



Case Study

EFFECTIVENESS OF SIDDHA MANUAL THERAPY IN TMJ-RELATED OROFACIAL AND CERVICOBACHIAL PAIN: A PROSPECTIVE CASE EVALUATION

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ABSTRACT

This case report presents the clinical outcome of Siddha manual therapy combined with targeted exercises in a 35-year-old female experiencing right-sided cheek pain radiating to the neck and right arm, restricted jaw movement, and recurrent headaches with priorly diagnosed Rheumatoid Arthritis (RA) causing pain and stiffness in the small joints of the hands, which appeared to aggravate the temporomandibular symptoms. Over a three-week treatment period, she underwent a Siddha-based Chakrasiddh protocol. The sessions focused on gentle manual techniques for TMJ and cervical alignment, stimulation of specific *Varmam* points related to facial and cervical nerve pathways, and corrective exercises to restore balanced muscle activity pre and post-therapy pain intensity was assessed using the Visual Analog Scale (VAS), Maximal Mouth Opening (MMO) was measured to evaluate mandibular mobility, and functional impact was recorded using a TMJ-specific disability questionnaire. Following therapy, significant reductions were observed in pain intensity, radiating symptoms, jaw clicking, and headache frequency. The patient also reported reduced stiffness in the cervical region and improved mobility in the small joints of the hands, accompanied by reduction in inflammatory markers associated with RA. This case suggests that a Siddha protocol integrating manual *Varmam* stimulation, therapeutic exercises, and lifestyle awareness may be an effective integrative approach for managing TMJ-related orofacial and cervicobrachial pain, with additional benefits in patients with coexisting inflammatory joint conditions such as RA. However, larger clinical studies are required to validate its therapeutic value.

INTRODUCTION

Temporomandibular joint dysfunction (TMJ) is a multifactorial pain condition involving the jaw, masticatory muscles, cervical spine, and associated myofascial structures.^[1] The TMJ dysfunction manifest with a wide spectrum of clinical features, including myofascial pain in the pre-auricular region, restricted mandibular movement, joint sounds, and impairment of essential orofacial functions such as mastication, speech, swallowing, yawning, and breathing and radiating cervical symptoms ^[2].

Myofascial trigger points in the masseter, temporalis, pterygoids, sternocleidomastoid (SCM), and trapezius often play a central role in symptom generation. TMJ-related pain commonly coexists with stress, sleep disturbances, postural deficits, or parafunctional habits such as clenching or bruxism. Epidemiological data indicate TMD as a global prevalence ranging from 4.7% to over 58%, with a higher burden observed among young adults; with studies confirming it increases with age from childhood to adolescence ^[3-5].

Myogenic TMJ pain is strongly associated with sustained muscular hyperactivity, reduced regional microcirculation, and accumulation of metabolic by-products within masticatory and cervical muscles, leading to fatigue, inflammation, and restricted joint mobility. These pathophysiological changes result in reduced maximal mouth opening and significantly

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impair oral health-related quality of life [6,7]. Also, persistent jaw muscle hyperactivity leads to increased altered neck biomechanics, compressing or irritating cervical nerve roots and peripheral nerves, especially in the lower cervical segments (C5–C7), which supply the shoulder, arm, and hand leading to numbness and pain [8,9]. In addition to mechanical and myofascial causes, studies indicate a high prevalence of temporomandibular joint (TMJ) involvement in patients with systemic autoimmune disease such as rheumatoid arthritis (RA), with clinical symptoms appearing in 40–86% of cases [10]. RA, primarily affects synovial joints and may involve the temporomandibular joint in approximately 17–30% of patients. Inflammatory involvement of the TMJ issues often follow the same destructive path as other joints in RA, manifesting as pain, functional limitations, and structural damage and restricted mandibular movement[11]. Moreover, RA-related inflammation affecting the cervical spine and upper musculoskeletal structures can alter cervical biomechanics and increase muscular tension in the cranio-cervical region, thereby aggravating TMJ dysfunction and contributing to radiating pain toward the jaw, neck, and upper limb [8,12].

