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FLAMING MOUTH SYNDROME IN THE NEUROLOGIST'S PRACTICE

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Abstract: Prosocranialgia (stomatoneurological syndromes, orofacial pain, neurostomatological syndromes) are frequently encountered in the practice of both dentist and neurologist. Up to 40% of patients with pain in the maxillofacial region who visit a dentist need to consult a neurologist.

Key words: blazing mouth syndrome, neurologist, orthofacial pain.

Introduction. Due to the high prevalence, sharp decrease in the quality of life and limitation of working capacity, the problem of facial pain is urgent and is actively studied by specialists.

According to the International Classification of Headache (ICHD-3 beta, 2013) [1] headaches in the facial region meet the diagnostic criteria for secondary facial pain and are coded as A11.9. "Headache or facial pain associated with other diseases of the skull, neck, eyes, ears, nose, sinuses, teeth, oral cavity or other parts of the face or neck". According to the IASP classification (2nd ed., 2011) [2], the following variants of pain syndrome are distinguished: neuropathic, musculoskeletal, due to damage to the oral cavity, nose, ear of various etiologies, etc. The latter include odontalgia on the background of enamel-dentin defects, pulpitis, periodontitis and periapical inflammatory processes with pain syndrome, alveolitis ("dry hole"), teething syndrome, etc. This group includes atypical odontalgia and flaming mouth syndrome, which are classified as non-dental orofacial pain. Orofacial pain of neuropathic nature includes various nosological variants, including secondary ones developed against the background of trauma, iatrogenesis, infections of various etiologies, etc. [3]. [3]. As a rule, neuropathic pain is characterised by a descriptive variety of clinical sensations that bother the patient (burning, tingling, shooting, frost sensation on the skin, itching, etc.). The diseases accompanied by excruciating burning pain or itching in the tongue and mucous membrane of the oral cavity, paresthesias, and impaired taste sensitivity (senestopathic sensations may occur) include burning mouth syndrome (BMS) [4]. BMS is an idiopathic disease [5], in which no visible pathological changes in the oral cavity are observed, the etiopathogenesis of this disease, despite a long history of study [6], is still unknown [7, 8], affects from 0.1 to 3.9% of the population [9], predominantly women aged 50 to 70 years [4].

Clinically, paresthesias of various shades (burning, itching, goosebumps, tingling, tingling) may be observed in SPR; at the beginning of the disease, unpleasant sensations in the tongue last from a few minutes to a few hours, later they may disappear for various periods of time and reappear, but they tend to increase in severity and duration [10]. Some patients report persistent tongue discomfort for months and years. Since there is an imprecision in the coding of the pathological condition, in clinical practice the diagnosis of such patients is not made immediately [11].

On the background of hypothermia, subfebrile temperature (37.1-37.2 °C) and throat parching appeared in the evening hours. Self-treatment included the use of antiseptics (strepsils, pharyngosept, koldakt), which led to improvement of the condition. After another hypothermia the condition worsened again. He did not consult a doctor, used folk remedies for treatment (radish with honey) and then independently took a course of broad-spectrum antibiotics (he could not specify which drug). On the background of therapy, the symptoms of throat constipation regressed, but general weakness,

decreased efficiency, sensory disorders in the facial area appeared (numbness of the left cheek, sensations of "crawling of goosebumps under the skin" on the left half of the face, congestion of the left ear). No pathology was revealed at the consultation with an ENT doctor (March 2017). Examined by a neurologist, who diagnosed: "atypical facial pain", the prescribed treatment with anticonvulsants and vascular drugs was ineffective. These sensory sensations continued to intensify, becoming excruciating, as a result of which the patient was forced to leave his job as a system programmer (the sensations prevented him from concentrating on his work). The patient was referred to an oral mucosa specialist who diagnosed oral mucosa disease, fungal lesion of the oral mucosa. Long-term (3 weeks) antifungal therapy was prescribed: local treatment of the oral cavity (foams, addition of balsam for irrigator), special sucking lollipops. The repeated study (20.10.17) of microflora scraping from the oral mucosa did not reveal clinically significant titres of pathogenic microflora. According to the results of the study it was recommended to continue therapy for up to 6-7 weeks. Re-examination (18.03.18): unpleasant sensory sensations in the tongue (burning) and cheek (numbness) do not bother.

During the period of diagnostic search all psychotropic medications were cancelled. Thus, this clinical case is considered as secondary facial pain on the background of combined lesions of the oral mucosa (staphylococcus, candida).

