



WELCOME
—We are glad you are here—

TMD – Occlusion, Bruxism and Splints?



Sarah Beach
BHSc, BA, ROHT, RDT, RDH, OMT

- *Advanced Scope OHT at Dental Health Centre, Brisbane*
- *Co-Founder iHealthCo – CPD courses*
- *Co-Founder FNFT Orofacial pain & TMD Seminar*
- *Exclusive Distributor LightScalpel CO2 Laser*
- *Clinical Director of Orofacial Myology Australia*
- *International Course Co-Ordinator and Orofacial Myologist, The Breathe Institute, Los Angeles*
- *Wife and mother of 3 kids*





OUR STORY

Timothy J. King

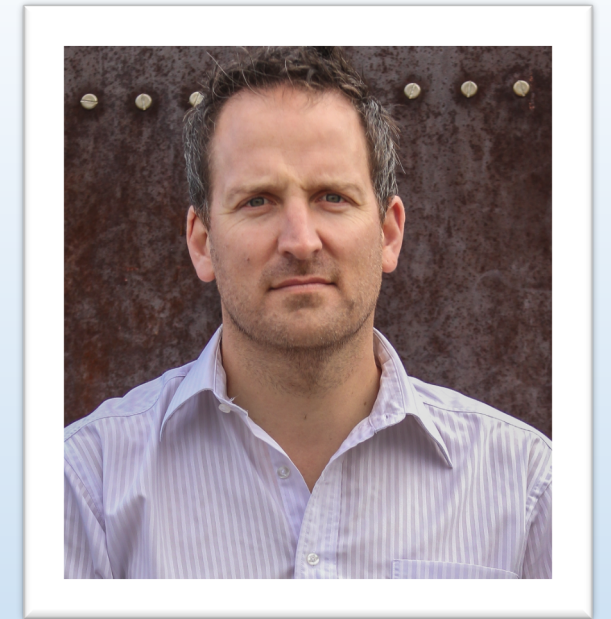
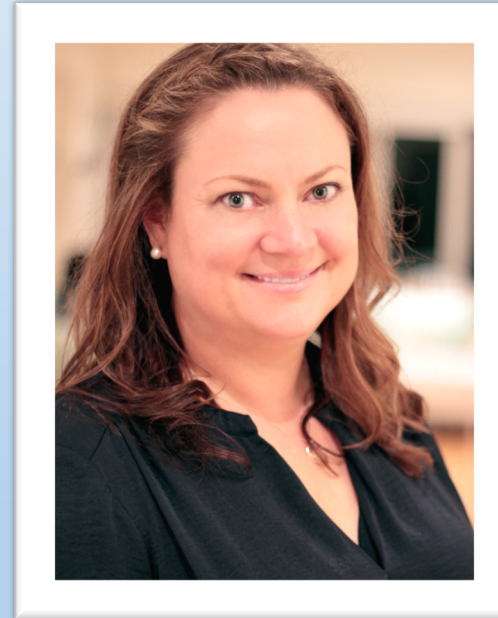
BTh. Adv. Dip. App. Sci Member MA



Sarah Beach

BHSc. BA SDT RDH ROHT (Qld)

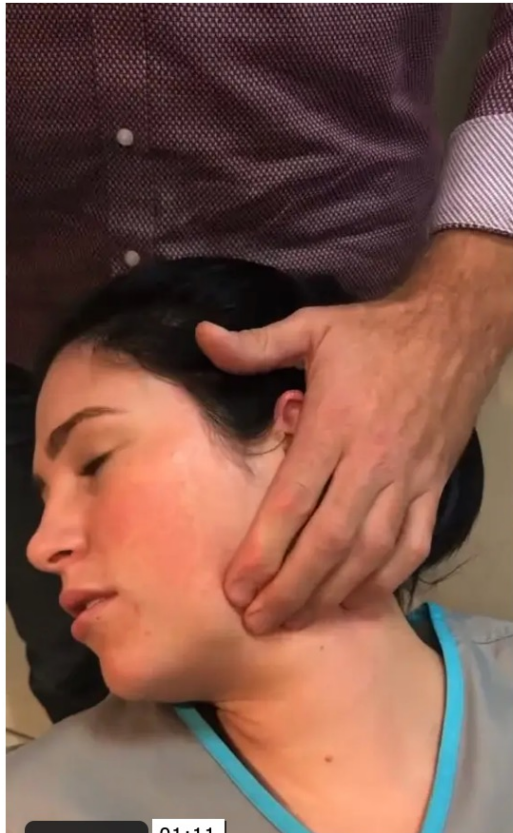
- The Breathe Institute
- Steven Olmos
- Coulson Institute
- LVI
- Tongue Tie Institute
- Myobrace
- Bowen Therapy
- Myomunchie
- Thomas Myers
- Larry Kotlow
- Dr Bill Hang - Orthotropics
- Walt Fritz
- Light Scalpel



...and much more...

