

Temporomandibular Joint Dysfunction Overview, Assessment and Dysfunction

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Preface

I practice Manual Medicine. My hands are the smartest part of me. My position is that those whom I have trained with and been trained by are physicians. Webster¹ defines a physician as “any person or thing that heals, relieves, or comforts” and defines “heal” as “to make sound, well or healthy again; restore to health; to remedy or get rid of grief, troubles, etc.” After I examine my clients and their unique sets of conditions, I treat through education, words of guidance, numerous acts of God and a little manipulation. The purpose of this paper is to address a specific aspect of the latter.

I am presenting this paper with a tacit understanding that the reader is a trained professional in the field of health care. That is, you have a working knowledge of gross anatomy, are trained to identify and assess deviations in structure and function, and possess the basic manipulation skills required to address issues and restore function in a wide range of cases.

Introduction

For the purposes of this paper I will use the phrase “Temporomandibular Pain Disorder Syndrome” (TMPDS) for what has commonly been called “Temporomandibular Joint (TMJ) Syndrome.”

TMPDS is defined by a triad of primary symptoms:

Pain and tenderness of the muscles of mastication.

Joint sounds with jaw opening.

Limited mandibular movement.

Secondary characteristics include referred pain to other areas of the head causing headaches, and retro-orbital, bitemporal, and occipital pain.

My intention with this paper is to present an overview of TMPDS, offer instruction on how to identify it in your clients, and offer several treatment approaches and techniques that I have found useful in my practice. I also will present the case for taking a detailed case history and performing an adequate physical examination. An illustrated appendix is included that will help you understand more clearly what I am attempting to put down in words.

There are a number of considerations that must be addressed before attempting to render aid to a suffering pain client of any type. Is the work that you are considering doing going to be done within the context of a traditional Rolfing series or will it be stand alone work? Will you be working with this client as a solo practitioner or as part of a treatment team? Is the client's complaint based on trauma or is it cryptogenic? Another serious consideration is whether this person is a pre- or a post-surgical case. I will address these issues briefly in this paper, but I believe that each case will present other aspects of the individual that must be closely examined.

The language I use is from the allopathic perspective. Most of the TMPDS clients I see are referrals from allopaths or have extensive history in the allopathic system. The allopathic language format is the one the client is most familiar with. With improved communication comes efficacy in treatment, and I believe that a common language is the first step towards better communication.

The TMJ Client

We have all seen them in our office. As many as four out of five clients are women. They are usually young: 15-45 years of age². Their complaints are common, they have pain in the TMJ region that is exacerbated by movement of most any type, from talking to eating. Headaches are also very common as is "clicking," and in some cases the jaw actually locks. Many complain of waking up with sore or tired jaws.

They describe their pain as on one or both sides of their face around the ear, in the cheek, or temple. Generally characterized as a dull, continuous, poorly localized ache of moderated intensity with a boring or gnawing quality, it may vary in the degree of discomfort through the course of the day.

They have tried over the counter medications, dental equilibration and plastic devices to go inside the mouth when they sleep. Many, especially in the last 20 years, have tried multiple surgeries. Most of the clients that I see have found that these remedies have been to little or no avail.

I believe that if more work was done in screening women, especially young women, for this condition we could prevent a good percentage of surgeries. This is important work. Once you are a failed TMJ surgical patient, very, very few allopaths will consider treating you other than to manage your morphine prescriptions.

It is not uncommon for the cryptogenic TMJ client to suffer from deviations from their ideal posture. One of the most common contributors to TMPDS is the forward head syndrome and given the dynamics of the human structure, usually the physician's examination will reveal distortions throughout the client's structure.

In general, remember that craniofacial pain of a musculoskeletal origin may arise from the muscles of mastication, the TMJ or directly/indirectly from the neck bones/musculature, but the entire body must be assessed for contributory factors.

Client History

Identifying TMPDS is usually achieved based on the client's history and clinical findings. In general, extensive radiographic evaluation is not necessary. Yawning, chewing or moving the mandible will often result in stabbing or severe pain, precipitating cramping or locking of the jaw. Long-term pain may also include cyclical periods of remission. Be aware also that chronic TMPDS clients will often present psychological characteristics that include anxiety, stress, depression, anger and frustration. The majority of the idiopathic based clients are women in the childbearing years of age.