The patient was diagnosed according to the following criteria:

- Headaches in the facial region fulfil the diagnostic criteria for secondary facial pain according to the ICHD-3 beta (2013-2018), coded as A11.9. "Headache or facial pain associated with other diseases of the skull, neck, eyes, ears, nose, sinuses, teeth, oral cavity or other parts of the face or neck" [1];
- the association of symptoms and broad-spectrum antibiotic therapy may indicate the development of pathogenic microflora in the oral cavity (candidal stomatitis followed by staphylococcal infection);
- ineffectiveness of therapy with carbamazepine for 1 month and absence of signs of neurovascular conflict on examination exclude trigeminal neuralgia; and ineffectiveness of long-term therapy (more than 3 months) with psychotropic drugs excludes atypical character of facial pain [12];
- absence of the most frequent symptoms of temporomandibular joint dysfunction (clicking/clicking sound when opening/closing the mouth; pain when yawning and wide-open mouth; headache in the frontal-parietal region; ear pain and pressing sensations behind the eyes) do not confirm temporomandibular joint dysfunction [13, 14];
- the absence of involvement of masticatory, mimic and pericranial muscles in the pathological process does not meet the criteria for craniomandibular disorder according to ICHD-3 beta (2013-2018) [1].

In recent years, a number of studies have been conducted to identify the characteristic manifestations of CPD in order to study the pathophysiological mechanisms of the formation of this disease and to develop therapeutic techniques. Thus, a study involving 47 patients with SPR aged 60.4±16.5 years [4], whose characteristic clinical manifestations were dysgeusia, geographic language, xerostomia, is described. The study noted that it is more difficult to treat those patients who have chronic course and more severe pain syndrome. Another study involved 56 female patients with SPR. It has been shown that xerostomia in this disease may be related to the presence of some systemic disease in the patient or medication [15]. Another study involving 20 female patients with SPR (68.1±7.4 years) and 20 healthy women (65.4±4.6 years) demonstrated the predominant role of psychological factors in the pathophysiology of SPR rather than mechanical sensitivity of the tongue [16]. One study involving 20 female patients with SPR aged 64.4±11.5 years (35-82 years) discussed the possibility of prescribing melatonin for therapeutic purposes [7]. In another study involving 52 patients (43 women, 9 men) aged 67.3±11.9 years - α-lipoic acid [17]. In the described case, the patient's complaints (burning and tingling in the tongue, sensations of "bursting bubbles" in the mouth and "goosebumps crawling under the skin") are descriptive in nature, typical of complaints of atypical facial pain. In this connection, a

diagnosis of atypical facial pain was made during the initial treatment. This syndrome according to ICD-10 is also denoted by the term "glossodynia" (K14.6), and in the neurological adaptation of the classification - as a syndrome of "flaming mouth" (G44.847). As a consequence, a diagnosis of "glossodynia" was made on examination by a dentist. Lack of efficacy from long-term therapy led to a change of diagnosis: "secondary facial pain, craniomandibular dysfunction". Also, the peculiarity of this case is the fact that a young man of 27 years old came for an appointment, and SPR is predominantly suffered by women over 50 years old [14, 15].

Currently, additional difficulties in the interpretation of this disease are associated with the latest 2018 changes in the International Classification of "Statistics of Mortality and Morbidity" 11th revision [18]. According to this classification, the "flaming mouth" syndrome is included in section 13, Diseases of the digestive system, subsections Diseases or disorders of orofacial complex, and is coded as DA0 °F "Sensory disturbances adversely affecting the orofacial complex", namely DA0 °F.0 "Flaming mouth syndrome". The criteria listed are: SPR - chronic orofacial pain accompanied by burning inside the oral cavity and/or dysesthetic sensations that recur more than 2 h per day, 50% of days out of more than 3 months, without obvious causative lesions on clinical examination and examination. It is characterised by marked emotional disturbances (anxiety, anger, reduced mood background) and impaired orofacial functions (eating, yawning, speaking). Chronic burning pain in the mouth is multifactorial: biological, psychological and social factors contribute to the development of the painful condition. A diagnosis of SPR is appropriate regardless of the biological or psychological factors identified, unless another diagnosis better matches the presenting symptoms. Other chronic headaches or pain in cancer patients are discussed in the sections chronic secondary headache and orofacial pain.

Conclusions: Thus, the presented case may be of particular clinical interest, both from the diagnostic and therapeutic point of view. We are of the opinion that the examination data of the described patient with pain sensations in the maxillofacial region are clinical manifestations of secondary facial pain - "flaming mouth" syndrome, which caused diagnostic difficulties for specialists of different profiles.

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