

# Persistent Idiopathic Dentoalveolar Pain

## Is It a Central Pain Disorder?



Gary M. Heir, DMD<sup>a,\*</sup>, Sowmya Ananthan, BDS, DMD, MSD<sup>b</sup>,  
Mythili Kalladka, BDS, MSD<sup>c</sup>, Manvitha Kuchukulla, BDS, MDS<sup>d</sup>,  
Tara Renton, BDS, MDS<sup>e</sup>, PhD<sup>e,\*\*</sup>

### KEYWORDS

- Nociceptive pain • Idiopathic facial pain • Atypical facial pain
- Persistent dentoalveolar pain (PDAP) • Atypical odontalgia (AO)

### KEY POINTS

- Nociceptive pain, formerly known as idiopathic or centralized pain, can present in the face and mouth as Persistent Idiopathic Pain (extraoral or intraoral) as designated by the International Classification of Orofacial Pain. There may be a familial and genetic predisposition.
- Diagnosis is by exclusion and a thorough history, and a holistic approach is of the utmost importance.
- Screening for comorbid pain conditions, mood, and sleep disorders is essential in optimizing the management of the patient presenting with nociceptive pain, as this type of pain is generally refractory to most treatments.

### INTRODUCTION

Defined by the International Classification of Orofacial Pain (ICOP) 6.3, persistent idiopathic dentoalveolar pain (PIDP) is a persistent unilateral intraoral dentoalveolar pain, rarely occurring at multiple sites, with variable features but recurring daily for more than 2 hours per day for more than 3 months, in the absence of any preceding causative agent (**Tables 1–3**).<sup>1</sup> The description is as vague as its cause or causes. For this

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<sup>a</sup> Department of Diagnostic Sciences, Center for Temporomandibular Disorders and Orofacial Pain, Rutgers School of Dental Medicine, 110 Bergen Street, Room D835, Newark, NJ 07101, USA; <sup>b</sup> Department of Diagnostic Sciences, Center for Temporomandibular Disorders and Orofacial Pain, Rutgers School of Dental Medicine, USA; <sup>c</sup> Institute for Oral Health, University of Rochester, Rochester, NY, USA; <sup>d</sup> Private Practice, Vermont; <sup>e</sup> Department of Oral Surgery, King's College London Dental Institute, London, United Kingdom

\* Corresponding author.

\*\* Corresponding author.

E-mail addresses: [heirgm@sdm.rutgers.edu](mailto:heirgm@sdm.rutgers.edu) (G.M.H.); [tara.renton@kcl.ac.uk](mailto:tara.renton@kcl.ac.uk) (T.R.)

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<b>Table 1</b>	
<b>Abbreviations</b>	
CWP	Chronic widespread pain
DPT	Dental panoramic tomography
FM	Fibromyalgia
PDAP	Persistent dentoalveolar pain
PIDP	Persistent idiopathic dentoalveolar pain

reason, this entity has been ascribed numerous identities, including psychosomatic pain, symptom somatoform disorder, atypical odontalgia, phantom pain, persistent dentoalveolar pain (PDAP), and now its current persona as persistent idiopathic dentoalveolar pain<sup>3</sup> (PIDP).

The cause or causes of PIDP are elusive and, as of now, have defied identification. Causality must be investigated for the patient presenting with unilateral chronic pain that is long lasting and nonresponsive to treatment. Necessary information includes the history of the following:

- The onset of symptoms as spontaneous or related to specific events.
- An assessment of psychological factors, such as grief, related to a significant life event or physical stress related to onset.
- A history of posttraumatic neuropathic pain or other nontraumatic causes for neuropathic pain is also required, including chemotherapy, heavy metal poisoning, radiation therapy, thermal injury, hematological/vitamin D/magnesium deficiencies, connective tissue disorders, and congenital neuropathies.
- Neurovascular pain often presents with neuropathic features, including migraines, and trigeminal autonomic cephalalgias must also be excluded.
- Comorbid pains; a common feature of nociplastic pain is chronic widespread pain as seen with fibromyalgia (FM) that may be part of a persistent idiopathic presentation.

The authors present a case of presumed PIDP meeting the ICOP criteria. It is hoped this case report will raise discussion as to whether we are truly dealing with an idiopathic entity or have merely failed to discover the “causative agent.”

