



TRIGEMINAL NEURALGIA ASSOCIATION OF CANADA

March 2013 Newsletter

Support Group



Eastern Ontario Support Group

We are planning a meeting in Ottawa in late March! Would you like to connect with others who understand the TN journey? Give us a call!

Our group consists of people from Kingston through to Cornwall and north to the hills of Gatineau! We are a group of people who enjoy coming together to encourage and support each other along the journey of TN. We share news on where we are at in our TN journeys and what paths we have travelled. Most of all we are always open and looking to welcome new members to our group. Our group is open to individuals with TN as well as their friends and family.

For more information and the time place of our next meeting please contact Jane at cmusicstudio@cogeco.ca or by calling 613.936.6977

Vancouver and Lower Mainland Support Group

Meeting: Saturday, April 27

Meeting Time: 1.00 – 3.30 pm

G.F. Strong Rehab Centre.

Vancouver

4255 Laurel St.

(Laurel at W. 26th, one block east of Oak)

Note new room:

The Boardroom 109. (Close to the cafeteria, just off the main lobby)

Friends, Family and Supporters welcome.

If you'd like to get in touch please call or email me:

Ann Hopkins 1 604 741 0662;

annhopkins@dccnet.com

Lethbridge Support Group

The Lethbridge Support Group meets every second Saturday of the month at 2:00 p.m. in Rm A, Lethbridge Senior Centre, 500 - 11th Street, S., Lethbridge, AB.

Coordinator: Marion Guzik, past president / founder TNAC

email mguzik@telus.net Phone: 403-327-7668

London Support Group

Are you in the London, ON area? We have a new support group serving Western Ontario.

Contact Name: Elizabeth Galbraith

Tel: 519.471.3439

energyworksnaturally@bell.net

www.tnsupportlondon.ca



IMPORTANT NEWS!!!!

**Lyrice Now Covered by
Pharmacare—BC Ministry of
Health**

TNAC is a small charitable organization but we do our best to listen to our members and to try to help where we can! We had a recent success in response to a request for support in the province of British Columbia. Pharmacare, which is a drug subsidy program run by BC's

Ministry of Health, provides partial coverage for medication after a deductible is reached. However it only covers scheduled drugs and Pharmacare didn't cover Lyrica for TN. TNAC took this up with Pharmacare and the Ministry of Health (BC) and we are delighted that Lyrica is now covered for TN in BC by Pharmacare.

We'd like to applaud the BC government for this welcome decision. We're very pleased



TNAC PRESENTS

Saturday March 30, 2013

4PM EST

TRIGEMINAL NEURALGIA:

A NEUROSURGEON'S PERSPECTIVE

By

Dr. Christopher R. Honey

Neurosurgeon (MD, D.Phil.,
F.R.C.S.)

Dr. Honey is Associate Professor of Neurosurgery at the University of British Columbia and Director of Research for the Division of Neurosurgery. He was the President of the Canadian Section of Stereotactic & Functional Neurosurgery for its first seven years. He is on the Board of the World Society of Stereotactic & Functional Neurosurgery and was on the Board of the American Society of Stereotactic & Functional Neurosurgery.

Registration is LIMITED
**TO REGISTER
GO TO:**

www.tnac.org

Registration for TNAC
members **(free)** begins
MARCH 11 2013.

*Registration for non-TNAC members
(cost \$10) open MARCH 20, 2013*

We had an overwhelmingly positive response to our first webinar. It was a wonderful learning experience and a great opportunity for everyone! The webinar recording is posted for members in our members only area (please contact us if you have lost your access code!)

Do not miss the chance to join us for our next TN webinar! A webinar is a seminar that is presented on the internet. You do not have to leave your home to attend. All you need is to register and then, at 4PM on Saturday MARCH 30, 2013 go to the URL (www.xxxxx) that we email to you, turn the speakers on your

computer on, and you can listen in to hear Dr. Honey speak about TN. You will be able to type in questions during the webinar which he will answer at the end (time providing) so the presentation will be interactive.

You **MUST** register in order to participate. Registration spots are limited. Once we are full we will have to close the webinar room. Registration will be on a first come first serve basis starting with TNAC members. If you are not a TNAC member and would like to join please go to www.tnac.org and download a membership form. You can pay your membership fee online by paypal.

To register go to www.tnac.org for the link to the registration page.

