

# Quarterly

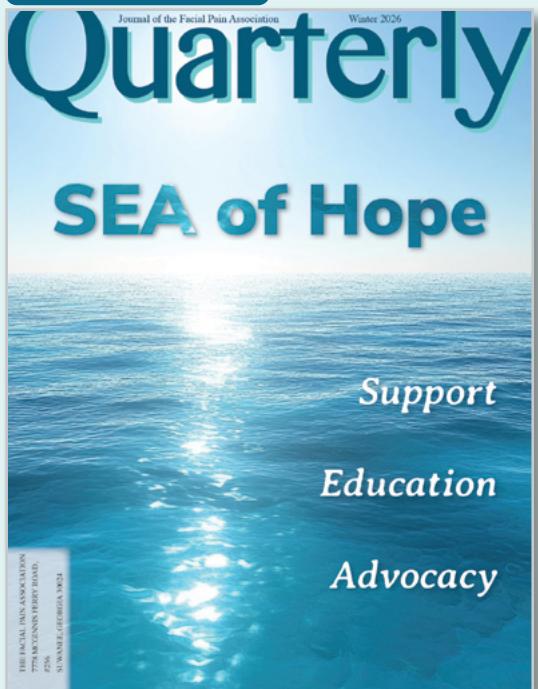
## SEA of Hope

*Support*

*Education*

*Advocacy*

ON THE COVER



Support, education, and advocacy are the pillars of our mission at the Facial Pain Association. Hosting webinars and writing books about facial pain, working with our peer mentor and support group leader volunteers, launching the Facial Pain Registry to support facial pain research, and projects like this Quarterly journal all make up our **SEA of Hope** — efforts to **Support**, **Educate**, and **Advocate** for members of the facial pain community. Together, we are finding new reasons to hope every day. When you share a post about facial pain on social media, inform a friend of your condition, find a new medication that works for you, or share your story with researchers, you are helping to grow this hope. Your courage strengthens our community, and your voice helps light the way forward. Each act of sharing, learning, or supporting becomes another step toward a brighter tomorrow. And with every connection we make, we prove that hope is not just possible — it's powerful. ■

## MAYFIELD Brain & Spine

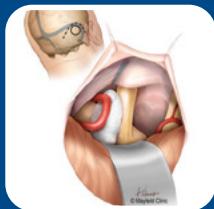
Mayfield offers several treatment options for patients with trigeminal neuralgia, glossopharyngeal neuralgia, hemifacial spasm, and other types of facial pain.

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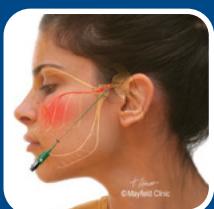
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# A Message From the CEO

## A SEA of Hope:

### Welcoming a New Year Together

As we welcome a new year, I am filled with gratitude and optimism for what lies ahead for our community. Each January offers a chance to pause, reflect, and renew our commitment to the mission that unites us all: to bring **Support**, **Education**, and **Advocacy** to those living with facial pain. Together, these three pillars form the foundation of our work and the heart of what we call our **SEA of Hope**.

Support is where hope begins. Each day, individuals newly diagnosed with trigeminal neuralgia and related facial pain conditions reach out to us seeking understanding and reassurance. Through our peer mentors, support groups, and compassionate volunteers, we remind them they are not alone. This coming year, we will continue to expand our support network, offering even more opportunities for connection, both in person and online, because every conversation, every shared experience, builds strength.

Education is how we empower. Knowledge transforms fear into action, and our mission to provide reliable, accessible information remains unwavering. From patient guides to expert webinars and the very pages of this Quarterly, we strive to ensure that every person touched by facial pain, including patients, families, and healthcare professionals, can make informed choices about care and treatment. In 2026, we will deepen our educational outreach, broadening our resources and amplifying the voices of medical experts and patients alike.

Advocacy is our promise for change. The Facial Pain Association stands as a national voice for those whose pain is too often misunderstood or overlooked. Through partnerships, policy engagement, and awareness



initiatives, we are working to ensure that facial pain receives the recognition and the support it deserves. This year, we will continue to advocate for better access to care, increased funding for research, and stronger understanding across the medical community.

Together, these three pillars — Support, Education, and Advocacy — form the SEA that carries us forward. They reflect the courage, compassion, and resilience of our members, volunteers, and partners who give this mission life every single day.

As we embark on this new year, I invite you to join us in navigating this SEA of Hope — to lend your voice, your story, and your heart to the journey ahead. Together, we can make a difference.

A quick note: I would like to thank FPA volunteer Vince Holtmann for the concept of a SEA of Hope. Vince serves as co-leader for the St. Louis Support Group and as a newly appointed Director on the FPA Board. He consistently shows his dedication to the FPA mission and shared this idea with Natalie Merrithew, our Manager of Marketing, Communications, and Events. Together they created our theme for 2026, which you'll see throughout the year. Thanks Vince and Natalie!

A handwritten signature in blue ink that reads "Melissa Baumbick".

**Melissa Baumbick**

Chief Executive Officer, The Facial Pain Association

# From the Board Chair



This issue of the Quarterly is focused on the theme that the FPA is a **SEA of Hope**, through our mission of **Support, Education and Advocacy**. I'd like to focus on education in this short message.

Everyone has heard that a smart patient is one who becomes knowledgeable about their condition, treatment options, etc. This platitude is true. However, the value of this advice is staggeringly more important for you — you with a rare condition. Why? Because most healthcare professionals don't see enough patients with trigeminal neuralgia and related facial pain conditions to develop a deep expertise in this area. Most of these healthcare professionals are wonderful, very well-educated people who want to help. But, without extensive experience, it's difficult to develop deep expertise. It's nobody's fault. There's no conspiracy. It's just the way it is. (There are experts in this area and the FPA can help you find them, but you will still benefit from being well educated on your condition.)

The FPA is unquestionably the premier place in the world for you to educate yourself on your condition and everything related to your condition. Why? Because we have had the benefit of the leading medical professionals from the premier medical institutions helping us develop the best information for you over the past 35 years! A good indication of this is the two outstanding books on this subject that the FPA has published in the past five years. However, these books are only the tip of the iceberg.

What are the things you should educate yourself about? From my perspective, the most important areas are your condition, treatment options (medications, surgical options, complementary & alternative medicines), and a reasonable overall approach/plan.

The FPA is built primarily around providing information for you. You can attend our in-person or virtual conferences, access our webinar or article library, get our patient guide, receive our newsletters, speak to our staff on the phone, buy our books (if you can't afford the book you want at this time, we'll send it to you free!), and much more. Browsing our website ([www.FacePain.org](http://www.FacePain.org)) or speaking to our staff (call 800-923-3608) are great ways to get started.

Educating you is our primary focus, but not our only educational effort. In recent years, we've been diligently working on educating dentists so they can recognize the difference between facial nerve pain and dental pain, so unnecessary dental procedures are avoided and people with facial nerve pain receive appropriate treatments faster.

The FPA is now educating neurologists, providing information on all the medications, surgical options, and complementary and alternative medicines available - as well as the resources we have to help them support their patients. And in the past six months, the FPA has launched a Patient Registry (please join today!) to collect information that will immensely help medical researchers develop new medications and other solutions for you and others with our condition.

Becoming educated about your condition is a very smart thing to do, and the FPA is the educational resource designed for you. Use us!

A handwritten signature in blue ink that reads 'David Meyers'.

**David Meyers**  
Board Chair, The Facial Pain Association

Journal of The Facial Pain Association

# Quarterly

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# Interview with Jeff Bodington



**Jeff Bodington**  
FPA Emeritus Board Member  
Former FPA Board Chair

As 2025 comes to a close and we wrap up the commemoration of our 35th anniversary, we look ahead to 2026. The FPA extends our deepest gratitude to every member of the facial pain community. For more than three decades, your courage, compassion, and persistence have shaped who we are and guided the work we do. Your willingness to support one another, to share knowledge, and to advocate for better care and greater understanding has allowed the FPA to pursue our mission with purpose and renewed commitment.

Each year, we learn more about facial pain, about the realities of living with it, and about the remarkable strength found within this community. Your stories, your questions, and your determination help drive research forward, inspire new educational efforts, and ensure that no one has to navigate this journey alone.