## THE PERIPHERAL NOCICEPTIVE SYSTEM

The peripheral nociceptive system serves a singular purpose. Monitoring the external environment, it warns of actual or potential tissue damage. It constantly reports changes in the environment, which may or may not represent a threat, through a complex system of transduction, transmission, modulation, and perception of noxious inputs. The brain interprets peripheral stimuli and activates or inhibits the descending pain inhibitory system accordingly. The presence of an actual or potential threat activates the immune system. Endocrinological changes consistent with fight or flight response<sup>4</sup> increase sensitivity to stimulation. The central nervous system processes noxious stimuli in various centers of the brain consistent with pain interpretation by the limbic system.<sup>5</sup> The final result is the perception of pain, or not pain.

Noxious stimuli can be inhibited or facilitated depending on how these signals are interpreted. In some instances, the processing of noxious stimuli within the central nervous system may be subject to misinterpretation.<sup>6</sup> Nonnoxious stimulation may result in the perception of a painful input through a variety of mechanisms, such as

Table 2 Glossary of terms	
Nociplastic pain (IASP)	Nociplastic pain or central sensitization is a type of pain that is mechanically different from the normal nociceptive pain caused by inflammation and tissue damage or the neuropathic pain that results from nerve damage. It may occur in combination with other types of pain or in isolation
Persistent idiopathic dentoalveolar pain (ICOP)	<p>Persistent unilateral intraoral dentoalveolar pain, rarely occurring at multiple sites, with variable features but recurring daily for more than 2 hours per day for more than 3 months, in the absence of any preceding causative event</p> <p>Diagnostic criteria:</p> <p>A. Intraoral dentoalveolar pain fulfilling criteria B and C</p> <p>B. Recurring daily for &gt;2 h/d for &gt;3 mo</p> <p>C. Pain has both of the following characteristics:</p> <ul style="list-style-type: none"> <li>• Localized to a dentoalveolar site (tooth or alveolar bone)</li> <li>• Deep, dull, pressurelike quality</li> </ul> <p>D. Clinical and radiographic examinations are normal, and local causes have been excluded</p> <p>E. Not better accounted for by another ICOP or International Classification of Headache Disorders-3 (ICHD-3) diagnosis</p> <p>ICOP classifies several diagnostic categories of PIDP</p> <ul style="list-style-type: none"> <li>• PIDP without somatosensory changes</li> <li>• PIDP with somatosensory changes</li> <li>• Probable PIDP</li> </ul>
Fibromyalgia <sup>2</sup>	<p>Fibromyalgia is characterized by widespread pain and tenderness (sensitivity to touch). Pain and tenderness tend to wax and wane and move about the body. Other symptoms include fatigue, sleep, memory, and mood issues. The diagnosis can be made with a careful examination. Fibromyalgia is most common in women, although it can occur in men. It most often starts in middle adulthood but can occur in the teen years and in old age. There is a higher risk for fibromyalgia in patients with a rheumatologic disease (health problem that affects the joints, muscles, and bones). These include osteoarthritis, lupus, rheumatoid arthritis, or ankylosing spondylitis. Fibromyalgia does not damage the joints or muscles. Comorbid complaints include the following:</p> <ul style="list-style-type: none"> <li>• Depression or anxiety</li> <li>• Migraine or tension headaches</li> <li>• Digestive problems: irritable bowel syndrome (commonly called IBS) or gastroesophageal reflux disease (often referred to as GERD)</li> <li>• Irritable or overactive bladder</li> <li>• Pelvic pain</li> <li>• Temporomandibular disorder, (TMD) often called TMJ by patients and nonspecialists (a set of symptoms including muscle and/or jaw pain, jaw clicking)</li> </ul>
Dysesthesia	An abnormal sensation, spontaneous or evoked, that is unpleasant (a sign, not a diagnosis)

peripheral and central sensitization.<sup>7,8</sup> The pain inhibitory system may be impaired or genetically deficient.<sup>9</sup> Literature suggests that chronic pain, mediated by the trigeminal system, can involve changes in pain inhibition and pronociceptive changes in processing noxious inputs.<sup>10</sup> Even in the presence of denervation, pain may persist in an area of lost sensation through mechanisms described as stimulus-independent pain or central pain mechanisms.<sup>11</sup> For example, pain experienced in a lost limb is the