Our Third webinar will be:

**Saturday June 1, 2013
4:00PM EST**

Topic to be announced

A third webinar, by Dr. M Hodaie, MD (University of Toronto) will follow in June.



5 Tough Choices You Face When Chronically Ill or in Pain

By *Toni Bernhard, J.D.*

Suffering from chronic pain or illness—or, as is often the case, *both*—can feel like a full-time job. One reason for this is that we must constantly assess and evaluate if we're managing our health and our relationships as skillfully as possible. This ongoing decision making makes up a major part of the workload in this full-time job—a position we certainly never applied for!

Here are five tough choices we continually face. There aren't easy answers to the issues they raise: that's why they're tough choices.

1. Do we talk openly about our health problems or do we keep them private?

This is an ongoing tough choice we face whenever we communicate with friends and family, whether it be in person, by phone, by email or even text. If we talk about our health problems, some of them may respond judgmentally or even turn away from us. And even those who don't turn away may change the way they relate to us. We want to be treated as whole people and as adults, but if we share our health struggles with others, we risk being treated like a shadow of our former self or, even worse, as dependent children.

On the other hand, if we keep quiet about our health issues—perhaps even acting “fake healthy” as I've been known to do— we risk leading others to misunderstand what we can and cannot do. In addition, by keeping quiet, we're passing up the possibility of receiving much needed support—both emotional and practical.

If you're like me, it can be exhausting, both physically and mentally, to continually assess and decide what you will and what you will not share with others about your health.

2. Do we ignore a new symptom or have it checked out by a doctor?

On the one hand, it's not good for us emotionally to be overly focused on

every little ache and pain in our body. In addition, we may be concerned that if we raise a new symptom, our doctor will think we're being oversensitive or even a hypochondriac—either of which could affect the quality of care we receive.

But consider this. I read in one of my chronic illness books about a woman who ignored a new symptom because she decided it was best to assume it was related to her chronic illness. She also said that she waited so long to see her doctor because she “didn't want to bother him.” The new symptom turned out to be stomach cancer.

What to do when a new symptom appears necessitates making another tough choice: wait or act immediately? We have to listen carefully to our body and decide for ourselves. It isn't easy, that's for sure.

3. Do we follow our doctor's treatment plan or do we try alternative and unconventional therapies?

There's no right or wrong course of action here, but it's a choice that, for me, has been costly, both to my pocketbook and, at times, to my health. I used to spend hours and hours, utterly exhausting myself, combing the Internet for cures. As I wrote about in my piece [“Finding the Health Information You Need on the Internet,”](#) anyone can create a website, set up a payment plan, and ask for your credit card number. *Anyone*. Treatments-for-sale can be packaged to sound very seductive. People spend thousands of dollars on false cures. I know because I've done it.

On the other hand, I've also read

about people who've been helped by alternative or unconventional treatments, so it may not be wise to decide to disregard them entirely. These tough choices—what to take, what not to take, how to assess the monetary costs, what to tell our doctor about what we're taking or not taking—also make up a major part of the workload for those of us with chronic health problems.

4. Do we push our body to the limit or do we always play it safe?

Sometimes, the desire to be like healthy people is so strong that we can talk ourselves into pushing our body to do what it cannot reasonably do. About two years ago, my granddaughter Camden was visiting. I was so frustrated by always feeling sick when she was here that I decided to “act healthy.” We have a park next door to our house. I took her there for over an hour, helping her with the slides, pushing her on the swings. I was in a defiant mood: “I'm tired of being sick. I'm just going to act as if I'm healthy.” What I got for my effort was a week of payback with exacerbated symptoms.

On the other hand, I find that if I always play it safe, my body gets so used to the strict regime I put it on that I lose my ability to be flexible at all. For example, if I always nap at noon sharp, then if I'm fifteen minutes late one day, I feel like I'm going to collapse on the spot. So I purposefully mix up the exact time I nap so that my body doesn't become conditioned to following a rigid schedule. That said, my ability to be flexible has its limits: I don't have the luxury to just skip the nap.

If it's possible for you, I recommend

a middle path of gently challenging your body now and then so that you don't fall into a fixed pattern of behavior that underestimates what you might be able to do. But, as with the other tough choices, I find this constant assessing and adjusting, assessing and adjusting to be exhausting in itself, both mentally and physically.

