Avoiding irreversible
dental treatment

Types of orofacial pain and understanding them correctly

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Pain is one of the most complex health conditions encountered, as it affects not only the sufferers, but also the community in which they live. It is often associated with other co-morbidities, especially anxiety, depression and chronic pain elsewhere. In the orofacial region, the most commonly reported pain is dental, and this inevitably requires a visit to a dentist, who in most instances can provide a cure. However, there are other pains encountered in the orofacial region that can become chronic, defined as pain that has been present for over three months. These pains need to be diagnosed correctly, as their management is different.

At present, we have no biomarkers for chronic pain, and the only way we can make a diagnosis is to listen carefully to the history the patient gives. We need to elicit the key features of pain, for example onset, duration, location, severity, character, provoking and relieving factors, as well as the impact on quality of life and activities of daily living. It is essential to determine the presence of other illnesses, especially other chronic pain. Chronic orofacial pain has a significant psychological impact, as the face used to express pain from other parts of the body is now in pain itself. Patients with chronic orofacial pain are also confused as to whom they should consult, a dentist or a doctor. Their choice of health care provider will significantly affect both first-line treatment and subsequent referral.

Pain is notoriously difficult to communicate and poor communication of pain is cited as the main barrier to treatment and management. This “unsharability” of pain can be correlated with its resistance to language. This results in an intense burden of suffering and isolation for the individual. It is further compounded when patients do not have the requisite language skills. Yet we know that words may help a clinician in the differential diagnosis; for example, patients with musculoskeletal pain will use words such as “heavy”, “aching” and “nagging”, whereas those with neurological causes will describe their pain as “burning”, “pins and needles”, “shooting” and “stabbing”.

We also try to measure pain using a scale of 1 to 10, but do these verbal measures really capture the experiences of those with facial pain? This question recently led to a project with a visual artist to create photographic images of pain. Thus images were co-created by the artist Deborah Padfield and facial pain sufferers, aiming to reflect the individual experience of pain. A selection of these images were then made into pain cards, which are now being used with other pain patients to help improve mutual understanding and communication between doctors and patients. They appear to be helpful in describing the characteristics of the pain, as well as initiating discussions about its impact.

Once a dental or oral mucosal cause of pain has been excluded, the commonest cause of pain in the lower part of the face is temporomandibular disorders (TMD). TMD can present as clicking or locking of the jaw and can come on suddenly. It can present on only one side or both. Pain in the muscles of mastication with or without pain in the joint itself is the commonest form of this group of disorders. It is very common and up to 20 per cent of cases can become chronic.

The pain is centred in the pre-auricular area and can spread down the mandible and neck, as well as up to the forehead. It can be associated with clicks on opening or closing and rarely with reduced opening. The pain is described as dull, aching, sore and occasionally sharp. When the main muscles are palpated, the same character pain is elicited.

A careful history is essential in order to identify any potential red flags. It is important to check for possible temporal arteritis in anyone over the age of 50 having his or her first episode, as prompt treatment with steroids is required to prevent blindness. Any history of malignancy, neurological deficits, weight loss or severe trismus will require prompt investigation.
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Traditional TMD has been managed symptomatically, but this may be due to the natural history of the condition. Current data from the world’s largest study on TMD in the US has highlighted that the most common provoking factors are psychological. There is increasing evidence that patients with TMD also experience pain in other parts of the body and are more likely to be headache and migraine sufferers. This data therefore suggests that our approach to management of these conditions needs to be radically changed to include a more holistic approach as described below.

A condition with increasing incidence is persistent dental/veolar pain, also known as atypical facial pain. This is pain in the region of the teeth and/or tooth-bearing area in which a dental cause cannot be identified. In some cases, the pain is related to nerve injury. This can occur after extraction of teeth, especially third molars, as well as after root canal work, implants or facial trauma.

This pain is often not identified and leads to extensive irreversible, unnecessary dental treatment. It is probably a neuropathic pain and so needs to be managed in the same manner as other reported neuropathic pains according to guidelines. Drugs such as anti-depressants and anti-convulsants are helpful; opioids are of no help in these conditions. However, management with medications alone is insufficient. Patients need to be given an explanation about pain and how it is influenced by past experiences, mood, attention, significant life events, as well as genetic variability.

Evidence shows that chronic pain outcomes are improved when a biopsychosocial approach is used. Cognitive behaviour therapy needs to be delivered by multidisciplinary teams that include clinical psychologists and physical therapists.

Pain that remains intra-oral and does not radiate externally is burning mouth syndrome. This is defined as a burning pain or discomfort often present continuously on the tongue and other parts of the oral mucosa. There are no local or systemic factors to account for this pain, and often it is associated with altered taste and changes in salivary flow. Its highest incidence is in perimenopausal women, and so it had for many years been labelled as a psychological pain; however, recent research has now shown that this is also a neuropathic pain with abnormalities especially in perception of warmth and cold.

There have been a number of randomised controlled trials performed, but the evidence of any efficacy is low. Cognitive behaviour therapy is effective, especially if it includes a careful explanation of the potential causes of this condition and a reassurance that it is not cancerous.

Another rare pain that dentists often see is trigeminal neuralgia. It is defined as a “sudden, usually unilateral, severe, brief, stabbing, recurrent pain in the distribution of one or more branches of the fifth cranial nerve” that is provoked by light touch activities. It has a highly significant impact on quality of life and if poorly managed leads to depression. In some rare cases, it is caused by multiple sclerosis or tumours, but its cause is unknown in the majority of patients. Many patients will have compression of the nerve inside the skull. The pain often presents in the mouth, leading patients to believe that the cause is dental and to ask dentists to investigate.

Again, many patients will undergo unnecessary irreversible treatment until patient or dentist realises that it is non-dental. In the early stages, the pain is highly responsive to anti-convulsants, either carbamazepine or oxcarbazepine and all guidelines suggest this as the first-line drug type. However, for trigeminal neuralgia, there is a wide range of treatments, both medical and surgical, and so patients need to be seen not only by neurologists or oral physicians, but also by neurosurgeons. In correctly diagnosed patients, surgical outcomes can give the longest pain relief periods.

It is increasingly important that dentists recognise that there are many non-dental causes of orofacial pain. Time needs to be spent in eliciting a careful history, and irreversible dental treatment must be avoided. Chronic orofacial pain patients will have better outcomes if managed by specialist teams with multidisciplinary staff.

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