Review Article

Magnetic resonance and sonographic imagings of masticatory muscle myalgia in temporomandibular disorder patients

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Summary  This article reviews recently published studies investigating the MRI and sonographic diagnosis of masticatory muscle myalgia in temporomandibular disorder patients. The MRI and sonographic features of muscle after treatment are also discussed. Literature published within the last 15 years was obtained from the PubMed database using the following Mesh terms: magnetic resonance imaging (MRI) or sonography, masticatory muscle pain, and treatment. MRI and sonography enable accurate visualization and evaluation of the masticatory muscles, thereby increasing our understanding of pathology and cause of pain associated with these muscles. Although therapeutic efficacy is often evaluated based on clinical findings, MR and sonographic imaging studies may also be valuable.

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1. Introduction

Masticatory muscles were evaluated using electromyography (EMG) [1–3], near-infrared spectroscopy (NIRS) [4], and so on, for purpose of evaluation of muscle activities and blood oxygen kinetics. Al-Saleh et al. performed systematic review of two studies (74 patients) that were collected using “Mesh” terms of TMD, jaw pain and EMG, and stated that the sensitivity of EMG in diagnosing TMD was low (0.25–0.40) [1].

In the recent years, studies using MRI and sonography in patients with masticatory muscle myalgia have frequently been reported, and the newly developed technologies have been introduced [5–38]. Muscles after treatment in those patients also have been evaluated using MRI and sonography [5–15].

This article reviews recently published studies focusing on the MRI and sonographic diagnosis of masticatory muscle myalgia in temporomandibular disorder (TMD) patients, and shows the intramuscular state, blood flow, and muscle hardness. The MRI and sonographic evaluations in relation to the efficacy of various treatments are also discussed.

2. Methods

Literatures published within the last 15 years were searched from the PubMed database using the following Mesh terms: (1) (MRI or sonography) and masticatory muscle pain; (2) (MRI or sonography) and masticatory muscle pain and treatment. Original papers and review articles published in English and Japanese were adopted. Selection criteria were MRI and sonographic features in diagnosis of masticatory muscle myalgia and in evaluation of muscle after therapy. Studies of neoplastic lesions and case report were excluded.

3. Results

3.1. MRI and sonographic diagnosis of masticatory muscle myalgia in TMD patients

The number of literature that met the mesh terms of (1) and the above-mentioned criteria was 34 [5–38].

Most MRI studies in TMD patients evaluated intra-articular changes, such as disk displacement [5–7,16–18], and MRI studies evaluating the masticatory muscles were a few. Zanoteli et al. evaluated changes in the signal intensities of the masticatory muscles in 15 patients with myotonic dystrophy on T1- and T2-weighted images, and diagnosed the presence of a high signal intensity area (fatty replacement) as abnormal [19]. Gregor et al. [20] and Okada et al. [21] investigated masseter muscle metabolism using 31P-magnet resonance spectroscopy. The former revealed a difference in masseter muscle metabolism between 11 dolichocephalic and 11 brachycephalic subjects, and the latter showed an increase in masseter muscle metabolism secondary to heat pack use in 12 healthy subjects.

The most common index for evaluation of masticatory muscles in the sonography studies was muscle thickness (Fig. 1) [8–12,22–29]. Ariji et al. showed that the masseter muscle thickness in 25 TMD patients was greater than that of 30 healthy volunteers [22]. Strini et al. showed that the masseter muscle thickness on sonography and the masseter muscle activity on electromyography were positively correlated with occlusal force in 19 TMD patients [23]. Other reports examined the relationship between masseter muscle thickness and facial morphology [24,25].

A next focusing index was the appearance of the intramuscular echogenic bands, which correspond to the internal fascia (Fig. 2) [39]. Masseter muscle appearance was classified into three types based on the internal echogenic bands, and it was revealed that the masseter muscles in 25 TMD patients frequently displayed thickened bands or reduction in the number of bands [22].

