

Psychosocial Impact of Chronic Orofacial Pain

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The aim of the study was to evaluate psychosocial impact of non-dental chronic orofacial pain (OFP) on daily living using the graded chronic pain (GCP) scale. It is also investigated the clinical profile such as demographics, event related to initiation of OFP and prior treatments for patients.

During previous 6 months since September 2008, 572 patients (M:F=1:1.5, mean age=34.7 years) with non-dental OFP attended university-based specialist orofacial pain clinic (Dankook University Dental Hospital, Cheonan) to seek care although 63% of them already experienced related treatment for their OFP problem. They visited the most frequently general dental practitioner and orthopedic doctors due to their pain problem and medication was the most commonly employed modality. Most of the patients (89.2%) had TMD and the most common related event to initiation of their pain was trauma, followed by dental treatment. Almost half of the patients (46%) suffered from chronic pain(≥ 6 M) and 40% of them exhibited relatively high disability due to chronic OFP.

GCP pain intensity and disability days were significantly different for age and diagnosis ($p < 0.05$) but not for gender and duration. GCP grades were affected by all the factors including gender, age, pain duration and diagnosis. ($p = 0.000$) Female gender, elders, and long lasting pain were closely related to high disability. The patients with neuropathic Pain and mixed OFP rather than TMD were graded as being highly disabled.

Conclusively, a considerable percentage of chronic OFP patients reports high pain-related disability in their daily, social and work activity, which suggest a need for psychosocial support and importance of earlier referral for appropriate diagnosis and tailored management.

Key words: Chronic, Orofacial pain(OFP), Graded Chronic Pain (GCP) scale, Disability, Psychosocial

I. INTRODUCTION

According to the definition by International Association for the Study of Pain (IASP),¹⁾ pain is

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Received: 2009-10-06

Accepted: 2009-11-20

* 이 연구는 2008년도 단국대학교 대학연구비의 지원으로 연구되었음.

an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. By the definition, pain is understood to represent a subjective psychological state rather than an activity that is induced solely by noxious stimulation. Pain may have a noxious transmission component, a psychological component and a very important modulatory component. Pain seriously impairs the lives of millions of people around the world.²⁾

A distinction between acute and chronic pain is important is as the management and to some extent the pathophysiology is different. Acute pain may be considered to be a protective mechanism for the

body, which by stimulating the sympathetic nervous system, is often accompanied by the autonomic signs of stress and anxiety. It is also of considerable diagnostic value to the clinician in determining the nature and site of the disturbance. It also warns of outside danger.³⁾ However, as the pain duration input continues, the levels of suffering increases even through the intensity of the input remains the same.²⁾ Chronic pain does not serve any apparent biological function and is socially and psychologically destructive. The sympathetic response becomes less apparent and signs and symptoms similar to those seen in depressive syndromes emerge.³⁾

In fact, chronic pain is a major problem for patients and poses a massive socio-economic burden for health services and the worldwide community.⁴⁾ It is important to address the physical and psychosocial aspects of any chronic pain. In the mid-1980s, work by Waddell and Main⁵⁾ revealed that the disability associated with chronic non-specific low back pain is only partly explicable in terms of physical factors found on examination. They discovered that psychological factors almost as significant as contributors to the level of disability.

Orofacial pain (OFP), defined as pain related to the face or mouth, is a common symptom in the population and in a significant proportion of cases it can become chronic and disabling.⁶⁻⁸⁾ OFP can be the presenting, and sometimes the only, complaint of many disorders that originate from cranial structures. In the clinical setting, the identification of the underlying cause, and therefore the decision about the investigations needed, occasionally represents a challenge, even for experienced physicians.⁹⁾