5. Should we aggressively fight to regain our health or should we accept our fate?

Constantly fighting to regain our health is also exhausting, physically and mentally. But the alternative of passively accepting that this is the way we're going to be for the rest of our lives doesn't feel like a wise choice either. Again, I recommend a middle path. It took me a while to realize that I could acknowledge and accept my health as it is right now, while at the same time continuing to try to regain the health I had before I got sick. These two courses of action aren't contradictory.

It wasn't until I began to accept—without aversion—however I happened to feel on any given day, that I was able to begin looking for ways to enjoy my life again. But an integral part of that life is keeping an eye out for new treatments. And, working to gracefully accept how I feel at the moment, while at the same time continuing to be proactive about my health is...you guessed it—exhausting.

I see that I've used the word "exhausting" five times in this piece (not counting its presence in this very sentence!). It's no surprise that mental and physical exhaustion are the consequences of having to

continually assess, evaluate, and choose a course of action while already sick or in pain. My wish for you is that you be as kind to yourself as you possibly can as you struggle with these tough choices.

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www.tonibernhard.com

I'm the author of the award-winning *How to Be Sick: A Buddhist-Inspired Guide for the Chronically Ill and their Caregivers*. My new book, *How to Wake Up: A Buddhist-Inspired Guide to Navigating Joy and Sorrow*, is available for pre-order and will be released in September.

Please join me on [Facebook](#), [Twitter](#), [Pinterest](#). You can also subscribe to my blog—see the choices above my picture on this page.

Source URL:

<http://www.psychologytoday.com/node/116739>



Health Canada warns of serious skin reactions in patients taking carbamazepine (Tegretol)*

CBC News

Health Canada has issued an advisory concerning carbamazepine, a drug commonly used to treat epilepsy, mania, bipolar disorder and trigeminal neuralgia, a facial condition.

Carbamazepine is sold in Canada under the name Tegretol.

The advisory stems from reports of serious skin reactions in patients of Asian ancestry taking the drug.

“Serious and sometimes fatal skin reactions known as Stevens-

Johnson Syndrome and Toxic Epidermal Necrolysis have been known to occur very rarely with carbamazepine,” reads the advisory. “While all patients treated with carbamazepine are at risk of these skin reactions, the risk is approximately 10 times higher in Asian countries than in Western countries.”

According to Health Canada, a genetic test is available that can identify a genetic marker in patients of Asian ancestry that has been linked to an increased risk of developing serious skin reactions to carbamazepine. The health agency encourages people who are considering taking the medication to consult with their doctors about this test.

Health Canada said it is revising the prescribing information for Tegretol and is also in the process of revising prescribing information for all generic carbamazepine products to include the possibility of serious skin reactions.

The following generic carbamazepine-containing products, with their makers in brackets, are sold in Canada:

- Apo-carbamazepine (Apotex Inc.).
- Bio-carbamazepine (Biomed 2002 Inc.).
- Carbamazepine (Pro Doc).
- Dom-carbamazepine (Dominion Pharmacal).
- Gen-carbamazepine (Genpharm ULC).
- Mazepine (Valeant Canada Ltd.).
- Novo-carbamaz (Novopharm Ltd.).

- Nu-carbamazepine (Nu-Pharm Inc.).
- PHL-carbamazepine (Pharmel Inc.).
- PMS-carbamazepine (Pharmascience Inc.).
- Sandoz-carbamazepine (Sandoz Canada Inc.).
- Taro-carbamazepine (Taro Pharmaceuticals Inc.).
- Tegretol (Novartis Pharmaceuticals Canada Inc.).

It warns patients who are not experiencing any skin reactions not to stop treatment before speaking with their physician.

However, all patients currently taking the drug should consult with a doctor immediately if they experience any signs of serious skin reactions such as a rash, red skin, blistering of the lips, eyes or mouth, or peeling skin accompanied by a fever.

As well, patients who have taken carbamazepine before and experienced skin reactions should not take the drug again, Health Canada said.

Source: [CBC News](#)



Contacting TNAC

For information on membership or general information:

president@tnac.org

613.936.6977

TNAC, 1602 Walton Street
Cornwall, ON, K6H 1W2

For information on support groups:

support@tnac.org

For information on advocacy:

advocacy@tnac.org

Do you have an article for the newsletter? Do you have a topic

you'd like covered? Do you have a drug you'd like profiled? Please let us know.