As we move into the next chapter, we encourage you to continue sharing your experiences and your voices. Every story widens the circle of understanding. Every connection offers comfort. And every act of advocacy helps illuminate a path forward. Together, we will continue to build hope, expand awareness, and strengthen the bonds that carry us all.

This moment of transition is also an opportunity to acknowledge the leaders who have helped bring the FPA to where it is today. In 2025, Jeff Bodington stepped down from the FPA Board of Directors. We celebrate his remarkable contributions and lasting impact over the past 15 years — especially during his tenure as Board Chair from 2012 to 2018. Under his steady leadership, the FPA made tremendous strides. His deep passion for the FPA was evident throughout our conversation, matched only by his hopes for its future.

A distinguished executive with deep expertise in the financial side of the electric power industry, Jeff brings drive and determination to every aspect of his life—including his recent summit of Mount Kilimanjaro.

Beyond these achievements, Jeff's personal journey with trigeminal neuralgia (TN) speaks volumes about his resilience. Having lived with the condition for years, he chose a surgical path a decade ago that has left him pain-free ever since.

Jeff's unwavering commitment to the FPA can be captured in one simple yet powerful phrase: for the patients. We offer our heartfelt thanks and admiration for his visionary leadership, tireless dedication, and the inspiration he's provided to all who have had the privilege of working with him. **Please read on for an interview with Jeff by Danielle Clements, our 35<sup>th</sup> Anniversary Correspondent.**



L-R, John Koff, former FPA CEO, Jeff Bodington, Ramesh Babu, MD, Jeffrey Brown, MD

**You've been an integral part of the Facial Pain Association for almost 15 years, overseeing so many different initiatives and the implementation of many changes. Going backwards a bit, what led you to the FPA in the first place?**

While I was dealing with the medications for my trigeminal neuralgia, I found out about a local support group. I went and found it quite useful. That was my introduction to organizations that provide help to people trying to manage their lives outside of the doctor's office. I thought, well, this is an organization which is really helping people, so I started supporting it. At one point, I received a call from the CEO who said, "Hey, would you consider joining our board? We'd like to talk to you about doing that." So, I joined the board.

Within two years, I was chairman of the board, and I was chair for seven years. I continued to be an active member under the new chair, David Meyers, who is very capable. I just recently stepped down from the board and now I'm an emeritus director.

**The FPA marked its 35th year as an organization in 2025. You've seen a lot of progress in your time. What would you like to see for the future of the FPA?**

I'd like to see a couple of things. We are already the go-to organization with more resources and more services [for patients with facial pain and discomfort] than any other organization on earth. While we're translated into a couple of other languages, the people that we really help are primarily in North America. Well, there are actually six other continents that we could be useful to. I'd like to see that.

I started what we call the Inclusive Initiative. The idea is that if you look at who is evident that we help, it is primarily well-educated and prosperous people for the most part. And why is that? Well, we provide a huge amount of information to people on the internet, and we're working to make it more available across people with facial pain.

Facial pain doesn't care what your education is or how much money you make or your religion or anything else. We're working to find a way to be more available to everyone with facial pain, and that's very difficult.

We provide everything free, the internet makes it free and available, but not everyone's facile with the internet. How do we reach those people? We need to figure that out. I would also like to see us, and we're working on this too, play a bigger role in research to help find better treatments.

"Jeff Bodington" continued on page 6



Jeff Bodington in the Karakoram mountain range in Northeastern Pakistan

"Jeff Bodington" continued from page 5

And that needs to be done carefully. It needs to be done in a way that takes advantage of what we can do well, which is deliver patients like no one else can on earth to researchers for studies. But be careful about things that we can't do well, like deciding who should get what research funding. We don't have that expertise. So, I would love to see us more involved in effective research, but in a way that uses our strengths and does not creep into things which we can't do well.

**Such a significant portion of the FPA revolves around volunteerism. There are so many support groups and various volunteer opportunities and positions. Why do you think support is so important for patients suffering with this kind of discomfort and pain?**

I'm going to start back a few steps. When, I'll say "I," but a lot of people get credit, but when I was pushing for elevating the role of the Young Patients Committee (YPC) and the importance of support groups, there were those at the FPA at the top on the staff and among the board who said, you know what, in-person stuff doesn't matter. The future is the internet. And I thought, that is wrong.

Especially amongst young people, it was so dramatic at one of our national conferences. We'd set aside a special room just for the YPC people to

get together. What happened in that room utterly destroyed the idea that this could be all done over the internet. These young people, who were so facile with the internet, got together in person with others who struggled with this disease, and they were in tears.

It was so moving, so important, so human. And that's the importance of the support groups as well. The internet cannot replace face-to-face, person-to-person interaction.

Being there in the same room is not the same as downloading a brochure. And I think that the interaction and the human connections made through support groups and getting people together at in-person conferences, as I've said, brings people to tears. You know, this disease will wreck your life.

Helping people find out they can manage it is a wonderful thing that the FPA does. And part of that is you're finding out you're not alone, and you can communicate with others about this disease and how it affects your life on more levels than downloading a brochure or a Zoom class.

**This has really been great, thank you so much for your time and of course your efforts over the years.**

**Here's to many more years of being pain-free and climbing. ■**



# When Your Mouth Feels Like It's on Fire:

## Understanding Burning Mouth Syndrome

### An excerpt modified from *Facial Pain: Living Well with Neuropathic Facial Pain*



**Gary Klasser, DMD**  
Associate Professor, Louisiana State University School of Dentistry  
Certificate in Orofacial Pain

Imagine waking up one morning and feeling as if your mouth is on fire. Your tongue tingles, your lips sting, and even water seems to make it worse. Yet when you look in the mirror, everything appears perfectly normal. For many people, this is the daily reality of Burning Mouth Syndrome (BMS), a puzzling and often frustrating condition that continues to challenge both patients and doctors.

## What Is Burning Mouth Syndrome?

Burning Mouth Syndrome is a chronic pain condition that causes a burning or scalding feeling in the mouth without any visible signs of irritation or infection. The discomfort can affect the tongue, lips, gums, roof of the mouth, or the inside of the cheeks. Some people also describe a dry or metallic taste, tingling, or numbness.

Doctors have been aware of this condition since 1935, but even after decades of study, there's still no single agreed-upon definition or clear diagnostic test. BMS has gone by many different names over the years — including "glossodynia," "burning tongue," "scalded mouth syndrome," and "oral dysesthesia"

— reflecting the uncertainty and confusion that surrounds it.

For patients, this can be deeply frustrating. They experience real and sometimes severe pain, but medical tests often come back normal. For clinicians, diagnosing BMS can also be difficult, as the mouth may look completely healthy, and no infection, sores, or other visible problems are found.

## Syndrome or Symptom?

Experts still debate whether BMS is a syndrome — meaning a disease in its own right — or a disorder, where the burning is a symptom of another underlying problem. In many cases, doctors classify BMS as a diagnosis of exclusion, which means it's identified only after other causes (like infections, allergies, or nutritional deficiencies) have been ruled out.

Regardless of terminology, what's clear is that BMS is a complex condition likely caused by several factors working together, from nerve changes to hormonal shifts to emotional stress.

"Burning Mouth Syndrome" continued on page 8



## Who Gets It?

Studies suggest that between 0.7% and 15% of adults may experience BMS at some point, depending on how the research is conducted. The condition is most common in women over 50, especially those who are postmenopausal. In fact, women are about five to seven times more likely to develop BMS than men.

Why women are more affected isn't entirely clear. Hormonal changes during menopause may play a role, but studies haven't found strong evidence linking hormone replacement therapy to symptom relief. BMS also appears to become more common with age, though it can occasionally affect younger adults.

## What Does It Feel Like?

People with BMS use many different words to describe the sensation: burning, scalding, tingling, stinging, or rawness. The pain often affects both sides of the tongue, the lips, or the roof of the mouth. Some people also notice a bitter or metallic taste or feel as if their mouth is unusually dry.

In most cases, symptoms start gradually and persist for months or even years. Some people report that the burning builds up throughout the day. It may be mild in the morning but reach its peak in the evening. Eating or drinking may temporarily relieve the discomfort, while spicy, acidic, or hot foods can make it worse.

