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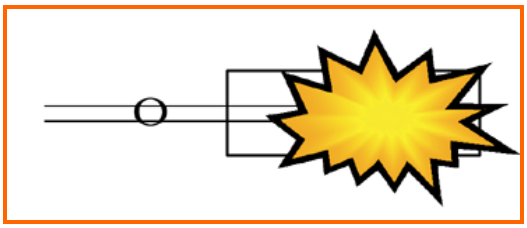

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Silas Weir MITCHELL
Guesteditor

# e-News for Somatosensory Rehabilitation

**The official e-Journal of the Somatosensory Rehabilitation Network**

# GUESTEDITORIAL
# The Case of George DEDLOW

To MD To neuroscientist To patient To therapist

## Silas Weir MITCHELL, MD[1]

The following notes of my own case have been declined on various pretests by every medical journal to which I have offered them. There was, perhaps, some reason in this, because many of the medical facts which they record are not altogether new, and because the psychical deductions to which they have led me are not in themselves of medical interest. I ought to add that a great deal of what is here related is not of any scientific value whatsoever; but as one or two people on whose judgment I rely have advised me to print my narrative with all the personal details, rather than in the dry shape in which, as a psychological statement, I shall publish it elsewhere, I have yielded to their views. I suspect, however, that the very character of my record will, in the eyes of some of my readers, tend to lessen the value of the metaphysical discoveries which it sets forth.

I am the son of a physician, still in large practice, in the village of Abington, Scofield County, Indiana. Expecting to act as his future partner, I studied medicine in his office, and in 1859 and 1860 attended lectures at the Jefferson Medical College in Philadelphia. My second course should have been in the following year, but the outbreak of the Rebellion so crippled my father's means that I was forced to abandon my intention. The demand for army surgeons at this time became very great; and although not a graduate, I found no difficulty in getting the place of assistant surgeon to the Tenth Indiana Volunteers. In the subsequent Western campaigns this organization suffered so severely that before the term of its service was over it was merged in the Twenty-first Indiana Volunteers; and I, as an extra surgeon, ranked by the medical officers of the latter regiment, was transferred to the Fifteenth Indiana Cavalry. Like many physicians, I had contracted a strong taste for army life, and, disliking cavalry service, sought and obtained the positionof first lieutenant in the Seventy-ninth Indiana Volunteers, an infantry regiment of excellent character.

On the day after I assumed command of my company, which had no captain, we were sent to garrison a part of a line of block- houses stretching along the Cumberland River below Nashville, then occupied by a portion of the command of General Rosecrans.

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[1] Mitchell, S.W. (1866). The Case of George Dedlow. *The Atlantic Monthly*. The text is available on http://www.gutenberg.org/catalog/world/readfile?fk_files=1443270&pageno=41. (accessed June 4, 2012).

The life we led while on this duty was tedious and at the same time dangerous in the extreme. Food was scarce and bad, the water horrible, and we had no cavalry to forage for us. If, as infantry, we attempted to levy supplies upon the scattered farms around us, the population seemed suddenly to double, and in the shape of guerrillas "potted" us industriously from behind distant trees, rocks, or fences. Under these various and unpleasant influences, combined with a fair infusion of malaria, our men rapidly lost health and spirits. Unfortunately, no proper medical supplies had been forwarded with our small force (two companies), and, as the fall advanced, the want of quinine and stimulants became a serious annoyance. Moreover, our rations were running low; we had been three weeks without a new supply; and our commanding officer, Major Henry L. Terrill, began to be uneasy as to the safety of his men. About this time it was supposed that a train with rations would be due from the post twenty miles to the north of us; yet it was quite possible that it would bring us food, but no medicines, which were what we most needed. The command was too small to detach any part of it, and the major therefore resolved to send an officer alone to the post above us, where the rest of the Seventy-ninth lay, and whence they could easily forward quinine and stimulants by the train, if it had not left, or, if it had, by a small cavalry escort.

It so happened, to my cost, as it turned out, that I was the only officer fit to make the journey, and I was accordingly ordered to proceed to Blockhouse No. 3 and make the required arrangements. I started alone just after dusk the next night, and during the darkness succeeded in getting within three miles of my destination. At this time I found that I had lost my way, and, although aware of the danger of my act, was forced to turn aside and ask at a log cabin for directions. The house contained a dried-up old woman and four white-headed, half-naked children. The woman was either stone-deaf or pretended to be so; but, at all events, she gave me no satisfaction, and I remounted and rode away. On coming to the end of a lane, into which I had turned to seek the cabin, I found to my surprise that the bars had been put up during my brief parley. They were too high to leap, and I therefore dismounted to pull them down. As I touched the top rail, I heard a rifle, and at the same instant felt a blow on both arms, which fell helpless. I staggered to my horse and tried to mount; but, as I could use neither arm, the effort was vain, and I therefore stood still, awaiting my fate. I am only conscious that I saw about me several graybacks, for I must have fallen fainting almost immediately.

When I awoke I was lying in the cabin near by, upon a pile of rubbish. Ten or twelve guerrillas were gathered about the fire, apparently drawing lots for my watch, boots, hat, etc. I now made an effort to find out how far I was hurt. I discovered that I could use the left forearm and hand pretty well, and with this hand I felt the right limb all over until I touched the wound. The ball had passed from left to right through the left biceps, and directly through the right arm just below the shoulder, emerging behind. The right arm and forearm were cold and perfectly insensible. I pinched them as well as I could, to test the amount of sensation remaining; but the hand might as well have been that of a dead man. I began to understand that the nerves had been wounded, and that the part was utterly powerless. By this time my friends had pretty well divided the spoils, and, rising together, went out. The old woman then came to me, and said: "Reckon you'd best git up. They-'uns is a-goin' to take you away." To

this I only answered, “Water, water.” I had a grim sense of amusement on finding that the old woman was not deaf, for she went out, and presently came back with a gourdful, which I eagerly drank. An hour later the graybacks returned, and finding that I was too weak to walk, carried me out and laid me on the bottom of a common cart, with which they set off on a trot. The jolting was horrible, but within an hour I began to have in my dead right hand a strange burning, which was rather a relief to me. It increased as the sun rose and the day grew warm, until I felt as if the hand was caught and pinched in a red-hot vise. Then in my agony I begged my guard for water to wet it with, but for some reason they desired silence, and at every noise threatened me with a revolver. At length the pain became absolutely unendurable, and I grew what it is the fashion to call demoralized. I screamed, cried, and yelled in my torture, until, as I suppose, my captors became alarmed, and, stopping, gave me a handkerchief,--my own, I fancy,--and a canteen of water, with which I wetted the hand, to my unspeakable relief.

It is unnecessary to detail the events by which, finally, I found myself in one of the rebel hospitals near Atlanta. Here, for the first time, my wounds were properly cleansed and dressed by a Dr. Oliver T. Wilson, who treated me throughout with great kindness. I told him I had been a doctor, which, perhaps, may have been in part the cause of the unusual tenderness with which I was managed. The left arm was now quite easy, although, as will be seen, it never entirely healed. The right arm was worse than ever - the humerus broken, the nerves wounded, and the hand alive only to pain. I use this phrase because it is connected in my mind with a visit from a local visitor,-I am not sure he was a preacher,- who used to go daily through the wards, and talk to us or write our letters. One morning he stopped at my bed, when this little talk occurred:

“How are you, lieutenant?”

“Oh,” said I, “as usual. All right, but this hand, which is dead except to pain.”

“Ah,” said he, “such and thus will the wicked be – such will you be if you die in your sins: you will go where only pain can be felt. For all eternity, all of you will be just like that hand - knowing pain only.”

I suppose I was very weak, but somehow I felt a sudden and chilling horror of possible universal pain, and suddenly fainted. When I awoke the hand was worse, if that could be. It was red, shining, aching, burning, and, as it seemed to me, perpetually rasped with hot files. When the doctor came I begged for morphia. He said gravely: “We have none. You know you don't allow it to pass the lines.” It was sadly true.

I turned to the wall, and wetted the hand again, my sole relief. In about an hour Dr. Wilson came back with two aids, and explained to me that the bone was so crushed as to make it hopeless to save it, and that, besides, amputation offered some chance of arresting the pain. I had thought of this before, but the anguish I felt--I cannot say endured--was so awful that I made no more of losing the limb than of parting with a tooth on account of toothache. Accordingly, brief preparations were made, which I watched with a sort of eagerness such as must forever be inexplicable to any one who has not passed six weeks of torture like that which I had suffered.

I had but one pang before the operation. As I arranged myself on the left side, so as to make it convenient for the operator to use the knife, I asked: “Who is to give me the ether?” “We have none,” said the person questioned. I set my teeth, and said no more.

I need not describe the operation. The pain felt was severe, but it was insignificant as compared with that of any other minute of the past six weeks. The limb was removed very near to the shoulder-joint. As the second incision was made, I felt a strange flash of pain play through the limb, as if it were in every minutest fibril of nerve. This was followed by instant, unspeakable relief, and before the flaps were brought together I was sound asleep. I dimly remember saying, as I pointed to the arm which lay on the floor: “There is the pain, and here am I. How queer!” Then I slept--slept the sleep of the just, or, better, of the painless. From this time forward I was free from neuralgia. At a subsequent period I saw a number of cases similar to mine in a hospital in Philadelphia.

It is no part of my plan to detail my weary months of monotonous prison life in the South. In the early part of April, 1863, I was exchanged, and after the usual thirty days' furlough returned to my regiment a captain.

On the 19th of September, 1863, occurred the battle of Chickamauga, in which my regiment took a conspicuous part. The close of our own share in this contest is, as it were, burned into my memory with every least detail. It was about 6 P. M., when we found ourselves in line, under cover of a long, thin row of scrubby trees, beyond which lay a gentle slope, from which, again, rose a hill rather more abrupt, and crowned with an earthwork. We received orders to cross this space and take the fort in front, while a brigade on our right was to make a like movement on its flank.

Just before we emerged into the open ground, we noticed what, I think, was common in many fights - that the enemy had begun to bowl round shot at us, probably from failure of shell. We passed across the valley in good order, although the men fell rapidly all along the line. As we climbed the hill, our pace slackened, and the fire grew heavier. At this moment a battery opened on our left, the shots crossing our heads obliquely. It is this moment which is so printed on my recollection. I can see now, as if through a window, the gray smoke, lit with red flashes, the long, wavering line, the sky blue above, the trodden furrows, blotted with blue blouses. Then it was as if the window closed, and I knew and saw no more. No other scene in my life is thus scarred, if I may say so, into my memory. I have a fancy that the horrible shock which suddenly fell upon me must have had something to do with thus intensifying the momentary image then before my eyes.

When I awakened, I was lying under a tree somewhere at the rear. The ground was covered with wounded, and the doctors were busy at an operating-table, improvised from two barrels and a plank. At length two of them who were examining the wounded about me came up to where I lay. A hospital steward raised my head and poured down some brandy and water,

while another cut loose my pantaloons. The doctors exchanged looks and walked away. I asked the steward where I was hit.
“Both thighs,” said he; “the doctors won't do nothing.”

“No use?” said I.

“Not much,” said he.

“Not much means none at all,” I answered.

When he had gone I set myself to thinking about a good many things I had better have thought of before, but which in no way concern the history of my case. A half-hour went by. I had no pain, and did not get weaker. At last, I cannot explain why, I began to look about me. At first things appeared a little hazy. I remember one thing which thrilled me a little, even then.

A tall, blond-bearded major walked up to a doctor near me, saying, “When you've a little leisure, just take a look at my side.”

“Do it now,” said the doctor.

The officer exposed his wound. “Ball went in here, and out there.”

The doctor looked up at him--half pity, half amazement. “If you've got any message, you'd best send it by me.”

“Why, you don't say it's serious?” was the reply.

“Serious! Why, you're shot through the stomach. You won't live over the day.”

Then the man did what struck me as a very odd thing. He said, “Anybody got a pipe?” Some one gave him a pipe. He filled it deliberately, struck a light with a flint, and sat down against a tree near to me. Presently the doctor came to him again, and asked him what he could do for him.

“Send me a drink of Bourbon.”

“Anything else?”

“No.”

As the doctor left him, he called him back. “It's a little rough, doc, isn't it?”

No more passed, and I saw this man no longer. Another set of doctors were handling my legs, for the first time causing pain. A moment after a steward put a towel over my mouth, and I smelled the familiar odor of chloroform, which I was glad enough to breathe. In a moment the trees began to move around from left to right, faster and faster; then a universal grayness came before me,--and I recall nothing further until I awoke to consciousness in a hospital-tent. I got hold of my own identity in a moment or two, and was suddenly aware of a sharp cramp in my left leg. I tried to get at it to rub it with my single arm, but, finding myself too weak, hailed an attendant. “Just rub my left calf,” said I, “if you please.”

“Calf?” said he.

“You ain't none. It's took off.”

"I know better," said I. "I have pain in both legs."

"Wall, I never!" said he. "You ain't got nary leg."

As I did not believe him, he threw off the covers, and, to my horror, showed me that I had suffered amputation of both thighs, very high up.

"That will do," said I, faintly.