FDA Requires Warnings about Risk of Suicidal Thoughts and Behavior for Antiepileptic Medications

The U.S. Food and Drug Administration announced it will require the manufacturers of antiepileptic drugs to add to these products' prescribing information, or labeling, a warning that their use increases risk of suicidal thoughts and behaviors (suicidality). The action includes all antiepileptic drugs including those used to treat psychiatric disorders, migraine headaches and other conditions, as well as epilepsy.

The FDA is also requiring the manufacturers to submit for each of these products a Risk Evaluation and Mitigation Strategy, including a Medication Guide for patients. Medication Guides are manufacturer-developed handouts that are given to patients, their families and caregivers when a medicine is dispensed. The guides will contain FDA-approved information about the risks of suicidal thoughts and behaviors associated with the class of antiepileptic medications.

"Patients being treated with antiepileptic drugs for any indication should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, or any unusual changes in mood or behavior," said Russell Katz, M.D., director of the Division of Neurology

Products in the FDA's Center for Drug Evaluation and Research. "Patients who are currently taking an antiepileptic medicine should not make any treatment changes without talking to their health care professional."

The FDA today also disseminated information to the public about the risks associated with antiepileptic medications by issuing a public health advisory and an information alert to health care professionals. Health care professionals should notify patients, their families, and caregivers of the potential for an increase in the risk of suicidal thoughts or behaviors so that patients may be closely observed.

The FDA's actions are based on the agency's review of 199 clinical trials of 11 antiepileptic drugs which showed that patients receiving antiepileptic drugs had almost twice the risk of suicidal behavior or thoughts (0.43 percent) compared to patients receiving a placebo (0.24 percent). This difference was about one additional case of suicidal thoughts or behaviors for every 500 patients treated with antiepileptic drugs instead of placebo.

Four of the patients who were randomized to receive one of the antiepileptic drugs committed suicide, whereas none of the patients in the placebo group did. Results were insufficient for any conclusion to be drawn about the drugs' effects on completed suicides. The biological reasons for the increase in the risk for suicidal thoughts and behavior observed in patients being treated

with antiepileptic drugs are unknown.

The FDA alerted health care professionals in January 2008 that clinical trials of drugs to treat epilepsy showed increased risk of suicidal thoughts and actions. In July 2008, the FDA held a public meeting to discuss the data with a committee of independent advisors. At that meeting the committee agreed with the FDA's findings that there is an increased risk of suicidality with the analyzed antiepileptic drugs, and that appropriate warnings should extend to the whole class of medications. The panel also considered whether the drugs should be labeled with a boxed warning, the FDA's strongest warning. The advisers recommended against a boxed warning and instead recommended that a warning of a different type be added to the labeling and that a Medication Guide be developed.

Acting under the authorities of the Food and Drug Administration Amendments Act of 2007 (FDAAA), the FDA is requiring manufacturers of antiepileptic drugs to submit to the agency new labeling within 30 days, or provide a reason why they do not believe such labeling changes are necessary. In cases of non-compliance, FDAAA provides strict timelines for resolving the issue and allows the agency to initiate an enforcement action if necessary.

The following antiepileptic drugs are required to add warnings about the risk of suicidality:

- Carbamazepine (marketed as Carbatrol,

Equetro, Tegretol, Tegretol XR)

- Clonazepam (marketed as Klonopin)
- Clorazepate (marketed as Tranxene)
- Divalproex sodium (marketed as Depakote, Depakote ER)
- Ethosuximide (marketed as Zarontin)
- Ethotoin (marketed as Peganone)
- Felbamate (marketed as Felbatol)
- Gabapentin (marketed as Neurontin)
- Lamotrigine (marketed as Lamictal)
- Lacosamide (marketed as Vimpat)
- Levetiracetam (marketed as Keppra)
- Mephenytoin (marketed as Mesantoin)
- Methosuximide (marketed as Celontin)
- Oxcarbazepine (marketed as Trileptal)
- Phenytoin (marketed as Dilantin)
- Pregabalin (marketed as Lyrica)
- Primidone (marketed as Mysoline)
- Rufinamide (marketed as Banzel)
- Tiagabine (marketed as Gabitril)
- Topiramate (marketed as Topamax)
- Trimethadione (marketed as Tridione)
- Valproic Acid (marketed as Depakene, Stavzor Extended Release Tablets)

- Zonisamide (marketed as Zonegran)

Some of these medications are also available as generics.