Many acute, chronic and recurrent painful conditions occur in the orofacial region.¹⁰⁾ Lipton et al¹¹⁾ reported that 22% of the US population have OFP on more than 1 occasion in a 6-month period. In a Canadian study,¹²⁾ 53% of participants had experienced some pain or discomfort in the orofacial region in the previous 4 weeks. The majority of

pain reports were tooth or gum related, whereas pain in the jaws, face, and oral mucosa were less common. A quarter of the adult UK population experienced facial pain symptoms over the past month, and 17% had to take time off work or were unable to carry out normal activities because of pain.¹³⁾ Furthermore, persistent and chronic pain is more prevalent in the head and neck region than in any other part of body.¹⁴⁾

Chronic OFP (COFP) remains a common cause of disability both in the USA and Europe accounting for 40% of all chronic pain problems.^{15,16)} Recent studies in the UK have shown that COFP of non-dental origin has a prevalence of 7%, and many of them will have chronic pain in other parts of the body.¹⁷⁾ Chung et al¹⁸⁾ reported the 6-month prevalence of OFP through a telephone survey over Korean elders, which was a relative higher proportion with OFP symptoms than in the Western population.

Patients suffering from chronic orofacial pain often lack a more refined diagnosis, which can result in treatment being unspecific and unnecessarily demanding on resources. In line with these observations are the finding from follow-up studies that a substantial proportion of COFP patients still experience pain several years after treatment, indicating that diagnosis and treatment have been less than successful.^{19,20)} The chronicity and intractability of pain-related problems as well as associated emotional distress may make patients more prone to dissatisfaction with care. Dissatisfied patients may miss appointments, fail to comply with prescriptions, or seek additional care when it may not be advisable.²¹⁾

As Pain is a comprehensive, biopsychosocial phenomenon, improved understanding and successful management of pain need assessment of health-related quality of life and psychological states. The aim of the study was to evaluate psychosocial impact of non-dental COFP on daily living using the graded chronic pain (GCP) scale. It is also investigated the clinical profile such as demographics, event related to initiation of OFP and

prior treatments for patients who attended university-based orofacial pain clinic for seeking diagnosis and treatment of their pain problems.

II. MATERIAL AND METHODS

1. Subjects

Inclusion criterion was all new patients attending the Oral Medicine-Orofacial Pain Clinic of Dankook University Dental Hospital, Cheonan, Rep. of Korea over a 6-month period since September 2008. Prior to the first consultation, all new patients in the waiting room were asked to fill in Questionnaires for patients with facial pain including Graded Chronic Pain (GCP) scale. All of them were examined clinically and diagnosed.

We exclude those who did not fully complete the questionnaires; who showed incomplete clinical records; with significant mental disorders; who were considered to have dental or psychological pain. Those who disagreed participating in the study were also excluded.

The study plan was approved by the ethic committee of Dankook University Dental Hospital and informed consent was obtained from all subjects (IRB No: H-0905/012/003).

2. Methods

Information was collected retrospectively from clinical records of the eligible patients, which included gender, age, pain duration, presence and types of related event to initiation of OFP and previous associated treatment. Data on numbers and types of specialty of the clinicians involved in the previous treatment prior to our consultation were also collected.

Age groups were divided into 3 groups: ≤ 39 years, 40–59 years, and ≥ 60 years. Chronic pain was considered based on duration of 6 month period. A variety of OFP conditions were classified into 3 diagnostic groups; neuropathic pain (NeP), mixed orofacial pain (MOFP) and temporo-

mandibular disorders (TMD). NeP included not only paroxysmal NeP conditions such as trigeminal neuralgia, but also continuous NeP conditions such as postoperative trigeminal neuropathic pain, atypical odontalgia and burning mouth syndrome (BMS). MOFP comprised subjects with more and two separate pain conditions and atypical facial pain, i.e., subjects suffering from continuous facial pain without any relevant abnormality.

