

The Craftsman and his Tools

By Debra Nelson-Hogan



R. Norman Harden, MD

Imagine trying to build a house if you only had a saw. Worse yet, what if you had a full tool box but chose only to use the saw? How can

you build a structure when your only tool cuts? Norman Harden, MD, describes interdisciplinary pain management as using all the available tools at their appropriate times. The physician as craftsman needs to understand every tool in the box to repair a person with pain.

Dr. Harden, RSDSA's recently appointed Chair of Clinical Affairs of the Scientific Advisory Board is passionate about interdisciplinary pain medicine. He says, "Nine-tenths of physicians who treat RSD/CRPS are obsessed with anesthesiological techniques and interventions. They just don't understand all the other tools available." Other tools, such as physical therapy (PT), occupational therapy (OT), biofeedback, psychotherapy, and medications remain in the box.

"It is crystal clear to me and others in the field that pain management has to be interdisciplinary. We can't obsess about a single treatment modality. Drugs, blocks, occupational therapy, physical therapy, psychology, etc., are critically important. If you focus on one modality, your hit rate is going to be about 20%. But if you bring all

the modalities together, you start getting results simply because you have people with different perspectives participating. They talk, they plan, and they get over the hurdles that hinder whatever is stopping treatment. If the physician gets stuck, maybe the physical therapist can get things moving again, or the biofeedback therapist. This is what works, this is the very best that we have to offer."

Dr. Harden was introduced to RSD/CRPS nearly 20 years ago as a neurology resident at the Medical University of South Carolina (MUSC) in Charleston. "A patient came in with a blue, swollen, sweaty, extremity and he was in excruciating pain. Neither the attending physician nor the head of the neurology department knew what was wrong.

"Then this older, wiser attending physician, said, 'Oh, he's got Reflex Sympathetic Dystrophy.' I said, what the heck is that? He said, 'well, we don't know very much about it, but what we do know comes from this'.

He handed me a book by Silas Weir Mitchell from the Civil War. He also directed me to some research and text."

Dr. Harden admits the discovery of a relatively unknown disorder was exciting for a resident. Without an established protocol, "I tried everything that was in my bag of tricks, which at that time was

pretty paltry. We tried some drugs, but at that time, opioids were not even an option." He found a member of the anesthesiology department who performed sympathetic blocks.

Then, Dr. Harden and a young, aggressive, anesthesiologist set up a small pain management team. They did blocks and used medications such as tricyclic antidepressants, some NSAIDs, and occasionally antiepileptic drugs.

Later, Dr. Harden collaborated with Tom Duk at MUSC. "He and I basically rolled up our sleeves and asked 'What can we do?'" We noticed that people with RSD/CRPS felt better after activity, so we added physical therapy to the protocol. After the Director of the Pain Center at MUSC died, Dr. Harden found himself "running this little interdisciplinary program. We used PT, OT, biofeedback, psychology, some injections, and medications. And we had great success, at least compared to other programs. We had a 5-state

catchment area — everybody with RSD/CRPS was coming to see us."

For his fellowship, Dr. Harden worked with Steven Brena, MD, at the Pain Control and Rehabilitation Institute of Georgia, which was affiliated with Emory University. He learned to do stellate and lum-

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bar blocks, but ultimately lost enthusiasm for them as a sole treatment modality. “I saw them as a temporary solution, a short-term fix. They didn’t work long term, and didn’t make any changes in people’s lives,” he said.

Post-fellowship, Dr. Harden was named Medical Director of the interdisciplinary pain program at MUSC. “There were 12 players and we were doing extraordinarily good work. I was sold—I saw people who were healed by PT, OT, or psychology; and there was still that 30% who benefited from the blocks.”

Ten years ago Dr. Harden was offered a position as director of the clinical pain management group at the Rehabilitation Institute of Chicago, a position he held until last year when he moved into research. He is now Director of the Center of Pain Studies, overseeing 16 projects, some pharmaceutical-related and others concerning diagnostic criteria and treatment guidelines. “This type of work is of critical importance to the RSD/CRPS world,” he says. He is working with Dr. Michael Stanton-Hicks of the Cleveland Clinic to create better and more precise information on RSD/CRPS. They also hold “think tank” conferences to refine treatment guidelines and to analyze the best way to diagnose.

He believes the best place to start is with the patient. “I ask people what is going on. What’s important? What are your goals? What are your hopes and what are your dreams? What makes you anxious? As I listen, I’m thinking, what causes your catecholamines to spill out, or your sympathetic nervous system to really clamp down and accentuate the symptoms of RSD?”

This is necessary, he explains, “for instance, if someone has a severe anxiety disorder that causes norepinephrine overflow or causes profound vasoconstriction, which causes some of the symptoms of RSD, you are going to fail if you go after them with a needle. You have to look, ask questions and bring in the expertise. Interdisciplinary pain management requires lots of personnel, lots of thought, and planning, but your hit rate is better. It’s the only thing that’s ever reliably been proven to work.”

