A mixed national picture
The current state of periodontology in the UK and why there needs a lot to be done
By Prof. Francis Hughes, London

The UK is gearing up to host the largest conference in Periodontology and Implant Dentistry ever held with EuroPerio8 taking place on 3–6 June at London ExCeL. Over 100 speakers will contribute to the main scientific programme and there are many additional sponsor sessions. Over 1,500 abstracts have been accepted. Already over 7,000 periodontists, implantologists, general dentists and dental hygienists from 96 different countries have confirmed their attendance. We expect to have nearly 10,000 people at the conference in total, a new record for a conference in this field, and it is not too late to register.

Given the huge popularity of this event, it is perhaps a perfect time to reflect on the state of periodontology in the UK. It is clear that periodontal disease is not going to go away any time soon. Although there is a lack of detailed epidemiology of the disease in the UK, the Adult Dental Health Survey provides a useful indicator of trends in the epidemiology of the disease, even if it probably seriously underestimates true prevalence.

Periodontal disease has now been associated with risk of a number of other systemic conditions, most notably cardiovascular and cerebrovascular disease, among many other conditions. It has been clearly shown that periodontal disease causes a measurable systemic inflammatory response but it is not at all clear that periodontal treatment actually reduces the risk of these conditions, or whether the conditions are associated through common factors such as genetic predisposition. Nevertheless, given the importance of these systemic conditions it is recommended that periodontal health should be regarded as part of general health.

Impact of periodontal disease
Periodontal disease has typically been seen as a “silent disease” which might have few consequences unless resulting in tooth loss. However, there is now lots of evidence to refute this concept. Patients with periodontitis consistently report significant impacts of the condition on their quality of life, particularly impacting on function, aesthetics, comfort and self esteem. Furthermore, even mild disease resulting in gingival bleeding and perhaps halitosis impact on social acceptability and remain highly legitimate reasons for treatment need. Prevention of more severe disease is of course best achieved by primary prevention and early disease control by achievement of high levels of plaque control together with management of modifiable risk factors, particularly smoking.

The good news is that there has been significant reductions in the number of people with visible plaque and calculus present, (but this is still reported as 45% of the population) and concomitant reductions in the amount of mild periodontal disease, consisting of gingivitis and those with low levels of attachment loss. However, perhaps unexpectedly, this has not been associated with similar reductions in moderate and severe periodontitis. In fact, the number of adults with severe periodontitis (pocketing of 6mm+) has increased from 6% in 1998 to 9% in 2009. The reasons for this may be complex but are likely to include the fact that we have an increasingly aging population, and that dentists are (rightly) taking out fewer teeth even when judged to have poor long term prognosis.

This disconnection between trends in plaque control to more severe destructive periodontitis is a common finding in a number of recent epidemiological surveys in different populations and underlines the complexity of aetiological factors which determine susceptibility to destructive periodontitis. Although plaque tends to correlate directly with gingival disease, in a majority of people this may not necessarily result in the progression to more severe periodontitis. The major risk factors which are implicated in this process including smoking, genetic factors, and medical factors, particularly diabetes and medications such as calcium channel blocker and hypertensive drugs.

The impact of the well documented rise in the numbers of older people may be particularly important for future treatment needs. The over 65-year olds are often fit and well and have high expectations for their continued health needs, even though they may also suffer from common medical conditions such as type 2 diabetes and hypertension and may take multiple medications.

Impact of periodontal disease
Periodontal disease has now been associated with risk of a number of other systemic conditions, most notably cardiovascular and cerebrovascular disease, among many other conditions. It has been clearly shown that periodontal disease causes a measurable systemic inflammatory response but it is not at all clear that periodontal treatment actually reduces the risk of these conditions, or whether the conditions are associated through common factors such as genetic predisposition. Nevertheless, given the importance of these systemic conditions it is recommended that periodontal health should be regarded as part of general health.

Manpower
Clearly there remains a major, often unmet, periodontal treatment need within the UK population, which represent a significant challenge for dental health professionals. There are currently over 30,000 registered dentists and over 6,000 dental hygienists in the country. In addition, there are approximately 500 periodontists on the specialist list, who work mainly in private specialist practices or in the hospital and university services. Given that there are an estimated five million cases of moderate to severe periodontitis, and perhaps 20 to 30 million with some signs of periodontal disease, it would appear that these relative proportions of dental manpower are not currently ideally suited for the provision of primary and secondary periodontal care according to actual clinical needs. There are of course a significant but unknown number of general dentists who provide a degree of periodontal treatments that might otherwise considered to be at secondary care level.

