Chronic idiopathic orofacial pain: II. What can the general dental practitioner do?

T. Newton-John,[1] G. Madland,[2] and C. Feinmann,[3]

Currently, the majority of facial pain patients are referred onto specialists but there are treatment options available to the primary care practitioner and, indeed, good reasons for interception at the acute stage to prevent the development of chronicity. This paper attempts to synthesize contemporary theory and clinical evidence into a management strategy for the general dental practitioner.

The first paper described current theory and evidence for the initiation and maintenance of chronic pain conditions, and the rationale for regarding facial pain as one of these, rather than as a phenomenon unique to dentistry. Whilst evidence supportive of specific therapies in facial pain may be lacking, there is plenty of support for a biopsychosocial model and cognitive-behavioural approach to management, analogous to those adopted for other medically unexplained symptoms. The management strategy described in this second paper is the result of many years' clinical experience, combined with evidence from our own research and that of others, as cited in the first paper. Of course, there remains a need for clinical trials, with which we are currently engaged, but it will be several years before these are complete, and it would seem beneficial to the primary care of patients to disperse our ideas now, and to dispel some of the myths surrounding these conditions. The strategy does not involve novel technological techniques warranting extensive investigation of unwanted effects, but rather a holistic patient-oriented approach based on good clinical practice.

In brief
- The pain history is the key to diagnosis
- Pain is only very loosely related to dental or TMJ pathology
- Sympathetic enquiry, into how the pain interferes with the patient's life, will reveal goals for improvement
- Early discussion and intervention may prevent the development of chronic symptoms

History taking

The practitioner needs to conceptualise chronic facial pain as a stressor and then to help the patient manage the pain. It is crucial to understand that patients are extensively investigated and frequently off-loaded from specialist to specialist in search of a diagnosis. Patients feel ill-understood and over-investigated. Recent evidence suggests that it may be more helpful to assess patients in terms of disability and coping strategies, rather than pain.[1] There is a real need to make diagnosis realistic in terms of what the patients are told and what they understand about their problems.[2,3]

The most important aspect of management is the taking of a pain history. Pain is subjective and therefore the patient is the only source of diagnostic information. Divergence from a classical picture of pulpitis or pericoronitis may well betray the influence of factors beyond identifiable local pathology. Pain cannot be diagnosed by x-ray, and the temptation to surgically investigate and treat apparent radiological anomalies, which bear no plausible relation to the reported symptoms, must be resisted.

Clinical features

Clinical features essentially involve pain in the face, as indicated in Figure 1. The pain is usually perceived as arising from muscles, although increased EMG activity does not correlate with pain.[4] Many patients complain of joint stiffness and there may be clicking and sticking in the joints, patients also report pain that radiates all over the head and neck and down to the arms, as well as general aches and pain. Symptoms wax and wane in intensity over days and weeks. Cold weather, psychological stresses and dental treatment may all make things worse.[5]

Associated disorders

In taking a medical history, the dental practitioner may uncover other health concerns. It is not unusual for patients with chronic facial pain to have a number of other problems such as irritable bowel syndrome, headache, neckache, backache, dysmenorrhoea, pruritis, as well as cold intolerance and cognitive dysfunction. Some patients have multiple sensitivities and dizziness.[5,6] About 50% of patients with chronic facial pain also complain of chronic fatigue and about 50–70% of pain patients suffer from sleep disturbance. In general those with long-standing pain can continue normal activities, despite the pain being a daily or near daily occurrence.[1]

Prognosis and impact

Treatment is most likely to be effective when the pain history is short.[5] Successful treatment of facial pain of many years' duration is a much greater challenge. There is little understanding of prognosis in these patients but growing evidence for psychological distress as a consequence rather than a cause of pain,[7–9] and this distress is likely

