A Collaborative Approach to Sleep/Airway Disorders

Richard Klein
Welcome to the Greater New York Dental Meeting

Greater New York Dental Meeting™
Executive Headquarters
200 West 41st Street, Ste. 1101, New York, NY 10036
Tel. (212) 398-6922, Fax. (212) 398-6934
E-mail: victoria@gnydm.com
www.gnydm.com
Sponsored by New York County & Second District Dental Societies

All programs and exhibits are held at the Jacob K. Javits Convention Center (unless otherwise indicated)
11th Avenue between 34th and 39th Street, New York City

General Registration Hours
Friday, November 29          12:00 Noon - 4:30 P.M.
Saturday, November 30         8:00 A.M. - 4:30 P.M.
Sunday, December 1 - Tuesday, December 3  8:00 A.M. - 5:30 P.M.
Wednesday, December 4         8:00 A.M. - 4:30 P.M.

Exhibit Hall Hours
Sunday, December 1 - Tuesday, December 3
9:30 A.M. - 5:30 P.M.
Wednesday, December 4 - 9:30 A.M. - 5:00 P.M.

COURSE REGISTRATION
Pre-registration is required for all continuing education courses with the exception of the “Live” Dentistry and Affiliated Groups. Your seat will be held for 15 minutes after the start of the course; after that, those without tickets will be seated according to space availability. When the room is filled, no additional people will be admitted due to fire department regulations.
If you have not pre-registered, please be prepared to select an alternate session to attend.

Tickets
Tickets are required for all courses excluding Live Dentistry. Tickets for all functions can be purchased at all general registration booths located in the Registration Area on the Upper Level in the Crystal Palace and online.

6 Days of Education Seminars, Hands-on Workshops & Essays
Friday - Wednesday

4 Days of Exhibits
Sunday - Wednesday

FREE “Live” Dentistry
Hi-Tech 450 Seat Arena

SUNDAY
9:45 - 11:45
VOCO America, Inc.
Drs. Ron Kaminer &
Marc Geissberger
Restorative

9:45 - 11:45
Shofu
Dr. Ron Kaminer
Restorative

12:00 Noon - 2:45
VOCO America, Inc.
Drs. Ron Kaminer &
Marc Geissberger
Restorative

First Fit
Drs. Frederick E. Solomon
Cyrus Tahmasebi
Digital

3Shape
Dr. Sundeep Rawal
Digital

MONDAY
1:30 - 2:45
Align I Invisalign I Itero
Drs. Karla Soto &
Christian Coachman
Restorative

TUESDAY
9:45 - 12:00
Millennium
Dr. Sunil D. Thanik
Laser

2:00 - 4:15
Glidewell
Dr. Justin Chi
Digital

WEDNESDAY
9:45 - 12:00
Apa / CareCredit
Drs. Michael Apa
Aesthetic

2:00 - 4:15
Benco / Vatech
Dr. Aeklavya Panjali
Implant

Celebrity Luncheon Speaker
John Quiñones
Monday, December 2nd
12:00 - 2:00 - Ticket 4010
$125.00

3D Printing & Digital Dentistry Conference
Dental Laboratory Technicians Programs
Sleep Apnea Symposium
Oral Cancer Symposium

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Richard Klein, D.D.S.

The Foundation for Airway Health Presents Airway Summit 2019: A Collaborative Approach to Sleep/Airway Disorders

11/30/19
Original Contributions: full article

Controlling TMD Enhances Cognitive and Emotional Responsiveness

Richard Klein, D.D.S. and Barbara C. Fisher, Ph.D.,CBSM

Abstract

There has been extensive research into neural mechanisms that motivate cognitive function. All individuals experience pain differently, meaning chronic pain can be felt, but lack a scientific explanation exists. This creates difficulties in calculations, as everyone undergoes a different experience. How can we better understand the link between pain and cognition? What is the stress level involved as it correlates to the fear of the unknown? Craniofacial pain is measurably different from pain in the rest of the body, both intellectually and subjectively. Typically, people assess head, neck and facial pain as the most severe and emotionally demanding. Incidentally, facial pain leads to an increased stimulation of the amygdala – the brain's fear center. Research in cognitive neuroscience and affective disorders has provided some findings on the link between cognitive influences and emotional connections. Dentists, for example, are aware of negative emotional and cognitive changes in patients. Over time, with proper treatment, TMD symptoms are ameliorated. Patients who are experiencing chronic TMD pain are also experiencing chronic pain throughout other parts of their body. This pain affects brain activity and function.

Background

While previous studies have focused on cognitive improvement over time, they have not necessarily focused on mood changes. The goal of this study was to address pain relief, in particular the immediate response of pain relief.