The number of specialist periodontists in training is small (certainly less than 20 every year), which is probably insufficient to maintain the total number on the specialist list over time. There is considerable interest and some commitment to providing a group of dentists with additional skills in specific restorative specialties including periodontology, who could potentially...
meet much of the treatment need for secondary care periodontal treatment, but this group does not really exist at the present time. It should also be commented that this model of periodontal care provision does remain essentially untested on a large scale at present.

Overall the picture of periodontal care provision in the UK at present is mixed at best. In most areas of the country, those choosing to seek their periodontal care from the private sector, are able to access specialist care from highly trained periodontists and their teams, who often provide a wide range of effective and sophisticated treatment options. However, outside the dental schools there is little or very patchy access to specialist treatment services within the NHS. Recognition of this manpower deficit and a move to address it through intermediate level training in periodontal therapy is an encouraging but still unproven development.

Possibly the most important health professional for the implementation of primary prevention are dental hygienists. Although there is little evidence on deployment of hygienists within primary care, anecdote suggests that they may spend much of their time removing supragingival calculus (as prescribed by their employing dentists) without any routine attention to properly targeted attempts to provide adequate personalised oral hygiene instruction. Indeed the whole issue of the routine “scale and polish” as a therapeutic intervention has been questioned and is the subject of current research projects whose findings are yet to be reported.

**Implantology**

Many aspects of implantology, including surgical management, management of soft and hard tissues, and management of peri-implant health and disease, are squarely within the realm of periodontal treatments, and implantology is indeed a substantial component of specialist training in periodontology. Whilst the growth in implant treatments has been markedly slower than in many other European countries, there is now a large and ever growing use of dental implants in UK dental practice and a wider acceptance from significant numbers of patients of the value of implants and their potential cost/benefits. It is rather clear that the implant treatment could never be met within the National Health Services as the costs could potentially swallow much of the total NHS budget. However, some recognition of the clinical needs and cost/benefits on a more individual basis even within the NHS dental services would appear to be inevitable in the future.

There are two major developing issues, which are partly related to each other, which may particularly affect the periododontist practicing implant dentistry. Firstly, there is the growing problem of peri-implantitis. Reported prevalence rates of long standing implants do vary but are typically on the region of 50%. This progressive destructive condition creates particular problems as it appears to be much more difficult to manage than its first cousin, periodontitis. As many more implants have been placed for a number of years there is great concern about the growth of this condition.

Secondly, apparently oblivious to the above problems and an understanding of long term survival rates of teeth and implants, there is a disturbing trend amongst some to advocate early removal of diseased teeth and replacement by implants. There may be some short term gains for the dentist and/or patient to be had from this approach but it is a sure way to store up major new problems for the future.

So there remains a lot to do to tackle periodontal disease in the UK. One of the most encouraging developments in the near future is the development of care pathways within the General Dental Services which place considerable emphasis on prevention, risk factor management and targeting early periodontal disease, as well as mapping out appropriate care pathways for those in need of more involved periodontal treatment. This will inevitably be painful for some as it represents a new way of service delivery based on evidence based outcomes. However it also carries with it the prospects for better provision of higher level periodontal care, particularly if the planned development of dentists with some specialist skills is successful.

**Challenges remain**

The challenge of managing periodontal disease in an increasingly aging population is likely to become a major issue going forward, and at the time the profession will have to consider how it interacts with general medical services, for example in screening and detection of the currently estimated 750,000 people in the UK who may have undiagnosed diabetes.

The private sector looks set to increase its provision of specialist periodontal care and implant provision. The challenges of long term implant survival and management of peri-implant disease will present new challenges for many. There will undoubtedly be novel treatments and developments which we can only speculate on. Interesting times indeed but there is lots to do.

Francis Hughes is Professor of Periodontology at Kings College London and Chair of the European Congress of Periodontology, London. He can be contacted at francis.hughes@kcl.ac.uk.
THE NEW 2014-2015 COLLECTION

EXPERIENCE OUR ENTIRE COLLECTION ON WWW.CROIXTURE.COM
Knowledge can save lives

Understanding and treating patients with eating disorders

By Linda Douglas, Canada

Eating disorders are psychiatric illnesses characterised by disordered eating and disturbed attitudes to eating and body image. They are often accompanied by inappropriate, dangerous methods of weight control. The three most common eating disorders are bulimia nervosa (binge–purge), anorexia nervosa (starvation) and binge-eating disorder (bingeing without purging). There are variations of disordered eating, including eating disorders not otherwise specified.