Although the pain can be moderate to severe, the mouth usually appears normal when examined. This mismatch between how it feels and how it looks can make patients worry that their pain is "in their head." It's not — the discomfort is real and can seriously impact quality of life, affecting eating, speaking, and sleep.

## Why Does It Happen?

The exact cause of BMS remains uncertain, but researchers believe it often involves nerve dysfunction. The nerves that control taste and pain in the mouth may send incorrect signals to the brain, creating the burning sensation even in the absence of an injury.

Other possible contributors include:

- Hormonal changes, especially around menopause
- Dry mouth (xerostomia) due to medications or reduced saliva flow
- Nutritional deficiencies, such as low iron, zinc, or vitamin B12
- Allergic reactions or sensitivities to dental materials, mouthwashes, or flavoring agents
- Psychological factors, such as stress, anxiety, or depression
- Neurological or autoimmune conditions, though these are less common

Because there's no single cause, there's also no one-size-fits-all treatment.

## How Is It Diagnosed?

Since BMS can mimic or overlap with many other conditions, diagnosis begins with a thorough medical and dental history. Your doctor or dentist will ask when the burning began, how long it lasts each day, and whether anything triggers or eases it.

They'll also review medications, diet, and oral care products and may run blood tests to rule out diabetes, vitamin deficiencies, thyroid issues, or infections. Tests for allergies, dry mouth, or taste changes may also be done. In some cases, imaging or biopsies are used to rule out other diseases.

If no specific cause is found and the mouth tissue looks healthy, BMS is diagnosed.

## Living With and Managing BMS

Although there is currently no cure for Burning Mouth Syndrome, many people find ways to reduce their symptoms and improve their comfort. Successful management often involves a multidisciplinary approach, meaning several types of care are used together — medical, dental, and psychological.

Here are some of the main strategies used today:

### 1. Self-care and Lifestyle Changes

Avoiding triggers can make a big difference. This might include:

- Using alcohol-free, flavor-free mouthwashes
- Avoiding spicy, acidic, or hot foods
- Limiting gum, mints, or cinnamon-flavored products
- Drinking plenty of water
- Reducing stress through exercise, yoga, or relaxation therapy

Some patients benefit from desensitizing mouth appliances or behavioral therapies that help reduce the focus on pain.

### 2. Topical Treatments

Doctors sometimes prescribe mouth rinses, gels, or lozenges that contain mild anesthetics, capsaicin, or clonazepam (a medication that can calm nerve

activity). Some studies suggest low-level laser therapy may help reduce pain, although research is still ongoing.

### 3. Oral or Systemic Medications

Because nerve signals are thought to play a major role, doctors may try medications used for nerve pain, such as certain antidepressants, anticonvulsants, or anti-anxiety drugs. These aren't "painkillers" in the usual sense but work by calming overactive nerve pathways.

### 4. Psychological Support

Since chronic pain and emotional distress can feed into each other, cognitive behavioral therapy (CBT) and stress management programs can be helpful. These don't mean the pain is psychological, rather, they teach coping skills and reduce the body's stress response, which can make symptoms less intense.



## The Outlook

For some people, BMS symptoms may fade over time, sometimes within a few years, though others may continue to experience discomfort long-term. Studies show that around half of patients experience at least partial improvement, and up to one in five may have complete remission over several years.

Even though there's no single "cure," understanding and managing the condition can significantly improve day-to-day life. Working closely with a knowledgeable dentist or orofacial pain specialist, oral medicine specialist, or neurologist, can help identify triggers, tailor treatments, and provide support.

## Hope for the Future

Researchers are continuing to explore how nerve pathways, hormones, and the brain interact to cause oral burning. With better understanding, new and more targeted treatments are likely to emerge.

In the meantime, the key message for anyone living with Burning Mouth Syndrome is this: your pain is real, and help is available. With the right combination of care and coping strategies, it's possible to find relief and reclaim comfort — one step, and one day, at a time. ■

[Learn more about  
Burning Mouth Syndrome](#)

This article is an excerpt from Dr. Klasser's chapter on Burning Mouth Syndrome from our most recent book. The full chapter and other important facial pain information can be found in *Facial Pain: Living Well with Neuropathic Facial Pain* — click @ left button to purchase.



## Meet the FPA Staff!

### Newest Addition: Liam Winters

### Manager of Development and Professional Outreach



"We are thrilled to welcome Liam to our team," said Melissa Baumbick, FPA CEO. "He brings a strong background in fundraising, donor engagement, and community-building, and we're excited to see his experience come to life in our mission.

His role will be vital in strengthening connections with our generous donors and fostering relationships with medical centers, physicians, researchers, sponsors, and

our valued members. We look forward to the impact Liam will make as we continue to grow and support the facial pain community."

Liam has over five years of experience in peer-to-peer and corporate development with the National Multiple Sclerosis Society and the National Alliance on Mental Illness and holds a master's degree in American government from Appalachian State University. He is incredibly excited to bring his experience supporting patient advocacy nonprofit organizations to the FPA. In his free time, he enjoys live concerts, reading, and going on hikes in the Shenandoah Valley. Liam lives in Richmond, Virginia with his girlfriend and dog Boba. You can contact Liam anytime at [lwinters@facepain.org](mailto:lwinters@facepain.org).

## The Rest of the Team



### **Melissa Baumbick, Chief Executive Officer**

Melissa brings more than a decade of nonprofit experience, following 17 years in corporate and small business marketing. She combines strategic vision with deep expertise in brand development and communications, all grounded in a strong commitment to mission-driven work. Her passion for serving those affected by rare conditions drives her efforts to raise awareness, build community, and create lasting impact.



### **Rose Gaffney, Social Media Coordinator**

Rose is a freelance filmmaker with over ten years of experience in videography and social media management. Rose brings her passion for connecting people to her role as the Social Media Coordinator for the FPA, striving to inform and engage patients, caregivers and healthcare professionals alike.



### **Regina Gore, Manager of Community Volunteer Programs**

Regina has more than 15 years experience working with volunteers in the nonprofit sector. She holds a Master in Public Administration from Drake University. Regina brings her compassion and organization skills to the volunteer effort for the FPA.



### **Christina McCurdy, Bookkeeper**

Christina oversees our financial data and compliance. She has more than 15 years of experience working in the accounting field and holds a Master's Degree in Business Administration from Webster University. Prior to joining our team, Christina worked with financial advisors, small businesses, and nonprofits.



### **Natalie Merrithew, Manager of Marketing, Communications, and Events**

Natalie is a communications professional with a background in non-profit digital and print media. She holds a Bachelor's Degree in English with an emphasis in Writing and Publication Studies and a minor in Writing for News Media from Clemson University. As our Marketing, Communications, and Events Manager, she strives to make our content accessible and engaging for all who desire support in living with facial pain.



### **Susan Mills, Database Coordinator**

Susan has held a variety of positions over her 30 years of work experience. She holds a Bachelor's degree in Information Systems Management from the University of San Francisco, is a certified paralegal, and a graduate of the International Travel Management Institute. She has served as an FPA Peer Mentor and Support Group Leader for Northern California, and recently initiated a support group for individuals suffering from trigeminal neuropathic pain due to dental injuries. She is responsible for the day-to-day management of the FPA's DonorPerfect management system.



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# Decoding Facial Pain: An Unrecognized Symptom of Headache Disorders



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AdventHealth Neuroscience Institute

**Dharani Mudugal, MD**

Neurologist and Headache Specialist  
AdventHealth Neuroscience Institute



**Facial pain can be a perplexing and distressing condition, often prompting individuals to seek answers and relief. While headaches are a common ailment, not everyone realizes that certain headache disorders can manifest as facial pain. This overlap can complicate diagnosis and treatment, making it essential to understand the nuances of both conditions.**

In this article, we will explore the various headache disorders that may present with facial pain, delving into their characteristics, potential triggers, and treatment options. By shedding light on these conditions, we aim to examine facial pain in the context of headache disorders. Whether you're a patient seeking relief or a health care provider looking to enhance your understanding, this exploration will offer valuable insights into the intricate relationship between headaches and facial pain.