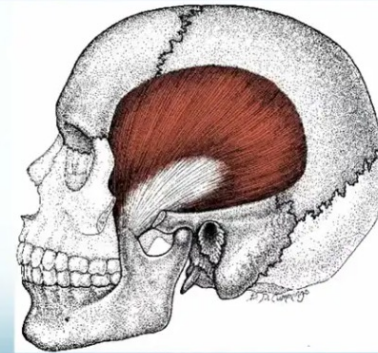
FNFT: TMD & Orofacial Pain

A Practitioners Guide to Treating TMD and Orofacial Pain



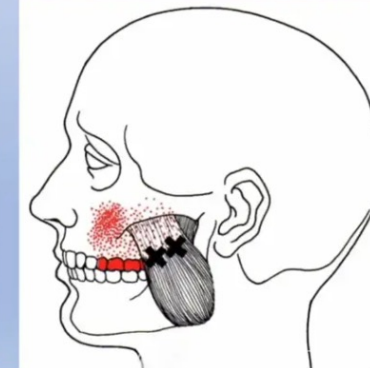
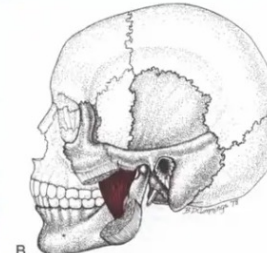
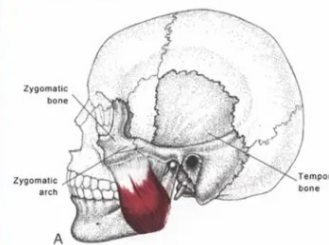
Case Study 1

Temporalis



Simons, D. G., Travell, J. G., (1999). Travell & Simons' myofascial pain and dysfunction: The trigger point manual, Vol 1. Baltimore, Williams & Wilkins.

Masseter



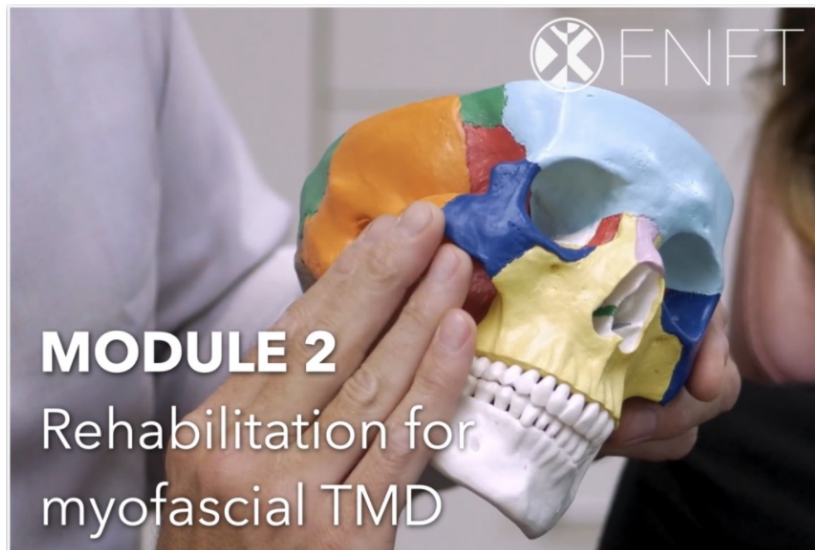
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Module 1 - Management for Acute Presentations

In this module you will learn the most efficient method of muscle manipulation to improve range of movement and restore muscle function using the most up to date science on myofascial restrictions with a rationale that helps explain FNFT's great clinical outcomes.



Module 2 - Rehabilitation for Myofascial TMD

Module 2 unpacks the relationship between tongue function, fascia and TMD. You will learn intraoral techniques, myofunctional exercises for TMD, anatomy and reinforce your learning through an incredible case study of the Four Muscle Protocol.



Module 3 - Considerations for complex presentations

Tongue function, airway, cervical posture, sleep and fitness can all contribute to chronic pain presentation, in module 3

A Functional approach to TMD and orofacial pain.

"...This is hands-down the best course that I have seen EVER on the connection between fascia, TMJ, cervical spine, tongue posture etc..."

- Angie Lehman RDH, COM, OMT

"... loving the fact it can be incorporated into my exams as part of diagnosis and management with minimal disruption... thanks guys!..."

- Dr Fozia – General Dentist

"...I have used this technique to resolve TMJ clicking many times since training with Tim and Sarah..."

Dr Abood – Orthodontist

"... What a powerful effect did the 4-5 min I spent working on each patient had on them! Thank you for your knowledge and skills...."

Dr Ferzli TMJ Dentist



What's the
problem?

Why are we here?

2. Temporomandibular disorders.

- 10-20% of the general population have TMD and orofacial pain symptoms but only 7% will seek treatment
- It's the second most common pain (after toothache) a dental practitioner will be presented with IF they ask the right questions.
- It can be associated with other pains such as headache and neck pain
- Usually people affected by TMD are between 20 and 40 years of age
- it is more common in females than males



Bruxism?
Splints?
Occlusion?

BIOLOGICAL ← underlying autoimmune disease
joint degeneration

Dentistry - mechanical
- cracked tooth
- 'perfect occlusion'

SPLINTS

TMD

posture

articular joint issues ← clicking
deviation
limited opening
stabbing pain.

anxiety/stress/depression/life trauma

occlusion

awakes

Bruxism App
MAPA splint
medication
hypnosis

bruxism ← asleep

sleep hygiene

sleep disorders

nutrition

breathing

ideal
EDOC

• make them aware
• context - when?
• ~~ad~~ counsel on
how its detrimental
to - teeth - cracks
- muscle spasms
- Mantra - apart!

ASK WHY? use orthotics at all?

BUY TIME

PAIN PROTECT

short term
wear off!

CONFUSION
& polarising
views!

relaxation
techniques




Occlusion?
Splints?
Bruxism?

3 Categories a patient may fit in to...



ACUTE
Acute articular TMD

The image shows a close-up, anterior view of a vertebral body fracture. A large, irregularly shaped, reddish-brown mass, representing a displaced intervertebral disk, is visible protruding from the fracture site. The surrounding bony structures are light brown and appear fractured. The text "Anterior Disk Displacement with Reduction" is overlaid in the center of the image in a yellow, bold font with a black outline.

