[IMAGE]

Integrated Bodywork

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TMD Assessment and Treatment Using NMT and SCS

A trawl through recent literature brought up a number of papers where the key topic related to temporomandibular joint disorder (TMD) and pain. Three papers in particular described the effectiveness of the use of neuromuscular technique and strain-counterstrain.

But before we look at that particular evidence, let’s consider some of the information that emerges from a telephone survey of 20,000 New York women, who were asked about "facial pain." [1] Following the phone interview (whether or not they reported facial pain), just under 800 of those surveyed were invited to be physically examined. Of the approximately 10 percent of people interviewed by phone who had reported facial pain, and who were also examined, about 95 percent were physically diagnosed as having the myofascial subtype of TMD (M-TMD).

The lesson we can learn from this is that a report of facial pain is most probably linked to TMD. This condition was found to be most common among younger women, among women of lower socioeconomic status, among black women, and among non-Hispanic women. The researchers also report that a substantial number of diagnosed cases of M-TMD had not actually reported facial pain in the phone survey.

What we can learn from that outcome is that TMD may not actually produce facial pain. Apart from palpation, one of the tools used in the study reported above were the Research Diagnostic Criteria for Temporomandibular Disorders. You can freely download the booklet (in a variety of languages) containing guidelines, forms and questionnaires, published by the University of Washington, from the Web site of the International RDC-TMD Consortium:
www.rdc-tmdinternational.org/RDCTMD/Protocol/tabid/72/Default.aspx.

A German team decided to evaluate which items in the RDC-TMD have the best predictive accuracy for a TMD joint-related, diagnoses.[2] More than 140 patients with TMD and about 50 asymptomatic individuals were evaluated using these criteria, as well as being assessed using MRI. The findings were:

- The most significant assessments involved - maximum unassisted jaw opening, maximum assisted jaw opening, history of locked jaw, joint sound with and without compression, joint pain, facial pain, pain on palpation of the lateral pterygoid area, and overjet - all proved suitable for distinguishing between subtypes of joint-related TMD.
- Less significant were measurements of excursion, protrusion and midline deviation.

I hope these current thoughts may be helpful as you deal with clients with facial and jaw problems. Ideally you should access the papers themselves, as my all-too-brief summaries do not do them justice.

NMT and SCS

Next, I will try to summarize aspects of a study, "Changes in masseter muscle trigger points following strain-counterstrain or neuromuscular technique," conducted at an osteopathic school in Madrid, Escuela de Osteopatıa de Madrid.[3] The study is available online via ScienceDirect and will be published in the *Journal of Bodywork and Movement Therapies*. (Hopefully, the print version will appear early in 2009, after which its abstract will be available on PubMed/MedLine, which is now indexing *JBMT*.) Here's a preview of the research that compared the treatment of trigger points in the masseter muscle, by either neuromuscular technique or strain-counterstrain (positional release), or no treatment (control group):

Latent trigger points in masseter were identified in more than 70 individuals, male and female, aged between 20 and 65. The patients randomly received either a basic strain-counterstrain (positional release) treatment, or neuromuscular technique, once weekly, for three weeks, or no treatment.

Outcomes were measured by assessing pressure pain thresholds (PPTs), using a pressure algometer, as well as by measuring active mouth opening, and by use of a visual analogue scale,(VAS) - after application of 2.5 kg(5 lbs)/cm2 of pressure, over the MTrP.

Results compared measurements a week before, and a week after, the three-week intervention. These showed that the application of a NMT - or SCS technique - over latent MTrPs in the masseter muscle, significantly increases the pain threshold, markedly increases active mouth opening, and decreases local pain induced by standard pressure.

This is a very strong clinical effect. The control group had negligible improvement.

To my knowledge this is the first time NMT and SCS have been compared in treatment of trigger point activity; they were found to be equally effective, which does not surprise me. The findings are highly informative, and will hopefully prompt other researchers to look at these methods in different contexts.

References

1. Janal M, et al. Prevalence of myofascial temporomandibular disorder in U.S. community women. *Journal of Oral Rehabilitation* 2008;(35)11:801-9.
2. Schmitter M, et al. Validity of temporomandibular disorder examination procedures for assessment of temporomandibular joint status. *Am J Orthod Dentofacial Orthop* 2008;133:796-803.
3. Ibanez-Garcıa, et al. Changes in masseter muscle trigger points following strain-counterstrain or neuro-muscular technique. *JBMT* 2009:IN PRESS.

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