## Types of Headache Disorders with Facial Pain

### Migraine

Migraine is a common, disabling, primary headache disorder. Migraine can sometimes resemble pain in the facial area. This means that patients with migraine localized in the face may confuse it for sinus, dental, or other orofacial pain. According to the American Migraine Foundation (AMF), approximately 90% of self-diagnosed sinus headaches are actually migraine. Many epidemiological studies have documented its high prevalence, along with its socio-economic and personal impacts. In the 2010 Global Burden of Disease Study (GBD2010), it was ranked as the third most prevalent disorder in the world. In GBD2015, it was ranked third-highest cause of disability worldwide in both males and females under the age of 50 years.

Migraines can cause facial pain through several mechanisms.

"Pain in the Face" continued on page 14

## Trigeminal Nerve Involvement

The trigeminal nerve is the largest of the twelve paired cranial nerves and relays sensations from the face, oral cavity and mucous membranes to the brain. It has three branches. The first branch is the ophthalmic branch (V1) which provides sensation to the top and front of the head, eyes, dura mater (a protective membrane around the brain and spinal cord), and frontal sinus. The second branch, known as the maxillary branch (V2), provides sensation to the middle of the face, including the cheek, maxillary sinus, top lip, upper teeth, and gums. The mandibular branch (V3) is the only branch to have both sensory and motor functions. It primarily innervates the skin of the lower face, lower teeth, tongue, temporomandibular joint, and muscles of the jaw. Head pain signals travel along tiny nerve fibers that start in a cluster of nerve cells called the trigeminal ganglion, which helps carry sensation from the face and head to the brain. These small nerve fibers act as messengers, sending pain signals from blood vessels and other tissues in the head toward the brainstem.

Along the way, they release natural chemical messengers, such as Substance P and calcitonin gene-related peptide (CGRP), that help amplify and transmit pain. These messages first reach a relay center in the lower part of the brainstem called the trigeminal nucleus caudalis, where they connect to second-order nerve cells.

From there, the pain information is sent to several deeper parts of the brain that process both the physical sensation and the emotional response to pain. These include regions involved in alertness, stress, and emotion (the reticular formation and limbic system), as well as areas that help the brain locate and interpret the pain (such as the thalamus and somatosensory cortex). In summary, headaches are driven by activation of the trigeminal nerve which is responsible for sensation in the face. This activation can lead to pain that radiates to the forehead, cheeks, jaw, and even the teeth.

## Differentiating Migraines from Other Causes of Facial Pain

The term migraine is derived from the Greek word hemicrania (half head) and refers to unilateral head pain characteristic of the condition. This syndrome may occur with or without accompanying focal neurological symptoms called the aura. Aura can involve visual disturbances like seeing flashing lights or zigzag lines, sensory changes such as numbness or tingling, and speech difficulties. Auras are typically temporary, lasting about 5 to 30 minutes, and are caused by a wave of electrical activity spreading across the brain. Migraine without aura occurs in about 80% to 85% of patients. The headache phase of migraine has the same characteristics regardless of the presence of aura. The international classification of headache disorders' 3 criteria describes migraine as head pain of moderate to severe intensity that is unilateral, pulsating, and worsened with routine physical activity, and that lasts, if untreated, from 4 to 72 hours in adults. Migraine headaches are usually associated with nausea, photophobia (extreme sensitivity to light), and phonophobia (extreme sensitivity to sounds). It is worsened with activity or movement.

## Treatment

Acute management includes triptans, nonsteroidal anti-inflammatory medications (NSAIDs), gepants (Ubrogepant, Rimegepant), ditans (Lasmiditan), and antiemetics. Preventive therapy includes CGRP monoclonal antibodies [ Erenumab, Framanezumab, Galcanezumab, Eptinezumab ], oral gepants (Atogepant, Rimegepant), Beta-blockers (Propranolol, Atenolol, Metoprolol), antiepileptics (Topiramate, Valproate), and onabotulinumtoxinA for chronic migraine. Lifestyle modifications and trigger avoidance are recommended.

## Trigeminal Autonomic Cephalgias as a Cause of Facial Pain

Trigeminal autonomic cephalgias (TACs) are a group

of headache disorders characterized by severe pain and autonomic symptoms. These conditions involve the trigeminal nerve, which is responsible for facial sensation, and the autonomic nervous system — leading to a range of symptoms that can include facial pain. TACs are known for their intensity and the distinct pattern of symptoms they produce.

### How TACs Cause Facial Pain

TACs cause facial pain through the involvement of the trigeminal nerve and the autonomic nervous system. The trigeminal nerve provides sensation to the face, and its activation during TAC attacks leads to severe pain in the affected areas.

## Types of Trigeminal Autonomic Cephalgias

### Cluster Headaches

Cluster headaches are recurrent episodes of unilateral, orbital (eye), supraorbital (forehead), and temporal (temple) head pain accompanied by autonomic signs showing on the same side of the body (ipsilateral), including conjunctival injection (eye redness), nasal congestion, lacrimation (tears/crying), rhinorrhea (runny nose), miosis (pupil constriction), ptosis (eyelid drooping), eyelid edema (swelling), and facial sweating. The attacks can last from 15 minutes to three hours and occur as infrequently as every other day or as frequently as eight attacks per day. This syndrome derives its name from the characteristic clusters or periods of frequent headaches which can last from weeks to months and separated by periods of remission that can be months or years in duration. Approximately 10% of patients eventually developed chronic symptoms without remission. During a cluster, the headache attacks are often cyclical, occurring at almost the same time every day. Exposure to even small amounts of alcohol or nitrates may trigger an acute attack during a cluster.

### Diagnostic Criteria for Cluster Headaches

- A. At least five attacks fulfilling criteria B-D
- B. Severe or very severe unilateral orbital, supraorbital and/or temporal pain lasting 15 to 180 minutes

(when untreated)

C. Either or both of the following:

1. At least one of the following symptoms or signs, ipsilateral to the headache:
  - Conjunctival injection and/or lacrimation
  - Nasal congestion and/or rhinorrhoea
  - Eyelid oedema
  - Forehead and facial sweating
  - Miosis and/or ptosis
2. A sense of restlessness or agitation

D. Occurring with a frequency between one every other day and eight per day

E. Not better accounted for by another ICHD-3 diagnosis

Some patients have been described who have cluster headaches and trigeminal neuralgia (sometimes referred to as cluster-tic syndrome). They should receive both diagnoses. The importance of this observation is that both conditions must be treated for the patient to become headache-free.

### Treatment

High-flow oxygen, subcutaneous/intranasal triptans; preventive therapy includes verapamil, lithium, and galcanezumab [FDA approved for prevention of episodic cluster headache]. Refractory cases may benefit from occipital nerve stimulation.

### Paroxysmal Hemicrania

This is a relatively uncommon syndrome which shares many features with cluster headaches, including unilateral orbital/temporal location, severe intensity and ipsilateral autonomic signs, including conjunctival injection, tearing, rhinorrhea, eyelid edema, forehead and facial sweating, miosis and ptosis. This differs from cluster headache in its brief duration (5 to 20 minutes), higher attack frequency (generally about five per day), predominance in females and absolute responsiveness to treatment with indomethacin (150

"Pain in the Face" continued from page 15  
mg per day or less).

### **Criteria for Paroxysmal Hemicrania**

- A. At least 20 attacks fulfilling criteria B-E
- B. Severe unilateral orbital, supraorbital and/or temporal pain lasting 2 to 30 minutes
- C. Either or both of the following:
  - 1. At least one of the following symptoms or signs, ipsilateral to the headache:
    - Conjunctival injection and/or lacrimation
    - Nasal congestion and/or rhinorrhea
    - Eyelid oedema
    - Forehead and facial sweating
    - Miosis and/or ptosis
  - 2. A sense of restlessness or agitation
- D. Occurring with a frequency of > 5 per day
- E. Prevented absolutely by therapeutic doses of indomethacin
- F. Not better accounted for by another ICHD-3 diagnosis

### **Short-Lasting Unilateral Neuralgiform Headache Attacks**

Short-lasting unilateral neuralgiform headache attacks with conjunctival injection and tearing (SUNCT) and short-lasting unilateral neuralgiform headache attacks with cranial autonomic symptoms (SUNA) are characterized by brief, intense pain around one eye, accompanied by prominent lacrimation and redness of the ipsilateral eye. These attacks can occur multiple times a day.

