Neuralgia do trigêmio tratada com fenitoína

Trigeminal Neuralgia

**Bergouignan**, *Revue de Laryngologie* (1942), reported the complete cure of essential facial neuralgia in three patients treated with PHT, 200-300 mg/day.


**Bergouignan and D'Aulnay** *Revue d'Oto-Neuro-Ophtalmologie* (1951), reported on the treatment with PHT of seventeen patients with trigeminal neuralgia. On PHT therapy, 300-600 mg/day, sixteen were benefited. The rapidity of the drug’s action was noted. The effects usually were felt within twenty-four hours.


**Jensen**, *Arztliche Wochenschrift* (1954), reported on the use of PHT, 300-600 mg/day, in treating forty-five cases of trigeminal neuralgia. Sixteen patients showed complete cessation of pain, which lasted after discontinuance of PHT. Nineteen patients experienced distinct improvement during PHT treatment. Pain returned when PHT was withdrawn. Four patients showed slight improvement and five patients did not improve. The author pointed out the desirability of PHT to relieve pain, as opposed to the potent pain relievers and opiates which all too easily lead to addiction.


**Jensen**, *Therapiewoche* (1955), in a subsequent study of fifty-nine typical cases of trigeminal neuralgia treated with PHT, reported that fifty-seven were completely freed of pain. Twenty remained so after medication was discontinued; but with thirty-seven, pain returned when PHT was withdrawn. Only two cases showed no improvement.


**Winiker-Blanck**, *Deutsche Stomatologie* (1955), reported that of twenty-seven cases of genuine trigeminal neuralgia treated with PHT, 300-600 mg/day, fifteen remained completely free of pain and seven showed lasting improvement making the condition entirely bearable for the patient. After the pain was under control, the patients were maintained on 100 mg/day. Because of its safety, PHT therapy was recommended as the treatment of choice.


**Ende**, *Virginia Medical Monthly* (1957), reported that over a period of two years he had successfully treated nine consecutive cases of trigeminal neuralgia with PHT. The author found that not only was PHT effective, but frequently relief began with the first capsule. These patients had been subjected previously to nearly every form of therapy recommended.


**Bergouignon**, *Revue Neurologique* (1958), reported that twenty-six of thirty patients who had been treated for trigeminal neuralgia were relieved of their attacks during the first three days of treatment with PHT. Ten of these patients had previously had peripheral or deep alcohol injections with transient or incomplete results and two had neurotomy.

Iannone, Baker and Morrell, *Neurology* (1958), reported that with PHT definite relief of pain was obtained and paroxysms of pain were controlled in all of four patients with trigeminal neuralgia and one with glossopharyngeal neuralgia.


Lamberts, *Journal of the Michigan State Medical Society* (1959), reported on thirty patients with trigeminal neuralgia treated with PHT, 200-400 mg/day. In almost every instance relief from pain was complete within forty-eight hours, but usually not before twenty-four hours after treatment commenced. The dosage had to be increased in two of the patients before the pain disappeared.


Kugelberg and Lindblom, *Journal of Neurology, Neurosurgery and Psychiatry* (1959), in a study of fifty patients with trigeminal neuralgia, investigated the relationship between stimuli applied to the trigger zone and the pain paroxysm. Intravenous PHT, 3-5 mg/kg, was found to raise the attack threshold as well as to shorten the duration of the attack.


Braham and Saia, *Lancet* (1960), used PHT, 300 mg/day, in twenty cases of trigeminal neuralgia. Relief of pain was complete in eight and partial in six.


Reeve, *Lancet* (1961), reported that PHT was effective in nine cases of trigeminal neuralgia and recommended that a trial of PHT precede more radical treatment.


Lindblom, *Svensk Lakartidningen* (1961), reported that of thirty cases of trigeminal neuralgia treated with PHT, 300-600 mg/day, complete relief or considerable reduction of the symptoms occurred in seventeen cases. Improvement lasted as long as the drug was administered.