Conventional management includes analgesics, muscle relaxants, occlusal splints, physiotherapy, and invasive interventions [13]. However, such approaches may be associated with adverse effects, high costs, or limited long-term benefits, highlighting the need for safe, non-invasive, and sustainable therapeutic alternatives. Growing research indicates that manual therapies such as massage, myofascial release, acupuncture, counterstrain techniques, and chiropractic adjustments can effectively reduce TMJ-related pain and improve jaw mobility [14,15]. Siddha *Varmam* therapy, a traditional South Indian healing system, focuses on stimulating vital neuromuscular points to restore normal musculoskeletal function, reduce tension, and improve circulation through precise stimulation of vital energy points (*Varmam* points) located in the oro-facial, cervical, and upper thoracic regions [16]. When combined with mild, structured therapeutic exercises focusing on jaw mobility, cervical alignment, and postural correction, *Varmam* therapy may enhance functional recovery. This integrative approach operates through a holistic framework emphasizing energy regulation and self-healing mechanisms[17]. Despite increasing clinical use of Siddha-based interventions for musculoskeletal disorders, systematic evidence evaluating the effectiveness of *Varmam* therapy combined with therapeutic exercises in TMJ disorders remains limited.

The present study was therefore designed to assess the impact of Siddha *Varmam* therapy with mild corrective exercises on pain intensity and maximal mouth opening in a patient with TMJ-related dysfunction and associated cervical symptoms. This case report documents that an integrative, non-invasive approach involving Siddha *Varmam* therapy, guided exercises, and dietary modification resulted in significant pain reduction and functional improvement. Additionally, improvement in cervical discomfort associated with underlying rheumatoid inflammatory activity was observed, suggesting that such integrative therapies may offer supportive benefits in patients with coexisting musculoskeletal and inflammatory conditions.

Case Presentation

Patient Profile

A 35-year-old female presented with an eight-year history of progressively worsening cervical symptoms and gradually increasing orofacial pain from last ten-months. She reported persistent pain over the right cheek region radiating to the neck and right upper limb, accompanied by intermittent headaches occurring three to four times per week. The patient also experienced audible jaw clicking during mouth opening and mastication, along with marked stiffness in the cervical region, radiating in her right arm which was aggravated by prolonged work time. Sleep was frequently disturbed due to pain and a sensation of muscular tightness. The symptoms had gradually increased in both frequency and intensity over time. The patient had also been previously diagnosed with Rheumatoid Arthritis (RA) and reported intermittent episodes of pain and stiffness involving the small joints of the hands and wrists, particularly during the morning hours. Occasional cervical discomfort associated with inflammatory joint stiffness was also noted during RA flare periods. However, the patient identified temporomandibular pain and associated cervical radiation as her primary disabling complaint at the time of presentation.

Over the course of her illness, the patient had consulted multiple healthcare providers and was managed with various conventional treatments for temporomandibular joint pain, including repeated courses of oral analgesics and muscle relaxants, multiple steroid-based medications. Six months back she had 2-botulinum toxin (Botox) injections administered to the masticatory muscles due to severe pain [13,18]. She was advised TMJ Arthroscopy but to avoid surgical intervention, she tried many physical therapies and massages from time to time [12]. Despite these interventions, she experienced only transient or minimal symptomatic relief, in pain intensity, jaw

function, or associated cervical symptoms, leading her to seek alternative therapeutic options.

Clinical Examination^[19-21]

On clinical examination, the patient exhibited pain and tenderness at multiple cranio-cervical regions. Severe tenderness (Grade-3) was elicited over the right temporomandibular joint, masseter, and temporalis muscles, with pain radiating toward the right cervical and shoulder region. Moderate tenderness (Grade-2) was noted in the upper cervical paraspinal muscles (C2–C5) and upper trapezius, accompanied by palpable muscular tightness and stiffness.

Pain intensity, assessed using the Visual Analog Scale (VAS), was 8/10 at rest and 9/10 during jaw movements and prolonged neck flexion. Mandibular assessment revealed audible clicking during mouth opening and mastication, accompanied by pain and functional limitation. Maximal mouth opening (MMO) was reduced to 26mm (restricted; normal > 35–40 mm), measured between the incisal edges, with slight deviation of the mandible toward the right side, indicating functional TMJ dysfunction.

