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Practice guidelines

French guidelines for diagnosis and treatment of classical trigeminal neuralgia (French Headache Society and French Neurosurgical Society)



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1. Preamble

1.1. Requesting body

These guidelines were elaborated at the request of the French Headache Society (SFEMC¹) and the French Neurosurgical Society (SFNC²).

1.2. Subject of the guidelines

These guidelines concern the diagnosis and treatment of classical trigeminal neuralgia.

1.3. Patients concerned

These guidelines are for adult patients.

1.4. Professions concerned

These guidelines are intended for healthcare professionals participating in the treatment of patients with classical trigeminal neuralgia: general practitioners; neurologists; neurosurgeons; ENT specialists; ophthalmologists; stomatologists; dentists; radiologists.

1.5. Guideline grade and working methods

The proposed guidelines are classed as grade A, B or C in accordance with the following:

- a grade A guideline is founded on scientific evidence established by studies with a high level of proof such as randomized comparative trials with high statistical power and free of major bias and/or meta-analyses of randomized comparative trials, decision analysis based on well-conducted studies;
- a grade B guideline is founded on presumptive scientific evidence provided by studies with an intermediate level of proof, such as randomized comparative trials with low statistical power, well-conducted non-randomized comparative trials, cohort studies;
- a grade C guideline is founded on studies with a lower level of proof, such as case-control studies, series of cases.

Unless mentioned otherwise, the guidelines proposed are based on expert agreement among members of the working group.

The absence of a level of proof does not signify that an elaborated guideline is not pertinent or useful. The absence of proof should incite researchers to conduct complementary studies when possible.

These guidelines were established by the SFEMC and the SFNC in compliance with AGREE methodology. The working group divided the theme into specific topics:

- anatomy and pathophysiology of trigeminal neuralgia (Michel Lanteri-Minet);

- epidemiology, natural course, clinical spectrum of trigeminal neuralgia and positive clinical diagnosis (Anne Donnet and Dominique Valade);
- differential diagnosis of trigeminal neuralgia:
 - differential diagnosis with other primary headaches (Caroline Roos and Solène De Gaalon),
 - differential diagnosis with other essential neuralgias (Malou Navez and Geneviève Demarquay),
 - differential diagnosis with secondary facial neuralgias and trigeminal neuropathy (Pierrick Giraud and Evelyne Guégan Massardier);
- imaging of trigeminal neuralgia (Christian Lucas and Delphine Leclercq);
- medical treatments (Anne Ducros and Anne Donnet);
- surgical treatments (Emmanuel Cuny and Emile Simon).

An editing committee was composed of SFEMC and SFNC members together with healthcare professionals working independently of the society.

2. Guidelines for the diagnosis and treatment of classical trigeminal neuralgia

2.1. Anatomy and pathophysiology of trigeminal neuralgia

The trigeminal nerve (V) is the most voluminous cranial nerve through which transits nearly all of the somatic sensory information coming from the anterior part of the cephalic segment (face, oral cavity and tongue, nasal and sinus cavities, supra-tentorial dura mater) via its three main branches: the ophthalmic nerve (V1), the maxillary nerve (V2) and the mandibular nerve (V3). These three branches harbor the trigeminal peripheral afferents and enter the cranium via the superior orbital fissure, the foramen rotundum and the foramen ovale respectively. The cell bodies of the peripheral afferents carried by these three branches are intracranial and are grouped together within Gasser's trigeminal ganglion situated in Meckel's cave. The central prolongations of these trigeminal peripheral afferents group together forming the trigeminal sensory root that penetrates into the brain stem via the pons then distributes to the trigeminal sensory complex constituting the first central sensory relay for orofacial and cranial somesthetic input. The trigeminal nerve is also a mixed nerve with motor function since it carries efferent fibers that innervate the masticator muscles via a branch of the mandibular nerve. Finally, while it does not have a specifically autonomous contingent, the trigeminal nerve is joined by parasympathetic fibers issuing from the facial nerve (VII) and the glossopharyngeal nerve (IX).

In order to better apprehend classical trigeminal neuralgia (CTN), the subject of these guidelines, it is essential to understand certain key anatomic and pathophysiological notions concerning the trigeminal nerve, including: i) the cutaneomucosal territories of the branches of the trigeminal nerve; ii) the somatotopic organization of fibers in the trigeminal ganglion; and iii) the role of neurovascular compression.

¹ SFEMC: Société française d'étude des migraines et des céphalées.

² SFNC: Société française de neurochirurgie.

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