These include diabulimia, where individuals intentionally take insufficient insulin in order to lose weight, anorexia athletica, which is obsessive, excessive exercising to the point of being detrimental to health, and bignorrhea, or muscle dysmorphia, where the individual perceives his or her body to be underdeveloped, despite having a large, muscular physique. Orthorexia nervosa is an obsession with the quantity and quality of the food consumed. The compulsive, excessive intake of food during the hours normally reserved for sleep—often getting up multiple times during the night to eat—is called night eating syndrome. Finally, there is pica, the persistent eating of non-food substances, and various food-related phobias.

The UK has the highest rate of eating disorders in Europe. Recent figures suggest that one in 100 British women have a clinically diagnosed eating disorder. In the US, anorexia nervosa is the third most common chronic illness among adolescents. Eating disorders occur mostly in females aged 15–25, but also occur in males, in children as young as 7 years of age, and in people aged over 50.

As one of the most common eating disorders, bulimia nervosa is characterised by a pattern of consumption of massive amounts of food (binge eating) and recurrent inappropriate weight control behaviours. These include purging through self-induced vomiting, abuse of laxatives and other substances, as well as behaviours such as fasting (not eating), 4

Table 1: Medical complications of eating disorders

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin (especially with anorexia)</td>
<td>Extremely dry, scaly, itchy skin with a grey cast, decreased scalp hair, increased lanugo hair</td>
</tr>
</tbody>
</table>
Oral findings

Traumatic lesions on the palate and oropharynx are caused by insertion of objects to induce vomiting. Signs of nutritional deficiencies occur, such as angular cheilitis, candidiasis, glossitis, and oral mucosal ulcerations. Individuals with eating disorders also experience a dry mouth related to dehydration or xenogenic medications, such as antidepressants and antiobiotics.

Aetiology

The aetiology of eating disorders is multifactorial and not completely understood. Contributing factors, however, include living in a culture where thinness is generally admired. There are indeed unrealistic depictions of beauty and thinness in most media. At about 6 feet (1.82 m) tall and 117 pounds (53.07 kg), today’s fashion model is not representative. There are indeed unrealistic depictions of beauty and thinness in most media. At about 6 feet (1.82 m) tall and 117 pounds (53.07 kg), today’s fashion model is not representative.

Anorexia nervosa is characterised by a refusal to eat enough to maintain body weight within 15 per cent of the minimal normal weight for age and height (the anorexic individual is often 20 per cent to 40 per cent below a healthy body weight); they have an extreme fear of gaining weight; and a distorted body image, which results in patients believing that they are fat, even when they are emaciated, and amenorrhoea (absence of menstruation).

A significant number of anorectic individuals also purge, and some have pica; they may consume cotton balls soaked in orange juice, for example, to control hunger. The main difference between bulimia nervosa and purging anorexia is that the individual with anorexia is underweight.

Binge-eating disorder is characterised by frequent consumption of abnormally large amounts of food in one sitting, while feeling a loss of control over eating. Individuals with this disorder do not purge afterwards, but feel depressed and guilty after overeating. Most individuals with binge-eating disorder are obese, with the related increased risks of diabetes, heart disease, certain cancers, and arthritis.

The weight of bulimic individuals even vomit five or six times per day. Most bulimics who die do so in the act of purging.

Anorexia nervosa is characterised by a refusal to eat enough to maintain body weight within 15 per cent of the minimal normal weight for age and height (the anorexic individual is often 20 per cent to 40 per cent below a healthy body weight); they have an extreme fear of gaining weight; and a distorted body image, which results in patients believing that they are fat, even when they are emaciated, and amenorrhoea (absence of menstruation).

A significant number of anorectic individuals also purge, and some have pica; they may consume cotton balls soaked in orange juice, for example, to control hunger. The main difference between bulimia nervosa and purging anorexia is that the individual with anorexia is underweight.

Binge-eating disorder is characterised by frequent consumption of abnormally large amounts of food in one sitting, while feeling a loss of control over eating. Individuals with this disorder do not purge afterwards, but feel depressed and guilty after overeating. Most individuals with binge-eating disorder are obese, with the related increased risks of diabetes, heart disease, certain cancers, and arthritis.

A significant number of anorectic individuals also purge, and some have pica; they may consume cotton balls soaked in orange juice, for example, to control hunger. The main difference between bulimia nervosa and purging anorexia is that the individual with anorexia is underweight.

