**Clinical Practice Guideline:** **Temporomandibular Joint Disorder**

**Date of Implementation:** **April 17, 2014**

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## GUIDELINES

American Specialty Health, Inc. (ASH) considers conservative approaches (physical therapy and manual therapy such as active and passive exercises, postural training, mobilizations/manipulative therapy and myofascial therapy) to be medically necessary when used in combination with one another.

Overall, the literature is insufficient to conclude that the use of active and passive exercises, postural training, and manual manipulative therapy, including intra-oral myofascial therapy individually are either clinically effective or ineffective in the treatment of temporomandibular joint disorder. Additional clinical trials are required to determine the effectiveness of each of these procedures for the treatment of temporomandibular joint disorder. Evidence does support use of these with one another as a conservative initial approach, with subsequent care based on evidence of clinically documented progress.

ASH considers electro-physiotherapy modalities (transcutaneous electrical nerve stimulation [TENS] and/or pulsed radio-frequency energy [PRFE]) and laser/light therapy (LLLT) for the treatment of temporomandibular joint disorder as not medically necessary.

Clinical evidence does not support the use or the effectiveness of these modalities for treatment of Temporomandibular Disorder (TMD). Additionally, pulsed radio-frequency energy (PRFE) has a negative benefit-risk profile and presents a health and safety risk when used due to its physical properties. There is some evidence that LLLT may improve function, but further research is needed to confirm results. There is also some evidence that dry needling improves pain and function, but again, further research is needed to confirm results. For additional information, please see the *Electric Stimulation for Pain, Swelling and Function in a Clinic Setting (CPG 272-S)*, *Laser Therapy (LT) (CPG 30 – S)*, and *Passive Physiotherapy Modalities (CPG 121-S)* clinical practice guidelines.

American Specialty Health – Specialty (ASH) considers the use of acupuncture for the symptomatic relief of temporomandibular joint pain as medically necessary. Please see the *Acupuncture Services Medical Policy/Guideline (CPG 264-S)* clinical practice guideline for additional information.

## DESCRIPTION/BACKGROUND

The temporomandibular joint (TMJ), a synovial hinge joint, is located where the mandible joins the temporal bone via an intra-articular disc. This complex synovial system is further comprised of articulating ligaments and masticatory muscles. The TMJ is functioning properly when the right-sided and left-sided joints are synchronized during movement. It is also one of the most frequently utilized joints within the body, used up to 2000 times a day for such functions as mastication, swallowing, respiration and speech.

TMD can be classified collectively as temporomandibular joint and muscle disorders that cause pain and dysfunction in the jaw joint and the muscles that control jaw movement or surrounding soft tissues. Normal mandible movement requires coordination between these structures to maximize function and minimize the damage to surrounding structures. A rather unique feature of temporomandibular joint articulation is that it has two joints. The articular disc between the condyle and the temporal bone serves to separate the structures into two separate joint cavities. In the inferior joint between the head of the mandibular condyle and the articular disc, the movement is almost completely of a rotary or hinge type; whereas in the superior joint between the temporal bone and the articular disc the movement is gliding, or translational.

The numerous epidemiologic studies on the occurrence of TMD in the general population indicate a number of consistent findings. Firstly, signs of TMD appear in about 60–70% of the general population, yet only about one in four people with signs are actually aware of or report any symptoms. The frequency of severe disorders that are accompanied by headache and facial pain, and that are characterized by urgent need of treatment is 1–2% in children, approximately 5% in adolescents and 5–12% in adults. Among those who seek treatment for TMD, by far the great majority are females, outnumbering males by at least four to one – although it is suspected that TMD affects both males and females in almost equal numbers in the general population.

Similar to other musculoskeletal disorders, pain during function, or while at rest is the primary reason that therapy is sought. Less commonly, patients seek TMD therapy for temporomandibular joint catching and locking, masticatory stiffness, limited mandibular range of motion, temporomandibular joint dislocation, and occlusal changes. Temporomandibular joint noises (clicking, popping, etc.) are common among the general population, however, this is generally not a concern for patients and practitioners; hence are not commonly treated.

## DIAGNOSTIC CONSIDERATIONS IN THE TREATMENT OF TMD

This disorder can be classified into three groups or types: disc displacement/internal derangement, muscle disorders, and arthroses. The most common disorder of the temporomandibular joint is disc displacement. In essence, this is when the articular disc, attached anteriorly to the superior head of the lateral pterygoid muscle and posteriorly to

the retrodiscal tissue, becomes displaced from between the condyle and the fossa, so that the mandible and temporal bone contact is made on something other than the articular disc. This, as explained above, is usually very painful, because disc displacement can lead to the development of secondary inflammatory changes and progressive degradation of the articular cartilage (Maizlin, 2010). Muscle disorders include pain dysfunction syndrome, myofascial pain and myofascial pain syndrome. This type presents with pain in the jaw, temple, face, preauricular area or inside the ear, at rest or during function. Lastly, arthroses TMD are comprised of arthritis (including osteo-, rheumatoid, traumatic and psoriatic arthritis), arthrosis and ankyloses (such as ankylosing spondylitis affecting the temporomandibular joint). Arthroses present with joint sounds, limited mandibular movements and pain, and can be secondary to muscular or disc displacement TMD.

The quality of the pain is generally an ache, pressure, and/or dull pain and may include a background burning sensation. There may also be episodes of sharp pain, and when the pain worsens, the primary pain quality may become a throbbing sensation. Patients with TMD tend to report that their pain is intensified by events such as stress, clenching, and eating, while it is relieved by relaxing, applying heat to the painful area, and taking over-the-counter analgesics. While the patient may be experiencing the aforementioned pain, it is useful to note that TMD can also be associated with various comorbidities such as tension headache, whiplash, fibromyalgia, tinnitus, vertigo, hearing loss, abnormal swallowing, hyoid bone tenderness, and otalgia.

Current insight into TMD indicates its etiology is multifactorial; whereas historically, occlusion of the jaw was considered the primary cause of TMD. Therefore, establishing a concise mode of treatment for the condition presents a challenge to the health care practitioner. A collaborative, interdisciplinary effort between practitioners in the diagnosis and management of TMD is thus encouraged.

The first line of non-surgical treatment for TMD has traditionally been physiotherapy, pharmacotherapy and splint therapy. However, TMD treatment trends in recent decades have leaned toward multi-modal as well as multi-disciplinary management, in line with that of other chronic musculoskeletal conditions. Such strategies often suggest the use of less invasive interventions such as biofeedback, cognitive and behavioral therapies, chiropractic and acupuncture.