Pain intensity and impact of pain were assessed through the GCP scale.²²⁾ The GCP scale combines seven questions reflecting pain intensity, disability days (loss of work days) due to pain, and interference in daily activities for a 0 - IV score (0, no pain; I, low intensity-low disability; II, high intensity-low disability; III, high disability-moderately limiting; IV, high disability-severely limiting) grading the pain intensity and interference with the usual functioning at home or work. Subjects with Grades I and II (low disability group) are considered psychosocially functional, with minimal interference or disability associated with their daily living, whereas subjects with Grades III and IV (high disability group) are considered psychosocially dysfunctional with greater impact on activities of daily living.²³⁾ The number of disability days was used to assess the days with pain during the previous 6 months. Korean version of GCP scale already validated in previous studies was used in this study.

3. Statistical Analyses.

Chi-square tests were used to investigate difference in the proportion of gender, age, pain duration in the diagnostic groups. *t*-tests, one-way ANOVA were employed to determine whether factors such as gender, age, pain duration and diagnosis affected pain intensity and disability days. To evaluate difference in levels of disability for patient with COFP according to age, gender, pain duration and diagnosis, Chi-square tests were performed. Level of significance was defined as $p < 0.05$.

III. RESULTS

1. Distribution of patients with OFP

Table 1 represents distribution of gender, age and pain duration in the OFP groups. During 6 month period, 640 patients visited Oral Medicine·Orofacial Pain Clinic due to their pain originating from face and mouth. Six of them were excluded because of lack of clinical data. 10.2% (N=65) of them had dental pain including oral soft tissues diseases and 89.8% (N=572) were found to have non-dental OFP. 572 patients had a male to female ratio of 1:1.5, the mean age of 34.7±17.1 years (range: 9~85 years), and suffered from pain with the mean duration of 17.9±31.4 months (range: a day~20 years).

Based on diagnostic criteria, 89.2% of patients had TMD whereas NeP was 6.3% and MFP 4.5%. Female preponderance was found in NeP and MOFP groups, which failed to demonstrate significant gender difference. While subjects with less or 39 years had TMD more common as compared to other elder groups, elders aged ≥ 40 years had high percentage of NeP.(p=0.000) There

was no statistical difference found between acute and chronic groups when chronic pain is considered as pain lasted for ≥ 6 months.

Acute and chronic groups were compared in Table 2. 54% of the patients were acute and 46% were chronic. Female preponderance was more noticeable in chronic group, presenting with mean duration of over 3 years. Chronic pain patients more frequently experienced the treatment related with the same pain prior to visit at our orofacial pain clinic.

2. Events and prior treatment related with OFP

While over 65% (N=376) of patients responded 'no' or 'not able to remember' as to whether any event related with their pain problem developed, 34.6% (N=199) reported such events as trauma, dental treatment etc.(Table 3) The most common event was trauma including traffic accidents and blow injury (29.1%), followed by routine dental treatment (24.6%) such as extraction and endodontic treatment, and chewing (16.6%).

Table 1. Distribution of gender, age and duration in the orofacial pain patients.

		NeP	MOFP	TMD
Gender	Men	11 (30.6%)	5 (19.2%)	293 (57.5%)
	Women	25 (69.4%)	21 (80.8%)	217 (42.5%)
<i>x² test: p=0.054</i>				
Age	≤ 39 years	2 (5.6%)	17 (65.4%)	381 (74.7)
	40~59 years	16 (44.4%)	4 (15.4%)	85 (16.7%)
	≥ 60 years	18 (50.0%)	5 (19.2%)	44 (8.6%)
<i>x² test: p=0.000</i>				
Duration	Acute (<6 M)	19 (52.8%)	10 (38.5%)	278 (54.5%)
	Chronic(≥6 M)	17 (47.2%)	16 (61.5%)	232 (45.5%)
<i>x² test: p=0.079</i>				
Total		36 (6.3%)	26 (4.5%)	510 (89.2%)

NeP: neuropathic pain group (N=572)

MOFP: mixed orofacial pain group

Table 2. Comparison of acute and chronic orofacial pain patients.

