Editorial

Cephalalgia
An International Journal of Headache

International Headache Society

Facial Pain is coming home

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Cephalalgia
2020, Vol. 40(3) 227–228

DOI: 10.1177/0333102420908506
journals.sagepub.com/home/cep

SAGE

Chronic facial pain that has no dental cause is probably underdiagnosed and definitely undertreated (1). Because chronic facial pain is usually perceived orally or in the mandibular/maxillar region, patients consult dentists who cannot find any dental pathology. When cranio-mandibular disorders have also been excluded, it becomes clear that the patient needs to be seen by a pain specialist but – more often than not – consults another dentist (2). One of the reasons why we do not recognize chronic facial pain is that we know so little about its mechanisms and have no specific treatment to offer. The consequence is a life-long odyssey of affected patients that often ends with all teeth removed and the pain still ongoing (3,4). This situation resembles in many facets the situation of headache patients some 30 years ago (5). The cornerstone allowing study of the pathogenesis, and discovery of highly specific treatments for headache has been the International Classification of Headache Disorders (ICHD) (6). ICHD has proven to be extremely valuable and indeed indispensable for the scientific and clinical progress in the field of headache medicine.

There are several reasons for the fact that, compared to the headache field, the investigation and subsequent development of treatment options for facial pain remained slow. An important factor was the lack of a comprehensive facial pain classification (7). By acknowledging and using such a classification we make sure that scientific progress is comparable between labs and that clinicians all over the world speak about the same disease when discussing, for example, atypical odontalgia. With the recent implementation of the first International Classification of Orofacial Pain (ICOP) (8), a huge step has been undertaken allowing standardized communication between professions, scientists and clinicians.

One of the enigmas of non-dental facial pain is the question whether facial pain is indeed a pain disorder in its own right or just another headache syndrome that slipped from the opthalmic to the second and third trigeminal branch (5). Headache is often referred to orofacial regions and may even be located exclusively within the orofacial region (9–11). Orofacial pain referring to the head presents a difficult clinical entity with manifold phenotypes. Rafael Benoliel was one of the "first voices in the wilderness", never tiring of pointing out to headache specialists that the headache field needs to develop an interest in chronic facial pain (12). And indeed, facial pain and its many facets are not reduced to trigeminal neuralgia, we need to see facial pain as an independent and distinct trigeminal disorder and such syndromes need to find a home in the headache field. In order to investigate we first need to distinguish (13) – the issue becomes important or even decisive when facial pain has to be distinguished from headache syndromes (9). Facial pain has been included and defined in the ICHD but the facial pain chapter in the ICHD excludes many dental and other facial disorders and is thus incomplete. With the advent of ICOP, this has changed. The classification committee included dentists, TMD specialists, neurologists and psychologists and also members of the Orofacial and Head Pain Special Interest Group (OFHP SIG) of the International Association for the Study of Pain (IASP), the International Network for Orofacial Pain and Related Disorders Methodology (INfORM), the American Academy of Orofacial Pain (AAOP) and the International Headache Society (IHS). These represent the major associations involved in orofacial and head pain, raising the acceptance and strengthening the future of ICOP. For the same reason, a lot of work went into harmonizing ICHD and ICOP. The recent definitions of trigeminal neuralgia and TMD were copied 1:1 to avoid having different definitions for the same disease. As such, ICHD-3 and ICOP can be cited *pari passu* but given that ICOP is more specific for facial pain it should be favored for this purpose.

Classifications are definitions and definitions are *per se* agreements (13,14) and the (in the pain field) unparalleled success story of headache has taught us

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that we need to have that agreement in order to study these diseases (9). Starting with a unifying and internationally accepted classification such as ICOP (8), we start turning around and redefining the field of facial pain and also strongly encourage active collaboration (15). New developments in pathophysiology and treatment are our long-term target and we need to use ICOP in scientific and clinical daily life – starting today.

Declaration of conflicting interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

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References

1. Benoliel R and Gaul C. Persistent idiopathic facial pain. *Cephalalgia* 2017; 37: 680–691.
2. Ziegeler C, Wasiljeff K and May A. Nondental orofacial pain in dental practices – diagnosis, therapy and self-assessment of German dentists and dental students. *Eur J Pain* 2019; 23: 66–71.
3. Benoliel R and Sharav Y. Chronic orofacial pain. *Curr Pain Headache Rep* 2010; 14: 33–40.
4. Pigg M, Svensson P, Drangsholt M, et al. Seven-year follow-up of patients diagnosed with atypical odontalgia: A prospective study. *J Orofac Pain* 2013; 27: 151–164.
5. May A. The exceptional role of the first division of the trigeminal nerve. *Pain* 2018; 159: S81–S84.
6. Headache Classification Committee of the International Headache Society. The International Classification of Headache Disorders, 3rd edition. *Cephalalgia* 2018; 38: 1–211.
7. Svensson P and May A. Classification: The key to understanding facial pain. *Cephalalgia* 2017; 37: 609–612.
8. The ICOP classification committee. International Classification of Orofacial Pain. *Cephalalgia* 2020; 40: 129–221.
9. Ziegeler C and May A. Facial presentations of migraine, TACs, and other paroxysmal facial pain syndromes. *Neurology* 2019; 93: e1138.
10. Gaul C, Gantenbein AR, Buettner UW, et al. Orofacial cluster headache. *Cephalalgia* 2008; 28: 903–905.
11. Yoon M-S, Mueller D, Hansen N, et al. Prevalence of facial pain in migraine: A population-based study. *Cephalalgia* 2010; 30: 92–96.
12. Benoliel R, Elishoov H and Sharav Y. Orofacial pain with vascular-type features. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod* 1997; 84: 506–512.
13. Schulte L and May A. Can "migraine" be defined? – yes and we have to. *Cephalalgia* 2015; 35: 1341–1342.
14. Schulte L and May A. What makes migraine a migraine – of the importance of disease classifications in scientific research. *Cephalalgia* 2015; 35: 1337–1338.
15. May A and Svensson P. One nerve, three divisions, two professions and nearly no crosstalk? *Cephalalgia* 2017; 37: 603.