RSD PUZZLE #42
"CRANIAL FACIAL RSD AND ROOT CANAL PROCEDURES"

The summary of your problem is that to begin with you had RSD starting from a knee injury and then this was followed by traumatic nerve blocks in the form of multiple epidural nerve blocks with leakage of spinal fluid as well as traumatic sympathetic ganglion blocks.

The problem would not have been so complicated if you did not have such an aggressive dentist. By the time the first root canal was done and you noticed a spread of RSD to the oral facial region, the dentist should have stopped right there and then.

Once the RSD spreads to the oral facial region, it causes necrosis (death of cells) of the maxillary and mandibular bones in the areas of the root canals. This is mistaken for surgical problems from root canals. Then the dentists and oral surgeons try to explore the area only to find disturbance of circulation as your dentist has found on numerous occasions. At the present time what you have is a vicious circle of RSD causing bone degeneration in the face aggravated by unnecessary root canal explorations.

You have got to put an end to this vicious circle. You are the only one who can do it. Just refuse to have operation for root canal. You have brought up a question, "what if you have an abscess in the area of previous root canal surgical procedures". There are newer antibiotics such as Zithromax which early in the developmental phase of abscess can eradicate the infection.

Apparently in one year you have had a dozen root canal operations because of the imaginary fear of development of abscess if you would have refused the surgical procedure. This logic does not make any sense. At least 3-4 times a year, I see patients from different parts of the country and Canada that go through the same torture that you are going through. The answer to all of them has been the same.

The treatment is as follows:

1. No more surgical exploration.

2. Systemic nerve blocks in the form of Clonidine Patch, or Hytrin, or Clonidine or Dibenzyline by mouth, the use of newer antidepressants for prevention and treatment of chronic pain, and proper oral hygiene. Gargling the oral cavity with warm water and epsom salt can be quite helpful. In the more severe cases, in the hands of an experienced oral surgeon, sphenopalatine ganglion block is quite helpful in management of the RSD involving the oral cavity.

The second question that you have brought up is the fact that when they do the root canal exploration, they find unusual things such as a dead and scared up nerve or necrotized (dead and liquid black tissue) bone structure. These are nothing but the side effects of RSD causing inflammation, lack of circulation, and death of the nerve and bone tissues. It is best not to keep digging into the area surgically because it only aggravates the condition.

The third question that you have is in regard to the fact that already your immune system has fallen apart. You are reporting abnormal killer T-cells, IGG deficiency (Immunoglobulin deficiency), and other defects of your immune system. The disturbance of the immune system in stage IV (this is the stage you are in) is quite common. The abnormalities that they have found in regard to your immune system are because of the fact that dozens of times the multiple surgical procedures have challenged your immune system and eventually have made it exhausted and deficient.

The sympathetic nervous system has three major functions:

1. Control of vital signs (blood pressure, pulse, and respiration)

2. Control of internal environment (temperature control and control of other function of internal environment.

3. Control of the immune system.

With the repetitive unnecessary and destructive operations that you have had in your oral cavity, your immune system has already become deficient and paralyzed.

There are only two things that can be done to enhance the function of the immune system:

1. I.V. Immunoglobulin treatment, a minimum of 10 gram in 1,000cc D5&W to be given as IV drip once a month for a minimum of 12 months. This should be done after they check your urine function and after they make sure that you have no problem in excreting protein through the urine.

2. The second method of improving the function of the immune system is what I have described in my book, "Chronic Pain, Reflex Sympathetic Dystrophy: Prevention and Management" (CRC Press, Boca Raton, Florida). In this method, ACTH in conservative doses is given to the patient not to simply stimulate the patient's own cortisone, but more importantly to increase the formation of endorphine and to enforce the function of the immune system.

Finally, the way your case has been handled is the glaring example of how RSD is being mishandled. The treatment has consisted of doing nothing but giving the patient repeated sympathetic ganglion nerve blocks which usually (as was in your case) are complicated by technical traumatic side effects.

You need a comprehensive multi-disciplinary treatment in the form of proper oral hygiene, enhancement of your immune system function, treatment with newer antidepressants, discontinuation of addictive narcotics and benzodiazepines, keeping the surgeon away, and doing other types of block other than the traumatic blocks that you have had.

A patient like you with craniofacial RSD invariably suffers from headache, dizziness, neck pain, and tinnitus (buzzing in the ear). Such patients benefit tremendously from paravertebral nerve blocks in the cervical spine region, and occipital nerve blocks.

You should not forget to keep working on treating the original source of your RSD which was the knee injury.

There is a strong denial and nihilism among care givers who believe that "RSD doesn't spread". I am enclosing a dozen references that prove that RSD does spread.

Also, in the volume one of my "RSD Puzzles" books I have described the nature of development of RSD and especially its relationship to craniocervical RSD.

Please do not forget. It is your decision, it is your life, it is your mouth, it is your head, it is your RSD, and do not let anybody approach you with a knife again.

H. Hooshmand, M.D.

RSD PUZZLE # 43
THE POSSIBLE LOSS OF FINGERNAILS AND TOENAILS IN RSD PATIENTS

Many thanks for your FAX letter dated 3/12/96. The question regarding the loss of fingernails or toenails in RSD patients is not an uncommon occurrence. However, it is uncommon for the patient to lose 8 fingernails at a time. Regardless, even if the patient loses all the fingernails at one time, they do grow back. There are multiple factors that cause the loss of fingernails.

The two most critical factors are the combination of ischemia or constriction of blood vessels in the hands or feet due to the application of ice or due to the repetitive exposure to cold. The second factor is the flair-up of inflammation of RSD usually due to a distressful condition causing recurrence of a new attack of RSD. This flair-up cause inflammation and poor circulation to the fingernails. The third factor contributing to the loss of finger or toenails is the disturbance of the immune system which is usually part and parcel of the inflammatory aspect of the RSD. As a result, the patient develops fungal infection on top of the poor circulation.