A month later, to the amazement of every one, I was so well as to be moved from the crowded hospital at Chattanooga to Nashville, where I filled one of the ten thousand beds of that vast metropolis of hospitals. Of the sufferings which then began I shall presently speak. It will be best just now to detail the final misfortune which here fell upon me. Hospital No. 2, in which I lay, was inconveniently crowded with severely wounded officers. After my third week an epidemic of hospital gangrene broke out in my ward. In three days it attacked twenty persons. Then an inspector came, and we were transferred at once to the open air, and placed in tents. Strangely enough, the wound in my remaining arm, which still suppurated, was seized with gangrene. The usual remedy, bromine, was used locally, but the main artery opened, was tied, bled again and again, and at last, as a final resort, the remaining arm was amputated at the shoulder- joint. Against all chances I recovered, to find myself a useless torso, more like some strange larval creature than anything of human shape. Of my anguish and horror of myself I dare not speak. I have dictated these pages, not to shock my readers, but to possess them with facts in regard to the relation of the mind to the body; and I hasten, therefore, to such portions of my case as best illustrate these views.

In January, 1864, I was forwarded to Philadelphia, in order to enter what was known as the Stump Hospital, South street, then in charge of Dr. Hopkinson. This favor was obtained through the influence of my father's friend, the late Governor Anderson, who has always manifested an interest in my case, for which I am deeply grateful. It was thought, at the time, that Mr. Palmer, the leg-maker, might be able to adapt some form of arm to my left shoulder, as on that side there remained five inches of the arm-bone, which I could move to a moderate extent. The hope proved illusory, as the stump was always too tender to bear any pressure. The hospital referred to was in charge of several surgeons while I was an inmate, and was at all times a clean and pleasant home. It was filled with men who had lost one arm or leg, or one of each, as happened now and then. I saw one man who had lost both legs, and one who had parted with both arms; but none, like myself, stripped of every limb. There were collected in this place hundreds of these cases, which gave to it, with reason enough, the not very pleasing title of Stump Hospital.

I spent here three and a half months, before my transfer to the United States Army Hospital for Injuries and Diseases of the Nervous System. Every morning I was carried out in an arm-chair and placed in the library, where some one was always ready to write or read for me, or to fill my pipe. The doctors lent me medical books; the ladies brought me luxuries and fed me; and, save that I was helpless to a degree which was humiliating, I was as comfortable as kindness could make me.

I amused myself at this time by noting in my mind all that I could learn from other limbless folk, and from myself, as to the peculiar feelings which were noticed in regard to lost members. I found that the great mass of men who had undergone amputations for many months felt the usual consciousness that they still had the lost limb. It itched or pained, or was cramped, but never felt hot or cold. If they had painful sensations referred to it, the conviction of its existence continued unaltered for long periods; but where no pain was felt in it, then by degrees the sense of having that limb faded away entirely. I think we may to some extent explain this. The knowledge we possess of any part is made up of the numberless impressions from without which affect its sensitive surfaces, and which are transmitted through its nerves to the spinal nerve-cells, and through them, again, to the brain. We are thus kept endlessly informed as to the existence of parts, because the impressions which reach the brain are, by a law of our being, referred by us to the part from which they come. Now, when the part is cut off, the nerve-trunks which led to it and from it, remaining capable of being impressed by irritations, are made to convey to the brain from the stump impressions which are, as usual, referred by the brain to the lost parts to which these nerve-threads belonged. In other words, the nerve is like a bell-wire. You may pull it at any part of its course, and thus ring the bell as well as if you pulled at the end of the wire; but, in any case, the intelligent servant will refer the pull to the front door, and obey it accordingly. The impressions made on the severed ends of the nerve are due often to changes in the stump during healing, and consequently cease when it has healed, so that finally, in a very healthy stump, no such impressions arise; the brain ceases to Dow nloaded from correspond with the lost leg, and, as *les absents ont toujours tort*[2], it is no longer remembered or recognized. But in some cases, such as mine proved at last to my sorrow, the ends of the nerves undergo a curious alteration, and get to be enlarged and altered. This change, as I have seen in my practice of medicine, sometimes passes up the nerves toward the centers, and occasions a more or less constant irritation of the nerve- fibers, producing neuralgia, which is usually referred by the brain to that part of the lost limb to which the affected nerve belonged. This pain keeps the brain ever mindful of the missing part, and, imperfectly at least, preserves to the man a consciousness of possessing that which he has not.

Where the pains come and go, as they do in certain cases, the subjective sensations thus occasioned are very curious, since in such cases the man loses and gains, and loses and regains, the consciousness of the presence of the lost parts, so that he will tell you, “Now I feel my thumb, now I feel my little finger.” I should also add that nearly every person who has lost an arm above the elbow feels as though the lost member were bent at the elbow, and at times is vividly impressed with the notion that his fingers are strongly flexed.

Other persons present a peculiarity which I am at a loss to account for. Where the leg, for instance, has been lost, they feel as if the foot were present, but as though the leg were shortened. Thus, if the thigh has been taken off, there seems to them to be a foot at the knee; if the arm, a hand seems to be at the elbow, or attached to the stump itself.

[2] Note from the Editor : in French in the text.

Before leaving Nashville I had begun to suffer the most acute pain in my left hand, especially the little finger; and so perfect was the idea which was thus kept up of the real presence of these missing parts that I found it hard at times to believe them absent. Often at night I would try with one lost hand to grope for the other. As, however, I had no pain in the right arm, the sense of the existence of that limb gradually disappeared, as did that of my legs also.

Everything was done for my neuralgia which the doctors could think of; and at length, at my suggestion, I was removed, as I have said, from the Stump Hospital to the United States Army Hospital forInjuries and Diseases of the Nervous System. It was a pleasant, suburban, old-fashioned country- seat, its gardens surrounded by a circle of wooden, one-story wards, shaded by fine trees. There were some three hundred cases of epilepsy, paralysis, St. Vitus's dance, and wounds of nerves. On one side of me lay a poor fellow, a Dane, who had the same burning neuralgia with which I once suffered, and which I now learned was only too common. This man had become hysterical from pain. He carried a sponge in his pocket, and a bottle of water in one hand, with which he constantly wetted the burning hand. Every sound increased his torture, and he even poured water into his boots to keep himself from feeling too sensibly the rough friction of his soles when walking. Like him, I was greatly eased by having small doses of morphia injected under the skin of my shoulder with a hollow needle fitted to a syringe.

As I improved under the morphia treatment, I began to be disturbed by the horrible variety of suffering about me. One man walked sideways; there was one who could not smell; another was dumb from an explosion. In fact, every one had his own abnormal peculiarity. Near me was a strange case of palsy of the muscles called rhomboids, whose office it is to hold down the shoulder-blades flat on the back during the motions of the arms, which, in themselves, were strong enough. When, however, he lifted these members, the shoulder-blades stood out from the back like wings, and got him the sobriquet of the “Angel.” In my ward were also the cases of fits, which very much annoyed me, as upon any great change in the weather it was common to have a dozen convulsions in view at once. Dr. Neek, one of our physicians, told me that on one occasion a hundred and fifty fits took place within thirty-six hours. On my complaining of these sights, whence I alone could not fly, I was placed in the paralytic and wound ward, which I found much more pleasant.

A month of skilful treatment eased me entirely of my aches, and I then began to experience certain curious feelings, upon which, having nothing to do and nothing to do anything with, I reflected a good deal. It was a good while before I could correctly explain to my own satisfaction the phenomena which at this time I was calle d upon to observe. By the various operations already described I had lost about four fifths of my weight. As a consequence of this I ate much less than usual, and could scarcely have consumed the ration of a soldier. I slept also but little; for, as sleep is the repose of the brain, made necessary by the waste of its tissues during thought and voluntary movement, and as this latter did not exist in my case, I needed only that rest which was necessary to repair such exhaustion of the nerve- centers as was induced by thinking and the automatic movements of the viscera.

I observed at this time also that my heart, in place of beating, as it once did, seventy- eight in the minute, pulsated only forty-five times in this interval--a fact to be easily explained by the perfect quiescence to which I was reduced, and the consequent absence of that healthy and constant stimulus to the muscles of the heart which exercise occasions.

Notwithstanding these drawbacks, my physical health was good, which, I confess, surprised me, for this among other reasons: It is said that a burn of two thirds of the surface destroys life, because then all the excretory matters which this portion of the glands of the skin evolved are thrown upon the blood, and poison the man, just as happens in an animal whose skin the physiologist has varnished, so as in this way to destroy its function. Yet here was I, having lost at least a third of my skin, and apparently none the worse for it.

Still more remarkable, however, were the psychical changes which I now began to perceive. I found to my horror that at times I was less conscious of myself, of my own existence, than used to be the case. This sensation was so novel that at first it quite bewildered me. I felt like asking some one constantly if I were really George Dedlow or not; but, well aware how absurd I should seem after such a question, I refrained from speaking of my case, and strove more keenly to analyze my feelings. At times the conviction of my want of being myself was overwhelming and most painful. It was, as well as I can describe it, a deficiency in the egoistic sentiment of individuality. About one half of the sensitive surface of my skin was gone, and thus much of relation to the outer world destroyed. As a consequence, a large part of the receptive central organs must be out of employ, and, like other idle things, degenerating rapidly. Moreover, all the great central ganglia, which give rise to movements in the limbs, were also eternally at rest. Thus one half of me was absent or functionally dead. This set me to thinking how much a man might lose and yet live. If I were unhappy enough to survive, I might part with my spleen at least, as many a dog has done, and grown fat afterwards. The other organs with which we breathe and circulate the blood would be essential; so also would the liver; but at least half of the intestines might be dispensed with, and of course all of the limbs. And as to the nervous system, the only parts really necessary to life are a few small ganglia. Were the rest absent or inactive, we should have a man reduced, as it were, to the lowest terms, and leading an almost vegetative existence.

Would such a being, I asked myself, possess the sense of individuality in its usual completeness, even if his organs of sensation remained, and he were capable of consciousness? Of course, without them, he could not have it any more than a dahlia or a tulip. But with them--how then? I concluded that it would be at a minimum, and that, if utter loss of relation to the outer world were capable of destroying a man's consciousness of himself, the destruction of half of his sensitive surfaces might well occasion, in a less degree, a like result, and so diminish his sense of individual existence. I thus reached the conclusion that a man is not his brain, or any one part of it, but all of his economy and that to lose any part must lessen this sense of his own existence. I found but one person who properly appreciated this great truth. She was a New England lady, from Hartford--an agent, I think, for some commission, perhaps the Sanitary. After I had told her my views and feelings she said: “Yes, I comprehend. The fractional entities of vitality are embraced in the oneness of the

unitary Ego. Life," she added, "is the garnered condensation of objective impressions; and as the objective is the remote father of the subjective, so must individuality, which is but focused subjectivity, suffer and fade when the sensation lenses, by which the rays of impression are condensed, become destroyed." I am not quite clear that I fully understood her, but I think she appreciated my ideas, and I felt grateful for her kindly interest.

The strange want I have spoken of now haunted and perplexed me so constantly that I became moody and wretched. While in this state, a man from a neighboring ward fell one morning into conversation with the chaplain, within ear-shot of my chair. Some of their words arrested my attention, and I turned my head to see and listen. The speaker, who wore a sergeant's chevron and carried one arm in a sling was a tall, loosely made person, with a pale face, light eyes of a washed-out blue tint, and very sparse yellow whiskers. His mouth was weak, both lips being almost alike, so that the organ might have been turned upside down without affecting its expression. His forehead, however, was high and thinly covered with sandy hair. I should have said, as a phrenologist, will feeble; emotional, but not passionate; likely to be an enthusiast or a weakly bigot.

I caught enough of what passed to make me call to the sergeant when the chaplain left him.

"Good morning," said he. "How do you get on?"

"Not at all," I replied. "Where were you hit?"

"Oh, at Chancellorsville. I was shot in the shoulder. I have what the doctors call paralysis of the median nerve, but I guess Dr. Neek and the lightnin' battery will fix it. When my time's out I'll go back to Kearsarge and try on the school-teaching again. I've done my share."

"Well," said I, "you're better off than I."

"Yes," he answered, "in more ways than one. I belong to the New Church. It's a great comfort for a plain man like me, when he's weary and sick, to be able to turn away from earthly things and hold converse daily with the great and good who have left this here world. We have a circle in Coates street. If it wa'n't for the consoling I get there, I'd of wished myself dead many a time. I ain't got kith or kin on earth; but this matters little, when one can just talk to them daily and know that they are in the spheres above us."

"It must be a great comfort," I replied, "if only one could believe it.

"Believe!" he repeated. "How can you help it? Do you suppose anything dies?"

"No," I said. "The soul does not, I am sure; and as to matter, it merely changes form."

"But why, then," said he, "should not the dead soul talk to the living? In space, no doubt, exist all forms of matter, merely in finer, more ethereal being. You can't suppose a naked soul moving about without a bodily garment--no creed teaches that; and if its new clothing be of like substance to ours, only of ethereal fineness,--a more delicate recrystallization about the

eternal spiritual nucleus,--must it not then possess powers as much more delicate and refined as is the new material in which it is reclad?"

"Not very clear," I answered; "but, after all, the thing should be susceptible of some form of proof to our present senses."

"And so it is," said he. "Come to-morrow with me, and you shall see and hear for yourself."

