

GUEST EDITORIAL

Orofacial pain

How much is it a local phenomenon?

Editor's note: In our continuous effort to improve your Journal, you may occasionally notice some modifications to JADA's customary style. In this issue, we have published three articles on a similar topic (in this case, the general topic of orofacial pain) with an accompanying editorial by an international expert in that topic (in this case, Dr. Yair Sharav of Hebrew University-Hadassah, Jerusalem). This approach to a cover story has not been used frequently in JADA, and while it is not our intention to follow this format in every issue, we are eager to learn our readers' reactions to it. Your comments and suggestions will be welcomed.

Dentistry has come a long way since the days of Costen's syndrome, when "correction of the bite" was the state of the art for the treatment of orofacial pain. Accurate pain diagnosis has become increasingly reliant on consensus classifications and diagnostic criteria. These classifications were clinically oriented and defined syndromes as "acute" and "chronic," as well as "primary" and "secondary," and were based primarily on clusters of signs and symptoms. As pain mechanisms became better understood, a mechanism-based classification has been advocat-

ed.¹ A mechanism-based approach allowed us to postulate that some types of toothache could share the same mechanisms with migraine,² and that vascular orofacial pain should be included as an entity within the group of vascular-type craniofacial pain syndromes.

Diagnosis and treatment of chronic orofacial pain have acquired central roles in today's modern dental practice. The density of anatomical structures, mechanisms of referred pain, and the underlying systemic and psychological pathology complicate diagnosis and

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treatment. The classification of chronic orofacial pain into musculoskeletal, neuropathic and vascular-type can facilitate the diagnostic process. For the dental practitioner, the most misleading conditions are those that mimic dental pain such as pretrigeminal neuralgia (discussed below). Another bewildering but not so rare condition is vascular orofacial pain, in which migrainelike mechanisms may give rise to tooth-pulp pain.² Cardiac ischemia can refer pain to the oral cavity, and what basically makes all these cases difficult to diagnose is the fact that the source of pain is

outside the orofacial area.

Three articles in this issue deal with various aspects of chronic orofacial pain.³⁻⁵ Although at first glance it appears that pain is the only common denominator, there is another important aspect that unites all three. They all highlight the interrelationship between local oral signs and symptoms and general physical and mental disease and emphasize dentistry as an integral part of medicine.

The article by Sarlani and colleagues³ presents a patient who initially appears to have a fairly common and straightforward diagnosis of trigeminal neuralgia. The final outcome is not that simple, and an underlying myelin degenerative disorder emerges. The importance of a multidisciplinary team approach is very clear and, I should add, mandatory. This case also demonstrates the complexity involved in the diagnosis of orofacial pain. While the signs and symptoms of idiopathic trigeminal neuralgia are typical, one should be aware, as is clearly demonstrated in this case, that symptomatic trigeminal neuralgia should always be kept in mind.

Pretrigeminal neuralgia is another issue to be addressed; it does not present with the short, electriclike, triggered pain that is typical of trigeminal neuralgia, though it responds to carbamazepine. Pretrigeminal neuralgia can be diagnostically challenging, especially for the dental practitioner, as the pain may be spontaneous and of longer duration and may resemble dental pain. One should bear in mind that about one-fifth of all trigeminal neuralgia cases start atypically, and ini-

tially most of these patients seek dental advice. Many unnecessary extractions and endodontic treatments have been performed erroneously for this condition.

The article by de Leeuw and colleagues⁴ examines the oral-medical interface by studying the prevalence of medical conditions in patients with orofacial pain. Interestingly, but not surprisingly, their study group demonstrates a significantly higher prevalence of medical conditions than does their control group. The importance of a thorough medical history in every dental patient and particularly in this group of patients is obvious. Some of these conditions are undoubtedly part of the signs and symptoms of the orofacial pain syndromes, such as earache and dizziness that are associated with muscle pain. Sinus pain and headache may be a part of a vascular-type craniofacial pain syndrome and therefore cannot be dissociated from the group of orofacial pain. There also is the possibility that patients with chronic orofacial pain have altered temporal

summation of pain, which renders them more susceptible and irritable to various stimuli. Finally, stress may be another factor in comorbid conditions such as panic attacks and psychiatric treatment.

The article by Glaros and colleagues⁵ deals with the possible role of stress and parafunction in relation to orofacial pain. While this question is not new, the methodology used for measuring the variables is refreshing and holds potential for other behavioral studies on orofacial pain. The authors use the experience sampling methodology that is based on repeated measurements in a natural environment.⁶ Subjects carried pagers that beeped or vibrated when contacted. A custom-programmed database was used to place calls to pagers every two hours. Subjects were instructed to fill out a preprinted card each time they were paged, and to report on pain, tooth contact, tension, mood and stress. The highest degree of relationship was found between tension and jaw pain, but the authors rightly comment

that the nature of their regression analysis does not allow a cause-and-effect statement about parafunction and psychological distress on pain. Finally, I agree with their statement that patients will benefit from the care of clinicians who assess both biological and behavioral/psychological factors and use both sets of data in generating a treatment plan for patients who report chronic pain. ■

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