



Masseter myofascial pain clinically mimicking trigeminal neuralgia: A case report

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ABSTRACT

Chronic orofacial pain is a relatively common condition that we encounter in the chronic pain clinic with a prevalence of around 10%. Trigeminal neuralgia is the most common cause of this condition. However, there are numerous other causes which cause facial pain. We report a case of chronic facial pain in a patient with recurrent maxillary ameloblastoma, who was diagnosed as having trigeminal neuralgia and started treatment for it. However, he developed side effects and was referred to our pain clinic. The pain was myofascial in origin with a positive trigger point in the left masseter muscle. We report this case to highlight the importance of being aware of other causes of facial pain despite the presentation being like trigeminal neuralgia. An accurate diagnosis plays a crucial role in the successful management of pain.

BACKGROUND

Chronic facial pain is a distressing condition with an estimated prevalence of 10%.⁽¹⁾ It is described as pain in the orofacial region bound by the eyes and the mandibles. There are numerous causes of facial pain such as trigeminal neuralgia and other types of orofacial pain attributed to lesion or disease of the cranial nerves, migraine and related conditions, vasculitis-associated pain, temporomandibular joint-associated conditions, idiopathic orofacial pain, myofascial orofacial pain, among others. Despite the similarity in presentation, it is important to identify the etiology of pain as it has implications for the effective treatment of each condition. In this case report, we discuss a case of a patient who presented with facial pain akin to trigeminal neuralgia, but further examination determined it to be of myofascial origin with a trigger point reproducing neuropathic-like distribution of pain. Differentiating the cause was essential to treat the pain effectively.

CASE PRESENTATION

A 64-year-old male patient diagnosed with recurrent left maxillary ameloblastoma presented to our pain clinic with left-sided chronic facial pain. He was initially diagnosed with the lesion in the year 2021 and underwent conservative excision of the lesion through left maxillary sinus debulking. The follow-up CAT scan in 2024 revealed a recurrent tumor that involved the gingivobuccal sulcus, the entire left maxillary sinus and infratemporal fossa and was planned for an en-bloc resection. The patient complained of left-sided facial pain involving the left upper jaw and cheekbone. The pain score reported was a 6/10. The pain was mainly described as continuous throbbing and nagging in nature with flare-ups of sharp, shooting and stabbing pain radiating to the left lower jaw and left temporal region. Pain would exacerbate with talking and chewing. It was relieved with rest and pain medication (oral oxycodone, ibuprofen and occasional aspirin). There was also evidence of local infection, which flared up the pain even more reporting a score of 10/10.

Physical examination of the area revealed left-sided facial swelling with left masseter fasciculation (video 1), limited mouth opening, hemifacial asymmetry. There was hypoesthesia in V2 and V3 territory. Allodynia to light touch of the left cheekbone and jaw was documented. Additionally, a positive masseter trigger point and spontaneous masseter fasciculations were found.

The patient was considered to present with myofascial pain syndrome of the masseter muscle as contributing to his chronic facial pain and was started on baclofen. Clinical improvement and satisfactory pain relief were noted in the 7-day follow-up.

DISCUSSION

Chronic facial pain (CFP) is a deeply distressing condition linked to a significantly reduced quality of life, sleep deprivation, disability, and multiple psychosocial disturbances. (1) CFP has a reported overall incidence rate of 38.7 per 100,000 person-years, is more common in women and increases with age. (2) The main etiologies of CFP include orofacial pain attributed to disorders of dentoalveolar and anatomically related structures, myofascial orofacial pain, temporomandibular joint pain, orofacial pain attributed to lesion or disease of the cranial nerves, orofacial pains resembling presentations of primary headaches and idiopathic orofacial pain. Temporomandibular pain has an estimated prevalence of 4.6% (6.3% in women and 2.8% in men). (3) Our patient was referred with a diagnostic impression of trigeminal neuralgia secondary to tumor invasion, but on further examination, the symptoms were better explained by myofascial pain associated with masseter dysfunction. A clear recollection of clinical characteristics regarding trigeminal neuralgia and myofascial orofacial pain was crucial in our diagnostic approach.

CONCLUSIONS

A thorough medical interrogation and physical examination allowed us to identify an important myofascial pain component in the patient and provide an appropriate treatment plan, avoiding misdiagnosis and pain persistence. Muscle fasciculation of this muscle, help identify the source of the pain. Chronic facial pain can often present a diagnostic challenge to physicians, and having a clear recollection of clinical characteristics for different etiological entities is crucial to facilitating an accurate diagnosis and treatment.

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