Facial Pain

Anesth Pain Control Dent. 1992 Spring;1(2):85-9.

The management of craniofacial pain in a pain relief unit.

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This paper reports the results of 34 craniofacial pain sufferers who were treated at the Dudley Pain Relief Unit over a 1-year period. Most of the patients were referred by their general medical practitioners. They were adults representing all age groups, with a female-male ratio of 4:1. The average history of pain was 5.5 years. Neuralgic pain (as distinct from temporomandibular joint dysfunction syndrome, migrainous disorders, and pain of iatrogenic origin) was most frequently seen. Oral drug therapy, local injection of corticosteroids and analgesics, peripheral neurolysis, magnetotherapy, hypnotherapy, and acupuncture were the lines of management available. By the end of this study period, pain had been relieved or eliminated in 30 of the patients (88%).

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Sphenopalatine Ganglion Analgesia.

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The sphenopalatine ganglion and its involvement in the pathogenesis of pain has been the subject of debate for the last 90 years. The ganglion is a complex neural center composed of sensory, motor, and autonomic nerves, which makes it difficult to determine its pathophysiology. Current indications for blockade of the sphenopalatine ganglion include sphenopalatine and trigeminal neuralgia, migraine and cluster headaches, and atypical facial pain. Methods of blockade use local anesthetics, steroids, phenol, and conventional radiofrequency and electromagnetic field- pulsed radiofrequency lesioning. The techniques for blockade range from superficial to highly invasive. Efficacy studies, though few and small, show promise in patients who have failed pharmacologic or surgical therapies.