greater emphasis should be given to aggressive medical management of CRPS. The use of short courses of steroids and the combination of tricyclic antidepressants and anticonvulsants for a period of not less than 4 weeks at the maximum tolerated dose should be recommended in addition to physical therapy as standard initial management. I would agree that sympathetic blockade should be reserved for all but the most refractory cases of CRPS but believe that medical therapy must be more comprehensive than that suggested in this article.

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(Accepted for publication April 25, 2012.)

In Reply:

First of all, we would like to thank our colleague for his comments on our article on predictors of sympathetic blockade (SB) in the management of complex regional pain syndrome type 1.[1] In our study protocol, patients were treated with a conservative therapy protocol, as described in evidence-based guidelines.[2] In this treatment protocol, corticosteroids, although there is some evidence for their use, were not recommended because of limitations in the methodological quality of the available studies and lack of specifications on dose and duration of therapy. Gabapentin was chosen above amitriptyline because although the latter is a first-line choice treatment of neuropathic pain, there are no controlled studies in complex regional pain syndrome type 1 to support this choice. For gabapentin, the dose of 1,800 mg daily for a duration of only 3 weeks proved effective in a randomized, double-blind, placebo-controlled crossover study in 58 complex regional pain syndrome type 1 patients.[3] The aim of our study was to determine predictors that would help us identify patients who responded favorably to SB. The time between the index event and the SB is an important predictive factor for treatment success. Therefore, patients in our study needed to be treated as early as possible with SB in order to increase the number of patients with a positive response after SB.[4] At the time of the initiation of the study, the interventional pain management techniques were recommended after a failed trial of 2–4 weeks with any particular therapy.[5] If we would have treated patients with a more extensive medical therapy protocol, as suggested by Neil, this would inevitably lead to a much longer duration of the conservative treatment protocol. Moreover, diagnosis usually is made several months after the initiating event. A longer duration of conservative treatment may diminish the number of patients who would respond to SB. Nonetheless, we agree with our colleague that a rigorous and multimodal rehabilitation protocol, comprising medicinal interventions as well as physiotherapeutic modalities, is essential for a disease as involved as complex regional pain syndrome. The results of our study, which reveal limited efficacy of sympathetic blockade and lack of clear predictors for a positive response, lends further support to this assumption. Although we are convinced that the therapy provided before the sympathetic blockade was up to standard, we cannot exclude the possibility that the use of other treatment modalities before the interventional procedure might have resulted in a different patient sample participating in this study, and therefore to other outcomes.

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(Accepted for publication April 25, 2012.)