

Snap, Crackle and Pop, Part II

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Last spring, I discussed the anatomy of the temporomandibular joint (TMJ). (*Editor's note: See "Snap, Crackle and Pop, Part I" in the May 2001 issue, available on line at www.massagetoday.com/archives/2001/05/08.html.*) Problems with this part of our anatomy are now commonly referred to as temporomandibular disorders (TMD) or TM dysfunction.

Numerous anatomical features may be involved in TMD, in large part related to the fact that many different clinicians are involved in its treatment.

One set of anatomical features involved in TMD is referred to as internal derangements. These problems involve problems with the articular disc, articular capsule, associated ligaments, and the bony articular surfaces. These problems may be related to osteoarthritis; neoplasia; fracture; disc displacement; etc.¹

An important set of anatomical features sometimes associated with TMD is occlusal misalignments. The literature is equivocal on the significance of malocclusion and TMD; nonetheless, dentistry often plays a significant role in the management of certain TMJ problems. Different occlusal elements, including missing dentition, misaligned dentition and broken dentition, have been implicated in the etiology of TMD. In addition, these abnormal dental features certainly have an impact on the function of muscles of mastication, face and neck. Simons et al discuss the involvement of myofascial pain and TMD. It is still unclear whether myofascial pain associated with TMD is a primary causative agent, or the result of internal derangements, as discussed above. In any event, there is often muscular pain associated with TMD. How this myofascial pain manifests itself will in part determine the type of clinician and modalities used to treat the problem. Sometimes pain is not apparent, but muscle imbalance creating uneven mandibular opening and closing is obvious.

Neuralgias may be associated with TMD, or even confused with it. These neuralgias may result from almost any condition, from posttraumatic to post-herpetic to nerve compression.

These anatomically based disorders are treated in several different ways. Acute pain can be managed palliatively until the cause can be identified and treated in an appropriate manner. Eliminating the cause can be complicated and time-consuming. The cause is often multifactorial, requiring cooperation between patient and clinician(s). Common causative factors include malocclusion; body mechanics; various forms of arthritis; chewing dysfunctions; and stress.

Although TMD can represent a very complex set of etiological factors, it also offers an opportunity for the cooperation of several different clinicians to help manage and solve its presenting features.

Reference

- Simons et al. Travell and Simons' *Myofascial Pain and Dysfunction: The Trigger Point Manual*, Vol. 1, 2nd Ed., 1999.
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