**Anterior Disk
Displacement
with Reduction**

Neck, Head and Jaw pain SIMPLIFIED.

- Neurological Pain
- Myofascial Pain
- 6300+ pts who presented with TMD showed 44% had muscle pain – compared to 22% with intracapsular pain

Dr Jeff Okeson DMD

Lomas J, Gurgenci T, Jackson C, Campbell D. Temporomandibular dysfunction. AJGP, Vol. 47, No. 4, April 2018.

<https://www.racgp.org.au/AJGP/2018/April/Temporomandibular-dysfunction>

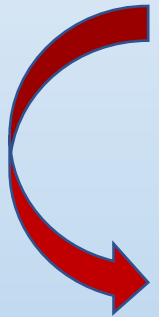
Durham, J.; Aggarwal, V; Davies, SJ; Harrison, SD; and 12 others. Temporomandibular Disorders (TMDs): an update and management guidance for primary care from the UK Specialist Interest Group in Orofacial Pain and TMDs (USOT). Royal College of Surgeons of England, 2013. 22 p. (Clinical Standard Series).

<https://www.escholar.manchester.ac.uk/uk-ac-man-scw:223426>

3 Categories a patient may fit in to...

ACUTE

Acute articular TMD



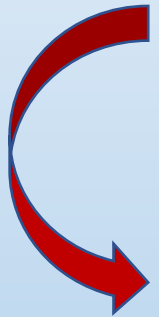
BIG TAKE-AWAY

"...Most interventions target inflammation but inflammation is the cause of pain in only 20% of TMD..."