Health care professionals and consumers may report serious adverse events or product quality problems with the use of this product to the FDA's MedWatch Adverse Event Reporting program either online, by regular mail, fax or phone.

- Online : www.fda.gov/MedWatch/report.htm



Surface Acoustic Wave Ultrasound in Trigeminal Neuralgia Pain

Sponsor:
Sheba Medical Center
Dr. Manuel Zwecker MD, Sheba
Medical Center

Overview of study in progress:

The "Suicide Disease", Trigeminal Neuralgia (TN) is arguably caused by one of the most discrete and eloquently reversible central nervous system lesions known to the field of neurology.

Recently Dr Adahan H. and Dr Binshtok A. have completed an open label series of 25 subjects with refractory TN showing a remarkable positive response rate to TN's treatment with Low Intensity Low Frequency Surface Acoustic Wave Ultrasound (LILF/SAWU).

The primary objective of this study, therefore, is to determine whether this apparent efficacy of Low Intensity Low Frequency

Ultrasound (LILFU) in the treatment of TN pain could withstand the rigors of an n=1 crossover placebo control study.

Participants with refractory trigeminal neuralgia pain despite optimized pharmacotherapy for at least six months will be screened for participation in the study based on rigorous inclusion and exclusion criteria. It is judged rather unlikely that such subjects will experience spontaneous regression of their disease in the course of this study.

Patients meeting the inclusion criteria will be treated with four weeks of a placebo Low Intensity Low Frequency Surface Acoustic Wave Ultrasound (LILF/SAWU) device while continuing with their pharmaco-analgesic regimen. All patients will be crossed over to active LILF/SAWU therapy for the next four weeks. Patients will be blinded to all treatments throughout the study. Patients will be instructed to use the device daily overnight, and remove it upon waking. The device is programmed to work in cycles of 30 minutes on and 30 minutes off, for a total of six-eight hours of intermittent treatment.

At the end of the second month of the study, patients will be offered a choice as to whether they wished to continue with the current (active) device or go back to the 1st (sham) device.

Patient's pain severity will be tracked every two weeks over the course of three months. Functional health and well being will be monitored at intake, post

“Placebo” period, post “Active” period and at completion of the study.



PAYPAL

Just a reminder that membership and donations can both be made by paypal. Our membership year runs from July – June each year. Donations are accepted at any time and are tax deductible. To use paypal:

MEMBERSHIP (new or renewal)

Go to www.tnac.org
Click on “Join TNAC”
Click on the Green box “Add to Cart” and it will connect you with paypal.

DONATIONS:

Go to www.tnac.org
Click on ‘donate’
Click on the Green box ‘Donate’ (under the words ‘donate online’) and it will take you directly to paypal. If you do not have a paypal account you will have to set up a paypal account. If you do have a paypal account you simply need to login and you are set to go.

Don't want to use paypal? Just print the membership application and you can mail a check for membership OR donation to TNAC. Both methods are perfectly fine.

TNAC continues to support research into diagnosis and treatment of trigeminal neuralgia across Canada. We rely on your donations to assist us in supporting people across Canada diagnosed with TN as well as researchers working towards better treatment and hopefully some

day an end to TN. Please consider donating to TNAC. TNAC is a registered charity with CRA and we do receipt all donations.

Ideas for donations include asking for donations to TNAC instead of birthday or anniversary presents, mentioning donations to TNAC in your will, or holding a fundraiser for TNAC in your neighbourhood.



Botox for trigeminal neuralgia

Botox injections relieve pain of trigeminal neuralgia, according to a new study just published in *Cephalalgia*, a leading headache journal. Trigeminal neuralgia is an extremely painful condition which manifests itself by intense electric shock-like pain on one side of the face. The pain is triggered by speaking, chewing and often without any provocation. Persistent pain can lead to malnutrition from the inability to chew and to severe depression and despondency. Epilepsy drugs, such as carbamazepine (Tegretol), oxcarbazepine (Trileptal), and other types of drugs often relieve the pain, but not always and at times the drugs can cause intolerable side effects. Research on the mechanism of action of Botox has shown that it may be blocking sensory nerves and this led me to try Botox for a few of my patients with conditions other than chronic migraines and other headaches. Several patients with post-herpetic neuralgia (shingles) and a few with trigeminal neuralgia responded very well. This rigorous double-blind, placebo-controlled study in *Cephalalgia* by Chinese researchers involved 42 patients with trigeminal neuralgia, of whom 40

completed the study. Among the patients who received Botox injections, 68% had significant improvement compared to only 15% of responders in the group that received placebo. This study strongly suggests that Botox is an effective treatment for some patients with trigeminal neuralgia. The advantage of Botox is that it has significantly fewer side effects than oral drugs.



