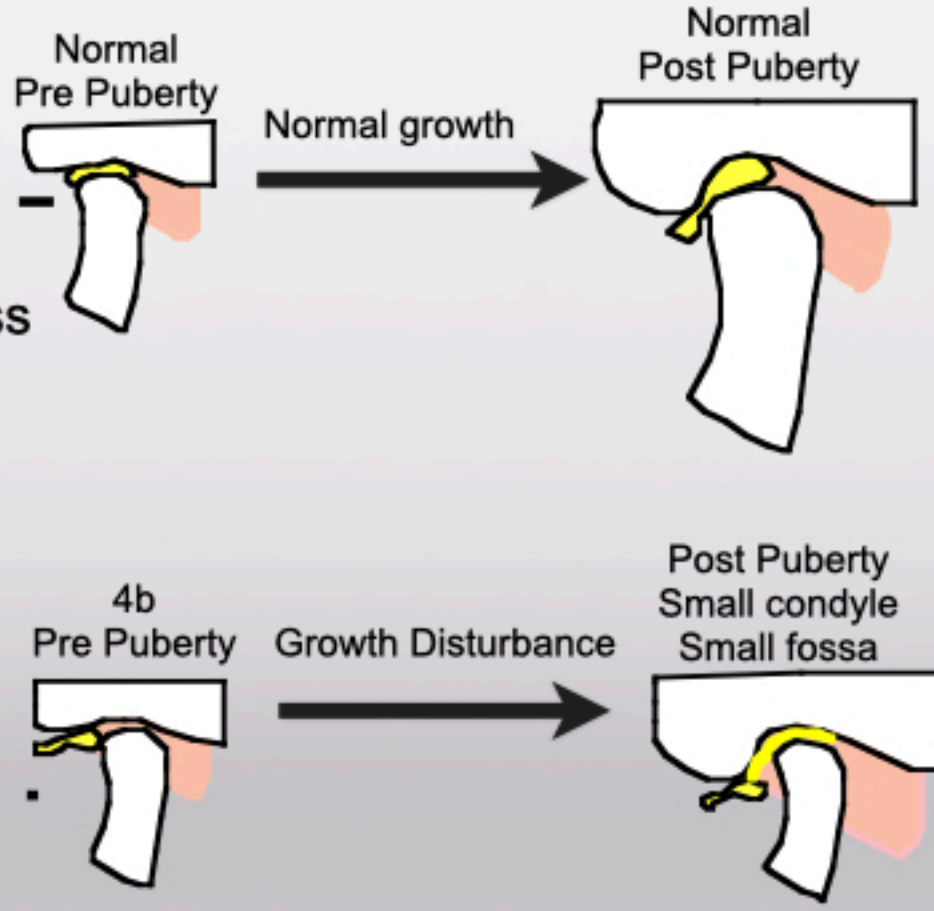
John R Droter DDS
Annapolis, Maryland

TMJ Damage Prepuberty

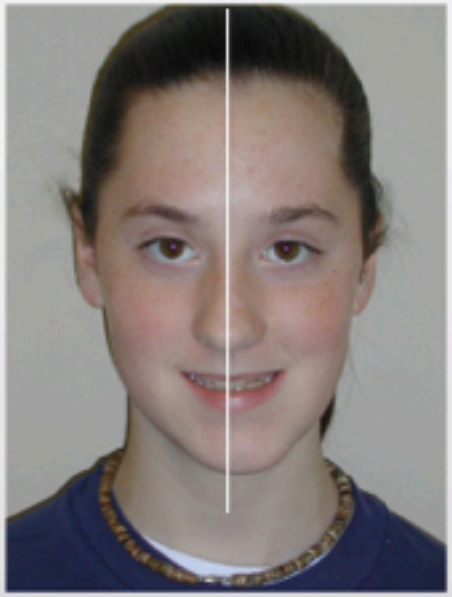
4b Pre-puberty is not a degenerative process

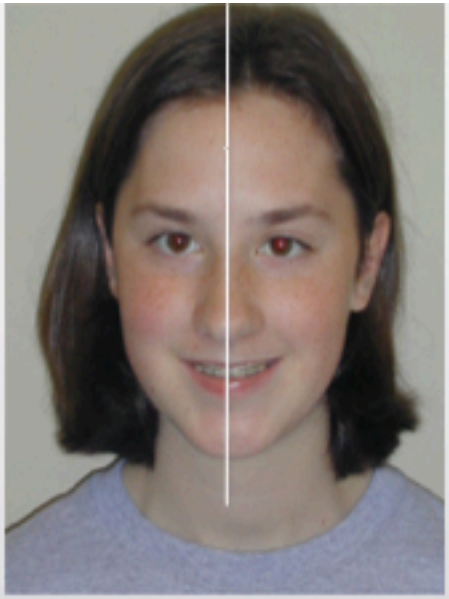
Can affect growth



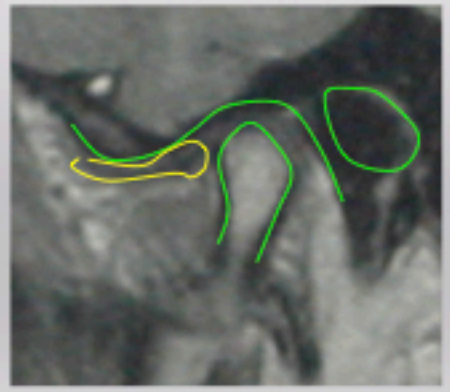


Age 17





R TMJ



L TMJ

Identical Twin Sister Age 17

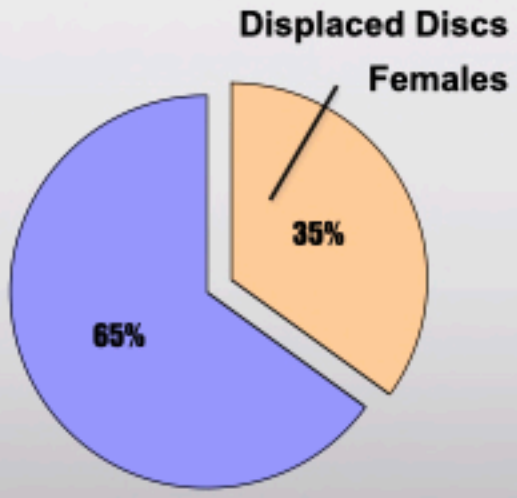
Pt of Ed Zebovitz, DDS

Şakar, O., Çalişir, F. (2013). Evaluation of the Effects of Temporomandibular Joint Disc Displacement and Its Progression on Dentocraniofacial Morphology in Symptomatic Patients Using Posteroanterior Cephalometric Analysis. Cranio, 31(1), 23–31.

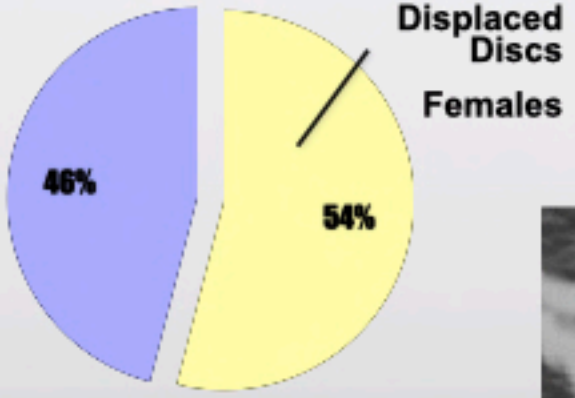
TMJ Damage Prepuberty

Prevalence Displaced Discs

Asymptomatic Volunteers



Presenting to Ortho Office



In patients with Displaced Discs
Condyles of Females Distalized
Significantly more than Males

The Prevalence of Disc Displacement in Symptomatic and Asymptomatic Volunteers
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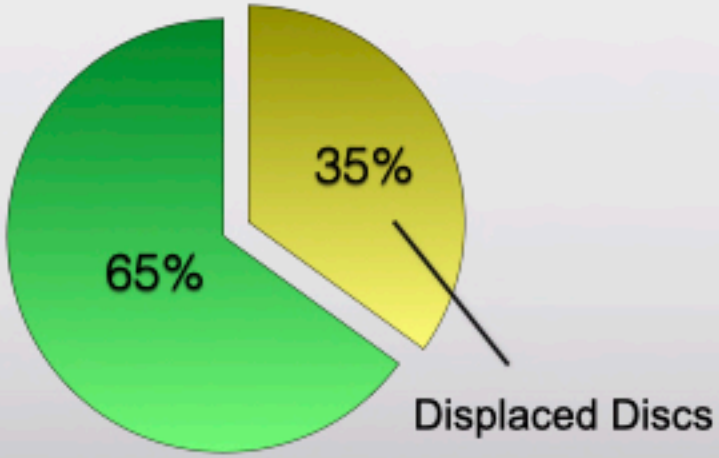
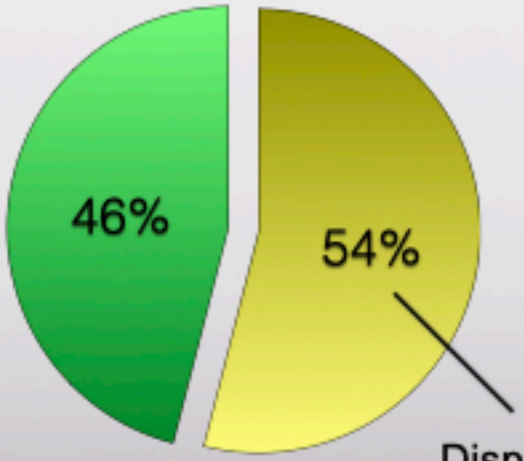
Prevalence Displaced Discs on MRI

Asymptomatic Volunteers



Females Presenting to Ortho Office



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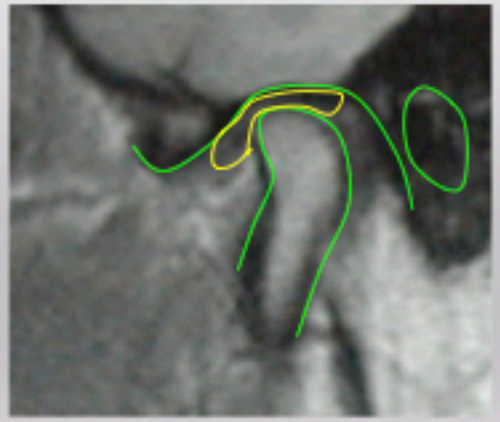
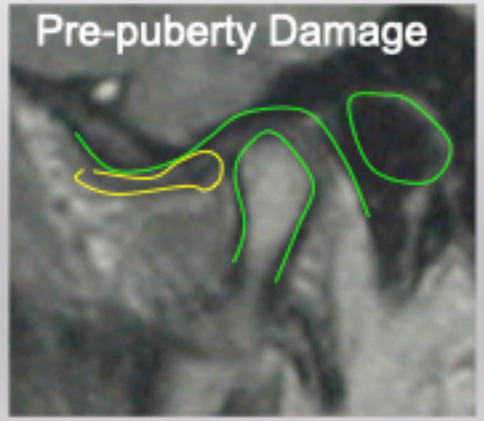
Basic Orthopedics

Joints are either
- Healthy or
- Damaged

If damaged, joints will be either:
- Actively Breaking Down
- Adapting
- Adapted Favorably Structurally and Mechanically
- Adapted Unfavorably





Small condyles due to TMJ damage:

Pre-puberty TMJ damage, the joints adapted, but did not grow.

Post-puberty TMJ damage will be a degenerative process.

