High Quality Search Comments

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20

Review of the clinical use of Botox for wrinkles and Orofacial pain.

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The TMD prevalence in patients seeking orthodontic treatment was high, with many individuals presenting painful TMD signs/symptoms. Female and older patients appear to have a greater occurrence of TMD. Although no strong association between TMD and malocclusion was established, several occlusal traits were implicated.

30

There is no scientific evidence to support a conclusive relationship between SB and OSA. Further, well-designed and randomized studies with control groups are needed to investigate whether possible mechanisms common to SB and OSA exist and whether OSA treatment could improve SB negative oral health outcomes in patients with SB and comorbidity of OSA.

51

The meta-regression analysis showed that patients with pre-existing signs and symptoms of TMD do not experience significant exacerbation of symptoms using the MAD. The presence of TMD does not appear to be routine contraindication for the use of MAD used for the management of OSA.

62

The mandibular advancement device is an effective treatment, improving the Apnea Hypopnea Index and the symptoms of patients with OSA in 92% of the subjects from all the investigated studies. The future may include the integration of a biosensor for the diagnosis and follow-up.

76

Diffusion imaging serves both an important basic science purpose in identifying pain mechanisms, but is also a clinically powerful tool that can be used to improve treatment outcomes.

83
There is little evidence found for human cause-effect relationships.

89
Protocol for study… This document describes the protocol for a proposed study to evaluate morphological and psychosocial aspects in children and adolescents with awake bruxism and their responses to photo- biomodulation therapy with infrared LED.

113
Oral myofunctional therapy was shown to be effective for the treatment of temporomandibular disorders, alone or associated with other treatments, in three out of four studies, with significant reduction of pain intensity when compared to other conservative treatments and no treatment.

119
The influence of BMI on OTM and related parameters in children and adolescents remains debatable.

134
Low-quality evidence limits the applicability of these findings and precludes recommendations for practice.

138
MMTAH is a condition in which the tendon and aponeuro-sis of the bilateral masticatory muscles exhibit hyperplasia, thus restricting muscle extension. One of the main symptoms of MMTAH is limited mouth opening.

154
Through this review, we recommend that for patients with severe OSA, it is beneficial to begin with a mandibular protrusion of approximately 70%, and in cases of mild to moderate OSA, begin with that of approximately 50%.

160
Despite frequently small sample sizes and a majority of short-term reports,

current evidence shows that Mono-block OA_m are more effective than Bi-block OA_m for OSA patients

204
The aim of this study was to assess the effects of occlusal splint therapy on headache symptoms in patients with migraine and/or tension-type headache comorbid with temporomandibular disorder. This is an under powered study, lack of adjustments of occlusal appliances during trial.

206
Hegab et al discussed the thickness of occlusal splints indicating that (1) splints ranging from 1 to 8 are related to different treatment results; (2) splints ranging from 12 mm to 15 mm in thickness may alleviate clenching; and (3) splints 4.4 mm to 8.2 mm in thickness may relax masticatory muscles more satisfactorily than 1- mm-thick splints. Thus, the vertical thickness of occlusal splints appears to be a key factor in treatment success.
This study demonstrated that an increase in splint thickness was associated with an increase in ante- roposterior condylar movements, anteroposterior disk movements, and vertical condylar movements and led to improved clinical outcomes. Although the results of this study may suggest that the thicker splint is effective in patients with TMDs with DDNR, it is difficult to deter- mine the best thickness of a splint. Based on MRI mea- surements and clinical outcomes in this study, the recommendation is a 4-mm vertical splint thickness for DDR and a 6-mm vertical splint thickness for DDNR cases and at least 1 year of treatment.

212
In June 2016, INfORM invited OFP researchers to a workshop designed to optimise the DC/TMD Axis-II. Workshop groups identified five sources of implementation barriers: (1) cultures and societies, (2) levels-of-care settings, (3) health services, (4) cross-cultural validity of self-report instruments and (5) provider and patient health literacy. Three core problems emerged: (A) mental health aspects are seldom fully considered, thus impairing the recognition of illness, (B) training in use of validated multi-axial assessment protocols is under-rated and insufficiently used, and (C) clinical assessment often fails to recognise that sensory and emotional dimensions are fundamental aspects of pain.