Binge-eating disorder is characterised by frequent consumption of abnormally large amounts of food in one sitting, while feeling a loss of control over eating. Individuals with this disorder do not purge afterwards, but feel depressed and guilty after overeating. Most individuals with binge-eating disorder are obese, with the related increased risks of diabetes, heart disease, certain cancers, and arthritis.
Vomit has a pH of about 3.8. During purging, the vomit hits the palatal aspects of the maxillary anterior teeth. Dental erosion due to purging by vomiting becomes apparent about six months after onset. It eventually undermines the palatal surfaces and leads to incisal fractures and chipping, and over-eruption of the mandibular anterior teeth. Erosion also occurs in the posterior teeth, causing perimolysis: tooth tissue surrounding restorations is eroded, leaving the restorations with a raised, island-like appearance. Eroded occlusal contacts also lead to loss of vertical dimension.

Bulimics tend to consume foods high in refined carbohydrates, and individuals with eating disorders often consume acidic diet beverages. Therefore, they have a high caries risk and impaired salivary buffering capacity. Dental hypersensitivity is also common. The loss of bone density increases the risk of jaw fracture during extractions.

Dental management of patients with eating disorders includes nutritional therapy to treat the medical complications and the starvation-related brain changes that perpetuate the illness. This is combined with psychotherapy and medication, such as antidepressants. Individuals with eating disorders also need regular dental visits in a supportive environment, for continuing care. They must be regarded as medically compromised, owing to the risk of grave medical complications, particularly cardiac arrest due to electrolyte imbalance.

Thorough clinical assessment includes general appraisal, which begins the moment we greet our patient. We should tactfully observe his or her general demeanour, gait, and facial symmetry. The skin should also be observed for lesions and pallor, and the hands for Russell’s sign or clubbed fingers. A comprehensive medical history is needed, as well as monitoring of the vital signs. Extra-oral and intra-oral examination, as well as examination of the oral hard and soft tissue, is needed, plus comprehensive documentation that includes detailed clinical notes, periodontal charts, radiographs, intra-oral photographs and study models to monitor damage.

When an eating disorder is suspected, this sensitive topic needs to be approached in a non-judgemental, non-threatening manner. It is beyond our scope of practice to diagnose eating disorders, but we can present the findings of our examination to the patient. For example, if there is dental erosion, we could mention some possible causes, like acidic drinks, acid reflux or frequent vomiting. This gives the patient an opportunity for disclosure. If he or she discloses his or her eating disorder to us, he or she should be referred to his or her physician. If he or she is not ready to tell us, we can still be supportive and initiate

Table 2: Psychological aspects of eating disorders

<table>
<thead>
<tr>
<th>Depression, anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perfectionist, overachiever</td>
</tr>
<tr>
<td>Low self-esteem</td>
</tr>
<tr>
<td>Mood swings</td>
</tr>
<tr>
<td>Guilt, shame</td>
</tr>
<tr>
<td>Alienation, loneliness</td>
</tr>
<tr>
<td>Social isolation</td>
</tr>
<tr>
<td>Eating alone</td>
</tr>
<tr>
<td>Compulsive behaviours</td>
</tr>
<tr>
<td>Misperception of hunger and satiation</td>
</tr>
<tr>
<td>Obsessive thoughts about food, calories and weight often weighing themselves several times per day</td>
</tr>
<tr>
<td>Secrecy and denial of their illness</td>
</tr>
<tr>
<td>Individuals with anorexia nervosa often dress to hide their body shape, and they might put coins in their pockets when being weighed</td>
</tr>
<tr>
<td>They often claim to have food allergies in order to justify their restrictive diet</td>
</tr>
</tbody>
</table>

Medical treatment of eating disorders includes nutritional therapy to treat the medical complications and the starvation-related brain changes that perpetuate the illness. This is combined with psychotherapy and medication, such as antidepressants. Individuals with eating disorders also need regular dental visits in a supportive environment, for continuing care. They must be regarded as medically compromised, owing to the risk of grave medical complications, particularly cardiac arrest due to electrolyte imbalance.

Thorough clinical assessment includes general appraisal, which begins the moment we greet our patient. We should tactfully observe his or her general demeanour, gait, and facial symmetry. The skin should also be observed for lesions and pallor, and the hands for Russell’s sign or clubbed fingers. A comprehensive medical history is needed, as well as monitoring of the vital signs. Extra-oral and intra-oral examination, as well as examination of the oral hard and soft tissue, is needed, plus comprehensive documentation that includes detailed clinical notes, periodontal charts, radiographs, intra-oral photographs and study models to monitor damage.

