Facial Pain referrals to Neurology

– advice for initial management in primary care

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Introduction

This Fact Sheet provides information on how to treat patients with facial pain with different symptoms, situations and circumstances.

What are the common causes of facial pain?

Like headache, facial pain diagnoses are fundamentally based on history. Common causes are:

Common causes	Description
Migraine	Facial pain is common as part of acute migraine.
Oral/Dental structures/ Salivary glands	This is usually intra-oral pain, occasionally facial pain.
Persistent idiopathic facial pain (previously "atypical facial pain")	Usually constant unilateral pain and resistant to all medication. Similar patient profile to fibromyalgia and other chronic pain syndromes.
Sinusitis	Over diagnosed from a neurology perspective (usually migraine or persistent idiopathic facial pain). ENT state that sinusitis **always** includes one of nasal blockage, nasal congestion or nasal discharge.
Temporal Arteritis	A rare but important cause of facial pain, usually in people >70 and rare in <60 years. Have a low threshold for checking ESR (usually >50) or CRP (>5). If suspected refer urgently to neurology.
Temporomandibular joint disorders (TMJ)	This is usually associated with jaw movement.
Trigeminal Neuralgias	Trigeminal neuralgia is the most common of the craniofacial neuralgias; characteristic history, 70% are over 60 years old, almost always unilateral (bilateral with alternating unilaterality very rare), typically V2 and V3 (cheek and jaw). Lancinating, stabbing, jolts of pain usually lasting seconds. Pain is spontaneous or triggered by simple stimuli such as touching, teeth brushing, talking/chewing. About half have underlying persistent facial pain.

When should I request a CT head?

CT head in persistent idiopathic facial pain or migraine is not usually indicated.
For trigeminal neuralgia it may be reasonable to refer for assessment and subsequent MRI, if you think the patient may be a candidate for surgical treatment. If they are not, and there are no other focal neurological symptoms or signs, then reasonable to manage in primary care.

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What treatments can I try in primary care and when should I refer?

Facial Pain condition	Treatment	When to refer to Neurology
Facial pain not fitting with above descriptions	If mild, consider tricyclic prior to referral.	
Migraine	As per migraine factsheet.	Treatment resistant migraine only (3 preventative agents >3 months and appropriate acute treatment (see RefHelp guidance on Migraine).
Persistent idiopathic facial pain ('atypical facial pain')	Tricyclics, e.g. Amitriptyline, Nortriptyline.	If no focal neurological symptoms or signs then suggest referral to pain service.
Sinusitis/TMJ/ Oral	Referral to Ear Nose and Throat (ENT)/Maxillofacial/Oral Surgery.	
Temporal Arteritis	Refer to oncall Neurology service if typical story and ESR and CRP high.	
Trigeminal Neuralgia	• Carbamazepine or Oxcarbazepine are the drugs of choice. • Second line agents (with poor evidence base) include lamotrigine, gabapentin, pregabalin, baclofen, phenytoin. • Invasive therapies: microvascular decompression or ablative procedures.	If not responding to medication then patient may be suitable for surgical treatment (refer to Neurosurgery). If not suitable for Neurosurgery or diagnostic uncertainty refer to neurology.

References:

Practical Neurology 2021;0:1-12. Lancet Neurology 2006;5:257-67