Cervical spine examination showed restricted active range of motion, particularly in right cervical rotation and lateral flexion, which reproduced facial and upper limb symptoms. The Neck Disability Index (NDI) score was 34/50, corresponding to severe functional disability, reflecting significant impact on daily activities, sleep, and occupational performance. Postural assessment revealed forward head posture, rounded shoulders, and reduced cervical lordosis, suggestive of chronic postural strain. Neurological examination of the upper limbs demonstrated normal muscle power, deep tendon reflexes, and sensory function, with no signs of true cervical radiculopathy. In addition, mild stiffness and discomfort were reported in the metacarpophalangeal and wrist joints, consistent with the patient's known history of rheumatoid arthritis. However, no acute inflammatory swelling was observed during the clinical assessment. These systemic inflammatory features were considered secondary contributors that may exacerbate cervical musculoskeletal tension and indirectly influence TMJ biomechanics, particularly through cervical spine involvement.

From a Siddha perspective, palpatory assessment identified heightened sensitivity and tenderness at key *Varmam* points along the mandibular–cervical energy axis, including *Kakattai Kalam*, *Thilartha Kalam*, *Pidari Varmam*, and *Adangal Varmam*, which are traditionally associated with jaw movement, cervical stability, and neural energy regulation^[22]. Disturbance in these *Varmam* points is

understood to disrupt the harmonious flow of *Uyir Thathukkal* (vital life forces), manifesting clinically as pain, stiffness, and radiating symptoms.

Overall, the clinical findings were consistent with myogenic temporomandibular joint dysfunction associated with cervicogenic pain, mediated by muscular hyperactivity, altered cervical–mandibular biomechanics, and disrupted neuro-energetic balance. The underlying rheumatoid inflammatory background was considered a secondary contributing factor that may have aggravated cervical discomfort and musculoskeletal tension, thereby influencing TMJ symptom severity.

Diagnostic Assessment^[23]

Lab investigations: Laboratory investigations conducted prior to Siddha therapy indicated elevated inflammatory markers consistent with active rheumatoid disease. The Rheumatoid Factor (RF) level was reported at 64 IU/mL (reference <20 IU/mL) and C-reactive protein (CRP) was 12mg/L, suggesting ongoing systemic inflammation. These inflammatory changes were clinically associated with cervical stiffness and radiating pain extending toward the temporomandibular region, which aggravated TMJ dysfunction.

X-Ray reports- pre-therapy temporomandibular joint OPG demonstrated mild condylar irregularity and reduced joint space on the right side, suggestive of functional overload without advanced degenerative changes.

Therapeutic Intervention

The patient underwent a structured Siddha-based integrative intervention over a period of three weeks, comprising six supervised sessions (twice weekly). The treatment protocol included Siddha *Varmam* therapy, targeted soft-tissue release, corrective therapeutic exercises, and lifestyle modification, aimed at addressing both local temporomandibular dysfunction and associated cervical–upper limb symptoms.

➤ **Siddha Varmam Therapy^[24]**- Siddha *Varmam* therapy was administered particularly to those energy points related to cervical and hands through manual, non-invasive stimulation described in Siddha literature as sites of concentrated *Pranic* flow; to encourage energy flow (*Prana* or vital energy). Point selection was based on pain distribution, muscle tenderness, and functional restriction. The following *Varmam* points were targeted: *Masseter Varmam*, *Thilar Varmam* (temporal region), *Kukundal Varmam* (mandibular region), cervical *Varmam* points and shoulder–arm meridian *Varmam* points. Manual stimulation was applied using graded pressure appropriate to patient tolerance. Additionally, gentle jaw

decompression and controlled mandibular mobilization techniques, derived from Siddha orthopaedic practice, were incorporated to reduce joint loading and enhance functional movement.

- **Cervical and Orofacial Muscle Release** ^[25]- Soft tissue pressures and myofascial release techniques were performed to address muscle tightness contributing to pain and movement restriction. Treatment included release of the sternocleidomastoid (SCM) and upper trapezius muscles, mobilization of the scalene muscle group, suboccipital muscle release and intraoral pterygoid muscle release, performed with informed patient consent, to reduce deep masticatory muscle spasm.
- **Energy healing sessions** ^[17]: Siddha practitioner performed two biofield alignment practices at week 2nd and 4th to reduce stress and muscular spasm. These are given to the patient for 10 mins duration for removing blockages associated with trauma, emotional or past incident.
- **Corrective Therapeutic Exercises** ^[26]- A supervised exercise program was initiated and progressively advanced over the treatment period. Exercises were selected to improve posture, neuromuscular control, and functional stability of the cervical and temporomandibular regions. The program included chin tuck exercises, controlled mandibular opening and closing exercises, masseter and temporalis stretching, scapular stabilization and strengthening exercises, diaphragmatic breathing exercises along with few postural correction drills.
- **Siddha dietary modifications** ^[27]: Anti-inflammatory and light liquid diet was formulated.