3 Categories a patient may fit in to...

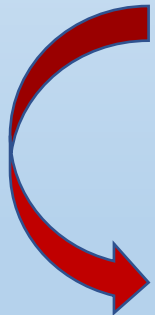
ACUTE

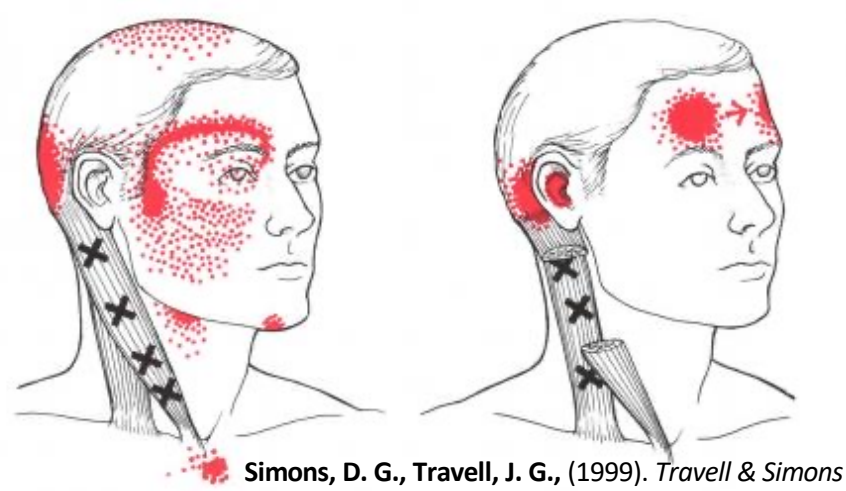
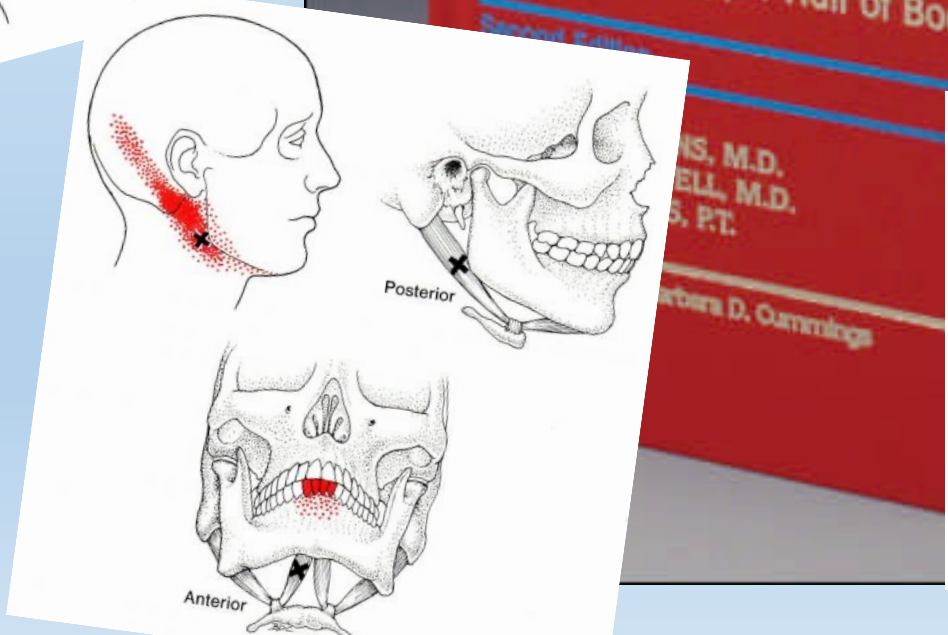
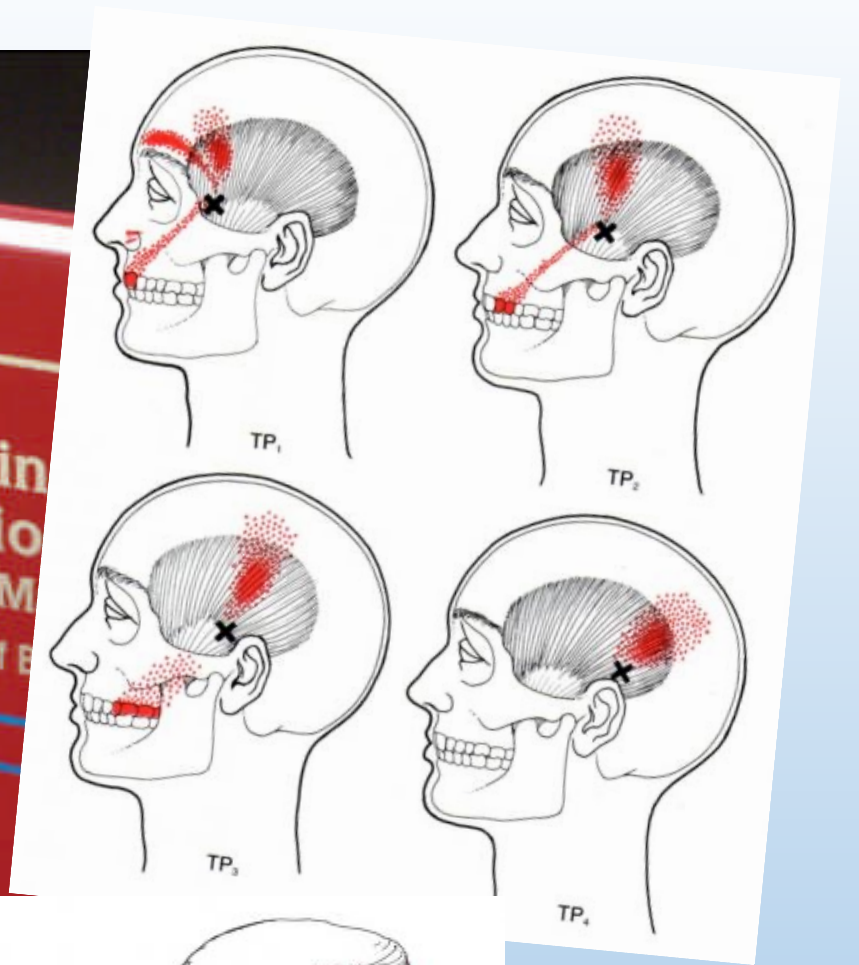
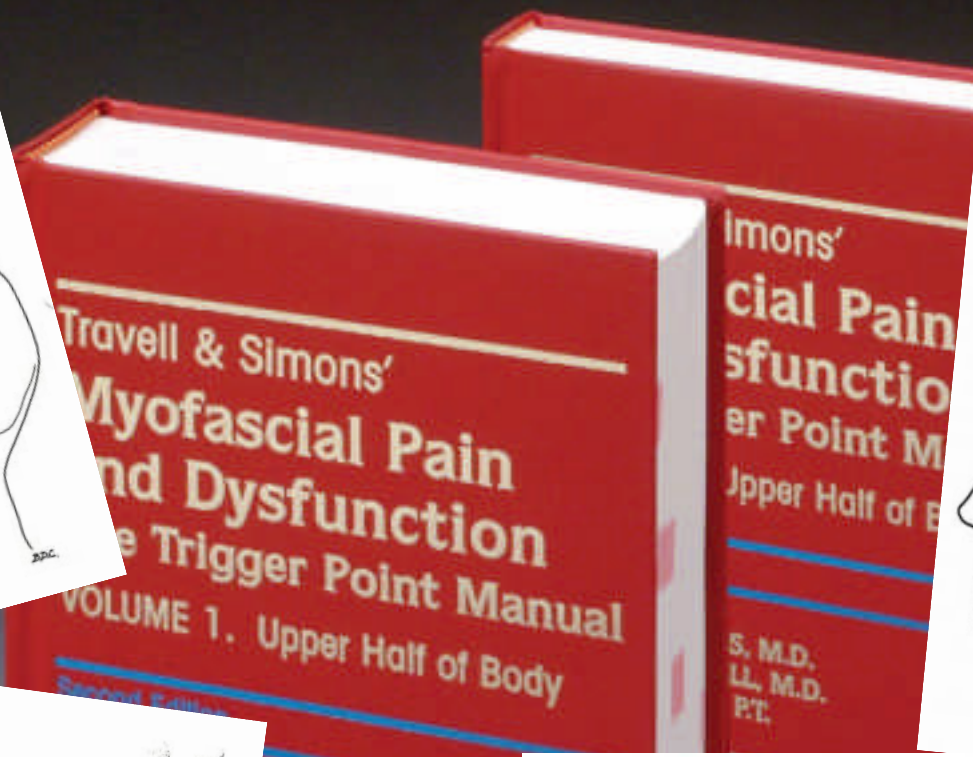
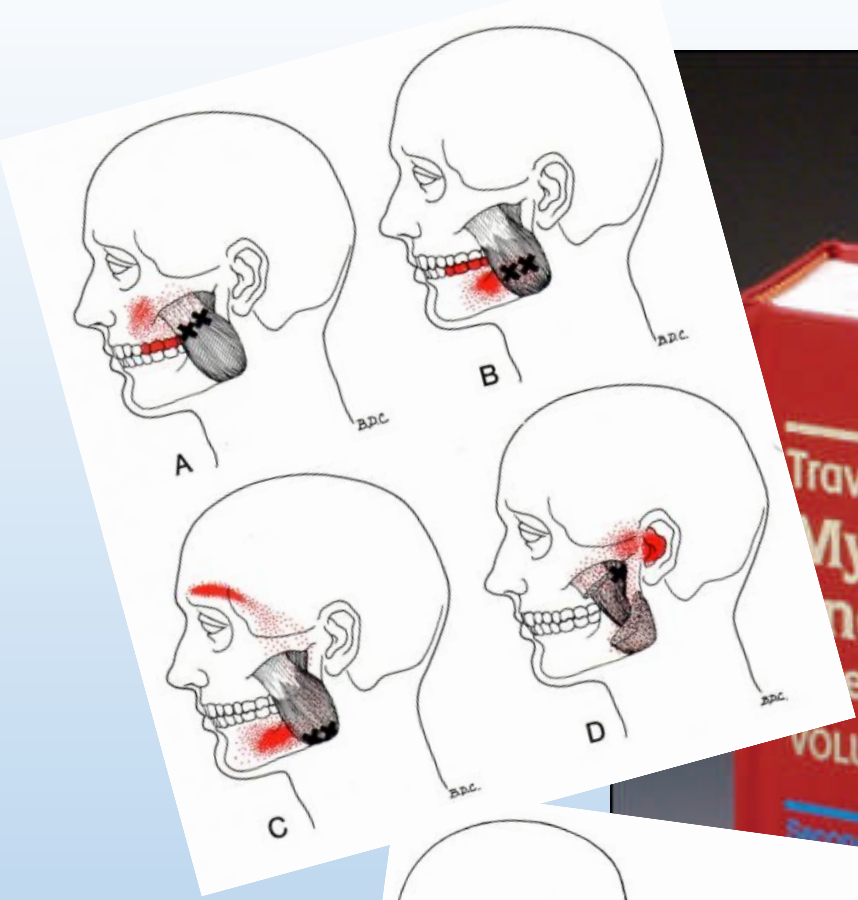
Acute articular TMD