Note ratio condyle size to fossa size

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drdroter@mac.com
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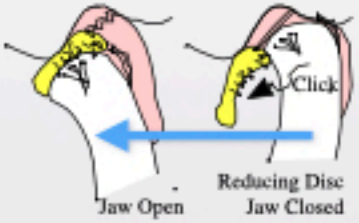
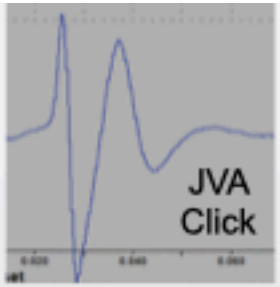
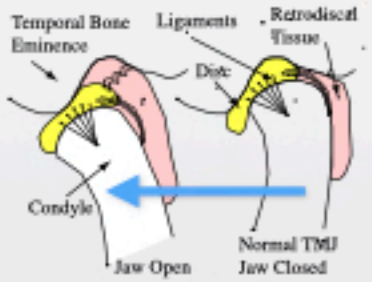
Differential Diagnosis of TMJ Clicking

Disc Reduction





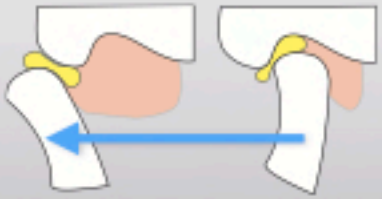
Normal



Adhesive Click

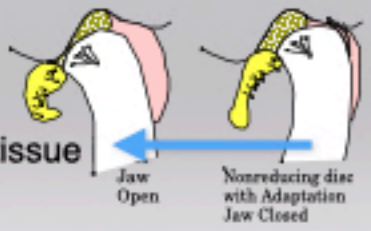
"Sticky Disc" - Disc sticks after prolonged clenching, then releases

Eminence Thud



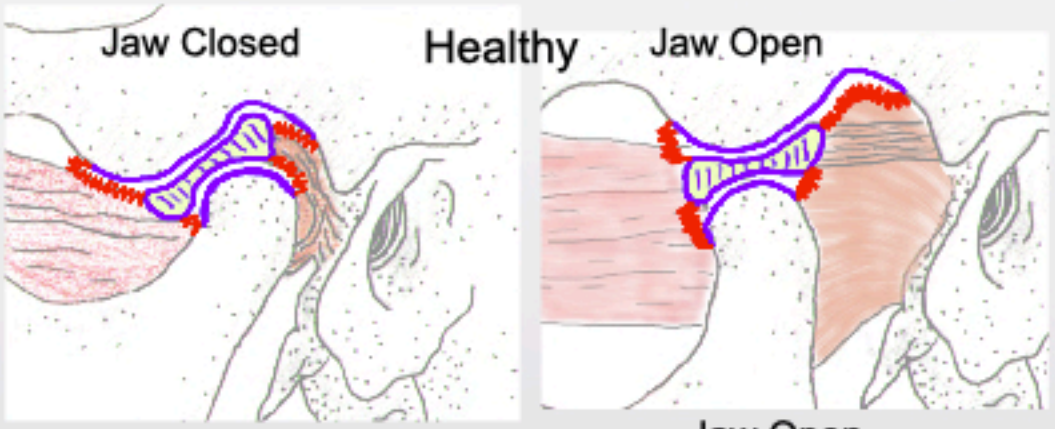
A hypermobile condyle moves past the crest of the eminence and makes a thud sound

Adhesion Crackle



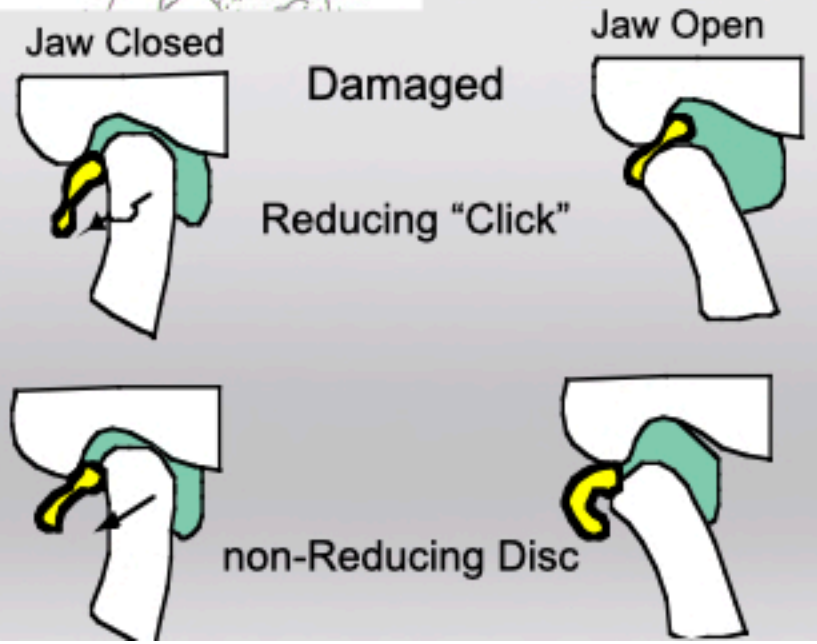
A small piece of fibrous tissue
4b joint is moved across

The Click



Key Points:

Clicking jaw joints are common, but not normal
All clicking joints are damaged
The “Click” usually does not need to treated
A non reducing disc is
not the #1 cause of limited opening



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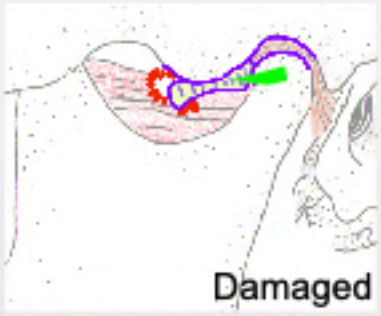
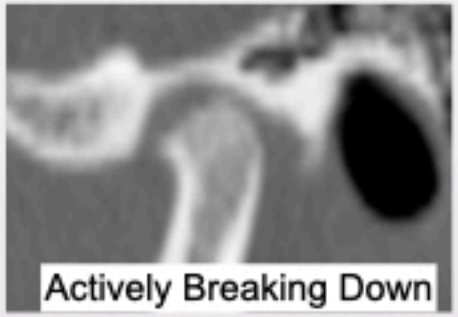
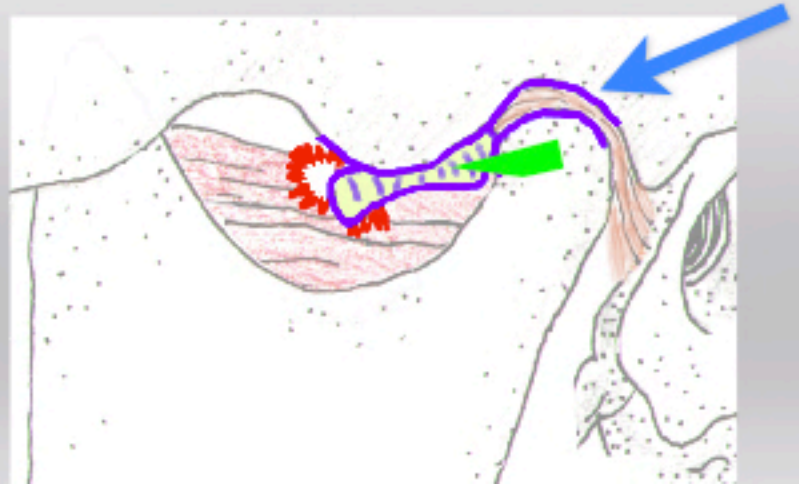




Majority of damaged TMJs adapt favorably



Posterior ligament, synovium, and retrodiscal tissue adapt to form a

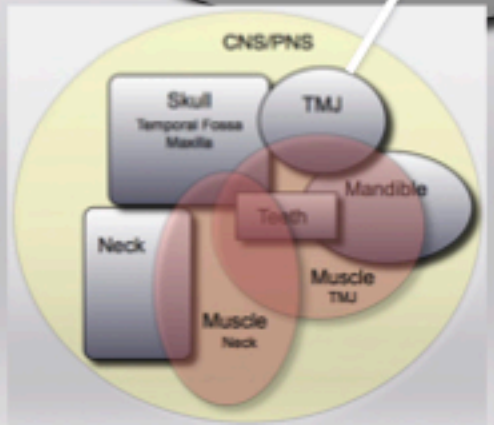
Pseudo-disc

Tissue Fibrosis

The TMJ: What You need to Know before you change an occlusion

TMJ

Does it Hurt?
Does it Move?
Does it Wobble?
Is it Structurallv Stable?

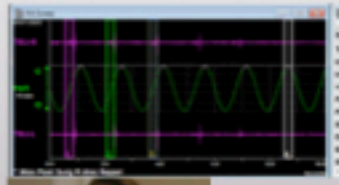


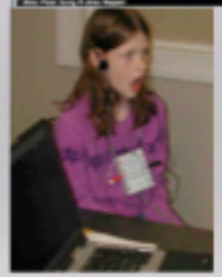
Palpate and Load the TMJ.

Measure Smoothness and Range of Motion (Quality and Quantity),
Record Joint Vibrations- JVA Bioresearch

D-PAS test: 2 weeks sleep, 2 days 24/7.

Take CT scan- see intact cortex of condylar bone and fossa.
CR ≠ Max IC less than 2mm (horizontal), not more than 3mm.





6 Common TMDs

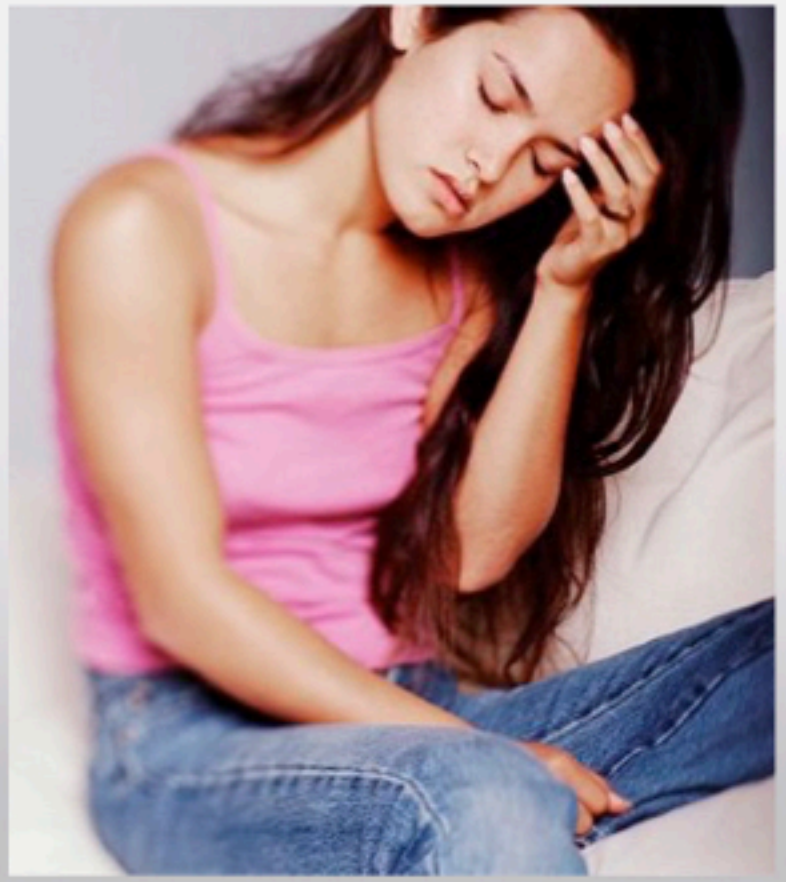
Parafunctional Clenching
Parafunctional Grinding
Occlusal Muscle Dysfunction
Osteoarthritis
Acute Sprain
Acute Closed lock of TMJ disc