## EVIDENCE AND RESEARCH

A systematic review by Brantingham (2013) identifies five trials for the treatment of TMD with what it calls “Manual and Manipulate Therapy” (MMT). The range of therapies comprising MMT include exercise, mobilization, manual distraction, massage, muscle relaxation and intra-oral myofascial therapy (IMT). Of these five clinical studies, four are randomized clinical trials and one a non-randomized trial. The review concludes that there is limited (level B) evidence supporting the use of MMT for TMD treatment. This is based

on the finding of "2 high-quality, 2 medium-quality and 1 low quality trials." It further concludes that the following interventions provide benefits for TMD: "intraoral myofascial therapy (IMT), post isometric relaxation, manual distraction, and self-mobilization in conjunction with a variety of exercises and gentle, high-velocity (very) low-amplitude manipulation, soft tissue MMT, or extra-oral soft tissue mobilization alone or as multimodal care." Finally, the review notes that in addition to these five trials there is a large body of mixed high, moderate and low-level evidence from a variety of studies including case series, case reports, single cohort pre-post studies, etc.

Of the five studies reviewed, three have very small (n<30) sample sizes and would be more properly viewed as pilot studies. Of the two larger studies (Kalamir, 2012; Minakuchi, 2001) only the Kalamir study reported positive results. Additionally, the heterogeneity of treatments, patient inclusion criteria and outcome measures represented by these studies are inconsistent and further studies with improved controls are necessary to demonstrate the effectiveness of manual manipulative therapy for the treatment of TMD. Two studies (Kalamir, 2010; Kalamir, 2012) did use a common treatment of intra-oral myofascial therapy (IMT). George et al. (2007) investigated the effects of manual therapy applied to the cervical-cranial junction to determine effects on mouth-opening capacity within an asymptomatic population. One hundred and one participants were randomly assigned to either an Active Release Technique (ART) group; high-velocity, low-amplitude manipulation (HVLA) group; or control group. A blinded investigator measured mouth opening using a TheraBite range of motion scale. Participants received ART to the suboccipital or HVLA to the cervical spine at C1 or sat with an investigator for 3 minutes with no treatment. After the treatment session, mouth opening was re-measured. ART and HVLA to the cervical spine did not significantly improve mouth opening in this asymptomatic population.

Alves et al. (2013) conducted a systematic review to identify whether mandibular manipulation technique is an effective and safe technique for the treatment of the temporomandibular joint disk displacement without reduction. Only two studies of medium quality fulfilled all the inclusion criteria. There is no sufficient evidence to support the effectiveness of the mandibular manipulation therapy, and therefore its use remains questionable. The analysis of the results suggested that additional high-quality randomized clinical trials are necessary and should focus on methods for data randomization and allocation, on clearly defined outcomes, on a priori calculated sample size, and on an adequate follow-up strategy. There are two additional randomized controlled trials (RCTs) that are not identified by the Brantingham review which are relevant. Kalamir, et al. (2013) carried out an RCT (n=46) again comparing intra-oral myofascial therapies (IMT) to education, self-care and exercise (ESC) for TMD. This study evaluated short-term differences, over a course of six (6) weeks (each patient receiving two [2] therapy sessions per week), in pain and mouth opening range between IMT and an ESC program. While the

study concluded that IMT presented a decrease in pain and increased mouth opening range, the results were not regarded as clinically significant.

Calixtre et al. (2015) studied manual therapy for the management of pain and limited range of motion in subjects with signs and symptoms of temporomandibular disorder. Their aim of this systematic review is to synthetize evidence regarding the isolated effect of MT in improving maximum mouth opening (MMO) and pain in subjects with signs and symptoms of TMD. Myofascial release and massage techniques applied on the masticatory muscles were more effective than control (low to moderate evidence) but as effective as toxin botulinum injections (moderate evidence). Upper cervical spine thrust manipulation or mobilization techniques were more effective than control (low to high evidence), while thoracic manipulations were not. There was moderate-to-high evidence that MT techniques protocols were effective. In conclusion, there is widely varying evidence that MT improves pain, MMO and PPT in subjects with TMD signs and symptoms, depending on the technique. Further studies should improve their design to strengthen clinical relevance.

Martins et al. (2016) studied the efficacy of musculoskeletal manual approaches (e.g. mobilization, manual traction, manipulation, myofascial release, trigger point therapy, manual translations) in the treatment of temporomandibular joint disorder within a systematic review with meta-analysis. From the 308 articles identified by the search strategy, only eight (8) articles met the inclusion criteria. The meta-analysis showed a significant difference ($p < 0.0001$) and large effect on active mouth opening and on pain during active mouth in favor of musculoskeletal manual techniques when compared to other conservative treatments for TMD. Authors concluded that musculoskeletal manual approaches are effective for treating TMD. In the short term, there is a larger effect regarding the latter when compared to other conservative treatments for TMD.

McNeely et al. (2006) reviewed the efficacy of exercise and postural therapy interventions for the treatment of TMD. This review is notable for its clear and explicit reporting of study quality on the 5-point Jadad scale. Four studies examined the effect of exercise interventions on TMD. However, the methodological quality of these four (4) studies was considered weak. Two studies examined the effect of posture training (in combination with other therapies) on myogenous TMD and reported significant improvements in pain and oral opening in favor of the addition of postural exercise training. After one (1) month, Komiyama et al. (1999) found a significant increase in mouth opening in patients who received postural training compared with patients receiving only cognitive intervention or compared with the control group. Wright et al. (2000) found a statistically significant improvement in maximum pain-free opening, pain threshold, and the modified symptom severity index in patients receiving postural treatment compared with patients receiving self-management instructions alone. Carmeli et al. (2001) compared the effect of manual therapy in combination with active exercise with the effect of treatment with occlusal splint therapy on anteriorly displaced temporomandibular disks on thirty-six patients with

arthrogenous TMD. The authors reported significant improvement in pain and oral opening in favor of the manual therapy/exercise group. Grace et al. (2002) examined the benefit of an oral exercise device compared to traditional therapies, including when the oral exercise device was used as part of a home program, on oral opening, pain, and wellness in patients with mixed TMD. Results indicated that the study groups demonstrated significant clinical improvement. However, the groups did not differ significantly from each other in degree of patient improvement. McNeely further reviewed the efficacy of various electro-physiotherapy modalities in the treatment of TMD pain and dysfunction and reported on six (6) studies (two [2] strong studies and four [4] weak studies). There was considerable heterogeneity among the studies in the type of TMD, the chosen modality and comparison group, and in the frequency and duration of the treatment.

