Nowadays, the theory of microvascular compression of the root entry zone of trigeminal nerve in case of trigeminal neuralgia is widely accepted.\[1\] Pathological contacts between a-beta fibres and c-fibres are believed to be caused by an arterial compression in the root entry zone. It is these ephaptic contacts that have led to a logical therapeutic sequence of treatment by means of membrane stabilising agents like anticonvulsant drugs as carbamazepine, nonablative - and, in view of the pathophysiological concept, causal - surgery in form of microvascular decompression described by Jannetta and ablative operative methods, which are restricted to certain well-defined indications.

In contrary, atypical facial pain (AFP) is characterized by a constant, poorly defined anatomically aching pain, lacking the paroxysmal quality, trigger point activation, and well-defined anatomical distribution of trigeminal neuralgia. Atypical facial pain is one of the most difficult syndromes to define and to treat. The origin of the pain may be not only the trigeminal nerve, but also the 7th, 9th and 10th nerves in AFP. Thus, understanding of the mechanism of the pain (pathology) and patient selection are very important to achieve optimal outcome in the treatment of AFP. In the current issue of “Neurology India” is presented a manuscript that deals with the treatment of atypical trigeminal neuralgia with microvascular decompression. In general, the operative outcome of microvascular decompression in patients with typical trigeminal neuralgia is better than that of patients with atypical trigeminal neuralgia, which may be related to short duration, late onset of pain, limited distribution, artery compression, and complete operative decompression. In the present manuscript, a complete pain relief was achieved in 13 out of 26 patients (50%) and 18% of patients showed no response to microvascular decompression. Preoperative sensory loss, that was present in most of these patients, is a negative predictor for good long-term results following microvascular decompression for AFP. In addition, it is well known from the literature that adults whose symptoms begin in childhood also do not have the same therapeutic response as patients with later onset symptoms.\[3\]

The patient series presented in the literature for AFP is very limited, and no consensus has been reached on medical treatment. However, the only current consensus is that surgery, especially ablative surgery, is not efficient in the treatment of AFP. Although no controlled clinical trial has shown benefit from microvascular decompression in AFP, microvascular decompression is occasionally tried for the individual patient with terrible intractable unexplained pain. In such cases, magnetic resonance imaging may suggest a rationale for surgical intervention should it happen to disclose a vessel coursing alongside the trigeminal nerve root, as it is done in the presented study. In addition, systematic clinical correlations are required for the sake of diagnostic clarity and treatment validity.

Although there is presently still no conclusion regarding surgical treatment of AFP, this study is important not only because it is one of the largest series in the literature regarding treatment with microvascular decompression, but also because there was a significantly longer period of follow-up of these patients. Traditional wisdom teaches that “good surgeons know how to operate, better ones when to operate and the best when not to operate.”\[4\] When treating patients with AFP, prudent application of this aphorism draws not only from experience but also from rigorous scientific investigation.

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References