Baxi, *Antiseptic* (1961), reported that eleven of fifteen patients with trigeminal neuralgia, treated with PHT, obtained relief within a week. The author stated that PHT not only gave lasting relief of pain but also relieved the apprehension of an impending attack.


Von Albert, *Munchener Medizinische Wochenchrift* (1978), reported on twelve cases of typical trigeminal neuralgia and two cases of glossopharyngeal neuralgia. Neither oral carbamazepine nor PHT had produced sufficient results. However, intravenous PHT, in some cases up to 750 mg over three to six hours, followed by oral PHT (200-400 mg/day), achieved freedom from pain in the fourteen patients. It was not found effective in four patients with herpetic neuralgia.


Von Albert, *Advances in Epileptology* (1983), reviewing eight years experience with PHT, states that intravenous PHT is very effective, not sedative, has only mild side effects, and is the therapy of choice for trigeminal neuralgia in elderly patients.

Swerdlow, The Pain Clinic (1986), presents a brief historical survey of the evolution of the use of anticonvulsant drugs for the relief of neuralgic pain. Trigeminal and glossopharyngeal neuralgia, diabetic neuropathy and the lighting pains of tabes have long been known to respond to treatment with this group of drugs. More recently a number of other pain syndromes have also been found to be responsive to this form of therapy. A description is given of the clinical features of this type of pain, and the therapeutic management of the patients is outlined. The drugs involved are carbamazepine, clonazepam, phenytoin and valproate, and details are given of dosage, timing of administration and side effects. It might be necessary to try in turn two or more of these agents to obtain optimal effectiveness with minimal side effects. Anticonvulsant therapy might well need to be maintained for a prolonged period of time. Adequate monitoring of the patient is necessary in order to ensure that effective blood levels are achieved and to avoid serious side effects. The pharmacology of the anticonvulsant drugs is discussed together with recent ideas on their mode of action in this type of usage. Important studies of the subject are described, including some double-blind investigations. There is also a discussion of the neurophysiology of the relevant types of neuralgia and deafferentation pain. Finally, it is pointed out that although a great deal more needs to be learned about the modus operandi of this form of treatment, there is no doubt that from a practical point of view, it can be valuable in many patients with deafferentation-type pain.


Mauskop, Journal of Pain and Symptom Management, (1993), presents a review of trigeminal neuralgia including the epidemiology, clinical features, differential diagnosis, pathophysiology and therapy of this painful syndrome. In the section on medical therapy, the author includes a discussion of the roles of phenytoin, carbamazepine, and baclofen, all of which he designates as first-line drugs for treatment of trigeminal neuralgia.


Qi, Liu and Huang, National Workshop of Clinical Use of Phenytoin, Chengdu, China (1995), randomly assigned 36 patients with trigeminal neuralgia to three treatment groups: phenytoin (17 pts); carbamazepine (11 pts); and combined phenytoin and carbamazepine (8 pts). After 4 weeks of treatment, the tabulated results showed no statistical difference (p > 0.05) between the effect of phenytoin and carbamazepine given separately (82.35 % and 81.81 %, respectively). The combined treatment was 100 % effective.


Cheshire, Journal of Pain and Symptom Management, (2001), treated three patients with trigeminal neuralgia refractory to oral medications and presenting with crisis pain, with fosphenytoin. One patient received .9 g PE of fosphenytoin over 20 minutes and upon completion of the infusion, her expression was beaming with joy and she had no pain. A second patient received 100 mg PE injected intravenously at intervals of 10 minutes with a planned maximum limit of 10 doses. Pain gradually improved during the infusions and fully resolved after the final dose. A third patient also received an incremental dosing regimen, with 10 doses of 100 mg spread over 3 hours. Following a total dosage of 1.0 g (14 mg/kg) PE, the pain had almost completely resolved and by the next morning, the patient was pain free.


See also Ref.


