Temporomandibular Joint Disorders

Management and Referral Criteria for Primary Care Clinicians

OVERVIEW

Temporomandibular joint disorders (TMJD) are a very common problem which affects over two thirds of people at least once in their lifetime. While the severity of symptoms varies from patient to patient the overwhelming majority of cases are mild and self-limiting and settle with little if any active treatment being required. For most patients it is a nuisance rather than a significant health problem although for patients with more severe symptoms a specific course of treatment may be necessary.

TMJDs may be due to overactivity in the muscles of mastication which may lead to clicking in the jaw joints, face pain, headaches and difficulty opening the mouth (particularly on waking up in the morning), eating hard or chewy foods or opening the mouth wide such as when yawning.

Occasionally, the jaw joints may feel as if they are stuck but actual dislocation of the jaw joint is very rare. It is commonly due to clenching or grinding of the teeth (often during sleep), biting fingernails or chewing pencils etc. These habits frequently happen when patients are overworked, under stress, worried or anxious. Sometimes it is due to an injury to the jaw joints such as from a punch to the jaw, a road accident, surgery (such as tooth extraction or tonsillectomy) or even from a wide yawn or laugh.

Management

The vast majority of patients with TMJDs will settle on conservative treatment and DO NOT require referral to secondary care services.

The Commissioning guide: Temporomandibular Joint Disorders 2014 (Royal College of Surgeons) state that:

- TMJD affects 30% of the population, with the muscular form being the most common.
- First line management in the majority of cases is conservative management which can be provided in primary care. Less than 20% require referral to secondary care
- Approximately 75% of patients will improve over 3-6 months with simple conservative management.

The initial management of patients with TMJD in primary care includes the following measures:

1. Assessment and diagnosis. A careful history should be taken to record the patients' awareness of the symptoms, whether they were of gradual or acute onset and whether there was an initiating event. The examination should be kept in simple sequence with easy recording methods and should include: TMJ examination (range of movement, TMJ tenderness – pre- and intra-auricular, joint sounds), muscle examination (masseter, temporalis and lateral pterygoid), signs of parafunction (scalloping of the lateral border of the tongue, ridging of the buccal mucosa on the inside of the cheeks and abnormal tooth surface loss) and occlusal examination.
2. Explanation of the condition and provision of TMJD patient leaflet (Tempromandibular Joint Disorder Patient Information Leaflet).
3. Reassurance that TMJD is not serious and that it usually responds to simple measures. Symptoms may recur from time to time.
4. Application of heat to the side of the face (eg hot water bottle wrapped in a towel) if the patient has muscle pain. This can be combined to simple massage to the tender muscle areas and relaxation techniques.
5. Advice concerning pain killer. Non-steroidal anti-inflammatory drugs (NSAID eg ibuprofen), are often helpful, unless contraindicated because of the patients' medical history. These should be taken regularly for a two to three week period, not just as necessary (PRN). NSAID gel can be applied topically to the area over the joint or the muscles of mastication (temporalis, masseter).
6. The identification and avoidance of parafunctional habits, such as clenching or grinding (particularly at night), nail-biting, lip/cheek biting and posturing the jaw.
7. Rest for the TMJ, including soft diet, particularly in the acute phase.
8. Acknowledgement that the condition may be related to stress, anxiety or even depression.
9. Provision of a soft occlusal splint, which can be worn at night – this is particularly useful for patients who grind their teeth at night.
10. Know when EARLY referral to secondary care is appropriate (see below).

Additional information

- Radiographic investigations are not usually required, except to rule out other causes of orofacial pain
- Dislocation. When a patient has a dislocation they cannot close their mouth. It is usually caused by excessive mouth opening (such as yawning, biting into a large sandwich, vomiting or during a dental procedure). Dislocation is more likely to occur in people who have had previous dislocations or who have looseness of the jaw (hypermobililty). The patient should be sent to the local emergency department where the jaw is typically maneuvered back into place by hand (manual reduction).
- When referring use the relevant TMJD referral form

Consideration should be given to referring a patient with TMJD to the local Oral and Maxillofacial services if they meet the following criteria:

1. Refractory TMJ dysfunction – defined as dysfunction that has failed to respond to conservative or primary care measures within 3-6 months

2. Progressively worsening limitation of opening (trismus) which is unrelated to surgical intervention or injury. History of closed lock less than 2cms.
3. Patient with an atypical presentation (eg numbness of the face, marked/persistent swelling)
4. Persistent inability to manage a normal diet
5. History of trauma to the TMJ eliciting the symptoms.
6. Pain or reduced jaw function in patients with known rheumatic joint disease
7. Recurrent dislocation of TMJ and/or associated syndromes (e.g. Ehlers-Danlos)
8. Concerns about the primary diagnosis or an uncertain diagnosis. Unexplained persistent pain or chronic widespread pain.
9. Marked psychological distress associated with symptoms and/or occlusal preoccupation (persistent hyperawareness or hypervigilance of their bite).

NB: Patients should not be referred for the provision of an occlusal splint –these can be provided in primary dental care.

All referrals to secondary care for patients with TMJDs must clearly state that the patient has followed the above treatment plan for a minimum of 6 months without improvement or give clear clinical reason for why it was not deemed appropriate. Non-compliant referrals will be returned to the referring practitioner.

References

1. Temporomandibular Disorders (TMDs): an update and management guidance for primary care from the UK Specialist Interest Group in Orofacial Pain and TMDs (USOT) 2013. Faculty of Dental Surgery RCS.
2. Commissioning guide: Temporomandibular joint disorders 2014. Royal College of Surgeons. BAOMS. https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/tmj-commissioning-guide/
3. TMJ disorders, Scenario: management. NICE – last revised Dec 2016. Accessible on https://cks.nice.org.uk/temporomandibular-disorders-tmds. Accessed on November 2017.