Successful Treatment of a Resistance Trigeminal Neuralgia Patient By Acupuncture

Trigeminal neuralgia (TN) is a neuropathic pain syndrome characterized by severe unilateral paroxysmal facial pain. Pain attacks are usually stimulated by tactile irritation within the region of the trigeminal nerve.¹ TN pain typically remits and relapses, even when patients are on conventionally used treatments, resulting in a major source of disability and poor quality of life. Various drugs, such as carbamazepine, oxcarbazepine, phenytoin, gabapentin and baclofen, have been used to treat TN.¹ Additionally, several minimally invasive approaches, such as trigeminal nerve block at the level of the sphenopalatine ganglion, microvascular decompression, radiofrequency rhizotomy and botulinum toxin injection, have been performed for the relief of pain.^{1,2} However, none of these methods are free of complications. The most common adverse effects after minimal invasive approaches are paresthesia, facial sensory loss, weakness or paralysis of masseter muscles and, rarely, loss of the corneal reflex.³ Herein, we report a

female patient with TN who was intractable to previous treatment with carbamazepine, trigeminal nerve block and radiofrequency rhizotomy and was treated successfully by acupuncture.

CASE DESCRIPTION

A 66-year-old woman was referred with a typical TN pain on the left side of her face for 25 years. She was diagnosed with TN after evaluation and work-up by a neurologist. She used medications, including phenytoin (200 mg per day) and carbamazepine (600 mg per day). The pain was triggered by speaking, eating or touching. The pain was evaluated using a visual analog scale (VAS), which ranged from 0 (no pain) to 10 (worst pain imaginable). According to the VAS, the patient rated her pain as 10. She had, to date, experienced no beneficial effects from several therapeutic methods, including medication (carbamazepine, gabapentin and valproic acid), nerve block and radiofrequency rhizotomy of the infraorbital branch of the trigeminal nerve. Acupuncture treatment was initiated without making any change to her drug regime. Acupuncture needles (0.20 x 13 mm needles for the face and 0.25 x 25 mm needles for the other regions) were inserted on the typical areas that are used for trigeminal neuralgia (4). For facial neuralgia, the protocol utilized local points of TH 17 and 21, GB2, SI 18, ST 2, 3 and 7, GV 26 and LI 20; systemic points included TH 5, LI 4, ST 36, ST 44, ST 45 and LIV 3. Auricular acupuncture points were also used (Shen Men, neuro, face and lung points). Needles were not manipulated, and no attempt was made to elicit De-Qi. Every treatment

session lasted about forty-five minutes, three times a week. After the fourth session, she reported that she had been relieved almost pain free. By the sixth week (14 sessions), the patient was completely free of pain (VAS = 0) and was still pain free at the end of sixth month.

DISCUSSION

TN is the most common neurologic cause of facial pain. Many patients with TN eventually may become refractory to drug treatments (1) and a few cases develop resistance to surgical treatment modalities.⁵ Additionally, serious adverse effects can occur, especially with the use of surgical methods. These patients are thus placed in a difficult situation, and they visit several physicians because of their intractable pain. Alternative approaches may be necessary to heal this small group of patients. Acupuncture is performed as a complementary or alternative therapeutic method for the treatment of several chronic diseases and pain control.⁶ The analgesic effect of acupuncture is due to increased levels of mediators, including endorphin, enkephalin and serotonin, in the plasma and brain tissue.⁷ Acupuncture is a highly safe procedure, with few complications reported. Most reported adverse effects are minimal and include bruising or hematoma at the needle site, metal allergy and local infection.⁸ Thus, acupuncture, which has virtually no adverse effects, may be an alternative method of treatment for such resistant patients. We wish to alert physicians to the benefits of acupuncture for patients with resistant TN who do not respond to other traditional treatment methods.