Taking a detailed case history and performing a competent physical examination are critical to the successful treatment of any condition by any physician. My suggestion is to collect several case history forms from other physicians and find what works best for your particular practice. Specifically, you will need to know how and when this complaint was first noticed. What were the events surrounding inception of the complaint? Is this complaint idiopathic or trauma based?

What type of trauma precipitated the onset of the complaint? Was it a direct blow to the chin, or was it a lateral blow, such as the head hitting the side window in a side impact motor vehicle collision? Knowing the details of the initial insult that the client suffered will better help you understand how the biomechanics of the region you are working with have changed from their prior given structure and arrangement. With this information you will be better able to bridge/integrate what you understand of body mechanics with the altered anatomy before you. Frankel³ found that 37.5% of whiplash patients had symptoms of TMJ trauma. Did they have time to react before the event happened? If so, the musculature that was contracted at the time of impact will have to be addressed before the damaged joint and immediate tissue can be manipulated⁴.

Is this client presurgical? If there has been no surgical intervention, then you have the advantage of having a clean anatomical theater in which to work. Your anatomical atlas will be a valid map for the presentation. If the client has a TMJ surgical history you need to be aware of the types of invasive procedures that TMDPS patient's commonly undergo; whether they have had a discectomy, a tissue implant and/or hard appliance implantation. Implant devices will be discussed later in this article.

If you understand the process and the possibilities, you and your client will be much happier. Taking a competent case history will bring about the increased possibility of a significant decrease in your client's suffering.

Physical Examination

Anatomy

Now what are we looking at here when we examine the TMJ? One of five joints in the body that functions with an intra articular meniscus, it is considered by many to be one of the most overused and abused joints in the entire body. Therefore it follows that it is subject to the same

type of pathological changes that any other joint goes through when insulted. It also follows that this joint can be treated just as you would treat any other joint, because like all other joints it is activated through direct muscular action and responds to manipulative therapy⁵.

Basically, the TMJ is a universal joint operating about an incongruous joint structure with a shifting axis of rotation. The surface of the condyle is ovoid and the fossa surface is sellar. Movement occurs as a combination gliding motion rather than an all-arch rotation. Opening the jaw is really a two-stage event: first the mandible rotates with the radius at the joint itself for about 25 degrees or so, then the condyle slides/glides anteriorly on the glenoid fossa cartilage for the rest of the opening action⁵.

The disc of the TMJ is fibrocartilage in structure and is held and elongated by the pterygoid muscle. The disc requires definitions in structure and function since it needs to remain soft and pliable and withstand physiological deformation every time the jaw opens or closes.

Function

Your examination will reveal the functional status of the mandible. First check the range of motion of the mandible. The client's first three fingers will serve as a general rule of thumb for this assessment. You will often find a limited mouth opening of less than three fingers.

Next, check the line of tracking of the mandible in motion. Does it deflect to one side? This will generally be the result of muscle splinting or spasm. Does it deviate in the middle of its range and then correct back to midline? This is often the result of a meniscal displacement where there is a failure of the condylar head to capture the meniscus appropriately during opening of the jaw. This can be because of a damaged or distorted disc.

Check for lateral deviation by asking the client to slightly open their jaw and for them to move the chin right and left. This will address issues related to contractile tissue. Next move the jaw in the same directions to assess the ligamentous, osseous and cartilage structures.

Audible soft clicks and pops are not considered significant, but hard clicking consistently occurring late in opening coupled with periodic closed locking may indicate pathologic changes in the meniscus or joint⁷.

Notice any differences in the outward appearance of the joint itself. Look for swelling, heat, redness, any significant alternation from what you would consider normal in your daily practice. Click your thumb and middle fingernail close to the external meatus for a gross hearing test. Palpate the muscles of mastication. Note the bony landmarks of affected structures. This would, at the least, include the atlantooccipital joint, the atlantoaxial joint and the cervicothoracic joint. Note also the relationship of the greater angle of the mandible and its relationship to the styloid process and the transverse processes of the atlas.

