INTRODUCTION

In order to discuss the clinical presentation of the disorder Reflex Sympathetic Dystrophy (RSD), a definition of the term is necessary.

The term was first used by Evans in 1946 (5), with reappearance over the next few years in a series of articles in the surgical literature. It was further popularized in the pain literature by Bonica (1), and came to indicate a spectrum of previously distinct syndromes. They have in common, regional pain, vasomotor and integumentary findings of varying severity, up to and including causalgia, a distinct entity following nerve injury. RSD has been defined by the International Association for the Study of Pain (IASP) as: Continuous pain in a portion of an extremity after trauma which may include fracture but does not involve a major nerve, and is associated with sympathetic hyperactivity (14). Although causalgia is left as a separate syndrome, this is arguable since the symptomatology and clinical presentations of the conditions overlap, as do their treatments, and possibly also their pathophysiology.

A review of the clinical syndromes which Bonica (1) grouped under the umbrella term "minor reflex sympathetic dystrophies" gives insight into the clinical presentation of the disorder or syndrome known as RSD:

- Sudeck's atrophy
- traumatic arthritis
- minor causalgia
- posttraumatic osteoporosis
1. RSD: Clinical Features

posttraumatic pain syndrome
posttraumatic oedema
posttraumatic angiospasm
shoulder-hand syndrome

Unfortunately, the general definition proposed by the Taxonomy Committee of IASP appears to include some rather surprising clinical cases. A review of the literature from the past two years has revealed 73 citations proposing RSD in areas as diverse as chronic knee pain (3), penile pain (2), and atypical facial pain (8) with treatments ranging from "Scottish baths" to contralateral sympathectomy. Perhaps a better understanding of the entity, its pathophysiology and causes will lead to more accurate diagnosis and appropriate treatment. Much clinical and laboratory research lies ahead as this volume attests.

CLINICAL DESCRIPTIONS

With this vagueness of diagnosis, the clinical descriptions cannot help but be somewhat imprecise, especially when considering mild to severe presentations. The cardinal areas to be considered in the clinical state are: (1) pain, (2) trophic changes, (3) autonomic (vasomotor and sudomotor) instability, (4) sensory abnormalities and (5) bony changes.

1. Pain

Pain is the most important symptom in RSD from both the patient’s and clinician’s viewpoint. Classically, the pain has a burning quality, but it may also present as an aching discomfort. It is generally felt in the distal part of a limb, initially in a non-segmental distribution. If the symptoms persist, the pain becomes more diffuse, gradually spreading proximally to involve the limb girdle. It may then involve the contralateral limb and has even been described as occurring in the other ipsilateral limb. This spreading discomfort is usually of an aching quality, especially when it involves limb girdles and other limbs (12).