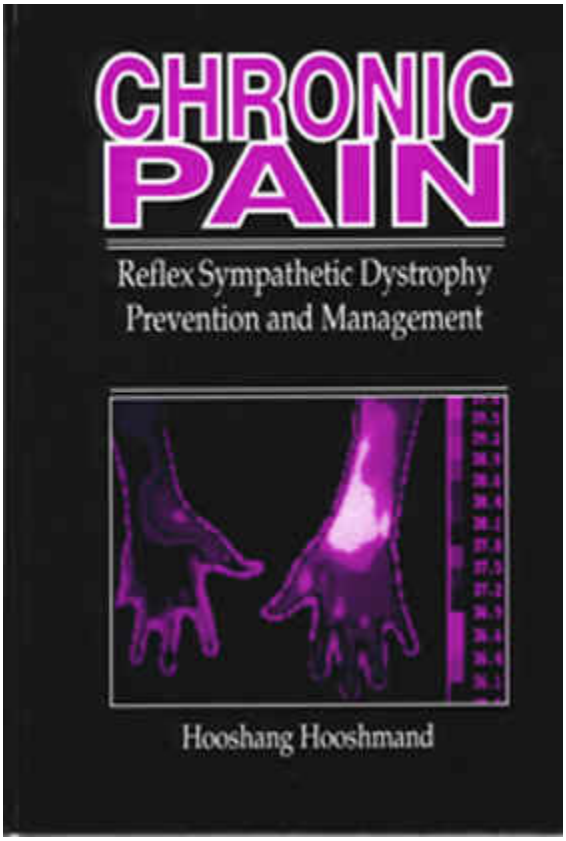
CHRONIC PAIN

REFLEX SYMPATHETIC DYSTROPHY

PREVENTION and MANAGEMENT

H. Hooshmand, M.D.

Neurological Associates Pain Management Center



Chronic Pain: Reflex sympathetic Dystrophy Prevention and Management is the first book devoted to the subject of Reflex Sympathetic Dystrophy (RSD). The book presents a new classification for the different stages of RSD and features the most comprehensive coverage of the literature on RSD and its related aspects. Qualitative and quantitative differences between natural endorphins and synthetic narcotics are described for the first time, as are long-term follow-ups on sympathectomy patients. Other topics considered include thermographic methods for the diagnosis of RSD, the role of ACTH in the management of chronic pain, and comparisons between the effects of ACTH and those of corticosteroids. The mechanism of development of RSD is clarified through an extensive collection of drawings and anatomical pictures. The book also explains why sympathectomy fails, but nerve block and physiotherapy is successful in the treatment of RSD.

Chronic Pain: Reflex Sympathetic Dystrophy Prevention and Management is an important reference for neurologists, neurosurgeons, physiatrists, thermographers, anesthesiologists, orthopedic surgeons, interns, and students interested in the topic.

Features

- Presents a new classification for the different stages of RSD
- Features the most comprehensive coverage of the literature on RSD and its related aspects
- Describes for the first time qualitative and quantitative differences between natural endorphins and synthetic narcotics
- Examines the role of ACTH in the management of chronic pain
- Clarifies the mechanism of development of RSD through an extensive

collection of drawings and anatomical pictures

- Explains why sympathectomy fails, but nerve block and physiotherapy is successful in the treatment of RSD

Contents

- Etiology of RSD
- Prevention of RSD
- Management of RSD

Excerpt From:

Chronic Pain:

Reflex Sympathetic Dystrophy Prevention and Management

Introduction

Chronic pain is being mismanaged universally. Impatient surgeons try unsuccessfully to excise the pain. Internists load the patient with narcotics and depressing tranquilizers. Chiropractors try to cure everything with their fingers. Acupuncturists shoot darts at the patients.

The inevitable failure in control of pain is compounded by the hostile attitude of the impatient healer. The victim suffers from magnified pain due to the side effects of "treatment". The physician considers the patient crazy and relegates the pain management to the psychiatrist who is not trained in the management of pain.

Even this late in the twentieth century, the patient has to cope with the nonsensical accusation that "it's all in your head" where every kind of pain obviously resides.

The most misunderstood and complex subject in medicine is the hyperpathic pain of *sympathetic dystrophy*. Understanding this self-perpetuating pain- which "never stops" - requires unbiased knowledge of physiology and pathology.

Above all, it requires the open mind of a physician who can understand that there is no dicotomy between "psyche" and "soma", between "brain" and "mind", or between "true" and "imagined" pain.

In contrast to somesthetic pain, sympathetic pain terminates in the limbic system. It can be more severe than the pain of cancer. It can be fatal: heart attack or suicide is more common among there patients than the rest of the population. It causes tremor, blepharospasm, flexion deformity, vasoconstriction, and severe vascular migraine headache.

RSD is more common than previously assumed by clinicians. Trauma is not at the top of the list of its variety of etiologies. It may have its origin in the periphery: head, cervical spin, trunk, or extremities. It may just as well originate in CNS: spinal cord, brain stem, or cerebral hemispheres.