You will be more successful in your efforts if you complete your examination with a structural and functional assessment of the client in toto and see how the TMJ region and its issues fit in with the whole person as they present before you.

At this point, you have completed a detailed case history as well as a thorough physical examination.

Palpation and Treatment

Approach

In my practice of what I call manual medicine, I have learned that on one level I assess by palpating. On another level, while palpating, I treat. The success of my treatment is measured by direct feedback, observation and further palpation. If necessary, I either modify my strategy to correct or further refine my line of work, or lay out a new line.

I understand that by putting this procedure into words and attempting to pass it on as teaching is akin to trying to teach someone to swim or ride a bike by having them read an article on it. However, if you will persist and are patient you can pick up most of these ideas and put them into your practice very quickly.

Specifics

My theory is that in the cryptogenic cases of TMPDS the client's complaints are really about a symptom. Most failures in allopathic treatment of this disorder come from focusing on joint dysfunction as the problem. This approach rarely brings about a permanent resolution to the issue for the client.

It is important to understand the tissue's response to injury. Generally, intracapsular inflammation stimulates the sensory innervation of the capsule. This is because this is the same nerve as the motor innervation to the muscles that bring about movement in the joint itself. As a result, the musculature goes into spasm, which in effect splints the joint⁸. In turn, pain and trismus is produced which are cardinal signs of TMPDS.

Usually the problem stems from one or two issues: A disruption of the integrity of the atlantooccipital joint (AOJ) and/or an imbalance in the tone of the pterygoids. The AOJ disruption, more often than not, involves a rotational displacement of the occiput on the atlas or a rotation of the atlas itself. When this occurs very often the anterior transverse process will be much closer to the posterior aspect of the ramus and the angle of the mandible. When this occurs pain will be palpated in this region. It appears that when these two osseous bodies get close to one another, connecting tissue webbing forms and seems to lock these bodies into their intimate positioning. Any time the body suffers pain, it attempts to lock down the area and keep it from moving/hurting any more than it already is.

The atlas and occiput are anatomically coupled and designed to rotate on the axis. This functional unit becomes bound onto the neck of the mandible, but only on one side. Binding of a rotational component (the transverse process of the atlas) to a component that swings in an arc and translates anteriorly/posteriorly (the mandible) results in a torquing of the mandible when it moves in any direction. What you find in palpation, you will not find drawn by Netter. It will most often feel like a tight band or a stringy mass of connective tissue between and

attaching to the transverse process of the atlas and the angle of the mandible. Sometimes it will appear to be a thickening of the platysma; don't be misled. It is on the next layer down and has horizontality to its fibers. Acknowledge and BE VERY CAREFUL OF THE STYLOID PROCESS of the temporal bone. Do not confuse this with the transverse process of the atlas. If you do, you could wind up with a nasty case of Bell's Palsy as well as a TMJ problem on your table. Your goal here is to free the mandible from the spine, nothing short.

To create the appropriate relationship between the atlas and the occiput, release the fascial adhesions in the atlantooccipital and atlantomandibular proximities. Your hallmarks will be an occiput that moves independently of the atlas and one that is in the appropriate anatomical relationship with the atlas. Create space and movement according to the joint's design. Utilize myofascial release techniques as well as joint mobilization. One procedure will not achieve your goal.

To attain this goal you will have to appreciate the suboccipital musculature. This includes the trapezius, spleni, semispinalis capitis and cervicis as well as the multifidi and rotatores. Six pairs of muscles that must be addressed for overall tone, right/left balance and length. Traditional myofascial release techniques are usually sufficient to bring about the appropriate relationships and facilitate the appropriate positioning of the atlas in relation to the occiput. Assess carefully and if you have not attained your goal, refer the client to another team member and get the appropriate osseous work.

Anterior to the suboccipital musculature is the floor of the mouth. The hyoid group must be addressed for anterior/posterior balance with the suboccipitals. This is not just a metaphorical relationship, it is literal. Palpate and understand this relationship. See how the anterior/posterior articulation of the atlantooccipital joint is balanced with these two sets of muscles once the extrinsics have been balanced.

