Is there a place for Botox in dentistry? Yes or No? However simple the answer may be, the opinions are certainly numerous. If the answer is no, then the discussion should end. If yes, the next logical questions are… should there be limits to the use of Botox by a dentist? Can a dentist use Botox for both aesthetic applications and therapeutic treatments such as in the treatment of TMJ disorders? The truth is… Botox was designed to treat muscle related anomalies such as spastic muscle conditions. It was only later recognized that Botox was a way to delay the formation of fine lines and furrows on or about the face. If dynamic facial lines (repetitive lines from facial expressions) exist, then Botox is an effective means to relax those lines and allow for secondary healing of the skin. The profession of dentistry has experienced numerous occasions over many decades where new techniques and material use was deemed inappropriate or beyond the scope of dentistry. However, as a demand for a new technique or material grew; the tipping point was reached and considered acceptable. Think about the use of alcohol or ether to dull the unpleasant sensations of dentistry. The use of mercury (a known potent neuro-toxin) as a component in amalgam fillings, saving teeth with endodontic treatment, the use of an acid to etch dentin in vital teeth, the placement of dental implants to replace teeth. All of these treatments were revolutionary at one time; only to become universally acceptable dental treatments.

The point is, what other medical profession is more intimate with the function and structure of the muscles of mastication and how they are related to the teeth? How the vital structures of the cranial complex and oral cavity are cautiously breached daily with needles, drills, scalpels, and lasers. It only seems natural that a dentist has access to both the therapeutic use of Botox and its aesthetic paradigm. What other medical profession has their clients returning every 4-6 months for dental cleanings and therapy year after year? Botox treatment and its inclusion in dentistry is the perfect complement to our profession.

Botox, also known as Botulinum Toxin A, is a prescription medication that received FDA approval in 1989 for the treatment of muscle related pathologies. It was more than ten years later that Botulinum Toxin A was granted use for the relaxation of muscles that contribute to the wrinkling of skin in the glabellar area. This later became universally known as “Botox”. It was only recently, in 2011, that Botox was FDA approved for the treatment of chronic migraines.

The mechanism of action for Botox, in its most basic description, is injected into muscle tissue where it diffuses into the muscle nerve complex inhibiting the release of acetylcholine necessary for the completion of a muscle contraction. Botox is not a toxin, but rather an active molecule which is a highly refined protein. The Botox medication contains absolutely no Botulinum bacteria.
The use of Botox for Therapeutic treatment of migraines and the symptoms associated with TMD (bruxing and clenching) is growing in the dental profession. As a neuromuscular trained dentist using sound physiologic principles one should pause and realize that the Botox treatment is only dealing with symptoms and not the etiology of these symptoms. It has been established at the Las Vegas Institute that bruxing can be controlled 100 percent of the time, and clenching 90 percent of the time. This is accomplished with the use of ultra-low frequency Myo-monitor TENS and a physiologic neuromuscular orthotic. The fact is, the LVI trained neuromuscular dentist is having significantly high success rates when controlling the destructive forces of a pathologic occlusion. The science is pure and measurable, not opinion. As more and more dentists recognize the growing success of physiologically based neuromuscular dental care in the treatment of TMD and its symptoms, fewer dentists will be compelled to use Botox for these “therapeutic” dental related procedures. It could be argued that Botox may be used in the acute cases of TMD, but, it should be recognized that it takes 24-36 hours for Botox to initiate its mechanism of action with full action in 30 days. The patient of an LVI trained neuromuscular dentist can already be experiencing the long term non-medicated benefits of proper phase one orthotic treatment.

The awareness of therapeutic Botox treatments for migraines and TMD among the general public creates a unique opportunity for the well trained dentist to explain the process for treating and actually healing the pathology that exists.

Botox for cosmetic treatment in dentistry is also growing in popularity. It is this application of Botox in which the dentist should be most active. The ability of a dentist to have a long term relationship with his or her clients allows for a unique opportunity to share this aesthetic procedure with them. A dentist has an intuitive sense of beauty and its relationship to the smile and face. The use of Aesthetic Botox to soften dynamic facial lines of the forehead, glabellar area and eyes is in the wheelhouse of dentistry. As more and more dentists seek new and innovative treatments to add to their menu of services, Botox should definitely be among them.

The learning curve for Botox use in the dental office is a surprisingly small step. Dentists, on average, give over a thousand intraoral injections yearly. Many times these injections are in the proximity of significant anatomic structures that could have adverse results. Botox injections are similar. With proper basic understanding of facial anatomy and technique the dentist can be providing this service almost immediately. There are many nuances in the application of Botox treatment that a provider develops over time. The chance of an unintended treatment outcome is rare and avoidable with proper training. With any new dental procedure look to LVI with its extensive curriculum to provide the education that provides you the knowledge for this appreciated and exciting service.