Commentary on Complex regional pain syndrome: observations on diagnosis, treatment and definition of a new subgroup. Zyluk and Puchalski.

The clinician's perspective of a condition is commonly informed via a combination of factors that may include published literature, information from colleagues, and the clinician's personal clinical experience, both current and previous. However, all of these factors are likely to be heavily influenced and filtered by the profession specific context within which the clinician sits. This 'filtered perspective' will arise from the time point at which the clinician usually encounters a patient along the condition trajectory and the type of profession specific intervention the patient has been referred for. When a condition such as Complex Regional Pain Syndrome (CRPS) is encountered by many different professions along a sometimes lengthy trajectory then the risk of profession-specific biases occurring is potentially increased. The article by Zyluk and Puchalski on CRPS needs to be viewed with this in mind.

It is well documented that the resolution rates of CRPS in the first year are approximately 70-85% (Geertzen et. al., 1998; Field et. al., 1992; Sandroni et. al., 2003) with a reduction to 36% within six years (de Mos et.al. 2007). This leaves a significant minority of 15-20% who will continue to demonstrate active features of CRPS at one year and many will demonstrate some permanent disability at 10 years after injury (Geertzen et. al., 1998; Shasfoort et. al., 2004). Clinical data collected by Zyluk and Puchalski over the past 20 years mimic these incidence recovery rates well with 77% of their cohort having early (acute) CRPS and 17% the more persistent form (chronic). It is this latter group that forms the

predominate focus of their article and which they propose is the “rarest and most severe form” of CRPS which should be considered a “separate form” or sub-group.

It is the nature of Hand Surgery that surgeons will see patients who require, or are requesting surgery and they will follow the patient’s progress through that surgical procedure to a reasonably time-limited post-operative period. For patients with persistent problems where further surgery is not required/advisable they are likely to be referred on to other medical providers. In the case of those with non-resolving CRPS this is usually the specialties of Pain Medicine and Rehabilitation. In these fields, due to the typically later referral to such care, refractory CRPS is the norm with resolving CRPS the rare ‘sub-group’. For example, in the UK national referral centre for CRPS, a rehabilitation centre of excellence for those with persistent pain, approximately 120 new referrals are received per year with only a handful of patients having a diagnosis of less than one year and the vast majority three years plus. These patients are predominantly female by a 3:1 ratio and middle aged with no obvious right/left dominance of the affected limb but a slightly higher incidence of upper, versus lower limb CRPS. They are not “exclusively 18-40 years old and female” as in Zyluk’s and Puchalski’s cohort but reflective of the normal epidemiological spread of CRPS as cited in published literature (de Mos 2007). Treatment for this challenging group is informed by published national guidelines (Goebel et. al., 2012) and includes a combination of physical and psychological rehabilitation that is facilitated by analgesia and education. A cure in these late stage patients is highly unlikely so optimising function and developing self-management skills

through multi-disciplinary rehabilitation is where treatment is focused (McCabe 2013).

Persistent CRPS carries a heavy personal and societal burden and identifying those at risk of progressing to this state, in amongst the considerably more common resolving form of CRPS, remains a challenge. This publication by Zyluk and Puchalski reiterates this point but also highlights the requirement for multi-speciality research groups to collaborate across the trajectory of this condition in order to see the full spectrum and impact of CRPS in significant sized cohorts. Having internationally recognised diagnostic criteria are also essential and it is helpful to know that the Modified IASP Diagnostic criteria (or 'Budapest criteria" (Harden et. al., 2010)) as cited in Zyluk's and Puchalski's paper, have been formally accepted by their IASP Committee for Classification of Chronic Pain and are available on their website (www.iasp-pain.org).

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