"I will," said I, "if the doctor will lend me the ambulance."

It was so arranged, as the surgeon in charge was kind enough, as usual, to oblige me with the loan of his wagon, and two orderlies to lift my useless trunk.

On the day following I found myself, with my new comrade, in a house in Coates street, where a "circle" was in the daily habit of meeting. So soon as I had been comfortably deposited in an arm-chair, beside a large pine table, the rest of those assembled seated themselves, and for some time preserved an unbroken silence. During this pause I scrutinized the persons present. Next to me, on my right, sat a flabby man, with ill-marked, baggy features and injected eyes. He was, as I learned afterwards, an eclectic doctor, who had tried his hand at medicine and several of its quackish variations, finally settling down on eclecticism, which I believe professes to be to scientific medicine what vegetarianism is to commonsense, every-day dietetics. Next to him sat a female -authoress, I think, of two somewhat feeble novels, and much pleasanter to look at than her books. She was, I thought, a good deal excited at the prospect of spiritual revelations. Her neighbor was a pallid, care-worn young woman, with very red lips, and large brown eyes of great beauty. She was, as I learned afterwards, a magnetic patient of the doctor, and had deserted her husband, a master mechanic, to follow this new light. The others were, like myself, strangers brought hither by mere curiosity. One of them was a lady in deep black, closely veiled. Beyond her, and opposite to me, sat the sergeant, and next to him the medium, a man named Brink. He wore a good deal of jewelry, and had large black side-whiskers--a shrewd-visaged, largenosed, full-lipped man, formed by nature to appreciate the pleasant things of sensual existence.

Before I had ended my survey, he turned to the lady in black, and asked if she wished to see any one in the spirit-world.

She said, "Yes," rather feebly.

"Is the spirit present?" he asked. Upon which two knocks were heard in affirmation. "Ah!" said the medium, "the name is--it is the name of a child. It is a male child. It is--"

"Alfred!" she cried. "Great Heaven! My child! My boy!"

On this the medium arose, and became strangely convulsed. "I see," he said--"I see--a fair-haired boy. I see blue eyes--I see above you, beyond you--" at the same time pointing fixedly over her head.

She turned with a wild start. "Where-- whereabouts?"

“A blue-eyed boy,” he continued, “over your head. He cries--he says, `Mama, mama!' “

The effect of this on the woman was unpleasant. She stared about her for a moment, and exclaiming, “I come--I am coming, Alfy!” fell in hysterics on the floor.

Two or three persons raised her, and aided her into an adjoining room; but the rest remained at the table, as though well accustomed to like scenes.

After this several of the strangers were called upon to write the names of the dead with whom they wished to communicate. The names were spelled out by the agency of affirmative knocks when the correct letters were touched by the applicant, who was furnished with an alphabet-card upon which he tapped the letters in turn, the medium, meanwhile, scanning his face very keenly. With some, the names were readily made out. With one, a stolid personage of disbelieving type, every attempt failed, until at last the spirits signified by knocks that he was a disturbing agency, and that while he remained all our efforts would fail. Upon this some of the company proposed that he should leave; of which invitation he took advantage, with a skeptical sneer at the whole performance.

As he left us, the sergeant leaned over and whispered to the medium, who next addressed himself to me. “Sister Euphemia,” he said, indicating the lady with large eyes, “will act as your medium. I am unable to do more. These things exhaust my nervous system.”

“Sister Euphemia,” said the doctor, “will aid us. Think, if you please, sir, of a spirit, and she will endeavor to summon it to our circle.”

Upon this a wild idea came into my head. I answered: “I am thinking as you directed me to do.”

The medium sat with her arms folded, looking steadily at the center of the table. For a few moments there was silence. Then a series of irregular knocks began. “Are you present?” said the medium.

The affirmative raps were twice given.

“I should think,” said the doctor, “that there were two spirits present.”

His words sent a thrill through my heart.

“Are there two?” he questioned.

A double rap.

“Yes, two,” said the medium. “Will it please the spirits to make us conscious of their names in this world?”

A single knock. “No.”

“Will it please them to say how they are called in the world of spirits?”

Again came the irregular raps--3, 4, 8, 6; then a pause, and 3, 4, 8, 7.

"I think," said the authoress, "they must be numbers. Will the spirits," she said, "be good enough to aid us? Shall we use the alphabet?"

"Yes," was rapped very quickly.

"Are these numbers?"

"Yes," again.

"I will write them," she added, and, doing so, took up the card and tapped the letters. The spelling was pretty rapid, and ran thus as she tapped, in turn, first the letters, and last the numbers she had already set down:

"UNITED STATES ARMY MEDICAL MUSEUM, Nos. 3486, 3487."

The medium looked up with a puzzled expression.

"Good gracious!" said I, "they are MY LEGS –MY LEGS!"

What followed, I ask no one to believe except those who, like myself, have communed with the things of another sphere. Suddenly I felt a strange return of my self- consciousness. I was reindividualized, so to speak. A strange wonder filled me, and, to the amazement of every one, I arose, and, staggering a little, walked across the room on limbs invisible to them or me. It was no wonder I staggered, for, as I briefly reflected, my legs had been nine months in the strongest alcohol. At this instant all my new friends crowded around me in astonishment. Presently, however, I felt myself sinking slowly. My legs were going, and in a moment I was resting feebly on my two stumps upon the floor. It was too much. All that was left of me fainted and rolled over senseless. I have little to add. I am now at home in the West, surrounded by every form of kindness and every possible comfort; but alas! I have so little surety of being myself that I doubt my own honesty in drawing my pension, and feel absolved from gratitude to those who are kind to a being who is uncertain of being enough himself to be conscientiously responsible. It is needless to add that I am not a happy fraction of a man, and that I am eager for the day when I shall rejoin the lost members of my corporeal family in another and a happier world.

# ARTICLE ORIGINAL
# Douleurs neuropathiques ou douleurs Aβ ?

Aux médecins
Aux patients
Aux scientifiques en neurosciences
Aux thérapeutes

C. J. SPICHER[3] & J.-M. ANNONI[4]

Les douleurs neuropathiques, traditionnellement associées aux fibres C, sont comme le suggérait déjà Valleix, en 1841, et Tinel, en 1916 véhiculées, entre autres, par les fibres myélinisées de gros diamètres, les fibres Aβ (Tableau I) ; ainsi Marshall Devor propose, dans *Exp Brain Res* 2009, le concept de douleurs Aβ. La théorie du « portillon », par ailleurs indiscutable, a créé une confusion : les fibres Aβ vont être dorénavant considérées exclusivement comme des fibres inhibitrices de la douleur et vont perdre leur ancienne connotation d'étiologie de la douleur. Le terme de fibre de la douleur utilisé fréquemment dans la stimulation neuroélectrique transcutanée (TENS), porte à confusion (Houghton *et al*., 2010): les fibres C sont des fibres qui transmettent le stimulus douloureux mais ne sont pas les seules fibres qui génèrent la douleur.

| Terminaisons | Fibres | Types | Couches | Systèmes | Cortex |
|---|---|---|---|---|---|
| Mécanorécepteurs | Gros diamètre | Aβ | IIb, III, IV, V | Lemniscal | S1 aires 3a, 3b, 1, 2 |
| Libres | Petit diamètre | C | I, IIa | Spino-thalamique | |

**Tableau I :** *Le système somesthésique cutané et ses deux systèmes afférents qui peuvent générer des douleurs neuropathiques. Ils sont organisés très distinctement en couches au niveau de la corne postérieure. La décussation du système lemniscal se situe au niveau du bulbe (lemnisque médian) ; la décussation du système spino-thalamique se situe au niveau segmentaire correspondant.*

Le système somesthésique est aujourd'hui au cœur de la nouvelle définition des douleurs neuropathiques: Douleurs apparaissant comme une conséquence directe d'une lésion ou d'une pathologie affectant le système somesthésique. Nous pouvons considérer l'altération du système somesthésique - et non seulement des fibres C - comme une des étiologies des

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douleurs neuropathiques. La zone douloureuse doit faire l'objet d'une évaluation rigoureuse. La première conséquence est de rechercher la première expression de lésions axonales Aβ : l'hypoesthésie partielle en périphérie de la lésion. Ce qui permet de formuler le paradigme de la méthode de rééducation sensitive de la douleur (Spicher, 2003), à savoir (Mathis *et al*., 2007): « Rechercher l'hypoesthésie, car diminuer l'hypoesthésie diminue les douleurs neuropathiques ».

Les douleurs neuropathiques (Hansson, 2003) sont définies par des douleurs spontanées *spontaneous ongoing pain* et/ou des douleurs au toucher *touch-evoked pain* (Tableau II).

| Types de douleurs | Status de la peau | Symptômes | Signes d'examen clinique | Diagnostics |
|---|---|---|---|---|
| **Spontanées** | **Hypoesthésie** | **Engourdissement** | **Esthésiographie** | **Névralgie** |
| **Au toucher** | **Hypoesthésie paradoxalement douloureuse au toucher** | **Hypersensibilité** | **Allodynographie** | **Allodynie mécanique statique** |

**Tableau II :** *Le concept de douleurs Aβ permet la recherche de deux sous-groupes de douleurs neuropathiques, et la recherche de deux signes d'examen clinique : l'esthésiographie qui circonscrit l'hypoesthésie et l'allodynographie qui circonscrit l'hypoesthésie paradoxalement douloureuse au toucher.*

La méthode de rééducation sensitive évalue très précisément la sensibilité vibrotactile cutanée altérée en surface et en qualité. Depuis 1869, Jean-Joseph-Emile Létiévant, chirurgien major de l'Hôtel-Dieu de Lyon (France), cartographie la surface de l'hypoesthésie partielle (Spicher *et al*., 2010) avec une esthésiographie. Auprès d'une majorité de patients douloureux neuropathiques, nous testons les capacités des mécano-récepteurs reliés aux fibres Aβ myélinisées, et pouvons ainsi mettre en place un traitement physique, en utilisant cette partie de peau hypoesthésique, reliée au fil de la douleur.

A noter que l'hypoesthésie peut être masquée par une hypersensibilité au toucher : une allodynie mécanique. Une fois l'allodynie mécanique de la peau traitée à distance et disparue, Spicher *et al*. (2008a) ont observé et fondé par la preuve, dans *Somato & Mot Res*, que la peau apparaît toujours hypoesthésique et donc jamais avec une sensibilité vibrotactile normale. Ainsi l'allodynographie signe toujours une hypoesthésie (Spicher *et al*., 2008b). C'est le paradoxe allodynique (Sukhotinsky *et al*., 2004).

En conclusion, les fibres Aβ, dont les lésions partielles génèrent des douleurs neuropathiques et physiologiquement, une hypoesthésie partielle, doivent être actuellement tenues pour co-responsables de la perception douloureuse.

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## Aphorisme saisonnier

Aux médecins
Aux patients
Aux scientifiques en neurosciences
Aux thérapeutes

**"C'est la nuit, qu'il est beau de croire à la lumière"**

Edmond Rostand (1908 – [1999]) – *Chantecler*. Paris: L'Harmattan.

## Seasonal aphorism

To MD
To patient
To neuroscientist
To therapist

**"When it is night, he who believes in the light is beautiful"**

## Temporada de aforismos

Para Médicos
Para pacientes
Para científicos en neurociencias
Para terapeutas

**"Es de noche, créer en la luz es bueno"**

## Aforismo sazonal

Para médicos
Para pacientes
Para cientistas em neurociências
Para terapeutas

**"É à noite que é belo acreditar na luz"**

## Leitmotiv

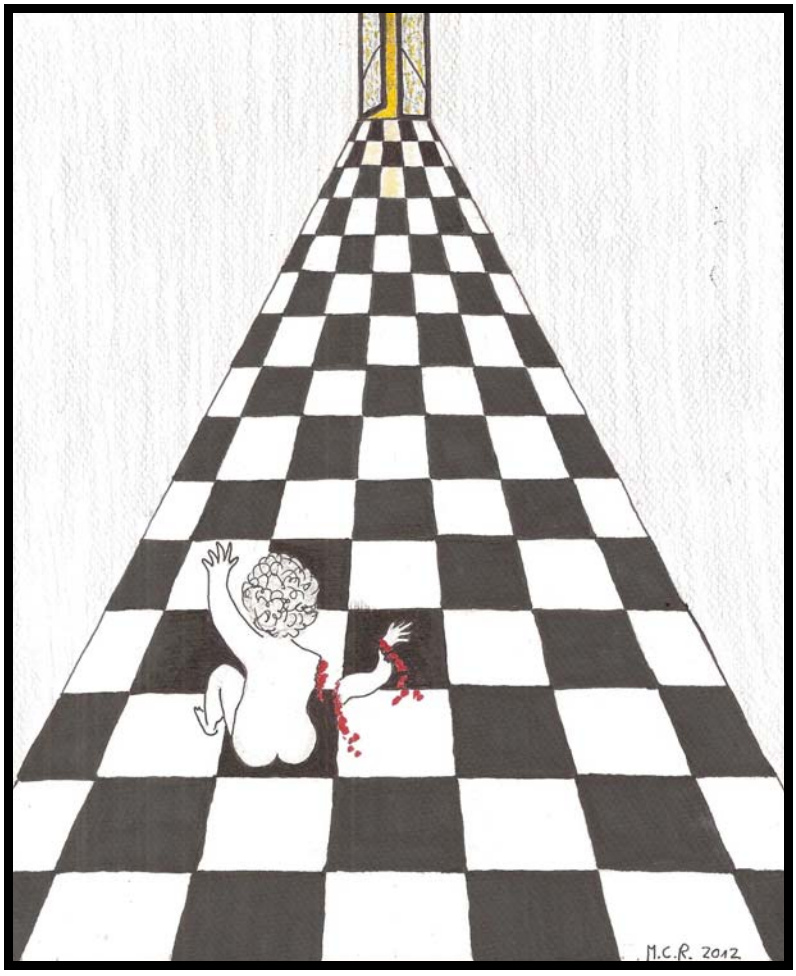
Für Ärzte
Für Neurowissenschaftler
Für Neurowissenschaftler
Für TherapeutInnen

