



Radio Frequency Abalation of Sphenopalatine Ganglion for Management of Refractory Atypical Facial Pain

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Received: December 30, 2024

Published: January 31, 2025

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Abstract

Atypical facial pain now termed as Persistent Idiopathic Facial Pain (PIFP), by IASP and ICHD2 is defined as a pain in the face which is present daily and persists for almost full day. This type of pain has no known etiology neither any symptoms of other cranial neuralgia. A 62-year-old male patient came to us with complaint of poorly localized holocranial headache occasionally radiating to the occipital region since 3 years. Pain is spontaneous in onset and continues the whole day. There is no aggravating factors but sometimes get relieved by instillation of Intranasal Lignocaine spray. There is also no associated neurological sign or abnormality. The Headache did not respond to any analgesics but sometimes responded to pethidine. A lot of consultations were taken but everything was in vain. This created a lot of anxiety in the patient and he was very depressed due to this and was taking a lot of antidepressant drugs. Our approach to treatment started with psychological counseling, pharmacological drugs and a regular follow-up. The patient felt a little satisfied. Still now very little studies have been done regarding role of Sphenopalatine ganglion Radiofrequency Abalation in Atypical facial pain. But we obtained a magical result to this pain after the Sphenopalatine ganglion radiofrequency ABALATION.

Keywords: Atypical Facial Pain; Chronic Pain; Depression; Management; International Association of Pain (IASP); International Classification of Headache Disorders (ICHD2)

Introduction

Frazier and Russell were the first to introduce the term atypical facial pain (ATFP) in 1924. It is defined as a pain distributed along the territory of the trigeminal nerve that does not fit the classic presentation of other cranial neuralgias. Pain is confined at onset to a limited area on one side of the face, deep aching, poorly localized and not associated with sensory loss or other physical signs, with no abnormalities in laboratory or imaging studies [1,2].

The main features of AFP are: no objective signs, negative results with all investigations/tests, no obvious explanation for the cause of the pain, and a poor response to attempted treatments. AFP has been described variably as a medically unexplained symptom, a diagnosis of exclusion, a psychogenic cause of pain

(e.g. a manifestation of somatoform disorder), and as a neuropathy. AFP is usually burning and continuous in nature and may last for many years. Depression and anxiety are often associated with AFP, which are either described as a contributing cause of the pain, or the emotional consequences of suffering with unrelieved, chronic pain. For unknown reasons, AFP is significantly more common in middle aged or elderly people, and in females (incidence <1%)

Case Report

A 62 years male patient reported to us with a complaint of holocranial headache radiating towards the occipital region since 3 years. The pain was dull aching, localized in region of lala of nose and ear superiorly till the lower border and angle of

mandible inferiorly and radiating towards the occipital region (Right side>Left side). The pain is occasionally associated with some features of autonomic involvement like redness of eyes, lacrimation and sometimes facial flushing. Anxiety, Depression, Mood Disorder, Irritable Bowel Syndrome (IBS) and unexplained pain in other areas of the body were associated with AFP. The pain starts spontaneously and continues the whole day without any neurological sign or any other abnormality. There is no associated aggravating factors but sometimes they get relieved by intranasal instillation of lignocaine spray.

Multiple doctor consultations were taken since the onset of pain but in vain. On examination patient was well built and nourished, but slightly tense and depressed and was taking a lot of antidepressant drugs. In local examination there was equal bilateral facial symmetry and normal function of bilateral temporomandibular joint. Palpation revealed mild tenderness of cheek, lower border and angle of mandible.

Provisionally on the basis of history and clinical examination as there was no specific etiology and anatomic pathway of pain, so it was considered as atypical facial pain.

Diseases with features similar with Atypical facial pain are trigeminal neuralgia, temporomandibular joint dysfunction syndrome, Temporal arteritis, myofascial Pain Dysfunction Syndrome, atypical Odontalgia. This were ruled out before starting our treatment [3].

Investigation

Complete haemogram and CTscan of brain revealed no significant abnormality.

Treatment

We started our treatment with Antidepressants, Anticonvulsants associated with Cognitive Behaviour Therapy.

The pain was not responding to any conservative management except for intranasal instillation of Lignocaine spray so we planned for a Radiofrequency ABALATION of sphenopalatine ganglion (Rt).

Pulsed RADIOFREQUENCY ABALATION(RFA) of the Rt Sphenopalatine ganglion was done after fluoroscopic confirmation. Two cycles of pulsed RFA was done at 42degree Celsius for 60 sec

and 90 sec respectively. After ablation Inj. Kenacort (40mg) and Inj. Bupivacaine (0.25%) were given.

Pain got reduced immediately and patient was satisfied.

Discussion

Atypical facial pain recently defined as persistent idiopathic facial pain (PIFP) by the revised classification of the International Headache Society (IHS) [1,2]. According to the IHS criteria, a diagnosis of atypical facial pain is possible when the facial pain occurs daily and persists for most of the day, which is confined at onset to a limited area on one side of the face or a part of it and is not associated with sensory loss or other physical signs. Investigations also didn't show any abnormalities [4].

Patients often report symptoms of paresthesia, pain, burning and throbbing Sensation. Physical examination may be normal, but hypoesthesia, hyperesthesia, and allodynia may be found.

Atypical facial pain can be differentiated from TRIGEMINAL neuralgia by the character of pain. Trigeminal neuralgia presents with a sharp electric shock like lancinating pain generally localized to one side of the face while Atypical facial pain presents with constant dull aching tingling sensation present bilaterally [8].

Psychiatric symptoms of depression and anxiety are present with this type of pain syndrome. So the treatment includes multidisciplinary approach including psychological counselling, pharmacotherapy and certain specific Interventions like Sphenopalatine ganglion RFA in our case [5-7,9,10].

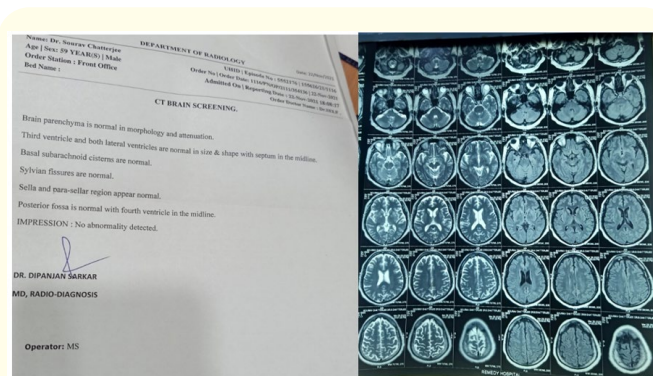


Figure a

Conclusion

Multidisciplinary approach including psychological counselling, pharmacotherapy and certain specific Interventions like Sphenopalatine ganglion RFA (in our case.) to treatment of Atypical facial pain should also be kept in mind.

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