

Michiganska udlaga i liječenje temporomandibularnog zgloba

Badel, Tomislav; Simonić-Kocijan, Sunčana; Lajnert, Vlatka; Dulčić, Nikša; Zdravec, Dijana

Source / Izvornik: **Medicina Fluminensis : Medicina Fluminensis, 2013, 49, 112 - 120**

Journal article, Published version

Rad u časopisu, Objavljena verzija rada (izdavačev PDF)

Permanent link / Trajna poveznica: <https://um.nsk.hr/um:nbn:hr:184:836591>

Rights / Prava: [In copyright](#)/[Zaštićeno autorskim pravom.](#)

Download date / Datum preuzimanja: **2025-01-14**



Repository / Repozitorij:

[Repository of the University of Rijeka, Faculty of Medicine - FMRI Repository](#)



Michigan splint and treatment of temporomandibular joint

Michiganska udlaga i liječenje temporomandibularnog zgloba

Tomislav Badel¹, Sunčana Simonić-Kocijan^{2*}, Vlatka Lajnert², Nikša Dulčić¹, Dijana Zadravec³

¹Department of Removable Prosthodontics, School of Dental Medicine, University of Zagreb, Zagreb

²Department of Prosthodontics, Department of Dental Medicine School of Medicine, University of Rijeka, Rijeka

³Department of Diagnostic and Interventional Radiology, Clinical Hospital Center Sestre milosrdnice, University of Zagreb, Zagreb

Primljeno: 7. 1. 2013.

Prihvaćeno: 12. 4. 2013.

Abstract. Splints, in a broader sense, include various groups of removable intraoral appliances which are used in biomechanical treatment approach and they help establish the neuromuscular functional balance between different parts of the stomatognathic system. The aim of the paper was to review the literature related to temporomandibular disorder (TMD) treatment with special attention given to clinical importance and the fabrication of the Michigan splint. A clinical case with a 9-year follow-up is presented within the framework of Michigan splint practical use and an evaluation of TMD treatment success until now. Generally, in TMD treatment, the principle of palliative medicine is preferred, which means treatment, control and alleviating of temporomandibular pain. The principle of non-invasive and reversible methods of treatment is preferred. The splint achieves a behavioral effect of self-awareness (cognition) about the position, function and parafunction of the mandible as well as a placebo effect.

Key words: magnetic resonance imaging, temporomandibular joint, treatment

Sažetak. Udlage u širem smislu predstavljaju velik broj skupina mobilnih intraoralnih naprava pomoću kojih se provodi biomehanička terapija te uspostavlja neuromuskularna funkcijska harmonija dijelova stomatognatnog sustava. Svrha rada je pregled literature vezan uz liječenje temporomandibularnog poremećaja s naglaskom na klinički značaj i način izradbe michiganske udlage. U sklopu praktične primjene michiganske udlage i dosadašnje znanstvene evaluacije uspjeha liječenja TMP-a opisan je klinički slučaj s 9-godišnjim praćenjem. Općenito, principi palijativne medicine preporučuju se u liječenju TMP-a, što podrazumijeva liječenje i kontrolu temporomandibularnog bola. Prednost se daje neinvazivnim i reverzibilnim metodama liječenja. Udlaga postiže bihevioralni učinak samosvjesnosti (kognicije) o položaju, funkciji i parafunkciji mandibule, te se postiže učinak placeba.

Ključne riječi: liječenje, magnetska rezonancija, temporomandibularni zglob

Adresa za dopisivanje:

*Sunčana Simonić-Kocijan, dr. dent. med.
Katedra za stomatološku protetiku
Medicinski fakultet Sveučilišta u Rijeci
Krešimirova 40, 51 000 Rijeka
e-mail:
suncana.simonik-kocijan@medri.hr

<http://hrcak.srce.hr/medicina>

INTRODUCTION

Temporomandibular disorders (TMDs) have a musculoskeletal origin and are part of orofacial pain problematic. As a form of somatic pain in the stomatognathic system, TMDs imply a disorder in the masticatory muscles and/or the temporomandibular joint (TMJ) with accompanying disturbances (limited mouth opening, noise and/or ear pain) as well as pathologic noise (clicking, crepitations) in the joint¹⁻³.

The aim of the paper was to review the literature related to treatment of TMJ with special attention paid to the clinical significance and fabrication of the Michigan splint. A clinical case with a 9-year follow-up is presented within the framework of Michigan splint practical use and an evaluation of TMD treatment success.

TMD DIAGNOSTICS

Diagnostics and differential diagnostics of TMDs are based on a standardized clinical examination. The Research Diagnostic Criteria (RDC)/TMD diagnostic system has become standard in scientific studies, wherein the clinical term TMDs has been divided into separate diagnoses^{4,5}. Thus, there is a distinction between a muscular disorder and TMJ disorder: osteoarthritis and anterior disc displacement. However, the generally accepted terminology does not explain all clinical aspects of temporomandibular pain as the most important clinical sign and symptom of the illness⁶.

