Staff Meeting Bulletin
Hospitals of the . . .
University of Minnesota

Facial Neuralgia

Volume VIII | Thursday, January 21, 1937 | Number 13

STAFF MEETING BULLETIN
HOSPITALS OF THE . . .
UNIVERSITY OF MINNESOTA

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INDEX

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William A. O'Brien, M.D.

I. LAST WEEK

Date: January 14, 1937

Place: Nurses' Hall
Recreation Room

Time: 12:15 to 1:20 P.M.

Program: Movie: The Solar Family

Abstract: Hemorrhage Late in Pregnancy

Present: 100

Discussion: C. E. McLennan
L. A. Lang
L. G. Rigler
W. H. Ude

II. MOVIE:

Titles: China Clipper
Juvenile Delinquency

Released by: March of Time
Sequence

III. ABSTRACT:

FACIAL NEURALGIA

R. W. Koucky

(I) Trigeminal Neuralgia

A. History:

First described by Avicenna, an ancient Arabian physician, as "facial agony". J. Fothergill, in 1776, accredited with first modern description. Mears (1884), Horsley and Mac Ewen (1886), Rose (1890), and Hartley and Krause (1891) were pioneers in the operation of ganglionectomy. In 1898, Hutchinson proposed partial resection of the ganglion. Spiller (1898) reported division of the sensory root. In 1901, Frazier and Spiller experimentally proved the efficiency of root section. Peripheral injection of the branches developed in 1902 (Petres and Verzer) and 1903 (Schlosser). Present day American authorities are Adson, Frazier, Cushing, Dandy, Horrax, Grant and others.

B. Synonyms:

Trifacial, trigeminal, major trigeminal, epileptiform, surgical neuralgia; tic douloureax; trismus dolorificus. The term "facial" neuralgia is discouraged and the term trigeminal neuralgia is favored.

C. Etiology:

The cause is unknown. The idea of active infection as an etiological factor, i.e., as in neuritis, is discouraged because of the absence of other neuritic signs such as anesthesia and paralysis. Also, especially in the past, unnecessary surgery has been done on teeth and sinuses in the hope of improving the condition.

Sclerosis of the ganglion (Frazier) and degenerative changes in the nerve and ganglion (Dana) have been suggested as causes although pathological examination has failed to show such changes. Adson states that the disease may be the end result of infections.

Dandy outlines his findings in 215 cases as follows:

Etiologic Agent	Cases	%
Tumors	12	5.6
Aneurysms	6	2.8
Angiomas	5	2.3
Artery on nerve	66	30.7
Vein on nerve	30	14.0
Congenital anomalies	2	1.0
Sensory root adherent to brain stem	7	3.2
No gross findings observed	87	40.00
	215	

Other authors have not been able to confirm these findings.

D. Age:

Age	Adson	Horrax & Poppen	Grant	Frazier	Total (1750 Cs.)	%
10-20	1	1	0	0	2	---
20-30	17	11	2	9	39	2.2
30-40	71	29	7	21	128	7.3
40-50	169	46	36	71	322	18.4
50-60	259	114	66	74	513	29.3
60-70	225	157	55	74	511	29.3
70-80	87	80	13)			
80-90	10	9	5)--	29	235	13.4
90-100	0	1	2)			

E. Sex:

Male	448	186	87	721	49.0
Female	391	282	98	771	51.0
				1,492	

F. Side:

Right	541	237	152	930	60.0
Left	285	202	98	585	38.0
Bi-lateral	13	19	0	32	2.0
				1,547	

G. Branch Involved

Adson	Cases	%
1st division (total)	253	30.0
2d " "	439	52.0
3d " "	551	65.0

H. In Individual Cases

Branch	Adson % + −	Horrax & Poppen % + −
1st alone	1.0	3.0
2d "	17.0	24.0
3d "	21.0	42.0
1st, 2d, 3d	15.0	5.0
1st and 2d	12.0	4.0
1st and 3d	1.0	0
2d and 3d	36.0	30.0

I. Concomitant Diseases

Several authors state that patients with trigeminal, neuralgia have a higher incidence of certain degenerative diseases. The incidence of these in 839 cases is given in detail by Adson.