5 Common Obstacles

Neck and Postural Instability
Wobbly TM Joint (Subluxation)
Compromised Breathing/Airway
Avascular Necrosis
Referred Pain Muscle Triggerpoints

1 TMD that **usually** does not need therapy

TMJ Clicking



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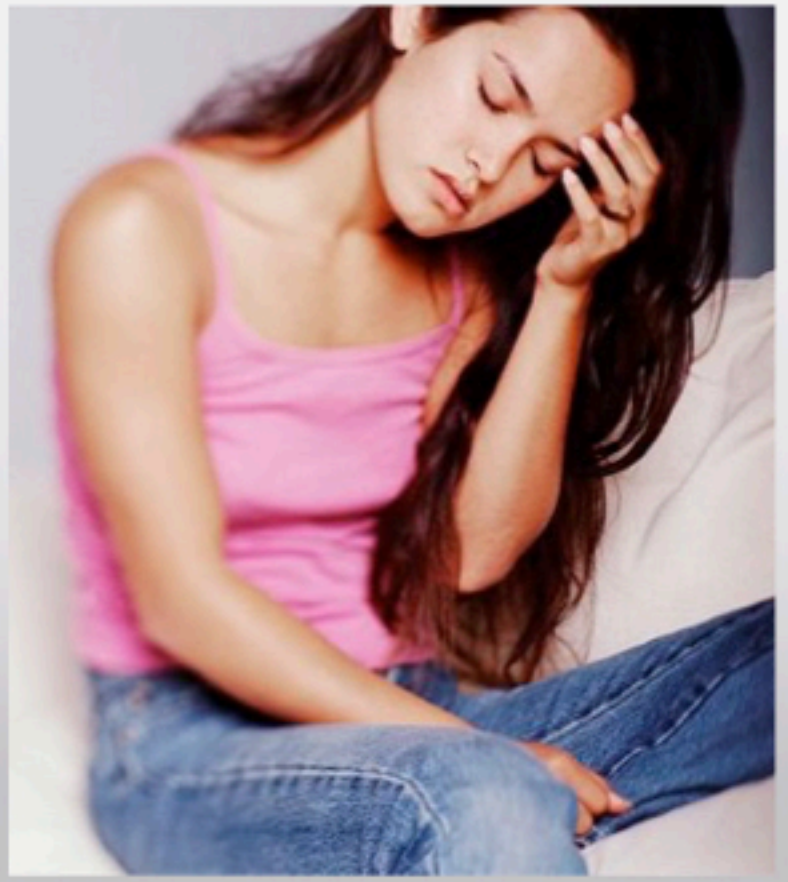

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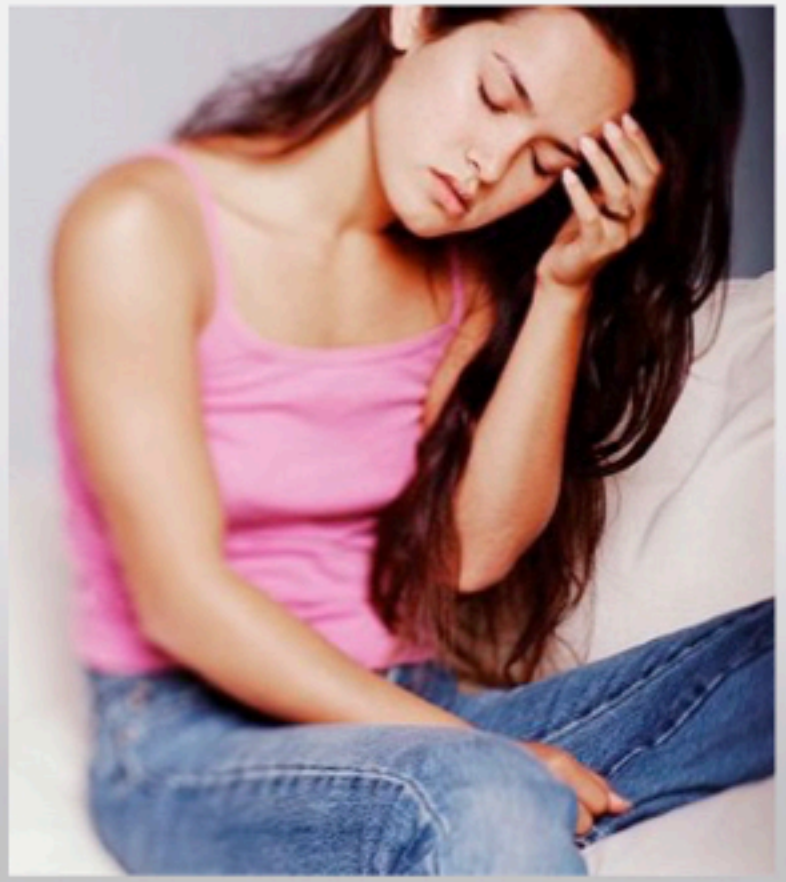
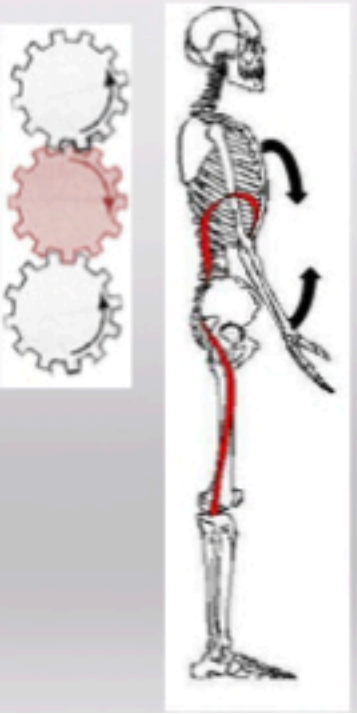


Neck and Postural Instability

This is a **dynamic** orthopedic System



A change in any one area will affect the others

CNS/PNS

Skull

TMJ

Teeth

Mandible

Teeth

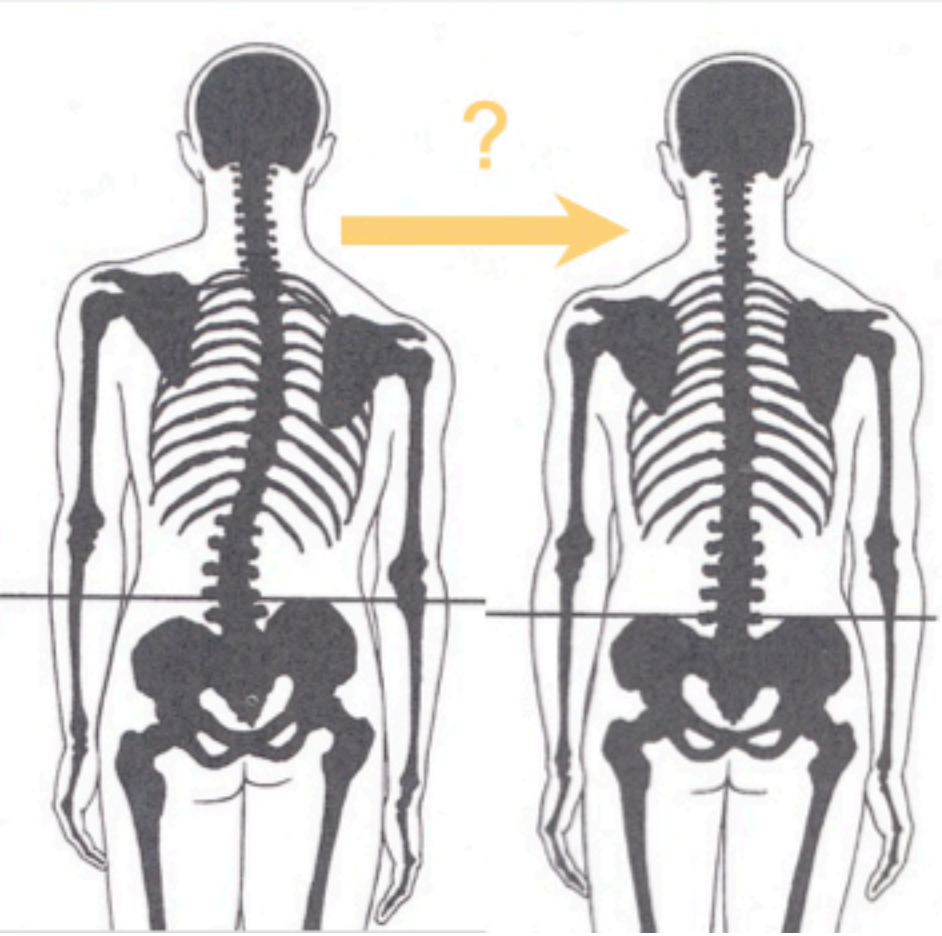
Neck

Muscle Neck

Muscle TMJ

venn diagram

How to Rehabilitate?



Define the Problem:
Bones not Stacked
Disproportionate Weak/Strong opposing muscle groups

Causes:
Postural- Habitual, Functional
Pain Avoidance- sore joint, sore muscle
Adaptation from physical damage
Genetics

Treatment:
Eliminate Pain
Mobilize Joints
Stack the bones
Strengthen weak muscle groups

Does stretching and palliatively eliminating TrP fix this?

TMD Therapies

Physical

Ice
Hot Cold Hot
Cold Laser
TENS in office
TENS home use
Range of motion exercises
Active Stretching: Manual, Tongue Blades, Dynasplint

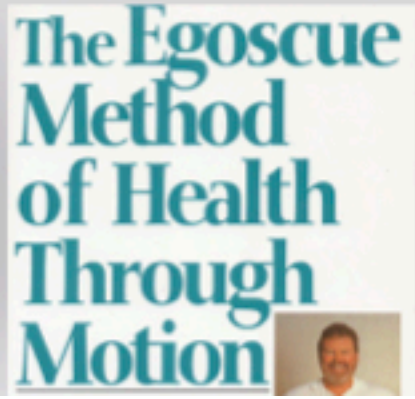
Postural Restoration Therapy

Dr Mariano Rocabado

Refer to Physical Therapy: Postural Restoration Therapy
Refer to Physical Therapy: Various Muscle Therapies
Refer to Physical Therapy: Rocabado mobilization

Refer to Chiropractic: Atlas Orthogonist
Refer to Osteopathic MD: Body alignment
Breathe, Walk , Exercise

If no access to professionals.
Do it yourself PT.
Strengthen weak opposing muscles