Methods

The focus of this study was 25 chronic TMD patients suffering from craniofacial pain. Trigger point injections were given to alleviate this pain, after a neurocognitive assessment was completed. Patients were then given the Epworth Daytime Sleepiness Scale, Beck Depression Inventory (BDI), and a measure of memory (Three Words Three Shape Test) and processing speed (Symbol Search from the WAIS III) test. This was performed on a voluntary basis.
Results

Out of 25 participants, 4.2% reported a pain ranking of 1 (on a scale of 0 to 3), 37.5% reported a pain ranking of 2, and 58.3% reported a pain ranking of 3. In regards to the origin of pain, 75% reported that trauma was the origin, 16.7% reported that stress was the origin, and 8% reported that the origin was anatomical in nature.

Conclusions

This study has shown that you have a higher chance of immediate increase in cognitive function in terms of processing speed, however memory is not as receptive to immediate change. Craniofacial muscles are therefore less tense.

Practical Implications

Can there be an immediate improvement in brain function when pain is eliminated? Dentists who are experts in treating TMD are proving to revert negative cognitive and emotional changes when TMD symptoms dissipate.

Key Words

Keywords: chronic pain, cognitive response, emotional response, memory disturbance, pain perception, psychological distress, cognitive improvement, pain relief, development, cognitive interaction, neurocognitive reaction
In my handouts for my TED like talk, I have enclosed information that takes up about 5% of my speaking time. It will briefly document the causality of multiple TMD signs and symptoms (the Great Imposter).

The majority of the few minutes I have with you will discuss the problems patients can have with chronic pain. I understand significantly more than I did decades ago prior to a Motor Vehicle Accident that changed my career and my life.

The handouts include information that I am very willing to share and, if you are interested, I am willing to converse with you regarding them. My email address is tmjsleepdr@michiganheadandneck.com
The following compendium is of the medical signs or symptoms of TMD that Dr. Richard Klein did not learn in dental school, but rather teaches at MSU Osteopathic Medical School, listed with casual explanation of relation to TMD.

**Blurred vision, pain behind the eyes, photophobia** — The sphenomandibularis muscle attaches to the inside of the mandible and to the greater wing of the ethmoid plate of the sphenoid bone. This smaller bone is behind the eye and when torqued by the tightened muscle can cause these eye symptoms. A trigger point in the trapezius muscle can refer pain directly above the eye on the ipsilateral side.

**Lacrimation** — Excessive tearing without emotional crying can easily happen when tight muscles pull and open the tear duct. Darwin was the curious observer not only of other species on Earth and the Galapagos, but was a curious observer of human kind. He hired a photographer to take pictures of 50 children crying. He noticed the common denominator was scrunched up tight muscles around the eye when they cried.

**Otalgie** — Ear pain is very commonly reported when the masseter has a trigger point in its zygomatic fibers. This trigger point refers pain deep into the ear.

**Dizziness** — The symptom relates to temporomandibular disorder since the tensor veli palatini muscle can constrict the eustachian tube and cause dizziness or balance problems.

**Hearing Loss** — The tensor tympani muscle functions to dampen sounds as it tugs on the eardrum to protect it from loud sounds. If it stays foreshortened due to TMD, then the person’s ability to hear is affected. Such can be seen in having muffled hearing for several days after hearing Bob Seger 5 nights in a row at Pine Knob in the 1970’s with good seats.

**Ear Congestion** — The tensor veli palatini muscle when in spasm can mimic the effects of swelling or inflammation on the eustachian tube, affecting its opening and closing and causing a feeling of stuffiness.

**Tinnitus or Buzzing of the Ears** — The anterior malleolar ligament repositioning the malleus bone in the ear can cause the symptom. This ligament traverses the petro tympanic fissure (a small tunnel in the bone between the ear and the TM joint) connecting to the bone and the disc. When tense, the ear noises can result.

**Dysphagia** — The symptom is a possible TMD symptom since the anterior digastric when tight will foreshorten and pull on the hyoid bone, which it surrounds as it attaches to the posterior digastric.
Why is TMD called the Great Imposter

by Richard E. Klein, DDS

Psychiatrists might evaluate a depressed person by evaluating for a hypoglycemia, diet or obstructive sleep apnea, etc. Also, when hip problems surface, the physician will evaluate a short leg discrepancy, as well as their patient’s lifestyle, along with many other considerations as to why they are there with their complaints. Physicians evaluate knee problems by watching a person’s gait or looking for foot pronation, and a multitude of many other observations. They look at anatomy that is distant to where the patient is complaining.

