[IMAGE]

Dynamic Chiropractic – August 29, 1990, Vol. 08, Issue 18

Chiropractic, Dentistry, and Cervical Adjustment

By Darryl Curl

Pamela G. Latimer, D.C., writes asking, "Would you comment on how cervical adjustments can affect temporomandibular (TMJ) treatments after a mouthpiece has been made. I think the cervical adjustment should be done first and then the mouthpiece; getting cooperation from the dentist can be difficult at times."

Dr. Latimer's question (and observation) is an excellent one so let's develop an answer for her.

Let's begin by commenting on your observation that the cooperation between the dentist and the chiropractor can be difficult at times. One point I try to make in the TM seminar is that cooperation between professions is dependent upon effective communication. Communication, in turn, is dependent upon the use of common terminology, descriptions of treatment models, and education.

Since her letter did not give us much to go on regarding her ability to communicate with her dental colleagues, let us assume she understands terms such as mandibular rest position, intercuspal position, joint systems of the skull, etc. Let us also assume she is able to effectively communicate to the dentist the chiropractic model for head pain.

Timing of Chiropractic Therapy

This, then, will allow us to focus our attention on the timing of chiropractic therapy when a dentist is contemplating placing an oral orthotic for a patient. Should attention be given to the cervical spine before or after the orthotic is placed? Or both?

First, and foremost, one must understand that the specific diagnosis of a given patient's TM disorder dictates whether or not there is a need to address the cervical spine prior to the placement of an oral orthotic. For instance, suppose the orthotic is placed to stabilize the temporomandibular joint for a few days to allow for proper recovery from an acute disc dislocation. Here, cervical adjustment is not required before its placement.

Suppose, on the other hand, that the orthotic is being placed to stabilize the muscles of the mandible so that the dentist can further evaluate the dental occlusal status. Here, we can develop an excellent rationale for cervical adjustment or other therapy to precede the placement of the orthotic. The basis for this discussion will rely on our knowledge of the role of head posture and its relationship to mandibular posture.

Dr. Latimer can refer the diffident dentist needing to know more about head posture to various references in the literature. For instance, she can direct the dentist to the article that appeared in Cranio in October of 1989, titled "The Sliding Cranium Theory." She can also refer to an article I wrote in Dynamic Chiropractic in the early part of 1988, wherein I discussed "Compensatory Head Posture."

The DC Is Often Placed First in the Co-Treating of Head Pain

One objective a dentist may have in mind when placing an oral orthotic is to remove the dental factors which may be contributing to the patient's head-pain complaint. While this procedure may sound simple, it really isn't. Unless the orthotic is ideally constructed, the orthotic itself may contribute or exacerbate the patient's head-pain complaint. Research and clinical studies continually report that the success of placing an orthotic can be enhanced when factors affecting head posture or cervical function are addressed first.

Why? Ultimately the answer lies in understanding the process the dentist must go through to construct the orthotic. Ironically, the dentist can follow the process to near perfection, only to find the orthotic makes the patient feel worse or no better than before. How can this happen?

I often make the analogy where a patient presents with back pain and is in an antalgic posture. The analogy continues by saying that the clinician has learned foot orthotics helps relieve patients from back pain. So, true to his or her training, the molds are taken while the patient is antalgic, thus beginning the fabrication of the orthotic. The patient returns in a few days and the orthotic is delivered. However, at this time the patient is not as antalgic as before.

What do we expect to happen? We expect the patient to return to the office complaining that the orthotic is either making them worse or is not helping to relieve the back pain. Why? The orthotic should have been made after the patient was out of the acute state of his problem. In other words, therapy to the back should have preceded the placement of the orthotic.

Very often patients with head pain present in an "antalgic" posture which may be overlooked by the dentist. Hence, the orthotic will be constructed to the specifications of this temporary posture. It would be much wiser to begin fabricating the orthotic after the functions of the cervical spine and cranium are brought closer to normal. This suggests then, that cervical manipulation and other needed therapy be provided first in a manner that better prepares the patient to receive the orthotic.

Conclusion

The bottom line that Dr. Latimer can draw here in her work will make the task of the dentist much easier. This should be sufficient motivation for the dentist to develop a closer working relationship with her office.

With each article I encourage you to write the questions you may have, or thoughts to share with your colleagues, to me:

Darryl Curl, D.D.S., D.C.
2330 Golden West Lane
Norco, California 91760

Please enclose your return addressed, stamped envelope.

Editor's Note:

Dr. curl will be teaching MPI's Temporomandibular ("TMJ") seminar on September 15-16, 1990, in Minneapolis, Minnesota. You may register by dialing 1-800-327-2289.

■