1. Arteriosclerosis	141
2. Multiple sclerosis	36
3. Migraine	26
4. Sciatica	20
5. Chronic nephritis	17
6. Intercostal neuralgia	6
7. Syphilis	5

J. Symptomatology and Course

The pain is variously described according to the patient's descriptive powers -- lightning-like; explosive, stabbing, tearing of flesh, boring hot iron, etc. It is located characteristically at the end of the nerve distribution, i.e. lip, nose, brow. However, in mild cases, this may not be the case. The pain comes on almost instantaneously, lasts a few minutes, and disappears like "a shooting star".

The attack is the period in which the patient is susceptible to the seizures of pain. Between the pains, there usually is no discomfort; occasionally there is prickling or uneasiness. The seizures of pain recur at variable intervals and usually are brought on by certain stimuli. The attacks are extremely irregular in sequence. They may recur daily for a few minutes or they may last for 1 to 2 weeks for 2 or 3 times a year. Between attacks, the patient is symptom-free. In general, the attacks become more numerous and longer as the duration of the disease progresses. Ultimately the attack may be continuous. They do not occur at night in the beginning but later even this period is not free of pain.

The stimuli producing the seizures of pain during the attack are variable: talking, eating, swallowing, heat, cold, noises, touch, washing, shaving, blowing the nose, etc. They may occur spontaneously. In most cases, there is one area more sensitive to these stimuli than the remainder. This is spoken of as the "trigger zone" and its location is well known to the patient.

The intensity of pain is such that "there is nothing comparable". It is not relieved by morphine and these patients, therefore, are not addicts. The habitual use of morphine is presumptive evidence against true neuralgia (Frazier).

K. Differential Diagnosis:

In general, all of the atypical neuralgias and facial pains which may be confused with true trigeminal neuralgias are characterized by the absence of the lightning-like strokes of pain recurring in attacks with complete absence of symptoms during the intervals. The pains of these atypical neuralgias are continuous with periods of greater severity. They are relieved by morphine. Specifically, these syndromes may be produced by (1) tumors of the cranial nerves, meninges, or pharynx (lymphoepithelioma), (2) herpes zoster (postherpetic). The history of onset, the presence of the scars of the vesicles and the hyperesthesia are helpful in the differentiation. (3) Infectious processes of the sphenopalatine ganglia (Studer's neuralgia). The pains about the nose, upper jaw and eye frequently radiate to the ear, mastoid and shoulders. (Infections of teeth and sinuses. The X-ray examinations are essential. (5) "Neurosis" - the differentiation may be very difficult.

L. Treatment:

Medical management. The usual procedures suggested by such an illness - reference for care of teeth and sinuses - should not be overdone.

Trichlorethylene. Twenty to 30 drops of the drug are placed on a handkerchief and held closely to the nose by the patient. The position assumed by the patient should be such that if he becomes partly anesthetized the hand drops away from his nose discontinuing the administration. Treatment is given three times a day for two weeks or for the duration of the attack. Results: (Horrax and Poppen), in 90 patients, "nearly one-half obtained sufficient relief so that they did not feel it necessary to have any other form of treatment" and the remaining patients either obtained no relief or subsequently required more radical methods.

Alcohol Injections. Regardless of whether or not more radical methods of treatment are planned for the patient, one to three alcohol injections are done. By this method, the patient is acquainted with the numbness and paresthesia which will follow the radical surgical procedures. Occasionally, patients suffer from these as much as from the original pain. Furthermore the result of the alcohol injection confirms the diagnosis and defines the results which will be obtained by the radical measures.

The injections are made at the foramina where the nerves leave the skull.

Ganglion injections are rarely done because it is generally considered to be more dangerous than operative methods.

Results:

Adson states that relief is obtained in about 75% of cases.

Grant's results are as follows (331 injections; trigeminal neuralgia, 250; malignancy of the face, 81):

	Successful	Failure	% of Failure
1st division	9	1	10
2d "	124	31	20
3d "	131	35	21

The duration of relief is:

	Grant	Horrax & Poppen
Supraorbital		6.0
Infraorbital		12.4
1st division	11	
2d "	14	12.4
3d "	16	14.3

Adson gives the average continuous relief as 9 months.