This integrative Siddha-based protocol was designed to address pain, neuromuscular dysfunction, postural imbalance, and energy flow disturbances, thereby promoting sustained functional recovery.

RESULTS

Following Siddha *Varmam*-based integrative therapy, the patient demonstrated substantial clinical improvement across all outcome measures in comparison to pre therapy recordings.

Marked reduction in tenderness was observed over the right temporomandibular joint, masseter, and temporalis muscles, with tenderness reducing from Grade-3 to Grade-1. Radiating pain toward the right cervical and shoulder region was no longer elicited on palpation. Upper cervical paraspinal muscles (C2-C5) and upper trapezius demonstrated minimal tenderness (Grade-0 to Grade-1), with significant reduction in muscle tightness and stiffness.

Pain intensity, assessed using the Visual Analog Scale (VAS), reduced from 8 to 2. Functional mandibular mobility improved significantly, with maximal mouth opening increasing from 26 mm to 41mm. Cervical spine range of motion, previously restricted and painful particularly in right rotation and lateral flexion showed near-complete restoration. The Neck Disability Index (NDI) score improved from 34/50, indicating severe disability, to 8/50, corresponding to mild disability. Jaw clicking reduced markedly and became painless, while radiating cervical pain to the right upper limb resolved completely [Table-1].

In addition to improvement in TMJ symptoms, the patient demonstrated clinical and systemic improvement in rheumatoid inflammatory activity-reduced morning stiffness in hand and wrist joints and their range of motion. Laboratory parameters showed a reduction in RF levels from 64 IU/mL to 38 IU/mL, CRP from 12mg/L to 5mg/L, and ESR from 38mm/hr to 18mm/hr following the three-week Siddha intervention protocol [Table-2].

Table 1. Clinical Outcome Measures Before and After Siddha Varmam-Based Therapy

Outcome Measure	Pre-Therapy	Post-Therapy
Pain Intensity (VAS, 0-10)	8	2
Maximal Mouth Opening (MMO, mm)	26 mm	41 mm
Cervical Range of Motion (ROM)		
Flexion	Restricted, painful	Near normal, pain-free
Extension	Restricted	Improved
Right rotation	Markedly restricted	Near normal
Left rotation	Mildly restricted	Normal
Lateral flexion	Limited with pain	Improved, pain-free
Neck Disability Index (NDI, /50)	34 (Severe disability)	8 (Mild disability)
Jaw Clicking	Present with pain	Occasional, painless
Radiating Pain to Upper Limb	Present	Absent

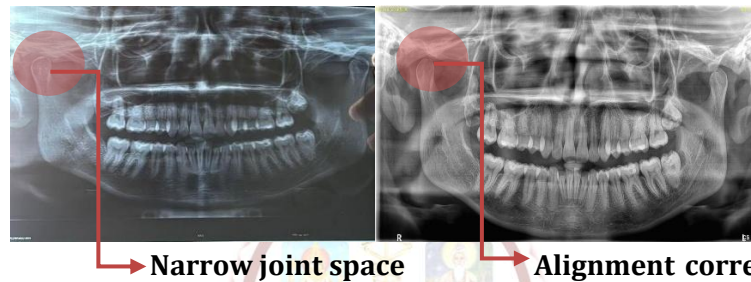
Table 2. Blood Investigations (before and after therapy)

Laboratory Parameters	Pre-Therapy	Post-Therapy
Rheumatoid Factor (RF)	64 IU/mL	38 IU/mL
C-Reactive Protein (CRP)	12 mg/L	5 mg/L
ESR	38 mm/hr	18 mm/hr

The patient mentioned headache frequency dropped from 3-4/week to once a week. The pain radiation to right hand reduced significantly and now occurring only occasionally. Postural reassessment revealed improvement in head and shoulder alignment, with reduced forward head posture, improved scapular positioning, and partial restoration of cervical lordosis. The functional improvement included improved chewing without discomfort, sleep quality better with more hours of sleep and increased tolerance for speaking and screen work. The patient

expressed high satisfaction with the therapy and continued home exercises.