Apart from the use of nonspecific clinical procedures (palpation, auscultation, measuring of active and passive mandibular mobility), the importance of orthopedic tests is also growing (manual functional analysis by Bumann and Groot Landeweer). This implies a modern, biomedical approach to the illness but also an individual approach to the patient and treatment procedures⁷⁻¹⁰.

Direct occlusal analysis is carried out in everyday practice and it provides data on static contacts between teeth in supportive areas as well as on dynamic occlusal relations between the teeth – a type of laterotrusion guidance, hyperbalance and interference contacts. The significance of various

static and dynamic occlusal variables has not been explained in the context of etiopathogenesis and treatment of TMDs. Although such an approach to TMDs has a strict dental focus, many patients (up to 45 %) have no indications for any kind of dental treatment^{11,12}. On the other hand, the prevalence of temporomandibular pain is relatively low (around 5 %) in general population and it is disproportionate with the serious public health issue of untreated teeth and thereby, with non-replaced teeth¹³⁻¹⁵.

The principle of occlusal therapy is the irreversibility and non-invasiveness in achieving orthopedic stability of TMJ.

MANAGEMENT OF TMDs

Etiopathogenesis of TMDs, as well as of other painful conditions of the musculoskeletal system (such as the public health issue of back pain), has not been completely explained and the treatment methods used are primarily those minimally invasive or completely noninvasive^{16,17}. Concepts of etiopathogenesis only included dental causes (neuralgia as a part of Costen's syndrome) but there was also a multifactorial concept and a biopsychosocial concept (apart from the somatic, RDC/TMD includes psychiatric testing of patients). For this reason, TMDs are defined by a concept of nonspecific etiology, similarly to other musculoskeletal disorders in the body. The concept of nonspecific etiology gains importance when it has to be applied on individual patients. In such a case, the personalized approach to dental medicine/medicine plays an important role and the idiopathic etiology is often mentioned at this stage of direct contact with the patient^{18,19}.

Unknown etiology of TMDs and particularly of TMJs does not lessen the importance of radiological diagnostics. Apart from the panoramic radiograph as a basic document of identification for each dental patient, there are also noninvasive but rather expensive radiological methods such as magnetic resonance imaging (MRI). Although it is possible to show osteoarthritis of TMJ on images of classical and computerized tomography,

MRI has been accepted as the gold standard in diagnostics of soft intraarticular structures^{20,21}. Since disc displacement is a common finding, mostly in younger population of TMD patients, MRI was accepted as the gold standard but there is still no agreement on the gold standard in TMDs treatment^{22,23}. The psychological factor can be evident, even in non-characteristic geriatric population of TMD patients, and it can contribute to the general clinical picture as a recurring etiological factor²⁴.

Priority is given to noninvasive and reversible treatment methods where the occlusal splint plays a key role in dental, that is, initial occlusal therapy²⁵. The occlusal splint is the most common and efficient treatment procedure of arthrogenic and/or myogenic forms of TMDs and bruxism. The occlusal stability is established by specific morphology of the splint which is placed on the teeth alignment of one jaw thus serving as an orthopedic means of TMJ stabilization²⁶.

The occlusal splint is used as a temporary means of obtaining therapeutic occlusion and as a preparatory stage for definite prosthetic treatment²⁷. In treatment with occlusal splints, their biomechanical concepts of activity, characteristics of position and retention have changed and complemented each other. The morphology of the occlusal splint plane has been tested as well as its influence on mandibular position and movements and the position and relationship between the intraarticular structures of TMJ. Depending on the indications of use and treatment effects of the occlusal splint, hyperactivity is reduced, that is, the masticatory muscles are relaxed, the condyle is therapeutically positioned, which means that it is placed into the centric relation position with the behavioral effects increasing awareness about the position, function and parafunction of the mandible thus achieving placebo effect^{28,29}.

MICHIGAN SPLINT – CHARACTERISTICS AND FABRICATION

Relaxation splints are used in treatment of bruxism as well as in management of arthrogenic and myogenic temporomandibular pain. The Michigan splint by Ramfjord and Ash is an occlusal bite plane stabilization splint with cusped rise and

freedom in centric in a space of 0.5-1.0 mm on the splint plane (Figure 1)³⁰. During occlusal movements, the concept of canine guidance is realized by planes of the splint in the canines region, whereas the interference, hyperbalance and balance contacts between other teeth and splint plane are avoided³¹.

Indications for Michigan splint are as follows: TMDs of arthrogenic and/or myogenic origin, management of nocturnal bruxism and uncontrolled parafunction during the day, maintaining of centric relations as a precondition to extensive prosthodontic restoration in patients with painful and stiff masticatory muscles or limited mandibular movements, and as a means of differential diagnostics of TMDs with respect to other ailments with similar symptoms (orofacial and craniocervical pain, tension headache, secondary tinnitus, etc.)^{32,33}.