When an eating disorder is suspected, this sensitive topic needs to be approached in a non-judgemental, non-threatening manner. It is beyond our scope of practice to diagnose eating disorders, but we can present the findings of our examination to the patient. For example, if there is dental erosion, we could mention some possible causes, like acidic drinks, acid reflux or frequent vomiting. This gives the patient an opportunity for disclosure. If he or she discloses his or her eating disorder to us, he or she should be referred to his or her physician. If he or she is not ready to tell us, we can still be supportive and initiate
a prevention protocol based on our clinical findings.

Definitive dental restorations cannot be completed while a patient is purging regularly, as acid erosion will compromise the restorations. Only essential restorative work should be done, to limit tooth damage and keep the patient free of pain. Pending the patient’s recovery from his or her eating disorder, the dental hygienist can provide interventions to limit damage to the oral hard and soft tissue, and relieve xerostomia and dental hypersensitivity. During dental hygiene appointments, such patients should be polished with a non-abrasive fluoride paste.

A protocol to reduce caries risk should include in-office fluoride varnish applications, plus self-applied neutral fluoride, and calcium and phosphate products, such as NovoMin, Recaldent and nano-hydroxyapatite, to remineralise and desensitise. Xylitol-containing products, such as toothpastes, gum and candies, are also beneficial. When used for 5 minutes, five times per day, they stimulate salivary flow, reduce the oral population of cariogenic bacteria, and reduce oral acidity. Patients should brush three times per day with a soft brush and a toothpaste containing 5,000 ppm fluoride. They should clean the interproximal embrasures daily and clean their tongue too, to remove biofilm and acid residue.

A mouth guard can be used to protect the dentition during vomiting. Brushing directly after vomiting causes more loss of tooth structure, and rinsing with water reduces the protective properties of the saliva. Instead, the oral pH should be neutralised by rinsing with one teaspoon of sodium bicarbonate in 250 ml water, or with a product containing calcium and phosphate ions. For additional support, we can share information on resources for those who struggle with eating disorders. With increased knowledge and vigilance, dental care professionals can enhance detection of warning signs of eating disorders, for improved patient care and favourable outcomes.

Editorial note: A complete list of references is available from the publisher.

The SCOFF questions*

1. Do you make yourself sick because you feel uncomfortably full?
2. Do you worry you have lost control over how much you eat?
3. Have you recently lost more than One stone (6.35 kg) in a three-month period?
4. Do you believe yourself to be fat when others say you are too thin?
5. Would you say that food dominates your life?

* One point for every “yes”, a score of ≥ 2 indicates a likely case of anorexia nervosa or bulimia.

Table 3: The SCOFF questionnaire utilises an acronym in a simple five-question test devised for use by non-professionals to assess the possible presence of an eating disorder.

Linda Douglas is a British dental hygienist currently residing in Ontario in Canada. She can be contacted at lindadouglas@sympatico.ca.
Pains is one of the most common and distressing conditions encountered, as it affects not only the sufferers, but also the community in which they live. It is often associated with other co-morbidities, especially anxiety, depression and chronic pain elsewhere. In the orofacial region, the most commonly reported pain is dental, and this inevitably requires a visit to a dentist, who in most instances can provide a cure. However, there are other pains encountered in the orofacial region that can become chronic, defined as pain that has been present for over three months. These pains need to be diagnosed correctly, as their management is different.

At present, we have no biomarkers for chronic pain, and the only way we can make a diagnosis is to listen carefully to the history the patient gives. We need to elicit the key features of pain, for example onset, duration, location, severity, character, provoking and relieving factors, as well as the impact on quality of life and activities of daily living. It is essential to determine the presence of other illnesses, especially other chronic pain. Chronic orofacial pain has a significant psychological impact, as the face used to express pain from other parts of the body is now in pain itself. Patients with chronic orofacial pain are also confused as to whom they should consult, a dentist or a doctor. Their choice of health care provider will significantly affect both first-line treatment and subsequent referral.

Pain is notoriously difficult to communicate and poor communication of pain is cited as the main barrier to treatment and management. This “unsharability” of pain can be correlated with its resistance to language. This results in an intense burden of suffering and isolation for the individual. It is further compounded when patients do not have the requisite language skills. Yet we know that words may help a clinician in the differential diagnosis; for example, patients with musculoskeletal pain will use words such as “heavy”, “aching” and “nagging”, whereas those with neurological causes will describe their pain as “burning”, “pins and needles”, “shooting” and “stabbing”.