	Acute	Chronic
No. of subjects	307 (54%)	265 (46%)
Male to female ratio	1:1.3	1:2.4
Age (years)	35.5±16.9 (range: 9~85)	33.9±17.4 (range: 13~79)
Pain duration (month)	1.1±1.3	37.6±37.9 (range: 6~240)
Presence of previous Tx	58.0%	75.8%
No. of clinician involved	1.3±0.7 (range:1~5)	1.5± 0.9 (range: 1~7)

37% (N=213) of patients visited our orofacial pain clinic on their own, without any referral or consultation, to seek care for their pain problem. It was reported that they had obtained information on orofacial pain clinic from web site, friends, relatives or neighbors. 63% (N=362) of the patients experienced prior treatment related to their OFP problem and medication (42.5%) was the most frequently experienced treatment, followed by consultation only (37%) and physiotherapy (24%).(Table 4) Table 5 shows specialty of the clinician involved in the previous treatment. The clinician whom the patients met the most was general dental practitioner (58%) and the second most was orthopedic doctors (18.8%). 9.9% of the patients had met oriental medicine doctors.

3. Impact of chronic orofacial pain

There was no significant gender difference in pain intensity and disability days on the GCP scale.(Table 6) Pain duration did not yield significant difference in pain intensity and disability days. However, factors such as age and diagnosis affected pain intensity and disability days. While patients aged ≤ 39 years had the lowest pain intensity of 42.4 and the least disability days of 23.5 days during previous 6 month' period, those aged ≥ 60 years suffered from the highest pain intensity of 71.9 and the most disability days of 55.6 days. In terms of diagnosis, patients with NeP presented with the highest pain intensity and the most

Table 3. Events related to initiation of orofacial pain.

Type of event	No. of subjects
Trauma	58 (29.1%)
Dental Tx	49 (24.6%)
Chewing	33 (16.6%)
Stress	25 (12.6%)
Wide opening	21 (10.6%)
Others	14 (7.0%)

Table 4. Prior treatment due to orofacial pain

Type of treatment	No. of subjects
Medication	154 (42.5%)
Consultation	134 (37.0%)
Physiotherapy	87 (24.0%)
Acupuncture	26 (7.2%)
Oral appliance	24 (6.6%)
Dental Tx	21 (5.8%)
Injection	20 (5.5%)
Surgery	2 (0.6%)

disability days while both scores for TMD group were the lowest.

According to distribution of GCP disability grade in the patients with COFP, 39.6% of them showed high disability due to their COFP, while 60.4%

Table 5. Clinicians involved in the prior treatment for orofacial pain.

Specialty of clinicians	No. of subjects
General dental practitioner	210 (58.0%)
Orthopedic	68 (18.8%)
Dental specialist	55 (15.2%)
Oriental medicine	36 (9.9%)
ENT	36 (9.9%)
Internal medicine	15 (4.1%)
Other medicine	19 (5.2%)

(N=362)

had low disability.(Table 7) Female gender was more in high disability group than male gender, which was inverted in low disability group. Age factor also showed difference in distribution of disability grade. Patients aged ≥ 40 years had higher proportion of high disability group, as compared to the youngest group (≤ 39 years). This finding was particularly considerable in the elder group ≥ 60 years. 26.7% of them complained moderately limiting high disability and 33.3% were severely limiting.

Long pain duration over 5 years increased disability, while there was no significant difference

Table 6. Pain intensity and disability days related with gender, age, pain duration and diagnosis in chronic orofacial pain patients.