In Michigan splint, centric relation serves as a therapeutic position which stabilizes the mandible in occlusal relations, wherein the habitual mandibular position is often identical to the centric position in the TMJ. Apart from excluding occlusal interferences, the relaxation of masticatory muscles is achieved by increasing the occlusal

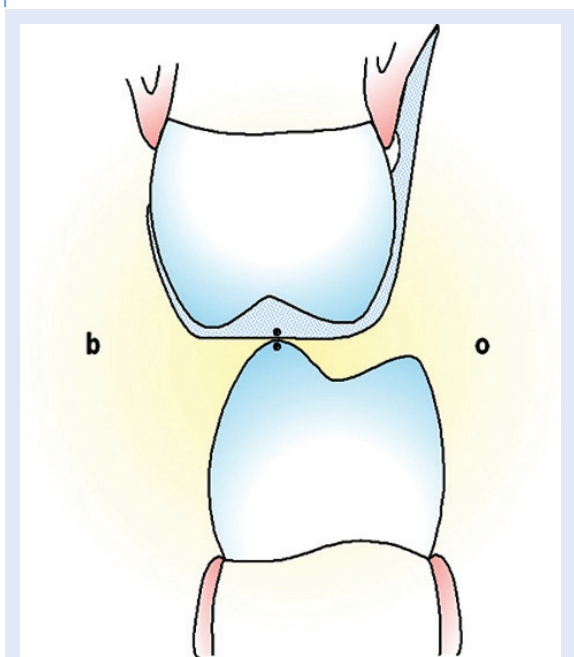


Figure 1 Antagonists are supported by working cusps of the posterior teeth on the flat occlusal plane of the splint (b, buccal; o, oral)

vertical dimension by the amount of thickness of the occlusal part of the splint. Michigan splint is most often indicated for the maxilla, but esthetic and phonetic reasons can also indicate its placement on the mandibular teeth.

Splint fabrication is of utmost importance because it has to be made individually and the dental technician has to be trained in Michigan splint fabrication. Although the methodology of fabrication is limited, apart from the method of directly applying the acrylic composite onto the definitive cast placed into the articulator, the advantage is given to the indirect method, which means that the splint is waxed-up first^{11,31}.

The impression of both jaws includes teeth alignment and surrounding tissues: the palate, marginal gingiva and edentulous spaces in the jaw in cases of partial tooth loss. The limits of the splint are drawn on the cast of the maxilla: vestibularly across the incisal edges of the anterior teeth (2 mm) as well as on the distal teeth in order to achieve splint retention, across the equator of the buccal planes. The palatal border follows the dental arch with the distance of 18-20 mm. Neuromuscular position of condylar centric relation is achieved by an anterior jig which is obtained by dripping aluminum wax onto the registration wax in the upper central incisors region. A definitive mandibular position in the contact position of centric relation is obtained by aluminum wax in the canine and first molars region (Figure 2)^{11,34}.

After mounting the cast of the maxilla into the articulator (it is recommended to use a semi-adjustable articulator with a corresponding facial arch), the incisal articulator pin is placed in the "+2 mm" position (registration wax thickness) prior to mounting of the mandibular cast. This is followed by checking of the space (about 1-2 mm between the cusps of posterior teeth) intended for the splint in order to enable subsequent occlusal adjustment and to compensate for splint wear.

Prior to modeling of the splint, the custom model bed should be prepared: blocking out the undercuts, interdental regions and deep fissures by using modeling wax or dental plaster. This helps to avoid difficulties in applying the splint, which can be caused by unwanted changes in acrylic dimen-



Figure 2 Centric relation record obtained from impressions of alu-wax in contact position of centric relation

sions during polymerization. The use of vacuum-adapted resin sheet wherein the outline of the splint is then cut off the cast along the vestibular and palatal edge is optional. The vacuum-adapted acrylic sheet is waxed-up – a layer of pink wax is softened over a flame and manually molded and immediately adjusted in closing movement made in the articulator so that the incisal pin can contact the guide table in the vertical dimension. The excess wax is removed and the occlusal plane is modeled. This is followed by waxing of slightly concave planes for canine guidance in hard "inlay-wax". Finally, occlusal contacts are preliminary checked by powder.



Figure 3 Vestibular edge (made by putty impression material) of the splint wax up (blue – planes for canine guidance)

The most complicated stage of laboratory fabrication is replacing the wax by acrylic, which begins by surrounding the vestibular splint edge with putty impression material. A space for excess acrylic putty is situated dorsally (Figure 3). The wax cast is replicated by dental stone fixator which will precisely copy the splint surface. By removing the hardened stone negative from the cast, the entire wax is also removed. The cast should then be isolated by a hard, clear resin sheet as well as the stone mould. The self-curing

transparent acrylic is used (such as Futura Jet®, Schütz Dental). The stone mould is slowly closed in order to squeeze out the excess acrylic mass (Figure 4). The cast with splint is then placed into a pressure chamber (6 bar and temperature 40°C/15min).