229
The choice of the composite cement is less relevant.Surface contamination has a negative effect on adhesion.New highly translucent zirconia shows a similar behavior, in terms of adhesion, to traditional 3Y-TZP. An adhesion protocol that provides unequivocal results has not yet been identified.

460
Given the current evidence, BTX should certainly be considered but due to financial implications and possible side effects, it seems appropriate that conservative options, such as self-management with explanation and physical therapies, should be exhausted first.

472
An interesting review of OVD controversies, by recognizable names (Calamita/Kois/Coachman).

532
Splint therapy and exercise treatment is currently the best investigated treatment approach, showing a decrease in tinnitus severity and intensity.

610
Intra-articular dextrose injection (prolotherapy) resulted in substantial improvement in jaw pain, function, and MIO compared with masked control injection at 3 months; clinical improvements endured to 12 months. Satisfaction was high

659
DDWR is the most common of the TMJ disc displacements. It is commonly an asymptomatic condition and no treatment is usually required, since the structures in this region may adapt and the progression is extremely benign for most cases.
684
It compared results of 2 surgical techniques to reconstruct TMJ.

686
A study comparing results of occlusal splints fabricated traditionally vs digitally.

704
This study determines that patient perception of occlusal discrepancies is not reliable.

760
The article compared 2 treatment modalities for pain relief and emotional symptoms. A weird project that was interesting only because of mention of Low power laser usage.

826
The general absence of standardized studies concerning children/adolescents with TMD pain states the evident need for further systematic prevalence and treatment evaluations. Considering this, it is not possible to achieve any evidence-based treatment strategies or guidelines for children and adolescents with TMD.

843
This RCT comparing the comprehensive standard treatment, including therapeutic exercise, and comprehensive standard treatment plus manipulation, showed no statistical difference in terms of mouth-opening limitation, pain, or sound, except for mouth-opening limitation after the initial treatment. Subgroup analyses regarding the pathological type of TMD indicated similar results. These results revealed that the effect of the manipulation was limited, in contrast to what we have shown in a previous RCT; the developed therapeutic exercise seemed to have a similar effect to that of manipulation over long term. The advantage of manipulation was observed only during initial treatment. Therefore, we encourage immediate implementation during the first visit for TMD patients with mouth-opening limitation, in the context of continual optimized therapeutic exercise.

849
An abstract that is poorly written, but the article promises some good info.

910
KT was identified as an easy-to-use treatment method for bruxism and was found to reduce muscle pain and increase mouth opening. KT is at least as effective as OS for the treatment of SB.

911
Bruxism and dysfunctional oral habits were shown to be risk factors for the presence of TMD symptoms also after combined orthodontic and surgical treatment. Treating such habits before orthognathic surgery should help prevent TMD.

957
This is an introduction to the concept of transcranial magnetic stimulation for sleep apnea and sleep bruxism.

958
This article discusses approaches to deal with TMD as a result of mandibular advancement sleep apnea therapy.

960
A review of 6 studies comparing results of arthrocentesis followed by splint therapy vs arthrocentesis alone. Within limits of this review, there is some evidence that splint therapy does not improve outcomes. It says further and better studies necessary.

978
In many instances of malunion of facial bones following facial trauma, malocclusion, TMDs and facial deformity can result. Treatment with orthodontics, prosthetics and palliative care or splint therapy for TMD is preferred to further surgical intervention.

983
A loss of interproximal contact between implant retained crowns and natural teeth occurs. Reason for change can be multifactorial. Prevention using occlusal splint or ortho retainer suggested.

987
Articular involvement in the TMJ in the disease process of Familial Mediterranean Fever is rare. Treatment protocol is non-existent in literature. A protocol to treat is forwarded.

1089
Low level case report/opinion based.

1093
This article is a valuable reminder for the importance of proper diagnosis.

1098
The article claims to be a systematic review (SR) however it appears to be of very low quality and is probably more accurately described as a narrative review of qualitive studies.

1110
A valuable article for the restorative dentist, and those who treat TMD and orofacial pain.

1123
This is a well-designed study and worth reading. It may support gender differences in responses to pain management.

1137
Most all of us are completing CAD/CAM crowns. This information could help with occlusion problems, etc.

1139
One of the conclusions here is the need for larger sample sizes in RCT's. This is a common conclusion in most SR's or RCT's. This article focuses on pain reduction with injection therapy or dry needling.