		Pain intensity	Disability days
Gender	Men (N=96)	46.7 \pm 26.6	28.1 \pm 57.6
	Women (N=170)	47.7 \pm 25.9	30.2 \pm 56.3
	<i>t-test</i>	<i>F=0.215</i>	<i>F=0.067</i>
Age	≤ 39 years (N=194)	42.4 \pm 23.9	23.5 \pm 51.2
	40~59 years (N=39)	49.1 \pm 28.6	36.6 \pm 60.9
	≥ 60 years (N=33)	71.9 \pm 23.3	55.6 \pm 73.7
	<i>ANOVA</i>	<i>F=20.480**</i>	<i>F=5.013*</i>
Duration	<1 year (N=101)	47.2 \pm 25.8	28.6 \pm 53.9
	1~5 years (N=117)	48.8 \pm 25.6	32.3 \pm 62.0
	>5 years (N=48)	42.6 \pm 29.0	24.2 \pm 49.0
	<i>ANOVA</i>	<i>F=0.927</i>	<i>F=0.363</i>
Diagnosis	NeP (N=18)	68.5 \pm 28.4	67.1 \pm 76.2
	MOFP (N=16)	54.2 \pm 25.5	35.4 \pm 51.2
	TMD (N=229)	44.6 \pm 25.3	26.3 \pm 54.7
	<i>ANOVA</i>	<i>F=8.080**</i>	<i>F=4.479*</i>

*, $p < 0.05$, **, $p < 0.005$

NeP: neuropathic pain; MOFP: mixed orofacial pain.

Table 7. Distribution of GCP disability grade related with gender, age, duration and diagnosis.

		GCP grade			
		Low disability		High disability	
		I (40.4%)	II (20.0%)	III (21.6%)	IV (18.0%)
Gender	Men (N=89)	39.3%	27.0%	21.3%	12.4%
	Women (N=156)	41.0%	16.0%	21.8%	21.2%
	Chi-square	<i>p=0.000</i>			
Age	≤39 years (N=180)	46.7%	18.9%	21.7%	12.8%
	40~59 years (N=35)	37.1%	14.3%	17.1%	31.4%
	≥60 years (N=30)	6.7%	33.3%	26.7%	33.3%
	Chi-square	<i>p=0.000</i>			
Duration	<1 year (N=44)	40.9%	15.9%	22.7%	20.5%
	1~5 years (N=157)	40.1%	22.9%	21.0%	15.9%
	>5 years (N=36)	33.3%	13.9%	27.8%	25.0%
	Chi-square	<i>p=0.000</i>			
Diagnosis	NeP (N=18)	16.7%	16.7%	22.2%	44.4%
	MOFP (N=16)	31.3%	6.3%	31.3%	31.3%
	TMD (N=211)	43.1%	21.3%	20.9%	14.7%
	Chi-square	<i>p=0.000</i>			

NeP: neuropathic pain; MOFP: mixed orofacial pain.

up to 5 years. With respect to diagnosis, 66.6% of patients suffering from NeP were found to have high disability and 62.9% of MOFP patients had high disability. In TMD group, a proportion of low disability (64.3%) was higher than that of high disability (35.7%).

IV. DISCUSSION

Disability is defined as any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human.²⁴⁾ As the association between pain and disability is highly relevant, the assessment of disability is crucial in studies involving pain patients.²⁵⁾ To assess pain-related disability, such questionnaires as the GCP scale, the Brief Pain Inventory (BPI),

the Pain Disability Index (PDI), the Oral Health Impact Profile (OHIP) have been well-validated and widely applied in pain researches.

The present study indicates 39.6% of patients with COFP reported high disability. Disability on the GCP scale was high in 32% of attendees at National conferences in US, UK and Australia organized by the Trigeminal Neuralgia Associations of the respective countries.²⁶⁾ Compared to this result, our result seems relatively high percentage in considering that TMD occupied a considerable percentage of the patients participated. In a study by Forssell et al,²⁷⁾ only 6% of 93 patients with TMD in primary care were graded as having high disability. Another study of John et al²⁸⁾ over 416 TMD patients indicated marked impairment in oral health-related quality of life (OHRQoL) for them

but only 9.4% of their patients showed high disability on the GCP scale.