The polymerized splint is not removed from the casting mould; it is mounted into the articulator for preliminary occlusal adjustment to obtain occlusal contacts in centric relations (Figure 5). After this, the canine guided movements are checked (Figure 6). The splint is then removed from the cast and the final polishing is carried out. Occlusion is also additionally adjusted when the splint is tried in by the patient.

The Michigan splint increases occlusal vertical dimension which has to provide comfort to the patient.

A CLINICAL REPORT

Clicking and pain in the right TMJ appeared 6 months before the 19-year-old female patient visited our clinic, and at the time of her first visit she complained about continuous pain in the joint without clicking. Apart from the preauricular region, she also felt pain in the right ear. She rated the pain with 5.6 on the visual-analogue scale (0 – no pain, 10 – the strongest pain). She had difficulties chewing and limited mouth opening (48 mm). Laterotrusion movements were canine guided, 12 mm to the right and 7 mm to the left with pain in the right TMJ. The occlusal status was Angle class I, vertical overlap was 3 mm, horizontal was 1.5 mm whereas the incongruity of the medial line amounted to 3 mm. She did not undergo any orthodontic treatment or tooth loss, there were no wear facets and she denied any bruxist experiences. The clinical examination determined pain and limited mouth opening on active movement and under dynamic compression. The right TMJ was also painful under passive compression (bilaminar zone). An isometric examination of the muscles confirmed pain in the right masseter and temporal muscle. The definitive diagnosis was confirmed by MRI, including disc displacement without reduction (Figure 7). She was treated by Michigan splint, which she wore regularly for three months at night. Follow-up was carried out by subsequent MRI recording after 3 months with the splint placed in the mouth. Clinical check-ups were carried out



Figure 4 Eliminating of excess acrylic is checked by joining the mouldage cast in lateral openings (arrows)

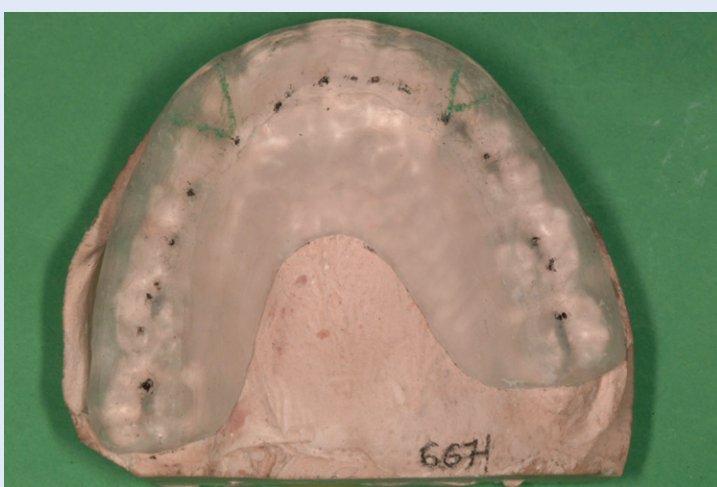


Figure 5 Even centric contacts between working cusps and incisal edges on the splint plane

after 6 and 12 months as well as after 5 and 9 years. A follow-up MRI was also performed then. All the procedures were carried out with the patient's written consent within the scientific study which was approved by the Ethics Committee of the School of Dental Medicine, University of Zagreb.

MRI showed DD without reduction and an osteophyte on the condyle as well as mild sclerosis of the tuberculum of right TMJ. The condyle was in the centric position which is shown on Figure 8 whereas it had a therapeutic position posteriorly within the glenoid fossa on the image with the splint applied in closed mouth position (Figure 8). The disc was displaced anteriorly in open mouth position. Regardless of the MRI finding, on check-ups, the patient had 50-51 mm painless mouth opening without clicking in the right TMJ. A long-term follow-up by MRI showed condyle in the centric position without any pronounced osteoarthritic changes. However, the disc had a less displaced position and there was reduction in open mouth position because beneficial remodeling changes correspond to the state of TMJ disorder improvement (Figure 9).

DISCUSSION

The prevalence of pain varies with age (mild pain was more frequent in younger age), with the peak occurring between 41 and 55 years of age. Another issue in the TMD epidemiology is dependence on the age and gender of the patient. Manfredini et al.²² differentiated two age peaks (two peaks of greatest incidence) in TMD patients (30-35 and 50-55 years) with the female: male ratio 5:1, which partly coincides with previous knowledge that the greatest prevalence is in women of reproductive age (that is between 18-45)^{11, 35}. Mobilio et al.¹³ found clicking as the most common TMD symptom (33%), whereas pain was present in 5.1% of subjects from the general population. Clicking can be a benign symptom of disc displacement in patients with dental anomalies in childhood³⁶.