In the double-blind, placebo-controlled study by Al-Badawi et al. (2004), forty patients received six (6) treatments of pulsed radio-frequency energy (PRFE) therapy, however PRFE was not found to be significantly better than sham PRFE for arthrogenous TMD pain. Treacy et al. (1999) reported that 20 sessions of transcutaneous electrical nerve stimulation (TENS), were not significantly better than muscular awareness relaxation therapy (MART) or sham TENS (n=23 patients). Significant improvements were found, however, in oral opening and electromyographic activity for the MART group when compared with treatment with TENS and sham TENS. The Treacy study is methodologically weak due to small sample size, lack of double blinding, and inadequate data collection methods.

A review by List (2010) examined the set of systematic reviews for the entire range of treatments for TMD including surgery, occlusal appliances, medication, as well as physical and manual therapies. This review found that there was great variability in quality and methodology of the reviews as well as in the primary studies, making definitive conclusions impossible. This analysis concluded that occlusal appliances, acupuncture, behavioral therapy, jaw exercises, postural training, and some pharmacological treatments were effective for TMD. There was insufficient evidence for effectiveness for electro-physiotherapy modalities.

Moraes et al. (2013) studied therapeutic exercises for the control of temporomandibular disorders. Their aim was to conduct a literature review concerning the types of exercises available and the efficacy for the treatment of muscular TMD. The results included seven articles which reported therapeutic exercises to be effective for the treatment of muscular TMD. However, these studies were deemed limited with regards to the conclusions because the exercises were combined with other conservative treatments. Other limitations included: small samples, lack of control group and no detailed exercise description, which should have included intensity, repetition, frequency and duration. Authors conclude that although therapeutic exercises are considered effective in the management of muscular TMD, the development of randomized clinical trials is necessary, since many existing

studies are still based on the clinical experience of professionals. Another study Kraaijenga et al. (2014) compared in a randomized controlled clinical trial (RCT) the application of the TheraBite® (TB) Jaw Motion Rehabilitation System with a standard physical therapy (PT) exercise regimen for the treatment of myogenic temporomandibular disorder (TMD). Mandibular function was assessed with the mandibular function impairment questionnaire (MFIQ). Pain was evaluated using a visual analog scale, and maximum inter-incisor (mouth) opening (MIO) was measured using the disposable TB range of motion scale. After six-week follow-up, patients using the TB device reported a significantly greater functional improvement (MFIQ score) than the patients receiving regular PT exercises (P=0.0050). At 6 weeks, no significant differences in pain, and active or passive MIO were found between the two groups. At three (3) months, patients in both treatment groups did equally well, and showed a significant improvement in all parameters assessed. This RCT showed that both treatment modalities are equally effective in relieving myogenic TMD symptoms, but that the use of the TB device has the benefit of achieving a significantly greater functional improvement within the first week of treatment.

Rashid et al. (2013) investigated the perceived effectiveness of physiotherapy for patients with TMD among consultants in oral and maxillofacial surgery (OMFS). A total of 208 responded (58%) and 72% considered physiotherapy to be effective. Amongst these respondents, jaw exercises (79%), ultrasound (52%), manual therapy (48%), acupuncture (41%) and laser therapy (15%) were considered to be effective. Twenty-eight percent of respondents did not consider physiotherapy to be effective. Reasons for this included lack of knowledge or expertise of the physiotherapist (41%) and lack of awareness of the benefits of physiotherapy (28%). Despite limited evidence to support its effectiveness, approximately three-quarters of OMFS consultants in the UK regard physiotherapy to be beneficial in the management of TMD. Chen et al. (2015) evaluated the efficacy of low-level laser therapy (LLLT) in the treatment of temporomandibular disorders (TMDs). Fourteen highly qualified RCTs reporting on a total of 454 patients, which evaluated the effectiveness of LLLT for patients suffering from TMDs were retrieved. The results indicated that LLLT was not better than placebo in reducing chronic TMD pain However, the LLLT provided significant better functional outcomes in terms of maximum active vertical opening (MAVO), maximum passive vertical opening (MPVO), protrusion excursion (PE) and right lateral excursion (RLE). Authors conclude that this study indicates that using LLLT has limited efficacy in reducing pain in patients with TMDs. However, LLLT can significantly improve the functional outcomes of patients with TMDs.

In an article by Shaffer et al. (2014), conservative management of TMJ disorders is discussed. Authors state that physical therapy is the preferred conservative management approach for TMD. They suggest that the potentially appropriate plan of care components may include joint and soft tissue mobilization, trigger point dry needling, friction massage, therapeutic exercise, patient education, modalities, and outside referral. Management

options should address both symptom reduction and oral function. Satisfactory results can often be achieved when management focuses on patient-specific clinical variables.

Wieckiewicz et al. (2015) presented the concepts of TMD pain clinical management based on the most current treatment plans. Results reported that the most common conservative treatments are massage therapy and individually fabricated occlusal splints. In addition to massage, other popular methods include manual therapy and taping, warming/cooling of aching joints, and light and laser therapy. Drugs are also commonly used. In the most severe cases of the temporomandibular joint degeneration, surgical restoration of the joint is sometimes applied. Authors conclude that conservative treatment including counselling, exercises, occlusal splint therapy, massage, manual therapy and others should be considered as a first choice therapy for TMD pain because of their low risk of side effects. In the case of severe acute pain or chronic pain resulting from serious disorders, inflammation and/or degeneration pharmacotherapy, minimally invasive and invasive procedures should be considered.

Gauer and Semidey (2015) reported on standard treatment for patients with TMD. They report that most patients improve with a combination of noninvasive therapies, including patient education, self-care, cognitive behavior therapy, pharmacotherapy, physical therapy, and occlusal devices. Nonsteroidal anti-inflammatory drugs and muscle relaxants are recommended initially, and benzodiazepines or antidepressants may be added for chronic cases. Referral to an oral and maxillofacial surgeon is indicated for refractory cases.

Armijo-Olivo et al. (2016) summarized evidence of randomized controlled trials that examined the effectiveness of MT and therapeutic exercise interventions compared with other active interventions or standard care for treatment of TMD. Randomized controlled trials involving adults with TMD that compared any type of MT intervention (e.g., mobilization, manipulation) or exercise therapy with a placebo intervention, controlled comparison intervention, or standard care were included. The main outcomes were pain, range of motion, and oral function. Forty-eight studies met the inclusion criteria and were analyzed. The overall evidence for this systematic review was considered low, with an unclear or high risk of bias. Most of the effect sizes were low to moderate, with no clear indication of superiority of exercises versus other conservative treatments for TMD. However, MT alone or in combination with exercises at the jaw or cervical level showed promising effects. Overall, there was no high-quality evidence, indicating that there is uncertainty about the effectiveness of exercise and MT for treatment of TMD.