As compared to pre OPG result, post-therapy radiographs showed improved bilateral joint symmetry with stable joint space and no evidence of progressive degeneration. These findings, when correlated with significant improvements in pain scores and jaw function, indicate improved functional alignment and reduced joint stress following Siddha Varmam-based therapy [Fig-1].

Fig-1: Pre and Post therapy OPG (TMJ)

→ Narrow joint space

→ Alignment corrected and space increased

DISCUSSION

Temporomandibular joint dysfunction (TMD) is a multifactorial musculoskeletal condition characterized by pain, restricted mouth opening, and associated cranio-cervical dysfunction. Recent epidemiological data indicate that the prevalence of TMJ-associated cervical pain ranges from approximately 10% to over 32%, particularly among young adults, a trend increasingly attributed to more of sports activity among young, prolonged screen exposure and poor postural habits [9]. In certain cases, systemic inflammatory conditions such as Rheumatoid Arthritis (RA) may also contribute to temporomandibular symptoms. RA is known to involve the temporomandibular joint in approximately 17–26% of patients, often resulting in synovial inflammation, joint tenderness, and restricted mandibular movement [11]. In the present case, the patient had a prior diagnosis of RA, and the associated cervical stiffness and inflammatory joint involvement may have contributed to aggravation of TMJ dysfunction. The TMJ shares close biomechanical and neuromuscular connections with the cervical spine, and dysfunction within this complex often results in myofascial trigger point activation in the masseter, temporalis, and cervical musculature. These trigger points frequently refer pain to the jaw, head, and upper limb, thereby mimicking or exacerbating TMJ

symptoms[7]. While pharmacological and surgical interventions remain treatment options, their limitations and potential adverse effects have shifted clinical emphasis toward conservative, multimodal therapeutic approaches, including manipulation therapy[29], acupuncture[28], Chinese massage techniques[30], physiotherapy[33] and Ayurvedic interventions [31].

The present case report of a 35-year-old female demonstrated involvement of both TMJ and radiating cervical pain, disability with joint stiffness. A comprehensive *Varmam* therapy with structured therapeutic exercises and lifestyle modification resulted in significant reduction of TMJ pain, improvement in maximum mouth opening (MMO), and resolution of associated cervical and upper-limb. The improvement in radiating arm pain observed in this case supports the concept of a functional musculoskeletal linkage between the temporomandibular region, cervical spine, and upper limb. This finding is consistent with prior research reports indicating that TMD may manifest beyond the craniofacial region, involving cervical and upper-quarter dysfunction [20,21]. The holistic framework of Siddha manual therapy, which emphasizes regional interconnections rather than isolated joint pathology, may explain the broader clinical improvements noted.

Interestingly, in addition to the improvement in TMJ symptoms, the patient also demonstrated reduction in rheumatoid inflammatory activity and improvement in peripheral joint mobility [11]. Laboratory parameters showed a decrease in Rheumatoid Factor (RF), erythrocyte sedimentation rate (ESR), and C-reactive protein (CRP) following the integrative Siddha intervention. Clinically, the patient reported reduced morning stiffness and improved range of motion in the wrist and metacarpophalangeal joints, along with decreased cervical stiffness [35]. These changes suggest that stimulation of specific energy points and associated energy regulation practices may have contributed not only to local neuromuscular relaxation but also to broader modulation of inflammatory processes affecting musculoskeletal function in this patient [24].

According to Siddha classical texts, TMD is primarily attributed to *Vaatham* derangement, leading to pain, stiffness, crepitus, and restricted mandibular mobility, clinical features comparable to *Hanustambha* described in Ayurveda [31]. Siddha *Varmam* therapy addresses this pathology through targeted manual stimulation of specific neuro-energetic points that regulate musculoskeletal coordination and neural signalling along the mandibular-cervical axis. Similar to Ayurvedic *Hanubasti*, which employs external oleation and sudation to counteract the *Rooksha* and *Sheeta* qualities of aggravated *Vata*, Siddha *Varmam* therapy utilizes graded pressure, warmth, and manual manipulation to restore tissue pliability, reduce stiffness, and normalize functional movement [36]. While both systems aim to reverse dryness, rigidity, and impaired joint lubrication, *Varmam* therapy uniquely focuses on precise anatomical energy points rather than regional oil retention. Functionally, these techniques resemble counter-strain and trigger-point release methods described in contemporary musculoskeletal literature, facilitating deactivation of hyperirritable nodules within taut muscle bands [25].

