



PERFECT CONTACTS, PERSISTENT PAIN: ARE WE MISTAKING OCCLUSAL MARKS FOR A DIAGNOSIS?

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The patient comes back following the delivery of a meticulously made prosthesis and says, "Doctor, everything looks perfect—but it still hurts." The margins are satisfactory, the contacts seem harmonious, and the articulating paper indicates there is no obvious premature contact. Nevertheless, the patient continues to experience symptoms. The articulating paper states that it is perfect, while the patient says that it causes pain. Which of these two accounts should we trust?

This apparently straightforward dilemma reveals a significant misconception in the field of Prosthodontics: the presence of visible occlusal contacts does not mean that the occlusion is functional. While articulating paper can show where contacts occur, it does not directly measure the occlusal force. The size of the mark may be affected by the thickness of the paper, the amount of saliva, friction, the movement of the mandible, and the patient's ability to close in a consistent manner. It follows that a very nice occlusal pattern is not necessarily evidence of a biologically harmonious occlusion.

There is a tendency to make adjustments, but should all significant marks be eliminated? Carrying out an occlusal adjustment without first making a diagnosis can turn uncertainty into a treatment that is irreversible. Pain that continues may be due to periodontal inflammation, pulpal pathology, tooth mobility, parafunction, muscle tenderness, temporomandibular disorders, an altered vertical dimension, difficulties with adaptation, or even come from a cause that has nothing to do with the prosthesis. In some cases, the most important thing to realise is that the prosthesis might not be the cause at all.

Modern digital occlusal analysis offers information that goes beyond that provided by conventional articulating paper, such as contact timing and the relative distribution of force. However, technology does not remove the diagnostic dilemma since a sophisticated measurement is still just a measurement and not a diagnosis. Isn't it possible that we are sometimes measuring things that are easy to measure rather than looking into what actually matters?

The clinician should therefore go beyond the occlusal mark and come back to the patient. What

are the character, position, duration, and trigger of the pain? Can it be reproduced? Does it happen while chewing, clenching, speaking, or at rest? Are the muscles, joints, the periodontium, the pulp, and the surrounding tissues normal? Only after these questions have been answered should the occlusion be considered in the wider clinical context.

Two statements certainly warrant equal caution: the one that says "The occlusion looks perfect, so it cannot be the problem" and the other that states "The patient has pain, so the occlusion must be adjusted." Both of these are diagnostic shortcuts. Since prosthodontics is becoming more and more digital and based on data, there is a risk of letting measurements, colour maps, and the reports produced by software take precedence over clinical judgment. Technology should be used to aid diagnosis, not to replace it.

Conclusion

Perhaps the most important lesson is that an occlusal contact is a finding, not a diagnosis. If the articulating paper says "perfect" but the patient says "pain," the answer may not be another adjustment but something that lies beyond the mark, something biological, neuromuscular, parafunctional, prosthetic, something in the patient's lived experience. In an era governed by measurable data and digital precision, we should remind ourselves that what we can measure is not always what we need to diagnose. So before we adjust what appears abnormal, we might want to ask ourselves: Are we treating the occlusion, or are we treating the patient?

A Call to Our Community

The Journal of Prosthetic and Implant Dentistry invites prosthodontists, educators, researchers, and students to join this timely conversation.

Call for Contributions

Theme: PERFECT CONTACTS, PERSISTENT PAIN: ARE WE MISTAKING OCCLUSAL MARKS FOR A DIAGNOSIS?

Submission Type: Viewpoints, Essays, Letters to the Editor, or Short Commentaries

Deadline: 30/11/2026

Word Limit: 500–1500 words

Submit to: ipskeralaeditor@gmail.com

Format: MS Word, Vancouver referencing style, max. 5 references