SUGGESTIONS:

1. The use of Epsom salt and almost hot water on a frequent basis. The Epsom salt being hyperosmolar magnesium sulfate saturates the extracellular space with magnesium. This secondarily works as a calcium channel blocker, and improves the function of the nerves in the skin and subcutaneous tissue helping the nerve to re-grow. As a matter of fact, Epsom salt and hot water should be the daily routine for treatment of RSD and should totally replace the harmful damage of cold water exposure.

2. Exercise in any way, shape, or form be it crumbling newspaper with the hand, walking for the feet, the use of play-doh, silly putty, rubber ball, tennis ball, etc. this improves the surface circulation or the hand and prevents constriction of the blood vessels and poor circulation to the root of the fingernails and toenails. In this regard, the use of warm paraffin is also helpful.

3. The use of Clonidine patch 0.1 to 0.2 mg to be applied at the lower cervical spine level at C-7 -T-1 level in the posterior aspect of the cervical spine. This type of nerve block opens up the circulation the circulation in the hands.

4. If the patient has not had nerve blocks recently, the nerve blocks will be very helpful for this condition. Especially, axillary nerve blocks are very helpful for this condition. The axillary nerve blocks are so effective and so low risk that we have practically completely replace the stellate ganglion blocks with axillary nerve blocks.

5. If at the time the doctor instructs the patient to use Clonidine patch over the lower cervical spine region, pressure on that are shows reddish discoloration of the skin due to the secretion of substance P, that area should be treated with paravertebral and epidural nerve block as well.

Once the fingernails start growing, then the patient should be taking a course of antifungal medication by mouth (one tablet of Nizoral daily for 7 days) either at the onset of the above plan of treatment or once the fingernails start growing.

H. Hooshmand, M.D.

RSD PUZZLE #44
Assistive Devices and Narcotics

1. An extremity suffering from RSD- is not suffering from a simply hyperactive sympathetic system. It suffers from a dysfunctional system. The circulation in the bone and muscle is accelerated at the expense of poor circulation to the skin and nerves. When you use a scooter or any other assistive device, causing non-weight bearing and no exercise, you are exaggerating this abnormal circulation. Eventually the x-ray shows practically no calcium in the bones and shows stress fractures. Then when you try to get out of the scooter to go to the bathroom those fractures and washed out bones can not carry your weight and you become shaky, you feel severe pain, and fall down. So you go back to the wheelchair never wanting to get out again. Your pain is worse; you need more medicine, resulting in more inactivity.

In the meantime your doctor has done so many nerve blocks on you that there is no more sympathetic ganglion left and the next time you try to sit up your blood pressure falls to practically nothing due to the absence of the protective effect of the sympathetic system. To make matters worse you undergo a spinal stimulator. Your sympathetic system was all messed up in the lower extremity because of a trauma (such as a knee injury or other injury). Inactivity was spreading the RSD to the rest of the body. The trauma of the spinal stimulator causes the spread of RSD to the upper extremities. More narcotics, more inactivity, and you have intractable, uncontrollable RSD.

As long as the patient reverses the process and becomes independent of the wheelchair (or scooter) they can afford the luxury of shopping in a big mall or the once in a lifetime pleasure of Disney World in a wheelchair or scooter.

2. The addictive narcotics are not just suppressing your Endorphins but also ACTH (which prevents inflammation), estrogen (which prevents osteoporosis) and natural cerebral antidepressants.

H. Hooshmand, M.D.

RSD PUZZLE #45
Agonists and Antagonists

The addictive narcotics are called morphine agonists because they mimic the side effects of morphine. The non-addictive narcotics are to some extent morphine antagonists because the brain does not recognize them as morphine.

The ultimate morphine antagonist is Naloxone. However, even though we have seen somebody using Naloxone for treatment of RSD it is useless because it suppresses the natural endorphin. The natural endorphin is not just another pain medicine. Non- Endorphin (morphine agonists) narcotics cause stress, shock, hypothermia, low blood pressure and suppression of sex hormone, where as the natural endorphins are just the opposite, they do not cause suppression of the hormones. Gram per gram endorphins are hundreds to thousands times stronger than narcotic medications. They are formed in extremely small amounts all over the brain as needed to counteract pain and to facilitate the sex hormones and natural tranquilizers. When a patient takes percodan or vicodin, the amount of medicine is so large that in combination with strong natural endorphins it can cause drowsiness or breathing problems so the brain shuts off the formation of its own endorphin. As a result the patient is on there own and they have to keep taking pain medication in the face of the lack of endophorins. If the patient skips one dose they will have pain in every part of their body. This is the way the brain lets us know it is in trouble due to the brain not secreting endorphins.

To prevent the above phenomena of addiction one can take medications that are not purely morphine agonists (meaning act like morphine and stop the formation of natural endorphin). The alternative is not Naloxone, but the so-called agonists/antagonists. It means this group of pain medicines at least partially does not suppress the formation of natural endorphins. This group consists of Stadol and Ultram. These two pain medicines do not cause withdrawal because they do not totally get rid of endorphin. For this reason they are not even classified as controlled drugs. When you read the PDR you notice that Stadol causes psychological dependence in only two out of 3000 people taking it. Certainly sugar or hamburgers have a higher percentage of psychological dependence. If Stadol and Ultram would have caused physical withdrawal as seen with the addicting narcotics they would also have been classified as controlled drugs. The reason people think that Stadol and Ultram are addicting is because they try to overlap them with other addicting narcotics. The combination of Stadol or Ultram with other narcotics causes vomiting and no pain control .The patient should be cold turkey from other Narcotics and they are put on these drugs. Ultram and Stadol can be abused as street drugs, but that is not equivalent of a medical addiction. One can sell contraband, endangered species meat, in the street but that does not mean the meat is addictive.

H. Hooshmand, M.D.

RSD PUZZLE #46
RSD AND OSTEOPOROSIS IN WOMEN

Question:

Dear Dr. Hooshmand,

I have Total Body RSD, and would like to know if you think the new drug for osteoporosis called Fosamax might be helpful to me. Also do you think taking calcium supplements might help retard the bone demineralization I've been (painfully) having?