<b>Table 3</b> <b>Common pharmacologic treatment modalities</b>	
Tricyclic antidepressants (TCA)	Serotonin reuptake inhibitors are sodium channel stabilizers, inhibit nociceptive input at the dorsal horn, and thereby reduce transmissions of noxious input
Serotonin-noradrenaline reuptake inhibitors (SNRI)	Serotonin-noradrenaline reuptake inhibitors are a class of antidepressant drugs that treat major depressive disorder, anxiety disorders, obsessive-compulsive disorder, social phobia, attention-deficit/hyperactivity disorder, chronic neuropathic pain, fibromyalgia syndrome, and menopausal symptoms
Gabonoids	Gabonoids, gabapentin, and pregabalin are anticonvulsants but also function as neuromodulators, as they reduce neuronal excitability by inhibiting the $\alpha$ -2- $\delta$ subunit of calcium-gated channels on presynaptic axons

result of the image of that pain interpreted by the brain as phantom limb pain, or pain felt in the missing appendage commonly recognized as neuropathic pain. One of the leading difficulties in diagnosis is pain presenting with neuropathic features. For example, known lesions or disease may present with positive features, such as allodynia, hyperalgesia, paresthesia, and hyperpathia, or negative features, including hypoesthesia, the absence of pain with sleep with worsening during the day, with stress or illness, but without a demonstrable neuropathic cause, preventing a diagnosis of neuropathic pain. ICOP recognizes PIDP with neuropathic findings, which may be a neuropathic pain with demonstrable positive and or negative signs; however, this variation requires further scrutiny and analysis. One of the most challenging obstacles is obtaining an adequate pain history from the patient. Differentiating preexisting nociceptive pain, such as inflammatory odontogenic pain, from de novo neuropathic or nociplastic pain before the inevitable root canal treatment can be challenging; thus, a clinician can be easily misguided when identifying the precipitating event. The cause and mechanisms of nociplastic pain remain elusive.

## **HISTORY OF THE PROBLEM AND DIFFICULTIES WITH NOSOLOGY**

### ***Pain Mechanisms: Local and Referred***

The clinical presentation of PIDP runs the gamut from dysesthesia to clinical features consistent with a neuropathic quality, that is, alteration in sensation, which may be spontaneous or provoked. For the purpose of this discussion, PIDP will be classified as a complaint of mild discomfort, aching and throbbing, sensorial changes, including burning, tingling, and occasional sharp pain. There is a disagreement in the literature regarding the presence or absence of a trauma to a tooth or teeth; as mentioned above, many patients will have had multiple medical and surgical interventions in trying to appease their pain. The key is establishing if pretreatment pain was odontogenic or neuropathic, or neurovascular or nociplastic, and if the pain changed after intervention. Thus, many references are made to the ICOP classification that includes a reference to the absence of an adverse event resulting in patient complaints. Despite this, many references are made in the literature to postimplant pain or postendodontic pain as PIDP, which are likely categorized as such owing to a lack of neuropathic cause in the region of pain.

One of the problems faced in arriving at a differential diagnosis is the classification of the clinical entity, or identification of a pain mechanism. The vague and confusing

diagnostic terms make the process of diagnosis and targeted therapies more difficult.<sup>12</sup> Although diagnostic terms in many fields of dentistry and medicine have evolved to the point where there may be little doubt regarding the patient's condition, terms such as atypical and idiopathic persist.

A review of the literature finds numerous references to atypical odontalgia,<sup>13,14</sup> psychogenic or symptom somatoform disorders,<sup>15,16</sup> phantom tooth pain,<sup>17,18</sup> idiopathic toothache, ill-defined neuropathic pain disorders, and now, PIDP. Treatment recommendations run the gamut from neuropathic pain to psychiatric care.<sup>19</sup> Adding to the diagnostic conundrum is confusion in the literature that suggests unknown causes while at the same time recommending specific treatments.

