www.HandLab.com
support@HandLab.com
2609 Atlantic Ave., Suite 213
Raleigh, NC 27604
USA

HandLab

Complex made Simple...clinically relevant education by Judy C. Colditz, OT/L, CHT, FAOTA

October 2017 ClinicalPearls No. 47

IS IT REALLY CRPS?

NOTE: *The author of this pearl is not an expert in pain management or in the diagnosis/treatment of CRPS.*

In my years of hand therapy practice, I have had hundreds of patients referred with a diagnosis of Complex Regional Pain Syndrome (CRPS) [previously RSD]. In my opinion, I have only treated a handful of patients who truly had CRPS. This experience has provoked these comments:Some **Individuals are More Sensitive than Others**

Some individuals blush more readily, sweat more profusely or have a more pronounced reaction to a bug bite. Given the same injury, some patients will thus have a more heightened sympathetic response than others. I refer to these patients as "hyper-sympathetic responders." (Not to be confused with a hypersympathetic state which results in heart rate and blood pressure increases.)

Perhaps it is helpful to think of a normal spectrum of pain, edema and reactivity. Those patients on the higher end of the spectrum do not deserve the label CRPS; they just need less stimuli, a gentler approach and more time for successful rehabilitation.

Pain Should be Logical

The type, location, and severity of pain should be explainable based on the location and mechanism of injury. Those few patients I have treated with CRPS displayed an illogical and unexplainable magnitude and profile of pain.

One patient with a comminuted distal radius fracture reduced and casted one week earlier was referred to therapy with a CRPS diagnosis. She presented with complaints of intense pain. Examination revealed severe median nerve compression; decompression brought the patient to reasonable, logical pain levels.

Is the Response to Treatment Logical?

In my experience, the primary hallmark of CRPS is that the usual treatment approaches do not work. If an illogical response is observed in a patient referred with CRPS, that individual deserves treatment by an experienced, integrated pain management team whose focus is not local tissue treatment.

Sometimes Doing Less is the Treatment

As mentioned above, there is a spectrum of response to injury. We as therapists can stimulate a hyper-sympathetic response with too much treatment.

A middle age man with an external fixator for a distal radius fracture applied 4.5 weeks earlier was referred with a diagnosis of CRPS to "mobilize his stiff fingers." Passive and active motion was painful but he was nevertheless observed constantly pushing his fingers into flexion because he had been told to do so. He admitted being a type A individual, who had been obsessive about exercise.

He demonstrated pitting edema in his hand and fingers, generalized tissue inflammation as compared to his uninjured hand, and about 50% of his normal active and passive finger flexion. He was sent home from therapy in a bulky dressing applied around the fixator which encompassed his fingers, hand and distal forearm. His instructions were to do nothing to this hand for 2 days, but to intermittently move his elbow and shoulder actively.

After two days, his edema and pain were significantly reduced and he slowly regained finger motion with a structured program that limited the quantity of both passive and active motion.

CRPS is a complex and poorly understood diagnosis

CRPS is tricky to diagnose in the acute stages of injury as signs and symptoms can be on a spectrum. Because of this difficulty, CRPS is often underdiagnosed. One should always have CRPS in mind during the process of confirming or refuting the working diag-nosis. Reviewing the *Budapest diagnostic criteria* as approved by the International Association for the Study of Pain may be helpful.

© HandLab; 2017 all rights reserved

Disclaimer: HandLab Clinical Pearls are intended to be an informal sharing of practical clinical ideas; not formal evidence-based conclusions of fact.