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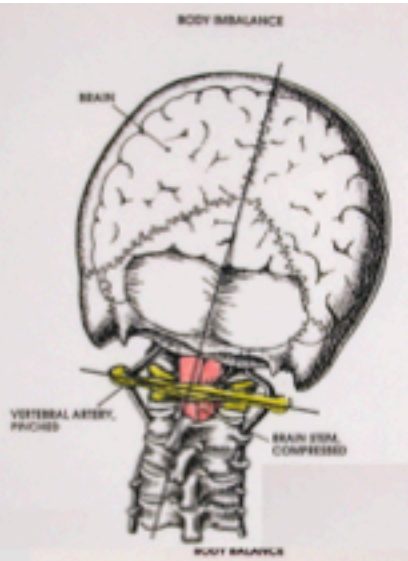
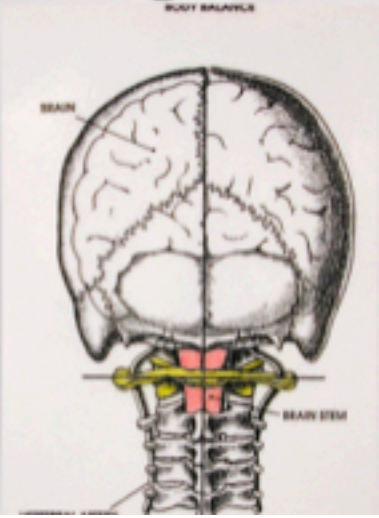
Breathe, Walk , Exercise

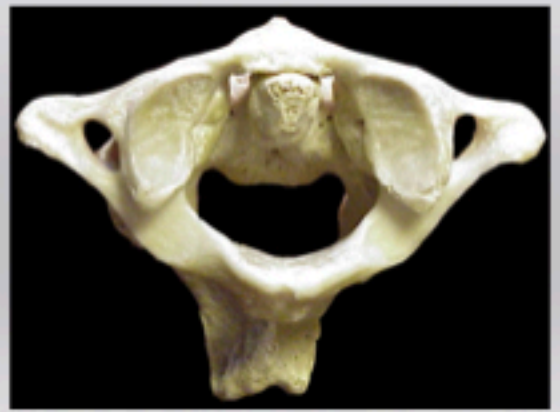
Atlas
Alignment

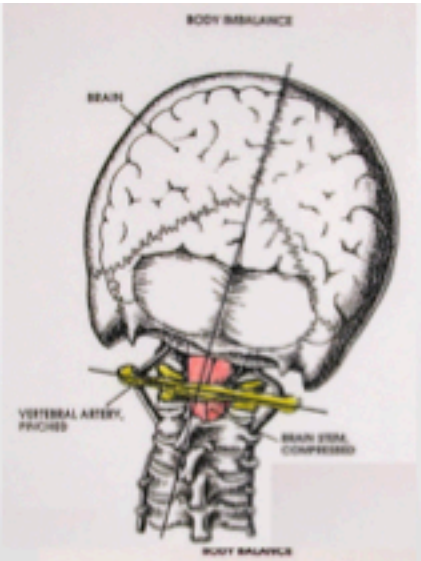


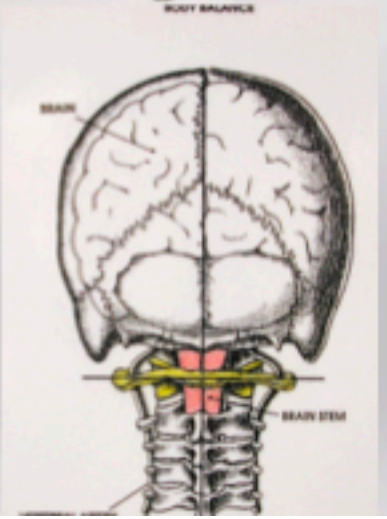


Atlas Orthogonist
Branch of Chiropractic Medcine

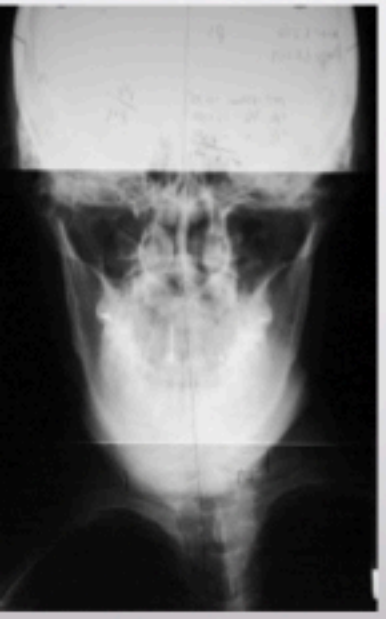
Uses sound wave to move atlas,
disrupts muscle bracing

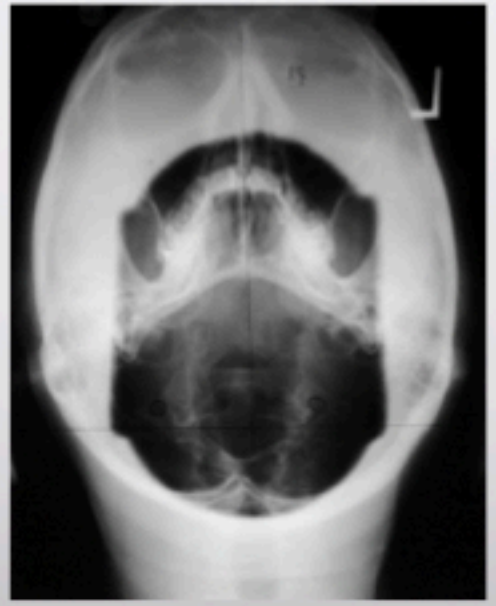


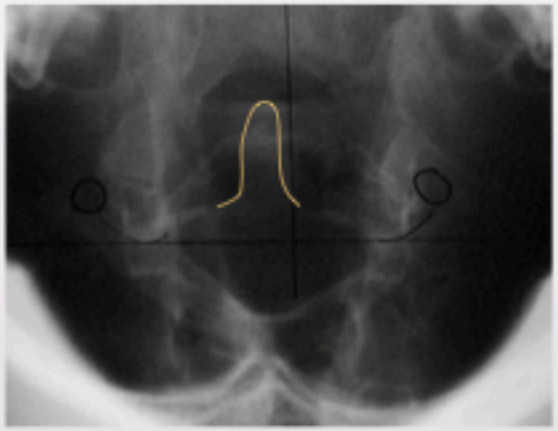




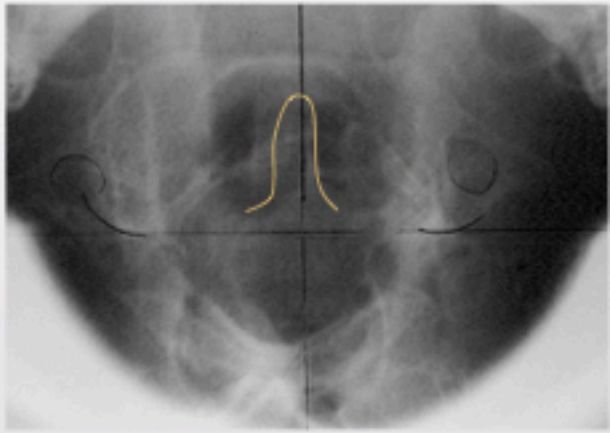
My Neck







Before Atlas Adjustment



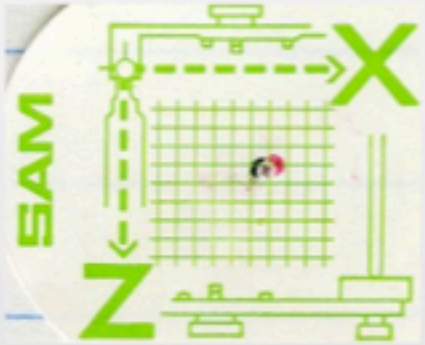
After Atlas Adjustment

CR Changes with Atlas position

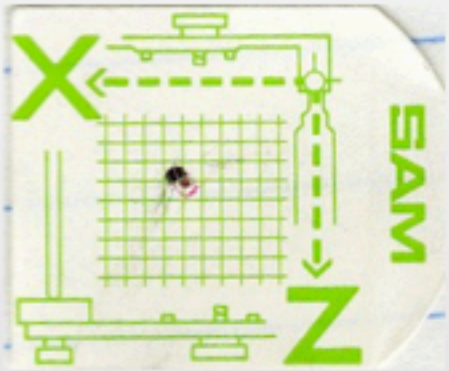
?Pressure on Occiput moves Temporal bone?

Put your teeth together and bend neck side to side

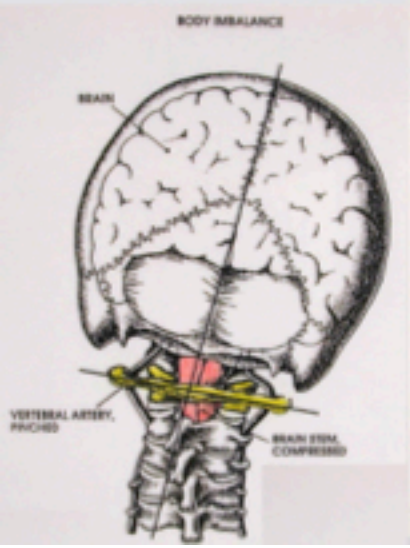
SAM Articulator Vericheck

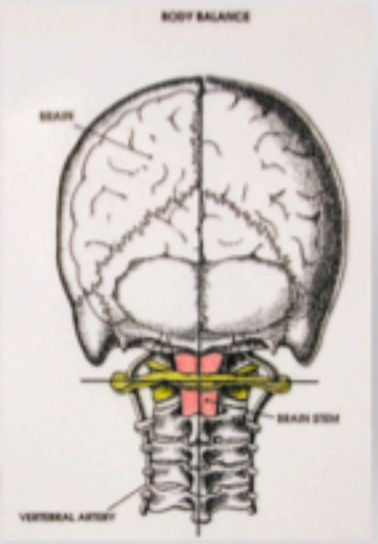


Right Condyle
Black- Atlas Out
Red- Atlas in shifts condyle up and forward 0.6mm



Left Condyle
Black- Atlas Out
Red- Atlas in shifts condyle down and back 0.5mm





Postural Restoration Therapist

Postural Restoration Institute®

posturalrestoration.com/

Physical Therapist with additional training

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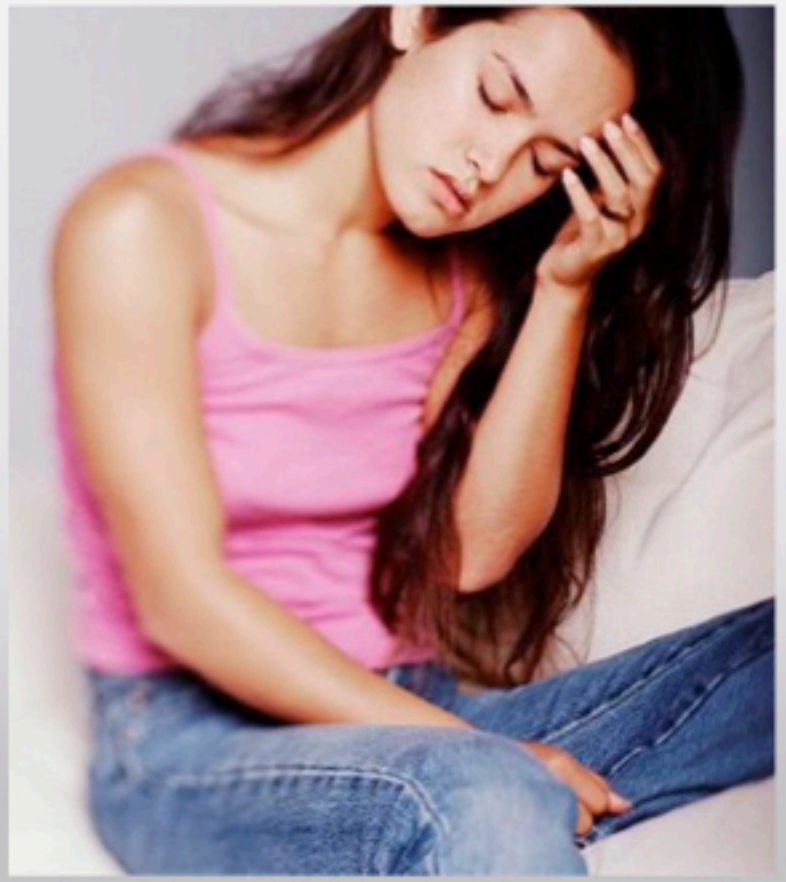


The TMJ:What You need to Know

Mechanical Stability

Mechanical Joint Stability

Shape condyle/disc/fossa provides stability when loaded

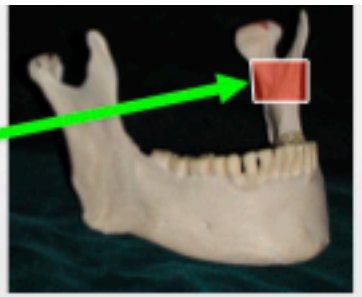
Capsular Ligaments provide stability when not loaded so pieces will be aligned and ready for loading.