The issue of occlusion in dental medicine has reached a dogmatic level, which in case of TMD patients should not apply, particularly the use of irreversible treatment methods as well as plan-



Figure 6 Canine guidance in left laterotrusion movement with the splint

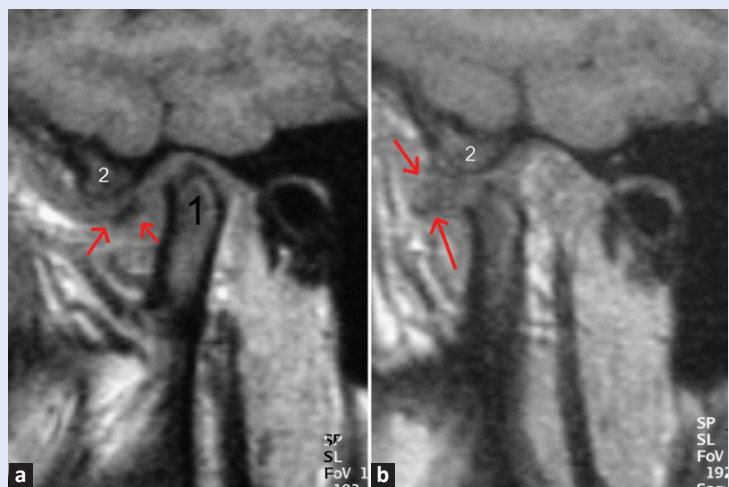


Figure 7 MRI of the right TMJ

A) in the closed mouth; B) open mouth position
Disc displacement without reduction (arrows; 1, condyle; 2 tuberculum)

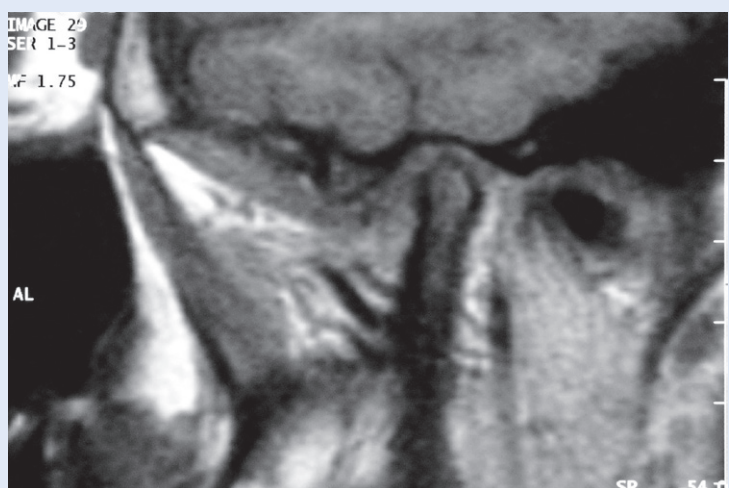


Figure 8 MRI of the right TMJ with the splint applied in closed mouth position. Note: condyle was situated in a therapeutic position posteriorly within the glenoid fossa

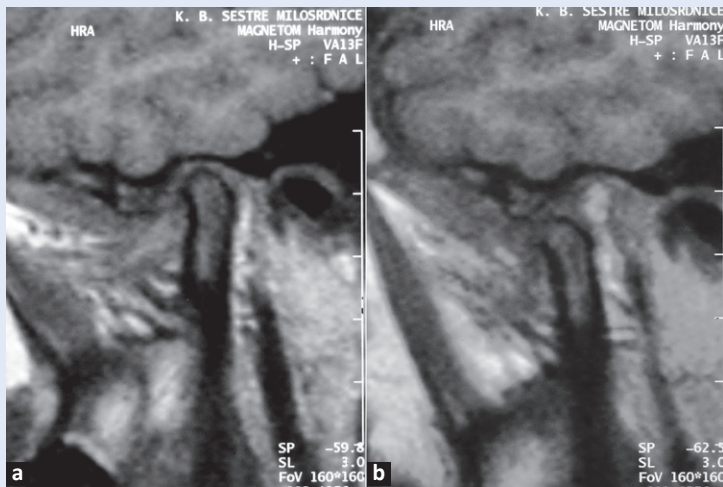


Figure 9 A long-term follow-up by MRI showed condyle in the centric position with reducing disc displacement in the right TMJ

A) closed mouth position; B) open mouth position

ning of possible preventive procedures³⁷. Current opinion¹⁹ is that TMDs are idiopathic in origin and the correlation with certain etiologic factors cannot be entirely confirmed³⁸. Although MRI is the gold standard in TMJ diagnostics, there is still no gold standard in diagnostics of temporomandibular pain³⁹.

