Validity of the Research Diagnostic Criteria for Temporomandibular Disorders Axis I in Clinical and Research Settings

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The commentary by Drs Steenks and de Wijer[1] is an important appraisal of the potential shortcomings of the Research Diagnostic Criteria for Temporomandibular Disorders (RDC/TMD).[2] Nothing is perfect and everything can be improved. Clinicians and researchers need to be aware of the pros and cons for any type of diagnostic or classification scheme of orofacial pain conditions and therefore a critical dissection of the merits of the RDC/TMD is much welcomed. The authors raise a number of questions and concerns and discuss them in a timely and fair manner. Nevertheless, I would like specifically to comment on two points.

Point 1: The RDC/TMD Axis I in clinical research settings need an update.[1] Yes, I think it is generally agreed that a 16-year-old recommendation should be updated. And the good news is that significant progress has been made in the field of TMD because of the accumulation of research papers using the RDC/TMD.[3–6] The RDC/TMD Validation Study group has addressed many of the concerns voiced by Steenks and de Wijer,[1] eg, the number of muscles to be palpated, additional palpation techniques, and temporomandibular joint (TMJ) tests, and provided novel information on reliability as well as validity. In fact, a recent workshop on this very topic was presented at the International Association for Dental Research (IADR) meeting in Toronto, Canada, in 2008.[7] Thus, the concerns that RDC/TMD will remain unchanged into adult life should be reduced. It is, however, not an easy task to make such revisions because of the magnitude of collected data and the time needed for careful analysis and interpretation. The RDC/TMD Consortium is currently planning a second international consensus workshop on Convergence on an Orofacial Pain Taxonomy, hopefully to be linked to the next IADR meeting in Miami in 2009. Actually, the scope is even broader than the next version of the RDC/TMD because, as also Steenks and de Wijer note, there is a need to consider other orofacial pain conditions as well (eg, neuropathic orofacial pains, burning mouth syndrome, atypical odontalgia, atypical pain, tooth aches, etc). Therefore, the Orofacial Pain Special Interest Group (SIG) of the International Association for the Study of Pain (IASP) is actively involved in the planning of these efforts and contacts with the classification committee of the International Headache Society (IHS) have been established. Also, other organizations and societies will be invited to participate so that a truly internationally accepted diagnostic and classification system can emerge. Such a system needs to consider not only Axis I domains but also Axis II domains and probably also an Axis III, and should be prepared to incorporate future findings of biomarkers of complex diseases, eg, genotyping and more advanced phenotyping tests. I believe that the RDC/TMD with the dual-axis system have provided the platform and recognition that we should not only assess the physical signs and symptoms, but also pay thorough attention to the impacts on daily function, well-being, and association with other co-morbid pain conditions. Incorporation of multidimensional and patient-based measures of pain is widely accepted[8] and should be further strengthened in new classification schemes. We need to look beyond the biomechanics of clicking and catching of the TMJ.

Point 2: The second note by Drs Steenks and de Wijer that the application of the RDC/TMD in clinical settings is not indicated also deserves a comment. I still believe that the quote from the RDC/TMD Consortium that "Our goal is to advance scientific knowledge of TMD and related pain conditions based on the use of a common set

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of tools applicable to both research and clinical settings" is true and correct. I do not see this as a recommendation for clinicians to use the RDC/TMD in an uncritical manner to diagnose and manage all orofacial pain patients. Obviously, many orofacial pain patients will fall outside the current diagnostic criteria for TMD or have a concomitant, but secondary, RDC/TMD diagnosis. It is true that clinicians will not provide optimal patient care if they only use the RDC/TMD for all their orofacial pain patients because a more comprehensive history and examination of the pain patient is needed. It is my impression that clinicians therefore add other questionnaires and examination techniques as described in textbooks.[9]

Overall, I agree with Drs Steenks and de Wijer that the RDC/TMD need an update. There is a need to extend the RDC/TMD to a RDC/orofacial pain and again work is in progress headed by the RDC/TMD Consortium and Orofacial Pain SIG. Finally, the RDC/orofacial pain should be converted to diagnostic criteria (DC) for orofacial pain. This DC/orofacial pain will require the collaboration between clinicians and researchers not only in the field of orofacial pain but also the input from neurologists, psychologists, rheumatologists, and other pain specialists. It is my personal belief that within a reasonable time frame consensus can be reached on a common and internationally accepted DC/orofacial pain profile, which then should be updated on a regular basis (less than every 16 years) as basic and clinical research teaches us more about the mechanisms and clinical presentations of pain. This should provide us with a good foundation to create evidence-based guidelines for management of the individual orofacial pain patient.

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