Mr. von Piekartz questions Dr. Stiesch-Scholz, et al.'s conclusions in their April 2002 article in *CRANIO*

Dear Editor:

The effect study of Stiesch-Scholz, et al.[1] suggests that with patients with anterior disk displacement, splint therapy and medication intervention is significantly better than splint therapy alone, and also significantly better than splintherapy and physical therapy, or the combination of the three therapy possibilities. Even the weaker results were scored, in the group of splint therapy combined with physical therapy.

There are other studies in which it is suggested, that physical therapy would provide only limited therapeutic value in the treatment of cranial facial pain.[2,3] However, an important point of discussion within these studies is the definition of physical therapy.

Too often it is considered that the isolated application of series of manipulative techniques, global exercises, icepacks, and ultrasound would be physical therapy. However modern physical therapy is more than that.

In general, it is concluded that the exact etiology of cranial facial pain is not clear, thus creating difficulties for sound research in outcome studies.[4] For example, with regards to etiology, it is suggested to increase research endeavours an cellular and molecular level in order to gain more understanding of the undergoing pathophysiological mechanisms of TMJ diseases, chronic muscle dysfunction, and chronic cranio facial pain.[5] Furthermore, it is suggested to include parameters for the influences of cognition, fear, other depressive reactions, and their influence an tissue health and the individual pain experience of a patient.[5],[6] However, in various studies and in different clinical settings these affective and cognitive phenomena are neither assessed nor integrated in the management of neuro-musculoskeletal dysfunction and pain.[7] Another dimension of difficulties in research in the cranio facial area is the classification of the disorders.[4] The criteria an which classifications of disorders are defined, depend an the paradigms of the professions concerned For clinicians these aspects have the consequences that they have to deal with a grey zone of Practice were it is obviously not all is black and white.[8]

A modern physical therapy approach, based an the assessment and analysis of movement dysfunctions has a lot to offer in the treatment of cranio facial pain syndromes. Physical therapy is currently described by the World Confederation of Physical Therapy as a "health Gare profession which deals with people to maintain and restore maximum movement and functional ability throughout the life span. Physical therapy is particularly important in circumstances where movement and function are threatened by the process of ageing, or that of injury or disease.

It places full and functional movement at the heart of what it means to be healthy."[9] Therefore, physical therapy follows a movement paradigm for research and clinical practice. It is suggested to define movement dysfunction (impairments) categories, in order to allow physical therapy specific inclusion and exclusion criteria for research.[10] A modern physical therapist who specializes in the assessment and treatment of disorders of the neuromusculoskeletal system, offers patients thorough evaluation and comprehensive treatment an an individual level.[11] Decision-making in physical therapy is currently based an modern clinical reasoning science rather than the mere application a techniques.[12],[13] This means that physical therapists cannot deal with gold standard tests but have to adapt their assessment procedures to the individual condition of the patient. They make their clinical decisions in a thorough assessment process of pain and movement dysfunctions, which is guided by clinical reasoning processes in which constantly multiple hypotheses concerning sources of dysfunctions, contributing factors, levels and kind of disability, prognosis, precautions and contraindications etc. are induced and tested.[12] These hypotheses give the physical therapist cues to adapt the assessment procedures and to individualize management programs to each patient concerned. Assessment an an individual level together with assessment of psychosocial dimensions linked in with the patient problem[4] constitutes the profession of modern physical therapy.[14]

Feine. et al.[15] concluded in review of controlled clinical trials that physical therapy is better than no therapy or a placebo in CMD. This leads to the question again: of what constitutes physical therapy? Stiesch-Scholz, et al.' indicate in their study that physical therapy is based on "the" *Guidelines for Manual Therapy* to mobilize the Temporomandibular Joint.1[6] In this study several manual joint techniques; massage and detuning exercises are used. Firstly, in general physical therapy there is no *the* guideline for manual techniques of The TMJ. Secondly, the nevertheless excellent book of Evjenth and Homburg,[16] is a fourth edition. Since the third edition, which was published in 1984, no changes based an contemporary insights of evidence-based practice have been integrated into these guidelines.

Therefore the conclusion of the article of Stiesch-Scholz, et al.,[1] gives a wrong view of what is considered physical therapy in the current views of the profession. It would have been more usefull if Stiesch Scholz, et al.[1] had integrated physical therapist with the following capacities: More than five years experience with a various range of cranial facial patients; sufficient variety of *hands an* skills for the cranial facial region; knowledge of the specialty of other disciplines, which are involved in the assessment and treatment of cranial facial problems in order to enhance communication with these groups; a variety of pain management skills; and freedom of the choice of physical therapy modalities and applications based an fundamental clinical reasoning skills. It is my expectation that, in that case, the outcome would have been completely different.

Further, l allow myself to put some question marks an elements of this study, which also have an influence an the conclusion with regards to the outcome: as a measure of pain intensity only the VAS was used which should measure the reduction of subjective Symptoms. However, the VAS has been criticized as a single measure for pain. No control group was included in this study.

From my point of view, there is no blame to the researchers Stiesch-Scholz et al.[1] They are not physical therapists and are probably not informed about the recent paradigm changes in physical therapy. It is the concern of many physical therapy organizations overall in the world to promote the development of special interest groups for the research, assessment, and Treatment of cranial facial pain to facilitate optimal consensus with other involved disciplines. It is sad, that research conducted by physical therapists themselves is still lacking; however it is promoted and facilitated by physiotherapy organizations and universities. In the fields of low back pain and neck pain, evidence is suggesting that a multimodal approach like individualized manipulative therapy, individualized exercises, and education, based an clinical reasoning provides better outcomes than standardized single physiotherapy approaches.[17] As far as I know, these types of studies have not been performed yet with patients with cranial facial pain. The idea that physical therapy would consist of a sum of standard applications and *recipe* treatment is outdated, and such approaches should not be encouraged in outcome studies which intend to compare effects between various approaches.

It is important to develop a modern attitude in research, towards a dynamic profession with its own typical paradigms which wants to induce and test its profession-specific knowledge in the challenging field of cranial facial pain.

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