Invasive surgical treatments in the form of sympathectomy, tractotomy, arthrodesis, or stimulative procedures are apt to fail in the long run. Narcotics, alcohol, and almost all benzodiazepines only exacerbate the sympathetic pain.

The physician can substantially increase the rate of success in the control of this intractable pain by taking advantage of early diagnosis, aggressive physiotherapy, multiple sympathetic blocks, as well as epidural blocks and antidepressants.

The goal of this book is to review the present knowledge regarding the understanding, prevention, and management of the scourge of reflex sympathetic dystrophy.

CHAPTER 1

History of Reflex Sympathetic Dysfunction

History

"It would be a great thing to understand pain in all its meanings."

Peter M. Latham

Reflex sympathetic dystrophy (RSD) is the most unpleasant and uncomfortable form of chronic pain. It is the extreme prototype of disabling chronic pain.

Chronic pain is the type of pain that persists long after the original injury. Obviously, recurrent attacks of acute pain due to new and repetitive damages from cancer or recurrent heart attack cannot be considered chronic pain even though they may be of longstanding duration.

It is estimated that approximately 30% of the general population suffers from chronic pain. One third of these patients suffers from RSD.

The chronic pain of RSD is typified by a marked emotional connotation. It is invariably accompanied by anxiety, phobia, and neuropsychological disturbances in the form of irritability, agitation, and depression.

Historically, chronic pain has been the subject of clinical debate among physicians for a few centuries. Greek philosophers considered the brain as the site of pain perception. The first references to hyperpathic sympathetic type of pain appeared in the literature in the late 1700s by the famous British surgeon Potts. He first mentioned that trauma can be the source of burning pain and atrophy of the extremity.

The first report of amputation for treatment of this type of pain was by Denmark in 1813. Even though amputation seems to be a drastic and extreme form of treatment for RSD, even at the present time surgeons are performing amputation for RSD accompanied by osteoporotic fractures.

Needless to say, no RSD patient should undergo amputation. Even multiple fractures in small bones of the foot can be corrected without surgery. Proper physiotherapy, weight-bearing, sympathetic blocks, etc., will always save the extremity from being amputated. However, amputation is done because of lack of understanding regarding the nature of RSD. It is done when all other measures have failed and especially because of the fact that only a small percentage of RSD patients are diagnosed in the early stages of the disease. By the time the disease becomes advance, the pathology takes a rapidly accelerating downhill course that may culminate in the disastrous procedure of amputation.

Amputation not only does not cure RSD, but it can be the cause.

In 1851 the French Father of Physiology, Claude Bernard,described the role of the sympathetic nervous system in preservation of *milieuinterne*. He was the first to describe the sympathetic nervous system as being responsible for temperature regulation of the internal balance in the body.

The first report of clear-cut pathologic sympathetic dystrophy was made by the American neurologist, S. Weir Mitchell,who reported for the first time the victims of sympathetic dystrophy on the wounded soldiers of the Civil War. He colorfully called this condition erythromelalgia, implying reddish sick pain. In 1867 he described the condition in more detailed and called it causalgia.....

Table of Contents

BOOK ORDERING

INFORMATION

This book is available from:

CRC Press

A CRC Company

Chronic Pain: Reflex Sympathetic Dystrophy, Prevention, and Management

AUTHOR/AFFILIATION:	Hooshang Hooshmand, Neurological Associates, Vero Beach, Florida, USA
KEY FEATURES:	• Presents a new classification for the different stages of RSD • Features the most comprehensive coverage of the literature on RSD and its related aspects • Describes for the first time qualitative and quantitative differences between natural endorphins and systemic narcotics • Examines the role of ACTH in the management of chronic pain • Clarifies the mechanism of development of RSD through an extensive collection of drawings and anatomical pictures • Explains why sympathectomy fails, but nerve block and physiotherapy is successful in the treatment of RSD

AUDIENCE:	Neurologists, Neurosurgeons, Psychiatrists, Thermographers, Anesthesiologists, Orthopedic Surgeons, Interns, Students.
SHELVING GUIDE:	Medicine, Clinical Science, Pain Management
SHORT TOC:	Chronic Pain: Reflex Sympathetic Dystrophy, Prevention, and Management is devoted to the subject of Reflex Sympathetic Dystrophy (RSD). The book classifies the different stages of RSD and describes the qualitative and quantitative differences between natural endorphins and synthetic narcotics. Included are long-term follow-ups on sympathectomy patients.
CATALOG NUMBER:	8667
PAGE/TRIM/BINDING:	224 7 x 10 Hard Cover
ESTIMATED ILLUSTRS.	
COLOR:	
B & W:	58
ISBN:	0849386675
PRICE:	$179.95 / £120.00
PUB DATE:	March 1993
	This book is available from:
	CRC Press, Inc. 200 Corporate Blvd, N. W. Boca Raton, FL 33431 1-800-272-7737
	You can order this book on-line at:http://www.crcpress.com e-mail: orders@crcpress.com