The importance of a correct clinical procedure used to determine centric relation is shown in the case of a patient with myalgia whose splint positioned the mandible in a non-physiological bite with shift on the left side²⁸. Ferrario et al.⁴⁰ noticed that the Michigan splint achieved equilibrium in the action of temporal and masseter pairs of muscles and that it also reduced electrical activity of the muscles.

An alternative to the traditional splints are those that not require the contribution of a dental laboratory, with the so-called "Nociceptive Trigeminal Inhibition" (NTI) being the best known in the treatment of TMDs and bruxism⁴¹. However, it has numerous adverse effects, mostly related to changes in occlusion, as well as less efficiency compared to the Michigan splint⁴². NTI covered the upper incisors only, just like many relaxation splints from the past: the original group of relaxation splints was based on muscular relaxation achieved by elevation of occlusal vertical dimension and by removal of posterior occlusal interferences by covering only the anterior teeth (Hawley retainer, plate by Sved, anterior jig etc.).

Unlike the above mentioned relaxation splints, the Michigan splint (occlusal bite plane stabilization splint with cuspid rise and freedom in centric) by Ramfjord and Ash is a splint covering all the teeth in the jaw, enabling antagonistic contacts on the flat planes according to occlusal concepts of freedom in centric position^{30,43}. The newly developed Relax splint (Unident), introduced into practice by Nilner et al.⁴⁴, has proven to be as effective in treatment of myofascial pain as the Michigan splint. On the other hand, the placebo effect of the splint on treatment of TMDs was proven in control groups of patients who wore non-occluding hard palatal oral appliance. Better efficiency of the Michigan splint and of the resilient splint was not proven in treatment of TMDs^{45,46}.

Within TMDs treatment modalities, physical therapy has shown efficiency in its unique methods as well as in those indicated for other musculoskeletal disorders. Namely, the basic principle of improving the function while removing pain is seen in mobilization exercises wherein the patient is directly involved. The basic exercises include performing physiological and accessory movements, such as kinesiotherapy by Schulte⁴⁷. Physical therapy is an equivalent of the Michigan splint treatment⁴⁸. Nonsteroidal anti-inflammatory drugs are a complementary treatment in acute pain, and apart from peroral use, they can also be applied topically^{49,50}.

Anterior disc displacement is perceived as a development malpositioning disc form which over time develops from a reducing to a non-reducing disc form. Also, degenerative bone changes had a significant relationship with non-reducing disc displacement⁵¹. On the other hand, a two and a half year follow-up of untreated painful disc displacement without reduction showed that 42.5 % were asymptomatic⁵². Apart from removing clinical symptoms, the influence of the Michigan splint was also observed in MRI studies, wherein not only the clinical success of the treatment but also the ability to recapture the previously anterior displaced disc was evident in 40 % of patients, which proved to be a greater success than the use of anterior repositioning splint⁵³. On the other hand, apart from clinical treatment suc-

cess, MRI analysis did not confirm improvement in non-reducing displaced disc⁵⁴. Hasegawa et al. reported that application of a splint resulted in antero-inferior condylar movement, and TMJ pain was associated with decreased disc movement in response to splint in the mouth⁵⁵. Biomechanics and load in the TMJ were never fully explained, in dynamic visualization of TMJ, Gallo⁵⁶ found disc deformation during condylar-disc complex motion, which should be taken into consideration when studying the biomechanical effects of the splint on the intraarticular structures of the joint. In conclusion, depending on the indications of use and achieving of Michigan splint therapeutic effects; there are several ways it participates in the management of TMDs. The occlusal splint has a behavioral effect which increases cognition on mandibular position and function of the stomatognathic system.