The complications apparently are minimal: hematoma, temporary dizziness and headache, transient nystagmus and diplopia, temporary paralysis of 6th or 3d nerves.

The outstanding objections are the extreme pain attending the injection and the recurrence (and expectation thereof) of pain.

The indications are (1) to acquaint the patient with the results, (2) to confirm the diagnosis, (3) for relief in the elderly individual and in those unable to undergo the major operation.

"Radical" Treatment. Peripheral evulsion of the nerves has been discarded as a form of treatment.

The change in methods of operative treatment is illustrated by Adson's review of a series of 587 cases at the Mayo Clinic. From 1909 to 1916, there were 15 ganglionectomies and evulsions of the roots.

In Adson's 1923 report, he lists the operations as follows:

Hutchinson operation	1
Ganglionectomies	15
Evulsions	42
Division of root and evulsion	22
Section of entire root	128

Since 1922, there have been 193 sections of the sensory root only with preservation of the motor root. At present the accepted operative procedure is section of only the sensory root. There are two modifications often discussed: (1) partial section of the root with preservation of the ophthalmic portion, and (2) section of the roots as they leave the brain stem through a transcerebellar route.

The conservation of the ophthalmic portion is said to reduce the incidence of corneal keratitis. It is criticized because it is an incomplete operation and patients may have a recurrence in this area. The transcerebellar section of the roots is said to relieve the pain while still retaining sensation in the skin. This statement needs further confirmation and furthermore the operation is more difficult and dangeous.

The most essential refinements of operative technique consist (1) in the development of suitable illuminated instruments to avoid trauma to the brain; (2) the avoidance of trauma to the ganglionic and postganglionic (peripheral) portion of the ophthalmic division to reduce the incidence of keratitis; and (3) the avoidance of disturbing the dural and arachnoid bed of the ganglion to prevent injury to the superficial petrosal nerve and thereby to the 7th nerve.

The results are very gratifying. In 208 cases (Adson), 176 had instant permanent relief and 22 more had relief of the pain but had to be given sedatives. Since 1918, there have been no recurrences.

The complications in a group of 587 operations (Adson) were as follows:

Conjunctivitis	34
Unpleasant paresthesias	30
Partial facial paralysis	24
Keratitis	12
Postoperative coma	5
Complete facial paralysis	4
Impaired hearing (subjective)	4
6th nerve palsy	2
Iritis	1
	116
	(20%)

The facial paralyses are temporary and usually have disappeared by the time the patient has left the hospital. The cause of the facial paralysis is unknown. However, Adson has found that if the dura and arachnoid around the ganglion is not disturbed the incidence of the palsy is markedly diminished. This suggests that injury to the superficial petrosal nerve is related to the palsy in some manner. Of the 47 eye complications, 2 resulted in enucleation and 6 in corneal opacities. These eye complications are very common whenever the ganglionic or postganglionic portions of the ophthalmic branch have been traumatized. The trophic disturbances apparently are decreased by maintaining the viability of these portions. Three of the 5 patients with postoperative coma recovered by the 6th day, 2 died.

The deaths in this group of 587 operative cases were as follows:

Pneumonia	3
Meningitis	3
Pulmonary embolus	2
Cardiac failure	2
Hemorrhage	1
Cerebral thrombosis	1
Cerebral hemorrhage	1
Diabetes and pneumonia	1
Cerebral arteriosclerosis with nephritis	1
Total	15
	(2.5%)

(II) Glossopharyngeal Neuralgia

This type of neuralgia was described by Weisenburg in 1910, by Sicard and Robinson in 1920, and Doyle in 1923.

It resembles in great many respects the trigeminal type in symptoms, type of pain and course. The pain is in the pharynx and radiates into the ear drum. The "trigger zone" is in the tonsillar fossa. The attack is brought on by yawning, swallowing, talking, laughing, coughing, etc. It is very significant that cocainizing the pharynx prevents the attacks. This is very important in differentiating this type from the trigeminal form.