### **Criteria for Short-Lasting Unilateral Neuralgiform Headache Attacks**

- A. At least 20 attacks fulfilling criteria B-D
- B. Moderate or severe unilateral head pain with orbital, supraorbital, temporal and/or other trigeminal distribution, lasting for 1 to 600 seconds and occurring as single stabs, series of stabs or in a saw-tooth pattern

- C. At least one of the following five cranial autonomic symptoms or signs, ipsilateral to the pain:
  - 1. Conjunctival injection and/or lacrimation
  - 2. Nasal congestion and/or rhinorrhea
  - 3. Eyelid oedema
  - 4. Forehead and facial sweating
  - 5. Forehead and facial flushing
  - 6. Sensation of fullness in the ear
  - 7. Miosis and/or ptosis

- D. Occurring with a frequency of at least one a day
- E. Not better accounted for by another ICHD-3 diagnosis

### **Treatment**

Treatment options include lamotrigine, topiramate, gabapentin, oxcarbazepine, and carbamazepine. Intravenous lidocaine may be considered for refractory cases. In some patients, a greater occipital nerve steroid injection can help abort attacks.

### **Hemicrania Continua**

Hemicrania continua is a rare primary headache disorder characterized by continuous, strictly unilateral pain involving the face, orbit, and temporal regions. It is associated with ipsilateral autonomic features, including conjunctival injection, lacrimation, nasal congestion, rhinorrhea, eyelid edema, facial sweating, miosis, or ptosis. Unlike other TACs, hemicrania continua is continuous, although patients may experience exacerbations or "pain spikes." Its absolute responsiveness to indomethacin is both diagnostic and therapeutic. Accurate recognition is essential to distinguish it from chronic migraine, paroxysmal hemicrania, and cluster headache.

### **Idiopathic Intracranial Hypertension (IIH) as a Cause of Trigeminal Neuralgia**

Idiopathic Intracranial Hypertension (IIH), also known as pseudotumor cerebri, is a condition characterized by increased intracranial pressure without an obvious cause. This elevated pressure can lead to various neurological symptoms, including headaches, vision problems, and trigeminal neuralgia in some cases.

## Cerebrospinal Fluid (CSF) Pressure Disorders as a Cause of Facial Pain — CSF Leak Presenting with Trigeminal Neuralgia

A cerebrospinal fluid (CSF) leak occurs when the fluid that surrounds and cushions the brain and spinal cord escapes through a tear or hole in the dura mater, the outermost layer of the meninges. It may cause facial pain due to mechanical traction on cranial nerves. Isolated facial pain is rare, and symptoms can be diverse including neck or shoulder pain, orthostatic headaches, tinnitus, muffled hearing, cognitive decline, changes in vision and changes in behavior.

### Treatment

Bed rest, hydration, caffeine, epidural blood patch; surgical repair if persistent. Transvenous embolization may be considered for cerebrospinal fluid venous fistula.

## Temporal Arteritis as a Cause of Facial Pain

Temporal arteritis, also known as giant cell arteritis, is an inflammatory condition affecting the blood vessels, particularly the temporal arteries. This condition can lead to various symptoms, including headaches, jaw pain, and, notably, facial pain. Understanding how temporal arteritis causes facial pain is crucial for timely diagnosis and effective treatment.

### Treatment

Immediate corticosteroids; long-term tapering with steroid-sparing agents (methotrexate, tocolizumab). Regular monitoring of ESR, CRP, and vision is essential.

**Table 1. Headache Disorders Presenting with Facial Pain**

Disorder	Pain Duration	Pain Location	Autonomic Symptoms	Key Diagnostic Feature	Treatment Response
Migraine	4–72 h	Unilateral/bilateral; face, jaw, sinuses	Mild lacrimation, nasal congestion possible	Nausea, photophobia, phonophobia	Triptans, CGRP antagonists, preventives
Cluster Headache	15–180 min	Orbital, supraorbital, temporal	Tearing, nasal congestion, ptosis	1–8 attacks/day, cyclical	Oxygen, sumatriptan, verapamil
Hemicrania continua	Present for > 3 months	Strictly unilateral headache	Similar to cluster headache	Absolute response to therapeutic doses of indomethacin	Indomethacin
Paroxysmal Hemicrania	2–30 min	Orbital, temporal	Similar to cluster headache	Absolute indomethacin response	Indomethacin
SUNCT/SUNA	1–600 sec	Orbital, temporal	Conjunctival injection, tearing	Brief stabbing/saw-tooth pain	Lamotrigine, topiramate
Idiopathic intracranial hypertension [IIH]	Continuous/variable	Diffuse, retro-orbital	None	Papilledema, raised CSF pressure	Weight loss, acetazolamide
Spontaneous spinal CSF leak	Variable	Trigeminal Neuralgiform pain; rare in isolation	None	Orthostatic headaches, Valsalva triggered or exaggerated headaches, other cranial nerve symptoms	Epidural blood patch, and CSF venous embolization when appropriate
Temporal Arteritis	Hours–days	Temporal, facial, jaw	None	ESR/CRP elevation, age >50	Corticosteroids

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## Data Speaks: The Power of Information

By: David Ciemnecki, Tristan Olinger, and Liam Winters

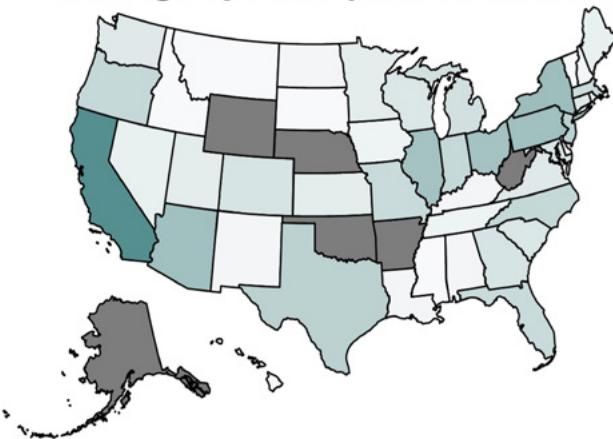
The FPA launched its registry in June 2025. Although it has only been active for six months, a compelling story is already emerging from the information you and others have contributed. Look at what we learned from the Getting Started Survey that is comprised of only four questions.

### You Are Not Alone

You are among 409 people with facial pain who completed at least one survey and this number grows daily. Ninety-two percent, or 377 people, completed all three available surveys. Your participation demonstrates the strength and support within our community.

If you have not yet contributed your information or completed all three surveys, you are invited to do so using the link or QR code below. It will take most people no more than 15–20 minutes. Your input helps researchers better understand facial pain and develop improved treatments. All responses are confidential and greatly appreciated.