LITERATURE

- Mikić V, Gržić R, Kovačević Pavičić D, Antonić R, Fugošić V. Etiologija temporomandibularnih poremećaja. *Medicina* 2006;42:237-42.
- Karibe H, Goddard G, McNeill C, Shih ST. Comparison of patients with orofacial pain of different diagnostic categories. *Cranio* 2011;29:138-43.
- Kopp S. Screening im kranio-mandibulären System. Die Sicht des Zahnarztes/Kieferorthopäden. *Manuelle Med* 2008;46:381-3.
- Türp JC, John M, Nilges P, Jürgens J. Schmerzen im Bereich der Kaumuskulatur und Kiefergelenke. Empfehlungen zur standardisierten Diagnostik und Klassifikation von Patienten. *Schmerz* 2000;14:416-28.
- Lajnert V, Gržić R, Kovačević Pavičić D, Bakarčić D, Badel T, Petričević N. Uporaba DKI/TMP protokola u dijagnostici temporomandibularnih poremećaja (TMP-a). *Medicina* 2009;45:56-9.
- Haley DP, Schiffman EL, Lindgren BR, Anderson Q, Andreason K. The relationship between clinical and MRI findings in patients with unilateral temporomandibular joint pain. *J Am Dent Assoc* 2001;132:476-81.
- Kordaß B, Fasold A. Manuelle Strukturanalyse. Teil 1: Grundlagen und klinische Untersuchung. *ZWR* 2012; 212:8-11.
- Badel T, Krapac L, Kraljević A. The role of physical therapy in patients with temporomandibular joint disorder. *Fiz Rehabil Med* 2012;24:21-33.
- Hoffmann RG, Kotchen JM, Kotchen TA, Cowley T, Dasgupta M, Cowley AW Jr. Temporomandibular disorders and associated clinical comorbidities. *Clin J Pain* 2011;27:268-74.
- Schulze W. Therapeutic communication with CMD patients – Part 2. *J Craniomandib Funct* 2010;2:149-60.
- Badel T. Temporomandibularni poremećaji i stomatološka protetika. Zagreb: Medicinska naklada, 2007.
- Badel T, Marotti M, Savić Pavičin I, Bašić-Kes V. Temporomandibular disorders and occlusion. *Acta Clin Croat* 2012;51:419-24.
- Mobilio N, Casetta I, Cesnik E, Catapano S. Prevalence of self-reported symptoms related to temporomandibular disorders in an Italian population. *J Oral Rehabil* 2011;38:884-90.
- Felton D, Cooper L, Duqum I, Minsley G, Guckes A, Haug S et al. Evidence-based guidelines for the care and maintenance of complete dentures: a publication of the American College of Prosthodontists. *J Prosthodont* 2011;20 Suppl 1:S1-12.
- Maixner W. Biopsychological and Genetic Risk Factors for Temporomandibular Joint Disorders and Related Conditions. In: Graven-Nilsen T, Arendt-Nilsen L, Mense S (eds). *Fundamentals of Musculoskeletal Pain*. Seattle: IASP Press, 2008;263-79.
- Dym H, Israel H. Diagnosis and treatment of temporomandibular disorders. *Dent Clin North Am* 2012;56:149-61.
- Houra K, Perović D, Radić A, Bartolek Hamp D, Vukas D, Ledić D. Minimalno invazivne procedure u liječenju križobolje i lumboishijalgije. *Medicina Flum* 2012;48: 259-70.
- Manfredini D. Etiopathogenesis of disk displacement of the temporomandibular joint: A review of the mechanisms. *Indian J Dent Res* 2009;20:212-21.
- Green SC. Concepts of TMD Etiology: Effects on Diagnosis and Treatment. In: DM, Green CS, Hylander WL (eds). *TMDs. An Evidence-Based Approach to Diagnosis and Treatment*. Laskin. Chicago: Quintessence, 2006; 219-28.
- Badel T, Marotti M, Keros J, Kern J, Krolo I. Magnetic Resonance Imaging Study on Temporomandibular Joint Morphology. *Coll Anthropol* 2009;33:455-60.
- Moen K, Hellem S, Geitung JT, Skartveit L. A practical approach to interpretation of MRI of the temporomandibular joint. *Acta Radiol* 2010;51:1021-7.
- Manfredini D, Piccotti F, Ferronato G, Guarda-Nardini L. Age peaks of different RDC/TMD diagnoses in a patient population. *J Dent* 2010;38:392-9.
- Syrop SB. Initial management of temporomandibular disorders. *Dent Today* 2001;21:52-7.
- Badel T, Kraljević Šimunković S, Marotti M, Kocijan Lovko S, Kern J, Krolo I. Study of temporomandibular joint disorder in older patients by magnetic resonance imaging. *Gerodontology* 2012;29:e735-41.
- Palla S. Grundsätze zur Therapie des myoarthropathischen Schmerzes. *Schmerz* 2002;16:373-80.
- de Leeuw R. Temporomandibular disorders. Guidelines for classification, assessment, and management (4th ed). Chicago: Quintessence, 2008.
- Badel T, Kraljević S, Pandurić J, Marotti M. Preprosthetic therapy utilizing a temporary occlusal acrylic splint: A case report. *Quintessence Int* 2004;35:401-5.
- Badel T, Stražanac J, Marotti M, Krapac L. Treatment of myogenic temporomandibular disorder by occlusal splint and physical therapy: a case report. *Acta Stomatol Croat* 2010;44:202-10.
- Dylina TJ. A common-sense approach to splint therapy. *J Prosthet Dent* 2001;86:539-45.
- Ash MM, Schmieseder J. Schienentherapie. München: Urban & Fischer, 1999.