Remember that earlier I said the problem of TMJ pain stemmed from the dysfunction of the AOJ and/or an imbalance of tone of the pterygoids. To get to the pterygoids we must first address the musculature of mastication. In many cases the temporalis, masseter and buccinator are secondary or compensatory muscles to the pterygoids.

After a traditional approach to releasing these muscles is completed, look at the tone of the pterygoids lateral and medial. The medial pterygoid is addressed first from an external approach looking first from the angle of the mandible posterior and superior. Look for balance in tone right/left. If absent, create it. I use my ring finger; it is more sensitive and less powerful. Ask for the jaw to open and close gently and slightly and release the contractures in the pterygoid as well as all of the affected hyoids. Ask for anterior/posterior translation of the mandible and repeat process until balance is attained.

The intraoral medial pterygoid work follows the muscle from the angle of the ramus to the belly of the muscle. This is accomplished by placing the pad of your gloved index finger on the same side medial aspect of the client's mandible and working from the greater angle medial up the belly of the pterygoid toward the palatine.

Next, use same side forefinger, with jaw opened moderately, and place the distal phalanx

posterior to the last molars and ask the client to close their jaw and squeeze your finger out of that space between their gums. This will cause more discomfort to the client than you will experience from being clamped down upon, and you will facilitate the work by sliding your finger out, but not too quickly. Encourage slow and gentle complete closure. The work needs to be done.

What is “the work?” Your finger will serve as a fulcrum and the TMJ will be leveraged open with very little movement. This action opens the capsular joint space in the most effective manner that I have found to date. Clients report that there is more space in the joint itself and a significant reduction in perceived pain. Do this work on yourself on both sides several times to practice. You will learn quite a bit about this technique that you won’t by working on others.

The masseter, temporalis and buccinator groups have a balanced action in that they are stretched and flexed as they go through their normal TMJ range of motion. The lateral pterygoids, especially the upper fibers, do not benefit from this action. The upper fibers contract to translate the disc back and forth in conjunction with pressure from the mandibular condyle. The disc changes shape to serve function with assistance from the pterygoid, then in the closing phase of the TMJ cycle it releases its tension. Posterior to the disc is a highly innervated fibrovascular zone full of blood vessels, lymphatics and dense connective tissue fibers. The disc has an elastic attachment that is affixed to the temporal bone and a non-elastic attachment that affixes to the superior and posterior aspect of the mandibular rami inferior to the condyle, according to Gorman⁹.

The lateral pterygoid has a limited range of motion. External manipulation is mandatory. The practitioner will find many TMPSD clients with masseters that are painful to palpate, but I will venture to say that they will find ALL lateral pterygoids painful to palpate¹⁰. Release this tension and balance the tone and you will reduce the client’s subjective complaint. You will not get these results by manipulation of the masseter, temporalis and buccinator alone.

Manipulation of aspects of the lateral pterygoid can be achieved from both extra and intraoral approaches. From outside, open the jaw wide and you will find the posterior aspects medial to the masseter. With your fingertip, the intention of work is directly medial. This is tender material, approach compassionately. Here you are working perpendicular to the plane of the surface of the molars with the pad of your finger on the mandibular notch, the dorsum of the digit under the posterior maxillary arch and the tip of your finger on the surface of the lateral pterygoid.

From inside the mouth, open the jaw only slightly to allow work on the inferior division of this muscle. It has a broad origin, as any strong muscle does, and a focused insertion. The only aspect that you can touch effectively is the lower aspect of the inferior division coming from the lateral pterygoid lamina of the sphenoid. Run your contralateral index finger superior and posterior until you can go no further; your index finger will be on the muscle in question, posterior to the last molar. Wisdom teeth make this manipulation more difficult, needless to say. Once touching the muscle your intention will be medial^{11,12}. Compassion, but get the work done: re-establish balance and function.

