chronic regional pain syndrome type 1 (CRPS 1), is recognized in children, and they highlight many of the difficulties faced in the management of this condition. They refer to the lack of quantification of outcome measures in RSD. We would like to draw the authors’ attention to our recently published studies of RSD in children [2, 3]. Data were collected over a 10-yr period, during which time 101 children with RSD (83% of whom were female) were treated in our unit. The age range of the children was 8–15 yr, with the majority aged 11–14 yr.

In our experience, common presenting symptoms are causalgia, hyperalgesia, allodynia, paraesthesia and autonomic changes. We noted a significant delay in diagnosis in many children, with a median time to diagnosis of 12 weeks (range 1–130 weeks). Many of the children had been seen by several different health professionals, had received multiple unnecessary investigations and had been given conflicting diagnoses, resulting in inappropriate treatments including limb immobilization. These factors undoubtedly served to escalate the problem in the minds of both the children and their families, who frequently appeared to have lost faith in the health profession. It is our strong belief that underlying psychosocial issues within the child’s environment are contributory to this condition, and addressing these issues is helpful if management is to be successful. We agree with Marshall and Crisp that a significant number of children attribute the onset of the RSD to an episode of trauma, which may be only minor.

All children with RSD in our unit have been treated by the same physiotherapy team. All children need an individually tailored treatment plan, beginning with a simple explanation of RSD, which we describe as a vicious circle of pain, protection and decrease in circulation. Rigid exercises following a set protocol have not been found to be effective. Lower limb involvement alone was the commonest pattern (65% of all cases). The majority of children recovered in fewer than five treatment sessions. The recurrence rate was 20% in the group, which we believe suggests a relationship to psychosocial issues at home. To date, six of the 101 patients have been lost to follow-up, and only three have failed to respond to physiotherapy treatment. We believe that analgesics are of limited value in the management of RSD in children, and none of our patients received sympathetic blockade or any other invasive therapy. We introduce the concept of referral for formal psychological input at the outset of management, but this form of treatment has rarely been needed.

In conclusion, we would emphasize the importance of early recognition of this not uncommon childhood condition, and the minimum number of investigations necessary to exclude organic disease. Early treatment in experienced hands with a consistent approach from all members of the multidisciplinary team has produced what we believe to be a favourable outcome in children with RSD.

Rheumatology 2001;40:590–591

Reflex sympathetic dystrophy

Sir, In their recent editorial, Marshall and Crisp [1] point out that reflex sympathetic dystrophy (RSD), or
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Accepted 14 November 2000

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3. Cohen AM, Kemp S, Perkins TER. The physiotherapy manage-  
ment of reflex sympathetic dystrophy. Arch Dis Child  
2000;82(Suppl. 1):A45.