Psychology Rather Than Morphology

In the authors’ opinion (1) a uniform classification system for facial pain can improve the options for “adequate treatment.” The extremely differentiated nosology they introduced was, however, clinically and statistically of little help, with the result that the authors themselves used outdated and their own terminology. Persistent idiopathic facial pain (PIFP) was the most common affliction in the patients in their specialist outpatient clinic. It is called “idiopathic” because no morphological concept can explain the pain.

“Adequate” therapy for PIFP consists of avoiding invasive measures, medication (as in neuropathic pain), and psychotherapy. Psychotherapy aims to move the patient to accept their pain and not to have unrealistic expectations of success—a truly modest result of decades of pain medicine, in which, ultimately, increasing nosological differentiation faces therapeutic de-differentiation. The reason for this is likely to be a disease theory that is based only on morphology and symptomatology. According to our investigations (2), PIFP is a pain disorder affecting the oral region (3), which can be explained by looking at a patient’s life history and psychodynamic development (which means it is absolutely not idiopathic), which should be diagnosed and treated according to the biopsychosocial model (4). The cause of this form of facial pain should not be sought in biological-structural pathology but in the patient’s psyche.

References

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In Reply:

The responses to our article (1) show that non-odontogenic facial pain constitutes a multidisciplinary and, as such, a far underrated problem.

Regarding the neuroablative treatment methods for the treatment of trigeminal neuralgia, we agree with Boström that Janetta surgery is a surgical intervention that is not always the therapy of choice, especially in older and physically ill patients. Gamma knife therapy can be beneficial in this setting; this is offered in Germany in a few specialized centers.

Jürgens emphasizes three factors based on the example provided: knowledge of the classification of maxillofacial pain, careful history taking and diagnostic evaluation, and—perhaps most importantly—the urgently needed intensification of training in recognizing non-odontogenic facial pain and how to treat it. Our own study results included more than 500 dentists in private practice as well as 130 dental medicine students and show a clear picture: only 30% of those survey participants reported feeling confident in diagnosing facial pain, and 92% of dentistry students declared that they had none or only very limited knowledge of non-odontogenic orofacial pain (2). If even students have practically no opportunity to learn anything about facial pain and headaches, we should not be surprised that many patients are not diagnosed and treated correctly. In medicine, the subject of pain has been included in the study curriculum as a cross-disciplinary subject—and there is hope that dental medicine will follow suit.

We do not concur with Seidl’s criticism on diagnostic over-differentiation. Quite the opposite: we have to set out definitions in order to be able to talk about the same things—(medical) progress is not possible otherwise (3). For this reason the International Classification of Orofacial Pain (ICOP) is the central prerequisite for scientific and therapeutic insights. We share the discomfort that was expressed regarding the ongoing lack of specific therapeutic options, but we are certain that the ICOP is going to change exactly that—in analogy to therapy for headache, which was similarly nihilistic before a uniform classification was agreed and enabled research to be done. We would respectfully remind readers that 35 years ago, patients with migraine were faced with the same dilemma as today’s patients with facial pain: because of a lack/unknown morphology (and lacking therapy, which was presumably even more important), their suffering was shifted into psychological models of explanation. Since those days, science has taught us that migraine is a hereditary and very specific biological illness, and we understand down to the cellular level how modern therapeutics work. Psychology still has an important role in the treatment—but definitely not in the genesis of the pain. This is exactly where research into the subject of thus far unexplained PIFP and other facial pain syndromes should and will go. And this long journey starts with the classification.

References

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Conflict of interest statement
The authors of all contributions declare that no conflict of interest exists.