CHRONIC Myofascial

Myofascial TMD





Simons, D. G., Travell, J. G., (1999). *Travell & Simons' myofascial pain and dysfunction: The trigger point manual, Vol 1.* Baltimore: Williams & Wilkins.

Neck, Head and Jaw pain *SIMPLIFIED.*

- **Number 1 reason for misdiagnosis is just looking at where the pain presents and not at the SOURCE ...**
- **Dr Jeff Okeson DMD**
- **Articles**

Lomas J, Gurgenci T, Jackson C, Campbell D. Temporomandibular dysfunction. AJGP, Vol. 47, No. 4, April 2018. <https://www.racgp.org.au/AJGP/2018/April/dysfunction>

Durham, J.; Aggarwal, V; Davies, SJ; Harrison, SD; and 12 others. Temporomandibular Disorders (TMDs): an update and management guidance for primary care from the UK Specialist Interest Group in Orofacial Pain and TMDs (USOT). Royal College of Surgeons of England, 2013. 22 p. (Clinical Standard Series). <https://www.escholar.manchester.ac.uk/uk-ac-man-scw:223426>

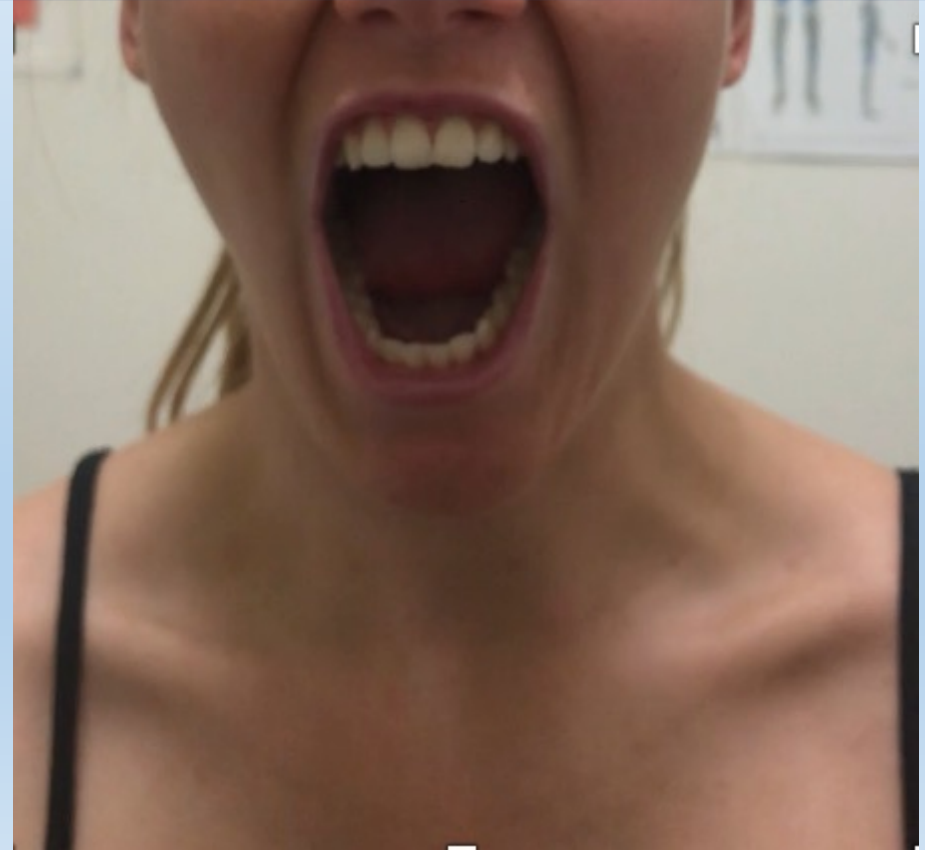
Temporomandibular disorders

Myofascial restrictions can be the sole cause of asymmetry and TMJ pain.