We also try to measure pain using a scale of 0 to 10, but do these verbal measures really capture the experiences of those with facial pain? This question recently led to a project with a visual artist to create photographic images of pain. Thus images were co-created by the artist Deborah Padfield and facial pain sufferers, aiming to reflect the individual experience of pain. A selection of these images were then made into pain cards, which are now being used with other pain patients to help improve mutual understanding and communication between doctors and patients. They appear to be helpful in describing the characteristics of the pain, as well as initiating discussions about its impact.

Once a dental or oral mucosal cause of pain has been excluded, the commonest cause of pain in the lower part of the face is temporomandibular disorders (TMD). TMD can present as clicking or locking of the jaw and can come on suddenly. It can present on only one side or both. Pain in the muscles of mastication with or without pain in the joint itself is the commonest form of this group of disorders. It is very common and up to 20 per cent of cases can become chronic.

The pain is centred in the pre-aureicular area and can spread down the mandible and neck, as well as up to the forehead. It can be associated with clicks on opening or closing and rarely with reduced opening. The pain is described as dull, aching, sore and occasionally sharp. When the main muscles are palpated, the same character pain is elicited.

A careful history is essential in order to identify any potential red flags. It is important to check for possible temporal arteritis in anyone over the age of 50 having his or her first episode, as prompt treatment with steroids is required to prevent blindness. Any history of malignancy, neurological deficits, weight loss or severe trismus will require prompt investigation.

Traditional TMD has been managed by dentists with the provision of a variety of intra-oral appliances. They do provide pain relief, but this may be due to the natural history of the condition. Current data from the world’s largest study on TMD in the US has highlighted that the most common provoking factors are psychosocial. There is increasing evidence that patients with TMD also experience pain in other parts of the body and are more likely to be headache and migraine sufferers. This data therefore suggests that our approach to management of these conditions needs to be radically changed to include a more holistic approach as described below.

A condition with increasing incidence is persistent dental alveolar pain, also known...
Orofacial pain can have many non-dental causes. This pain is often not identified and leads to extensive irreversible, unnecessary dental treatment. It is probably a neuropathic pain and so needs to be managed in the same manner as other reported neuropathic pains according to guidelines. Drugs such as anti-depressants and anti-convulsants are helpful, opioids are of no help in these conditions. However, management with medications alone is insufficient. Patients need to be given an explanation of warmth and cold.

There have been a number of randomised controlled trials performed, but the evidence of any efficacy is low. Cognitive behaviour therapy needs to be delivered by multidisciplinary teams that include clinical psychologists and physical therapists. Pain that remains intra-oral and does not radiate externally is burning mouth syndrome. This is defined as a burning pain or discomfort often present continuously on the tongue and other parts of the oral mucosa. There are no local or systematic factors to account for this pain, and often it is associated with altered taste and changes in salivary flow. Its highest incidence is in perimenopausal women, and so it had for many years been labelled as a psychological pain; however, recent research has now shown that this is also a neuropathic pain with abnormalities especially in perception of warmth and cold.

Another rare pain that dentists often see is trigeminal neuralgia. It is defined as a “sudden, usually unilateral, severe, brief, stabbing, recurrent pain in the distribution of one or more branches of the fifth cranial nerve” that is provoked by light touch activities. It has a highly significant impact on quality of life and if poorly managed leads to depression. In some rare cases, it is caused by multiple sclerosis or tumours, but its cause is unknown in the majority of patients. Many patients will have compression of the nerve inside the skull. The pain often presents in the mouth, leading patients to believe that the cause is dental and to ask dentists to investigate. Again, many patients will undergo unnecessary irreversible treatment until pa-tients or dentist realises that it is non-dental. In the early stages, the pain is highly responsive to anti-convulsants, either carbamazepine or oxcarbazepine, and all guidelines suggest this as the first-line drug type. However, for trigeminal neuralgia, there is a wide range of treatments, both medical and surgical, and so patients need to be seen not only by neurologists or oral physicians, but also by neurosurgeons. In correctly diagnosed patients, surgical outcomes can give the longest pain relief periods. It is increasingly important that dentists recognise that there are many non-dental causes of orofacial pain. Time needs to be spent in eliciting a careful history, and irreversible dental treatment must be avoided. Chronic orofacial pain patients will have better outcomes if managed by specialist teams with multidisciplinary staff.

Chronic orofacial pain patients will have better outcomes if managed by specialist teams with multidisciplinary staff.