Correspondence

To the Editor:

Re: Longterm Treatment of Intractable Reflex Sympathetic Dystrophy with Intrathecal Morphine[1] (Can J Neurol Sci 1995; 22: 153-159)

The authors have described the clinical picture in RSD and their treatment with morphine has been based upon the assumption that their diagnosis is a correct one. Although it is generally held that psychological and social factors can increase the felt intensity of pain which arises on an organic basis and that they can also result in chronic pain without any physical basis, the paper does not contain any information about the emotional state, life situation or associated stresses which could be significant factors in the causation of the patient's pain and disability. Swelling and vasomotor changes readily follow disuse and guarding of an extremity for whatever reason. They are often secondary to this in such patients rather than to an hypothesized primary sympathetic dysfunction. Swelling and skin changes are also recognized findings in factitious disorders in which patients will resort to the use of tourniquets and self-injuries. In my neurologic and neuropsychiatric practice, I have seen many examples of patients who have been diagnosed as reflex sympathetic dystrophy after minimal blows or soft tissue injuries, in which the clinical picture does not stand up to critical examination and in which emotional and situational factors are prominent, such that an alternative diagnosis of pain on a psychological basis is at least equally if not more probably correct.

Case 1

This 35-year-old child care worker had suffered a minor rear-end collision four years ago without any body blows, followed by neck, low back and right knee pain. Right knee and leg pain persisted, was unusually severe with exquisite tenderness to the lightest touch, and she became unable to walk. Changes in skin colour, temperature and increased sweating led to a diagnosis of reflex sympathetic dystrophy. She received much medical attention, numerous assessments, hospitalization, the excision of a fat pad at the knee, injections of local anaesthetic and, eventually, a sympathectomy about one year later, all without improvement. A few weeks before the accident, she had been kicked in the knee while at work. Emotional symptoms became prominent and led to several hospital admissions for depression, suicidal attempts, histrionic and difficult behaviour. About two years after the accident, a surgical procedure for temporomandibular joint dysfunction was done and her multiple symptoms of neck, low back, knee and leg pain worsened such that she had to use a walker, a motorized scooter and hand controls on her automobile. A thorough history revealed lifelong adjustment difficulties with shy, solitary behaviour, family and interpersonal conflicts, angry, willful histrionic behaviour, and strong religious interests. Her pre-accident health records revealed an extraordinary number of health problems including multiple allergies, chronic abdominal pain, a vagotomy procedure for peptic ulcer, surgical treatment of hiatus hernia, a myelogram at the age of 20 for neck and back pain, a previous whiplash injury, a head injury with concussion, two previous knee injuries, temporomandibular joint syndrome and numerous visits to her doctor for other minor symptoms. Of her 20 or so specialist examiners, there was only one neurologist and one orthopaedic surgeon who remarked that her illness behaviour and disability were markedly out of proportion to the nature of the accident and that it was on an emotional rather than on a physical or RSD basis. Examination approximately four years after injury revealed a considerably overweight patient who walked with crutches. There was no vasomotor or trophic change of the right leg and the appearance and skin temperature were no different from that of the left. There was exquisite tenderness to the lightest of touch over the anterior and lateral portion of the knee with a stocking type sensory loss, without muscle wasting or reflex abnormality.

Case 2

This 46-year-old delivery driver with a history of epilepsy, controlled for many years on Dilantin, suffered a recurrent seizure while driving which resulted in a collision and musculoskeletal symptoms of shoulder and upper back pain. About six months later he developed bilateral hand numbness, suggestive of carpal tunnel syndrome, but with swelling and redness of the left thumb and index finger which led to a diagnosis of reflex sympathetic dystrophy. He received much medical attention, repeated hospitalizations, medications and numerous nerve blocks without any improvement and with an overall worsening and the occurrence of additional symptoms. He admitted that the accident had been very frightening as his seizures had been under control for many years and he lived in fear that a further seizure would occur if he should return to driving. His license had been revoked and he had become afraid when travelling as a passenger. Symptoms of depression, nervousness, irritability, anger, frustration and severe anxiety with respect to automobile travel were present, and there was severe itching of the thumb and index finger with throbbing, sharp pain, weakness, tremor of the fingers, weight gain, insomnia, fatiguability, occasional dizziness, repeated episodes of falling out of bed during sleep, longstanding abdominal pain, forgetfulness and episodes of panic and severe anxiety in relation to automobile travel. Examination revealed redness and swelling of the thumb and index finger with limitation of movement, without temperature change or abnormality of the nail, with diminished sensation over the dorsum of the involved thumb, index finger and adjacent hand and with numerous excoriations of a dermatitis artefacta type. He had received cortisone injections, sympathetic blocks, repeated sodium amytal interviews, ischemic blocks with the use of a tourniquet and the implantation of a dorsal column stimulator without improvement.

I would say that, by the logic of diagnosis and in pain states of an unusual nature, the differential diagnosis must include functional (non-organic) disorders or, as more recently termed, "somatization disorders" and that an assessment of such patients should always include an understanding of their emotional state and life situation.

1. Becker WJ, Ablett DP, Harris CJ, Dold ON. Long Term Treatment of Intractable Reflex Sympathetic Dystrophy with Intrathecal Morphine. Can J Neurol Sci 1995; 22: 153-159.

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