

Chronic Orofacial Pain and Behavioral Medicine



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KEYWORDS

• Chronic pain • Somatic arousal • Somatic quieting • Cognitive-behavioral therapy • Mindfulness

KEY POINTS

- Most patients with orofacial pain have chronic pain disorders that are heavily impacted by psychological issues that require recognition and management if patients are to recover.
- Patients with orofacial pain are somatically aroused, and treatment of their pain should include techniques that can provide somatic quieting.
- Focused breathing mindfulness has been shown to be very effective in causing somatic quieting.

INTRODUCTION

Patients with chronic orofacial pain (OFP) present in various types of pain clinics with a variability of complex problems that have a significant impact on their pain and impose roadblocks to the clinician who is trying to help patients. The clinician needs to identify and address these roadblocks if he or she is to effectively treat patients. Furthermore, whether the clinicians realize it or not, they may become part of patients' problems by avoiding or ignoring these roadblocks; they may be reinforcing the factors that cause the pain to be persistent. One of the primary roadblocks to managing patients' chronic pain is *somatic arousal*. This phenomenon is commonly observed in patients with chronic pain, and failure to address it leads to frustration and failure for both patients and the clinician. In this article, the authors discuss somatic arousal and review strategies that will directly address it.

The International Association for the Study of Pain^{1,2} defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." This definition recognizes the association between the sensory and emotional aspects of pain. Chronic pain has been recognized as pain that persists past the normal time of

healing, often described as persisting for more than 3 months. With the advent of functional MRI studies that allow for real-time brain imaging in experimental conditions, we can see what areas of the brain are activated by acute and chronic pain; those areas include lobes in the limbic system, consistent with the definition of pain as not only a sensory but also an emotional experience. This new ability now allows us to observe what is happening in the brain in real-time in response to different treatment modalities, including psychological interventions.

Over several decades of evaluating patients with chronic pain with various behavioral or personality inventories, the most frequently observed personality trait observed in patients with chronic pain was somatic overfocus. Patients who suffer from chronic pain are highly sensitive to their body symptoms and begin to focus on their symptoms with heightened awareness, in part, because of their frustration that doctors have not been able to give a definitive diagnosis or apply effective treatment. This circumstance leads to constant worry or anxiety that the pain is symptomatic of some potentially devastating problem, such as cancer, that is not being found. The wise clinician will recognize this problem during the initial visit and start to use somatic quieting exercises to

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help refocus and restructure the cognitions. Often, the clinician, becoming aware of the psychological impact on the patients' pain, will make a referral to a psychologist without realizing that the physical medicine program itself, used as part of the treatment administered by the clinician, can begin to address many of the behavioral aspects of the patients' chronic pain and start the process of somatic quieting.

The most pervasive problem seen in the OFP population is muscle pain. Although the spectrum of OFP problems involves neuropathic pain, headaches, and musculoskeletal pain, patients with nonmusculoskeletal pain conditions often have head and neck muscle pain in addition to the other types of pain conditions. Physical medicine protocols are given to these patients in addition to directly addressing the nonmusculoskeletal pain with disorder-appropriate procedures and medicines. The physical medicine modalities given to patients with chronic OFP include recommending a soft diet, use of moist heat and ice, and muscle specific stretches. Although it is obvious that the stretching part of the physical medicine program is addressing the muscle component of their pain, there are other techniques that can be given to patients to enhance the physical medicine protocols. These other modalities of the physical medicine program include focused breathing, time outs from the current stress, focused relaxation, and mindfulness practices. These aspects of the physical medicine program are important for all categories of chronic OFP disorders and should be incorporated into the overall management program that is taught to patients, not only to address the painful muscles but also for neuropathic pain and headache because the procedures use techniques that aid in somatic quieting.

This article focuses on the psychological aspects of chronic pain, whether it is musculoskeletal, neuropathic, or neurovascular, and discusses the aforementioned techniques that are used effectively to mediate patients' pain through using behavioral interventions involving somatic quieting.

OROFACIAL PAIN DISORDERS AND SOMATIC FOCUS

Patients with chronic OFP usually present with complex pain and abnormal sensation disorders in the orofacial region. The average general dentist or graduate from a dental specialty has little or no training or experience in dealing with these disorders. Most dental school training focuses on managing acute pain conditions, which does not prepare the student to recognize, diagnose, and

treat the chronic pain disorders, including temporomandibular disorders (TMDs). This circumstance is particularly problematic because failure to recognize OFP disorders and using acute dental pain management techniques can push suffering patients down the pathway to frustration, distress, and somatization. The 3 main subtopics of OFP are neuropathic pain, neurovascular pain, and musculoskeletal pain. Each of these general disorders can be associated with comorbid somatization. Within the rubric of neuropathic pain, the International Headache Society (IHS) has classified neuropathies of the head and neck as "painful cranial neuropathies and other facial pains." Within this category, the system lists classic trigeminal neuralgia and painful trigeminal neuropathy as the neuropathic disorders of the trigeminal nerve. However, going further into the breakdown of this category of pain are burning mouth syndrome (BMS), persistent idiopathic facial pain, and central neuropathic pain. BMS has been particularly frustrating to diagnose and treat and has long been shackled with the assessment that patients are somatizing. The pathophysiology of BMS is still unknown, and the most effective treatment to date is use of clonazepam specifically but not the other benzodiazepine-type drugs. Most of the patients with BMS are postmenopausal women who are depressed and are an easy target for attributing the disorder to somatization. The hallmark of BMS is bilateral burning pain in the anterior mouth or tongue, including the lips. Topical or local anesthetic does not block the pain, and it probably represents a centralized pain disorder. These patients do become somatically aroused because no one is giving them a diagnosis or effective treatment, and fear of a serious life-threatening condition is always present.³

Persistent idiopathic facial pain has replaced the previous IHS classification of atypical facial pain in an attempt to disentangle these facial pain disorders from the psychological burden of somatization. Nevertheless, this remains a poorly defined category of pain and probably represents several different facial pain syndromes that could be categorized under neuropathic pain disorders but continue to be unclearly or inaccurately described.⁴⁻⁶ Solberg and Graff-Radford⁶ have reported on a group of these patients who were eventually diagnosed with centralized neuropathic pain that responded to stellate ganglion blockade.

An additional category of disorder often seen in the dental office is occlusal dysesthesia. This disorder is created by the unsuspecting dentist who has attempted to treat a complaint of *my bite is off*, by readjusting the occlusion after patients suffered a trauma to the jaw or had recent dental work

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