**“TMJ” – What is it?  How does it apply to everyday dentistry?**

“Reciprocal Click”? – Opening Click at a greater vertical opening than the closing click.

Opening click - Dislocated disc reducing, getting in to position between the condylar head and the fossa

Closing click – Disc that was in position between the condylar head and the fossa slipping off from its position, before teeth come into occlusion. Closing clicks are usually barely audible.

“TMJ” myths that I had learned:

1. Painless TM joint clicks are normal.
2. “TMJ” disorder is self-limiting and settles down in time.
3. Once the articular disc is damaged, “bone-on-bone”, TM joint surgery is the only possible treatment.
4. “TMJ” is primarily a “BiopsychoSocial disorder”, it is stress-induced.
5. Pain in the TM joints and TM joints locking open or closed constituted “TMJ” symptoms.
6. Flat plane bite guard for “TMJ”. If it resolves it, it is a muscular problem. But if that does not resolve it, the patient needs a referral to either a surgeon or a psychiatrist or both.
7. Condylar head of TM Joint only rotates for the first 20 mm of opening. Once this hinge axis of rotation is determined, then an adjustable articulator that opens / closes like a hinge, is used to build the occlusion.

OUTCOME – the end results the patient seeks - be pain-free, great smile, chew any food I want, keep my natural teeth for life

MEANS – How to achieve those outcomes - Treatment options

COST – Consequences - what does it take to implement a treatment option, how long would it take, how would it look, how much would it hurt, possible risks, how many dollars does it take, what would ‘insurance’ pay towards this option etc.

**Take home points:**

* Almost all dental treatment we do, has an effect on the Trigeminal input to Central Nervous System, jaw muscles & TM Joints
* Every time we change the occlusion on a single tooth / many tooth, we are affecting the TM Joints and cervical spine. Thankfully, patients have adaptive capacity!
* Primum non nocere. “First, do no harm”
* Preserve posterior teeth /stops
* Maintain posterior occlusal stops
* Don’t “make them low; let them grow”
* When restoring distal molars avoid “check bite” impressions
* Check occlusion while upright
* Record presenting occlusion while upright, prior to anesthetizing
* Unexplained tooth pain could be referred from trigger points in hypertonic jaw / neck muscles
* Unexplained ‘endodontic failures’ – TMD / CCMD?
* Unexplained bone loss & tooth mobilities in patients with scrupulous dental hygiene – TMD?
* Don’t tell patients that TMJ clicks are “normal”, if they are “painless”
* Equilibrating teeth for TMD treatment is rarely helpful. It is also irreversible
* Avoid any treatment that results in posteriorizing the mandible
* Freedom of entry into & exit from Maximum Inter-cuspation Position while chewing
* If your patients are struggling with symptoms that seemingly defy medical solutions, think CCMD / TMD
* Offer some hope & give them information / referral