In recent years, sonoelastography has been used to evaluate the skeletal muscles [40–43]. The principal of sonoelastography can be divided into two types: strain and shear wave elastography [44]. Strain elastography is based on the distortion due to vibration caused by manual pressure. Hardness on strain elastography is displayed as a relative value compared to the reference (Fig. 3). Shear wave elastography is based on the propagation velocity of the shear wave generated by acoustic radiation force. Hardness on shear wave elastography is displayed as the shear wave speed or Young’s modulus (Fig. 4).

Studies regarding the masseter muscle hardness on strain elastography recently have been reported [30,31]. Hardness on strain elastography is expressed as elasticity index (EI). The EI was originally developed for sonography machine and software, and defined as the strain values of each area compared with the average strain value (EI = 1) of the whole area of interest. The EIs of the softer and harder areas than the average EI were assigned as 0–1 and 1–6, respectively. EI ratio of the masseter muscle was evaluated compared with
the reference tissue, such as the subcutaneous fat or coupling agent (Fig. 3). Ariji et al. evaluated the difference in the masseter muscle hardness between eight TMD patients and 35 healthy volunteers using the EI ratios of the masseter muscle against the subcutaneous fat [30]. As a result, there was a significant difference in the EI ratios between the symptomatic and asymptomatic sides in TMD patients. The EI ratio of the symptomatic side in TMD patients was greater than that seen in the healthy volunteers. Nakayama et al. adopted a coupling agent with a known Young’s modulus as a reference in order to be generally available to EI ratio, and measured the EI ratio of the masseter muscle against the coupling agent in 25 healthy volunteers [31].
A few studies on masseter muscle hardness using shear wave elastography were found. Arda et al. reported that the average Young’s moduli of the masseter muscles in 127 healthy volunteers was $10.4 \pm 3.7$ kPa [32]. Ariji et al. measured the average Young’s moduli of the masseter muscles in 30 healthy volunteers using the other sonoelastographic device, and reported that it was $42.8 \pm 5.56$ [33]. Badea et al. found no significant difference in the shear wave velocities of the masseter muscles between 25 healthy volunteers and 13 TMD patients [34]. As such, further research investigating masseter muscle hardness may be required.

Experimental attempts to explore the cause of myalgia using imaging have also been made. Based on the hypothesis that masseter muscle myalgia is partially caused by edematous changes in the masseter muscles, the following studies investigated the water content in the masseter muscles during jaw clenching using MRI: Nagayama et al. adopted magnetization transfer contrast (MTC) imaging, and revealed that the magnetization transfer ratios of masticatory muscles in 50 TMD patients were significantly lower than in 28 healthy volunteers [35]. They concluded that MTC imaging strongly reflected edematous changes in masseter muscle, possibly related to masseter muscle myalgia. Shiraishi et al. examined changes in the diffusion parameters of the masseter muscles in 11 healthy volunteers during jaw opening and clenching on diffusion-tensor imaging [36]. Ariji et al. assessed edematous changes in the masseter muscles of 10 healthy volunteers caused by low-level static contraction on T2-weighted interactive decomposition of water and fat with echo asymmetry and least-square estimation (IDEAL) water images [37]. A similar study was performed using sonoelastography, which showed that the thickness and hardness of the masseter muscles increased immediately after contraction [38]. When changes in the masseter muscles by contraction were compared using MRI and sonoelastography, the soft area ratio of muscle on sonoelastography increased in correlation with increases in water signal on MRI [41]. Therefore, sonoelastography could also evaluate edematous changes in the masseter muscles.

3.2. MRI and sonographic evaluation of masticatory muscle and therapeutic efficacy

TMD patients with masticatory muscle myalgia were treated by splint therapy [45–47], medication [48–50], physical therapy [51–53] and so on. As an index for evaluating the therapeutic efficacy, the clinical findings, including pain intensity (visual analog scale) [52,53], pressure pain threshold [50,52,53], degree of mouth opening [49,50], and degree of jaw function impairment [49,52,53], were analyzed. Muscle activity was also evaluated using electromyography [1–3,51]. To assess the efficacy of massage therapy on the skeletal muscles, muscle hardness was generally evaluated using a muscle hardness meter [54,55]. Hiraiwa et al. evaluated the change in masseter muscle hardness after massage therapy using a muscle hardness meter, and confirmed that the hardness decreased after massage treatment [56].