According to Butts et al. (2017), a review of the literature revealed limited support of strengthening exercises targeting the muscles of mastication. There was also limited evidence for manual soft tissue work targeting muscles of mastication, which may be specifically related to the limited accessibility of the pterygoid muscles to palpation. For

the reduction of pain, there was little to no evidence supporting splint therapy and electrophysical modalities, including laser therapy, ultrasound, TENs and iontophoresis. However, for the reduction of pain and disability, non-thrust mobilization and high-velocity, low amplitude thrust manipulation techniques to the TMJ and/or upper cervical articulations that directly and indirectly target the TMJ joint capsule were generally supported in the literature. Studies that used dry needling or acupuncture of the lateral pterygoid and posterior, peri-articular connective tissue also led to significant improvements in pain and disability in patients with TMD. Thus, the most effective conservative management of TMD seems to be techniques best able to impact anatomic structures directly related to the etiology of TMD, to include the joint capsule, articular disc and muscles of mastication, specifically the superior and inferior head of the lateral pterygoid.

Garrigós-Pedrón et al. (2018) investigated the effects of adding orofacial treatment to cervical physical therapy in patients with chronic migraine and temporomandibular disorders (TMD). A total of 45 participants with chronic migraine and TMD aged 18 to 65 years were randomized into two groups: a cervical group (CG) and a cervical and orofacial group (COG). Both groups continued their medication regimens for migraine treatment and received physical therapy. The CG received physical therapy only in the cervical region, and the COG received physical therapy in both the cervical and orofacial regions. Both groups received six sessions of treatment that consisted of manual therapy and therapeutic exercise in the cervical region or the cervical and orofacial regions. Scores on the Craniofacial Pain and Disability Inventory (CF-PDI) and the Headache Impact Test (HIT-6) were primary outcome variables, and the secondary outcome variables were scores on the Tampa Scale for Kinesiophobia (TSK-11), pain intensity measured on a visual analog scale (VAS), pressure pain thresholds (PPTs) in the temporal, masseter and extratrigeminal (wrist) regions, and maximal mouth opening (MMO). Data were recorded at baseline, posttreatment, and after 12 weeks of follow-up. There were 22 CG participants (13.6% men and 86.4% women) and 23 COG participants (13% men and 87% women). The ANOVA analysis revealed statistically significant differences for group × time interaction in CF-PDI, HIT-6 in the last follow-up, pain intensity, PPTs in the trigeminal region, and MMO, with a medium-large magnitude of effect. No statistically significant differences were found in the PPTs of the extratrigeminal region or in the TSK-11. Authors concluded that both groups reported a significant improvement in CF-PDI, HIT-6, and pain intensity. Cervical and orofacial treatment was more effective than cervical treatment alone for increasing PPTs in the trigeminal region and producing pain-free MMO. Physical therapy alone was not effective for increasing the PPTs in the extratrigeminal region (wrist) or decreasing the level of TSK-11.

Shimada et al. (2019) authored a review focused on the effects of exercise therapy for the management of painful TMD. The aims of this review were to summarize the effects of exercise therapy for major symptoms of painful TMD and to establish a guideline for the

management of painful TMD, resulting in higher quality and reliability of dental treatment. In this review, exercise modalities are clearly defined as follows: mobilization exercise, muscle strengthening exercise (resistance training), coordination exercise and postural exercise. Furthermore, pain intensity and range of movements were focused as outcome parameters in this review. Authors concluded that mobilization exercise including manual therapy, passive jaw mobilization with oral appliances and voluntary jaw exercise appeared to be a promising option for painful TMD conditions such as myalgia and arthralgia. Calixtre et al. (2019) sought to determine whether mobilization of the upper cervical region and craniocervical flexor training decreased orofacial pain, increased mandibular function and pressure pain thresholds (PPTs) of the masticatory muscles and decreased headache impact in women with TMD when compared to no intervention. Sixty-one women with TMD were randomized into an intervention group (IG) and a control group (CG). The IG received upper cervical mobilizations and neck motor control and stabilization exercises for 5 weeks. The CG received no treatment. Pain intensity showed significant time-by-group interaction, with significant between-group differences at four and five weeks, with large effect sizes ($d > 0.8$). The decrease in orofacial pain over time was clinically relevant only in the IG. Change in headache impact was significantly different between groups, and the IG showed a clinically relevant decrease after the treatment. No effects were found for PPT or mandibular function. Authors concluded that women with TMD reported a significant decrease in orofacial pain and headache impact after five (5) weeks of treatment aimed at the upper cervical spine compared to a CG.

Vier et al. (2019) systematically reviewed the effects of dry needling on orofacial pain of myofascial origin in patients with temporomandibular joint dysfunction. Seven trials were considered eligible. There was discrepancy among dry needling treatment protocols. Meta-analysis showed that dry needling is better than other interventions for pain intensity as well as than sham therapy on pressure pain threshold, but there is very low-quality evidence and a small effect size. There were no statistically significant differences in other outcomes.

Authors suggested that clinicians can use dry needling for the treatment of temporomandibular joint dysfunction. However, due to the low quality of evidence and high risk of bias of some included studies, larger and higher quality studies are needed to assess the effects of dry needling on orofacial pain associated with temporomandibular joint dysfunction. Madani et al. (2020) compared the efficacy of low-level laser therapy (LLLT) versus laser acupuncture therapy (LAT) in patients with temporomandibular disorders (TMDs). In this randomized, double-blind clinical trial, 45 TMD patients were randomly divided into three groups: group 1 (LLLT), group 2 (LAT), and group 3 (placebo) underwent treatment with sham laser. There was no significant difference in mouth opening between the groups, but the amount of lateral excursive and protrusive movements was significantly greater in LLLT and LAT groups than the placebo group at some intervals. The overall pain intensity and pain degree at masticatory muscles (except temporal muscle) and TMJs were significantly lower in both experimental groups than the placebo group at

most intervals after therapy. Authors concluded that both LLLT and LAT were effective in reducing pain and increasing excursive and protrusive mandibular motion in TMD patients. LAT could be suggested as a suitable alternative to LLLT, as it provided effective results while taking less chair time.

Reynolds et al. (2020) sought to determine the immediate and short-term effects of adding cervical spine high-velocity, low-amplitude thrust (HVLAT) to behavioral education, soft tissue mobilization, and a home exercise program on pain and dysfunction for people with a primary complaint of temporomandibular disorder (TMD) with myalgia. Fifty individuals with TMD were randomly assigned to receive cervical HVLAT or sham manipulation for 4 visits over 4 weeks. Participants in both groups received other treatments, including standardized behavioral education, soft tissue mobilization, and a home exercise program. Primary outcomes included maximal mouth opening, the numeric pain-rating scale, the Jaw Functional Limitation Scale (JFLS), the Tampa Scale of Kinesiophobia for TMD (TSK-TMD), and a global rating of change (GROC). Self-report and objective measurements were taken at baseline, immediately after initial treatment, and follow-ups of 1 week and 4 weeks. Results indicated that there was no significant interaction for maximal mouth opening, the numeric pain-rating scale, or secondary measures. The HVLAT group had lower fear at 4 weeks and improved jaw function earlier (1 week). The GROC favored the HVLAT group, with significant differences in successful outcomes noted immediately after baseline treatment (thrust, 6/25; sham, 0/25) and at 4 weeks (thrust, 17/25; sham, 10/25). Authors concluded that both groups improved over time; however, differences between groups were small. The additive clinical effect of cervical HVLAT to standard care remains unclear for treating TMD.

