Chronic/Persistent Idiopathic Facial Pain

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KEYWORDS

• Facial pain • Persistent idiopathic facial pain • Cognitive behavior therapy • Antidepressants

KEY POINTS

- Persistent idiopathic facial pain is a poorly localized, often continuous nagging pain of the face for which no cause as yet has been identified.
- Patients are often overinvestigated in their quest to obtain a diagnosis and current conventional investigations are all normal.
- Systematic reviews highlight the paucity of randomized controlled trials of high quality with a combination of antidepressant and cognitive behavior therapy providing the best pain relief and decreased interference with life.
- A multidisciplinary biopsychosocial approach provides for the best outcomes, as these patients have significant comorbidities, including other chronic pain, personality disorders, and a history of significant life events.

INTRODUCTION

There has been considerable controversy about the condition currently called persistent idiopathic facial pain (PIFP) by the International Headache Society Classification (ICHD).[1] The term persistent as opposed to chronic is preferred, as it implies that relief may be a possible outcome. It is often called atypical facial pain (AFP).[2] In this text, both terminologies PIFP and AFP are used, but it is assumed that these are the same disorders. It may include more than one condition; for example, atypical odontalgia or persistent dentoalveolar pain. In the neurosurgical literature it has been termed AFP, and Burchiel[3] emphasized that it excludes disorders for which a cause has been identified and that this is a somatoform disorder diagnosed by psychological testing.

The ICHD description is "persistent facial and/or oral pain, with varying presentations but recurring daily for more than 2 hours per day over more than 3 months, in the absence of clinical neurologic deficit." See **Box 1** for criteria.

Box 1
International Headache Society Classification diagnostic criteria for persistent idiopathic facial pain

Diagnostic criteria

1. Facial and/or oral pain fulfilling criteria 2 and 3
2. Recurring daily for more than 2 hours per day for more than 3 months
3. Pain has both of the following characteristics:
   a. Poorly localized, and not following the distribution of a peripheral nerve
   b. Dull, aching or nagging quality
4. Clinical neurologic examination is normal
5. A dental cause has been excluded by appropriate investigations

Patients are diagnosed into this category frequently as an exclusion diagnosis; however, with improved appreciation of the need to take

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careful history, patients who were previously put in this category may in fact have other identifiable causes of pain, such as neuropathic pain and myofascial pain, and so do not belong here.[4,5]

The cause remains unknown but it has been suggested that it could be a consequence of deafferentation and central sensitization but is still is not clear if peripheral or central mechanisms are involved.[4,6] Not surprisingly, psychological factors are identified but these also could be as a consequence of having chronic pain, lack of diagnosis, and attitude of health care professionals. Gustin and colleagues[7] have shown that psychological and psychosocial factors are universal to chronic pain and are no different between patients with orofacial pain relative to diagnosis.

EPIDEMIOLOGY

A study in primary care in the Netherlands found an incidence rate of 4.4 (95% confidence interval 3.2–5.9) for AFP with a predominance in women of 75% and mean age of 45.5 years (SD 19.6).[8] A review of 97 patients with facial pain attending a neurologic tertiary center in Austria classified 21% as having PIFP.[9] In a UK community-based study, chronic orofacial pain was identified in 7% of the population and these patients often have other unexplained symptoms, such as chronic widespread pain, irritable bowel syndrome, and chronic fatigue, and show high levels of health anxiety, reassurance-seeking behavior, and recent adverse events.[10]

Risk Factors

- Psychological distress
- Maladaptive response to illness
- Women
- Retrospective perception of unhappiness in childhood.[11,12]

On the other hand, in the large Finnish birth cohort study of 5696 individuals, a question on facial pain was added and a correlation was found with optimism, which was an important factor in reducing facial pain.[13]

Using the Chronic Graded Pain Scale, Chung and colleagues[14] showed, in a population study of elderly Koreans, that disability was high in nearly 50% of patients with chronic facial pain but lower than for other forms of facial pain, such as burning mouth and joint pain.

Major Predictors of Outcome

- Patients' illness beliefs such as serious consequences of continued pain
- Low personal control[15]
- Optimism[13]

CLINICAL FEATURES

If there is a history of trauma, extensive dental work before pain onset, for example, of 6 months, then the pain may be neuropathic and so should not be classified under this category. Trained staff may be able to establish a more accurate diagnosis that avoids the label of PIFP.[16] Taking a careful history, including family history, social history, and performing psychological testing, is imperative, as comorbidity is common.[17,18]

Table 1 lists the key features.

Pfaffenrath and colleagues[19] and Zebenholzer and colleagues[20] have both used the ICHD criteria to determine if the criteria are correct and both suggested alterations. Zebenholzer and colleagues[20] put forward very simple criteria for PIFP under which most chronic orofacial pain could be classified.

INVESTIGATIONS

Many of these patients will have had numerous investigations including MRIs and yet is it questionable whether they should have an MRI scan, as these are normal. Lang and colleagues[21] showed that patients with PIFP do not have neurovascular compression of their trigeminal nerve at the route entry zone. However, patients with PIFP have brain morphology changes consistent with those who have chronic pain,[22] but studies suggest that somatosensory processing is not used to maintain the pain.[23] Conditions such as temporal arteritis may need to be excluded in patients older than 50 years by appropriate investigations.

Table 1
Features of persistent idiopathic facial pain

Character	Dull, aching, nagging, sharp
Site and radiation	Deep, poorly localized, nonanatomic, intraoral, extraoral, change over time
Severity	Varying but can be intense
Duration and periodicity	Long, slow onset; continuous, intermittent
Provoking factors	Stress, fatigue
Relieving factors	Rest
Possible associated factors	Multiple other bodily pains Pruritus Dysmenorrhea Life events Personality disorders Anxiety, depression Sleep disturbance