**« Es ist in der Nacht, wo es schön ist ans Licht zu glauben"**

# Témoignage illustré N° 38 d'une patiente
## *«Une histoire»*

Aux médecins
Aux patients
Aux scientifiques en neurosciences
Aux thérapeutes

*« Peut-être n'est-ce que la plus extrême finesse, la plus extrême douceur du toucher extérieur qui peuvent nous relier au plus fin, au plus subtil de l'intérieur ».*




## Dessin N° 1 : fin février 2012

C'est la première fois que j'accepte de donner forme au ressenti traumatique, du plus lointain souvenir lié à la douleur. Cela me fait horriblement peur, mais j'en ressens aussi le besoin impérieux. La douleur, le traumatisme a réveillé les douleurs et les traumatismes figés, restés en suspend et qui résonnent en écho. Je devais avoir environ 3 ans, tout allait bien, je me balançais une main dans chacune des mains de mes parents, ils me soulevaient de terre, et j'avançais d'un élan, d'un bond. Et tout à coup trop d'élan peut-être, mon corps emporté par

la gravité, a fait un tour complet sur lui-même, mes bras eux sont restés dans leurs mains déboîtant mes épaules. J'ai eu mal, si mal, je n'avais jamais eu aussi mal de ma vie.

J'ai hurlé de douleur, de peur, de surprise. Black-out après. Souvenirs d'un couloir au bout duquel je vois disparaître ma mère. La peur, la douleur physique, le choc émotionnel, le ressenti, le sentiment d'abandon, se sont liés, fondus, bloqués, ensemble.

Il m'en reste cette peur immense, comme une vague immense, prête à m'engloutir.

Panique, depuis toujours, d'avoir mal de nouveau, de tout re-sentir, de nouveau, de ne rien pouvoir faire, de subir, me sentir sans défense et si impuissante. Sentiment de trahison, de solitude face à la douleur ; je suis inconsolable, rien, ni personne ne peut me consoler, me préserver du mal, c'est cette première prise de conscience là qui émerge de cette expérience. Elle s'est inscrite en moi, au plus profond, dans les os et dans la chair.

Sans doute n'y a-t-il pas d'autre issue que de retraverser l'épreuve, avec mes yeux et ma conscience d'adulte cette fois ?


## Dessin N° 2 : 1er mars 2012

Je pleure sur ma petite sœur, qui est partie au ciel lorsque j'étais enfant et sur la perte de laquelle ma mère n'a pas cessé de pleurer. Elle, je, nous pleurons chacune sur l'aile brisée, sur tout ce qui est perdu à jamais. Mais peut-être n'est-ce pas l'autre aile qui me manque, peut-être est-ce celle qui me reste qui m'encombre, qui m'a toujours encombré, elle me retient

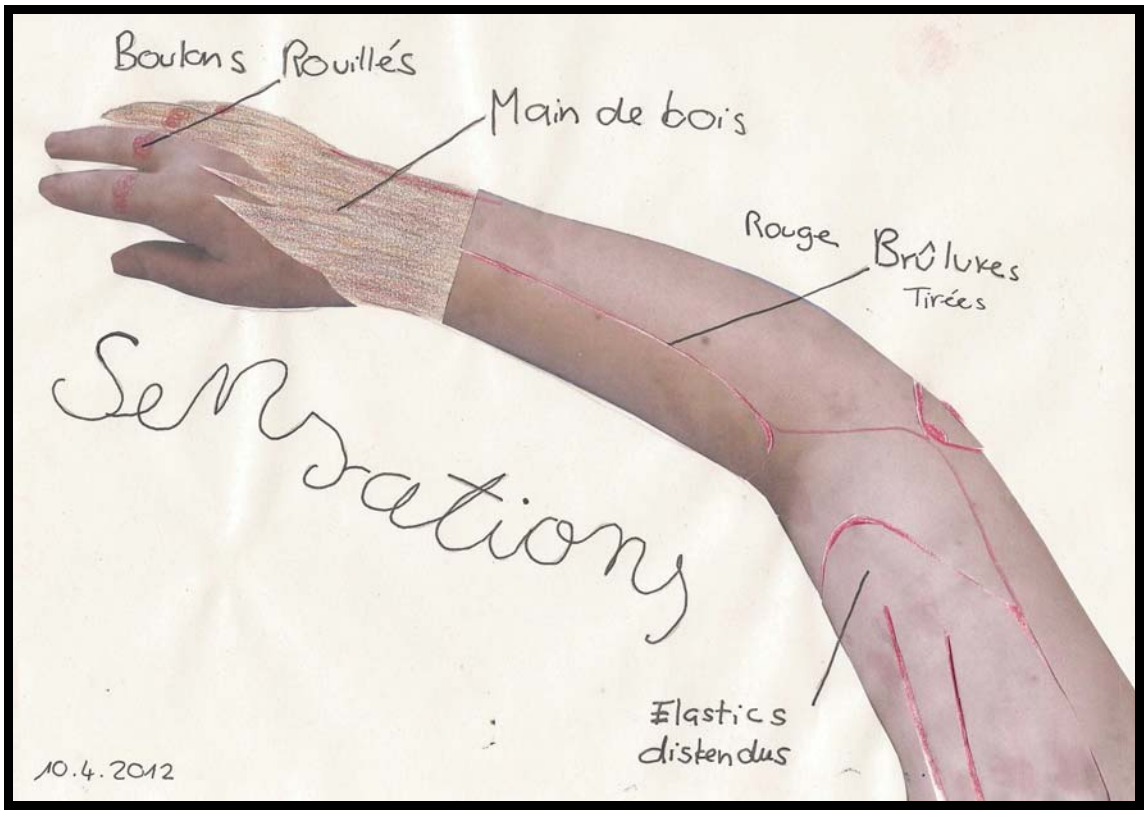
prisonnière, me fait tourner en rond, pour me libérer, peut-être faut-il la laisser se détacher sans regrets, pour devenir pleinement ce que je suis, un être humain incarné.

L'ange que j'aurais voulu être n'a jamais existé que dans mon imagination.


## Dessin N° 3 : 1er mars 2012

Ce qui m'a coupée en deux, qui m'a arraché une aile, c'était pendant l'enfance la participation involontaire à la guerre que mes parents se livraient.

La blessure, la déchirure de la guerre, du divorce d'alors, résonne aujourd'hui dans celui brutal et inattendu de mon fils unique. Fracture, guerre extérieure, guerre intérieure, ressentis paradoxes, confrontation à mon impuissance à « sauver » ceux que j'aime, à les préserver du chagrin et des épreuves de la vie.




## Dessin N° 4 : 10 avril 2012

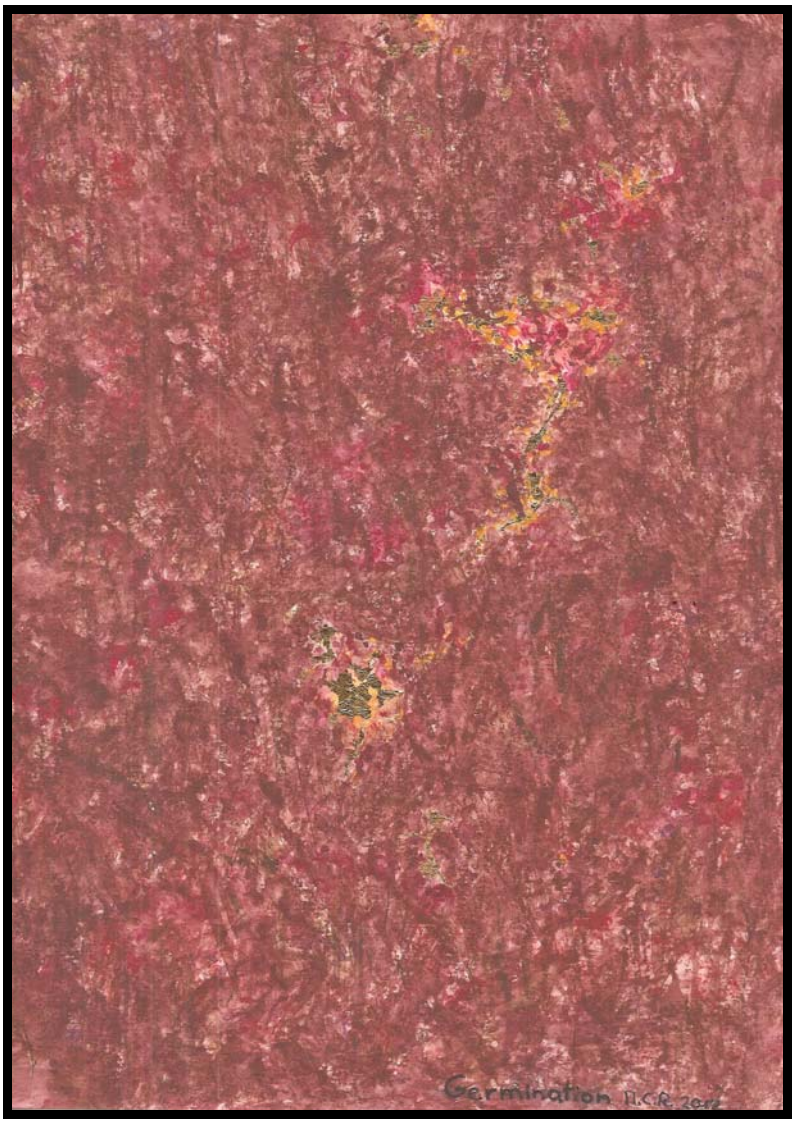
L'ergothérapeute, Monsieur Spicher, m'a demandé si je faisais du dessin, ou une peinture, et si je serais d'accord d'en faire un : « Que voit-il que je ne vois pas » ? Une porte, une issue possible ? J'accepte l'invitation de me dévoiler, de mettre en forme le ressenti d'aujourd'hui.

C'est le nouveau point de départ, ici et maintenant.

C'est mon bras qui s'est imposé, c'est lui qui m'obsède, c'est lui qui parle. Je ne le reconnais pas, il est comme morcelé comme ma vie, au propre et au figuré en sensations paradoxales.

Peut-être me montre-t-il aussi le chemin à suivre, séparer tous les éléments, défusionner, il faut aller au fond des choses, même si c'est très désagréable. Peut-être que les choses occultées parce que trop pénibles ou source de trop d'angoisse vont-elles petit à petit prendre leur vraie dimension et place, tout comme mes os, mes muscles, tendons et nerfs.

C'est peut-être l'invitation, l'occasion de me réapproprier mon bras ainsi que ma vie.

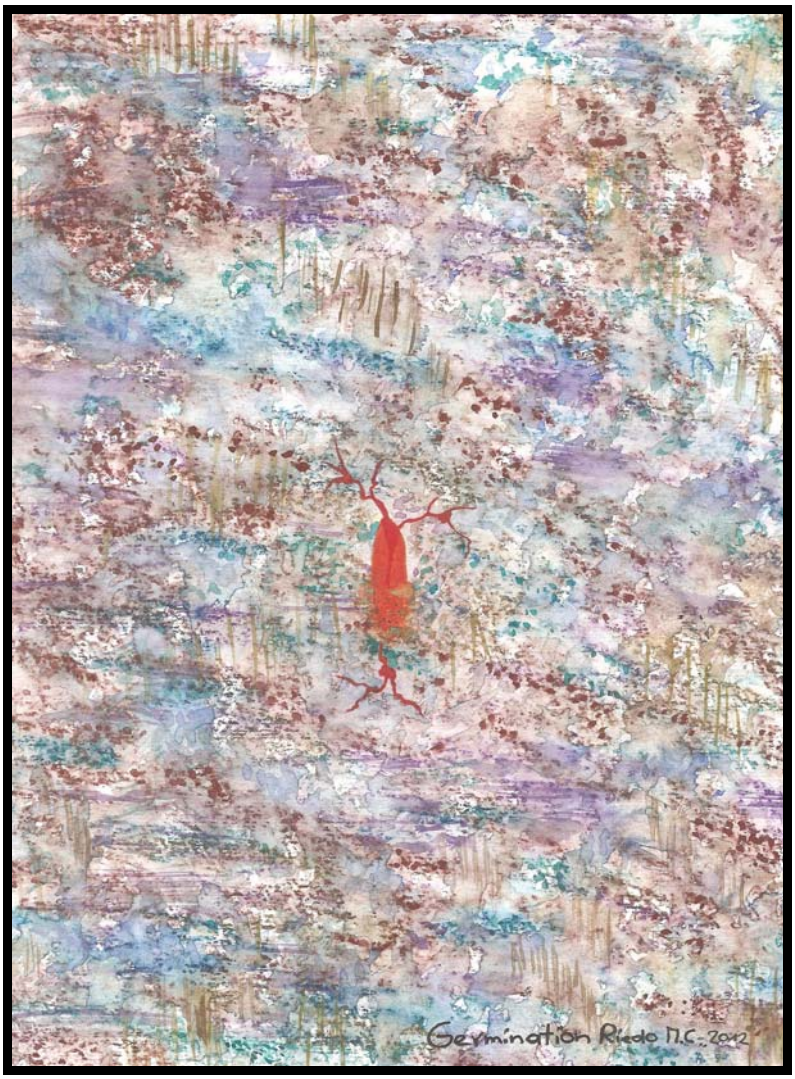



## Dessin N° 5 mi-avril 2012

Germination, ce mot me plaît, il me parle. Dans un des articles du journal sur la rééducation sensitive ils parlent de repousse des nerfs. Je me l'imagine, moi, comme une graine endormie qui avertie par quelque mystérieux signal se met à germer.