Capsular Ligaments other roles are to provide end point of joint movement and proprioception

CR Load Zone

When the masseter fires and seats the joint, where do the condyles load?

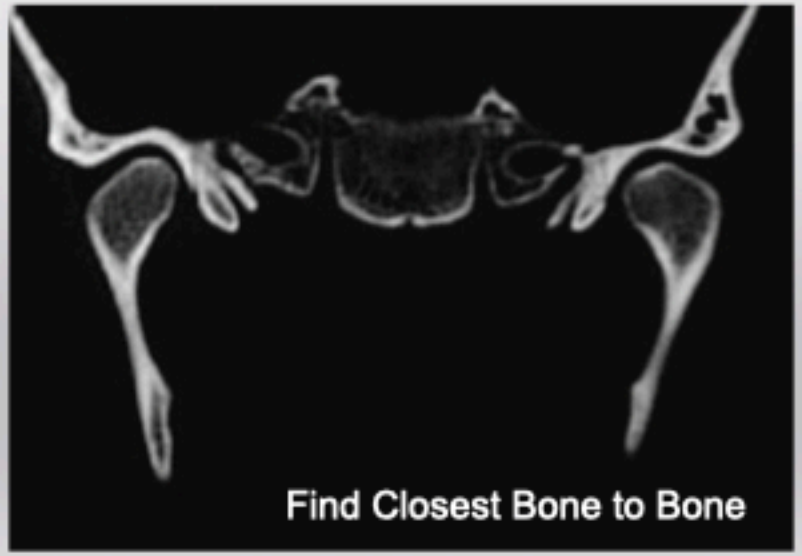
Sore Muscle

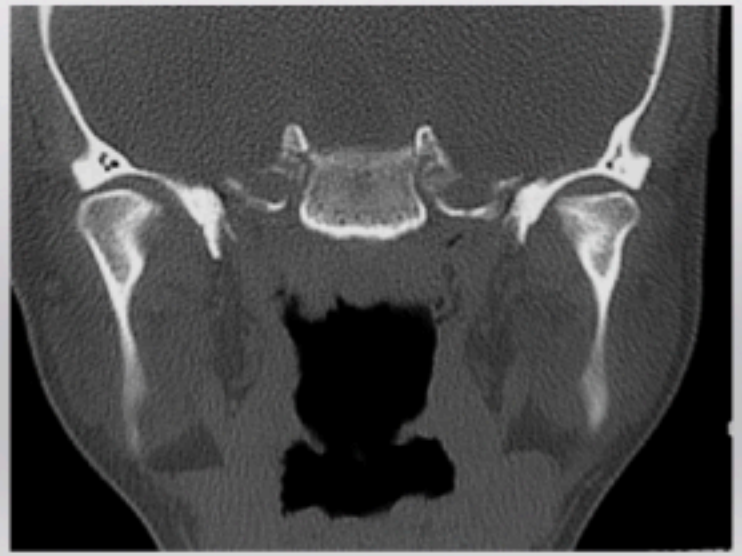


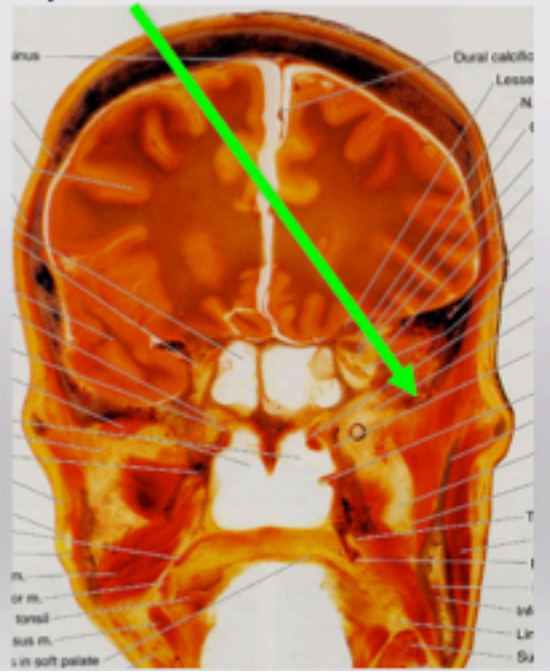
Medial Bracing is ideal

Lateral Load right TMJ
This joint can "wobble" side to side
Non-Linear Joint Deformity

Deep Temporalis runs horizontally
Sphenoid to Inferior Coronoid







Non-Linear Joint Deformity-
Mechanically Unstable TMJs- "Wobbly Joint"

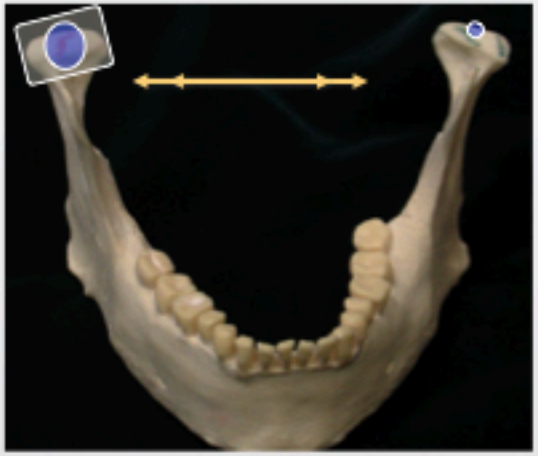
TM Joint subluxates under load
  Adapted CR "wobbles"

TMJ Muscle hyperactivity
  Looks similar to OMD
  Muscles must stabilize the joint
  Deep temporalis especially sore

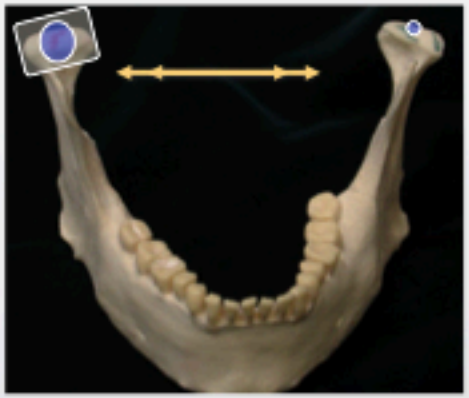
Clinically:
  Hypersensitive bite
  Increase muscle pain with anterior deprogrammer
  Continued muscle disharmony with flat plane orthotics
  CT Scan- CR load zone not medial
  JVA- after tooth tap see "wobble- 50hz vibration

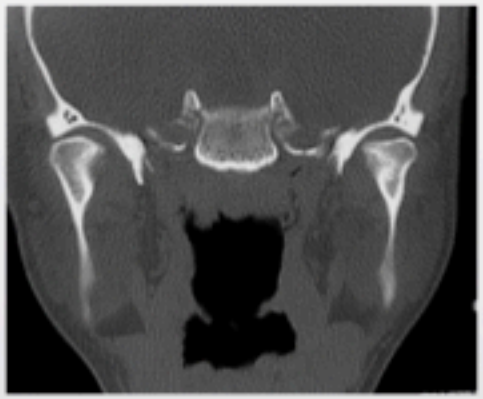
How to Avoid Missing Dx- Offer complete exam to crown patients
  Include anterior stop dx test
  Let patients decide which risk to take.

Treatment: Indexed Orthotic 6 months, the CR orthotic, then D-PAS.



Diagnosis:
Hypersensitive Bite





Non-Linear Joint Subluxation
- There is not a mechanically stable CR load zone.
- The joint deforms when loaded

Clinical Presentation:
- The deep temporalis will be sore.
- Their muscles will not relax with a CR splint.
- They will not like an anterior deprogrammer like the D-PAS.
- Muscles are braced to stabilize the joint, not to protect from occlusal interferences.
- Coronal CT images will show CR load zones that allow side to side movement.
- On JVA you will see "wobble" near the tooth tap.
- They are dependent on their working and nonworking interferences for some stability.
- Do not remove the working and nonworking interferences.

How to Avoid Missing the Diagnosis of Non-Linear Joint Subluxation:
- Clinical History- Changes of microns to the teeth affect patients comfort level
- Identify CR load zone on CBCT
- Anterior deprogrammer test 24/7 for 2 days

Palatal Anterior Stop Orthotic

Indexed Orthotic

Dentists can inadvertently remove a critical bracing tooth contact with a crown prep or occlusal adjustment

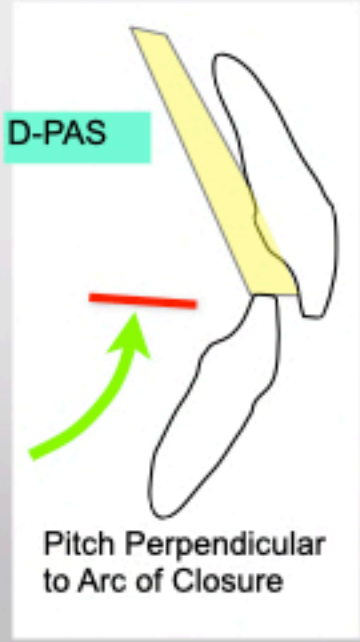
Diagnostic Palatal Anterior Stop

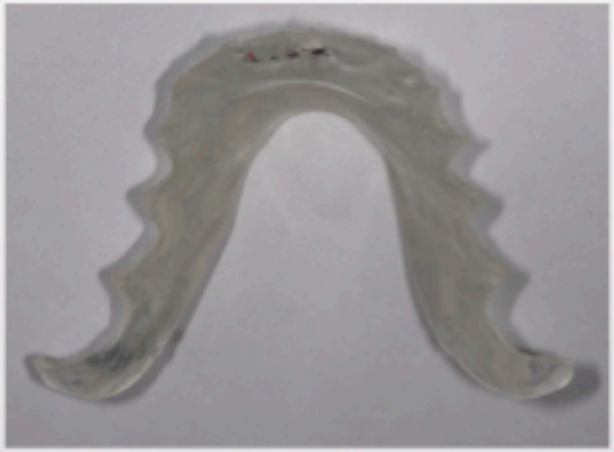
D-PAS Test: Wear 2 weeks for sleep, and occasional daytime

Better- Decrease in Symptoms
- Sleep Clenching Inhibited: Wear D-PAS as night guard
- Orthotic Improved Airway: D-PAS as night guard
- Occlusal Muscle Disharmony: Occlusal Adjust

Worse- Increase in Symptoms
- Mechanically Unstable TMJ, joint subluxation
- Intracapsular Problem TMJ
- Orthotic Made Sleep Airway Worse