31. Badel T, Pandurić J, Kraljević S, Dulčić N. Initial treatment of prosthetic patients with a Michigan splint. *Acta Stomatol Croat* 2003;36:207-10.
32. Badel T, Savić Pavičin I, Podoreški D, Marotti M, Krolo I, Grbeša Đ. Temporomandibular joint development and functional disorders related to clinical otologic symptomatology. *Acta Clin Croat* 2011;50:51-60.
33. Badel T, Pandurić J, Marotti M, Krolo I. Funkcijski poremećaji u važnomu sustavu. *Med Jadertina* 2005; 35:81-6.
34. Türp JC. Vorstellung einer Methode zur Kieferrelationbestimmung für die Michigan-Schiene. *Quintessenz Zahntech* 2011;37:1136-43.
35. Badel T, Keros J, Marotti M, Kern J, Kocijan Lovko S, Rošin Grget K. Therapy of displaced disk of the temporomandibular joint in relation to anxiety. *Period Biol* 2008;110:101-5.
36. Badel T, Lajnert V, Marotti M, Krolo I, Kovačević Pavičić D. Poremećaj čeljusnog zgloba u 12-godišnje bolesnice. *Medicina* 2008;44:91-7.
37. Carlsson GE. Some dogmas related to prosthodontics, temporomandibular disorders and occlusion. *Acta Odontol Scand* 2010;68:313-22.
38. Badel T, Marotti M, Krolo I, Kern J, Keros J. Occlusion in patients with temporomandibular joint anterior disk displacement. *Acta Clin Croat* 2008;47:129-36.
39. Ahmad M, Hollender L, Anderson Q, Kartha K, Ohrbach R, Truelove EL et al. Research diagnostic criteria for temporomandibular disorders (RDC/TMD): development of image analysis criteria and examiner reliability for image analysis. *Oral Surg, Oral Med, Oral Pathol, Oral Radiol, Endod* 2009;107:844-60.
40. Ferrario VF, Sforza C, Tartaglia GM, Dellavia C. Immediate effect of a stabilization splint on masticatory muscle activity in temporomandibular disorder patients. *J Oral Rehabil* 2002;29:810-5.
41. Lobbezoo F, van der Zaag J, van Selms MK, Hamburger HL, Naeije M. Principles for the management of bruxism. *J Oral Rehabil* 2008;35:509-23.
42. Magnusson T, Adiels AM, Nilsson HL, Helkimo M. Treatment effect on signs and symptoms of temporomandibular disorders—comparison between stabilisation splint and a new type of splint (NTI). A pilot study. *Swed Dent J* 2004;28:11-20.
43. Ash MM Jr, Ramfjord SP. Reflections on the Michigan splint and other intraocclusal devices. *J Mich Dent Assoc* 1998;80:32-5,41-6.
44. Nilner M, Ekberg E, Doepel M, Andersson J, Selovuo K, Le Bell Y. Short-term effectiveness of a prefabricated occlusal appliance in patients with myofascial pain. *J Orofac Pain* 2008;22:209-18.
45. Ekberg E, Nilner M. The influence of stabilisation appliance therapy and other factors on the treatment outcome in patients with temporomandibular disorders of arthrogenous origin. *Swed Dent J* 1999;23:39-47.
46. Nilsson H, Vallon D, Ekberg EC. Long-term efficacy of resilient appliance therapy in TMD pain patients: a randomised, controlled trial. *J Oral Rehabil* 2011;38:713-21.
47. Schulte W. Die exzentrische Okklusion. Folge-schäden im stomatognathen System. *Diagnose, Therapie und Prophylaxe*. Berlin: Quintessenz, 1983.
48. Niemelä K, Korpela M, Raustia A, Ylöstalo P, Sipilä K. Efficacy of stabilisation splint treatment on temporomandibular disorders. *J Oral Rehabil*. 2012;39:799-804.
49. Badel T, Rošin-Grget K, Krapac L, Marotti, M. Principi farmakoterapije temporomandibularnih poremećaja. *Medicus* 2007;16:241-50.
50. Badel T, Krapac L, Savić Pavičin I, Zdravec D, Rosić D, Kocijan Lovko S et al. Fizikalno liječenje i korištenje ke-toprofen gela za poremećaj temporomandibularnog zgloba potvrđenog magnetskom rezonancijom (abstract). *Reumatizam* 2012;59:182-3.
51. Campos MI, Campos PS, Cangussu MC, Guimarães RC, Line SR. Analysis of magnetic resonance imaging characteristics and pain in temporomandibular joints with and without degenerative changes of the condyle. *Int J Oral Maxillofac Surg* 2008;37:529-34.
52. Kurita K, Westesson PL, Yuasa H, Toyama M, Machida J, Ogi N. Natural course of untreated symptomatic temporomandibular joint disc displacement without reduction. *J Dent Res* 1998;77:361-5.
53. Fayed MM, El-Mangoury NH, El-Bokle DN, Belal AI. Occlusal splint therapy and magnetic resonance imaging. *World J Orthod* 2004;5:133-40.
54. Badel T, Marotti M, Kern J, Laškarin M. A quantitative analysis of splint therapy of displaced temporomandibular joint disc. *Ann Anat* 2009;191:280-7.
55. Hasegawa Y, Kakimoto N, Tomita S, Honda K, Tanaka Y, Yagi K et al. Movement of the mandibular condyle and articular disc on placement of an occlusal splint. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 2011;112:640-7.