Answer:

Dear Donna,

Fosamax is a very good medicine. Make sure that you don't lie down for at least a half an hour after taking. It can irritate the stomach. Also take it with lots of water. This medicine is not enough. The cause of osteoporosis is avoidance of use of the extremity. When a part of the body is not moving the RSD gets worse and skin becomes cold at the expense of bone and muscle having a lot of flushing and increased blood circulation. Nothing works better than weight bearing and activity. In addition to Fosamax and exercise the soaking of the body in Epsom salt and warm water helps a lot. It improves skin conditions and counteracts the excessive bone circulation.

Calcium tablets are not as effective as cabbage and low-fat dairy products. In addition both for sake of RSD and osteoporosis if at all possible you should be treated with female hormone supplement if your Gynecologist does not find any contraindications.

Because your RSD has spread, it is time to get rid of the wheelchair and start moving around with help of a combination of muscle relaxants such as Baclofen (Lioresol) as well as strong non- addicting pain medications (like Klonopin).

Exercise is important in treatment of RSD but only if done briefly, intermittently, with a lot of rest in-between. In activity and exercise both can cause pain. It is best to alternate the two to counteract the complication of RSD.

H. Hooshmand, M.D.

RSD PUZZLE #47
The Effects of Surgery on RSD Patients

Question:

Dear Dr. Hooshmand,

My daughter is 22 year old and has RSD. She had a simple knee trauma, treated initially with PT and NASI but a new physician determined she needed surgery and she had arthroscopic followed by an open release of the tendon. The retinucalar release was "over-released" causing the patella to go off track medically discovered by the physical therapist. The surgeon did not believe anything wrong. My daughter complained of a pain much greater than pre-op and he told her she should grow up and not be a chronic complainer. It was documented in her Physical therapy, her tolerance to ice and increased pain, we knew of RSD at this point. Six months later her RSD was diagnosed and more surgery was done to reverse the ligament repair. This got rid of one pain but caused an increase in RSD symptoms. She is now going downhill, her mobility is severely impaired complicated by orthopedic problems, the Orthopaedist says fix the RSD, the Neurologists says fix the orthopaedic problems. It has been a royal run around and all the time I see her getting worse and her pain increasing. Now she is being sent to a clinic. Thank you for listening, we appreciate all your work with RSD and your input.

Pat

Answer:

Dear Pat,

I truly empathize with your plight. What you daughter is going through is nothing but the routine of the "Miracle of Modern" medicine. She is simply caught between a rock and a hard place. They are offering to her nothing but sticking a spinal stimulator in her or operating on the knee. Both being operative surgical procedures stimulating the RSD rather than calming it down. As I warned you several months ago muscle spasm around the knee suffering from RSD will pull the patella to one side. Instead of proper physical therapy and muscle relaxants they did an operation to make it look good. She did not need esthetic surgery, which only made the RSD worse. It is time to "say No" to any surgery. She needs to be in a comprehensive, multidisciplinary, assertive and conservative treatment. Sending her to the Clinics that have the policy of inserting a spinal cord stimulator (SCS) in RSD patients is not in the best interest of your daughter.

H. Hooshmand, M.D.

RSD PUZZLE #48
MS Contin... Pain Reliever, But Not A Key To Recovery

Dear Margaret,

Many thanks for your comments regarding MS Contin. I agree that MS Contin, as you say, "doesn't aggravate inactivity". This is the key to the whole problem. MS Contin is nothing but a continuous anesthesia. You don't feel anything so you feel good. The problem is that recent research in the past two years has shown that there are a certain type of sensory nerves deep in the muscle and bone in the extremities that are called "sleeping nociceptors". God has gifted us with these sensory nerves that are usually totally silent and do not give any kind of pain signals unless the extremity becomes inactive for a long period of time. In RSD, the first response of the body to the pain is keeping the painful extremity still. Temporarily there is nothing wrong with it. However, if it is done on a long term basis such as with the application of cast or with the intake of a lot of narcotics that cause inactivity, then these "sleep nociceptors" wake up. As they become activated (because of prolonged lack of exercise of the extremity), the patient feels severe pain in the extremity. If the patient is given copious amounts of addicting narcotics causing drowsiness and inactivity, the pain will be gone but the damage to the extremity will continue under the protection of the pain medication. This is in the form of osteoporosis weakness and atrophy of the muscles. That's the reason God gave us these sleeping nociceptors (which I call the "Maytag repair men"). MS Contin, being one of the most potent pain medications, takes away the pain but doesn't stop the damage of osteoporosis, fracture of bone, atrophy of muscles, etc. Enjoy yourself while you are inactive and doing nothing about this disease in the extremities because sooner or later the price has to be paid in the form of sympathectomy, amputation, permanent confinement to wheelchair or bed, etc.

Dr. Basbaum, who is the number one researcher in RSD changes in animals, has shown that narcotics cause problems with spread of the RSD to other parts of the body in the animals. He has also shown in animals that the use of narcotics causes permanent changes in the genetic structure of the nerve cells making them lose their plasticity (power of recovery). This may be the reason for inactivity accelerating the course of the RSD from stage I through stage IV and causing serious complications that are part and parcel of the late stages of RSD.

As we always say, if you want to take your medicine and rest and watch O.J. on T.V. power be with you. My job is to warn you, but please, for God's sake please don't kill the messenger. Incidentally, if you are interested, I can mail to you the reprints of some of the excellent work done in the past one year by Dr. Basbaum (which I have quoted here).