The TM joint is a joint. Any physiatrist might treat joints with injections, pressure relief, recommend alterations in activities of daily living and lifestyle, utilize pharmaceuticals, physical therapy and/or physical medicine techniques. The TM joints, acute or chronic, should be treated, as any joint in the body would be by a physiatrist or pain management specialist. Orthotics is sometimes and generally necessary, but not always. When there is a diagnosis of temporomandibular disorder, its causality is not always malocclusion or a recent injury. The symptoms may simply be the result of muscle-guarding tenseness in areas related to the craniomandibular complex that are not eliciting pain in the usual areas. For example, most temporomandibular joint dysfunctions include popping or clicking, jaw pain or headaches. However, these symptoms do not have to be present when TMD is a problem, just as physiatrists understand for other joints in the body.

I learned this back in the 1970s: An eight-year-old girl came to my office as a new patient. Her health history form documented that she had slowly lost her hearing in her left ear. No other symptoms indicated that she had a TMJ problem since she could chew; she didn’t hurt, she didn’t have pain in her face or her jaw and she didn’t click. Her Otolaryngologist was perplexed. Her previous dentist had extracted a deciduous molar. This resulted in the opposing dentition to naturally extrude, so this girl basically was biting with malocclusion. I did as any dentist would, I placed a space maintainer with an occlusal metal attachment to hold the upper tooth from extruding again and I equilibrated the maxillary tooth. A month later she and her parents came back with a cake and thanked me for bringing her hearing back. I thanked them for the cake and told them I had no idea what happened, but would look it up. Medical ENT textbooks basically said the ear and the TM joint both are initially formed in the fetus from Meckel’s cartilage. It then, less informatively, stated that the ear and the TM joint have confusing symptoms since they are so closely anatomically related. Well that didn’t help much, but I was still happy for my patient even though I did not know why.

Today some insurance adjusters are not aware of the advances in TMD research and routinely deny payments for TMD unless the “jaw is stuck or hurts”.

Well, we now know that the tensor tympani muscle protects the tympanic membrane. Its purpose is to protect the eardrum when loud noises are present that could damage the eardrum. The eight-year-old girl had a temporomandibular joint problem without tenderness or pain. Her symptom of loss of hearing was the only overt sign. Over the years I’ve seen many patients that have had blurred vision without jaw pain.
and lacrimation without TMJ clicking, retro-orbital pain without jaw tenderness, ear congestion without any other TMD sign or symptom, who subsequent to treatment for TMJ, experienced amelioration of the eye or ear problems. TMD does not necessarily always have to be accompanied by jaw pain, headaches or clicking.

Dysphagia can occur if the anterior digastric muscles tense and torque the hyoid bone. A small amount of Marcaine injected to the ligamentous attachment of the muscle on either side of the symphysis of the chin can help them chew and swallow. Common ear complaints related to TMD are ear congestion, dizziness, hyperacusis, otalgia, and pain around the ear. Eye problems caused from TMD are intermittent blurred or double vision, lacrimation, retro-orbital pain caused by a foreshortened sphenomandibularis muscle, pain above the eye referred from the trapezius, and swelling below the eye.

This woman had 24/7 constant ear pain for three years. Multiple doctors had told her. “Sorry honey your accident hurt your ear and there is nothing we can do. I placed Marcaine into the zygomatic fibers of the Masseter and her Otalgia was absent within a minute. This was 1988, TMD treatment has come a long way since then.

Janet Travell knew this many years ago. She was President Kennedy's physician and she mapped every muscle in the human body and documented that trigger points in any muscle could refer symptoms, pain or dysfunction to other areas. Sixty years later, no one has improved on her original anatomical maps. I was fortunate enough to study under her in the 1980s while she was 88, in a wheelchair, and still teaching.

The statements made here are not my personal feelings. They are all statements of fact based on, not my opinion and my experience, but they are gathered from peer-reviewed journal articles or textbooks. I use them when teaching medical students at Michigan State Osteopathic Medical School and the residents at Henry Ford and St. John Hospitals. Physicians understand this concept - dysfunction does not have to be accompanied by pain and pain can initiate from a distance away from where the pain is actually felt.

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Keep State Informed about Patient Records

Here's a reminder -- if you retire or move and close your current office, you are required to notify the state about the move and where your patient records are stored.

Michigan’s Public Health Code mandates that dental treatment records be kept at least 10 years after the performance of the last service performed upon the patient. Medicaid records must be kept for six years.

Complete information on dental record-keeping, storage, and disposal is available on the MDA website. Visit www.smilemichigan.com/pro and click on “Professional Topics,” “Legal Services” and “Dental Records.” If you have additional questions, contact the MDA's Grace DeShaw-Wilner at 517-346-9413.