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- Park, K.M., Max, M.B., Robinovitz, E., Gracely, R.H. and Bennett, G.J., Effects of intravenous ketamine, alfentanil, or placebo on pain, pinprick hyperalgesia, and allodynia produced by intradermal capsaicin in human subjects, *Pain*, 63 (1995) 163–172.
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Response to Stanton-Hicks et al.

With great interest we read the landmark paper 'Reflex sympathetic dystrophy: changing concepts and taxonomy' (Stanton-Hicks et al., 1995).

It is refreshing that finally the defective terminology RSD as well as its defective definition, has been re-evaluated. In our experience, the blockbusting around the sole role of the ortho-sympathic system has prohibited the development and propagation of new thoughts in this field. Papers from our department indicating an excessive inappropriate inflammatory response in generating this ailment, have been rejected up to three times by leading journals, because the diagnosis was not confirmed by sympathetic blocks. On the other hand, we started these studies because our pain-team refused to administer sympathetic blocks because of the poor results in the acute stage (Driessen et al., 1983).

We fully agree with most of the propositions formulated in the new concept. We, however, would suggest not to include pain as 'the sine qua non for diagnosis' and not to require 'an initiating noxious event'.

In a consecutive series of 829 patients (Veldman et al., 1993), showing the complex symptomatology of RSD or CRPS, 7% of the patients did not complain of (severe) pain, including pain as a prerequisite for CRPS might indicate an observer bias, as the authors of the above article all are actively involved in pain clinics. We therefore would suggest the terminology CRDS, complex regional dysfunction syndrome. The presenting (early) symptoms of CRDS as seen in a large trauma policlinic differ in this respect from the symptoms of a selected sub-population seen in a pain clinic.

Furthermore, in our study CRDS did not occur after a previous noxious event in 10% of the patients. In these 'spontaneous' CRDS patients, symptomatology could not be differentiated from the post-noxious event CRDS patient.

Only opening up our mind will help solve the tremendous problems, caused by RSD, CRPS or CRDS, whatever the name.

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Primum non nocere – a paradoxical ally in defense of placebos in analgesic trials?

In the thirty five years since Bradford Hill (1963) posed the question, the ethics and use of placebos in clinical trials continue to be debated and divisive, in print (Turner et al., 1994; Rothman et al., 1994; Collier, 1995; Rothman, 1996), and at meetings (Public Policy Forum: 1997).

Protagonists and Regulatory Authorities claim that use of a placebo comparator is essential for robust scientific proof of efficacy, particularly when the assessment is entirely subjective as in the relief of pain, and that informed consent enables the patient to refuse enrollment in the study. For the case against placebo, antagonists insist that any new drug should be compared with the established drug for the condition in question and in support cite the Nuremberg Code, the Declaration of Helsinki and denial of effective or best available therapy. This latter point is important because no one would wish knowingly to provide inadequate therapy to patients. Yet even therapy that is accepted as effective or best available leaves some patients inadequately treated and surely it is our responsibility as physicians to have as few of these individuals as possible?