

It's Time ADA, Come on Along (An open letter to the American Dental Association)

"Why wouldn't my dentist know that my jaw joint was going bad?" asks the all too often, perplexed dental patient. "Dental schools don't have enough time to teach about the TMJ in an already crowded curriculum further stressed with new and improved materials and techniques in most disciplines of dentistry. They just don't have any additional time," I alibi. I'm getting tired of making excuses for the American Dental Association (ADA) and dental schools when the honest truth is that they are just indifferent.

How can you continue to ignore the dysfunctional temporomandibular joint while allowing dental students to place restorations on patients' teeth that are attached to an unhealthy jaw? Shouldn't the first step be to decide whether or not the main controlling joint is in a stable condition? Why continue to place good dental work on jaws that are destined to cause the patient more pain and problems?

Thirty years ago, when most of us were just learning about internal derangements, it was understandable that patients couldn't find a good TMJ dentist in their immediate area. Now it's embarrassing that more "good dentists" aren't diagnosing early onset temporomandibular joint problems. The periodontists have done a fine job of getting all dentists and dental hygienists to probe around in their patients' mouths for five mm pockets. It takes a lot less time to place your two fingers over the patients' right and left TMJs and feel for popping, clicking, and locking. This followed by a few well-placed questions should help the practitioner uncover a TM joint problem in the unsuspecting patient who is complaining of headaches.

I am not the only one who has asked these questions. I learned from many mentors who were knowledgeable long before I would discover their truths for myself. A few of my mentors were: Weldon Bell, L.D. Pankey, Parker Mahan, Bill Farrar, Robert Ricketts, Clyde Wilkes, Harold Gelb, Peter Dawson, Peter Neff, Mariano Rocabado, Jack Haden, Janet Travell, and the list goes on.

Why then has it taken so long to implement these known concepts into the normal dental curriculum? Some would say, "a lack of published information." In response to that, I would point out the 110 issues of *CRANIO: The Journal of Craniomandibular Practice*, as well as the *Journal of Orofacial Pain*, and other scientific journals whose manuscripts have and still are validating the basic concepts over and over again. Also, just this past year (2009), two new excellent resources have been published. One is a book by Clifton Simmons entitled, "Craniofacial Pain: A Handbook for Assessment, Diagnosis and Management" with 17 clinically practicing contributors.¹ The other is a book by Noshir Mehta entitled, "Head, Face, and Neck Pain - Science, Evaluation, and Management: An Interdisciplinary approach." It has 37 chapters, 722 pages and some 59 astute contributors.² I point out these two books to show evidence of the maturity of this field.

What if you, ADA, choose not to accept these 30 plus years of labor and knowledge that have been prepared on your behalf to advance the profession of dentistry through better service to our patients? Who will assume the leadership—possibly medical orthopedics, ENT, osteopathic medicine, or even the chiropractic field? This information has been accomplished and undergirded with documentation for you. It's been a long time since ADA President Robert H. Griffiths held "The President's Conference on the Examination, Diagnosis, and Management of Temporomandibular Disorders" in Chicago in 1982. You need to show current involvement in this important area of development.

You did a good job selecting Oral Maxillofacial Radiology as your 9th specialty area—what about now acknowledging TMD as well? *It's time ADA, come on along.*

Gordon Christensen said in *Dentistry Today* (February 2000), "The three major diseases we treat are caries, periodontal disease, and occlusion. Occlusion remains the major untreated disease in dentistry today."³ I personally would modify *occlusion disease* to include

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all TMJ, head, and neck pain. There are now sufficient Cone Beam C.T. units either in the offices of TMD practitioners or just down the street to provide an upgraded diagnosis of maxillofacial tumors, cervical calcifications, which could lead to carotid artery disease, unrecognized temporomandibular osteoarthritis, and/or developmental jaw malformations. Haven't you been preaching for the last few years how dentistry should lead in medically relevant health issues of the head and neck? *It's time ADA, come on along.*

Your appointment of Kathleen O'Loughlin as executive director is refreshing. However, for decades, your male-dominated boards have understood that TMD is a women's problem. The most accepted office percentage is 85% female to 15% male ratio.⁴ Little, if anything, has been done to advance women's health. Hopefully, there will be a more appropriate, apolitical consideration given this issue, in both your supported research and endorsed policy. *It's time ADA, come on along.*

Surely by now, ADA, you are familiar with the Shimshak studies that were published in *CRANIO* in 1997 and 1998.^{5,6} You should be, because I discussed the findings over the years with several members of your executive board. The study shows that out of 692,707 Blue Cross Blue Shield members, 1097 matched exactly on all four criteria (age, sex, relationship, and employer group).

They were divided into two categories: a. patients with a TMJ diagnosis (TMJ population) and b. patients without a TMJ diagnosis (non-TMJ population). Over a two-year period, the amount paid out for the non-TMJ population was \$5,406,835 while the amount paid out for the TMJ population was \$10,814,535 or almost exactly twice as much and required only a diagnosis. It did not follow up on case completions or finalized treatment results. It does, however, clearly show the impact on the patient's health, involving treatment in other medical fields, such as the digestive system and musculoskeletal system, etc. Pregnancy was the only medical claim that was the reverse (or diminished). Apparently, if most TMD patients have headaches, then fewer pregnancies will result. These numbers show the significance of a TMD diagnosis. The patients, diagnosed and treated earlier, would become healthy sooner,⁷ thus using fewer insurance dollars and saving insurance companies money. Delayed care, conversely, leads to chronic cases that are less amenable to early inexpensive intervention. The results of inadequate TMD treatment lead to higher medical expenses; the numbers don't lie. *It's time ADA, come on along.*