H. Hooshmand, M.D.

RSD PUZZLE #49

The Role Of Bone Scan In The Diagnosis And Management Of RSD

Dear Sandy:

You had asked about the role of bone scan in the diagnosis and management of RSD. The recent study published in the Journal of Hand Surgery 4 months ago reported the research work done by Doctors Lee and Weeks of Lexington, Kentucky showed that bone scan is diagnostic or accurate in the diagnosis of RSD in only 55% of the patients [1]. This is an atrociously low percentage. If it was 50% it would be flip of a coin. It is ludicrous to resort to a test that has the accuracy of flipping a coin. Yet, a lot of patients that I see have been told "You don't have RSD because bone scan was normal". Bone scan has no place in the diagnosis or management of RSD. If I have a heart attack and they tell me that they are going to do a test that has 55% chance of diagnosing my heart attack, obviously I'm not going to consent to such a test. The reasons for bone scan being so inaccurate are legendary. Symmetrical involvement of RSD, spread of the RSD to other parts of the body, changes of bone circulation during different stages of RSD, and conditions that mimic RSD such as arthritis, are some of the reasons the bone scan becomes useless in the diagnosis and management of RSD. There is no special test-be it thermography, bone scan, QSART, Doppler flow studies, or surface temperature studies-that can diagnose RSD. RSD is a clinical diagnosis with four principles.

1. A burning, stabbing, pain that can be elicited even with simple touch.

2. Motor dysfunction in the form of muscle spasm, weakness, tremor, and constriction of blood vessels.

3. Disturbance of immune system in the form of inflammation, swelling, skin rash, etc.

4. Constant input of pain to the brain causing insomnia, agitation, depression, and poor judgment. Do not waste your money on any bone scan.

H. Hooshmand, M.D.

Reference:

1. Lee GW, Weeks PM: The role of bone scintigraphy in diagnosing reflex sympathetic dystrophy. J Hand Surg [Am] 1995; 20: 458-63.

RSD PUZZLE #50
RSD By Any Other Name Is Still The Same

Question:

Dear Dr. Hooshmand,

After two and a half months I have found out that I do not have RSD. I went to see an RSD doctor up North yesterday and he confirmed that I do not have it. I have Myofacial Pain Syndrome, nerve damage, etc... but no RSD. I was told that a lot of the symptoms mimic each other. The cold, hair growth, burning, and shooting pain, etc...

Debbie

Answer:

Dear Debbie,

A rose is a rose by any name.

First of all, Myofacial pain syndrome was originally coined almost 20 years ago for any soft tissue pain that couldn't be specifically classified. It refers to a tender spot under the skin. That is all-nothing less nothing more. It is not accompanied by, as you say "the cold, hair growth, burning shooting pain, etc..."

These are the symptoms of RSD, but due to the nonspecific terminology of "Myofacial syndrome". Thoracic outlet syndrome", "Fibromyalgia", "Carpal tunnel syndrome", and a dozen other euphemisms RSD is left untreated, mistreated, and ignored until it becomes too advanced or too late to be managed.

H. Hooshmand, M.D.

RSD PUZZLE #51
FERTILITY AND RSD

Dear Grace,

In regard to the problem with fertility, it has nothing to with the side effects of sympathectomy. Sympathectomy causes a lot of complications but plays not role in infertility. It also has nothing to do with the MS Contin. The commonest form of infertility is in late stages of RSD, especially if the patient is wheelchair bound. In the late stages of RSD, there is inflammation and hyperthermia (rapid washout of blood) in the viscera (guts, pelvic structure, etc), bones and muscles. Obviously the use of a wheelchair makes this worse. The rapid washout and inflammation deprives the early-stage fetus of proper oxygen intake. This is also complicated by the fact the rapid washout deprives the fetus from proper nutrition: the same way I explain to the students is, to imagine the Publix Grocery Trucks loaded with food driving 70 miles per hour on the freeway, that food is no good for the people who work on the freeway. So the blood could have the best proteins and vitamins but it is circulating to fast to be useful for the fetus.

I hope this information is of some use to you. It is good for the RSD patient to become pregnant in early stages, but it may be stressful in later stages. Even if the mother is lucky enough to become pregnant and deliver a baby, there is a strong chance it is going to be a somewhat malnourished newborn, with a probably not so perfect immune system.

Many thanks for a good question that a lot of people ask.

With Best regards,

Hoosh

RSD PUZZLE #52
Should You Rely On Prescription Drugs?

The problem with relying on the principal of prescription drugs is that just because a doctor prescribes them it does not make it right and kosher. First of all there is no such thing as small doses of MS Contin. Even the smallest dose of MS Contin will block the formation of endorphines.

Secondly, the studies that you have referred to are the studies of a mixture of acute pain which absolutely needs narcotics for treatment on a temporary basis, Cancer pain which needs narcotic treatment on long term basis, but not complex chronic pain of RSD which needs non addicting narcotics (morphine antagonists) but also needs natural endorphines and other brain hormones to heal itself. I always emphasize that there is no way RSD can be controlled unless the pain is controlled. The pain control should be with the help of analgesic antidepressants, non addicting narcotics, and morphine pump which provides such a minute continuous dose of morphine to the brain that does not suppress cerebral endorphines.

MS Contin application introduces morphine to be processed through the liver and blood-brain barrier so the amount of morphine in it is at least 30 times stronger than the morphine in the pump. Finally every human being is born an addict. I am a workaholic, foodaholic, etc... Making the brain dependent on strong addicting narcotics is the best set up for addiction. I am just quoting the study of a mixed bag of pain patients with narcotics does not deny the strong potential of addiction of such drugs.

I agree with you wholeheartedly that in medical profession when the doctor suffers from the guilt of not being able to fix the patients condition, he transfers it by calling the patient an "addict" or a "fake". It is an unfortunate fact that the doctor start s the patient on large doses of Methadone or MS Contin, forces the development of rebound and tolerance, messes up the entire function of the brain, and at the end tells you the patient "you don't have a RSD, you are just an addict". The patient is then sent to a pain clinic to "learn to live with it". The care provider then bows out of the picture and the patient is left with no coverage and no treatment of the damages due to the "Miracles of Modern Medicine".