Delgado de la Serna et al. (2020) investigated the effects of adding cervico-mandibular manual therapies into an exercise and educational program on clinical outcomes in individuals with tinnitus associated with temporomandibular disorders (TMDs). Sixty-one patients with tinnitus attributed to TMD were randomized into the physiotherapy and manual therapy group or physiotherapy alone group. All patients received six sessions of physiotherapy treatment including cranio-cervical and temporomandibular joint (TMJ) exercises, self-massage, and patient education for a period of one month. Patients allocated to the manual therapy group also received cervico-mandibular manual therapies targeting the TMJ and cervical and masticatory muscles. Primary outcomes included TMD pain intensity and tinnitus severity. Patients were assessed at baseline, one week, three months, and six months after intervention by a blinded assessor. Authors reported that this clinical trial found that application of cervico-mandibular manual therapies in combination with exercise and education resulted in better outcomes than application of exercise/education alone in individuals with tinnitus attributed to TMD.

Fisch et al. (2020) explored if physical therapy is an effective approach to treating patients with TMJ disorders. They sought to determine the effect of conservative physical therapy

interventions on pain, maximal mouth opening, and TMJ disability index for patients with TMD. Medical records from 2013-2018 were retrospectively reviewed to identify patients and obtain demographic, baseline, and short-term outcomes of maximal mouth opening (MMO), pain, and temporomandibular disability index (TDI). A total of 100 patients were included. Significant changes were noted in MMO, pain rating, and TDI from initial evaluation to discharge from physical therapy. Sex, age, and weight did not affect the outcomes. There was also no correlation between the number of visits attended and change in MMO. Patients treated conservatively did show improvements in short term outcomes (MMO, pain rating, and TDI). These changes were statistically significant, indicating that conservative therapy may be a beneficial treatment option for patients with TMJ dysfunction. Future studies assessing the long-term outcomes of TMJ patients treated conservatively would determine if this treatment is beneficial in the long-term. In addition, researching the effectiveness of specific interventions for TMJ patients, and if certain TMJ disorders are more responsive to conservative care than others would be valuable in providing information on the effectiveness of conservative treatment in this patient population.

Fernández-de-Las-Peñas et al. (2020) aimed to discuss clinical reasoning based on nociceptive pain mechanisms for determining the most appropriate assessment and therapeutic strategy and to identify/map the most updated scientific evidence in relation to physical therapy interventions for patients with temporomandibular disorders (TMDs) in this narrative review. Authors conclude the following: the clinical examination of patients with TMDs should be based on nociceptive mechanisms and include the potential identification of the dominant, central, or peripheral sensitization driver. Additionally, the musculoskeletal drivers of these sensitization processes should be assessed with the aim of reproducing symptoms. Therapeutic strategies applied for managing TMDs can be grouped into tissue-based impairment treatments (bottom-up interventions) and strategies targeting the central nervous system (top-down interventions). Bottom-up strategies include joint-, soft tissue-, and nerve-targeting interventions, as well as needling therapies, whereas top-down strategies include exercises, grade motor imagery, and also pain neuroscience education. Evidence shows that the effectiveness of these interventions depends on the clinical reasoning applied, since not all strategies are equally effective for the different TMD subgroups. In fact, the presence or absence of a central sensitization driver could lead to different treatment outcomes. Authors report that it seems that multimodal approaches are more effective and should be applied in patients with TMDs. van der Meer et al. (2020) systematically evaluated the literature on the effectiveness of physical therapy on concomitant headache pain intensity in patients with TMD. Randomized or controlled clinical trials studying physical therapy interventions were included. Authors concluded physical therapy interventions presented small effect on reducing headache pain intensity on subjects with TMD, with low level of certainty. More studies of higher methodological quality are needed so better conclusions could be taken.

Aisaiti et al. (2021) evaluated the effect of photobiomodulation therapy (PBMT) (aka low level laser therapy) on painful temporomandibular disorders (TMD) patients in a randomized, double-blinded, placebo-controlled manner. Participants were divided into a masseter myalgia group (n = 88) and a temporomandibular joint (TMJ) arthralgia group (n = 87) according to the Diagnostic Criteria for Temporomandibular Disorders (DC/TMD). Both groups randomly received PBMT or placebo treatment once a day for 7 consecutive days, one session. The PBMT was applied with a gallium-aluminum-arsenide (GaAlAs) laser (wavelength = 810 nm) at pre-determined points in the masseter muscle (6 J/cm2, 3 regions, 60 s) or TMJ region (6 J/cm2, 5 points, 30 s) according to their most painful site. Pain intensity was rated on a 0-10 numerical rating scale (NRS) and pressure pain thresholds (PPT) and mechanical sensitivity mapping were recorded before and after the treatment on day 1 and day 7. Jaw function was assessed by pain free jaw opening, maximum unassisted jaw opening, maximum assisted jaw opening, maximum protrusion and right and left excursion. Pain intensity in arthralgia patients decreased over time for both types of interventions, however, PBMT caused greater reduction in pain scores than placebo. For myalgia patients, pain intensity decreased over time but without difference between interventions. PPTs increased in both myalgia and TMJ arthralgia patients over time but without difference between interventions. Overall, PBMT was associated with marginally better improvements in range of motion compared to placebo in both myalgia and arthralgia patients. Pain intensity, sensory function and jaw movements improve after both PBMT and placebo treatments in myalgia and arthralgia patients indicating a substantial non-specific effect of PBMT.