#### U.S. Registry Participants as of November 2025\*



Join the Facial Pain Registry



### You are among an international group of people with facial pain.

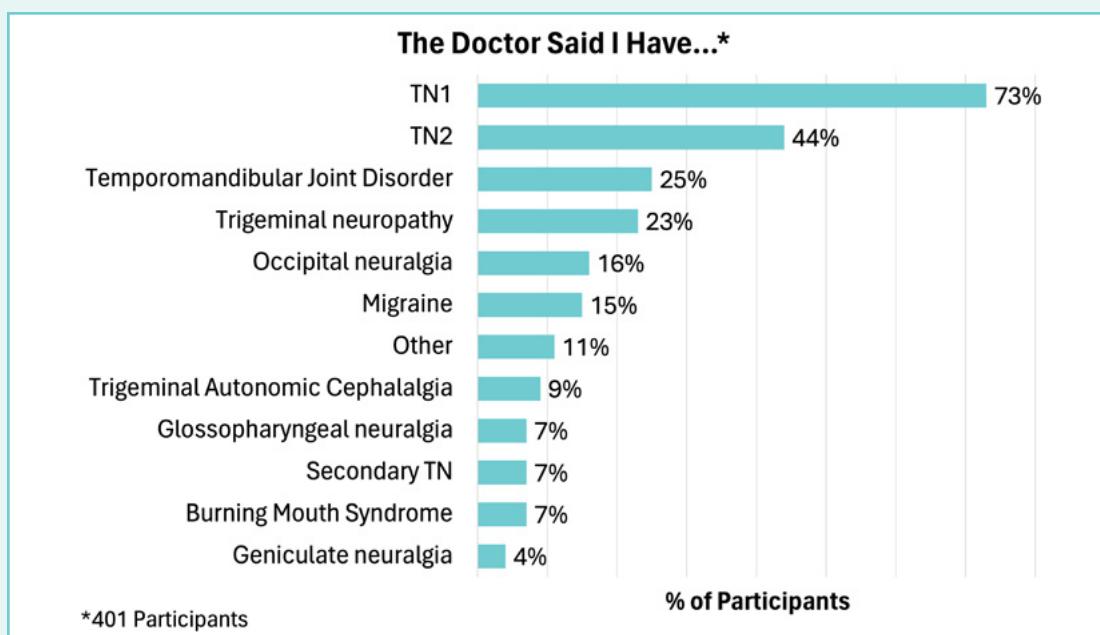
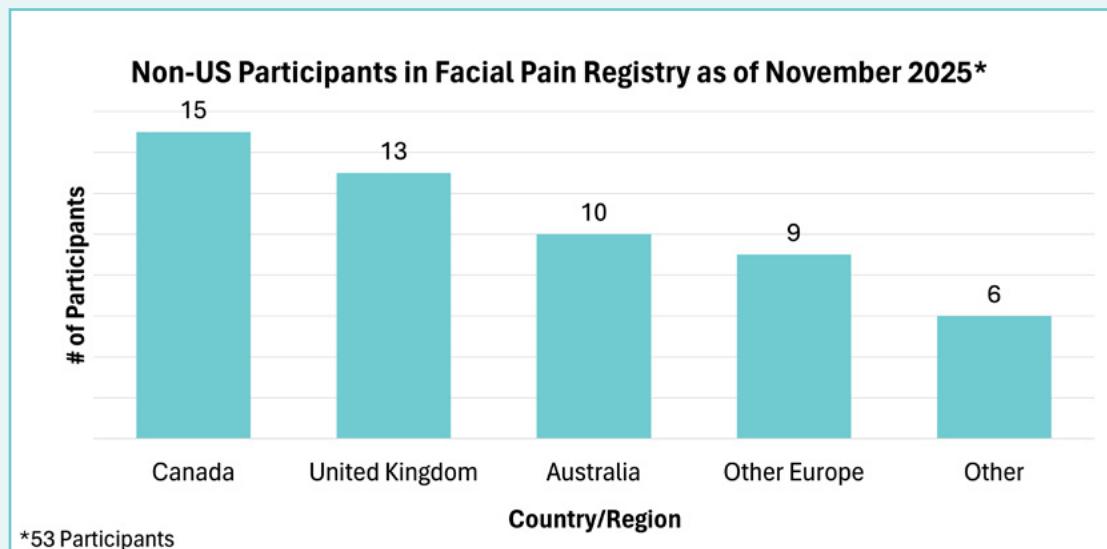
Registry information has been provided by individuals from across the United States (87%) and from around the world (13%), reflecting a truly global community.

But there are some US States that are not represented or underrepresented, including Alaska, Arkansas, Oklahoma, West Virginia, and Wyoming.

Males are also underrepresented. If you live in one of those states or if you are male, we especially need your participation.

"Facial Pain Registry" continued on page 20

Most non-US participants are from Canada, the United Kingdom and Australia. A handful are from other European or Oceanic countries. EVERYONE is welcome to be counted in the registry. More participants equals more knowledge about the treatment of trigeminal neuralgia and other facial pain.

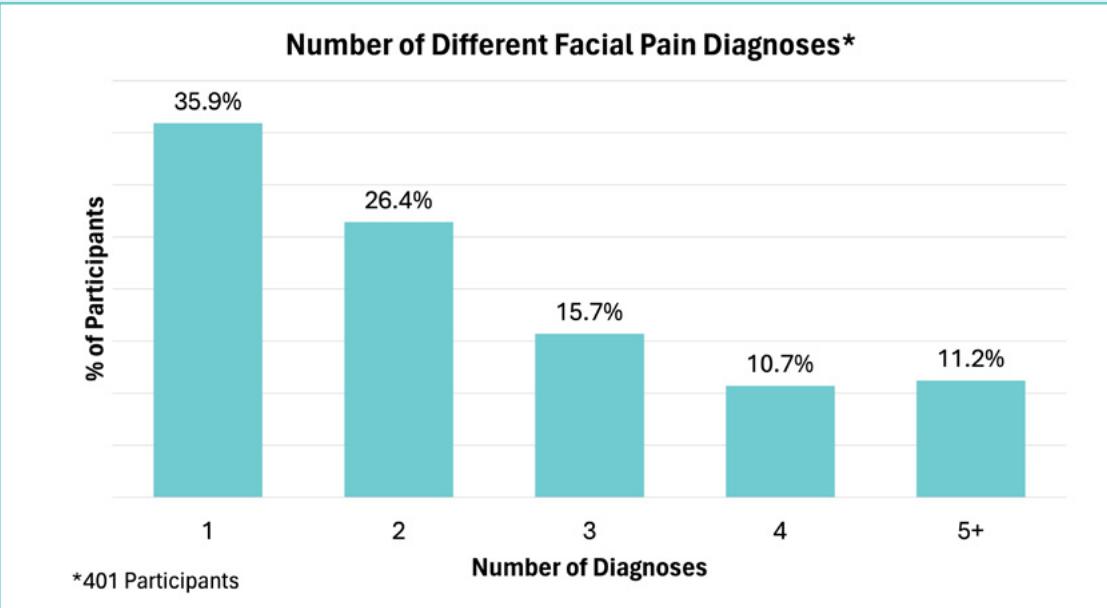


**There are many types of orofacial pain**

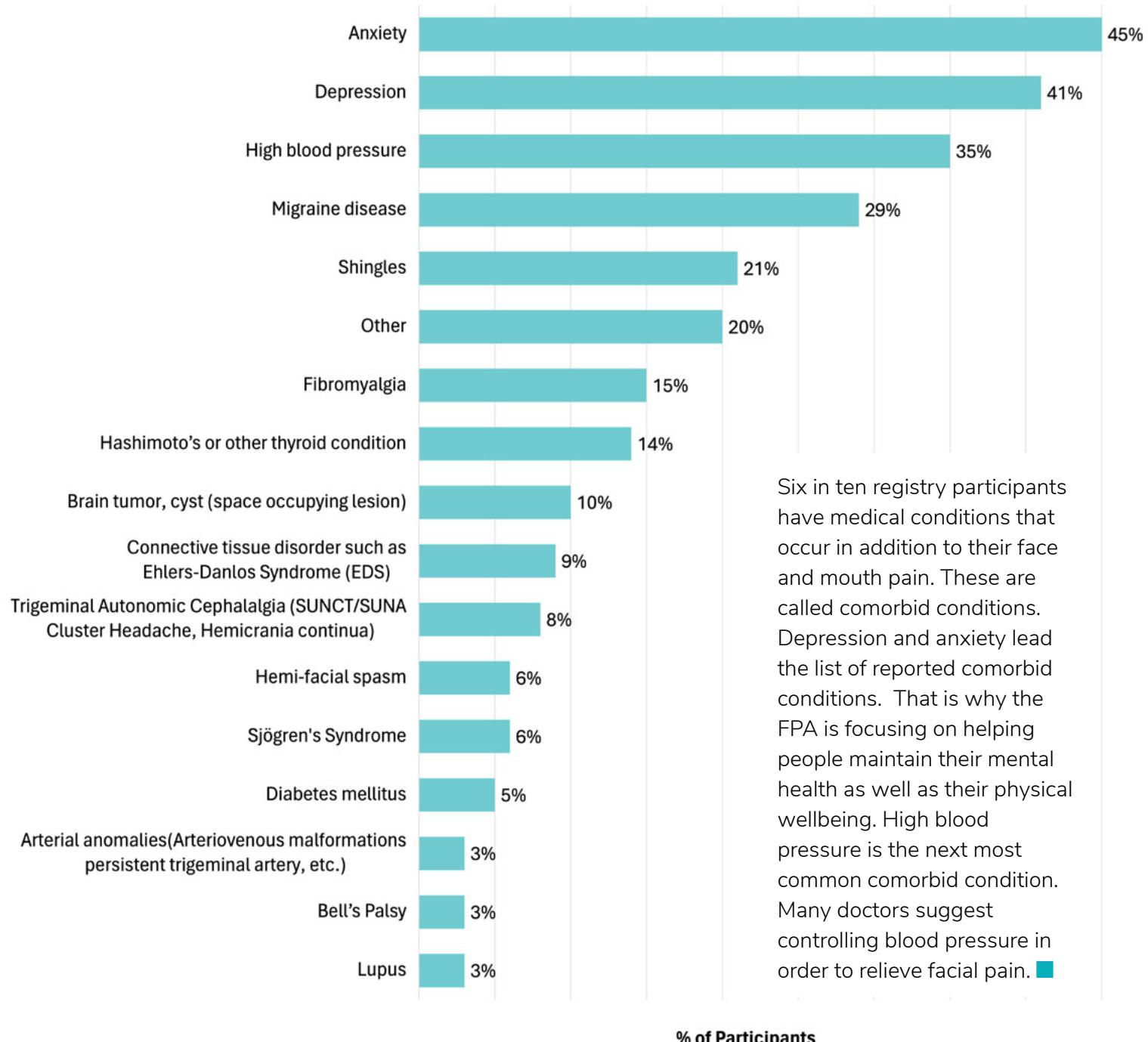
While TN1 is the most common orofacial pain diagnosis, affecting nearly three-quarters of registry participants, it is far from the only one. Nearly half have been told by a doctor they have TN2. And a quarter have been told they have TMJD and/or Trigeminal Neuropathy.