As to the evaluation by MRI and sonography, the number of literature that met to the mesh terms of 2 and the previously-mentioned criteria was 11 [5–15]. These were studies on the evaluation after the splint or massage therapies. Of them, all 3 MRI studies evaluated changes in disc position after therapy, and did not evaluate changes in the muscles [5–7]. In studies using sonoigraphy, an useful index for therapeutic efficacy is the thickness and intramuscular echo appearance of the masseter muscle following treatment (Figs. 1 and 2) [8–15].

A stabilization splint therapy is considered as a therapy of weak recommended level (Grade 2C) for patients with masticatory muscle myalgia, according to the Japanese Society’s temporomandibular joint evidence-based clinical guidelines [45]. A systematic review on the efficacy of stabilization splints showed that the use of a stabilization splint aided patients with masticatory muscle myalgia [46,47]. However, a stabilization splint did not appear to yield a better outcome than a soft splint, a non-occluding palatal splint, physical therapy, or body acupuncture [46]. Following stabilization splint therapy, Aldemir et al. evaluated the changes in the masseter muscle thickness in 35 patients with myofascial pain, and reported that a reduced thickness was found [10]. Bertram et al. evaluated the changes in the masseter muscle thickness in 29 patients and reported that the asymmetry index of thickness decreased [11,12]. The change in appearance of the intramuscular echogenic bands is controversial; Aldemir et al. found no change [10], whereas Sasaki et al. reported a change in intramuscular echo types in 12 of 40 patients [15].

A few studies performed randomized controlled trials of massage therapy for masticator muscle myalgia [51–53]. Gomes et al. compared the efficacies among massage therapy, splint therapy, and the combination therapy (n = 15 patients in each group), and showed that the combination of two therapies demonstrated a greater improvement although no significant difference among the groups [51]. De Laat et al. compared the efficacies between 4 weeks and 6 weeks of physical therapies (n = 24 patients in each group) [52], and Craane et al. compared the efficacies between physical therapy (n = 23) and control group (n = 26) [53]. The physical therapy including massage showed improvement in pain and jaw function, but the degree of improvement was not significant between the groups.

In order to adapt of massage therapy to masticatory muscle pain, an oral rehabilitation robot was previously developed [57]. Ariji et al. investigated the safety, a suitable treatment regimen, and the efficacy of masseter and temporal muscle massage treatment using this oral rehabilitation robot (Fig. 5) [8.13]. No adverse events occurred with any of the treatment sessions. Suitable massage was delivered at a pressure of 10 N for 16 min. The standard treatment regimen was five sessions, spaced 2 weeks apart for a 9.5-week duration. This massage therapy regimen was effective in 70.3% of the patients [8].

As to the sonographic evaluation of the masseter muscles after massage therapy, the thickness decreased in all of 41 patients [8,9], and fine echogenic bands began to appear in 93.3% of the therapy-effective 26 patients [14]. Ariji et al. also evaluated changes in the masseter muscle hardness using sonoelastography (Fig. 4) [14,30]. The EI ratio decreased after massage therapy. [14,30] In particular, the EI ratio in the effective-therapy group significantly decreased in early period of treatment, and therefore, the EI ratio may be an effective tool for predicting therapeutic efficacy [14].
4. Discussion and conclusion

This review provides a summary of the literature published within the last 15 years investigating the MRI and sono-
graphic diagnosis of masticatory muscle myalgia in TMD patients. With the recent advances in imaging technology, edematous changes and muscle hardening in patients with masticatory muscle myalgia can be visualized using MRI and sonography.

Evaluation of therapeutic efficacy should be based not only on the clinical findings, but also on imaging findings. Massage therapy using an oral rehabilitation robot would give a certain therapeutic effect. In future, it should be generalized. Sonography will enable the clinician to select the appropriate treatment modalities for managing masticatory muscle myalgia.

Conflict of interest

The authors have no conflicts of interest to declare.

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References


MRI and sonographic diagnosis of masticatory muscle myalgia