Case Study 2.

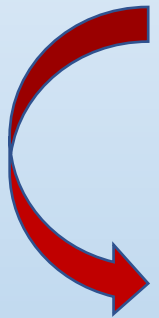
Initial Consultation



3 Categorisations a patient may fit in to...

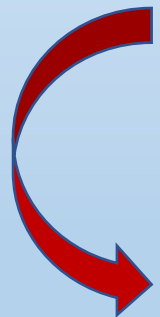
ACUTE

Acute articular TMD



CHRONIC Myofascial

Myofascial TMD



COMPLEX multifactorial

Chronic complex TMD with psycho / social triggers



HANDOUT

Practical take-home advice.

The foundation for successful treatment of any chronic condition is:

*'...Listen to your patient.
They are telling you your
diagnosis!...'*

Sir William Osler 1849-1919





HANDOUT

Practical take-home advice.

Education:

Rear molars should not be in contact at rest.

Movement is good for you.

1. Airway, breathing and anxiety

Beaching

- Neutral Cervical spine – flat surface (Chin Tucked)
- Tongue on spot
- Lips sealed - Nasal breathing
- Diaphragmatic breathing
- Commence with 10 mins 2x per day for 10 days

So simple!



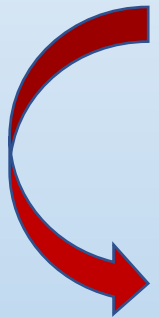
Inspired by:

Sarah **BEACH**
and
Timothy **KING**

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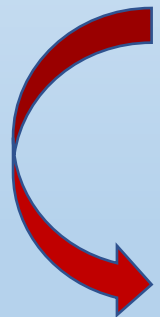
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Myofascial TMD



COMPLEX multifactorial

Chronic complex TMD with psycho / social triggers

Occlusion?



Manfredini D, Lombardo L, Siciliani G. Temporomandibular disorders and dental occlusion. A systematic review of association studies: end of an era? J Oral Rehabil. 2017 Nov;44(11):908-923. doi: 10.1111/joor.12531. Epub 2017 Jul 2. PMID: 28600812.



Bruxism?



Self-reported bruxism and temporomandibular disorders: findings from two specialised centres

D. MANFREDINI*, E. WINOCUR†, L. GUARDA-NARDINI‡ & F. LOBBEZOG§
*Department of Maxillofacial Surgery, University of Padova, Padova, Italy; †Orofacial Pain and TMD Clinic, Department of Oral Rehabilitation, The Maurice and Gabriela Goldschlager School of Dentistry, University of Tel Aviv, Tel Aviv, Israel; ‡TMD Clinic, Department of Maxillofacial Surgery, University of Padova, Padova, Italy and §Department of Oral Kinology, Academic Centre for Dentistry Amsterdam (ACTA) and Research Institute MOVE, University of Amsterdam and VU University Amsterdam, Amsterdam, The Netherlands

SUMMARY The aims of this investigation were to report the frequency of temporomandibular disorders (TMD) diagnoses and the prevalence of self-reported awake and sleep bruxism as well as to describe the possible differences between findings of two specialised centres as a basis to suggest recommendations for future improvements in diagnostic homogeneity and accuracy. A standardised Research Diagnostic Criteria for TMD (RDC/TMD) assessment was performed on patients attending both TMD Clinics, viz. at the University of Padova, Italy ($n = 219$; 74% women) and at the University of Tel Aviv, Israel ($n = 397$; 79% women), to assign axis I physical diagnoses and to record data on self-reported awake and sleep bruxism. Significant differences were shown between the two clinic samples as for the frequency of TMD diagnoses (chi-square, $P < 0.001$) and the prevalence of at least one positive response to bruxism items (chi-square, $P < 0.001$). The more widespread use of TMJ imaging techniques in our clinic sample led to a higher prevalence of multiple diagnoses, and the higher prevalence of self-reported bruxism in patients with myofascial pain alone described in the other clinic sample was not replicated, suggesting that the different adoption of clinical and imaging criteria to diagnose TMD may influence also reports on their association with bruxism. From this investigation, it emerged that the features of the study samples, as well as the different interpretation of the same diagnostic guidelines may have strong influence on prevalence and on the association between the two disorders.

KEYWORDS: temporomandibular disorders, Research Diagnostic Criteria/temporomandibular disorders, bruxism, temporomandibular disorders

Accepted for publication 18 November 2011

Introduction

Bruxism is commonly considered a major risk factor for temporomandibular disorders (TMD), but there are still many unsolved issues concerning the diagnosis of both disorders and their relationship (1, 2). The design of scientifically sound studies is complicated by difficulties in diagnosing clinical bruxism, as well as by the unclear relationship between instrumentally detected bruxism on the one hand and clinically diagnosed or self-perceived bruxism on the other hand (3, 4). These

difficulties also affect investigations on bruxism aetiology and treatment (5, 6), and a recent systematic review of the literature pointed out that inconsistent findings on the bruxism-TMD relationship may depend upon the adoption of non-homogeneous diagnostic techniques among studies (7). Works on self-reported or clinical bruxism diagnosis commonly showed a positive association with TMD pain (8–11), while, on the contrary, such positive association was not always confirmed with studies using instrumental bruxism detection, viz. by means of



Splints?