Ahmad et al. (2021) evaluated the efficacy of LLLT in the treatment of temporomandibular joint disorder within a systematic review. Thirty-seven articles were considered eligible for this systematic review. Out of 37 studies, 33 (89.18%) are high methodological studies, which have an overall low risk of bias or with some concerns, while only 4 studies have a high risk of bias. Eighteen studies showed that LLLT was efficacious in diminishing TMD pain, whereas 12 studies showed that LLLT had similar efficacy as of placebo/controls/other intervention in TMD pain diminution. Four studies presented varied effects of LLLT on pain intensity, mandibular motion, EMG activity, and masticatory efficiency. Two studies revealed that LLLT improved the psychological and emotional aspects associated with TMDs, joint noises, masticatory efficiency, and EMG parameters, respectively. One study focused on subjective tinnitus, whereas another study suggested laser acupuncture (LAT) therapy as a suitable alternative to LLLT. The results demonstrate that LLLT appears to be efficient in diminishing TMD pain with variable effects on the outcome of secondary parameters. The results demonstrate that LLLT appears to be efficient in diminishing TMD pain with variable effects on the outcome of secondary parameters. Also, LLLT provides advantages as the therapeutic regimen is non-invasive, reversible, with fewer adverse effects, and may also improve the psychological and emotional aspects associated with TMDs. Therefore, this systematic review highlights the role of LLLT as a promising therapeutic regimen for TMDs.

Zhang et al. (2021) compared the effects of exercise therapy and occlusal splint therapy on pain and mobility in individuals with painful temporomandibular disorders (TMD) in a systematic review. Six studies were included (498 patients: 251 occlusal splint therapy, 247 therapeutic exercise). The results revealed that exercise therapy was not superior to occlusal splint therapy for pain reduction in patients with painful TMD. The effectiveness of occlusal splint therapy and exercise therapy was found to be equivalent in the maximum mouth-opening range, right laterotrusion, left laterotrusion, and protrusion for painful TMD patients. Authors concluded that given the limitations of the study, the small number of studies included in the sub-analysis for pain relief and the maximum mouth-opening range, and the small overall standardized mean difference for pain relief and mandibular movement observed, no high-quality evidence was found to distinguish the clinical effectiveness between occlusal splint therapy and exercise therapy for painful TMD patients. It appears that more randomized controlled trials comparing the effects of exercise therapy and occlusal splint therapy need to be implemented.

Urbański et al. (2021) compared the degree of relaxation of the anterior part of the temporal muscles and the masseter muscles, achieved through the use of post-isometric relaxation and myofascial release methods in patients requiring prosthetic treatment due to temporomandibular joint disorders with a dominant muscular component. Sixty patients who met the inclusion criteria were alternately assigned to one of the two study groups, either group I-patients received post-isometric relaxation treatment (PIR), or group II-patients received myofascial release treatment (MR). The series of ten treatments were performed in both groups. The comparative assessment was based on physiotherapeutic examination, a surface electromyography (sEMG) of the anterior temporal and masseter muscles and the intensity of spontaneous masticatory muscle pain, assessed using the Visual Analogue Scale (VAS). Authors observed a significant decrease in the electrical activity of examined muscles and a significant drop in the intensity of spontaneous pain in the masticatory muscles both in group I and II. There were no significant differences between groups. Both therapeutic methods may be used as successful forms of adjunctive therapy in the prosthetic treatment of TMD.

Kulesa-Mrowiecka et al. (2021) aimed to present the occurrence of HJS among patients with myogenic TMD and disc displacement with reduction. The secondary goal was to assess the effectiveness of physiotherapy directed to TMD with coexisting HJS. The study involved 322 patients with symptoms of TMD. HJS was diagnosed using the Beighton Scale, which confirmed its occurrence in 26 cases. 79 subjects (7 males and 72 females; mean age, 33.9 ± 10.4 years) were selected and divided into two groups: HJS + TMD (n = 26; 2 males and 24 females; mean age, 27.1 ± 9.4 years) and TMD (n = 53; 5 males and 48 females; mean age, 37.4 ± 9.2 years). These patients completed 3-week physiotherapy management. Before and after physiotherapy, the myofascial pain severity on Numeric Pain Rating Scale, linear measurement of maximum mouth opening, and opening pattern, were assessed. A statistically significant improvement was obtained in decreasing

myofascial pain in both groups. Coordination of mandibular movements was achieved in both groups. Generalized joint hypermobility occurred among patients with TMD. Physiotherapy directed to TMD was effective in reducing myofascial pain and restoring TMJ's coordination also in patients with HJS.

Shousha et al. (2021) assessed the efficacy of low-level laser therapy (LLLT) as compared to occlusive splint therapy (OST) on the TMJ opening index (TOI) and sEMG of masticatory muscles. 112 female subjects suffering from unilateral myogenous TMD, aged 21-30 years-old, were recruited and divided into three groups: LLLT; soft occlusive splint therapy OST and a waitlist group as controls. Outcome measures included TMJ opening index (TOI), Visual analogue scale (VAS), surface electromyography (sEMG). Results noted a significant reduction was reported in TOI, VAS and the sEMG within the LLLT and OST groups as well as significant decrease in all outcomes between groups in favor of the LLLT group. Authors concluded that findings supported an evident short term therapeutic effect of the LLLT on improving VAS, TOI and sEMG in females suffering from myogenous TMD. Magri et al. (2021) sought to characterize short- and long-term assessment of the low-intensity laser therapy (LLLT) effectiveness in women with TMD of muscular origins and to evaluate whether the information about the treatment received (active or placebo) modifies the pain intensity. Forty-one women with painful TMD (31.7 ± 5.2 years) were divided into laser (n = 20) and placebo (n = 21) groups. The pain intensity was measured at the baseline, after the LLLT (T8), 6 and 12 months. At the 6-month follow-up, the groups received information about the active or placebo treatment. Results demonstrated that at T8 and 6-month, both active and placebo LLLT were effective in reducing pain. After one year, the groups showed similar pain. Active LLLT was more effective in reducing pain palpation and referred pain in the region of the TMJs. The information about the treatment modified the perceived pain intensity. Authors concluded that active and placebo LLLT are effective for painful TMD of muscular origins in the short-term. Information about the treatment impairs the subjective perception of pain.

Dinsdale et al. (2022) evaluated the effectiveness of conservative interventions on self-reported and physical measures of bite function in individuals with TMD in a systematic review. Eleven studies were eligible for this review. Interventions included splinting, photobiomodulation, needling, exercise, manual therapy, and patient education, which were evaluated using mastication-related pain, self-reported chewing difficulty, and bite force/endurance outcome measures. Findings suggested manual therapy, needling, oral splinting, exercise, and PBM interventions may improve bite function in TMD, although confidence in cumulative evidence ranged from moderate to very low. There was no evidence that patient education improved bite function. Authors concluded that conservative interventions may be helpful to address bite-related impairments associated with TMD, although further research is needed to improve the quality of evidence and direct clinical guidelines