H. Hooshmand, M.D.

RSD PUZZLE #53
RSD DOES NOT DISCRIMINATE

Question:

This question is from the Prodigy Network: RSD and Friends Medical Support Bulletin Board.

"...Are none of us BLACK? And if not, what does that say about RSD... If anything"?

Answer:

RSD does not discriminate.

African Americans are a small minority of the population. However, in our experience, they got more than their share of RSD.

This seems to be due to socioeconomics. Proportionately more African American women work in factories and other industrial type jobs than White women. Because of the fact that a majority of African American and White RSD patients are work injuries, many do not have the privilege of Non-workers comp medical care.

H. Hooshmand, M.D.

RSD PUZZLE #54
How To Detoxify

1. Dr. Basbaum did not concoct the "sleeping nociceptors". It was a researcher from Germany by the name of Dr. Koltzenburg. It was the most significant research reported in RSD in 1995. Those nerves are there and they become active causing severe pain when the limb is inactive (wheelchair) so the patient needs more and more pain medicine.

2. Dr. Basbaum used the standard equivalent dose of pain medicine in the animals.

3. I hate the term addiction. It is a political terminology. The proper word is drug dependence. If I need food to live then I am dependent on it. If a person needs alcohol to calm down on an as needed basis then they are dependent on it, etc... Unfortunately, I receive many late stage RSD patients who are dependent on narcotics that cause withdrawal pain, tolerance, and inactivity. Once the doctors given them such drugs on a long term basis, they then advise the patient "You do not have RSD, You are an addict". There are better narcotics which are stronger than MS Contin and do not cause dependence.

4. In late stages of RSD or failed back syndrome there is the alternative of the morphine pump which provides excellent pain relief without dependence; however, because of the universal misunderstanding regarding pain medicines, the patient is provided with both the pump and other drug dependent narcotics. The end result is disastrous to the patient.

5. Taking Methadone and Percocet is a sign of tolerance, (increasing dependence).

6. The previous study regarding dependence in chronic pain was flawed by the fact that a lot of the patients died from the disease and a lot of other patients were kept on drug dependent medications with the excuse that they were prescribed by a doctor.

7. The alternative is, first of all, cold turkey, switch to drugs such as Stadol and Ultram, but do not overlap old and new drugs. This should be followed by the patient to "Say No" to spinal stimulators, sympathectomy, and other unnecessary operations. Get up and walk to calm down the sleeping nociceptors.

8. Finally, I may not feel the pain but I spend my life helping the unfortunate victims. You are frustrated with the pain. I am frustrated with the latest most destructive trend in the management of RSD consisting of spinal cord stimulators that only stimulate the sympathetic system and make the RSD worse, multiple unnecessary surgeries for fictitious, imaginary conditions secondary to inflammation of RSD. I do not need to name them because practically every one of you has had these operations. The end result is Stage IV with horrible consequences. All of this is done while you are going through the "Rip Van Winkle" phenomenon, slowing watching yourself deteriorate.

H. Hooshmand, M.D.

RSD PUZZLE #55
STROKE AND RSD

Stroke can be the cause of pain in approximately 5-7% of RSD patients. It can be self-limiting as in most cases of central pain, or it can be persistent. Stroke (similar to heart attack) can be the cause of frozen shoulder and shoulder-hand syndrome, which leads to RSD.

RSD on the other hand can cause heart attack and stroke in the late stages of the disease. This can be due to hypertension secondary to RSD, or disturbance of immune system causing bleeding, clotting, or poor circulation.

According to Lee, and van Donkelaar when the brain is under attack with disturbance of the immune system (one of the three main functions of the sympathetic nervous system), it eventually becomes defective to properly protect the immune system against stroke or prolonged chronic pain. The brain undergoes an anatomical and functional change that makes it more susceptible to the above mentioned damages.

In addition to the immune system disturbance in RSD contributing to the development of stroke, the fluctuating of blood pressure in the late stage (stage IV) of RSD causes a high risk for stroke.

The sympathetic nervous system has the three major duties of control of vital signs (including pulse and blood pressure), control of immune system, and control of the body temperature. As the disease becomes uncontrollable and chronic, fluctuation of the blood pressure develops. Unfortunately, the hypertension in RSD patients is traditionally treated with medications that are used for other types of hypertension. Such medications as diuretics or newer anti-hypertension medications cannot influence the sympathetic mediated hypertension. For your type of hypertension the best medications are the alpha blockers such as Hytrin, Clonidine, or ideally Dibenzyline.

If you are not on an alpha blocker, then you should discuss it with your doctor to consider such treatment.

Thirdly, like any other complication of RSD, the disease does not improve at all until the pain is under control. The best way to control such a chronic pain is treatment with analgesic effect of a specific antidepressant such as Trazodone, and treatment with non-addicting strong pain medications which are not even classified as controlled drugs such as Stadol and Ultram.

The treatment with addicting medications such as Morphine patch or any other type of strong addicting narcotics (Vicodin, Dilaudid, etc.) is going to cause fluctuation of pain because of withdrawal effect and that can aggravate your hypertension and cause further stroke.

The fourth point to bring to your attention is the cigarette smoking. I do not force my patients to go off cigarette smoking cold turkey. That is not going to be well tolerated by RSD patients. Instead, I convince them to use nicotine patch which provides more than enough nicotine to the system but bypasses the respiratory system and does not cause a change of 30% of the blood oxygen to carbon monoxide which is more damaging than the cold extremity of RSD could be.

Obviously, other addicting drugs such as chocolate, alcohol, and hot dogs should also be completely eliminated.

With best wishes,

H. Hooshmand, MD

RSD PUZZLE #56
Prescription Drug Dependence

Prescription drug dependence caused by medical doctors is quite common.

It is second in incidence to alcoholism and far more common than cocaine dependence.

First of all, none of the victims forced the doctor to prescribe such dangerous drugs.

Secondly, they had the natural faith in their physician and followed his or her instructions so it is not the patients fault.