Le signal ce sont peut-être les vibrations répètées, en douceur, qui résonnent dans l'espace subtil, à la frontière du visible et de l'invisible, là où le matériel et l'immatériel se rencontrent, communiquent et créent une nouvelle réalité….

Peut-être n'est-ce que la plus extrême finesse, la plus extrême douceur du toucher extérieur qui peuvent nous relier au plus fin, au plus subtil de l'intérieur.




## Dessin N° 6 mi-avril 2012

Germination. Quelque chose se passe…. au cœur de la chair ... Ce n'est plus seulement une idée qui me plait, je la ressens dans mon corps, dans mon esprit, quelque chose s'est dénoué, s'est mis en mouvement... connecté, incarné (devenu réel dans la chair).

Nous sommes tous (moi, les thérapeutes, le médecin) un peu surpris de la rapidité de l'amélioration. Que s'est-il passé pour que ça se dénoue si vite ? Sans doute le trouble était-il assez léger, récent. Peut-être le travail intérieur a-t-il contribué à préparer le terrain, comme le labourage de la terre prépare les semailles….je ne sais pas, je peux juste constater et rendre grace….dire MERCI.

O.M.C

**[Vous pourez lire dans *l'e-News 10*(1), Un Fait clinique sur cette patiente qui souffrait d'un syndrome douloureux régional complexe (*CRPS*) de la branche dorsale du nerf ulnaire depuis 3 mois]**

**Mémoire d'ergothérapie**
**Juin 2012**

Aux médecins
Aux patients
Aux scientifiques en neurosciences
Aux thérapeutes

# La rééducation sensitive de la douleur : Spécificités, apports et limites.

www.lelievre_memoire_2012_la_reeducation_sensitive_de_la_douleur.pdf

**M., LELIEVRE**[5]

**RESUME**

**Contexte**

Neuf longues années se sont écoulées depuis la parution du « Manuel de rééducation sensitive du corps humain ». Cette publication marque le réel commencement des formations en rééducation sensitive de la douleur et donc, de l'exportation de la méthode au-delà des frontières suisses. Toutes ces années d'enseignement et de pratique permettent, aujourd'hui, de discuter des spécificités, apports et limites de la rééducation sensitive de la douleur.

**Buts**

- Etudier l'intérêt des thérapeutes et des patients pour la rééducation sensitive de la douleur.
- Définir les apports et les limites d'application de cette approche rééducative.

**Sujets**

- Un questionnaire concernant la pratique quotidienne de la méthode a été mis à disposition des thérapeutes sur le forum de rééducation sensitive. Au total, 28 thérapeutes (27 ergothérapeutes et 1 algologue) ont répondu. Ces derniers pratiquent la rééducation sensitive de la douleur depuis 21 mois en moyenne (min: 2 ; max: 60).
- Une enquête a également été menée auprès des patients suivis en rééducation sensitive, afin de connaître leur ressenti vis-à-vis de la méthode. Sur le même principe, un questionnaire a été posté sur le forum pour que les thérapeutes le proposent à leurs patients. Au final, 8 patients (2 femmes, 6 hommes ; 50% hypoesthésie, 50% allodynie mécanique) ont répondu au questionnaire.

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**Méthode**

- Le questionnaire à l'intention des thérapeutes comprend 36 questions réparties en 8 catégories :
  - Renseignements généraux
  - Présentation de la méthode au patient
  - Bilans et rééducation du territoire hypoesthésique
  - Bilans et rééducation du territoire allodynique
  - « Manuel de rééducation sensitive du corps humain »
  - « Atlas des territoires cutanés du corps humain »
  - Forum de rééducation sensitive
  - « *e-news for Somatosensory Rehabilitation* »
- Le questionnaire adressé aux patients comprend 16 questions et se divise en 4 parties :
  - Renseignements généraux
  - Bilan de la sensibilité
  - Protocole de rééducation sensitive
  - Evaluation des douleurs et amélioration de la qualité de vie

**Résultats**

Cette étude met en évidence un grand nombre de points positifs imputables à cette approche rééducative novatrice. En effet, nous pouvons noter, d'une part, l'importante diversité des supports de bilans proposés : à la fois, graphiques, quantitatifs et qualitatifs. D'autre part, nous relevons de nouveaux outils intéressants spécifiques aux thérapeutes : « Manuel de rééducation sensitive du corps humain », « Atlas des territoires cutanés du corps humain », « *e-news for Somatosensory Rehabilitation* », et forum de rééducation sensitive. Enfin, un rôle non négligeable est attribué au patient qui reste le principal acteur de sa prise en charge.

Cependant, certaines limites d'application sont mises en évidence par les thérapeutes formés à la méthode. Ces dernières concernent plus particulièrement la réalisation des bilans (manque d'exemples concrets) et les divergences observées entre la pratique quotidienne de la méthode et la théorie initiale.

**Conclusion**

La méthode de rééducation sensitive de la douleur marque un renouveau dans la prise en charge des troubles sensitifs. Elle permet aux thérapeutes de proposer une alternative thérapeutique satisfaisante au patient. Néanmoins, l'expérience des praticiens formés et des patients suivis révèle certains domaines qu'il faudrait réactualiser.

# No Comment N° 25

To MD. To neuroscientist To patient To therapist

Buchet, N. (OT, ST certified CREA-HELB) & Spicher, C.J. (BSc OT)

Lors de l'évaluation initiale effectuée au Centre de rééducation sensitive de Fribourg le 6 mai 2011, Monsieur P., 40 ans, présentait des douleurs neuropathiques **depuis 36 mois**.

Status après plusieurs interventions pour stabilisation de la cheville gauche.

Diagnostic somesthésique mis en évidence le 6 mai 2011:

**Névralgie fémoro-poplitée permanente du nerf cutané sural latéral gauche avec allodynie mécanique (Stade IV de lésions axonales)**

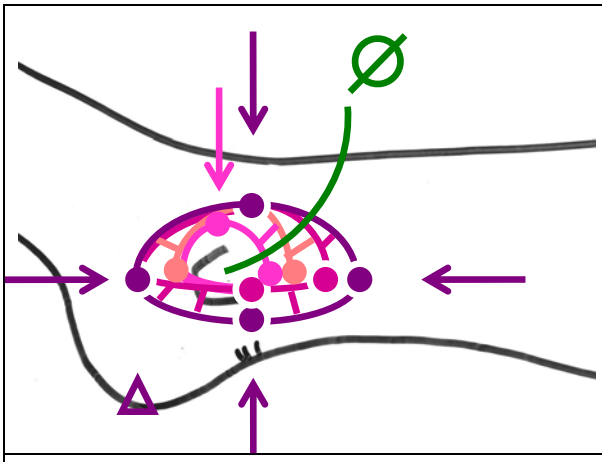

**Fig. 1 :** *Allodynographies successives à **15,0 grammes** du nerf cutané sural latéral, effectuées du **6.5** ($t_0$) au **19.8.2011** ($t_{104}$), sur la face latérale de la cheville.*

$t_0$ ; $t_{14}$ ; $t_{28}$ ; $t_{53}$ ; $t_{104}$ ;

*L'allodynographie circonscrit le territoire allodynique: la portion de peau où l'application de 15 grammes est perçue comme douloureuse (EVA : 3/10 cm).*
*Les flèches indiquent les axes le long desquels la perception douloureuse de 15,0 grammes a été testée.*
*Les points indiquent la localisation où l'application de l'esthésiomètre de 15,0 grammes (marque 5.18) est perçue de manière nociceptive.*
*Le triangle indique le point à partir duquel les mesures ont été pises*

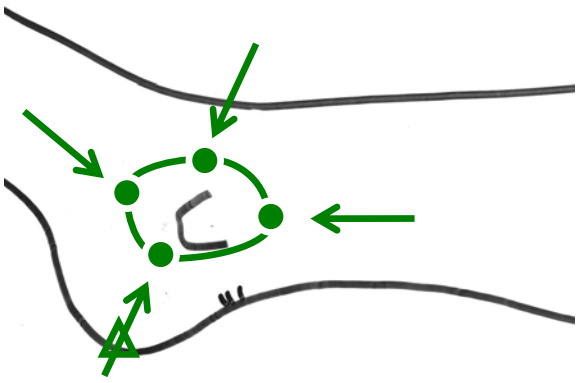

**Fig. 2** : *Esthésiographie secondaire à **0,7 gramme** du nerf cutané sural latéral effectuée le **19.8.2011** ($t_{104}$), sur la face latérale de la cheville.*

*L'esthésiographie secondaire circonscrit le territoire hypoesthésique donc la portion de peau où cet esthésiomètre n'est pas détecté.*

*Les flèches indiquent les axes le long desquels il est appliqué.*

*Les points indiquent l'endroit où l'application de l'esthésiomètre de 0,7 gramme (marque 3.84) n'est pas détectée.*

*Le triangle indique le point à partir duquel les mesures ont été pises*

| Temps | Douleurs | Somesthésie | | | | |
|---|---|---|---|---|---|---|
| | Questionnaire de la douleur St-Antoine | Territoire de distribution cutanée | Arc-en-ciel des douleurs | $SPP_{(c)}$ | $2\ pts_{(c)}$ | Stade |
| $t_0$ | 14 à 69 points | Allodynie | VIOLET | Intestable | | IV |
| $t_{48}$ | 10 à 62 points | Allodynie | VIOLET | Intestable | | IV |
| $t_{76}$ | 0 à 44 points | Allodynie (Fig. 1) | VIOLET | Intestable | | III |
| $t_{104}$ | ND | Hypoesthésie sous-jacente (Fig. 2) | Ø | ND | 41 mm | III |
| $t_{111}$ | 0 à 30 points | Hypoesthésie sous-jacente | Ø | 1,2 g | ND | III |
| $t_{118}$ | ND | Hypoesthésie sous-jacente | Ø | ND | 35 mm | III |
| $t_{125}$ | ND | Hypoesthésie sous-jacente | Ø | 0,8 g | ND | III |
| $t_{130}$ | ND | Hypoesthésie sous-jacente | Ø | 0,6 g | ND | III |
| $t_{139}$ | 0 à 3 points | Hypoesthésie sous-jacente | Ø | Normalisé | 6 mm | I |

**Tableau I :** *La diminution des douleurs neuropathiques par 16 séances de rééducation sensitive (n=139 jours) est corrélée avec la disparition de l'allodynie mécanique, puis avec la diminution de l'hypoesthésie sous-jacente ; ND : Non déterminé.*

# Somatosensory Rehabilitation Centre's Statistics

To MD To neuroscientist To patient To therapist

Spicer, C.J. & Vittaz, M.[6]