In a study¹⁸⁾ concerning pain disability for Korean elders, 45.8% of subjects with joint pain reported high disability which was higher than Caucasian populations. The authors explained relatively higher percentage of high disability by some reasons: (1) the relative older sample population; (2) Korean elders may express their emotional distress or disability more easily such behavior may be tolerantly accepted by their society²⁹⁾; (3) East Asians in general may be more likely than Westerners to make dysphoric and negative responses to items asking their psychological status.³⁰⁻³²⁾ Difference in the age of the sample between theirs and ours could result in a relatively lower percentage of high disability in the present study, which is still higher than those from Westerners. Forssell et al²⁷⁾ explained that most TMD patients with low disability appeared to be adaptive copers and most patients with high disability psychosocially dysfunctional. The patients with COFP attending our clinic appear to be psychosocially dysfunctional due to their pain problem.

Mewes et al²⁵⁾ showed that higher disability scores on the PDI were related to higher age, but not to gender, in the general population. In accordance with this, Chibnall and Tait³³⁾ found an age effect in their sample of chronic pain patients. The missing relationship between disability and gender was also confirmed in samples with chronic pain.³⁴⁾ In contrast, Chibnall and Tait³³⁾ found a significant but very small main effect for gender and Tait et al³⁵⁾ found somewhat higher disability scores in women than in men. In the present study, pain intensity and disability days were significantly different for age and diagnosis but not for gender and duration. However, GCP grades were affected by such factors as gender, age, pain duration and diagnosis. These findings could be interpreted by that women felt more disabled than men in spite of same pain intensity. Gender differences exist with respect to experience and perception of pain.

Women not only report greater emotional distress, but may also use more emotion-focused problems which may be less beneficial in the long term.³⁶⁾

Time factor (i.e., chronicity) also seems to yield the similar negative impact on daily life at some extent. Pain outcomes are highly variable over time and between individuals.³⁷⁾ Von Korff et al³⁷⁾ pointed out that defining chronic pain by pain duration has not yielded evidence-based methods for assessing and classifying chronic pain. Chronic pain has multiple attributes, including psychological and behavioral components, in addition to pain severity and duration.³⁸⁾ Emphasis places on factors other than pain (e.g., activity limitation and depression), suggesting avenues for improving pain outcomes in addition to controlling pain per se (e.g., increasing activity levels and treating depression). By broadening the defining features of chronic pain to include factors other than pain duration, both clinicians and patients may become more aware of opportunities to improve outcomes when pain continues past the normal time of healing. Increasing activity levels and addressing emotional distress may be perceived more readily as viable options for reducing risks of pain running a chronic course, along with biomedical interventions addressing underlying physical causes of pain and palliative interventions that seek to control pain per se.

Successful management for COFP needs a holistic approach and should aim to obtain: (1) maximum freedom from negative impact of pain; (2) increased efficacy of drug therapy by appropriate choice of medication; (3) decreased anxiety, depression; (4) improvement of quality of life through self management; (5) to educate patients and enable control to be regained.¹⁷⁾ Coulter and Ellins³⁹⁾ suggest that there is some evidence of a benefit to patients by improving their confidence and coping abilities.

In addition to disability levels of patients with non-dental COFP, it was also investigated the clinical profile of patients who visited University-based specialist orofacial pain clinic to

seek care for their pain problems during a 6-month period. According to the results, most of the patients had TMD, which indicates a need to pay more attention to variable OFP conditions rather than TMD, aside from relatively high prevalence of TMD in this field. A study conducted by the authors before through a country-based database of Health Insurance Review and Assessment Service (HIRAS) also showed lack of participation of dental profession in OFP conditions such as trigeminal neuralgia, atypical facial pain and burning mouth syndrome.⁴⁰⁾ Role of dental profession, especially OFP specialists, in assessment and management of OFP should be recognized by public as well as clinicians of other specialties.

The present study shows that patients with acute or chronic pain were almost half to half proportion, which may, in part, reflect the situation of University-based specialist orofacial pain clinic in Korea as being not only a primary but also a tertiary care service. A large number of patients with non-dental orofacial pain were still seeking care for refined assessment and management for their pain conditions although 63% of them already experienced related treatment for their OFP problem. Importance of earlier referral should be emphasized.