(III) SUMMARY:

1. Descriptions of trigeminal neuralgia date to ancient times. Modern methods of treatment were devised from 1890 to 1910. Standardization of treatment has occurred since 1920.
2. The cause is unknown. Infection, degeneration, postinfectious phenomena, and pressure factors have been suggested.
3. Ten per cent of cases occur before 40 years of age, 77% between 40 and 70, and 13% after 70.
4. In 1500 cases, the male-female ratio was equal.
5. The right side is uniformly involved more often than the left in a ratio of 60 to 38. Two per cent of cases are bilateral.
6. The 1st, 2d and 3d branches are involved in 30, 50 and 65% of cases, respectively.
7. The distribution by divisions of the nerve varies somewhat in the different series. In the largest series, the distribution was 2d and 3d division (36%), 3d division (21%), 2d division (17%), all three divisions (15%), and 1st and 2d divisions (12%).
8. The incidence of concomitant disease is high (31%). Arteriosclerosis, multiple sclerosis, migraine, other neuralgias, nephritis, diabetes, and syphilis occur in the order named.
9. The pain is characterized by its terrific severity, its sudden onset and cessation, its short duration, and the absence of distress between pains.
10. The pains recur in attacks or bouts of variable duration (few minutes to several weeks) and the interval between attacks varies from weeks to years.
11. Between attacks, there are no symptoms.
12. As the disease becomes of longer duration, the attacks are more frequent and longer.
13. The stimulus producing the pain usually is external. One area is most sensitive and is known as the "trigger zone".
14. The pain is so severe it is rarely controlled by morphine.
15. Differentiation must be made from neuritic pains, postherpetic neuralgia, atypical nasopharyngeal neuralgias, neurosis, and glossopharyngeal (true) neuralgia.
16. Such neuralgia-like (excepting the last mentioned) syndromes are usually more or less continuous, less severe, relieved by morphine, atypical in distribution and are not relieved by alcohol injection of the nerve.
17. Trichlorethylene (20 to 30 drops inhaled from a handkerchief) 2 to 3 times a day relieves mild attacks and dulls the pain of others.
18. The only successful palliative procedure is alcohol injection. It is succesful in about 70% of cases.
19. Alcohol injections are made into the nerve as it leaves the skull. Ganglion injections are not recommended because of its dangers.
20. Continuous relief is obtained for an average of 9 months.
21. The complications are minimal. The injections are very painful.

22. One to 3 alcohol injections should be done prior to section of the roots: (1) to acquaint the patient with the anesthesia; (2) to confirm the expected results.
23. The standard operative procedure is transtemporal section of the entire sensory root with preservation of the motor root.
24. Modifications of this plan have been suggested but not yet generally accepted.
25. In 208 sections, 176 had permanent relief and 22 more had relief of the pain but requires sedatives.
26. The complications (20%) in order of frequency are conjunctivitis, paresthesias, facial palsy (temporary), corneal keratitis, coma, impaired hearing, 6th nerve palsy and iritis.
27. By refinements of technique, these complications have been very much reduced.
28. In 587 operations, the mortality was 2.5% and many of these deaths were attributable to systemic disease.
29. Glossopharyngeal neuralgia presents a picture identical to the trigeminal type except the pain is in the pharynx and radiates to the ear drum. The "trigger zone" is in the tonsillar area. It is relieved by section of the nerve roots. The syndrome is rare.

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IV. CASE REPORTS:

(1) Female, 62 years of age.

Onset
1926 - Onset of dull burning pain involving corner of mouth, right lower lip, right side of tongue, and right cheek. Attacks of pain lasted several hours and occurred every few months.

Progression
1931 - Attacks gradually becoming more frequent and more severe. They are now sharp and stabbing and continue for hours and even days. No change in distribution of pain.

9 year duration
11- -35 - Seen in Out-patient Department. Patient suffering from severe pain in distribution of the right mandibular division of the 5th cranial nerve, involving the skin over the mandible, the right side of tongue, and inner surface of right cheek. Touching any part of involved skin or even touching inner surface of cheek with tongue makes pain more severe. Feels as if she has a sharp toothache in all her lower teeth on right side. Trigger point seems to be the first bicuspid in the lower right side. Patient during this attack is unable to open her mouth or swallow.

Alcohol injection
12- -35 - Alcoholic injection of 3d division of right 5th cranial nerve.

Relief for 6 months
Patient obtained complete relief of pain for a period of 6 months.