Stays the Same- No Change in Symptoms
- Damaged TMJ are mechanically stable
- Pain not related to occlusion





Stapelmann H, Türp JC. The NTI-tss device for the therapy of bruxism, temporomandibular disorders, and headache…..BMC Oral Health. 2008 Jul PMID: 18662411

APS
ArrowPath Sleep

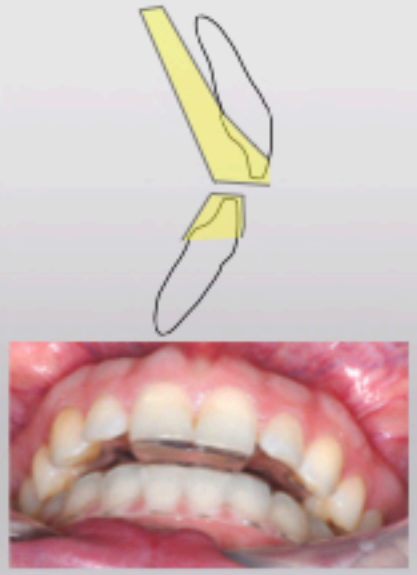
LIVING TREE DENTAL LAB

Nate Brock, CDT
(865) 509-4509
connect@livingtreelab.com

3D Printed Orthotics

D-PAS
Diagnostic-
Palatal Anterior Stop

Brux-PAS
with lower Essix



Hard Lower Posterior Stop
with upper essix

Hard Lower Full Coverage
Centric Relation Orthotic

5 Common Obstacles

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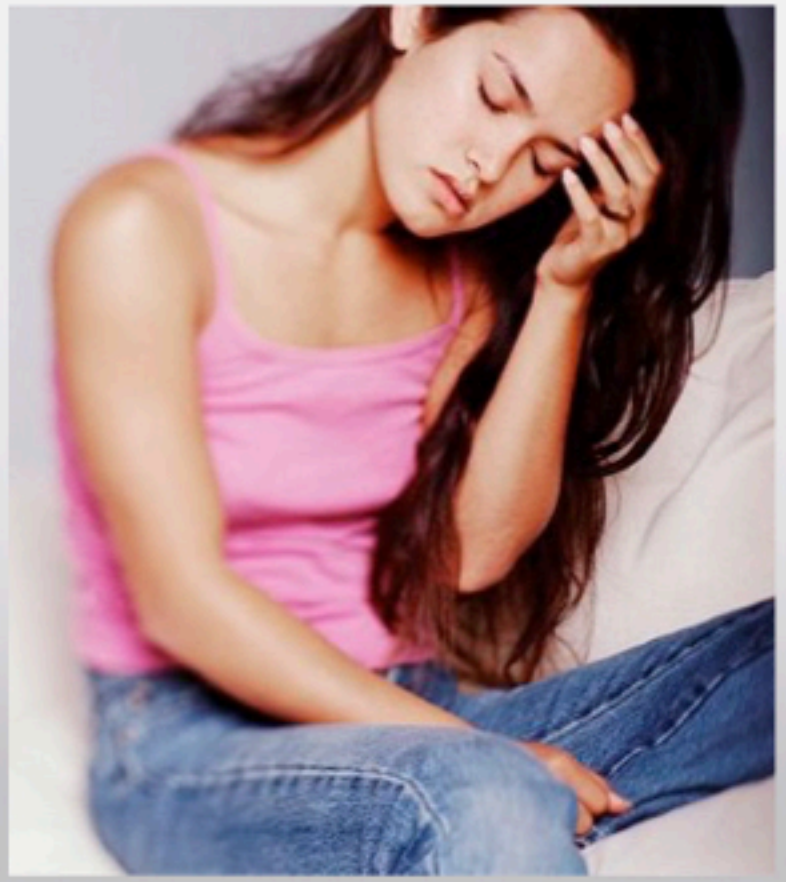
Compromised Breathing/Airway
Avascular Necrosis
Referred Pain Muscle Triggerpoints



Disordered Breathing Disease Progression

Disease Stage 1

Predisposing Factors

Small Airway

Tongue Tie, Lip Tie
Bottle Fed as Infant
Dysfunctional Swallow
Allergies
Nasal Obstruction
Large Tonsil
Large Adenoids
Large Tongue
Mid-face Deficient
Mandibular Deficient
4 Bicuspid Extraction

Disease Stage 2

Compensation:
Airway Maintained

Signs
- Mouth Breathing
- Head Postured Forward
- Jaw Postured Forward
- Tongue Bracing
- Indents in Tongue
- Sore Masseters
- Sore Neck Muscles

Symptoms
- Facial Ache
- Not Waking Rested
- Daily Fatigue
- Neck Soreness

Disease Stage 3

Sleep
Airway Partial Collapse

Signs
- All of stage 1 and 2 plus…..
- Upper Airway Resistance
- 2-4% Drop O_2 Saturation
- RERA- Respiratory Arousals
- Sleep Teeth Grinding
- ⬇ Growth Hormone

Symptoms
- Heart Rate Fluctuation
- Snoring or “Purring”
- Weight Gain
- Cognitive Impairment, ADD
- Hyperactivity

Disease Stage 4

Sleep
Airway Full collapse

Signs
- All of stage 1, 2, 3 plus….
- 4%+ drop O_2 Saturation
- Apnea
- Cardiovascular Damage
- Elevated BP
- GERD

Symptoms
- All of stage 2, 3 plus….
- Worn Teeth

John R. Droter DDS

Disordered Breathing Disease Stage 4

OSA- Obstructive Sleep Apnea

AHI- Apnea Hypopnea Index

Apnea and Hypopnea events per hour

Apnea- Stop airflow for 10 seconds

Hypopnea- <50% airflow or 4+% O_2 Desaturation

AHI 1-4 "Normal" ??	AHI 5-15 Mild OSA	AHI 15-30 Moderate OSA	AHI 30+ Severe

Signs

- Apnea
- 4% drop O_2 Saturation
- Cardiovascular Damage
- Elevated BP
- GERD

Symptoms

- Not Waking Rested, Daily Fatigue
- Cognitive Impairment

Irreversible Damage

John R. Droter DDS

Age 19F
cc: Severe jaw pain since 12y/o, Wiggle jaw to open

Patient Safety
Inc Pulse Ox
Sleep Screening

Brux PAS pm wear, jaw exercises

1 week, significant decrease in pain, much less wiggle to open.

4% RDI = 3/h

Autonomic Arousals 19 /h

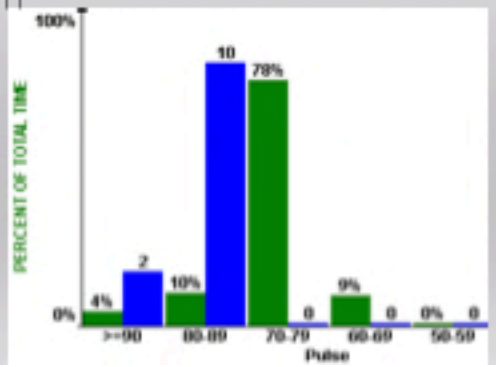
PULSE RATE DATA

Autonomic Arousals

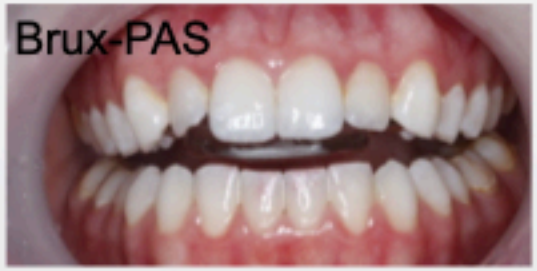
Index (#/hr): 19

Pulse Rate Range

Mean:	76	76
Min:	60	
Max:	225	



Brux-PAS



4% RDI = 1/hr

Autonomic Arousals 9 /h

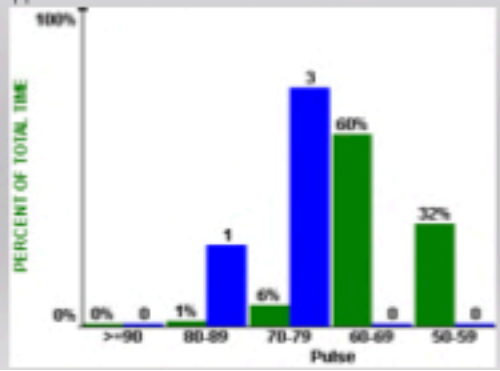
PULSE RATE DATA

Autonomic Arousals

Index (#/hr): 9

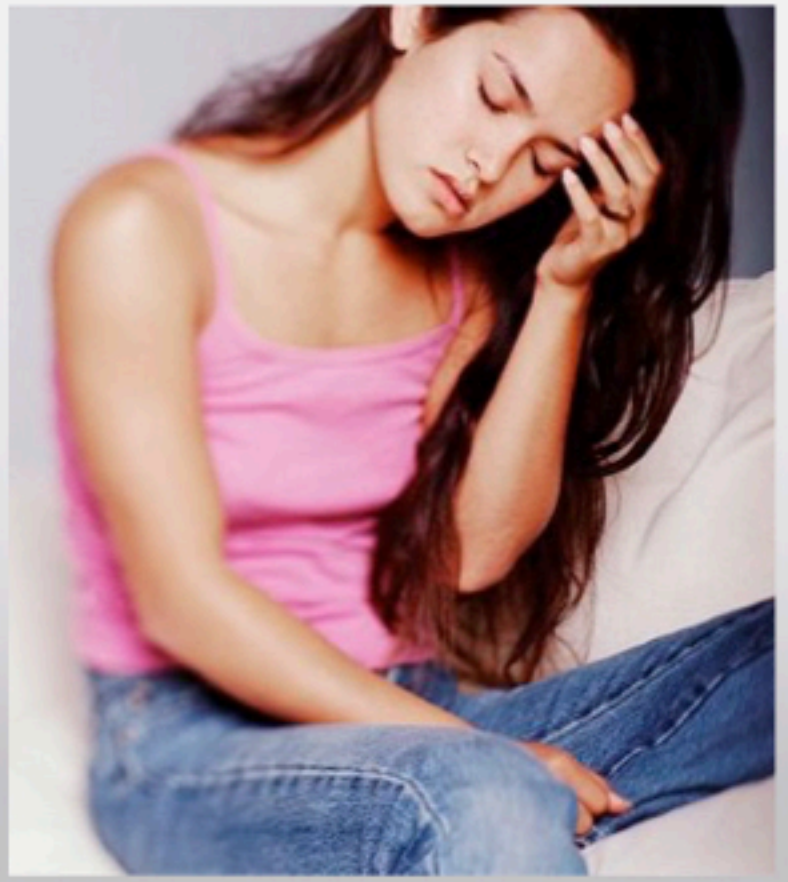
Pulse Rate Range

Mean:	63	63
Min:	52	
Max:	120	



5 Common Obstacles

Neck and Postural Instability
Wobbly TM Joint (Subluxation)
Compromised Breathing/Airway
Avascular Necrosis
Referred Pain Muscle Triggerpoints



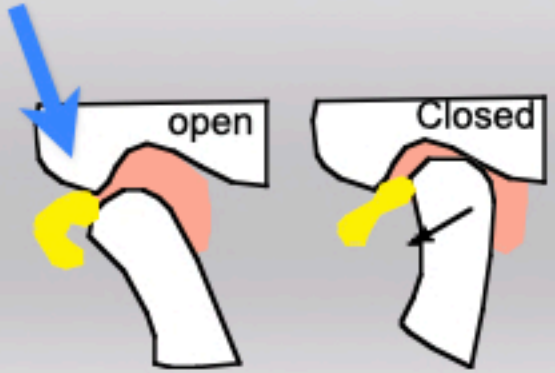
When the clicking stops (4a to 4b):