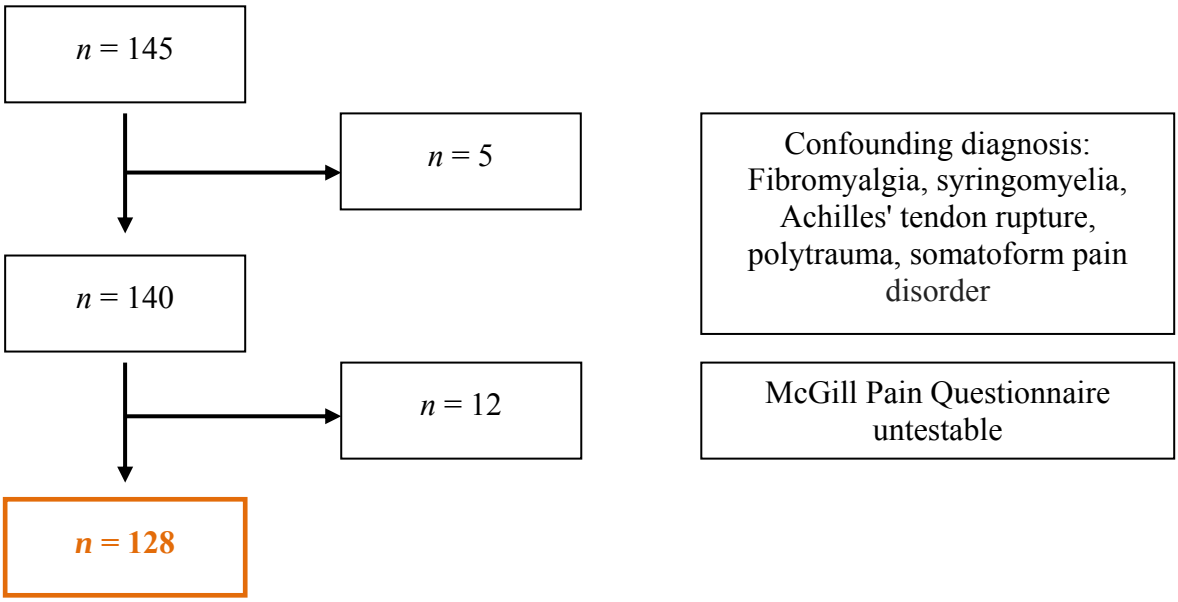


**Table I:** *Demographic table of the 145 patients. Inclusion criteria: (1) Has been assessed between the 1st of January 2011 and the 31st of December 2011 (2) Has finished treatment before the 25th of May 2012 (Deadline of the statistics).*

| | Patient WITH: | Patient WITHOUT: | |
|---|---|---|---|
| | An e-mail address or a webaccess | | |
| | n=95 | n=33 | |
| | n=128 | | |
| Efficacy | 1.64 | 1.76 | NNT |
| | 60.97 % | 56.66 % | % |
| Compliance | 74.73 % | 66.66 % | Nb Treatment finished |

**Table II:** *Impact of the reading of the e-News for Somatosensory Rehabilitation on the efficacy and on the compliance to treatment.*
*Note: NNT ≡ Number Needed to Treat with somatosensory rehabilitation (to obtain one patient with more than 50% pain relief).*

[6] OTs in the Somatosensory Rehabilitation Ctr, Fribourg (Europe)
reeducation.sensitive@clniquegenerale.ch

SOMATOSENSORY REHABILITATION EDUCATION

CONTINUOUS EDUCATION

6, Hans-Geiler Street
CH-1700 FRIBURG

info@neuropain.ch

5th WEEK for SOMATOSENSORY REHABILITATION 2013

## What can we offer our patients suffering from neuropathic pain?

www.neuropain.ch/education/calendar

The 5th week for **somatosensory rehabilitation** is a four day comprehensive theoretical and hands-on course for therapists, physicians and others, about sensory re-education for neuropathic pain patients (NPP).

**Somatosensory Rehabilitation of Pain** (Spicher, 2006) includes: Assessment of cutaneous sense disorders and their painful complications (CRPS, mechanical allodynia, neuralgia i.e post carpal tunnel syndrome) and rehabilitation.

### Problem

Cutaneous sense disorders, including hypoaesthesia and/or mechanical allodynia are often significant contributors to chronic pain.

The normalisation of the cutaneous sense has a positive impact on **neuropathic pain**. The shooting pain, the burning sensations decrease, offering NPP a better quality of life.

### Concepts

The concept of Aβ pain was proposed by Marshall Devor [*Exp Brain Res* 2009] many years after Tinel (1917) suggested that neuropathic pain is conducted partly through the Aβ fibers. The etiology of neuropathic pain hinges on this idea. It means that chronic neuropathic pain can arise from the alteration of the somaesthetic system and not only from the alteration of the C fibers. Therefore, the painful area must be carefully assessed in order to determine the presence of Aβ fibers lesions (hypoaesthesia and/or mechanical allodynia). Consequently, the normalisation of the cutaneous sense has a positive impact on neuropathic pain.

### Overall Learning Aims

- To rehabilitate the disorders of the cutaneous sense on the basis of the neuroplasticity of the somaesthetic system;
- To avert the outbreak of painful complications by rehabilitating the cutaneous sense;
- To build bridges between rehabilitation, medicine and the neurosciences.

### Instructors of the Somatosensory Rehab Network

- Claude Spicher, BSc OT, Swiss certified HT, University scientific collaborator; www.unifr.ch/neuro/rouiller/collaborators/spicher.php
- Rebekah Della Casa, OT, ST certified CREA-HELB, therapist in the Somatosensory Rehabilitation Ctr. linkedin.com/profile/dellacasa

### Course Informations

| | |
|---|---|
| Date | 17th to 20th of June 2013 |
| Time | 9 am – 12 am & 1 pm – 5 pm |
| Duration | 28 hours |
| Location | Clinique Générale; 6, Hans-Geiler Street ; Friburg |
| Price | CHF 990 / 1050 CAD Dollars / 1070 US Dollars / € 780 / £ 660 (Work Documents in English + Handbook + Atlas). |

### References

Spicher, C.J. (2006). *Handbook for Somatosensory Rehabilitation.* Montpellier, Paris: Sauramps Médical.

Spicher, C.J., Desfoux, N. & Sprumont, P. (2010). *Atlas des territoires cutanés du corps humain.* Montpellier, Paris: Sauramps Médical (58 charts, each branch named in English. Foreword, Patients & method in English).

Devor, M. (2009). Ectopic discharge in A-beta afferents as a source of neuropathic pain. *Exp Brain Res*, *196*, 115–128.

Tinel, J. (1917). *Nerve wounds*. London: Baillère, Tindall & Cox.

## 5th Week for Somatosensory Rehabilitation

www.neuropain.ch/education/calendar

5th Week for Somatosensory Rehabilitation
17th to 20th of June 2013

# REGISTRATION FORM

Deadline: Monday, 13th May 2013

**Name:**

**First (given) name:**

**Professional occupation:**

**Address:**

**e-mail address:**

**Please fill and return to:**

Claude J. Spicher
Somatosensory Rehabilitation Network
Department of Continuous Education
6, Hans-Geiler Street
CH-1700 Friburg
Switzerland

e-mail : info@neuropain.ch

***or***

Fax: +41 26 350 06 35

# Read for you

**Handbook for Somatosensory Rehabilitation by Claude J. Spicher**
**published by Sauramps Medical 2006 ISBN 2-84023-470-x**

To MD. To neuroscientist To patient To therapist

## P., HIGMAN[7]

This book is written by an expert; Claude Spicher has spent over 20 years working with clients suffering from somatosensory problems as well as researching the topic. In that time he has observed what is useful and has tried this out so that his experience has enabled him to develop assessment and treatment techniques which successfully relieve the suffering of his clients. It is a book which every hand-therapist needs and which is of great interest to most occupational- and physio-therapists who are interested in treating patients with pain. It contains so much information which is based on practical experience that it must be considered essential equipment in these departments or practices.

The book is divided into two parts, the first describing the "testing and rehabilitation of basic cutaneous sense disorders in cases of neurological lesions". The second is devoted to the "testing, rehabilitation and prevention of painful complications of cutaneous sense disorders in cases of peripheral neurological lesions". Both parts provide useful definitions to make it clear exactly what some of the technical terms mean. To start with there is a description of the fine distinctions between different senses - muscle sense, cutaneous sense - which in itself is then divided into the protective and the vibrotactile senses - and how these different senses may be tested. Following this there are suggestions for rehabilitations approaches and proposals for documentation.

The second part discusses the use and interpretation of the McGill Pain Questionnaire, how to assess mechanical allodynia and some of the current vibration generators which can desensitize the sites of axonal lesions. This is an area where more research is required so as to enable therapists to provide a more accurate and therefore better treatment. This need is also discussed.

The difficulties that neuralgias and neuropathic pains provide for the sufferers and their therapists are presented together with a brief history of the development of both the nomenclature and treatments. This enables therapists today to use the best possible evidence when making their clinical decisions.

[7]Prof., MSc. Dipl. COT, Hochschule Frensius, D-65510 Idstein, Germany;
e-mail : pip@higman.de;

Throughout the book important statements are backed up by appropriate citations from current research. Claude Spicher quotes from up to date literature as well as from most of the standard and classical sources on pain. Finally there is a very nice chapter on "Prevention or how to argue with the patient". This becomes necessary when offering patients rehabilitation at an early stage with the aim of preventing such conditions as complex regional pain syndrome type II and neuralgia or a painful nerve complaint, both of which may develop if the necessary measures are not taken early enough. However at the time of discussion with the patient the situation has not arisen and many patients find it difficult to imagine that it could.

The book is completed following the extensive list of sources by a number of useful annexes including tables and classifications as well as assessment instruments which may be used by therapists in the somatosensory rehabilitation. This 200 page book is available from the author or through the usual book trade for € 45.60.

## Participant Point of View No 2

4. Week voor Somatosensory Revalidatie
5 – 8 Maart 2012 – Fribourg - Zwitserland

To MD. To neuroscientist To patient To therapist

# K. BOER-VREEKE & P. DE GROOT[8]

**Zit pijn tussen de oren?**

Al enige jaren krijg ik regelmatig de *e-news Somatosens Rehab* via mijn mail. Elke keer dacht ik, interessant, zou dit de oplossing zijn voor al de patiënten met pijn waar ik geen vat op kan krijgen? Dit voorjaar besloot ik de stoute schoenen aan te trekken en schreef mij in voor de cursus in Fribourg. Met mij had ook Peter de Groot hetzelfde idee. Samen volgden we begin maart de cursus somatosensorische revalidatie in Fribourg.

De eerste dagen duizelde het ons van de begrippen en termen waar we nog niet echt bekend mee waren. De benadering is zo anders dan wij tot nu toe gewend waren dat we moeite hadden de lijn te vatten. Want, aan elke neuropatische pijn ligt een hyposensibiliteit ten grondslag die paradoxaal pijnlijk is. Gelukkig werd er veel herhaald en was er veel ruimte voor vragen en discussie.

Naarmate de dagen vorderden kregen we meer grip op de stof en kreeg de behandeling vorm in onze hoofden. Het grappige is dat er dan steeds patiënten uit het verleden in je gedachten schieten, waarbij je nu een diagnose zou kunnen stellen en die je wellicht zou kunnen helpen

[8] e-mail : kboer@bronovo.nl; & peter.degroot@vumc.nl;

met de pijnklachten. Dat rijtje patiënten werd steeds langer en wij werden steeds enthousiaster over de methode van diagnostiek, het letterlijk in kaart brengen van de pijn en de relatieve eenvoud van de behandeling. Omdat we ook bij behandelingen aanwezig mochten zijn zagen we ook daadwerkelijk hoe mensen met deze methode geholpen kunnen worden.

En dan ga je terug naar huis, enthousiast en vol plannen en ideeën. Dan moet je aan je collega's gaan uitleggen wat je hebt geleerd. Dat blijkt nog erg lastig. Als je er in zit klinkt het allemaal zo logisch. We zijn begonnen met het vertalen van de aantekeningen en documenten in het Nederlands om het voor onze patiënten bruikbaar te maken. Ook moest ik nog de volledige Semmes Weinstein set bestellen voordat ik aan de slag kon. En eigenlijk hebben we nog een vibradol nodig om de complete behandeling te kunnen uitvoeren.

Op dit moment zijn we nog vooral bezig met het diagnosticeren en het geven van de huiswerkoefeningen om het zenuwstelsel te prikkelen. Maar naarmate we meer patiënten zien en handiger worden in het afnemen van de tests wordt het steeds duidelijker wat je er allemaal mee kan. Voor veel patiënten is het prettig dat de pijn, waar ze soms echt letterlijk gek van worden, zichtbaar wordt en omschreven wordt. Door het gestandaardiseerde onderzoek kun je de pijn betekenis geven en het pijngebied nauwkeurig in kaart brengen. Het afnemen van de VAS score aan de hand van een referentiewaarde voor de pijn, was nieuw voor ons. Door de referentiewaarde krijgt de pijn een veel zinvollere score met een duidelijkere betekenis dan wanneer de patiënt de pijn alleen een cijfer geeft.

Patiënten waarderen het dat de pijn in kaart gebracht wordt en dat de klacht serieus wordt onderzocht. Letterlijk een tekening maken van het pijngebied is verhelderend en je kunt zo in de atlas opzoeken welke zenuw is aangedaan en ook de zogenaamde referred pain is hierdoor te verklaren. Ook de Mc Gill pijnvragenlijst geeft een duidelijke waarde aan de pijn waardoor het meetbaar gemaakt kan worden, maar ook inzicht geeft in het verschil tussen sensorische en affectieve pijn.

Omdat we nog maar zo kort bezig zijn kunnen we nog moeilijk zeggen welke resultaten we boeken. Het kiezen en uitleggen van de juiste behandeling is nog lastig en zoals gezegd een vibradol hebben we niet. De vibraties die we kunnen toepassen komen uit een gewone vibrator, massage apparaat of welk apparaat dan ook wat trilt. Wel is duidelijk dat de patiënten die met huiswerkoefeningen zijn gestart merken dat er iets gebeurd. Bijzonder vond ik het om te ontdekken dat drie patiënten met een zelfde trauma in het verleden, van de nervus medianus, alledrie pijnklachten hebben, maar nu drie verschillende diagnoses hebben gekregen. De ene heeft een allodynie en is gestart met DVCS, de ander heeft een S3+ en is gestart met hands on therapy en de derde heeft een S3 en is gestart met line rehab. DVCS, line rehab en hands on therapy zijn drie specifieke behandelmethoden die in Fribourg zijn ontwikkelt. Het meten van de sensibiliteit is zo specifiek dat je na een paar weken wel veranderingen kunt meten, al is langer behandelen noodzakelijk om te kunnen zeggen of de pijn ook verminderd.

