TN'S JOLTING SYMPTOMS AND THE DRUGS THAT HELP

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TNA Medical Advisory Board
TNALERT, Spring Issue, 1995

There should be little difficulty in diagnosing trigeminal neuralgia if doctors take a careful patient history and watch for clues that are very specific to this Jolting pain.

TN rarely occurs in patients under age 30. The pain is of high intensity, typically lasting 20 to 30 seconds and then disappearing' only to be followed by another sudden stab later.

The pain also usually is triggered by a light touch to a particular area or two of the face, especially around the nose and mouth. Often parents say they seem to feel a sense of numbness or deadness in the face, although an exam usually doesn't bear that out.

One of the biggest clues, though, is not what TN patients say but what they do. In almost every other facial pain syndrome, patients will be found massaging the painful area or rubbing it or applying heat or cold.

With TN, exactly the opposite occurs. The patient goes to great lengths to avoid any stimulation of the Face or mouth whatsoever. Thus it's characteristic of TN patients to avoid touching the face, washing the face, shaving, biting, chewing or anything else that stimulates the trigger zones and produces the pain.

Many factors may produce TN. These include aging, a persistent viral infection of the trigeminal ganglion (the cluster of nerve cells just before the nerve splits out into its three branches in the face) or an abnormality that is compressing the trigeminal nerve, such as a blood vessel, tumor, cyst or aneurysm (a blood vessel bulging at a weak area).

In about 3 percent of the cases, multiple sclerosis is at the root of the pain. MS plaques can form on me trigeminal nerve and destroy the nerve's protective coating.

Besides giving doctors descriptions of pain that are as accurate as possible, TN patients also should have a magnetic resonance imagine (MRI) scan of the brain to search for tumors and aneurysms.

If those disorders are ruled out, most doctors agree that medical Treatment is the best first step. How a patient responds to medications also can help nail down a definite diagnosis of TN. If, for example, a patient presumed to have TN does not rapidly respond to carbamazepine (e.g. Tegretol) in 24 to 48 hours, the diagnosis is then seriously in doubt.

If the patient does respond to carbamazepine, then clearly this is the treatment of choice. Doctors who have followed patients with TN for more than a decade have found the condition ebbs and floes, so it may be possible when using drugs to nudge the patient into another remission. When that occurs, the drug can be decreased and perhaps stopped.

If the response to carbamazepine is only partial, other drugs also may be useful, including phenytoin (e.g. Dilantin) and baclofen (e.g. Lioresal).

Some neurosurgeons suggest that unpleasant side effects occur frequently with carbamazepine and that up to 20 to 30 percent of patients taking this drug need to stop it, which is surprising since the drug seems better tolerated when used to heat epilepsy.

Nonetheless, carbamazepine may produce undesirable sedation and other side effects, including in rare cases, blood disorders. For that reason, patients who are taking it should undergo periodic blood tests.

Commonly used pain-killing drugs i are of little use in treating TN. Carbamazepine, for example, is not an analgesic drug at all but an anticonvulsant that helps TN pain by reducing the sensitivity of the bigger zones.

WORKS FAST

Carbamazepine often helps dramatically and quickly -- sometimes in as little as 4 to 24 hours. Generally, treatment starts with 100 to 200 me doses of carbamazepine taken two or three times daily.

If this dose is well tolerated, the doctor should attempt to adjust the medication according to the severity of the pain. If the pain persists, the dosage should be increased, if the pain is well controlled, the dosage can be scaled back. It may be necessary to continue the carbamazepine at a maintenance level, such as 200 mg per day, in order to keep the patient pain-free.

If symptoms persist while taking carbamazepine in adequate doses, I add another drug to the regimen. Generally, baclofen is the choice, beginning with 10 mg daily and increasing to 60-to 80 mg daily in divided doses along with carbamazepine.

Rarely, if pain persists, a third drug -usually phenytoin -- is added. By the time a three-drug treatment is reached, though, it's time to consider referring the patient for surgery.

Other drugs such as sodium valproate (e.g. Depakene, Depakote, Epilim) and clonazopam (e.g. Klonopin, Rivotril) are sometimes used, but no formal studies have been done to document their effectiveness in treating TN.

The drug pimozide e.g. Orap) is another medication that as been offered for use in treating TN. In one study of 48 patients, pimozide was found to be superior to carbamazepine for pain relief. However, this anti- psychotic drug can cause a variety of side effects that should weighed carefully before prescribing it.

NEW DRUG BEING TESTED

Yet another drug, oxcarbazepine (e. g. Trileptal), is currently being tested. Early studies of this drug, similar in makeup to carbamazepine, are showing an "excellent therapeutic response," according to a pair of European neurologists who are testing it. However, this drug so far is not available in the United States.

Two other researchers have reported some success using a cream containing capsaicin, the chemical that makes hot peppers hot. Six of 12 patients who rubbed this non-prescription cream on the painful area for several days got complete relief, while four others got partial relief. Two had no pain relief. Four of the 10 who were helped found their pain returned in three to five months, but after a second round of cream, the pain did not return for the remainder of the year.

Approximately 25 to 50 percent of TN patients eventually will fail on medical therapy and will need some form of neurosurgical treatment.

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