the classic practice of orthodontics as has been taught for the past several decades, emphasizing straight teeth with little regard given to the final mandibular position created in relation to the base of the skull, often resulting in a retruded mandible? The same rationale applies, by the way, to the rules implemented by the Royal College of Dental Surgeons (RCDS) of Ontario, which is overrun with orthodontists and vehemently opposed to any technique encouraging mandibular advancement procedures. Apparently only mandibular retrusion is acceptable. There is no reason for this in science or logic. There has never been.

Why he quotes the efforts of the RCDS and Dr. Mohl, when they have been completely discredited and sanctioned by the Ontario public court system and the U.S. Food and Drug Administration, respectively, for pursuing their vendetta against NMD without scientific validity. The RCDS has since softened their stance against the practice of NMD in Ontario, a fact neglected in Dr. Greene’s diatribe.

Why no dentist trained in NMD has ever abandoned NMD. I’ve made this simple statement over the past 15 years in front of audiences all over the world, numbering in the thousands. Never once has it been challenged. How powerful must this philosophy be? The same cannot be said for any other philosophy, as I personally know dentists who have abandoned all other approaches. We all do.

Why the superior belly of the lateral pterygoid pulls forward. If indeed the condyle is supposed to be back and up, or forward and up, or just straight up, why did Mother Nature attach a muscle directly to the head of the condyle that pulls it forward? Centric relation is not supported in the literature or in logic. If it were correct, the TMJ would be the only joint in the body that operates physiologically at an extreme position. No joint does.

It’s time to reflect upon that time in dental school when you thought you knew some things, to find out years later that what you thought you knew (based on selected scientific studies) was wrong (e.g., dentin bonding). Thinking you know something is truly the greatest deterrent to learning, and it is a point Dr. Greene has yet to arrive at. He arrogantly believes that his approach is correct, by paying attention to selected scientific studies and ignoring not only the majority of those very studies, but also logic and Mother Nature at the same time. He suffers from the same delusion as most dentists ignorant of the true value of NMD. It is not about the money, it is about patient care. Allowing someone to suffer for years, when a solution exists, is not only malpractice, but ethically unforgivable. What if Dr. Greene’s wife were suffering every day, unable to eat properly, unresponsive to splint therapy and pharma-
maceuticals, as 2 of my own patients were within the past month? What if finding a neuromuscularly balanced position was able to relieve that pain? Would he still be pursuing this goal?

One has to wonder.

Tony Pensak, DDS
University of Western Ontario
London, Ontario

doi:10.1016/j.tripleo.2010.10.040

Diagnosis and treatment of temporomandibular disorders

To the Editor:

I thank the editor for giving me the opportunity to respond to the many letters that were sent to this journal regarding the publication of my editorial about the American Association for Dental Research (AADR) statement on temporomandibular disorders (TMDs).1 Some of the letters expressed positive reactions, but several were negative. I have read many of those negative letters and e-mails, and the most striking thing about them is that almost all have come from a particular group of practitioners who describe themselves as being “neuromuscular dentists.” The tone and substance of each letter is remarkably the same, combining personal invective against me with outrage at OOOOE for daring to publish this document. Once those thoughts are expressed, the authors move on to praise the technologies they use in their practices, often including testimonial anecdotes about all the TMD patients they have cured. Other journals also have received copies of these same letters.

After so many years of arguing about the validity and utility of these technologies, there is no point in revisiting the details of this controversy. Instead, I believe the readers of OOOOE would be better served by my clarifying a few points about how the AADR statement on TMDs was developed, including how it came to be published in this journal as well as in other dental journals around the world.

The AADR is the U.S. branch of the International Association for Dental Research, which is the premier research organization in the dental profession. The IADR Neuroscience Group which developed the TMD statement is composed of basic and clinical scientists from every part of the world, and for many of them orofacial pain is a major research area. Many of the important TMD and orofacial pain clinics in dental schools and hospitals around the world have Neuroscience Group members on their faculty, and thousands.
of patients have been treated and studied within those clinics.

The AADR has a Science Information Committee (SIC) that is charged with the task of developing and ultimately presenting state-of-the-art summary statements about various oral health topics. If readers will look at the Web site cited at the beginning of the TMD statement, they will find 8 current statements about topics such as TMDs, fluorides, sealants, nutrition, amalgam, and so forth. These statements are accessible for direct viewing on the AADR Web site and are intended to provide both practicing dentists and members of the public with the latest scientific information about these topics.

The approval process for new or revised statements was summarized in my article, along with a history of events leading up to the current statement. I wrote a 1-page introduction for the Journal of the American Dental Association and several other journals to give readers some background about the development of the TMD statement. Because I am a member of the editorial board for OOOOE, I was invited to write a longer introduction in the format of an editorial; consequently, I take full responsibility for what appears in that portion. However, the TMD statement itself was not authored by me alone; instead, it went through an elaborate process of writing and revision within the Neuroscience Group before it was submitted to the SIC. The final product was modified many times to ensure accuracy of each sentence and each reference, and only then did the AADR Board of Directors and AADR Council approve it.

Therefore, the criticisms of the statement that describe it as a biased personal opinion are incorrect. Instead, it is based on in-depth reviews and analyses of the extensive literature dealing with the diagnosis and treatment of TMDs. As a result, the conclusions in that 1-page statement represent a broad consensus among expert researchers and clinicians in the orofacial pain and TMD field.

Finally, it should be noted that the AADR statement deals with only 2 of the major issues in the TMD field: diagnosis and treatment. Practitioners are advised to use validated diagnostic methods and to initially provide conservative and reversible therapies. If the letter writers want to follow a different pathway, nobody is stopping them, but the rest of the dental profession deserves to hear what the largest dental research organization in their field has to say about these matters. This is what the original goal was in developing these guidelines and in disseminating them around the world, and we see no reason to apologize for doing that once the TMD statement was formally adopted by the AADR. Instead, we have been working with journal editors and TMD interest groups in countries spanning the globe to get the Statement translated into several languages for publication and also to distribute it electronically. In addition, the statement has now been formally endorsed by organizations including the American Academy of Orofacial Pain and the European Academy of Craniomandibular Disorders.

Therefore, those who direct criticisms toward the author or toward this journal are simply out of touch with this larger reality. I hope the readers of OOOOE will consider all of these issues as they reach their own conclusions about the real value and significance of the AADR statement on TMDs, and I thank the editors for having the courage to publish my editorial.

Charles S. Greene
College of Dentistry, University of Illinois
Chicago, Illinois

REFERENCES

doi:10.1016/j.tripleo.2010.10.037