Supplementary Table 1. The most cited studies of the treatment types used in the analyzed articles

Treatment	Study/ Participants	Intervention	Outcome Measurements	Results
Occlusal Splint Therapy	Festa et al[12] n=5	-Passive splints and biofeedback exercises (3 months treatment)	-Functional nuclear magnetic resonance of the brain and TMJ -Muscular palpation tests -Visual analog scales (VAS)	All five of the patients' myofascial discomfort was alleviated by gnathological therapy, which included passive aligners and biofeedback exercises. Patients with TMD may benefit from using passive splints in addition to jaw exercises as a form of treatment.
Physical Modalities and Electrotherapy	Shousha et al.[13] n=112 female Exp I (n=37) Exp II (n=37) Con (n=38)	- Exp I low-level laser therapy (LLTT): intended masseter and temporalis muscles for 10 seconds with an energy density of 2.5 J/cm2. (3 days a week, total 10 sessions treatment) - Exp II: occlusive splint - Con: None	-Surface electromyography (sEMG). -TMJ opening index (TOI), -VAS	The results show that the LLLT has a clear short-term therapeutic benefit on improving TOI, VAS, and sEMG in female patients with TMD.
Pharmacological treatment	Tchivileva et al.[14] n=200 Exp (n=100) Con (n=100)	Exp: propranolol hydrochloride (60 mg, BID) Con: placebo (9 weeks treatment)	Facial pain index (FPI)	With the exception of the propranolol group experiencing fatigue, dizziness, and sleep disorders more frequently than the other treatment groups, adverse event rates were comparable. After nine weeks of treatment, propranolol was effective in attaining FPI reductions of ≥30% and ≥50% among participants with TMJ dysfunction, but it did not differ from placebo in terms of mean FPI reduction.
Therapeutic Exercises	Crăciun et al.[15] n=64 Exp (n=33) Con (n=31)	Exp: drug and physiotherapy treatment (PT): mandible manipulation techniques, active, active- passive, and passive stretching exercises, exercises to prevent joint noises, home exercise. Drug treatment: diclofenac, ibuprofen, meloxicam, naproxen or pirox- icam Con: Only drug treatment (Both groups three months treatment)	-The Jaw Functional Limitation Scale 8 (JLFS 8) -VAS -Diagnosis criteria for TMDs (DC/TMD) -Neck Disability Index (NDI)	In both groups, pain and spasms in the muscles lessened. Both groups saw a considerable drop in NDI and JFLS 8, with the PT group experiencing the greatest decline.
Manual therapy	Melo et al.[16] n=89 Exp I (n=24) Exp II (n=21) Exp III(n=19) Exp IV (n=25)	Exp I: Occlusal splint, Exp II: Manual therapy, Exp III: Counselling Exp IV: Occlusal splint and counselling) (a month treatment)	-The State-Trait Anxiety Inventory -VAS -Anxiety and Depression Scale -Beck Anxiety Inventory	One month after finishing, all four groups experienced a statistically significant decrease in their pain and anxiety symptoms. As a result, no group outperformed the others in terms of lowering the variables under study.
Cognitive Behavioral Therapy	Lam et al.[17] n=43 Exp (n=20) Con (n=23)	Exp: A dentist-assisted internet-based multimodal pain program with seven modules based on self-management principles and cognitive behavior therapy. Con: Occlusal splint therapy. (3 and 6 months follow-up)	-depression, anxiety, catastrophizing, and stress. -jaw functional limitation -characteristic pain intensity, -pain-related disability	In patients with chronic TMJ pain, this study was unable to show a difference in treatment result between occlusal splint therapy and an internet-based multimodal pain program. On the other hand, the results indicated that the online multimodal pain treatment enhances jaw function.
Intra-articular injection	Pihut & Gala[18] n=100 Exp I (n=50) Exp 1I (n=50)	Exp I: platelet rich plasma (PRP) injection. Exp II: hyaluronic acid (HA) injection	-DC/TMD -VAS -Maximal interincisal distance	Given that there was no statistically significant difference in clinical measures between the groups, it can be concluded that both of the drugs supplied were successful in repairing intra-articular structures. When injected intraarticularly into temporomandibular joints, PRP and HA have a beneficial impact on a few clinical measures and reduce discomfort in the event of disc displacement without reduction.

