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Trauma symptoms inventory scale, return-to-work and atypical Complex Regional Pain Syndrome type 1?

Sir,

We read with a particular interest the paper of Collins et al about the Trauma related neuronal dysfunction Symptoms Inventory (TSI)[1]. We think, in addition of the interesting work made by the authors that return-to-work should also be discussed, especially for Complex Regional Pain Syndrome type 1 (CRPS1).

The TSI was developed after a complete literature review. It included a very precise description of the complaints, in order to compare chronic pains syndrome like CRPS1 and fibromyalgia[1]. However, authors did not included disability and return-to-work in their scale nor in the evaluation, although the impact of these syndromes on return-to-work known by rehabilitation specialists and occupational physicians.

It is true, considering CRPS1 for instance, that very few studies report its socioeconomic impact [2-8], and there appears to be wide variability in the rate of return to work, from as little as 30% [2] to as much as 75% [6,7] or more [8], with most being based on a small number of patients (20 patients, or fewer for 5 studies). A proportion of return to work of over 50% in 12 to 18th months seemed common, depending on the localisation (upper limb), the cause of CRPS1 (work accident, severe trauma for instance[6]), and in case of comorbidity (alcoholism, medicinal products).

We think then the authors of the TSI are probably right to not include disability and return-to-work in their scale, taking into account the heterogeneity of results associated with very different situations. While it appears most patients with early stages of CRPS1 return to work, these are not necessarily the same patients observed in occupational medicine or rehabilitation units. However, by the example of CRPS1, further validation should necessarily include aspects in the validation procedure. Furthermore, we also could conclude that further studies are necessary to describe the return-to-work among patients with atypical forms of CRPS1.

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References:

1. Collins S, van Hilten JJ, Marinus J, Zuurmond WW, de Lange JJ, Perez RS. Development of a symptoms questionnaire for complex regional pain syndrome and potentially related illnesses: the Trauma Related Neuronal Dysfunction Symptoms Inventory. Arch Phys Med Rehabil. 2008;89:1114-20.

2. Subbarao J, Stillwell GK. Reflex sympathetic dystrophy syndrome of the upper extremity: analysis of total outcome of management of 125 cases. Arch Phys Med Rehabil. 1981;62:549-54.

3. Grunert BK, Devine CA, Sanger JR, Matloub HS, Green D. Thermal self-regulation for pain control in reflex sympathetic dystrophy syndrome. J Hand Surg. 1990;15:615-8.

4. Finsterbush A, Frankl U, Mann G, Lowe J. Reflex sympathetic dystrophy of the patellofemoral joint. Orthop Rev. 1991;20:877-85.

5. Geertzen JH, Dijkstra PU, Groothoff JW, Ten Duis HJ, Eisma WH. Reflex sympathetic dystrophy of the upper extremity – a 5,5 year follow-up. Part II. Social life events, general health and changes in occupation. Acta Orthop Scand Suppl. 1998;279:19-23.

6. Dauty M, Renaud P, Deniaud C, Tortellier L, Dubois C. Conséquences professionnelles des algodystrophies. Ann Readapt Med Phys. 2001;44:89-94.

7. Singh G, Willen SN, Boswell MV, Janata JW, Chelimsky TC. The value of interdisciplinary pain management in complex regional pain syndrome type I: a prospective outcome study. Pain Physician. 2004;7:203-9.

8. Paraskevas KI, Michaloglou AA, Briana DD, Samara M. Treatment of complex regional pain syndrome type I of the hand with a series of intravenous regional sympathetic blocks with guanethidine and lidocaine. Clin Rheumatol. 2006;25:687-93.