Asquini et al. (2022) aimed to evaluate the effectiveness of manual therapy applied specifically to the craniomandibular structures (Cranio-Mandibular Manual Therapy [CMMT]) on pain and maximum mouth opening in people with TMD. A total of 2720 records were screened, of which only 6 (293 participants) satisfied the inclusion criteria. All studies showed some concerns in risk of bias, except for one, which was high risk of bias. The overall quality of evidence was very low for all outcomes because of high heterogeneity and small sample sizes. All studies showed a significant improvement in pain and maximum mouth opening for CMMT from baseline in the mid-term, but only two showed superiority compared to other interventions. Given the high heterogeneity and small sample sizes of the included studies, a quantitative synthesis was not performed. Authors concluded that there is the need for future high methodology research investigating different manual therapy techniques applied to different regions and different populations (e.g., chronic versus acute TMD) to determine what is most effective for pain and maximum mouth opening in patients with TMDs. Tran et al. (2022) authored a knowledge-to-action rapid review of systematic reviews published in the past 5 years and guidelines published in the past 10 years concerning the management of TMD. In total, 62 systematic reviews and nine guidelines considering a range of treatment modalities were included. In concordance with current guidelines, moderate evidence supports a multi-modal conservative approach towards initial management. Contrary to existing guidelines, occlusal splint therapy is not recommended due to a lack of supporting evidence. The evidence surrounding oral and topical pharmacotherapeutics for chronic TMD is low, whilst the evidence supporting injected pharmacotherapeutics is low to moderate. In concordance with current guidelines, moderate quality evidence supports the use of arthrocentesis or arthroscopy for arthrogenous TMD insufficiently managed by conservative measures, and open joint surgery for severe arthrogenous disease. Based on this, a management pathway showing escalation of treatment from conservative to invasive is proposed. La Touche et al. (2022) analyzed the effectiveness of exercise and manual therapy interventions in patients with disc displacement without reduction in a systematic review. Ten articles were included, according to the inclusion criteria. Most of the interventions showed statistically significant improvements in the primary outcomes. Results show that interventions based on therapeutic exercise or manual therapy may be beneficial and play a role in the treatment of disc displacement without reduction. Limited evidence suggests that exercise significantly improves mouth opening in comparison to splints. Due to the heterogeneity of the included studies, these results should be interpreted with caution.

Al-Moraissi et al. (2021) aimed to identify the best treatment for adult patients with M-TMD in a network meta-analysis (NMA). Authors identified randomized clinical trials (RCTs) which are comparing two or more of the following treatment modalities in patients with M-TMD: counseling therapy; occlusal appliances; manual therapy; laser therapy; dry needling; intramuscular injection of local anesthesia (LA) or botulinum toxin-A (BTX-A); muscle relaxants; hypnosis/relaxation therapy; oxidative ozone therapy; and placebo or no

treatment. Primary outcome variables were the reduction of pain and mechanical sensitivity. The secondary outcome was the maximal mouth opening (MMO). 52 RCTs were included in this NMA. At the most follow up moments, manual therapy, counseling therapy, occlusal splints therapy, and needling using BTX-A or LA as well as dry needling significantly decreased post-treatment pain intensity in M-TMDs, when compared to placebo. At short term (≤5 months), the four highest-ranked treatments for post-treatment pain reduction were manual therapy (83.5%, low quality evidence), ozone therapy (75.7%, very low quality evidence), counseling therapy (71.2%, moderate quality), and occlusal appliances (71.7%, moderate quality evidence). When intermediate term (≥6 months) was considered, BTX-A (85.8%, very low quality evidence), counseling therapy (80%, low quality evidence), occlusal appliances (62.8%, low quality evidence) and hypnosis (50.6%, very low quality evidence) were the four highest-ranked treatments. This NMA reveals that manual therapy can be considered the most effective treatment for M-TMD, followed by counseling treatment, intramuscular injection of LA, and occlusal appliances. However, considering the limitations of the studies included, and the scarcity of strong evidence, the present findings should be interpreted cautiously.

Ekici et al. (2022) evaluated the effectiveness of high-intensity laser therapy (HILT) in the short and long term in the treatment of patients with the myogenic temporomandibular joint disorder (TMD). This prospective, double-blind, controlled clinical study was conducted on patients with myogenic TMD at a university's oral and maxillofacial surgery clinic. Seventy-six patients were randomized into two groups (HILT, and control group), including 38 patients in one group. The patients were evaluated for pain, the range of motion of the jaw, disability, and quality of life. Assessments were performed before therapy (week 0) and after therapy (weeks 4 and 12). Data were evaluated using SPSS-20 and the level of significance was set at $p < 0.05$. There was no significant difference between the groups in terms of socio-demographic characteristics of the groups at the beginning of the study. In the 4th week, the VAS pain score was significantly decreased in the HILT group (47%) compared to the placebo HILT group (4%). The maximum mouth opening was significantly increased in the HILT group (27%) compared to the placebo HILT group (4%) at week 12. The HILT group showed a significant improvement in Jaw Functional Limitation Scale 20 (JFLS-20) and Oral Health Impact Profile (OHIP-14) compared to the placebo HILT group. Authors concluded that HILT is a highly effective, non-invasive therapeutic method for patients with myogenic TMD. Fertout et al. (2022) assessed the efficacy of transcutaneous electrical nerve stimulation (TENS) for the management of temporomandibular disorders (TMD) and to determine the indications and most appropriate application modalities. Fourteen articles were retained, corresponding to a total of 532 patients, among which, 285 had a TMD. Immediately after a TENS session, significant relief of pain (19.2% to 77%), significant functional improvement (mouth opening amplitude increased by between 8.7% and 19.46%), and reduced electromyographic activity of the anterior temporalis and masseter muscles were observed. However, studies comparing TENS to other physical medicine modalities (ultrasound and

laser) reported equivalent results. Authors concluded that further randomized comparative clinical trials are necessary to optimize the use of TENS (program, duration of sessions, duration of treatment) for different types of TMD.

**Acupuncture**

Cho et al. (2010) assessed the effectiveness of acupuncture for the symptomatic treatment of TMD. Nineteen studies were reviewed. There was moderate evidence that classical acupuncture had a positive influence beyond those of placebo (three 3) trials; 65 participants); had positive effects similar to those of occlusal splint therapy (three trials; 160 participants); and was more effective for TMD symptoms than physical therapy (four trials; 397 participants), indomethacin plus vitamin B1 (two (2) trials; 85 participants), and a wait-list control (three (3) trials; 138 participants). Only two (2) RCTs addressed adverse events and reported no serious adverse events. This review concluded that there is moderate evidence that acupuncture is an effective intervention to reduce symptoms associated with TMD.

Jung et al. (2011) carried out a systematic review and meta-analysis of randomized, placebo-controlled trials assessing the efficacy of acupuncture for treatment of TMD. A total of seven (7) RCTs met the appropriate inclusion criteria for the purpose of this review. The review and meta-analysis concluded that the evidence for acupuncture as a symptomatic treatment of TMD is limited.