Understand that the pterygoids are the muscles of TMDS. Both pterygoids originate from the

sphenoid. When hypertonicity exists bilaterally the tendency is for the sphenoid to rotate on its horizontal axis. If one side is hypo and the other hypertoned, then there is a torque on the mandible and the sphenoid as well. There are many negative and far reaching consequences to any displacement of the sphenoid beyond the scope of this paper, but take note: this is not a good thing. Take a moment here and survey the tone of the pterygoids and psoas. You will be surprised, but that is another paper.

Travell shows the posterior attachment of the superior division of the lateral pterygoid attaching to the capsular ligament and the articular disc as well as the upper one-third of the front of the neck of the condyle¹¹. This component of the pterygoids is directly responsible for the placement of the disc in the TMJ. If you study the dynamics of this disc and the nature of its task you will be amazed that it lasts as long as it does in the average structure. Joe Breck, my illustrious colleague of the last decade, pointed out the fact that this disc must be made of very unusual material to last as long as it does while undergoing the radical structural and physiological changes that occur every time the jaw is opened.

Cartilage

The disc and the articular cartilage play a predominant role in normal joint motion and also in TMDS. Glenoid fossa cartilage and the material covering the condyle are both fibrocartilagenous. This composite is different from the condylar surfaces and menisci of other synovial joints in the body. Physiologically, these tissues deform in all directions of TMJ movement. Most significant deformation is seen in flexion, extension, protrusion, retraction, lateral motion and circumduction¹³.

In the knee joint the meniscus moves with the femur in rotation and with the tibia in flexion-extension¹⁴. The TMJ disc actually changes its shape during all movement of the jaw and then returns to its original shape at the end of the movement. The posterior aspect of the disc is directly affixed to the mandibular condyle. With this understanding, the physician can see how the joint “locks” only when the disc doesn’t go through the deformation and reformation phases that define its function. By definition, the disc must change shape and return to the original state to be optimally functional.

By unloading the TMJ through an ordered process such as the Roling Series, the surrounding structure is balanced in tone. When this happens the components of the joint move towards order. This encourages the cartilage to reshape and function closer to its ideal state. This is especially true of the TMJ disc.

Clicking and Disc Movement

Is there clicking? Without locking? Is there lateral deviation upon opening/closing of the jaw? From this you can easily ascertain the status of the disc. Is it being captured properly? Has its structure been compromised and lost function? These issues have their origins in disc damage. Assessing major disc damage is not difficult for trained eyes. If you have gotten this far in your reading, more than likely, you have trained eyes.

Once it has been ascertained that the disc is damaged, as usual, create space. If you can decompress the joint area, you have a chance at training the mandible by tracking it manually through its range of motion. I stand my clients with their heads up against the wall and stand directly in front of them. With eight fingertips pointing medially with moderate force on the masseters and thumbs on the chin, I call for motion. The fingers bring balance to the superficial and some of the deeper jaw muscles while the thumbs, with help from the fingers, keep the jaw tracking in a more ideal anatomical plane. This work is usually done at the end of the treatment. It helps “ground” them as well as significantly improve their mandibular tracking. Improvement will be noticed by all that have not fallen asleep to Enya or Prince Valium.

Given that the soft tissue holds bones in any particular arrangement, what I have found is that the contralateral lateral pterygoid is most often at the base of etiology of common TMDS. That is to say, if the left TMJ is the affected joint then look for the right pterygoid to be more contracted than the left.

Considerations

Idiopathic or cryptogenic-based TMPDS more often than not will necessitate a longer time in treatment. This is due to the fact that over time clients unconsciously compensate for pain and dysfunction and the trauma in the primary tissues becomes more deep seated. Results are often found in the form of scar tissue, adhesions, lesions, fixations and anatomical distortions. Trauma based issues, depending on the type and severity, can often times be resolved with a much shorter time frame especially when promptly addressed.

Are you seeing this client in the context of a traditional series or doing only what I call manual medicine? Are you working alone or are you part of a team? I strongly suggest teamwork. The chronic pain client, research has shown clearly, will only respond to a multi-disciplinary team approach when a long-term solution is being sought. Psychologists, sex therapists, chiropractors, osteopaths, dentists, oromaxillaryfacial surgeons, and general practitioners should be strongly considered when dealing with chronic TMPDS clients. Without a team, you are only putting band-aids on a bad situation.

