Critical Commentary 3

Reliability and Validity of the DC/TMD Axis I

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First of all, we would like to thank our esteemed colleagues Drs Steenks, Türp, and de Wijer for their thoughtful Focus Article[1] related to the Diagnostic Criteria for Temporomandibular Disorders (DC/TMD).[2] In a way, it is almost déjà vu, as Drs Steenks and de Wijer already in 2009[3] aired their concerns about the Research Diagnostic Criteria for Temporomandibular Disorders (RDC/TMD),[4] which in essence would have been one of the many factors leading to the publication of the DC/TMD.[5] Steenks et al now raise a number of new critical comments that no doubt will be valuable to consider in the next revision of the DC/TMD.

Consensus is, unfortunately, difficult to obtain among researchers and clinicians, and the history of TMD clearly shows that many different definitions, preferred clinical methods, and conceptual frameworks have been used in the past. However, in order to boil down the concerns and disappointments with the DC/TMD as expressed in the Focus Article, you could say that the single most important problem stated would be its premature implementation in clinical practice. We will focus our comments on this concern.

We will certainly agree that the DC/TMD is not the perfect tool for classification of all TMD or orofacial pains; in fact, the unusual step was taken to write a Letter to the Editor in response to its publication, although the authors of that Letter were all co-authors and contributors to the DC/TMD.[6] Other constructive suggestions for future improvements of the DC/TMD have also been published.[7] There are still less-than-perfect components in the DC/TMD—for instance, some inconsistencies in referred pain on palpation from jaw muscles and joints, and lack of sensitivity and specificity values for a few of the included muscle pain diagnoses.[6] Also, as stated in the Focus Article,[1] the fact that muscle palpation does not take into account muscle texture or other muscle symptoms may deserve more attention. Nevertheless, the DC/TMD builds on the same principles as the RDC/TMD, with simple yet rigorous and operationalized criteria for clinical examination paired with a structured and integrated interview. The ground rules for a DC/TMD diagnosis (ie, history, clinical examination, and additional examination only if needed) are clearly laid out with detailed descriptions and ample supplementary information. Obviously, the DC/TMD is still not intended to be a standalone tool for diagnosis of all orofacial pain complaints, for which we need a comprehensive classification both in research and clinical practice. Indeed, efforts are ongoing to start the development of a DC/orofacial pain and an International Classification of Orofacial Pain Disorders. This work is being undertaken by a task force of the International Association for the Study of Pain and will put primary and secondary chronic orofacial pain conditions into a larger and more comprehensive classification system for all types of chronic pain.[8] Perhaps this is an ambitious enterprise, but it is badly needed because TMD and orofacial pain must be recognized and identified by the entire pain field as well as by other health care providers. We believe most clinicians dealing with orofacial pain conditions, even on an infrequent basis, will realize that painful TMD only represents a subset of other possible orofacial pain problems that, again, may be subsets of other chronic pain problems, such as chronic primary pains or chronic musculoskeletal pains, that would need to be ruled in or out. If you do not realize this, you will for sure

doi: 10.11607/ofph.2018.1.cc3

be in trouble in the clinic. Nonetheless, we are optimistic and believe that through systematic dissemination and teaching efforts, this important message will not be lost. Recently, there has also been increased awareness of the potential overlaps and distinctions between headaches and orofacial pains.[9,10] Therefore, is it really premature to introduce the DC/TMD into clinical practice despite its imperfections and the limitations raised by the Focus Article? We will continue to argue no. Clinicians and researchers urgently need to speak the same language when they compare and exchange information and experience related to TMD, and we need to speak the same diagnostic language as, for example, our colleagues in the headache field.[9,10] With appropriate training and a willingness to learn and understand, the DC/TMD examination can and should be part of every clinical practice. The tools, in terms of examination forms and questionnaires, are readily available, but are they then too extensive and time consuming to allow implementation in clinical practice? We realize that many clinicians will consider a 10- to 12-minute examination far too much time to spend on jaw muscles and joints and that the number of questionnaires may seem excessive; however, there are screening questionnaires that are validated and can be used to determine if a full DC/TMD examination is indicated[11] while not forgetting other possible causes of orofacial pain. It is sad but true that having the responsibility of treating patients with painful TMD will always take a longer time than other routine dental examinations and procedures. We sincerely believe that clinicians cannot and should not try to give a TMD diagnosis in a split second. It seems prudent to us that the time spent on the identification of the patient's problem involves the use of tools that have been attempted to be validated and tested for reliability. There are simply no other current diagnostic or classification systems that have shown to be better, faster, more valid, or more reliable than the DC/TMD. Research will continue to guide us if specific items should be revised, removed, or added. We should not try to beat the DC/TMD, but join it—and in so doing, make it even better. We need input from both clinicians and researchers in this process, and we should aim to continue collaboration and the natural development of the DC/TMD into a DC/orofacial pain classification scheme. This is a cumbersome and tedious process, and all inputs like the present Focus Article will help to achieve the ambitious goal to have a unified diagnostic system for orofacial pains.

Our final comment is that we should not forget that our current classifications, such as the DC/TMD, are based on consensus of certain well-characterized clusters of signs and symptoms, and that we essentially continue to lack a deeper understanding of the underlying causes and mechanisms.[6,12] If we could start to agree on the simple classifications that already have taken so many decades to establish, then we could perhaps also start to be concerned about the underlying pain mechanisms, how best to manage the conditions, and how to make more accurate predictions of the outcome.

Join the DC/TMD—you cannot beat it! But you may be able to help guide it into the next round!

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