**Some of you have been diagnosed with more than one type of pain.**

All but 8 registry participants have received a diagnosis from their doctor. Nearly two-thirds have been diagnosed with more than one facial pain condition and over one-third have been diagnosed with three or more.



### In Addition to Facial Pain, the Doctor Said I Have...\*



\*249 Participants

# Fall 2025 Facial Pain Resiliency Academic Scholarship Recipient

**Elaine R. Santos**

## Facial Pain's Impact on My Life

Facial pain significantly impacted my academic and personal life. I tried to balance clinical rotations, coursework, and many doctors' appointments while in constant pain and on heavy medications. Ultimately, the impact on my health contributed to being dismissed from my anesthesia program. This devastated me after years of preparation, and I fell into a deep depression. There were moments when the pain was so overwhelming that I questioned whether I could go on living.

Yet even in my darkest moments, I chose not to give up. I reminded myself of my family, my goals, and the possibility of creating change for others like me. Only two weeks after leaving my anesthesia program, I enrolled in a dual Family Nurse Practitioner (FNP) and Psychiatric Mental Health Nurse Practitioner (PMHNP) program. That decision marked a turning point. Rather than viewing my condition as the end of my career goals, I considered it as the beginning of a path that aligned more closely with my purpose. I realized that I wanted to become the kind of provider who listens, validates, and advocates for patients who feel disregarded.

## Advice for Other Young Patients

If I could share advice with another young patient struggling with facial pain, I would tell them never to



give up on themselves. Even when doctors dismiss your symptoms, continue to advocate for yourself and seek answers. Conduct thorough research, find specialists, and engage with support groups. Online communities, such as Facebook groups, showed me that I was not alone in my journey. Knowing others experienced the same pain gave me hope. It is also important to remember that while solutions may take time, they do exist. Some providers will listen, and specific treatments can be beneficial. Most importantly, your pain does not define your future; your resilience does.

## My Journey

My journey through facial pain has been long, painful, and often isolating, but it has allowed me to grow. I have learned to persevere, to advocate for myself, and to never give up on my goals. While I once dreamed of being a nurse anesthetist, I now see that my true calling is to become an FNP and PMHNP, where I can care for patients holistically and advocate for those who feel unheard. As I prepare for my microvascular decompression surgery and continue my NP education, I carry with me a new purpose. My story is not just about enduring pain; it is about turning pain into resilience, compassion, and drive to help others who walk the same difficult road. ■

## Fall 2025 Facial Pain Resiliency Academic Scholarship Recipient

### Autumn Randall

Although I will never be a pilot because of my trigeminal neuralgia, I am at peace with that reality now. I discovered a new joy in aviation maintenance, one that is equally fulfilling in its own way. There is nothing quite like the feeling of watching a plane take off, knowing I played a role in ensuring it was safe to fly. I may not be at the controls, but I am still part of the team that makes flight possible.

My perseverance paid off. In May 2025, I graduated from high school with both my Aircraft Maintenance License and an Associate's Degree in Aviation Maintenance Technology. Today, I am in my first semester at the University of Dayton, majoring in Mechanical Engineering with a concentration in Aerospace Engineering. Although my path changed, my determination has not. I still aim to work in defense aviation, not as a fighter pilot, but as the person who fixes and designs the very aircraft they fly.

My journey has been shaped by both struggle and resilience. In my junior year of high school, I often doubted whether I would graduate at all. I spent more time in hospitals than classrooms, more time with doctors than teachers. Yet I refused to give up. My diagnosis changed the course of my life, but it did not end it. Instead, it challenged me to fight harder for the things I love.

Living with chronic illness has taught me perspective. It has shown me that my life is not defined by my pain, but by the strength and determination I show in overcoming it. My



story is not one of tragedy, but of resilience. I may not have the life I once imagined, but I have built a new one that is full of meaning, purpose, and passion.

To other young patients, I would say this: your illness does not define your success or your future. It may change your path, but it cannot silence your passion or take away your opportunities unless you allow it to. A diagnosis is not the end of your story — it is the beginning of a new chapter. My life did not end when I was told I could never be a pilot. Instead, I discovered a new dream and a new way to stay connected to the field I love.

The greatest lesson I have learned is that life does not end when something difficult happens to you. Instead, it is in those moments of hardship that you discover who you really are. My illness taught me to live boldly, to speak loudly, and to pursue my dreams without fear. Even though I cannot fly, I will always be a part of aviation, and I will continue to push forward with the same determination that carried me through my darkest days. ■

# Living With Burning Mouth Syndrome

## My Story: By Natasha Collier



**In December 2022, after what seemed like a routine tooth extraction, I woke up to burning pain that changed my life. My tongue felt as though it had been sliced by a thousand tiny blades, and the sensation spread through my mouth and throat. My saliva disappeared, leaving my mouth painfully dry. Eating became difficult, and I lost fifty pounds in a few months.**

Over the next year, I visited every specialist imaginable — gastroenterologists, gynecologists, ENT doctors, dermatologists, dentists, allergists, and oral surgeons. None could find a cause, and some implied it was psychological. One physician told me bluntly, “There’s no cure — be grateful you’re not dying.” It was a lonely and disheartening journey through a system unprepared for something it couldn’t see.

Finally, I found an orofacial pain specialist who diagnosed me with **Burning Mouth Syndrome (BMS)** — a chronic neuropathic condition that causes burning, tingling, or scalding sensations in the mouth without any visible signs. BMS affects 1-5% of the population based on location and differing diagnostic criteria. Mostly postmenopausal women, it affects women to men by 7:1. Its cause is not fully understood; it may involve nerve dysfunction, hormonal changes, or alterations in the brain’s pain pathways. Spontaneous remission is rare, occurring in only 5% of patients.

Treatment focuses on managing symptoms with antidepressants, anticonvulsants, or topical therapies designed to calm overactive nerves. Approximately half find some relief and half, like me, find little to none. I’ve personally tried thirteen different medications, but my severe dry mouth — a common side effect — has made treatment especially difficult. I’ve also spoken to people who have lived with BMS for 15, 30, even 45 years without relief. Hearing that is sobering, but it also reminds me how urgently more research and awareness are needed.

The daily impact of BMS goes far beyond physical pain. Before it began, I loved cooking — creating meals, sharing food, and experimenting with flavors. Now, even mild foods can set my mouth on fire. Acidic ingredients, tomatoes, and spices are out of the question. Cooking became difficult, and I eventually stopped altogether.

The greatest personal loss, though, was giving up operatic singing. Singing was part of my identity — an outlet for joy and expression. The burning and dryness made it impossible to concentrate for more than 15 minutes at the most, where performing in operas required me to sing for hours. Accepting that loss has been especially hard.

And yet, the physical pain is only part of the story. Many people with BMS stay silent because of how they’re treated when they try to talk about it. Since it leaves no visible signs, others assume it’s exaggerated or emotional. Patients are sometimes labeled anxious or unstable. Family members may dismiss or even make fun of them. That disbelief isolates people further and discourages them from seeking help.