The International Association for the Study of Pain defines orofacial pain as "pain derived from local sources, dysfunction of the nervous system or referral from distant sites."<sup>20</sup> As stated, pain may be referred to a distant site even though the perception of pain is in an area with impaired innervation or which can be, in fact, missing. There is a new descriptive term that coincides with PIDP, nociplastic pain. "Nociplastic pain arises from altered nociception despite no clear evidence of actual or threatened tissue damage causing the activation of peripheral nociceptors or evidence for disease or lesion of the somatosensory system causing the pain."<sup>21</sup> This new definition, suggested by the International Association for the Study of Pain in 2017, seems to encompass all prior descriptors of PIDP. This diagnostic concept has been applied to chronic widespread pain disorder, such as FM, and used to identify patients with either diffuse or focal hypersensitivities in the absence of a diagnosis of neuralgia, neuropathy, or other causes.<sup>22</sup>

The hypothesis is strong for a central mechanism whereby discomfort or pain arises from central sensitization or central pain generators. In seminal research, the OPERA study identified a group of individuals who were pain prone or pronociceptive with a predisposition to pain, or an exaggerated perception of nonnoxious stimuli as painful. This fits within the rubric of central pain mechanisms or nociplastic pain as a viable explanation of PIDP, especially for those individuals with comorbid chronic pain complaints who are more likely to experience pain to nonnoxious stimulation. Demographically, the population of individuals suffering from FM or FM-like symptoms has similar demographic presentations as those of the PIDP population. This may also explain why similar medications used for FM are effective for this condition.<sup>23,24</sup>

## CASE PRESENTATION

### *General Information*

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A 35-year-old woman presents to a dental clinic with the complaint of dull, diffuse nonspecific burning pain in the mandibular right posterior quadrant.

### *Chief Complaint*

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The pain is constant, burning, and intense and has been present for approximately 6 years, waxing and waning in intensity. "My lower teeth hurt on the right, sometimes on top. I know it's a toothache, but no one can find it. They tell me my teeth are perfect, but I know something is wrong."

## CURRENT PRESENTATION

### *Medical History*

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The patient sustained injuries during a motor vehicle accident that occurred approximately 8 years earlier during which she incurred low back and cervical injuries. She states, "I had six months of physical therapy, but never fully recovered." The patient is also diagnosed with hypothyroidism and complains of always feeling

uncomfortable. She cannot clearly define her discomfort but implies global sensitivity and discomfort. She also reports achy joints and muscles, sensitivity to temperature changes, and is easily fatigued. She also reports daily headache and occasional migraine, and “I have TMJ.”

### **Trauma History**

Trauma history includes motor vehicle accident 8 years earlier in which the patient was the restrained driver of the vehicle, which was struck from the rear by another at a high rate of speed. She immediately realized cervical and low back injuries and was taken by ambulance to an emergency department and admitted to the hospital for 3 days for observation of what was perceived as a mild concussion. Imaging was negative, and the patient was discharged to physical therapy with no medications other than over-the-counter pain remedies.

### **Review of Systems**

Review of systems includes controlled hypothyroidism, borderline diabetes, controlled hypertension, and irritable bowel syndrome.

Current medications include acetaminophen, 325 mg, or naproxen sodium, 220 mg, often taken 2 at a time several times per week. Hydrocodone acetaminophen, 5-325, is used occasionally for more severe pain. Amlodipine, 5 mg, and levothyroxine, 100 µg, are taken daily for management of hypertension and hypothyroidism. Alprazolam, 2.5 mg, is taken at bedtime for sleep.

### **Past Treatment**

Past treatment includes multiple dental evaluations and routine dental interventions not preceding the pain onset. Medical treatment is with tricyclic antidepressants, gabapoids, nonsteroidal anti-inflammatory drugs (NSAIDs), and acetaminophen. These and many other medication trials have not impacted her pain. The patient has sought multiple consultations with otolaryngology, rheumatology, and endocrinology with no specific findings. She has not received any specific dental treatment for her complaint of what she perceives is of odontogenic origin other than several intraoral orthotics to treat a nonspecific temporomandibular disorder. She returned to physical therapy over the course of the past 6 years at on least 4 occasions. She has received no benefit from any treatment.