La Touche et al. (2010) carried out a systematic review and meta-analysis of randomized controlled trials for the use of acupuncture treatment. A total of four (4) RCTs were considered acceptable. These four (4) studies showed positive results such as reducing pain, improving masticatory function, and increasing maximum interincisal opening. The results of this meta-analysis suggest that acupuncture is a reasonable adjunctive treatment for producing a short-term analgesic effect in patients with painful TMD symptoms. As a caveat, although the results described are positive, the relevance of these results was limited by the fact that the meta-analysis was carried out on a total of only four (4) studies, representing a relatively small global size (n=96), which makes it more difficult to detect a sample bias.

Two of the systematic reviews (Jung; La Touche) identified essentially the same set of clinical trials. All of these trials were very small, sample sizes ranging from only 10 to 20 subjects per treatment group. The Cho review was less restrictive in its inclusion criteria and a few larger trials were included. Notwithstanding, the evidence in this domain is limited to pilot-study-size clinical trials.

Fernandes et al. (2017) sought to determine the effectiveness of acupuncture in treating myofascial pain in temporomandibular disorder (TMD) patients in a systematic review. A total of four randomized clinical trials using acupuncture (traditional, trigger point, and

laser) for TMD treatment met the eligibility criteria and were included. Although the studies featured small sample sizes and short-term follow-up periods, acupuncture yielded results similar to those observed in groups treated with occlusal splints and were significantly superior than those obtained from placebo acupuncture-treated groups. Authors concluded that despite the weak scientific evidence supporting its efficacy, acupuncture treatment appears to relieve the signs and symptoms of pain in myofascial TMD. More controlled and randomized clinical trials with larger sample sizes are needed.

A network meta-analysis (NMA) of randomised clinical trials (RCTs) was performed by Al-Moraissi et al. (2020) aiming to compare the treatment outcome of dry needling, acupuncture or wet needling using different substances in managing myofascial pain of the masticatory muscles (TMD-M). Twenty-one RCTs involving 959 patients were included. The quality of evidence of the included studies was low or very low. There was significant pain decrease after PRP when compared to an active/passive placebo and acupuncture. There was a significant improvement of MMO after LA and dry needling therapy versus placebo. The three highest ranked treatments for short-term post-treatment pain reduction in TMD-M (1-20 days) were PRP (95.8%), followed by LA (62.5%) and dry needling (57.1%), whereas the three highest ranked treatments at intermediate-term follow-up (1-6 months) were LA (90.2%), dry needling (66.1%) and BTX-A (52.1%) (all very low-quality evidence). LA (96.4%) was the most effective treatment regarding the increase in MMO followed by dry needling (72.4%). Authors concluded that based on this NMA the effectiveness of needling therapy did not depend on needling type (dry or wet) or needling substance. The outcome of this NMA suggests that LA, BTX-A, granisetron and PRP hold some promise as injection therapies, but no definite conclusions can be drawn due to the low quality of evidence of the included studies. This NMA did not provide enough support for any of the needling therapies for TMD-M.

Peixoto et al. (2021) evaluated current studies to establish and compare the efficacy of traditional and laser acupuncture in reducing the signs and symptoms of temporomandibular disorders (TMD). Six studies that evaluated the intensity of pain and the level of mouth opening of the patients submitted to acupuncture were selected, and all showed improvement. However, similar results were also observed in the groups treated with occlusal splint and placebo acupuncture. Only one study evaluated laser acupuncture and showed a higher proportion of patients with remission of symptoms in the experimental group. Authors concluded that the traditional acupuncture seems to relieve the signs and symptoms of TMD, as well as laser acupuncture when associated with occlusal splint. However, more rigorous and high-quality clinical trials are needed. Kalladka et al. (2021) provided an overview of the etiopathogenesis, clinical features and diagnosis of TMD, and summarized the current trends in the therapeutic management in review. Effective treatment requires a clear diagnosis based on an understanding of pathophysiologic mechanisms, a detailed history with assessment of predisposing local and systemic factors, perpetuating factors, a comprehensive clinical evaluation and a diagnostic workup. Authors

concluded that a thorough history and clinical examination are the gold standards for diagnosis of TMD. The treatment goals for TMD are to control pain, restore mandibular function and facilitate the return to normal daily activity and improve the overall quality of life of a patient. They report that based on the evidence, conservative modalities including home care regimens, pharmacotherapy, intraoral appliance therapy, local anesthetic trigger point injections, physiotherapy and complementary modalities may be beneficial in patients with TMD's.

Li et al. (2021) discussed the present thinking in the etiology and classification of TMD, followed by the diagnostic approach and the current trend and controversies in management. When focusing on the treatments, this review reports that physiotherapy has been suggested to be an important part in the management of TMD, which may be particularly useful for myalgia or myofascial pain. Understanding the loading of the stomatognathic system, and the existence of any tension and parafunctions, is important in delivering physiotherapy such as muscle training and changing of behavior. Evidence shows that physiotherapy is effective in treatment of TMD, in particular the headache symptoms associated with the condition; future research into this area will further ascertain these findings. For myogenous TMD, Botox injection and dry-needling techniques have been suggested. They note that Botox is not considered a standard treatment option for TMD, while dry-needling, or acupuncture, may be an effective method to reduce tension in some patients. Additionally, initial results regarding extracorporeal shock wave therapy for myogenous TMD appear to show positive results. Authors also note that there has been increasing evidence demonstrating that psychosocial assessment serves as a powerful tool in terms of predicting treatment outcome. For those patients with a significant psychosocial component, counselling seems to be a promising treatment adjunct, which might be most beneficial when included in a multimodal approach. Other conservative treatment options for TMD include stress reduction techniques and diet modification. In the past, a causative relationship between occlusion and TMD had been suggested, but it is now considered an outdated theory not supported by robust evidence, and occlusal adjustment is an irreversible treatment which is no longer supported by the recent literature.

Liu et al. (2021) aimed to use a systematic review and meta-analysis method to understand the efficacy of warm needle acupuncture (WNA) for the treatment of TMD. The meta-analysis included 10 studies with a total of 670 patients, which included 340 patients in the experimental group and 330 patients in the control group. The data in this review showed that WNA is superior to treatments such as acupuncture alone, acupuncture therapy combined with TDP, drug therapy, and ultrasonic therapy in terms of effective rate and cure rate for the treatment of TMD. Authors concluded that this systematic review and meta-analysis provides new evidence for the effectiveness of WNA for the treatment of TMD. However, the above conclusions need to be further verified by multicenter prospective studies of larger samples and higher-quality RCTs.

## PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services.

It is best practice for the practitioner to appropriately render services to a patient only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and expert training, it would be best practice to refer the patient to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

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