The therapeutic rationale of *Varmam* stimulation also parallels principles observed in Chinese manual therapy and acupressure, wherein techniques applied along meridians regulate *Qi* flow, relieve muscular spasm, and reduce pain [25,28]. In Siddha medicine, disruption of *Varmam* points is believed to impair the harmonious flow of *Uyir Thathukkal*, manifesting clinically as inflammation, crepitation, restricted movement, and radiating symptoms. Manual activation of mandibular, cervical, and upper-limb *Varmam* points produces effects analogous to the *Snigdha* and *Ushna* qualities achieved through Ayurvedic *Sneha* and *Swedana* therapies, facilitating reduction in pain, stiffness, and swelling. The resolution of crepitus observed clinically may be

attributed to restoration of joint lubrication and improved neuromuscular coordination. Oral and manual procedures such as *Gandusha* in Ayurveda, aimed at enhancing TMJ strength and reducing stiffness, find functional equivalence in Siddha through orofacial *Varmam* stimulation and intraoral muscle release, which improve mandibular stability and muscular relaxation [38]. Diet including curcumin, ginger, black pepper, long pepper and amla along with liquids having herbs emphasizing on anti-inflammatory principles further contributed to reduction in inflammation and swelling, consistent with existing evidence [27].

Manual therapy is known to exert analgesic effects through modulation of myofascial tone, enhancement of local circulation, and activation of endogenous pain-inhibitory mechanisms, including endorphin release. Palpatory assessment in this case revealed heightened tenderness at key *Varmam* points along the mandibular-cervical functional axis, including *Kakattai Kalam*, *Thilartha Kalam*, *Pidari Varmam*, and *Adangal Varmam* points traditionally associated with mandibular mobility, cervical stability, and neuromuscular regulation. Targeted stimulation of these points, using patient-tolerated graded pressure, aimed to reduce masticatory muscle hyperactivity, alleviate myofascial trigger point sensitivity, enhance microcirculation and lymphatic drainage, and normalize neuromuscular coordination [16,22]. Additional manual soft-tissue techniques, including release of the sternocleidomastoid, upper trapezius, scalene, suboccipital muscles, and intraoral pterygoids, were performed to address deep muscular spasm and restore normal cervical and mandibular biomechanics. These interventions were complemented by corrective exercises such as deep cervical flexor activation, controlled mandibular movements, stretching of masticatory muscles, scapular stabilization, and diaphragmatic breathing to reduce autonomic overactivity [8,14].

This case report provides evidence that Siddha *Varmam* therapy combined with therapeutic exercises represents an effective, non-invasive conservative intervention for temporomandibular joint dysfunction. The observed improvements in pain, mouth opening, cervical mobility, and associated upper-limb symptoms, along with reduction in rheumatoid inflammatory markers and improved mobility in the hand and wrist joints, suggest that Siddha-based integrative therapy may offer broader musculoskeletal benefits in patients with coexisting inflammatory conditions. Unlike pharmacological interventions, *Varmam*-based therapy poses minimal risk and promotes long-term functional restoration by addressing underlying neuromuscular and energetic

imbalances. Further controlled clinical studies are warranted to validate these findings and to establish standardized integrative treatment protocols for TMD within traditional and contemporary medical systems.

CONCLUSION

This case underscores the efficacy of Siddha manual therapy, combined with cervical and jaw corrective exercises and dietary modification, as an effective non-pharmacological intervention for TMJ-associated orofacial and cervicobrachial pain. Significant reductions in pain, radiating symptoms, and headache frequency, along with improved jaw function and cervical mobility, were achieved within three weeks. The improvement in RA values also suggests the effect of this integrative therapy on inflammatory process affecting musculoskeletal functions. This integrative approach offers a promising alternative for patients seeking holistic, safe, and sustainable relief from TMJ myofascial pain syndromes.

Given the encouraging results observed in this case, further research and clinical trials are needed to validate the findings and effectiveness of siddha therapy in disorder related to TMJ and cervical dysfunction. Such studies could be a platform to support the integration of siddha practices into broader therapeutic protocols and potentially more effective approach to manage TMJ associated pain.

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