To overcome the limitation of the present study in terms of high proportion of patients with TMD, it is needed a study with a larger sample of other OFP conditions rather than TMD to clearly compare a variety of complex OFP conditions. A further study should also be performed to determine how change in pain intensity related to successful management affects disability through long-term follow-ups.

V. CONCLUSION

During previous 6 months, 572 patients with non-dental OFP attended University-based specialist orofacial pain clinic to seek care although 63% of them already experienced related treatment for their OFP problem. They visited the most

frequently general dental practitioner and orthopedic doctors to assess and manage their pain and medication was the modality most commonly employed. Most of the patients (89.2%) had TMD and the most common related event to initiation of their pain was trauma, followed by dental treatment.

Almost half of the patients (46%) suffered from chronic pain and 40% of them exhibited relatively high disability due to COFP. Pain intensity and disability days were significantly different for age and diagnosis but not for gender and duration. GCP grades were affected by all the factors including gender, age, pain duration and diagnosis. Female gender, elders, and long lasting pain were closely related to high disability. In terms of diagnosis, patients with NeP and MOFP rather than TMD were graded as being highly disabled, i.e., psychosocially dysfunctional.

Conclusively, a considerable percentage of COFP patients reports high pain-related disability in their daily, social and work activity, which suggest a need for psychosocial support to teach the patients to understand their pain better and develop coping skill. Importance of earlier referral for appropriate diagnosis and tailored management should also be highlighted.

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국문요약

만성 구강안면통증의 사회심리적 영향

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본 연구는 6개월 이상의 만성 비치성 구강안면통증(orofacial pain, OFP) 환자들을 대상으로 통증으로 인한 사회심리적 영향을 평가하고, 대학병원의 구강안면통증 전문클리닉에 내원한 OFP 환자들의 임상적 특성(유발사건, 이전 치료병력 등)을 조사하고자 하였다.

연구를 위하여 2008년 9월부터 6개월간 단국대학교 치과대학 부속 치과병원 구강내과·구강안면통증클리닉에 내원한 초진 환자 중 OFP 환자들의 초진시 진료기록과 면담 전 대기실에서 작성한 만성통증척도(Graded Chronic Pain Scale, GCPS) 설문지를 조사분석하였다.

본원에 지난 6개월간 내원한 다양한 비치성 구강안면통증 572 명의 환자들 중 63%는 이전 치료 경험이 있었고 약물치료, 상담, 물리치료의 순으로 빈도가 높았고, 전문과목은 일반치과와 정형외과의 순서였다. 환자들의 89.2%는 턱관절장애였고 6.4%는 삼차신경통을 포함한 신경병성통증, 4.5%는 2가지 이상의 OFP가 공존하는 복합성 안면통증(mixed OFP)이었다. 통증의 발생과 관련한 유발요인에 대해서는 환자들의 약 35%가 인지하고 있었으며, 외상, 치과치료의 순으로 빈도가 높았다.

OFP 환자의 약 반 정도(46%)는 만성 통증을 가진 환자였으며, 이 중 40%에 이르는 많은 환자들이 구강안면통증으로 인하여 일상적인 활동과 사회적 활동 및 업무능력에 상당히 제한(high disability)을 받는다고 보고하였다. 여성일수록, 나이가 많을수록, 통증병력이 길수록(>5년) 그리고 턱관절장애보다는 신경병성 통증과 복합성 구강안면통증 환자들이 더 심한 사회심리적 활동제한을 보였다.(p=0.000)

이러한 연구결과는 환자가 자신의 만성통증에 수반되는 사회적, 심리적 장애(disability)를 잘 이해할 수 있도록 사회심리적 지원이 필요하며, 가능한 한 조기에 전문가에게 내원하여 정확한 진단을 받을 필요가 있음을 보여준다.

주제어: 만성, 구강안면통증, 만성통증척도, 통증활동제한(disability), 사회심리적