Thirdly, none of them get "high" from taking such medications. They are dependent because their endorphin is gone and they are in perpetual withdrawal pain every three to four hours. They are miserable rather than enjoying it.

Amazingly, the same doctor who forced the drug dependence by prescribing the medication to you to begin with, then turns around and says "there is nothing wrong with you, you are just an addict". This is a cheap insult to the patient and transference of guilt.

Finally the logic of "It was legally prescribed to me" is no different than saying, "Alcohol is legal, so there is nothing wrong with taking it".

H. Hooshmand, M.D.

RSD PUZZLE #57
THE STAGES AND OUTCOME OF RSD

The best study about the outcome of RSD and the advanced stages of RSD has been written by Dr. Poplawski from Canada which was published in 1983. He showed that RSD diagnosed in the first 2 years has a chance of successful treatment in 80% of the patients and after two years each year drops the percentage of the success significantly [1].

As I have discussed in my book on the subject of RSD, there are more than three stages in RSD. The first stage is dysfunction, the second is dystrophy, and the third is atrophy. The fourth stage is when the disease becomes chronic enough and it's serious enough that the patient develops disturbance of immune system, hypertension, chest pain, stroke, and heart attack, and is at higher risk than the general population for high blood pressure and cancer. In the fourth stage, there is a high mortality due to suicide due to side effects of improper operations and improper treatments [2].

In over 500 RSD patients that we have studied, the success rate in the first 6 months is as high as 85%. After two years, the success rate drops to 70 to 80%. After five years, the successful treatment of RSD drops to less than 10%.

There are certain factors that accelerate the course of the disease and the disease can go into stages three and four in the matter of a few weeks or months. One is the case of causalgia secondary to intravenous needle insertion or secondary to amputation when the patient develops an accelerated course of deterioration of RSD.

The other factor is operations such as neurectomies, cryosurgery (surgery with ice cold equipment), sympathectomy, and unnecessary operations for the so-called diagnoses of carpal tunnel syndrome, tarsal tunnel syndrome, etc., and the use of spinal stimulators in the late stages of RSD. Obviously, treatment with ice or ice and heat challenge as well as resorting to assistive devices such as braces, wheelchairs, and especially the use of casts, accelerates the disease and push the patient farther down to the 100% failure.

One important factor in poor prognosis in late stages of the disease is that the patient has had some partial treatment earlier in the course of the disease such as nerve blocks which change the nature of the illness and the patient does not develop the full-blown picture of stage two or stage three. The patient stays in stage one due to the partial beneficial effect of the treatment and suddenly jumps into stage four with the complications mentioned above. As the patient stays in stage one, the doctors doubt the diagnosis of RSD on the peculiar logic that if the patient has had RSD for years she shouldn't be looking so good.

By the time the RSD is over 4 to 5 years old and has not responded properly to treatment and by the time such a patient continues to deteriorate on her rapidly downhill course, the only thing that can help the patient is an infusion pump. This is in the form of Morphine or Morphine and Baclofen combination, or Morphine and Clonidine combination. In our series of over 80 patients followed for more than 3 years who were 100% failure, the infusion pump has had a success rate of 80%. However, the success rate of the infusion pump in the future is going to be far lower because the doctors who apply infusion pumps do not understand the principle of not adding other narcotics to the treatment of the patient who is already on the infusion pump. When the patient is given other narcotics along with the infusion pump, the disease becomes much worse and the patient develops a lot of inflammation, arthritis and rapidly deteriorates. I personally do not insert the infusion pump. It is usually done by an anesthesiologist or a neurosurgeon but I make certain that my patient who is on the infusion pump does not take any other narcotics and does not go over the safe limit of daily dosage of Morphine administration in the pump.

There is no quick, fixed and easy method of treatment for the late stages of RSD. Unfortunately, one of the criteria for RSD is the disturbance of limbic system (emotional part of the brain), and the patient easily becomes convinced that the best thing they can do is to find any surgeon who is willing to operate on them and to resort to a wheelchair and addicting medications.

At any stage of the disease and regardless of how far gone the disease is, the patient can be helped as long as they are willing to change their medication and eating habits, and is also willing to stay active, and avoid surgical procedures be it with a radio frequency knife or a gamma knife or other types of surgical procedures.

H. Hooshmand, M.D.

References:

1. Poplawski ZJ, Wiley AM, Murray JF: Post traumatic dystrophy of the extremities. J Bone Joint Surg [Am] 1983; 65:642-55

2. Hooshmand H.: Chronic pain: Reflex sympathetic dystrophy. Prevention and management. Boca Raton, FL, CRC Press, 1993.

RSD PUZZLE #58
MEDICATION RESEARCH

You have said that you bet if a doctor were to have chronic pain there would be much more research and understanding regarding the pain. I take your challenge. I empathize with you for your severe pain. You should be on stronger narcotic pain medicines than you are now. The research has been done; such medications are available and totally legal. However, they can not be taken with other pain medications that cause physical dependence (e.g. MS Contin, Duragesic, Lortab, etc). A patient like you who is in severe pain should consider being switched to the following:

1. Trazodone-which is Naloxon reversible analgesic (works identical to relief of pain by Morphine). This should be followed by blood tests to make sure there is enough Trazodone in the blood.

2. Stadol alternated with Ultram. THESE ARE BOTH STRONG NARCOTICS, BUT THEY DO NOT CAUSE PHYSICAL DEPENDENCE.

3. Simultaneously "cold turkey" stopping the strong narcotics that cause physical dependence.

4. After 2 months of this regimen, the Ultram and Stadol should cut down to use one or the other.

5. ACTH injections for your rheumatoid arthritis - ACTH also stimulates your brain endorphines.

6. With this trial of treatment the success rate is over 90%. If all fails and you are one of the unlucky 10%, then the Morphine pump provides another high percentage of pain management (over 80%).