Supplementary Table 2. The most cited studies of the treatment types used in the analyzed articles, continued

Treatment	Study/ Participants	Intervention	Outcome Measurements	Results
Arthrocentesis	Ghoneim et al.[19] n=40 Exp I (n=20) Exp II (n=20)	Exp I: arthrocentesis with ringer solution Exp II: intra-articular injection with 1.5 ml injectable Platelet-Rich Fibrin (i-PRF) and arthrocentesis	-VAS, -Lateral movement (mm) clicking -Inter-incisal opening (mm)	When compared to the arthrocentesis group, the i-PRF group showed a statistically significant decrease in pain intensity and clicking sound as well as an increase in mouth opening and lateral movement.
Botox	Raphael et al.[20] n=79 Exp I (n=35) Con (n=44)	Exp I: Botox injection to two Btx treatment cycles Con: Botox injection to received none.	-Regions of interest (ROI) -Bone density (Cone Beam CT)	Both the condylar volume and the mean density of the major and secondary ROIs were comparable among exposure groups. Btx injections into the masticatory muscles did not result in clinically meaningful changes connected to the TMJ bone.
Acupuncture	Sant'Anna et al.[21] n=40 Exp I (n=20) Exp II (n=20)	Exp I: acupuncture plus occlusal splint Local and distal acupuncture spots were selected (LI4, LI11, ST36, LR3, TE21, LR2, TE17, LU19, and ST6) Whereas the distal spots were randomly selected; the local spots were chosen on the painful side of the face. Furthermore, ST36 was contralateral to LI4, LI11, and LR3. -once a week, four weeks. Exp II: acupuncture only	-VAS -Masseter and anterior temporalis muscles pressure pain threshold	With the exception of the fourth session, VAS dropped following each G1 session. In G2, the pressure pain threshold remained constant, and the VAS only started to decline after the first session. In patients with TMD, the evaluated treatments had no effect on the masseter or anterior temporalis muscles' threshold levels for pressure pain. Our results imply that using occlusal splints in addition to acupuncture may not always be necessary.
Chiropractic	Chu et al.[22] n=1	Chiropractic techniques, spinal adjustment, exercise rehabilitation and soft tissue therapy. (Four weeks treatment)	-VAS -Maximum mouth open (MMO) Cervical range of motions -Tenderness to palpation masticator muscles and TMJ	Showed improvements in subjects' cervical lordosis, open-mouth anatomy, and spinal range of motion.
Dry needdling	Dunning et al.[23] n=120 Exp I (n= 62) Exp II (n= 58)	Exp I: Upper cervical spinal manipulation plus dry needling Dry needdling: 7 points, the temporalis muscle, the superficial masseter muscle, the inferior head of the lateral pterygoid muscle, the peri-articular capsule of the posterior TMJ. (20 mins, 1–2 times per week, 4 weeks treatment). Exp II: Diclofenac (Voltaren) 3X50mg per day for 4 weeks and interocclusal splint and TMJ manipulation.	-Maximum assisted and unassisted opening. -Palpation of mastication muscles -The distance between the lower and upper central incisors -Active,pain-free mouth opening	For TMD patients, upper cervical spinal manipulation and dry needling proved more beneficial than diclofenac, TMJ mobilization and interocclusal splint therapy.
Orthognathic surgery	Abate et al.[24] n=20	Surgically assisted rapid maxillary expansion (SARME)	-sEMG examinations	When comparing the EMG data obtained before and after SARME with respect to the standardized electrical activity of the masticatory muscles (masseter and anterior temporalis), the statistical analysis revealed no statistically significant alterations. The results of this study demonstrate that the masticatory musculature assessed after around eight months of therapy is capable of adapting effectively to SARME.
Patient education	Xu et al.[25] n=54	Physical therapy: ultrasound therapy, low-frequency pulse laser therapy, posture training, manual therapy, and muscle relaxation exercises. 1– 3 times a week, 40 min per session, 3–10 consecutive treatments. Patient education: once, 10–20 min.	-MMO (mm), -Oral Behaviour Checklist (OBC) score - JFLS score -VAS score	When combined, physical therapy and patient education may alter the oral behaviors of TMD patients; however, nine months after the start of the intervention, this impact essentially vanished.