Do occlusal splint appliances decrease pain and improve temporomandibular function in the adult population that present with temporomandibular joint disorders?

A CRITICAL LITERATURE REVIEW

by

Timothy J King

CMY305A Critical Literature Review – Lecturer: Amber Moore

Word count: 3999

Southern School of Natural Therapies

22 November 2020

Declaration

I declare that except where I have referenced, the work I am submitting in this attachment is my own work. I acknowledge and agree that the assessor of this assignment may, for the purpose of authenticating this assignment, reproduce it for the purpose of detecting plagiarism. I have read and am aware of the Think: Colleges Academic Integrity Policy and Procedure. Viewable online at www.think.edu.au/policiesandforms

Student Name: Timothy King

Date: 22.11.202



HANDOUT

Practical take-home advice.

The foundation for successful treatment of any chronic condition is:

1. **Therapeutic alliance**, listening, rapport.

Your therapy is proven to be more effective when your interaction is good.

Fuentes J (2014) Enhanced therapeutic alliance modulates pain intensity and muscle pain sensitivity in patients with chronic low back pain: an experimental controlled study. Phys Ther. Apr;94(4):477-89.

Practical take-home advice.

The foundation for successful treatment of any chronic condition is:

1. Therapeutic alliance, **listening**, rapport.

Average time a patient speaks for before being interrupted is 20 seconds.

A small icon in the top left corner showing a white document with the word 'HANDOUT' in red at the top and several horizontal red lines representing text below. The document is flanked by two grey silhouettes of people's heads.

HANDOUT

Practical take-home advice.

**Treat the person not just
the condition!!**

- The successful treatment of any chronic condition is:
1. Therapeutic exercise
 2. Pain education, self-management, and self-efficacy
 3. Manual therapy, exercise prescription, and patient education (red and yellow flags).

1. Airway, breathing and anxiety

- Neutral Cervical spine – flat surface (Chin Tucked)

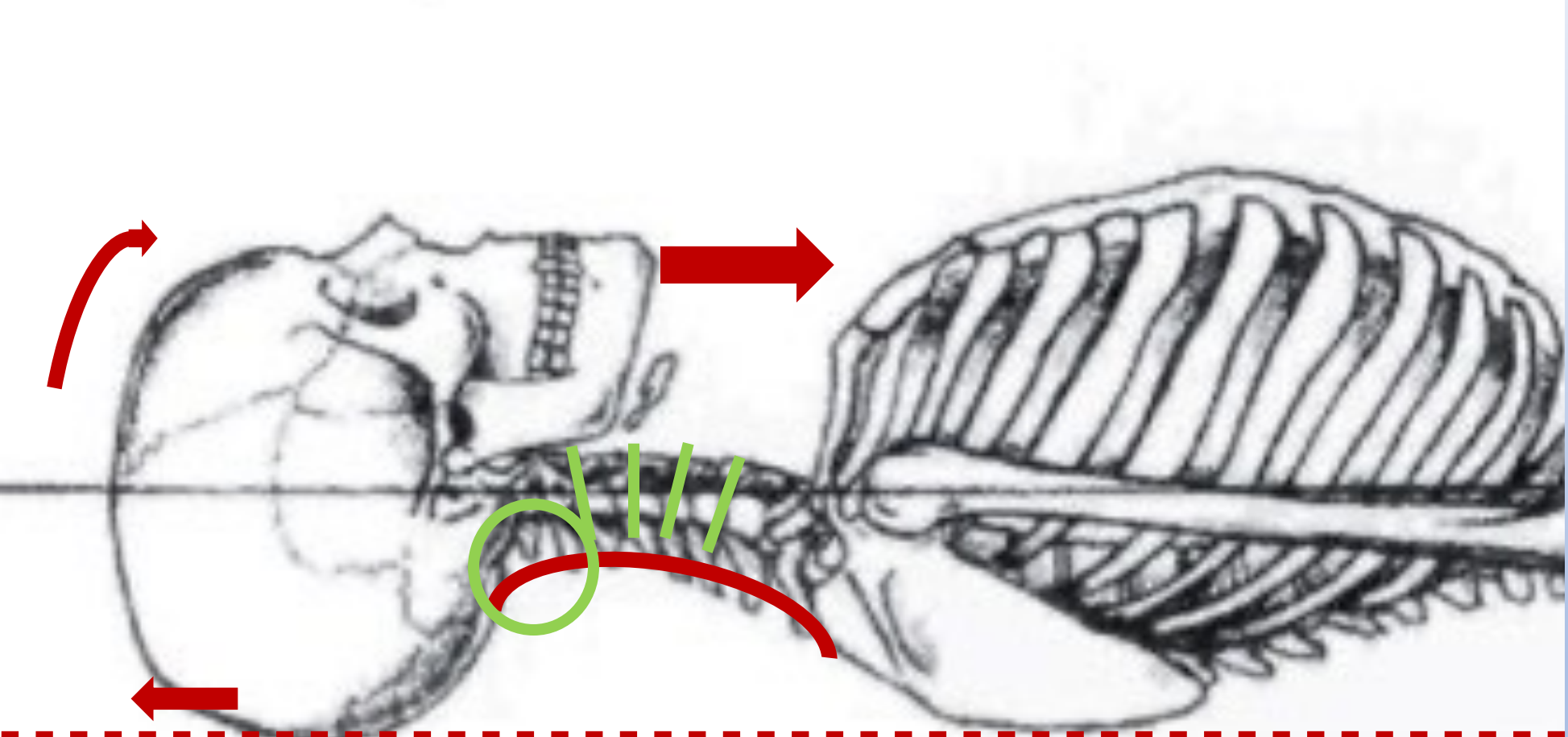
Beaching

Inspired by:

