Letter

Dear Editors,

I really enjoyed reading this paper *[J Oral Facial Pain Headache 2018;32:198–207. doi: 10.11607/ofph.1457]* and agree there is a place for using arthrocentesis early in treatment. However, I am concerned about a few areas that were not addressed:

1. The text was confusing regarding when splint therapy was initiated in the usual care group (page 200). My interpretation was that it was begun after 6 weeks of rest and physical therapy (etc), but the paper states that the conservative treatment (which included splints) took 6 weeks in total. How could the splint treatment be evaluated if it was not started until after 6 weeks, but conservative treatment was only for 6 weeks total, including splints? Did you mean to say that splint therapy was after the nonsplint conservative therapy, and therefore conservative plus splints lasted 22 weeks?
2. "Joint pain" is not a diagnosis, and arthrocentesis may be more effective than splints only in patients with anterior disc displacement without reduction. I feel that joint pain is too broad a category for this study and specific diagnostic categories should have been used, especially regarding disc disorders and osteoarthritis. Impaired range of motion with pain would have been appropriate as well.
3. If splint therapy was utilized in a group from day 1, this may have changed the data. Delaying the use of splints is a significant factor.
4. Long-term costs must be evaluated since usual care and long-term use of splints at night may prevent the recurrence of symptoms (as this addresses the causation of the joint pain) and arthrocentesis only treats the symptoms.

This last item is the most significant problem I have with the paper, since arthrocentesis does not address the underlying causation and the joint pain is likely to return.

Sincerely,

Joseph R. Cohen, DDS
Past President, American Academy of Orofacial Pain
Past President, American Board of Orofacial Pain

Response

Dear Dr Cohen,

In response to your comments:

1. With regard to the timing of splint therapy, this was applied after 2 weeks of soft diet, but only if the pain did not decrease and the most prominent symptom was indeed pain and not restricted mouth opening. This is described in Fig 2. Unfortunately, a correction has to be made with regard to Fig 2: Under "Determination of most prominent symptom" is stated "no pain," but this should be "pain."
2. Patients were diagnosed using the revised Research Diagnostic Criteria for Temporomandibular Disorders. Disappearance of pain following intra-articular anesthesia confirmed intra-articular pathology; therefore, it makes sense to apply a treatment modality that addresses the intra-articular pathologic process.
3. Because delaying the use of a splint may be a significant factor in the course of the disease, this delay was minimized to 2 weeks.
4. Cost analysis was conducted from a societal perspective for a period of 1 year postoperative. Furthermore, there is no evidence that splint therapy addresses the causation of the joint pain. On the contrary, arthrocentesis, or joint lavage, directly removes degradation products from the joint cavity and also eliminates inflammatory mediators (page 199).
5. We are currently analyzing the 5-year results. We hope these results will provide some insight into whether the pain is likely to return or not.

On behalf of my co-authors,

Sincerely,

Lukas M. Vos, MD, DMD, PhD

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