Now that Congress and President Obama have passed and signed health care changes, there is still the need for reason and logic to prevail. Why not show the American

Table 2
Distribution of Total Claim Payments by Type of Claim

Type of Claim	TMJ Population		Non-TMJ Population		Matched Pair Differences	
	Amount Paid	Mean	Amount Paid	Mean	Mean	P
Blue Cross	\$ 5,900,247	\$3,244	\$3,076,712	\$1,691	\$1,553	<.0001
Blue Shield	3,926,973	2,159	1,826,381	1,004	1,155	<.0001
Extended Benefits	151,587	83	55,846	31	52	.0042
Pharmacy	835,728	459	447,896	246	213	<.0001
Total	\$10,814,535	\$5,945	\$5,406,835	\$2,972	\$2,973	<.0001

NOTE: Table 2 is reprinted from the *Journal of Craniomandibular Practice*, 1997; 15(2):153 (Shimshak DG, et al.).

Table 4
Distribution of Blue Cross Inpatient Claims by ICD-9-CM Major Diagnostic Categories (MDC)

Major Diagnostic Categories (MDC)	TMJ Population			Non-TMJ Population		
	Number of Admissions	Number of Hospital Days	Amount Paid	Number of Admissions	Number of Hospital Days	Amount Paid
Infective, Parasitic	15	33	\$ 36,944	7	21	\$ 19,668
Neoplasm	26	138	309,940	28	222	236,221
Endocrine, Nutrition	8	47	44,192	3	25	28,681
Blood	4	20	19,528	2	25	14,142
Mental Disorders	72	1,500	728,479	33	597	306,178
Nervous System	25	83	89,793	10	56	36,898
Circulatory System	61	262	444,453	29	166	273,103
Respiratory System	36	75	77,582	18	56	47,667
Digestive System	87	508	790,404	30	175	247,318
Genitourinary System	44	160	192,106	30	93	102,252
Pregnancy	76	213	213,417	109	322	359,163
Skin	5	21	17,552	3	15	9,312
Musculo-skeletal	36	174	237,328	18	74	84,523
Congenital Anomalies	4	7	6,657	1	2	3,913
Conditions of Newborn	1	7	2,580	0	0	0
Signs, Symptoms	38	324	301,905	21	123	89,355
Injuries, Accidents	60	221	192,827	25	90	81,795
Total*	598	3,796	\$3,705,737*	367	2,062	\$1,940,269*

*Blue Cross outpatient claims are not included in this table, resulting in a difference between the total amounts reported in Tables 2 and 4.

NOTE: Table 4 is reprinted from the *Journal of Craniomandibular Practice*, 1997; 15(2):154 (Shimshak DG, et al.).

public how an early diagnosis and treatment of TMJ problems could save 25-50% in medical care costs involving a TMD diagnosis? This estimate doesn't even include time lost from work. One source states that facial pain conditions alone cost approximately \$1.9 billion per year, and the quality of life costs for the facial pain patient are often incalculable.² A Swedish six-year study emphasized the benefit of TMJ treatment in reduced costs to society of days of sick leave are more than five times the treatment costs for the patients.⁸

The field of TMJ associations has unified under The American Alliance of TMD Organizations⁹ (an alliance of TMD organizations, Chris Brown, Chairman, Versailles, IN). The *Alliance* is comprised of ten groups representing over 16,000 practitioners. The member

organizations represent most of the major TMJ practitioners. Their bylaws allow support for various projects and positions that a majority of the groups accept. This is a positive example of the TMD field solidifying its leadership.

Like a good general who sends his scouts out first to assess the situation, we have been doing this for you for years. Now it has been done ADA; the field is scouted, and victory is assured. *It's time ADA, come on along.*

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References

1. Simmons HC, ed.: *Craniofacial pain: a handbook for assessment, diagnosis and management*. Chattanooga, TN: Chroma, 2009.

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2. Mehta NR, Maloney GE, Bana DS, Scrivani SN, eds.: *Head, face, and neck pain: science, evaluation, and management*. Hoboken, NJ: Wiley-Blackwell, 2009.
3. Christensen G: The future of dentistry. *Dentistry Today* 2000; 66(2):39-41.
4. Lunn RH. Should TMD be a woman's issue? *J Craniomandib Pract* 1995; 13(3):142.
5. Shimshak DG, Kent RL, DeFuria M: Medical claims profiles of subjects with temporomandibular joint disorders. *J Craniomandib Pract* 1997; 15(2):150-158.
6. Shimshak DG, DeFuria M: Health care utilization by patients with temporomandibular joint disorders. *J Craniomandib Pract* 1998; 16(3):185.
7. Simmons HC, Gibbs SJ: Anterior repositioning appliance therapy for TMJ disorders: specific symptoms relieved and relationship to disk status on MRI. 2005; *J Craniomandib Pract* 23(2):89.
8. Bjorne, A, Agerberg, G: Reduction in sick leave and costs to society of patients with Meniere's Disease after treatment of temporomandibular and cervical spine disorders: a controlled six-year cost benefit study. *J Craniomandib Pract* 2003 21(2): 143.
9. The American Alliance of TMD Organizations:
 American Academy of Craniofacial Pain
 American Academy of Pain Management
 American College of Prosthodontics
 American Equilibration Society
 International Association of Comprehensive Aesthetics
 International Association for Orthodontics
 International College of Cranio-Mandibular Orthopedics
 Pennsylvania Craniomandibular Society
 Sacro Occipital Technique Organization,
 Tennessee C.R.A.N.I.O.