### **Pain History**

Using the SOCRATES acronym, an accurate and comprehensive pain history can be taken:

Site	Lower left posterior mandible
Onset	Spontaneously 6 y ago
Character	Ongoing deep aching burning pain, which is constant but fluctuates
Radiation	Occasional radiating up to posterior left maxilla with no pattern
Associations	None. The pain does not coincide with headaches or other comorbid pains
Timing	Constant with fluctuation
Exacerbating factors	None. The pain “just does its own thing”
Alleviating factors	None
Severity (reported on a visual analogue scale of 0–10/10)	The pain ranges between 4 and 6 out of 10 but can escalate to 8 out of 10 occasionally

### **Psychosocial Assessment**

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The patient is married with 3 children and appears despondent over not finding a solution for her pain. She has missed work because of her chronic pain and is considering applying for disability. She is distressed over the fact that she is constantly ill and its impact on her family, no longer socializes, and is short tempered with her family. She is also worried that her pain is becoming progressive.

- Family history: Mother and both sisters are diagnosed with chronic widespread pain and FM
- Habit history: Previous smoker, quit 10 years ago, drinks 12 units per week of alcohol
- Illegal substance use: None
- Psychological-psychiatric treatment: None

### **Clinical Examination**

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- Neglected personal appearance, seems agitated and stressed
- Mental status: Anxiety, depression
- Maxillofacial examination
  - Facial symmetry
  - Head and neck: Nothing abnormal detected (NAD)
  - Oral cavity: Mucosa seems normal, dentition moderately restored, mild attrition
  - Masticatory system: NAD
  - Mandibular function: NAD
  - Occlusal examination: Angle's class 1
  - TMJ joint noise: None
  - TMJ joint palpation: NAD
  - Cervical muscle examination: NAD
- Neurological examination
  - A cranial nerve screening examination found all cranial nerves intact

### **Diagnostic and Assessment Tools**

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Axis 2 assessment determined significant anxiety as assessed by the Generalized Anxiety Disorder 7-Item (GAD-7) Scale,<sup>25,26</sup> and possible major depression as assessed by the Patient Health Questionnaire (PHQ-9).<sup>27</sup> The patient also demonstrated a significant sleep disorder using the Insomnia Severity Index (ISI),<sup>28</sup> but obstructive sleep apnea was not found using the STOP-BANG Score for Obstructive Sleep Apnea.<sup>29</sup>

- Current affective symptoms
  - Sleep disorder symptoms: Clinical insomnia with no risk for obstructive sleep apnea, subclinical insomnia (ISI and STOP-BANG)
  - Anxiety: High levels of anxiety, somatic disorder (GAD-7)
  - Probable major depression (PHQ-9)

As part of the psychosocial pain history, the patient completed a modified American College of Rheumatology (ACR) preliminary diagnostic criteria form criteria of FM (Fig. 1).

It should be understood that scoring of this form represents a continuum rather than a yes or no answer. FM is not a yes or no condition but presents as a range of complaints from none to severe and can be categorized depending on the point score of this form. The higher the score, the more severe the patient's complaints. The higher

**Fibromyalgia Symptoms (Modified ACR 2011 Fibromyalgia Diagnostic Criteria)**

1. Please indicate below if you have had pain or tenderness over the past 7 d in each of the areas listed below. Check the boxes in the diagram below for each area in which you have had pain or tenderness. Be sure to mark right and left sides separately.

No Pain

2. Using the following scale, indicate for each item your severity over the past week by checking the appropriate box.

**No problem**  
**Slight or mild problems:** generally mild or intermittent  
**Moderate:** considerable problems; often present and/or at a moderate level  
**Severe:** continuous, life-disturbing problems

	No problem	Slight or mild	Moderate	Severe
a. Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Trouble thinking or remembering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Waking up tired (unrefreshed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. During the past 6 months have you had any of the following symptoms?