Sarah **BEACH**
and
Timothy **KING**



Chin tucked for neutral Cervical spine



1. Airway, breathing and anxiety

Beaching

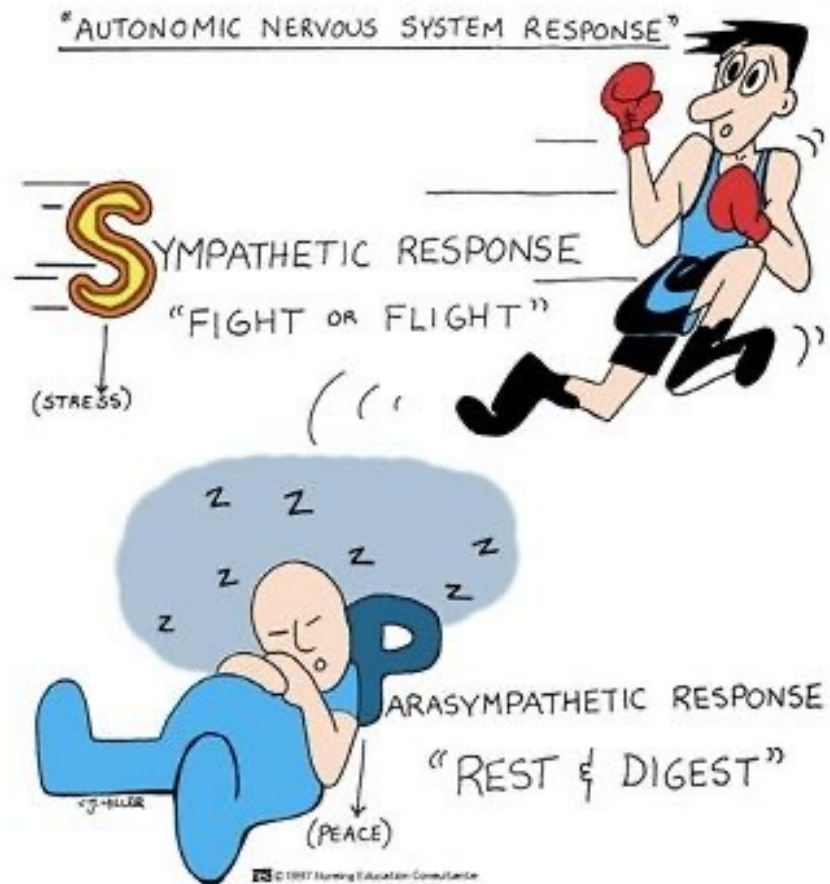
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1. Airway, breathing and anxiety



1. Airway, breathing and anxiety

Beaching

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MODULE 1
Management for
acute presentations



MODULE 2
Rehabilitation for
myofascial TMD



MODULE 3
Considerations for
complex presentations



MODULE 4
Bonus material

A Functional approach
to TMD and orofacial pain.

~~\$USD 795~~

\$USD 495

• Use "EMS"
for USD\$300 off

24-hours ONLY



www.fastandfunctional.com/tmd-online



FNFT - TMD and Orofacial pain

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Send Message



Write a post...



Photo/Video



Tag Friends



Check in

...

Community

See All

Invite your friends to like this Page

711 people like this

754 people follow this

Daniel Abood and 109 other friends like this or have checked in



Recommendations and Reviews



My time with Tim and Sarah has changed how I approach TMD and craniofacial pain as an orthodontist. ... See More



February 11, 2019

References p. 1

Lobbezoo F; Ahlberg J; Manfredi D; Winocur E; Are bruxism and the bite causally related? J Oral Rehabil. Vol. 39, No 7, pg. 489-501, 2012.

Manfredini D, Lombardo L, Siciliani G. Temporomandibular disorders and dental occlusion. A systematic review of association studies: end of an era? J Oral Rehabil. 2017 Nov;44(11):908-923. doi: 10.1111/joor.12531. Epub 2017 Jul 2. PMID: 28600812.

MANFREDINI, D., WINOCUR, E., GUARDA-NARDINI, L., & LOBBEZOO, F. (2012). *Self-reported bruxism and temporomandibular disorders: findings from two specialised centres. Journal of Oral Rehabilitation, 39(5), 319–325.* doi:10.1111/j.1365-2842.2011.02281.x

Manfredini D; Cantini E; Romagnoli M; Bosco M; Prevalence of bruxism in patients with different research diagnostic criteria for temporomandibular disorders (RMC/TMD) Cranio, Vol. 21, No. 4, pg. 279-285, 2003.

Travell J., Simons, D. (1999) Myofascial pain and Dysfunction – The Trigger Point Manual. Vol 1. Upper half of the Body. Second Edition. Lippincott Williams & Wilkins, USA

References p. 2

Yoon, A., Zaghi, S., Weitzman, R., Ha, S., Law, C. S., Guilleminault, C., & Liu, S. Y. C. (2017). Toward a functional definition of ankyloglossia: validating current grading scales for lingual frenulum length and tongue mobility in 1052 subjects. *Sleep and Breathing*, 21(3), 767–775. <https://doi.org/10.1007/s11325-016-1452-7>