[1]*Consultant in Clinical Psychology, Eastman Dental Institute and Hospital;* [2]*Clinical Tutor in Oral Medicine, Eastman Dental Institute and Hospital, 265 Gray's Inn Road, London WC1X 8LD; and Research Fellow in Health Psychology, Royal Free & University College Medical School, 2nd Floor, 48 Riding House Street, London W1N 8AA;*
[3]**Reader in Psychiatry, Eastman Dental Institute and Hospital and Royal Free & University College Hospital*
**Correspondence to: C Feinmann*
email: C.Feinmann@eastman.ucl.ac.uk
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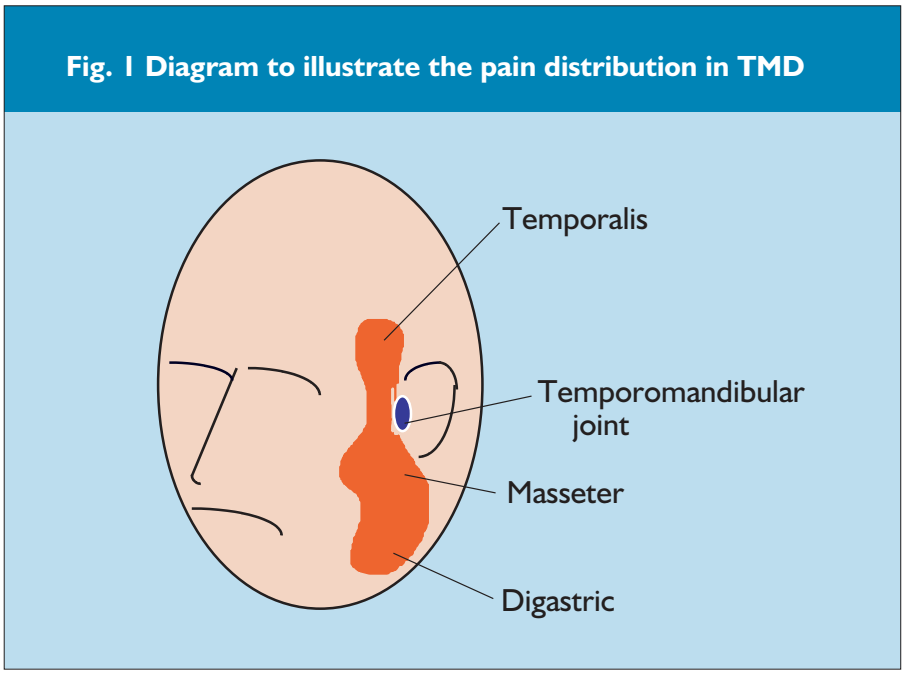
to contribute to the persistence of symptoms. Some patients improve quickly with conservative management, including physical therapy, occlusal splints, and antidepressants; others respond to cognitive therapy, hypnosis and other forms of treatment. However, improvement is only sustained when an attempt is made to resolve psychological problems. It is not clear who responds to what treatment, or indeed what problems actually need to be treated. Assessment of disability may lead to more precise treatment guidelines.

It is only recently that facial pain has been examined in terms of disability. Facial pain patients report that pain and fatigue adversely affect their quality of life. Typical problems such as difficulties in mouth opening affect their capacity to eat in public and enjoy a full social life. Disability, in terms of impact on mood, speech, self-image, taste and digestion, has been shown to predict a significant proportion of associated psychological distress.[1] Sympathetic inquiry by the practitioner will help to assess the level of interference with the patient's life, and provide a record against which subsequent improvement may be gauged.

Management

Glover *et al.*[10] have written cogently and sensitively on patient management within the primary dental care system, and readers are urged to consult their chapter. Their emphasis is not on testing different pharmacological therapies, splints or exercises, but on dentist-patient communication. They argue that effective communication during the early phases of facial pain can prevent the development of long-term problems. Dentists should be aware of the importance of listening to the patient's beliefs about their pain, and of trying to address their concerns without resorting to outdated psychogenic models of pain. Reassurance about the non-malignant nature of chronic pain is also important, but empty promises that 'things will get better' are unhelpful. The message is that talking to patients is often more useful, albeit sometimes more demanding, than operating on them.

Fig. 1 Diagram to illustrate the pain distribution in TMD



Conclusion

Chronic symptoms are a major health issue: they are common, persistent, disabling and costly. Although a minority of patients is likely to be troubled by recalcitrant symptoms and resultant psychological distress, necessitating complex clinical psychological or psychiatric treatment, the majority will respond to simple and inexpensive interventions available to the primary care practitioner.

Time and financial constraints might appear insurmountable barriers to the successful management of chronic pain patients. However, there is an obligation for primary care health workers to intervene conservatively at the acute stage in unexplained symptoms, in an attempt at preventing them from turning into chronic problems, which are so much more difficult and costly to remedy. Rather than 'heart-sink' cases, these patients can be extremely receptive to advice and reassurance, and thus rewarding to treat.

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