Door deze cursus zullen we nooit meer op dezelfde manier naar patiënten met pijn kunnen kijken als voorheen. Neuropatisch pijn zie je niet op een MRI, x-foto, CT een echo of welke

beeldvorming dan ook. Van Claude, Isabelle en Rebekah hebben we geleerd de pijn zichtbaar te maken en te behandelen door het zenuwstelsel te leren de prikkels anders te interpreteren. Neuropatische pijn zit dus letterlijk tussen de oren en daar probeert de somatosensorische revalidatie een antwoord op te geven! Wil je meer weten over deze behandelmethode, dan kun je contact opmenen met een van ons.

## Participant Point of View No 2

4th Week for Somatosensory Rehabilitation

5 – 8th of March 2012, Fribourg

To MD To neuroscientist To patient To therapist

# K. BOER-VREEKE & P. DE GROOT[9]

**Abstract**

We have been recieving the *e-News for Somatosensory Rehabilitation* for a few years and out of curiosity Peter and I decided to follow the course for Somatosensory Rehabilitation in Fribourg.

The first days were difficult for us because of the new method and the new terms. But as it became clearer we got more enthusiastic.

Back home we had some difficulties explaining the others what we learned, but we started trying the diagnostic testing of axonal lesions on some of our patients and were amazed the diagnosing works. Using the instruments like McGill pain questionaire, VAS, allodynography and aesthesiography really helps distinguish the pain and confirms to the patient the pain is there and known.

Especially Karin was amazed to discover that three of her patients who had the same traumatic lesion of the median nerve in the past, and were still complaining about pain actually had somatosensory disorders. One was diagnosed with an allodynia, one with an $S_3$ hypoaesthesia and one with an $S_3^+$ hypoeasthesia. Although the measuring shows that we have some progress even without using a Vibradol®, we still need further treatment to tell something about the pain.

So, after this course we won't look at patients with pain like we did before, it has really changed our treatments.

[9] e-mail : kboer@bronovo.nl; & peter.degroot@vumc.nl;

CLINIQUE GÉNÉRALE Ste-Anne

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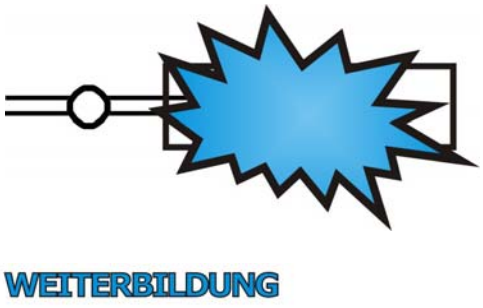


**SOMATOSENSORISCHE SCHMERZTHERAPIE KURS 2013**

# WAS KÖNNEN SIE FÜR IHRE PATIENTEN, DIE UNTER ELEKTRISIERENDEN, BRENNENDEN SCHMERZEN LEIDEN, TUN ?

www.neuropain.ch/weiterbildung/kalender

*PROBLEMSTELLUNG*

Wie wollen wir die Hoffnung auf ein anderes Morgen wieder erwecken, wenn uns Patienten, die uns anvertraut werden, mit gequältem Gesichtsausdruck anschauen, weil sie bereits zu lange unter zuviel Schmerz leiden:
Indem sie weniger elektrische Entladungen, weniger brennende Empfindungen usw. erleben oder kurz gesagt mittels der Reduktion ihrer peripherer neuropathischer Schmerzen.

In der grossen Mehrheit zeigen chronische Schmerzpatienten Störungen der Sensibilität der Haut (Oberflächensensibilität). Die Reduktion der Hypoästhesie (Bsp. Schwelle der Druckempfindung) trainiert gleichzeitig auch eine Verminderung ihrer neuropathischen Schmerzen (z.B.: McGill Schmerz-Fragebogen).

*GENERELLE ZIELE*

Vermindern der chronischen neuropathischen Schmerzen mittels der Somatosensorischen Erfassung und Rehabilitation der Haut.
Vermeiden von Schmerzkomplikationen mittels somatosensorischer Reha-Methode
Brücken bauen zwischen der Rehabilitation, der Medizin und der Neurowissenschaft (z.B.: Neuroplastizität).

*DETAILLIERTE INHALTE*

Erfassen der Sensibilität der Haut (Oberflächensensibilität): Ästhesiografie, statischer 2-Punkte Diskriminationstest, Hoffmann-Tinelzeichen und somatosensorische Symptome, Schwelle der Druckempfindung, usw.
Erfassen der neuropathischen Schmerzsyndrome mittels McGill Schmerz-Fragebogen: mechanische Allodynie, CRPS (Morbus Sudeck), Neuralgie, Polyneuropathien.
Behandlungsplanung bei chronischen Schmerzkomplikationen
Einbringen der Kenntnisse des ZNS in die Rehabilitation der neuropathischen Schmerzen und umgekehrt
Beobachten von drei Schmerztherapie, auf Deutsch, mit echten PatientInnen.

*KURSLEITUNG*

**Claude Spicher**, dipl. Ergotherapeut, zert. Handtherapeut SGHR im Somatosensorischen Rehazentrum, Clinique Générale, Freiburg & wissenschaftlicher Mitarbeiter der Universität Freiburg,
**Irene Inauen,** dipl. Ergotherapeutin, zert. ST CREA-HELB in Praxis für Handrehabilitation, Rheinfelden,
**Andrea Grass,** dipl. Ergotherapeutin in Praxis für Ergotherapie Biel GmbH & anerkannte Ergotherapeutin des somatosensorischen Rehazentrums.

| | |
|---|---|
| Datum: | 17. – 20. Juni 2013 |
| Kurszeiten: | 9 Uhr – 12 Uhr & 13 Uhr – 17 Uhr |
| Dauer: | 28 Stunden |
| Ort | Clinique Générale, Hans-Geiler-Str. 6, CH-1700 Freiburg |
| Preis: | CHF 990.- / 780 € (Arbeitdokumente auf Deutsch + Handbook in English + Atlas inkl.) |
| Literatur: | Spicher, C.J. (2006). *Handbook for Somatosensory Rehabilitation*. Montpellier, Paris: Sauramps Médical.<br>Spicher, C.J., Desfoux, N. & Sprumont, P. (2010). *Atlas des territoires cutanés du corps humain.* Montpellier, Paris: Sauramps Médical (58 Abbildungen, jeder Ast in Latein gennant ist). |

## Anmeldetalon:

### SOMATOSENSORISCHE SCHMERZTHERAPIE KURS 2013

Name, Vorname : .....

Beruf : .....

Adresse: .....

PLZ Ort: .....

Tel : .....e-mail: .....

Datum: .....Unterschrift: .....

**Bitte ausfüllen und zurückschicken an** (Anmeldeschluss: **Montag den 13. Mai 013**):

Marie-Joëlle Fleury
Somatosensorisches Reha-Netz
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Hans-Geiler-Str. 6
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**SOMATOSENSORISCHE SCHMERZTHERAPIE**

**KURS 2013**

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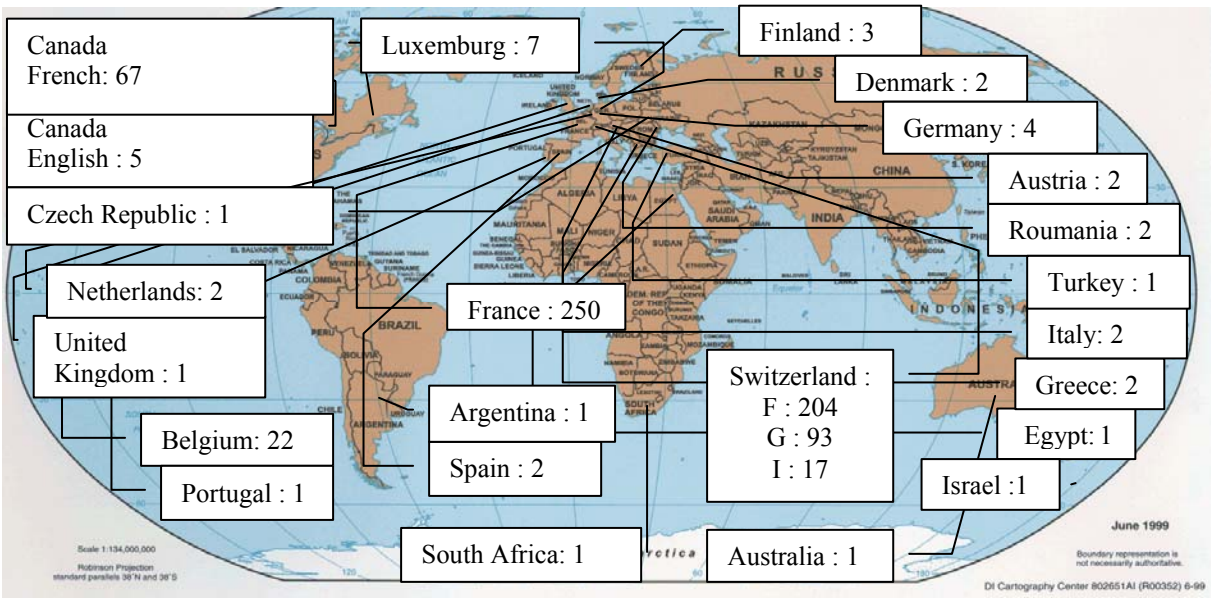
# Therapists in Somatosensory Rehabilitation of Pain in the World

To MD ✸✸✸ To patient ✸✸✸

To neuroscientist ✸ To therapist ✸✸✸

The first communication about somatosensory rehabilition of pain was given at the 1st Congress of the swiss society for hand therapy (SSRM) in 1992. In 2001, a course to train therapists and physicians in this method was taught for the first time. As of November 23 2010, 500 therapist and medical doctors have been trained to the somatosensory rehabilitation method. To mark this occasion, we created this section to visualize the international scope of specialists practicing somatosensory rehabilitation of pain.




| | | |
|---|---|---|
| 1 | France | 231 |
| 2 | Switzerland : French speaking | 204 |
| 3 | Switzerland : German speaking | 93 |
| 4 | Canada : French speaking | 67 |
| 5 | Belgium : French speaking | 22 |
| 6 | Switzerland : Italian speaking | 17 |
| 7 | Luxemburg | 7 |
| 8 | Canada : English speaking | 5 |
| 9 | Germany | 4 |
| 10 | Finland | 3 |
| 11 | Denmark | 2 |
| 12 | Austria | 2 |
| 13 | Roumania | 2 |
| 14 | Greece | 2 |

| | | |
|---|---|---|
| 15 | Spain | 2 |
| 16 | Netherlands | 2 |
| 17 | Italy | 2 |
| 18 | United-Kingdom | 1 |
| 19 | Turkey | 1 |
| 20 | South Africa | 1 |
| 21 | Czech Republic | 1 |
| 22 | Australia | 1 |
| 23 | Argentina | 1 |
| 24 | Portugal | 1 |
| 25 | Egypt | 1 |
| 26 | Israel | 1 |

**TOTAL 695**

## Ombre & Pénombre

Aux médecins ✸✸✸ Aux scientifiques en neurosciences ✸
Aux patients ✸✸✸ Aux thérapeutes ✸✸✸

# Toucher est une façon de visiter le monde

« Dans la sculpture, le toucher est une part importante parce qu'évidemment, on a le crayon quand on dessine et on a toute la matière quand on va sculpter. Et toucher, c'est une façon de visiter le monde, visiter le réel ; tout ça avec les mains, à travers ce que sentent les doigts et les mains. »

**Extrait du DVD :**

de Riedmatten, E. (2008) – Christine Aymon, un portrait. Verossaz : christine.aymon@bluewin.ch;

## Témoignage N° 39 d'une patiente
## *«Comment entendre l'indicible ?»*

Aux médecins ✸✸✸ Aux scientifiques en neurosciences ✸
Aux patients ✸✸✸ Aux thérapeutes ✸✸✸

J'ai commencé à avoir mal dans le bas-ventre quelques mois après avoir accouché, en mars 2009, alors que je venais d'arrêter d'allaiter ma fille. C'était un peu comme une douleur prémenstruelle, sauf qu'elle était localisée à gauche et qu'elle se manifestait presque tous les jours sauf pendant les règles. J'ai supposé qu'il s'agissait de séquelles de mon accouchement, lequel a été long et très pénible (avec forceps).

Alors je me suis adressée à ma gynécologue qui, après m'avoir fait les contrôles d'usage, m'a fait faire une échographie abdominale et une radio. Comme ces examens n'ont donné aucun résultat, elle m'a envoyée chez mon médecin généraliste, me disant qu'une cause gynécologique semblait exclue. Ce dernier m'a toutefois dit que je souffrais peut-être d'endométriose, alors il m'a fait une injection de progestérone en début de cycle, me disant que si c'était effectivement de l'endométriose, cela pouvait la faire régresser et donc calmer la douleur… or une telle injection n'était pas conseillée, dès lors qu'elle bloquait l'ovulation et que j'espérais être enceinte.