Despite the challenges, I’ve learned to adapt. I monitor triggers, manage stress, and stay informed about emerging treatments. I’ve connected with others living with BMS, and I’ve seen how vital awareness is. Too many patients are dismissed or misdiagnosed. Too many are told their pain isn’t real.

To anyone suffering in silence: please don’t give up. Keep searching for a doctor who listens, explore new therapies, and know that your experience matters. And to the medical community: we need more research — more clinical trials, more curiosity, and more compassion. BMS may not be visible, but it is real, and its impact on quality of life is profound.

My life changed that December morning, but I still believe in the possibility of change again — that with time, awareness, and scientific attention, the burning will quiet, and healing will come. ■

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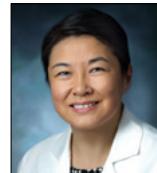
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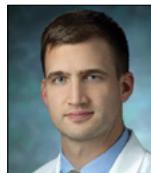
### Meet our neurosurgery experts:



Chetan Bettegowda,  
M.D., Ph.D.



Judy Huang, M.D.



Christopher  
Jackson, M.D.



Risheng Xu, M.D.,  
Ph.D.

To schedule an appointment, call **443-997-1808**.  
Learn more at [hopkinsmedicine.org/neuro/TN](http://hopkinsmedicine.org/neuro/TN).



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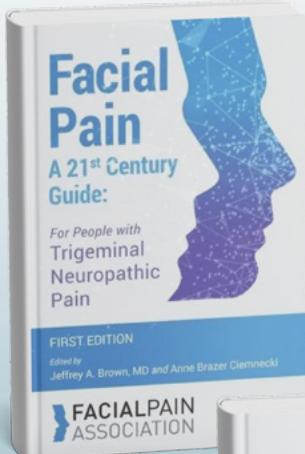
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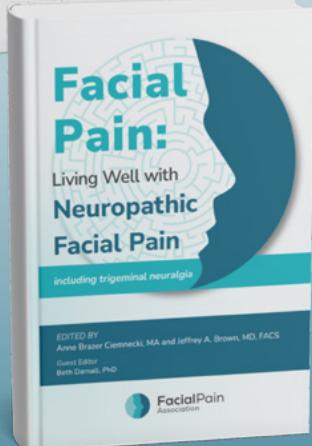
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## Facial Pain Book Bundle

Our newest book, *Living Well with Neuropathic Facial Pain* takes a comprehensive, "whole-person pain relief" approach, focusing on proven medical treatments, the psychology of pain, and accessible solutions to eliminate or mitigate the pain. The book aims to empower individuals to live their best lives by providing insights into various types of neuropathic facial pain, finding the right medications and surgical solutions, and navigating the challenges of affording medication and disability. It also dives into the more personal aspects of pain that can impact daily life. It provides coping strategies, including important and less frequently discussed areas such as mental health, support groups, sleep, relationships, and more.

This book is a companion to the FPA's first book, *Facial Pain, A 21st Century Guide: For People with Trigeminal Neuropathic Pain*, which provides essential information across a broad set of subjects to serve as an introduction to this condition. Both books are valuable resources for individuals living with neuropathic facial pain, as well as caretakers and loved ones.



Purchase your copies today!

# YOUR VOICE MATTERS

Let Data Tell Your Story



Join the Facial Pain Registry Today!





**Facial Pain**  
Association

## When Extractions And Root Canals Are Not The Solution — Neuropathic Pain In The Dental Chair

If your patient has pain but shows no pathology in their teeth, treating them with root canals or extractions may make their pain worse. Before you act, consider that your patient may have trigeminal neuralgia (TN) or nerve damage, called trigeminal neuropathic pain.

Trigeminal neuralgia symptoms include sudden, intense, sharp pain in the face, often described as electric shocks. This sharp shooting pain may last a few seconds to several minutes and may be accompanied with continuous background pain. Triggers include touching the face, cold wind, chewing, speaking, or brushing teeth. It may involve a blood vessel pressing on a nerve, which may be visible on an MRI, and may improve with advanced surgical treatment such as microvascular decompression (MVD). Multiple sclerosis and brain tumors may be secondary causes of trigeminal neuralgia. Dental procedures have never been shown to be an effective treatment; rather, dental procedures are known to cause a flare-up in pain and can lead to immense suffering.

Trigeminal neuropathic pain, sometimes also referred to as trigeminal neuropathy, occurs following injury to one or more components of the trigeminal nerve,

such as with shingles infection, facial trauma, cancer resection surgeries, or from a dental procedure.

When trigeminal neuropathic pain is resultant from facial and/or dental injury, it is subclassified as “post-traumatic trigeminal neuropathic pain” or PTTNp. Symptoms, which are predominantly dysesthetic (ordinary stimulus, like touch, causes unpleasant or painful sensation) and constant, may include pain in the mouth and face, tingling, burning, numbness, and pressure. If nerve injury is a known cause of post-traumatic trigeminal neuropathic pain, it is illogical to think that more nerve injury (i.e., dental procedures) will be helpful. Procedures like tooth extractions and root canals are known to exacerbate the existing neuropathic pain, thus making it more resistant to treatment.

Both trigeminal neuralgia and trigeminal neuropathic pain involve any of the branches of the trigeminal nerve but are more prevalent in the maxillary and/or mandibular branches. Both trigeminal neuralgia and trigeminal neuropathic pain can be disabling and cause interference with daily functioning, such as eating, speaking, shaving, kissing, and the ability to work. Depression, anxiety, and strained relationships may be unfortunate side effects.

Some dental procedures that can precipitate Post-traumatic Trigeminal Neuropathic Pain include:

- Removal of teeth, particularly impacted third molars, can injure the inferior alveolar nerve, the lingual nerve, or the trigeminal nerve
- Placement of dental implants
- Endodontic procedures, including overfills and intrusion into the IAN canal
- Local anesthesia injections, which penetrate the nerve

- Chemical nerve injuries, such as irrigation of intracanal medicaments and failure to rinse acid etchants

Trigeminal neuralgia, trigeminal neuropathic pain, and post-traumatic trigeminal neuropathic pain are challenging to treat, often requiring some trial and error, and a combination of therapies. Specialty care is often needed. Connect with the Facial Pain Association at [www.FacePain.org](http://www.FacePain.org) to learn more.

## How The Facial Pain Association Can Help Your Practice and Your Patients

- Accurate diagnosis is important to finding the right treatment. The FPA hosts a national conference each year (alternating years in-person and virtual) offering the opportunity to hear from the nation's leading experts on the treatment of facial pain. Join the FPA's email list for conference details and visit the FPA website for access to live webinars on relevant topics such as medications for pain management, microvascular decompression (MVD), rhizotomy, radiosurgery, motor cortex stimulation, complementary and alternative medicines (CAMs), the psychology of pain, emerging neuromodulatory approaches and more.
- Free continuing education credits for dental professionals are offered with complementary online seminars. Go to [www.FacePain.org](http://www.FacePain.org) and click the "Healthcare Professionals" tab for more information on opportunities to earn free CME and CDE credit.
- Your patients can tell you that coping with facial pain is lonely, frightening, and daunting. The FPA offers group and one-on-one support through peer-led support groups and peer mentoring. Support groups can be accessed in all 50 states and abroad, as many are available on Zoom. Support group

members say that fellowship with people who understand their pain is a lifeline for them. Peer mentors are available to speak one-on-one to help with coping and questions.

- The FPA provides information about current research and supports research projects through community connection. This effort fosters the development of new solutions for the treatment of facial pain by leading universities and medical schools along with organizations in the pharmaceutical industry.
- The FPA recently launched the Facial Pain Registry, offering members of the facial pain community an important opportunity to share their experiences. The registry will serve as an international resource for researchers and medical professionals, helping to advance studies and drive new developments in the field.
- The FPA has released its second book in four years: *Facial Pain: Living Well with Neuropathic Facial Pain*. This book deals with diagnosis, treatments, the psychology of pain, and how to live your best life. It is a valuable resource for anyone living with neuropathic pain and is available through the website: [www.FacePain.org](http://www.FacePain.org).

Connect with the  
Facial Pain Association  
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