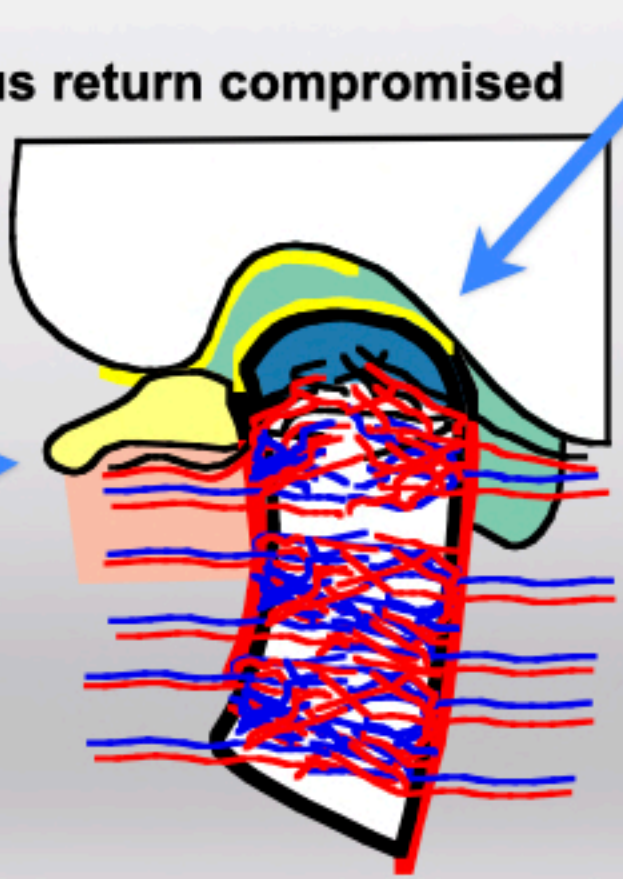
Condyle Distalized

Venous return compromised

Compromised Condylar Perfusion
Blood flow through condyle is decreased

Disc Anterior





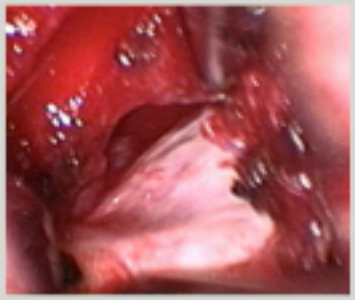
3 Outcomes of Compromised Condylar Perfusion

Bone cells die

Avascular Necrosis

One and Done

Condyle collapses 1y later.
Cartilage remans intact
Occlusion shifts once, AVN is finished.



or

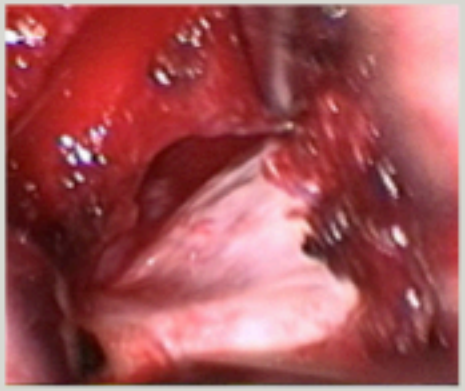
Nothing

Compromised but adequate.
99% patients have no problems

Inflammatory Tissue Bone Resorption

Cortex Collapses, Cartilage tears
Inflamed tissue contacting bone
Inflammatory cells activate Osteoclasts

Droter JR, An orthopaedic approach to the diagnosis and treatment of disorders of the temporomandibular joint. Dent Today 2005 Nov;24(11):82, 84-8



2 Possible Outcomes of Avascular Necrosis

or

AVN Finished- Condyle Remodels

Cortex Collapses
Cartilage intact
Remodels fast- 3-6 weeks
Condyle can look smooth
and normal, only smaller
Retrodiscal Tissue Fibroses
OA develops gradually

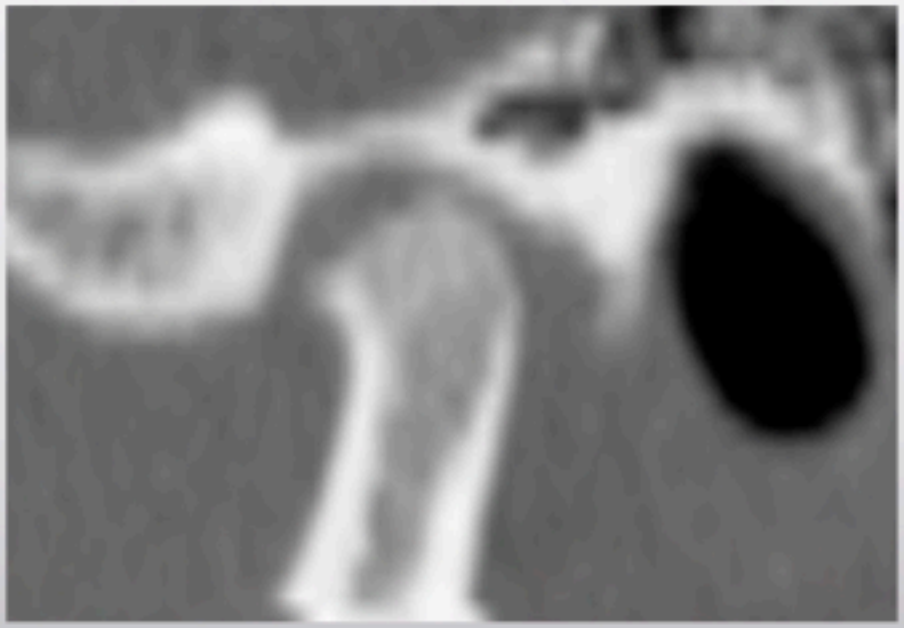
Inflammatory Tissue Bone Resorption

Cortex Collapses, Cartilage tears
Inflamed tissue contacting bone
Inflammatory cells activate Osteoclasts
Progressive Condylar Resorption
Does not have to be very painful
Eventually OA also develops

Hypoxia Induced Progressive Condylar Resorption
HI-PCR

On CT see Flat condylar surface
Missing Subchondral Cortex During Active Phase
Slow, Progressive Condylar Resorption

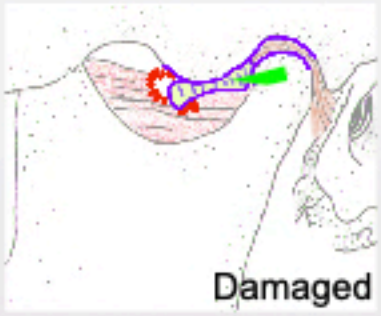
Occlusion will constantly be changing

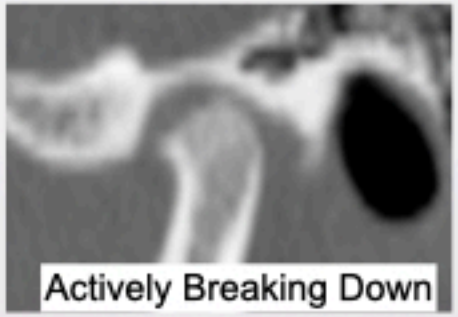


Basic Orthopedics

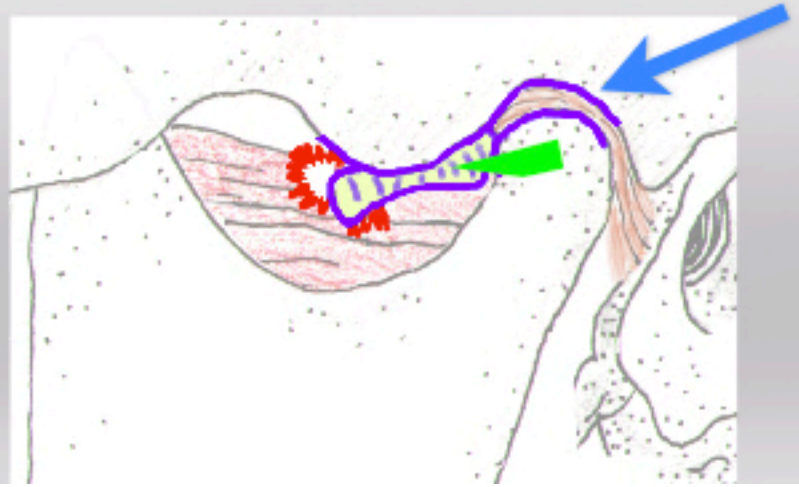
Joints are either
- Healthy or
- Damaged

If damaged, joints will be either:
- Actively Breaking Down
- Adapting
- Adapted
  - Structurally, Mechanically
  - Favorably, Unfavorably





Majority of damaged TMJs adapt favorably



Posterior ligament, synovium, and retrodiscal tissue adapt to form a

Pseudo-disc

Tissue Fibrosis

Adult Onset Anterior Open Bite Differential Diagnosis

Developed Post-Puberty

TMJ has changed
- TMJ Bone Loss (See bone loss choices)
- Recent Large Disc Displacement
- Condylar Fracture

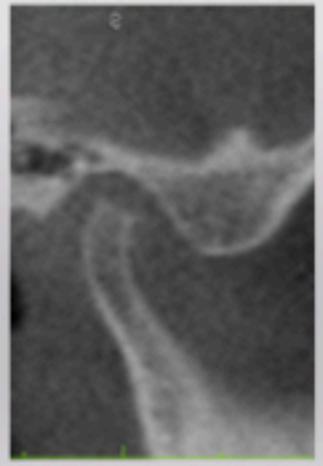
Teeth have moved
- Tongue used as occlusal cushion
- Tongue used to stabilize neck or TMJ
- Iatrogenic: Orthotics, Retainers

Both have loss of anterior coupling

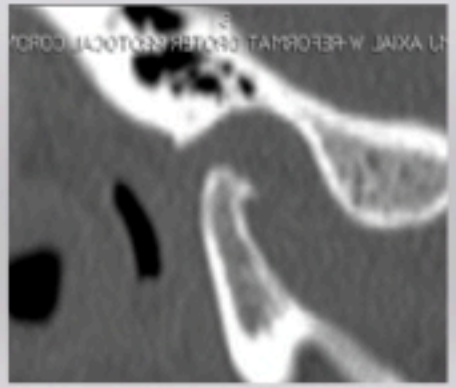
Anterior Openbite with Active TMJ Bone Loss

Use articulator to calculate how much distraction:

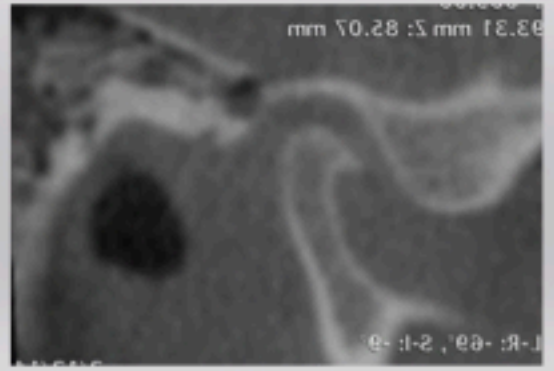
Right condyle down 6.2 mm back 2 mm
Left condyle down 4.5 mm back 2 mm



