Summary of: Retrospective examination of the healthcare 'journey' of chronic orofacial pain patients referred to oral and maxillofacial surgery

FULL PAPER DETAILS

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Objective To gain a deeper understanding of the clinical journey taken by orofacial pain patients from initial presentation in primary care to treatment by oral and maxillofacial surgery. **Design** Retrospective audit. **Sample and methods** Data were collected from 101 consecutive patients suffering from chronic orofacial pain, attending oral and maxillofacial surgery clinics between 2009 and 2010. Once the patients were identified, information was drawn from their hospital records and referral letters, and a predesigned proforma was completed by a single examiner (EVB). Basic descriptive statistics and non-parametric inferential statistical techniques (Krushal-Wallis) were used to analyse the data. **Data and discussion** Six definitive orofacial pain conditions were represented in the data set, 75% of which were temporomandibular disorders (TMD). Individuals within our study were treated in nine different hospital settings and were referred to 15 distinct specialties. The mean number of consultations received by the patients in our study across all care settings is seven (SD 5). The mean number of specialities that the subjects were assessed by was three (SD 1). The sample set had a total of 341 treatment attempts to manage their chronic orofacial pain conditions, of which only 83 (24%) of all the treatments attempted yielded a successful outcome. **Conclusion** Improved education and remuneration for primary care practitioners as well as clear care pathways for patients with chronic orofacial pain should be established to reduce multiple re-referrals and improve efficiency of care. The creation of specialist regional centres for chronic orofacial pain may be considered to manage severe cases and drive evidence-based practice.

EDITOR'S SUMMARY

The expression 'the patient's journey' first came to light a few years ago and sounded, to me at least, a rather pretentious description of what should be regarded as the more personal sounding epithet of patient care. On reflection, perhaps it is better applied than I first thought. Journeys come in many forms and not all of them are happy affairs sitting comfortably and gazing at the countryside. Others will tell you that it is better to travel hopefully than arrive and this is perhaps the summary of this audit.

The paper charts what may be described by the patients involved in the journeying as bewildering, stressful and tedious as they are passed from practitioner to specialist, practice to department and hospital to specialism. Across their travels; doubtless being subjected to car parking charges, conflicting signage, confusing instruction, repeat requests for the same information from them, sitting in various waiting rooms, corridors and draughty places they faced nine different hospital settings, were referred to 15 distinct specialties (mean number of three per patient) and had an average of seven consultations each.

Never mind, one might reflect, at least they were seen and treated eventually. Well, not really no. Of the 341 'treatment attempts' only 24% yielded a successful outcome. It paints a rather sorry picture which makes one wonder at the organisation and at the inevitable squandering of resources through repetition and referral. Especially as I am sure everyone involved was conscientiously doing their best.

However, one purpose of an audit is to observe, make changes and repeat. So, what changes could come out of this? Firstly, there are six definitive orofacial pain conditions represented here, so the surgical sieve is not that large, especially as 75% were TM joint disorders. The authors conclude that improved education and remuneration for primary care practitioners, clear care pathways and the creation of specialist regional centres for chronic orofacial pain may be ways in which the situation can be improved. Let's hope that someone who could take control reads this, and does.

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 214 issue 5.

Stephen Hancocks
Editor-in-Chief

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IN BRIEF
- Provides insight into the 'journey' taken by chronic orofacial pain patients through the healthcare setting.
- Illustrates the potential for multiple different treatment modalities being employed with limited clinical success.
- Emphasises the need for nationally standardised clear-cut care pathways for patients with chronic orofacial pain, in order to reduce multiple re-referrals and improve efficiency.

RESEARCH

COMMENTARY

Patients with chronic orofacial pain, most commonly presenting as TMDs, undergo numerous appointments in secondary care with multiple specialties before diagnosis, which subjectively increases some patients' psychological distress, likely impacting on their complaint. This novel retrospective audit, of 101 consecutive patients suffering from chronic orofacial pain attending oral and maxillofacial surgery clinics between 2009 and 2010, aimed to retrospectively investigate the 'journey' taken by orofacial pain patients, from first presentation to treatment by the oral and maxillofacial surgical team.

The majority of subjects (75%) had a diagnosis of TMD with only 24% consistent with the sub-categories of the gold standard diagnostic tool, the Research Diagnostic Criteria. The remaining 25% of the sample was made up of: awaiting results (3%), no diagnosis (7%), trigeminal neuralgia (4%), neuropathic pain (4%), atypical facial pain (4%), temporal arteritis, (2%) and burning mouth syndrome (1%).

The patients were treated in nine different hospitals and assessed by 15 distinct specialities with an average of three visits. 88% of the consultations took place in secondary care, with a total of 332 different treatment attempts to manage chronic orofacial pain conditions, with only 25% of all treatments yielding a successful outcome. In addition, many patients underwent unnecessary radiographic investigations and dental extractions.

The authors recommend that patients with chronic orofacial pain conditions are diagnosed early, ideally in the primary care setting. Education and explanation for the patients' pain as opposed to referring them onwards without a diagnostic 'label' may help to avert worsening psychological consequences.

This report highlights inefficient use of NHS funding, with a lack of patient centric care in this field. National initiatives to produce standardised chronic pain management protocols, such as the ongoing map of medicine project, would help provide a framework for all practitioners (specialist or non-specialist), empowering them and giving them confidence in primary management of chronic orofacial pain with resultant improvement in quality and accessibility of care.

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AUTHOR QUESTIONS AND ANSWERS

1. Why did you undertake this research?
When initially assessing chronic orofacial pain patients on oral and maxillofacial surgery clinics it became apparent that the healthcare journey they had travelled up and to that point had little uniformity. Even accepting that multiple specialities should potentially have a role to play in this sometimes complex group of conditions, we wanted to audit the pathway patients reported to understand a little more about.

Clinical audit is a quality improvement process which allows formal reflection and drives both evidence-based practice and future research. We hope that the results of this audit can prompt further research into chronic orofacial pain, such as the ongoing DEEP study (http://research.ncl.ac.uk/deepstudy/), which leads to improved quality, efficacy, and efficiency of care for chronic orofacial pain sufferers.

2. What would you like to do next in this area to follow on from this work?
Assessing management of chronic orofacial pain patients within primary care and its success was out of the scope of this audit. Primary care-based, and led, research could help to provide evidence-based clinical guidance to help formalise the primary care management of chronic orofacial pain. There are already some good examples of this type of work both in the literature and ongoing at present. We would like to build on these and collaborate with individuals interested in this area.