All of these are conditioned upon the total abstinence from alcohol and dependent types of narcotics. The bottom line is in 100% failure cases there will be only 10% residual of failure before the pump and around 3% failure after the pump if one goes through the above protocol religiously. However, we do not live in a utopia and at each stage of such an algorithm everything falls apart. For example, if you are on large dose of Prednisone your adrenal gland undergoes atrophy and causes constant stress. Your physician will be reluctant to put you on ACTH to correct such a process. If you undergo a Morphine pump treatment and the pain is not 100% controlled your physician will keep increasing the dosage of Morphine until the Morphine pump changes to any type of large dose, flooding Morphine treatment similar to MS Contin. If you are being switched to Stadol or Ultram very likely you are slowly tapered off the other pain medicines. The combination of the two types of pain medicine will make you very sick and you wills top taking the medication. The key is to cold turkey and not to overlap such medications. In conclusion, the facilities are there to straighten up the pain but there is a desperate need for the doctors to understand how to use them. In the meantime people are dying from the combination of Methadone and other strong narcotics, and combination of the pump and other narcotics.

Blaming the pump is the same as blaming the F-16 fighter jet crashing when the pilot does not know how to operate it.

H. Hooshmand, M.D.

RSD PUZZLE #59
Sympathectomy and Amputation

Question:

Dear Dr. Hooshmand,

I have had this disgusting disease for 5 miserable years. I've been through every nerve block, medication, and procedure. Now I am having very bad ulcers on my foot that are infected. My doctors want me to have a sympathectomy or amputation.

Wilma

Answer:

Dear Wilma,

Do not let anyone do a sympathectomy or amputation. If you have an amputation your RSD will accelerate several times and you will have dozens of nerves in the stump of the amputation causing dozens of sources of RSD and Causalgia.

A sympathectomy, be it surgical or chemical, is useless for your advanced RSD. It will cause rapid spread of your RSD to other parts of the body. A chemical sympathectomy is as destructive as a surgical sympathectomy. The surgical sympathectomy is at least clean and circumscribed. The chemical sympathectomy damages the surrounding normal tissues and causes more scarring and pain.

There are many things that can be done for your ulcers. Immediate avoidance of ice application, switching to soaking in a warm bath with a small amounts of Epsom salt, weight bearing and walking, and I.V. Mannitol treatment, and treatment with ACTH are some things which will probably help. Expose your extremity to fresh air and do not keep it wrapped up in dressings.

H. Hooshmand, M.D.

RSD PUZZLE #60
CRPS and Social Security Disability

The ultimate goal of CRPS treatment should be aimed at effective pain relief, mobilization and return back to normal life activity. If at all possible, the patient should show enough improvement to return to some type of work. Depending on the type of treatment, these goals are achieved in different degrees. For example, surgery especially sympathectomy, rhizotomy, osteotomy, thoracic outlet syndrome operation, carpal tunnel surgery, and surgery for removal of neuroma are apt to aggravate the disease. CRPS is usually originated from a relatively minor trauma when the patient is caught off guard or has a relatively minor trauma due to repetitive strain injuries. Any surgical procedure changes the disease from minor nerve injury to a major new source of pain and CRPS in the surgical scar region. So, the first goal is to avoid surgery. Surgery has a tendency to spread the CRPS to other parts of the body and makes the patient more disabled.

Besides surgical treatment, application of ice as well as immobilization with application of cast, confinement to wheelchair, and prolonged bed rest are strong aggravators of the disease, drastically reduce the chances of the patient returning back to work.

Early diagnosis and proper conservative treatment with effective antidepressants, anticonvulsants, anti-inflammatory medication, proper epidural nerve blocks, and avoidance of repetitive sympathetic nerve blocks, as well as effective physical therapy and moderation in rest and activity help the patient overcome the curse of CRPS and help the patient recover and return to some form of normal life.

The percentage of the patients treated with surgery, ice application, and immobilization, becoming able to return to work is less than 10% -20%. The proper treatment as outlined above in our experience helps the patients to return to work by over 55% range if the disease is diagnosed earlier than two years, and around 40% if the disease is diagnosed after two years.

We are extremely reluctant to consider the patient totally disable from any type work because inactivity is just as harmful as too much activity.

Eventually, some of these patients become so disabled that they have to apply for Social Security Disability. Specifically, polytherapy with stronger and longer lasting narcotics drastically increases the number of patients unable to work. Obviously, if the patient is on Methadone, MS Contin, Fentanyl or any combination of above drugs, the patient is not going to be able to work. If anything, the patient will be accident prone, harmful to himself and to others.

Starting in the 1930's, President Roosevelt signed into law the present Social Security system. The system is aimed at the government withdrawing a percentage of an individual's income as a saving for retirement or for permanent disability unemployment. The amount of money that has been saved in the system is more than eight trillion dollars. Obviously, if you try to inquire, you are not going to find any part of health or treasury department holding eight trillion dollars in the banks or in saving accounts for Social Security. The eight trillion dollars is a theoretical number in the books even though the money has already been spent.

Because the cash is not there, the government will obviously see to it that only the ones who are totally disabled, and can prove it to the court through proper legal channels can have access to their savings. If the individual is not injured, but is counting for spending the Social Security money for the days of his retirement, the formula is set to let the individual to collect 100% of the money only after 100 years of age. So, if the individual retires at 70 years of age, then 70% of the money will be gradually available to him in the form of monthly payments. Obviously, there are only 300,000 centenarians (old people over 100 years) in the entire world, so the majority of us will not have access to the money saved any time after 80 to 90 years of age. In theory, the government has borrowed the Social Security money and has used it for budget deficit or other spending purposes. This is the only money the government borrows and never pays a penny of interest on it to the individuals who have trusted their money to the system. It is not like a bond that the government has to pay interest on it.

If the doctors have proven the patient is disabled, that does not mean the patient is going to have access to his disability money. Even after the patient is totally disabled, the individual has to prove his disability beyond any doubt. Otherwise, after three appeals he will lose access to his Social Security money.