10- -36 - Readmitted because of continued severe pain in right side of face. Last attack has continued for past 5 days and patient has been unable to take food or fluid for 3 days. Attack so severe that patient refuses to talk and covers her right face with both hands. Distribution of pain unchanged. Examination negative aside from above pain. Laboratory studies normal.

Operation - 7th nerve palsy
10-16-36 -Operation performed. The lower 1/2 to 2/3 of the sensory root of the right 5th nerve was cut. Following operation, pain entirely disappeared. There was an almost complete 5th cranial nerve. Corneal reflexes were intact. There was slight right 7th nerve paralysis. A few days after operation, she developed a herpetic eruption in the right maxilla. Patient discharged 10-21-36.

Relief
12- -36 - Seen in Out-patient Department. No return of pain. Seventh nerve paralysis still present but much improved. Patient has complete loss of superficial sensation on right side of tongue, but only reduced sensation in right side of face.

(2) Female, 76 years of age.

Rapid course
1- -35 - Onset of quick lancinating pain over left side of upper lip. The painful area gradually increased to include the entire left cheek. By the summer of 1935, pain was almost continuous and patient was completely incapacitated. Trigger zone lateral to left corner of mouth.

Alcohol injections (2) - no relief
7- -35 - Alcoholic injection of 2d and 3d divisions of 5th nerve with relief for one week.

8- -35 - Injection repeated with similar relief. Trichlorethylene inhalations produced no relief.

Alcohol injections repeated - no relief
1- -36 - Admitted to hospital. Great difficulty in talking, eating and washing face, as any movement or pressure on the affected area cause severe pain throughout the whole left side of face, excluding the orbital region and forehead. Examination otherwise was essentially negative. Laboratory studies were normal.

1-30-36 - Alcoholic injection again attempted with no relief of pain.

Operation - root section and ganglionectomy - relief
2- -36 - The mandibular and maxillary divisions of 7th nerve, together with the ganglion, was excised. Neurological examination: Two days later showed complete anesthesia of the left lower lip and the left side of the chin, decreased sensibility to cotton and pin prick over the left side of the face, but not including the forehead. Corneal reflex still present. Relief of pain was immediate and complete.

Follow-up one month later revealed no change in the findings as compared to those present postoperatively.

(3) Male, 62 years of age.

2 yr. history
1933 - Had some teeth removed. Shortly after this, suddenly developed severe pain in region supplied by mandibular division of right 5th cranial nerve. Involvement gradually spread to include maxillary division. Pain were knife-like and shooting in character, and gradually increased in duration until it became quite steady and interfered with most of patients activities. Patient unable to wash face or even touch face since such actions precipitated paroxysms of pain. No distinct trigger zone found.

Unsuccessful injection
2- -35 - Attempt was made to cut sensory roots of right 5th nerve. Patient went into respiratory collapse before operation was completed and so the operation was curtailed.

Operation completed - relief
3- 4 -35 - Patient was reoperated and the sensory roots of the right 5th nerve were severed.

3- 6-35 - Neurological examination reveals intact superficial sensation above right eye. Corneal reflex on right retained. Complete sensory paralysis in region supplied by mandibular and maxillary divisions of 5th cranial nerve. Definite deviation of jaw to the right indicating some impairment of the motor division of right 5th nerve. Relief of pain complete.

4- 1-35 - Findings unchanged. Relief from pain still complete. Still has weakness in motor V.

Relief persists
10- -35 - Still has complete relief of pain. No mention made of condition of motor division of 5th nerve. Complete sensory loss in region supplied by 2d and 3d divisions of 5th nerve.