So why is interdisciplinary pain management not the standard protocol? “All the money in pain management is in intervention. The inter-disciplinary pain programs

go out of business because they can’t support themselves. People go into the system and get blocks, then if that doesn’t work we give them a spinal cord stimulator or an implant, and if that doesn’t work, we just load people with opioids. This is wrong. This is not the best thing we can do,” he says.

Dr. Harden’s other peeve is that blocks, spinal cord stimulators, and injections have never been subjected to evidence-based medicine to prove their efficacy. “I’m not saying don’t do the blocks, but let’s evaluate them like we do for pharmaceuticals. I’d like to see three randomized controlled trials. Currently, you only have to prove to the FDA that a device doesn’t kill anybody.”

He explains that there’s never been a more desperate time for interdisciplinary care. “It’s been brewing for five years. The insurance companies look at us and say, ‘that sounds very expensive.’ Sure enough, our sickest patients could go into an interdisciplinary program for about \$20,000. Compare it to a spinal cord stimulator for \$40,000 or even an implantable pump for \$40,000, which has an additional cost of \$750 per month to refill it. Batteries need to be replaced, or the technology changes and a new one gets put in for another \$40,000. We’re talking about \$1,000 to \$1,500 per month to maintain pain control using these devices. When you look at it this way, interdisciplinary pain management doesn’t look very expensive.”

As RSDSA’s Scientific Advisory Committee Clinical Affairs co-chair, he would encourage physicians to use all the tools in their boxes, starting with the low-tech ones and moving up from there. He would also like to work to establish the many subsets of RSD/CRPS. “We did a very elementary version of this with CRPS Type I and II, but that’s not even scratching the surface. We need to be thinking in terms of different mechanistic subsets of the syndrome; then we can begin effectively to say, for this subset, these therapies are most likely to work. Then you can analyze therapies by evidence-based medicine. Now when we research “RSD” we are actually studying a heterogeneous collection of different diseases and mechanisms—and nothing works.

“We need to understand the mechanisms better, we need to better define terms for our diagnoses, and we need to get off the stick and start doing some open-minded research not guided by economic principles

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cover the purchase of a machine for home use; however, I am arranging for purchase of a STS machine and am about to get a unit on my own, as this particular therapy has helped me the most.

I am starting a RSD/CRPS support group and working on legislation for RSD Awareness and Prevention in Hawaii. As a licensed massage therapist who has worked in injury care for over 12 years, I can honestly say my own injury has been the toughest case I have ever had to treat. Having RSD/CRPS has been my worst nightmare, but my best education. My primary goal is to educate in the prevention and treatment of RSD/CRPS and to help others with this disease find answers to overcome the challenge of living with RSD/CRPS. To all those who live with RSD/CRPS, I offer a simple Hawaiian prayer:

Ho`omaka ana e ola hou (Let the healing begin)

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methods. People need to be responsible for their health. Wellness care is essential. And we always focus on abilities rather than disabilities.”

Currently the ACPA has more than 400 active support groups, both nationally and internationally. The ACPA is funded through donations, some grants and member dues. “It’s amazing how much we’ve grown considering the little money we have,” she says.

One of these amazing things is spearheading the Partners for Understanding Pain, a consortium of 45 groups (including RSDSA) which has come together to raise awareness of pain among the community at large. The partners will work to build understanding that pain is a serious public health issue. They will target health care professionals, legislators, business people, individuals with pain and their families. “Pain touches all aspects of society,” Cowan said.

For more information on the American Chronic Pain Society, visit www.theacpa.org or call 916-632-0922; toll-free 800-533-3231.

Mission Statement

Our mission is to promote public and professional awareness of Reflex Sympathetic Dystrophy Syndrome (RSD) and to educate those afflicted with the disease, their families, friends, insurance and healthcare providers, on the disabling pain the disease causes. We encourage individuals with RSD to offer each other emotional support within affiliate groups. And finally, we are committed to raising funds for research into the cause and cure of RSD.

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but guided more toward helping people get on with their lives and feel better. And become whole people again.

“My campaign always is and always will be this: we have a lot of tools available for any given patient and you have to keep applying the different tools. To start with something very dangerous, unproven and high-tech, like spinal cord stimulation is wrong.”

Posters Available

New 4-color posters entitled, “Anybody Can Get RSD. We did” feature photos of RSDSA members. If you would like some copies to distribute, please call the home office at (203) 877-3790 or send an e-mail to info@rsds.org

Our Future Depends on You

Please remember RSDSA in your estate planning. Our legal title is: Reflex Sympathetic Dystrophy Syndrome Association of America P.O. Box 502, Milford, CT 06460

Bounty of Hope 2003 Fundraising and Awards Dinner

Thursday, November 6, 2003
The Union League Club
New York, NY

Mark your calendars!

Shop On-Line and Help RSDSA

When you shop on-line at www.igive.com, you can designate RSDSA as your charity of choice and a percentage of each sale (up to 12.5%) will be donated. Retailers include CD Now, J. Crew, Avon, and many others.

Log on today for more information!