

## Peripheral Nerve Blocks Relieve Symptoms Mimicking CRPS

Linda Pembrook

SAN FRANCISCO—Patients with symptoms of complex regional pain syndrome (CRPS) but whose pain is predominantly along a single peripheral nerve distribution should be managed initially by peripheral nerve blocks with local anesthetic, steroids and application of adjuvant topical cream. This should be done regardless of documented nerve injury and before lumbar sympathetic block is considered, researchers said at the 2006 fall meeting of the American Society of Regional Anesthesia and Pain Medicine.

The recommendations are based on experience with three patients, who were referred to the investigators for treatment of CRPS. In an attempt to exclude neuropathy of saphenous and sural nerves, the investigators performed nerve blocks with local anesthetic and steroid. Subsequently, all patients showed symptom relief and improved functioning.

“A potential cause of symptoms should be ruled out before the diagnosis of CRPS I or II is made,” said co-investigator Shashank Saxena, MD.

Pain clinics receive frequent referrals for lumbar sympathetic blocks to diagnose and treat CRPS, according to Dr. Saxena, assistant professor, University of Pittsburgh Medical Center, and staff physician, Veterans Administration Hospital, in Pittsburgh. However, lumbar sympathetic block is a more invasive procedure involving more risks than peripheral nerve block.

The three patients had classical complaints of CRPS, including hyperalgesia/ allodynia, a history of edema, vasomotor changes and sharp shooting pain in the lower extremity. However, in all three cases, most of the pain was along single peripheral nerve distribution, reported Dr. Saxena and co-investigator Nashaat N. Rizk, MD.

The first patient was a 16-year-old female with persistent swelling of the right knee and hyperalgesia/allodynia in the medial thigh along a saphenous nerve distribution following a right knee arthroscopy. On three visits, she underwent saphenous nerve block in Hunter’s canal with local anesthetic and steroids. She also used topical AGL cream (amitriptyline 5%, gabapentin 3%, and lidocaine 5%). She reported full relief from her symptoms.

The second patient was a 36-year-old female who had suffered right thigh trauma 11 months previously and had persistent hyperalgesia/allodynia. She received saphenous nerve block and scar neuroma injections with local anesthetic and steroids and also used adjuvant topical KAGL cream (ketamine, amitriptyline, gabapentin and lidocaine). After three injections, she showed good improvement in her symptoms.

The third patient was a 51-year-old male who had pain and swelling in the left foot after multiple surgeries. The symptoms persisted despite sural nerve transection for persistent ankle pain. He had hyperalgesia/allodynia of the lateral aspect of the left foot and a patch of numbness behind the lateral malleolus. After treatment with sural nerve block with local anesthetic and AGL cream, he had complete resolution of symptoms.

The findings suggest that “patients who have a well-defined area of pain that is involved with a single peripheral nerve can obtain significant improvement with a simple, well-tolerated nerve block and topical anesthetic,” commented Sunil Panchal, MD, president, COPE Foundation, in Tampa, Fla. “This may be a reasonable way to treat patients very early on instead of putting them on a lot of pharmacotherapy. It may also save costs, because compounded topical creams are very inexpensive.”

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