Differential Diagnosis of Temporomandibular Joint Pain

Generally, there are two types of problems that define TMJ arthralgia: intracapsular and extracapsular. Intracapsular arthralgia issues include fixed or locked jaw, degenerative joint changes, subluxation and/or a displaced disc creating clicking. Extracapsular issues include dysfunction of both pterygoids, masseters, and temporalis musculature.

There are two basic types of joint or intracapsular type injuries: those that permanently deform the disc and essentially render it dysfunctional, and those injuries that only temporarily alter shape and/or function of this disc.

When there have been repeated disc dislocations, the cartilage of the glenoid fossa as well as the mandibular condyle wind up being damaged to the point of being classified as degenerative arthritis. This often leads to extracapsular arthralgia where the soft tissue reacts to the pain

in the joint and the client often presents with multiple myofascial contracture patterns in the muscles of mastication shortly after the initial insult¹⁵.

Brief Summary of Current TMJ Implant Devices

Since 1934 various materials have been used to replace failed components of the TMJ. Autogenous graft surgeries utilizing the patient's own tissues such as ear cartilage were performed as late as the 1990's¹⁶. Ear cartilage has some of the consistency of the disc if you don't look too closely. The trouble with it was that it did not have the physiologic property of being able to change shape and form, and then return to its original state over and over again, without disintegrating. Then they started pulling down strands of the tendons of the temporalis to use as disc material. The temporalis tendons at least had a blood supply to them and had a remote chance of living until the patient's first bowl of hospital gruel. It is difficult for the writer to understand how the FDA approved these two procedures even on an experimental basis.

The hard appliances became available soon after these repeated failures started rolling in. The "Morgan" and the "Christensen" devices are the most common types used in the last two decades. Due to a combination of politics, failed appliance history (81% in the case of the Christensen device¹⁶), litigation, and poor IMHO medical case management, both of these devices have been removed from the AMA-approved list of devices. I do not believe that you will see many other types of devices in your practice for some time to come.

The only device that is approved for use at the time of this writing is the ANSPACH device. This device utilizes a titanium mesh fossa component that is designed to encourage bone growth around and through it. The condylar component is made of polyethelyne. Very few medical doctors have been trained and certified to perform this implantation.

The recipients of these fossa devices will present a surgical site anterior to the articular capsule and inferior to the maxillary arch. An incision is made along the greater angle of mandible, the patient's condyle is removed and the device is screwed in place onto the upper portion of the ramus.

Obviously the musculature of mastication will be disturbed as a result of these procedures. The temporal and mandibular branches of the trigeminal nerve will be disturbed as well. One of my clients presents as affected by Bell's Palsy due to damage sustained to the trigeminal nerve during a fossa device implantation. In the case of the condylar implant it is necessary to remove the patient's natural condyle and fix the appliance with multiple screws. Christensen's are typically affixed with short screws that go only through the outer lamina. The Morgans used the longer ones that went through both laminae somehow. Be careful on inner mouth work. You can imagine what the tips of these little sharp screws feel like when they are drilled into the lateral aspect of the pterygoid attachments on the rami of the mandible.

Early screws were stainless steel and patients complained a lot with changes in the weather. They also had a tendency to back out frequently. Because of the frequency of the screws backing out and the resulting screw heads no longer sitting flush with the condylar appliance,

they continually tear into the masseter. In some cases these screws back completely out of the lamina and create a total implant failure. Later procedures utilized titanium screws with fewer problems of this type.

According to *The TMJ Association, Ltd.*¹⁶ a company called VITEK bought a substance called “Proplast” from Dow Corning in the 70’s and 80’s in an attempt to avoid some of the previous failures. VITEK marketed this material to be used to form the fossa component in TMJ surgeries figuring that it could conform to the natural condylar surface that was different with each patient.