V. GOSSIP

Macnider Wetherby post-chortles from Mexico that he is having a good time and wishes that we were there. Lucky devil.....The Inter-Departmental Seminar meets in the Eustis Amphitheater the fourth Wednesday of each month during the regular school year, while the Minnesota Pathological Society meets the third Tuesday of each month.....The name given by psychologists to one's ability to start a stream of words on very slight provocation is verbomania.....
...The Minnesota State Obstetrical and Gynecological Society met last Saturday, January 16, 1937, in the Hennepin County Medical Society rooms. The program was varied, and representative of the type of obstetrical and gynecological thought in this section (radiographic pelvic measurements, blood loss during labor, version, endometriosis, lymphogranuloma inguinale, etc). In the evening, after dinner at the Athletic Club, embryologist Richard E. Scammon spoke on the growth and development of the uterus and other pelvic organs. The new society under the presidency of Robert D. Mussey, Mayo Clinic, bids fair to take its place with the other special state groups...
...When Dr. Oscar E. Locken died in Crookston on January 18, the medical profession of Minnesota not only lost a distinguished member, but the people at large also suffered the loss of one who has always taken an active interest in them. Mayor of Crookston to President of the League of Minnesota Municipalities; President of the Board of Health in Crookston to President of the State Sanitary Conference; Chairman of the local committee on Civic Betterment to a member of the State Planning Commission. The University will miss him as one of her most loyal and interested alumni, and the Public Health Association will find it difficult to replace him. In recent conversations with him, it was suggested that he better start a "save Locken campaign."

Never very strong, his frail and wiry body seemed to carry him on to great possibilities for service both to medicine and to society. Death came from pneumonia at the age of 45.....When we heard that Dr. A. W. Adson was to be our guest today, we asked Rudolph Koucky to prepare an appropriate program for the meeting. Dr. Koucky in his characteristic, efficient manner, turned out one of those crisp, informative bulletins of which he is so capable of doing. Dr. Adson in his many visits to our group has never failed to give us that certain extra something which characterizes very good teachers.....Radiologist Jack Sagel, Gary, Indiana, writes that all is well, and discusses at some length the case of a young child with a proven radiosensitive Ewing's tumor. Jack will be remembered by many as a former member of our Radiological Group.....The Post-Graduate Medical Institute opened Monday, January 18, at the Center for Continuation Study on the Campus. The opening sessions have been held in the seminar room or library. The class has been in our hospital on many occasions and also at the Minneapolis General Hospital. The first week seems to be going very well. It has developed into a cooperative enterprise in which both teacher and students have made a special effort to give their best. Drs. Wallace Cole, O. J. Campbell, R. R. Cranmer, A. A. Zierold, Edward Regnier, Edward T. Evans, O. H. Wangensteen, C. C. Chatterton, H. A. Carlson, C. W. Waldrom, and W. T. Peyton have served as staff members. A full enrollment of 16 students for the first section makes it look as if the project is to be a success. Next week the subject will be Obstetrics and Gynecology, followed by Pediatrics the third week, and Medicine the fourth week. Plans are already being formulated for another Institute in the near future. The first class, which has been so much photographed, is with us today at Staff Meeting.....
..Charles E. McLennan, who prepared the meeting for last week, deserves the orchids he received for his initial contribution. Dr. McLennan, a man of few words, used very effectively the ones he employed in telling us about ablatio placenta, placenta previa, and our records. Dr. McLennan lived up to his Scotch principles, and we are truly grateful...
...An annual custom (for 20 years) of the Swedish Hospital Staff is to be entertained by the retiring President (Chief) at the final meeting. The gathering this year was held at the Minneapolis Club and Swan Wright was the host. It was truly a remarkable meeting with a full Staff attendance of seventy-five. This is apparently a better idea than movies.....The annual Staff Meeting of St. Mary's Hospital in Duluth is also quite an affair with the hospital doing the honors for the grand dinner. Each year some new feature characterizes the gathering. Attics were ransacked, wives bribed, and friendly enemies contributed various pictures of the Staff Members in days gone by. A lantern slide demonstration of the Chamber of Horrors brought many a laugh from the crowd. The meeting also had its more serious moments.....
...Those who wish to attend the general University Convocation at Northrop Auditorium will find it possible to do so and return for lunch and the meeting proper, which usually starts at 12:30, after the picture.....Preparations are being made for the meeting to be held February 4, 1937, when Dr. Evarts Graham of St. Louis, here to deliver the Judd Lecture, will speak at Staff Meeting on his favorite subject, the "Gallbladder"..
...Kenneth Maxcy's appointment to the Rockefeller General Scientific Board has been well received throughout this section. Dr. Maxcy in the short time he has been here as head of our Department of Preventive Medicine and Public Health has favorably impressed all who have come in contact with him. We are hoping in his new connection that Santa Claus may look this way.

Adios.