



The Future of Orofacial Pain Services

The treatment of orofacial pain has been, and continues to be, a dominion of dentistry in most parts of the world. However, specialist orofacial pain services are also run by neurologists and anesthesiologists. In most cases, these three professional groups manage complex patients on their own without a significant interdisciplinary approach. Patients may have visited—sometimes on their own initiative—a dentist, their general practitioner, and a neurologist, but the interactions among these professionals remain minimal, if any. However, over the past years, there has been a growing awareness that an interdisciplinary approach is much more effective, a view that I share based on my personal experience, having worked in this field in several countries with very different health care systems.

Considering the steep increase in health care costs experienced worldwide, one may legitimately ask the question of whether an interdisciplinary approach is appropriate. Looking at this question in more detail, why should an interdisciplinary setting be established, and which specialties should be part of it?

First, orofacial pain syndromes are frequently comorbid with other chronic pain conditions (eg, fibromyalgia, back pain) or psychiatric disorders (eg, depression, anxiety). Additional factors such as sleep disturbances may complicate the clinical picture. It is evident that the complexity of the conditions afflicting many of these patients requires systemic pharmacologic approaches that may include the use of multiple medications in high doses that are frequently associated with significant side effects. While the dentist is indispensable for performing a dental examination and excluding an underlying oral pathology, the systemic use of anticonvulsives, antidepressants, and other similar medications and the management of their side effects is more the domain of the neurologist or psychiatrist. This is further complicated by the fact that in some countries, dentists are not allowed to prescribe these substances. In addition, when several pain syndromes coexist in a given patient, polypharmacology should be reduced to a minimum, as should medications that may induce dependency. Therefore, the adequate management and choice of synergistic treatments should involve a close interaction between these specialties.

Second, facial pain syndromes may present with a similar phenotype but have entirely different underlying causes. A typical description of this scenario is the patient who experiences pain in a specific tooth but whose oral examination is unremarkable. We recently

conducted a clinical audit in our tertiary orofacial pain clinic that assessed the diagnoses of patients with headache and facial pain disorders in which dental causes had been excluded.¹ Interestingly, 44% of these patients had a probable trigeminal autonomic cephalalgia diagnosed on the basis of the International Classification of Headache Disorders third edition (ICHD-3 beta) criteria and, when appropriate, responsiveness to indomethacin. The second-largest group among these patients were those suffering from episodic or chronic migraine. These findings demonstrate that primary headaches are a relatively common cause of orofacial pain, but, most importantly, they highlight the importance of a multidisciplinary approach so that the adequate diagnosis is quickly made and treatment can be initiated, avoiding unnecessary delays for the patients.²

Third, given that facial pain syndromes commonly cause substantial disability and loss of quality of life, quick access to psychology and psychiatry services is essential. Comorbid depression and anxiety may have a substantial impact on treatment success, and beyond this may limit the use of potentially effective medications, as some of them may aggravate these symptoms as a side effect. Beyond that, the impact that chronic pain has on the patient's ability to play their role in their family and professional life may be severe. Therefore, the utility of the support of a specialized psychologist and/or psychiatrist within a tertiary orofacial pain service can't be highlighted enough.

Finally, from a research perspective, the interaction among the different specialties opens many opportunities to improve research in the area of orofacial pain. The publication of the first edition of the International Classification of Headache Disorders 30 years ago laid the foundation for structured headache research. As a result, our understanding of many primary headache syndromes has increased dramatically since then. Regarding orofacial pain syndromes, the diagnostic pathways have unfortunately been less clear. Therefore, the publication of the International Classification of Orofacial Pain (ICOP) in 2019 is a huge step forward and likely represents the beginning of a similar success story. This classification will certainly help to standardize clinical studies, thereby streamlining research activities and vastly improving the quality of the obtained findings. Beyond that, preclinical models of specific orofacial pain models are urgently needed to understand the neuroanatomical and molecular mechanisms behind these highly disabling syndromes. Therefore, it is essential that

the different specialties collaborate closely and exchange their knowledge in this field so that research activities can thrive.

Therefore, returning to my initial question, I am convinced that a tertiary orofacial pain clinic vastly improves the quality of the management of orofacial pain patients. Considering the highly disabling nature of these syndromes, as well as the delay in receiving adequate management due to time-consuming referrals from one specialist to the next and the lack of communication between them, the multidisciplinary approach in which the different specialties work alongside each other in one and the same clinical setting is, in my view, more than justified and likely to expand over the next years.

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References

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