	No	Yes
a. Pain or cramps in lower abdomen	<input type="checkbox"/>	<input type="checkbox"/>
b. Depression	<input type="checkbox"/>	<input type="checkbox"/>
c. Headache	<input type="checkbox"/>	<input type="checkbox"/>

4. Have the symptoms in questions 2-3 and pain been present at a similar level for at least 3 months?

	No	Yes
	<input type="checkbox"/>	<input type="checkbox"/>

5. Do you have a disorder that would otherwise explain the pain?

	No	Yes
	<input type="checkbox"/>	<input type="checkbox"/>

**Fig. 1.** The 2011 survey criteria for FM.<sup>30</sup> Each positive response to question 1 on the left carries a 1-point score. The response to question 2, a, b, c, carries point scores as follows: no problem = 0; slight or mild = 1; moderate = 2; and severe = 3. Responses to question 3, a and b, score 1 point each. Questions 4 and 5 are for information only and carry no point score. Scoring ranges from 0 to 19, for question 1 on the left, and 12 possible points to questions 2 and 3 on the right. The maximum score is 31 with 12 or below consistent with FM-like symptoms.<sup>31</sup> Scores from 13 to 31 support the diagnosis of FM.

the response score for any individual, the more likely they will report symptoms of increased fatigue, memory loss, headache, comorbidity of chronic pain conditions, and possible overuse or poor response to peripherally acting medications. The higher the score, the more likely is the presence of a centrally mediated pain disorder. Patients with high scores, especially those beyond 13 of this pain scale, indicate likely FM diagnosis.

Although the modified ACR form has not been applied to patients with PIDP, it is hypothesized that the responses will be similar. This patient scored 23 using this assessment, indicating fibromyalgia symptoms (FMS), a nociplastic pain-related disorder owing to centralized sensitization and presentation with multiple responsive pain sites.<sup>32</sup>

### Problem-Oriented Workup

- Severe pain on function causing difficulty in daily activities
- Anxiety and depression
- Insomnia
- Family history of FMS
- Possible medication overuse headache

### Differential Diagnoses

Prior motor vehicle accident, hypothyroidism, multiple comorbid pains, anxiety, and depression are all risk factors for chronic widespread pain, which is likely contributory

to the idiopathic intraoral pain. The patient also has a family history of FMS, which also increases the risk of nociplastic pain.

Pain has not responded to recurrent dental interventions, antibiotics, NSAIDs, or opioid analgesics; thus odontogenic pain can be excluded. Recent dental radiographs were not contributory. The pain distribution does not fit for temporomandibular disorder. This presentation does not align with neurovascular pain, as her oral pain is constant and unrelated to her migraine headaches. In addition, the intraoral pain does not respond to her migraine treatments. This presentation does not align with a neuropathic pain presentation, as it is not related to onset during trauma or other life events. However, in a recent retrospective review of 160 patients with assumed idiopathic oral pain, only 68 were confirmed with PIDP after scrutiny using ICOP PIDP diagnostic criteria.<sup>3</sup>

This study reported that the most common site of pain was the molar mandibular teeth of 75 of 78 patients, implants in 1 patient, or edentulous postextraction sites in 2 patients. In 54 of the 78 patients, the painful site had been endodontically treated. Mechanical allodynia of the gingival sulcus was found in 68 of 75 teeth and in 1 implant. These features would infer posttraumatic neuropathic pain with a burning quality affecting 42% of the patients. Burning pain was the most common pain characteristic reported, which is also generally described as a characteristic of neuropathic pain.<sup>33</sup> Undisturbed sleep and a pain-free interval after waking were frequently reported in this patient cohort, also a characteristic of neuropathic pain.<sup>34</sup> Delayed onset of pain following irritation reported in 41% of patients has also been described in neuropathic pain. This study highlights the differential diagnostic challenges in these cases, and proposed a differential diagnostic table was suggested to facilitate exclusion of other classified ICOP conditions (**Table 4**).

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### **Final Diagnoses**

- Medical conditions:
  - Nociplastic pain/PIDP, which may be the same entity
  - Possible medication overuse pain
  - FMS with migraine
- Psychological conditions:
  - Anxiety and depression
  - Insomnia

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### **Treatment Plan**

#### **Management**

The clinician must exclude dental pathologic condition and other more common pain pathologic condition and reassure the patient that this pain is real and likely owing to her generalized pain condition and worsened by her mood and sleep disorders. Her family history may suggest a familiar representation of pronociception.

Medication overuse pain must not be overlooked. The patient must be advised to refrain from regularly using NSAIDs and acetaminophen and ideally not take them for 12 weeks to minimize central pain modulation impairment by regular use of over-the-counter pain medications.

