HYPERSENSITIVITY OF MEDIAL KNEE IN A COLLEGIATE FEMALE ATHLETE
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**Background:** A 20 y.o. female goalie entered her freshman year of college already experiencing hypersensitivity of the right knee. The athlete felt pain upon light touch above the Medial Collateral Ligament. Symptoms appeared during rigorous activity and daily tasks. She had previously been diagnosed but, never surgically treated, for a Medial Collateral Ligament sprain. She explained it as an acute injury occurring on February 24, 2004 during a valgus stress position drill. Her pain level ranged from 5/10 to 8/10. She had mild edema, no deformity, mild difference in skin temperature bilaterally, brittle toenails on the affected leg, modeled skin, full ROM, and full strength. **Differential Diagnosis:** Grade 1 Medial Collateral Ligament Sprain, Medial Meniscal Tear, Anserine Bursitis, and Reflex Sympathetic Dystrophy Syndrome.

**Treatment:** Valgus and Varus Stress Tests, Lachman’s, Anterior Drawer, and Apley’s Compression. No locking, catching or instability was found. Doctors were only able to diagnose the athlete based on signs and symptoms. Initial treatment included Lidoderm patches over a month’s time, providing minimal relief. Solarcaine Spray was also used with Capzasin Cream, attempting to reduce pain. TENS was applied each evening and Neurontin taken for pain over the course of a year. This caused the athlete drowsiness and to later develop an allergic reaction causing her to be nauseated, unable to concentrate, and tachycardic. Use was discontinued upon athlete’s request. A sympathetic block, was then attempted for 12-15 weeks. Pain returned within two days of use, revealing its ineffectiveness. The next choice of treatment was Omnipaque injections and Radiofrequency Sympathetic Ganglion Ablation. Neither gave complete pain relief leading to the final treatment decision. The athlete was treated invasively on May 17, 2005 through radiofrequency ablation surgery of the L2 and L3 sympathetic nerves. The athlete’s pain was greatly reduced but still present on occasion along with minimal modeling on the right foot. Medication taken after surgery was limited to 200 mg Ibuprofen due to previous allergic reactions, and Zoloft for her depression, which is debated to be a symptom of RSD patients. Rehabilitation exercises and modalities consisted of straight leg raises, PNF, D1 and D2 directional theraband exercises, and led into manual resistance, a series of squats, lunges, and side walks. The athlete also swam to regain cardio fitness. Four months post surgery the athlete returned to full play. **Uniqueness:** This syndrome is also known as Sudeck’s Atrophy, Post Traumatic Dystrophy, and Reflex Neurovascular Dystrophy. It is brought on typically by an acute traumatic blow to an area of the body. The nerves then become hypersensitive to all sensation. It is important to note that X-Ray, EMG, MRI and CAT scans are not effective in diagnosing RSD other then helping to rule out other possibilities. When determining the athletes’ problem, a thermogram could be used to decipher temperature differences in the skin caused by RSD. Other possible treatments would have been spinal cord stimulation, morphine Pump or three phase radionuclide bone scan although its reliability is controversial. RSD most commonly affects women in their mid thirties. Treatment plans for RSD patients should include education, with therapeutic and rehabilitation goals. **Conclusion:** The athlete has endured an immense amount of pain and tried various treatments. With the final treatment choice, she still experiences mild to moderate pain, but continues with full participation. She has no limitations other then her pain tolerance which varies day to day. **Keywords:** acute hypersensitivity, modeled skin, reflex sympathetic dystrophy syndrome, complex regional pain syndrome, radiofrequency ablation.