Condylar Distraction



Ball needs to land in the hole



Anterior Openbite with Active TMJ Bone Loss

Non Surgical Therapies

Condylar Distraction

Anti Inflammatory Therapies

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Neck and Postural Instability
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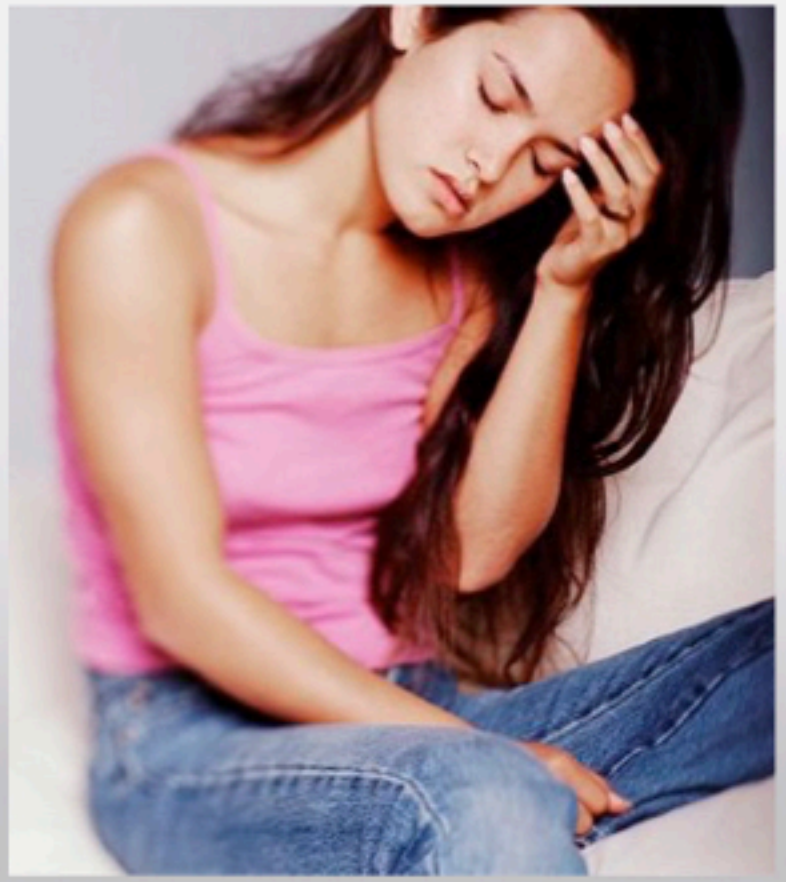
Compromised Breathing/Airway
Avascular Necrosis
Referred Pain Muscle Triggerpoints

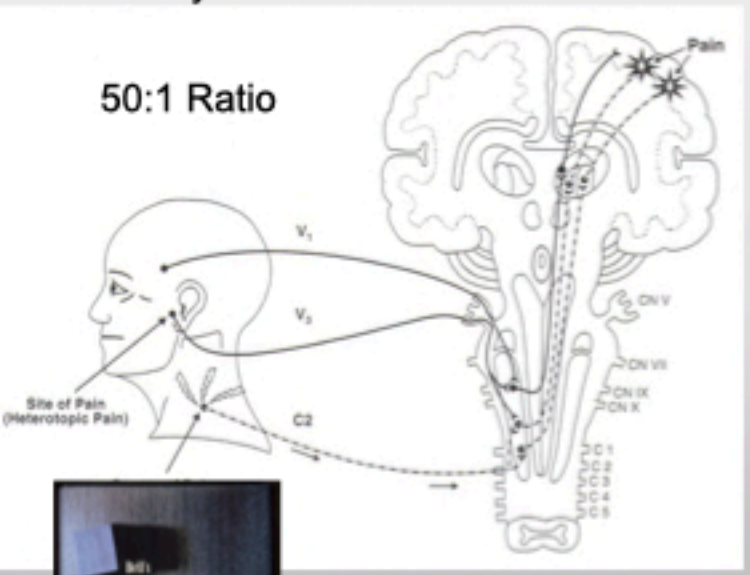


Referred Pain

Convergence

More primary sensory neurons than secondary neurons that travel to brain

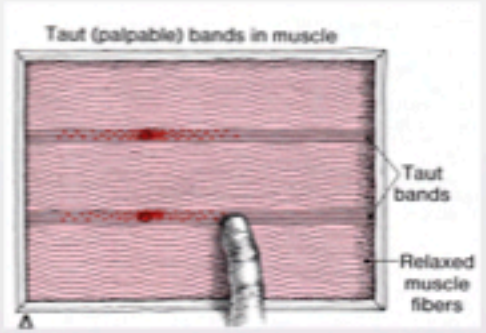
50:1 Ratio

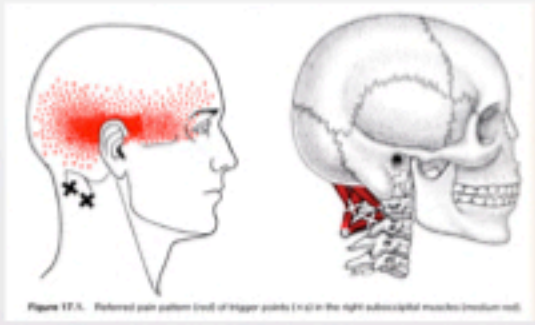


"Bells Orofacial Pain"
Jefery Okeson

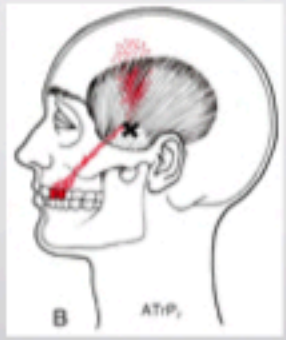
Trigger Points

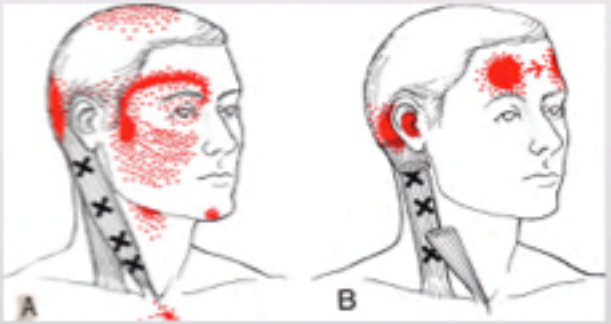
Contracted mass of actin, myosin and histamine

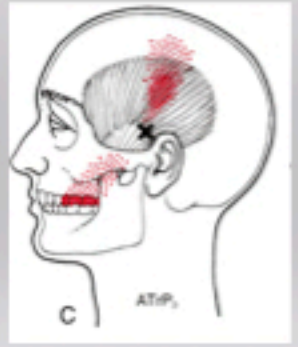


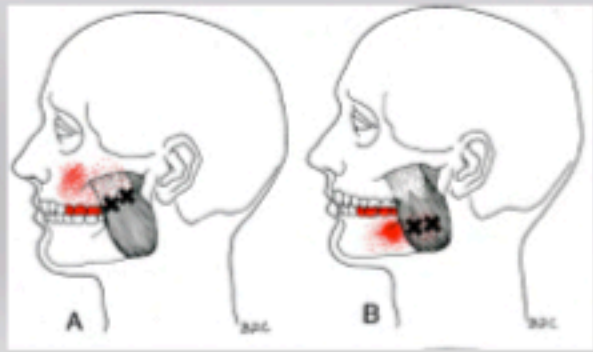


"The Trigger Point Manual"
Janet Travell, MD









TMD Therapies

Physical

Ice
Hot Cold Hot

Cold Laser
TENS in office
TENS home use
Range of motion exercises
Active Stretching: Manual, Tongue Blades, Dynasplint
Refer to Physical Therapy: Rocabado mobilization
Refer to Physical Therapy: Postural Restoration Therapy
Refer to Physical Therapy: Various Muscle Therapies
Refer to Chiropractic: Atlas Orthogonist
Refer to Osteopathic MD: Body alignment
Breathe, Walk , Exercise

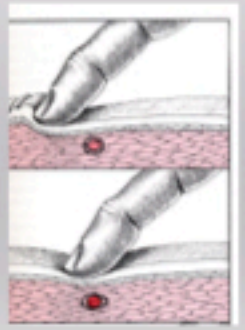
Ice Pack
15 min 3-5x a day

ThermoSafe
U-Tek Cold Pack
-23° C

Wet Towel in Microwave
3 Min Hot
3 Min Hot

3 Min Cold

Triggerpoint
in muscle



MLS Laser: BioResearch

808 nm Continuous, 905 nm Pulsed

Multiwave Locked System Laser

Diode Laser

Stimulates metabolic processes in cells
Increase release NO from cells
Decrease inflammation
Pain Reduction
Faster Healing
Eliminates Trigger Points
Much better than Dry Needling

Chung, H., Dai, T., Sharma, S. K., Huang, Y.-Y., Carroll, J. D., & Hamblin, M. R. (2012). The nuts and bolts of low-level laser (light) therapy. Annals of Biomedical Engineering, 40(2), 516–533.

Ilbuldu E, Cakmak A, Disci R, Aydin R. Comparison of laser, dry needling, and placebo laser treatments in myofascial pain syndrome. Photomed Laser Surg. 2004 Aug;22(4):306-11.

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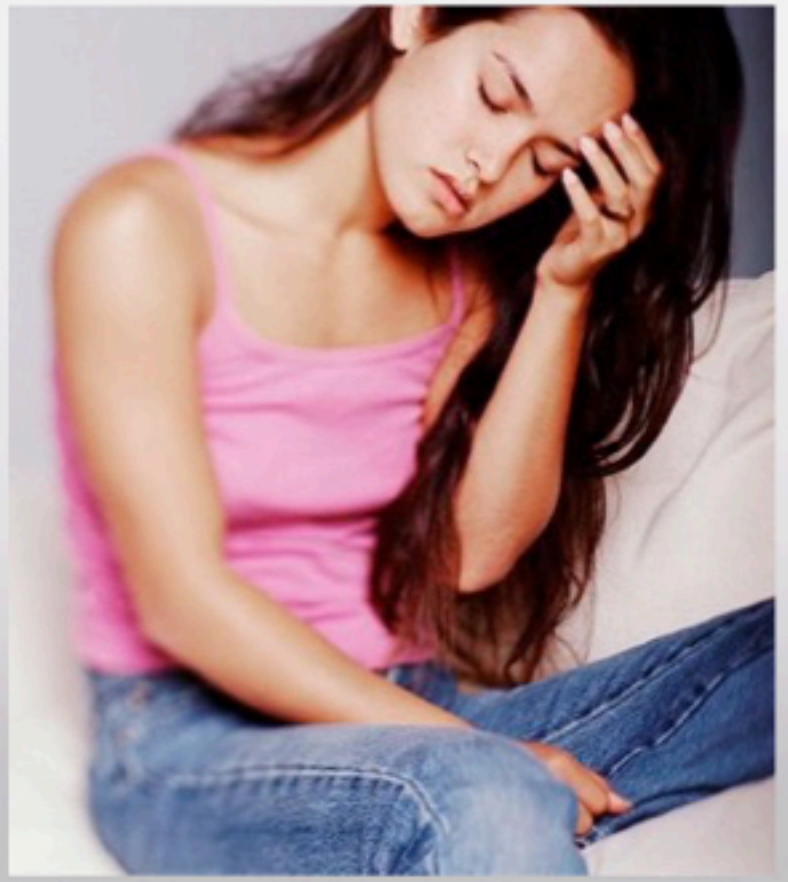

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