Pain management for patients with nociplastic pain presenting as PIDP or FMS is more likely to respond to centrally acting medications.<sup>35</sup> However, the comorbid mood disorders (anxiety and depression), sleep disorders, and history of prior abuse and neglect must not be overlooked, requiring referral to clinical psychology, sleep clinic, and psychiatric specialist care in supporting her pain management.

<b>Table 4</b>	
<b>Exclusion of nonpersistent idiopathic dentoalveolar pain conditions<sup>33</sup></b>	
<b>Relevant Clinical Findings and Case History</b>	<b>Diagnosis</b>
Tenderness to percussion of tooth, apical tenderness, evidence of deep caries, mobile restorations, internal or external resorption, crown or root fractures of the affected teeth or their neighbors or antagonists, pain to heat or cold when applied to the teeth	Odontogenic pain: Symptomatic pulpitis, symptomatic apical periodontitis, bleeding on probing, pathological pocket depths, mucogingival lesions, periodontal and mucogingival pain
Myogenic trigger points or active or passive movements that reproduce the typical pain, radiographic signs of maxillary sinusitis, pain in the tuber region or paranasal pressure pain, swollen and sensitive salivary glands, medical history or clinical examination findings relevant to head and neck tumors or sickle-cell anemia	Nonodontogenic inflammatory pain
Referred orofacial pain, head and neck tumors, sickle-cell anemia. Symptoms of the autonomic orofacial nervous system (eg, running tears, running nose) associated with the intensity of the pain	Referred pain
Occurrence of other typical constellations of findings listed in the ICOP 5.1–5.3 definition (ICOP, 2020) or pain relief by triptans. Various incarnations of facial headache pain	Neurovascular pain or primary headaches
Intense shocklike pain within the affected trigeminal distribution and occurrence of typical general medical and specific pain-related history as listed in ICOP 4.1.1 (ICOP, 2020)	Trigeminal neuralgia. A neurological disorder known to be capable of causing, and explaining, the trigeminal neuropathic pain has been diagnosed and occurrence of diagnostic criteria as listed in ICOP 4.1.2.4 (ICOP, 2020).
Trigeminal neuropathic pain attributed to other disorders. Pain in a neuroanatomically plausible area within the distribution(s) of one or both trigeminal nerve(s) and a history of trauma to the peripheral trigeminal nerve(s) and other criteria listed in ICOP 4.1.2.3 and 4.1.2.3.1 (ICOP, 2020). Criterion C: History of external trauma and iatrogenic injuries from dental treatments, such as local anesthetic injections, root canal therapies, extractions, oral surgery, dental implants, orthognathic surgery, and other invasive procedures within 6 months before the onset of pain Criterion D: Associated with somatosensory symptoms and/or signs in the same neuroanatomically plausible distribution	Possible or likely posttraumatic trigeminal neuropathic pain

A trial of serotonin-noradrenaline reuptake inhibitors (SNRIs), the only group of medication not previously tried for this patient, was recommended, along with the other recommended referrals noted above.

### Outcomes

The patient was well managed on SNRIs, and psychological interventions had significantly reduced her anxiety and depression, and she was sleeping better.

### SUMMARY

PIDP is a dubious entity. This article attempts to establish a connection with other systemic chronic pain conditions, and not as a specific dental issue or a pain manifestation of the head and face. It attempts to change the thought process away from the location of pain and to consider an adverse event that may be driving the patient's complaints. The answer may be found by looking to more central causes, including more than physical findings or the somatic experience, but also the cognitive experience of the patient. It is hoped this will broaden the concept that chronic pain disorders may in actuality have an adverse event that may not be coincidental with the location. As with the case presented, the patient failed all attempts at treatment at the site of pain and only responded to more centrally acting medications combined with psychological support.

### CLINICS CARE POINTS

- Holistic assessment and management of the patient enable the clinician to evaluate the totality of the presenting condition and not just the dental or medical diagnosis.
- Optimal patient management will not be possible without recognizing the functional and psychological components of the patient's presentation.
- The clinician should recognize that patients with persistent idiopathic dentoalveolar pain are long-term chronic pain patients and require continued support. It may not respond to local remedies or procedures.

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