appropriate diagnosis and management of temporomandibular disorders (TMDs) represents a timely update of the first version crafted by the Neuroscience Group. This statement represents an excellent integration of the available evidence, emerging from a 3-year vetting process that entailed multiple levels of scientific review. OOOOE should be congratulated for taking this bold step of disseminating this TMD statement to the dental profession.

Based on the history of this controversial field, it is likely that opposition to these guidelines will occur, but what evidence will be provided to support such opposition? Although the use of evidence as the basis for clinical practice is hardly new, evidence has become a more prominent feature of contemporary practice. Today, it is even fashionable to talk about evidence, as long as the evidence supports our clinical activities. When the evidence collides with our belief systems, it is certainly important for the conscientious practitioner to examine whether the evidence is valid, but this sometimes can be difficult (e.g., when the supporting science is outside our area of expertise). It is often easier to simply deny or reject the evidence rather than adhering to evidence-based guidelines when they would require that we change our actions or beliefs. Given the extensive review process that led to this TMD statement, it would seem that the burden of proof regarding whether the statement is “true” or not should shift to the individual who chooses to deny or disagree and reject the stated conclusions.

The topic of biobehavioral factors, often neglected in biomedical contexts, is nicely included in both the statement and the introduction by Greene. They note, based on the evidence, that biobehavioral factors are important for understanding and managing pain in general and chronic pain in particular. Furthermore, the statement indicates that standardized and validated psychometric tests may be used as part of assessment. Evaluation of the biobehavioral domain is normal standard of care in rehabilitation medicine, and protocols, such as the Research Diagnostic Criteria for Temporomandibular Disorders provide an accurate template and method for doing so within dental settings. Standardized and validated tests are, in the long run, more accurate than clinician judgment in detecting who is at risk.

As a researcher and clinician in this field for >25 years, I would like to highlight the overall importance of such evidence-based consensus guidelines in patient evaluation regarding what kinds of procedures (e.g., technologic diagnostic devices) should not be used as well as what kinds of procedures (e.g., standardized self-report instruments for assessing biobehavioral status) should be used. Pain is the overwhelmingly most common symptom that propels individuals to seek professional care, and the patient’s history of pain remains the standard for whether there is, in fact, a complaint that warrants investigation, diagnosis, and treatment; the history of pain remains the cornerstone for the differential diagnosis among the various overlapping pain disorders affecting the orofacial region. When the history of complaint is properly used, the pain characteristics remain, based on the available scientific information, the sufficient level of information (aside from adjunctive use of imaging) for that all-important first working diagnosis, and for establishing the benchmarks regarding assessment of disease course as a response to treatment. The desire to use “technologic diagnostic devices” is often the result of not adequately appreciating the value inherent in the classic history and clinical examination.

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REFERENCES

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A response to the AADR’s “Managing the care of patients with temporomandibular disorders: a new guideline for care”

The field of temporomandibular disorders (TMDs) is certainly controversial, with many clinicians and researchers differing in their thoughts of etiology, diagnosis, and management. The rationale behind these differences lies in the fact that TMD is a multifactorial group of musculoskeletal disorders often with combined etiologies that demand different treatment strategies. In the past, we dentists often attempted to manage all TMD patients with a single treatment regime. Such focus often misses the full scope of these musculoskeletal problems. I believe the statements made in the position paper presented by the American Association for Dental Research (AADR) are true and accurate. They directly reflect our current knowledge base. We must professionally come to the realization that our TMD data are far from being perfect and in some instances are nonexistent. This is not a reflection of an
illiterate profession, but more a reflection of the complexity of the problem. The fact that past treatments were successful does not provide evidence regarding why or how the treatment favorably affected the symptoms.

As health care providers, we must appreciate that our main professional duty is to reduce the suffering of our fellow men and women. We are obligated to do this with the overriding principle of “do no harm.” Therefore, our treatment choices must be based on scientific evidence. In the absence of evidence, we are obligated to provide the most conservative approach possible. The AADR statement is merely reminding us of this obligation. If we think that different or more aggressive treatments are indicated, it is our obligation to demonstrate the evidence that supports such direction. Until that time, we need to select treatments for our patients with the overriding premise of “do no harm.”

On the surface, one would assume that diagnostic instruments do not harm. They certainly do not harm the patient when they are used to collect data. However, if the data derived from these instruments lead the clinician to incorrectly diagnose an orofacial pain problem or to select inappropriate treatment, then harm can be done. It is logical to assume that instruments that provide more data and perhaps more measurability should be helpful in diagnosing and selecting treatment. However, the validity, reliability, specificity, and sensitivity of these instruments must be demonstrated before data can have meaning.

Some clinicians are upset with the AADR position statement. Perhaps this is because it does not align with their own personal experiences and clinical opinions. I suggest that instead of being upset, we use this opportunity to motivate us to research more and better ways of managing TMDs. The overarching concept is that this must be done in the best interest of our patients and must be founded on evidence-based science.

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New technologies on TMJ diagnosis

To the Editor:

I have recently read an article in OOOOE (August, 2010), “Diagnosis and treatment of temporomandibular disorders: emergence of a new care guidelines statement,” with special attention to the paragraph affirming that electronic diagnostic devices, such as electromyography, jaw movement trackers, and sound recorders have failed to meet standards of reliability and validity, not satisfying the requirements for sensitivity and specificity that are essential for clinical diagnosis of individual patients.

I have been using these technical devices (Myotronics system) since 1995 in Brazil, gathering >9,000 examinations since then. The editorial alerts us to the true need for a new guideline statement, but it jumps to a mistaken conclusion when affirming that this equipment fails in reliability and validity. These technologies are extremely accurate in giving detailed information on biometry, and the reliability of the data is above any doubt or questioning. Actually, the equipment’s role is to give us information about the patient, and this goal is a clear achieved. It is our (professional) role to establish the relationship between the data given by the system and temporomandibular joint (TMJ) pathology. The writers of the article failed in establishing the technology–TMJ disorder connection, and that is far from meaning that the technology is not reliable.

This connection is a long journey, and we have already gone a long way working hard (40 years of surveys and published papers all over the world) to establish secure and clear relationships between TMJ disorders and electronic device data in several clinical situations. For example, it is now inadequate to undertake surgical procedures such as orthognatic and TMJ surgery without deep analyses of patient muscular, jaw tracking, and sound information. I remind you that this same technological confusion has happened in the past with other diagnostic technologies that have improved afterward to be trustworthy become very useful in medicine. Denying this shows, at least, disrespect and inconsideration to several serious scientists.

Please keep in mind that America is the “cradle” of medicine technology development, and the editorial makes an apology of discrediting an important tool for diagnosis, leading TMJ science to a slow-motion pattern of development. You must realize the important place of OOOOE and the responsibility attached to the position of Chief Editor. Only God is omniscient, but we humans must have “omniscient behavior,” keeping our minds open to new achievements of the future.

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One has to wonder . . .

To the Editor:

One has to wonder . . .

Why Dr. Greene has chosen to try to prevent the practice of neuromuscular dentistry (NMD). Could it be that he is motivated by the same concern for protecting