Like Bridgestone/Firestone/Ford of late, evidence and history of Proplast’s failures in Canada when used to repair other joints was suppressed, probably for business reasons. It was certainly not in the best interest of patients. The substance was, as a result, successfully marketed in the United States as the most promising procedure in TMJ repair at that time.

In short, Proplast implantations failed in joint repair here as it had in Canada. Failure in most patients, including two of mine, involved primarily the splintering of the Proplast material. The natural fossa region of the skull is very thin. In both of my client’s cases splinters of Proplast material were driven into the cranial cavity and in one case into the brain itself, as well as dropping down into the musculature of mastication.

Dow Corning essentially played dumb as to what VITEK was doing with their product and they both filed for bankruptcy when one of my clients took them to court.

Not all patients who received Proplast implants had them removed. You need to know the history of your client. If your client was a recipient of Proplast and it is still in place, you need to operate with caution in the TMJ region as well as in the muscles of mastication. There may be foreign body splinters in these regions. The myofascial contracture pattern in these patients may be secondary to Proplast splintering.

One of my clients, after ten or more surgical failures, wound up having a five-inch section of her fifth rib incised on both sides. These bones were attached to the rami, bilaterally, with the sternocostal aspect being used as the condylar component in a titanium fossa. At 30+ years of age no one expected the ribs to begin growing again, but they did. Since this procedure in 1987, the ribs were removed from the mandible and replaced with total “Christiansen” devices. She has completed three residential treatment stays, works full time as a local business owner dealing with the public, takes 12-16 Vicodin daily and drives to work.

Conclusion

I hope that I have presented the readers with an overview of the issues and problems related to a very complicated and painful syndrome. I also hope that I have given you some basic tools to add to your repertoire in the treatment of craniomandibular pain conditions. I have also addressed the failures of some of the folks working within the allopathic system.

I have not addressed re-balancing the involved musculature through specific exercises,

dietary changes, postural corrections, client education, or lifestyle changes. People with TMPDS are chronic pain sufferers. They need a good Roling Series as all of their systems are strongly affected. A team approach is the only intelligent way to provide these folks with any significant, long-term relief. Establish a network that includes dentists, oral surgeons that specialize in TMJ reconstruction, biofeedback practitioners, psychologists, and the whole host of physicians out there who know how and want to help people who have suffered for a long time. A good resource to start with if you are interested in working with these folks is: The TMJ Association, P.O. Box 26770, Milwaukee, WI 53226, Fax: 414-259-8112, E-Mail: info@tmj.org.

I have also not addressed what the bulk of my real work has been in the field of helping others: prevention. I believe that whatever your modality or specialty is in facilitating improved health, you will find that helping people create competent structure, better balance and improved function will be the biomechanical hallmarks by which you can measure your success. We all have a responsibility to make sure that we do our best to prevent TMPDS. We will do it by assisting others in their efforts to bring order to what I have heard Dr. Rolf¹⁷ called “randomness.”

Appendix

Figure 1: Schematic of Typical Total TMJ Implant

Figure 2: Total “Christensen” Device Implant: Fossa and Condylar Components
Right Lateral View

Figure 3: Total “Christensen” Device Implant: Fossa and Condylar Components Anterior View

Figure 4: Total “Morgan” Device (Box Type) Implant: Fossa and Condylar Components
Anterior View

Figure 5: Total “Morgan” Device (Box Type) Implant: Fossa and Condylar Components Left
Lateral View

Figure 6: Bilateral Total “Christensen” Device Implant: Fossa and Condylar
Components Anterior View

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 - (13) Cailliet, R. Head and Face Pain Syndromes. F.A. Davis, Philadelphia, 1992. p.148.
 - (14) Sheikoleslam, A., Holmgren, K., and Riise, C. J Oral Rehabil. 1986. 13:p.137-145.
 - (15) Cailliet, R. Head and Face Pain Syndromes. F.A. Davis, Philadelphia, 1992. p.153.
 - (16) The TMJ Association Newsletter [www.tmjassociation.com], Temporomandibular Joint Implants. Spring/Summer 1994. p.5.
 - (17) Rolf, I.P. Rolfing. Dennis-Landman, Santa Monica, CA, 1977. p.69
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