In almost over 80% of the cases, the Social Security Department Executives see to it that the patient will not be qualified and certified for disability. On the other hand, when the cases are properly taken to the judge of Social Security, the percentage of ability to have access to the deserved Social Security is several times higher because of the fact that the judges of the Social Security are very impartial and fair.

To be able to prove the case with the judge of Social Security requires hiring a Social Security attorney after the appeal has been turned down twice. If the Social Security attorney knows what he is doing, he will provide proper medical reports from the doctors to meet the 12 minimum requirements of the proof of disability. Never try to practice law and take the case without a proper attorney to court.

Do not become distracted, furious, and do not lose your "cool" when in the first and second stages of application, the Social Security Officers send you to doctors who are likely to declare you able to go back to work. Usually these doctors are selected and are on the list of the Social Security Officers because they are no

experts, and are not familiar with the patient's illness. These are the doctors who are likely to believe, similar to majority of the general population, that when you apply to get your Social Security money, you are costing the tax payers a lot of money. Obviously, you are applying to receive the portion of your own money that you have trusted with the government.

You don't want an ambulance chaser type of doctor or an HMO servant to examine you and to destroy your chances of earning your disability. There are enough doctors knowledgeable enough in their field that do not need to take sides with one party or the other, and are able to prove or disprove that you meet the 12 minimum requirements.

In conclusion, the Social Security System works as long as your case is heard by the judge of Social Security. Try to resort to any and every kind of non-invasive and effective treatment so that you don't end up needing Social Security Disability.

Especially in the case of CRPS patients, early retirement is the beginning of the end. If at all possible, you should keep your mind and body busy with some for of a vocation rather than feeling sorry for yourself and becoming a couch potato. From there you are quite likely to end up in a nursing home because of inactivity. Inactivity causes severe depression, severe chronic fatigue, and severe intolerable deep pain.

The mind is a terrible thing to waste with retirement. I plan on practicing beyond 80 years of age.

H. Hooshmand, M.D.

RSD PUZZLE #61
What To Do For Severe Pain In The Abdominal And Pelvic Area

Intestine and Bowel problems are often the signs of inflammation in RSD. This is very similar to the same inflammation that involves the extremities.

Helping Treatments:

1. Aloe Vera Liquid - drink a few times a day.

2. Drink cold water with ice in it a few times a day.

3. Move, Move, Move, walk, and exercise.

4. Epsom salt enema once every day or other day: not for constipation but to decrease swelling.

5. IV Mannitol 90 gm in 1000 cc D 5 W once every three days x three.

6. Epidural Blocks or Coeliac Ganglion Blocks.

Sincerely,

H. Hooshmand, M.D.

RSD PUZZLE #62
AXILLARY NERVE BLOCK

My doctor wants to do axillary nerve block. What are the risks? Does it work?

The axillary nerve block is quite effective and safe. It is far superior to stellate ganglion block. It is an easy nerve block which takes much less time than stellate ganglion block, it is far less painful, and it has minimal if any complications.

The rate of success with axillary nerve block for the upper extremities is close to 100%. This is the kind of success rate the stellate ganglion block cannot match.

According to the late Dr. JJ Bonica who is considered the father of chronic pain management, as he specifies in his book, the stellate ganglion blocks in the best of hands (which would be Dr. Bonica) has a 25% rate of failure [1]. This is because the stellate ganglion has a very vague anatomical structure which is different from patient to patient. So, it usually takes a few or several sticks before the ganglion block is done. A truly successful stellate ganglion block is accompanied by Horner's syndrome, by Horner's syndrome is successfully achieved in around 75% of the patients who undergo the block. It also has other serious complications which would be redundant to repeat here.

The worst feature of the stellate ganglion block is the fact that repeated stellate ganglion blocks result in the bombardment and traumatic needle damage to the stellate ganglion sympathetic nerve cells. God created those nerve cells not to be needled and destroyed.

Quite frequently, after several stellate ganglion blocks, the patient develops sympathetically independent pain (SIP) in a patient who before the ganglion blocks had sympathetically maintained pain (SMP). This confuses the clinician and because a successful block doesn't help the patient anymore, the patient is accused of being a malingerer or not having "RSD anymore".

Frequently in such patients the hand and forearm become warm and stay warm because of the virtual sympathectomy due to the needling of the stellate ganglion. However, amazingly some people continue with doing blocks even though the stellate ganglion has been totally destroyed and the patient has undergone a traumatic sympathectomy verified by warm and dry hand and forearm.

The axillary nerve block does no have any of these complications because the drug is done by infusation of the blocking agent around the trunk of the nerve following the axillary and brachial artery down to the arm.

On the other hand, there is one limitation for axillary nerve block and that is it does not do anything for sympathetic dysfunction or RSD involving cranio-cervical region (head and neck). However in such cases with cranio-cervical RSD (for example oral surgical complications ending in RSD, the sever vascular headaches are mistaken for cluster headaches which are due to RSD), the patients can undergo sphenopalatine (SPG) ganglion block with more effective sympathetic nerve blockage developed for the head and face than stellate ganglion block.

In our clinic, we rarely resort to stellate ganglion block. Instead, the patient undergoes other alternatives of axillary nerve block, BEIR block (as long as the needle is not inserted in the area of nerve damage); any combination of stellate ganglion as well as epidural and paravertebral nerve blocks in the cervical spine regions. Also in patients with more severe and more complicated sympathetic dysfunction, the patients undergo both SPG and axillary nerve blocks which are quite effective.

We have to realize that RSD in not just a hyperactive sympathetic dysfunction but a distorted and pathological sympathetic dysfunction. That's why some patients have warmer extremities and some patients have colder extremities. The damage to the sympathetic ganglia be it in the form of sympathectomy, chemical sympathectomy (both these sympathectomies are cardinal sins), or stellate ganglion blocks are damaging and can complicate the chronic RSD pain further rather than helping the patient.

H. Hooshmand, M.D.

Reference:

1. Bonica JJ: The management of pain. Philadelphia: Lea and Feibiger. 1953.