Chapter 7

Employing T–Scan Synchronized with Electromyography to Treat Chronic Occluso–Muscle Disorder

Robert B. Kerstein, DMD
Former Clinical Professor at Tufts University School of Dental Medicine, USA & Private Dental Practice Limited to Prosthodontics and Computerized Occlusal Analysis, USA

ABSTRACT

This chapter discusses chronic Occluso-Muscle Disorder, which is a myogenous subset of Temporomandibular Disorder symptoms resultant from occlusally activated muscle hyperactivity. Published T-Scan-based research since 1991 has determined that a significant etiologic component of Occluso-Muscle Disorder is prolonged (in time) occlusal surface friction that occurs between opposing posterior teeth during mandibular excursions. This friction results in prolonged compressions of the Periodontal Ligament fibers of the involved teeth, which triggers excess muscle contractions within the masticatory muscles. This chapter describes the neuroanatomy of how the excursive friction induces masticatory muscle hyperactivity and illustrates the patient occlusal factors that promote prolonged occlusal surface friction. It explains the patient section criteria for determining if an Occluso-Muscle Disorder patient is a candidate for occlusal intervention, details the computer-guided Occluso-Muscle Disorder treatment known as Disclusion Time Reduction, and supports this measured occlusal treatment with the research studies that validate using this highly effective Occluso-Muscle Disorder therapy.

INTRODUCTION

Chronic Occluso-muscle Disorder (Dawson, 1989a) is a myogenous subset of Temporomandibular Disorder symptoms that afflicts the masticatory musculature with chronic pain, headaches and dysfunction. The associated muscle hyperactivity is a primary source of the frequently observed and highly similar group of symptoms that suffering patients commonly describe (Glickman, 1979a; Dawson, 1989a):

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• Chronic facial pain, chronic temporal headaches, frequent clenching and grinding of the teeth, morning jaw pain, eye strain, earaches, chewing fatigue, chewing muscle and tooth pain, temperature sensitive teeth, and mild clicking and popping of the Temporomandibular Joints.

Muscle hyperactivity etiologies previously cited within the literature are Bruxism (Clayton, Kotowicz, & Zahler, 1971; Dawson, 1989b), clenching habits (Bertram, Rudisch, Bodner, & Emshoff, 2002), malocclusion (Mohlin, et. al., 2004), Trigeminal Neuralgia (Zakrzewska & McMillan, 2011), and occlusal interferences (Glickman, 1979b; Baba, Yugami, Yaka, & Ai, 2001).

Longstanding advocated treatments for chronic masticatory muscle hyperactivity have attempted to treat the symptomatology (Herman, Schiffman, Look, & Rindal, 2002) without addressing an underlying non-physiologic occlusal surface friction problem, that has been shown to be etiologic for the hyperactivity (Williamson and Lundquist 1983; Kerstein & Wight, 1991; Kerstein, 1995; Kerstein, Chapman, & Klein, 1997; Kerstein & Radke 2006; Kerstein & Radke, 2012). Despite the number of studies that have demonstrated an occlusal surface friction/masticatory muscle hyperactivity relationship to symptom appearance and frequency, an occlusal etiology as being causative for chronic Occluso-muscle Disorder symptoms, has not yet been widely accepted within the differing disciplines of Dental Medicine. In the traditional approaches to treating Occluso-muscle Disorder symptoms, the occlusion has been considered a limited component of the etiology, in favor of emotional and psychological factors, where it has been suggested that treatments be reversible and non-invasive to the teeth and oral structures.

Appliance therapy (Bertram, Rudisch, Bodner, & Emshoff, 2002) is the most frequently employed treatment. The main effects an intraoral appliance creates that can improve Occluso-muscle Disorder symptomatology are:

• The appliance interferes with the function of the teeth by limiting frequent tooth interdigation and fictional occlusal surface excursive contact that occurs during parafunction and swallowing. This buffers the physiologic occlusal friction problem that is etiologic for the hyperactivity, by not letting teeth frictionally engage when the appliance is in place

• The appliance opens the vertical dimension, repositions the mandible in a chosen new anteroposterior and mediolateral position, and unloads the Temporomandibular Joint structures by moving the condyle vertically down and slightly out of the glenoid fossa.

Appliance therapy is often combined with muscle relaxant, pain, and anti-inflammatory medications, physical therapy to the jaw musculature (McNeely, Armijo, Olivo, & Magee, 2006), trans-cutaneous electronic nerve stimulation (TENS) (Alvarez-Arenal, Junquera, Fernandez, Gonzalez, & Olay, 2002), and soft food diets. All of these treatment approaches have been reported to be somewhat helpful to the chronic Occluso-muscle Disorder patient, and are considered viable, reversible Occluso-muscle Disorder treatments. Occlusal adjustment procedures, if employed at all in the conventional treatment protocol, follow the Appliance Therapy treatment phase, because the appliance has been considered to be a reversible therapy (Okeson, 1985a; Solow, 2011).

Occlusion’s potential etiologic role has been minimized, likely because unmeasured occlusal adjustment procedures in studies have shown limited effectiveness in treating Occluso-muscle Disorder symptoms (Goodman, Greene, & Laskin, 1976; Forssell, Kirveskari, & Kangasniemi, 1986; Wenneberg, Nyström, & Carlsson, 1988; Tsolka, Morris, & Preiskel, 1992). A 1984 review article analyzing studies involving occlusal disharmonies, CR-CO coincidence, non-working side interferences, maximum intercuspation of teeth, occlusal