Comme cela faisait plus d'une année qu'avec mon mari nous essayions d'avoir un deuxième enfant, sans succès, je ne suis pas retournée chez lui, préférant m'adresser à une endocrinologue spécialisée dans la reproduction - laquelle m'avait déjà suivie par le passé - afin de faire un bilan hormonal. Elle a demandé à ma gynécologue de me faire une laparoscopie, afin de détecter une éventuelle endométriose. J'ai donc subi cette opération au mois de mars 2010, pour rien si ce n'est pour me dire que j'allais très bien ! Comme nous étions sur le point d'entamer une procédure de procréation médicalement assistée, je me suis focalisée sur mon objectif d'avoir un bébé… même si pendant ce temps la douleur continuait de me pourrir la vie.

Après avoir eu un accident de voiture en juin 2010, j'ai commencé un traitement de physiothérapie. J'ai parlé de cette douleur à mon physiothérapeute, lequel m'a assuré que c'était purement congestif et que cela passerait en faisant régulièrement un exercice qu'il m'avait conseillé. Mais cela n'a rien changé, et après trois inséminations artificielles ratées, plus le cambriolage de notre maison au mois de novembre 2010, ainsi qu'une chute dans les escaliers qui m'a valu une cheville foulée, j'ai mal commencé l'année 2011.

Etant très déprimée, j'ai consulté un psychologue, et c'est lui qui m'a conseillé de contacter le Cabinet d'antalgie de la Clinique Générale de Fribourg. J'ai immédiatement téléphoné à ce cabinet, mais on m'a expliqué que je devais passer par mon médecin généraliste. J'ai lui ai donc téléphoné, mais n'ai pas pu le joindre dès lors qu'il était trop occupé pour me parler. Son assistante m'a dit qu'il me rappellerait, mais j'ai attendu en vain… après quelques jours c'est moi qui ai rappelé, pour m'entendre dire par son assistante qu'il ne voulait pas m'adresser au centre en question, parce que tout ce qu'ils feraient serait de me bourrer de médicaments antalgiques, ce qui ne résoudrait pas mon problème. Et c'est tout… je n'ai même pas pu lui parler, et il ne m'a pas dit ce que je pouvais faire d'autre !

J'étais dépitée, et j'avais tellement mal… la douleur se manifestait toujours quotidiennement, survenant par crises et disparaissant après 20 à 30 minutes d'immobilité. J'avais déjà remarqué qu'elle apparaissait quand je m'allongeais le soir dans mon lit, ou quand je m'installais dans ma voiture après une journée au travail, assise derrière un ordinateur... puis j'ai constaté que je commençais le plus souvent à avoir mal quand je croisais les jambes ou quand je me couchais en chien de fusil. J'ai aussi senti qu'elle était devenue plus intense, et que désormais elle irradiait le long de ma cuisse gauche et autour de l'aine. C'était insupportable… et j'étais fatiguée d'avoir mal presque tous les jours, depuis plus de deux ans.

J'ai donc fini par consulter un autre médecin qui, après m'avoir fait passer une IRM et constaté qu'il n'y avait rien de visible, m'a adressée au cabinet d'antalgie. Je m'y suis rendue en décembre 2011, et c'est là que j'ai entendu parler de rééducation sensitive…

N'ayant aucune idée de ce que cela pouvait bien être, c'est avec une certaine appréhension que je suis allée à mon premier rendez-vous le 3 janvier 2012. J'en suis ressortie heureuse et très motivée, Monsieur Spicher m'ayant expliqué qu'il s'agissait certainement d'un nerf qui était abîmé à force d'être compressé (si j'ai bien compris), ce qui pouvait tout à fait être "réparé"

grâce à la rééducation sensitive, et m'ayant conseillé de voir une ostéopathe dont il m'a donné le nom. A mon deuxième rendez-vous, j'ai rencontré Madame Vittaz, qui m'a demandé de décrire ma douleur (ce qui n'a pas été facile), a fait une sorte de carte de la zone où j'avais mal, laquelle était comme "endormie", et m'a demandé de faire plusieurs fois par jour la "thérapie du touche-à-tout", qui consiste à toucher avec différents tissus la zone endormie, puis la même zone de l'autre côté, là où ce n'est pas endormi, le but étant d'apprendre à mon cerveau que la sensation doit être la même des deux côtés. Je dois avouer que j'étais un peu sceptique. A chaque séance, Madame Vittaz ou Monsieur Spicher, à tour de rôle, ont fait des tests et de savants calculs pour voir si la zone définie sur la "carte" était moins endormie que la fois précédente. Entre temps, je suis allée voir à plusieurs reprises Madame Genevois-Zürcher, ostéopathe dont Monsieur Spicher m'avait parlé… elle a remarqué que mon bassin ne bougeait pas et que cela me créait de grosses tensions. A ma grande surprise, j'ai constaté, après quelques semaines, que j'avais mal moins souvent, et que la douleur était moins intense ! Et ça n'a fait que s'améliorer au fil des semaines. J'ai eu mon dernier rendez-vous au Centre de rééducatin sensitive le 3 avril 2012, soit exactement 3 mois après avoir débuté le traitement, et je regrette un peu d'avoir attendu si longtemps avant de prendre les choses en main. Je n'ai pas du tout eu mal depuis, et c'est merveilleux de pouvoir se coucher sans appréhensions… mon moral va mille fois mieux et c'est mon mari qui est heureux de me voir sourire à nouveau. Je vous remercie pour tout !

A. N.

**Témoignage No 39 d'une patiente**

## Epilogue

Aux médecins 
Aux patients 
Aux scientifiques en neurosciences 
Aux thérapeutes 

***Follow-up* de 84 jours:**

« La bonne nouvelle est que les douleurs ne sont pas revenues ☺. Je continue de voir régulièrement Madame Genevois-Zürcher, et cela me fait le plus grand bien !

Pour ce qui est de mon témoignage, je souhaite le laisser tel qu'il est, vu que c'est ainsi que je l'ai ressenti au moment où je l'ai écrit. Je n'ai rien à y ajouter. »

A. N.

**[Vous pourez lire dans *l'e-News 10*(1), le No Comment N° 26 sur cette patiente qui souffrait en fait d'une névralgie lombo-abdominale intermittente du nerf ilio-inguinal gauche depuis 36 mois]**

## *Certificat en rééducation sensitive de la douleur*
## Le module II vécu de l'intérieur (mai 2012 – Bruxelles)

Aux médecins
Aux patients
Aux scientifiques en neurosciences
Aux thérapeutes

# C. Couvreur[10]

Nous voilà réunis, à nouveau, dans ce joli petit plat pays. Une fois !

En effet, il y a déjà 3 mois que nous nous sommes quittés après le premier module, les esprits avides de connaissances, et nos mains chargées d'esthésiomètres et de monofilaments !

C'était le moment de partager nos expériences, forts de nos cas cliniques, de notre petite pratique et de nos nombreuses questions !

C'était le moment de compléter nos informations, et de recevoir de nouvelles données de notre orateur, Claude Spicher … notre pilier en matière de troubles sensitifs.

C'était le moment de découvrir les territoires sensitifs armés de nos marqueurs de couleur ! Et quel souvenir, ces multiples tracés colorés sur nos bras ! Surtout quand Alice a fait le choix judicieux de marqueurs parfumés qui ont égayé la séance d'anatomie pratique !

C'était aussi le moment de sympathiser, de créer de nouveaux liens, de rencontrer des gens passionnés de tous horizons et de spécificités différentes, des gens de toutes les régions francophones (de Bordeaux à Sion, en passant par la Bretagne et Charleroi).

C'était le moment de partager de bonnes adresses, de petits restaurants et de pauses brassicoles (n'est-ce pas Marion ?).

C'était le moment de s'ouvrir à de nouvelles approches, de penser à s'essayer à des techniques encore inexplorées.

Mais c'était aussi le moment de se dire, que l'aventure n'est pas finie, que nous nous retrouverons en novembre, ou plus tard. Avec nos nouvelles expériences, et nos nouvelles questions… pour y trouver des réponses et grandir encore sur le chemin de la rééducation sensitive !

Merci à toutes et tous, pour ces trois riches journées de partages et d'apprentissages. Merci à Claude pour son écoute et sa disponibilité.

Et bonne route à tous les rééducateurs sensitifs !

[10] Coordinatrice du centre de rééducation fonctionnelle, CHU A. Vésale, ISPPC, Charleroi, Belgique catherine.couvreur@chu-charleroi.be

# Continuous Education – Weiterbildung - Formation continue

SOMATOSENSORY REHABILITATION EDUCATION

**Date: 17-20 June 2013**

**5th Week for Sensory Rehabilitation**

***What can we offer our patients suffering from neuropathic pain?***

**See page 128 in this issue**

Claude J. Spicher, BSc OT, university scientific collaborator
Rebekah Della Casa, OT, ST certified CREA-HELB

**Place** : Somatosensory Rehabilitation Centre, Fribourg**,** Switzerland, Europe

www.neuropain.ch/education/calendar

SOMATOSENSORISCHE SCHMERZTHERAPIE WEITERBILDUNG

**Datum: 17.-20. Juni 013**

**Somatosensorische Schmerztherapie Kurs 2013**

***Was können Sie für Ihre Patienten, die unter elektrisierenden, brennenden Schmerzen leiden, tun?***

**Siehe Seite 135 in diesen Nummer**

Andrea Grass, dipl. Ergotherapeutin in Praxis für Ergotherapie Biel GmbH, anerkannte Ergotherapeutin de somatosensorischen Rehazentrumes;
Irene Inauen, dipl. Ergotherapeutin in Praxis für Hanrehabilitation, Rheinfelden, zert. somatosensorische Schmerztherapeutin CREA-HELB;
Claude Spicher, dipl. Ergotherapeut, zert. Handtherapeut SGHR, Wissenschaftlicher Mitarbeiter der Universität Freiburg.

**Ort** : Somatosensorisches Rehazentrum, Freiburg**,** Schweiz, Europa

www.neuropain.ch/de/weiterbildung/kalender

**Date: 7 - 8 février 2013**

**Certificat en rééducation sensitive de la douleur**

***5ème volée***

**Diminution des douleurs neuropathiques par rééducation sensitive**

**Module 1 : Troubles de base I & II – Comment traiter les syndromes du canal carpien, algodystrophies et hémiplégies.**

Rebekah Della Casa, ET, RS certifiée CREA-HELB

**Lieu** : CREA-HELB, Campus ERASME, Bruxelles, Belgique

**Info :** www.crea-helb.be / crea@helb-prigogine.be

Ces formations peuvent être comptabilisées pour :
Le Certificat en rééducation sensitive de la douleur

# IXème COURS

***Depuis 2005***

## Le traitement des syndromes douloureux neuropathiques par la rééducation sensitive de la douleur

**Date: 25 - 28 mars 2013**

**Certificat en rééducation sensitive de la douleur**

**Troubles de base I & II, Complications douloureuses I & II**

Rebekah Della Casa, ET, RS certifiée CREA-HELB

Claude Spicher, ET, collaborateur scientifique universitaire

**Lieu** : Enseignement Permanent de l'Ergothérapie, Montpellier, France

**Info :** http://www.ergotherapiemontpellier.com/formation.html

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| **6–7 septembre 2012** | **Certificat en rééducation sensitive de la douleur : Module 1 Troubles de base I & II – Comment traiter les syndromes du canal carpien, algodystrophies et hémiplégies.** |
| **Nouveau lieu** | Hôtel de l'Institut, Montréal, Canada |
| **Info** | www.neuropain.ch/fr/enseignement/calendrier |
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| | Le Certificat en rééducation sensitive de la douleur |

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|---|---|
| **10–11-12 septembre 2012** | **Certificat en rééducation sensitive de la douleur : 4ème volée Module 3 : Anatomie clinique II, Gestion du lien thérapeutique & Complications douloureuses II** |
| **Nouveau lieu** | Hôtel de l'Institut, Montréal, Canada |
| **Info** | www.neuropain.ch/fr/enseignement/calendrier |
| **Formateurs** | Claude SPICHER, BSc erg, rééducateur de la main certifié SSRM<br>Collaborateur scientifique universitaire<br>Marc ZAFFRAN, MD, université de Montréal |
| | Ces formations peuvent être comptabilisées pour : |
| | Le Certificat en rééducation sensitive de la douleur |

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|---|---|
| **2–6 October 2012** | **14th World Congress on Pain** |
| | International Association for the Study of Pain |
| **Place** | Yokohama, Japan |
| **Info** | http://www.iasp-pain.org/Yokohama |

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| **8–9 novembre 2012** | **14ème congrès SSRM / 46ème congrès SSCM** |
| **Lieu** | Thoune, Suisse |
| **Info** | http://www.congress-info.ch/sgh-sghr2012/p1.html?n=&l=2 |

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| **14–16 novembre 2012** | **Certificat en rééducation sensitive de la douleur : module 3 Gestion du lien thérapeutique, Anatomie clinique II & Complications douloureuses II 3ème volée** |
| **Lieu** | CREA-HELB, Campus ERASME, Bruxelles, Europe |
| **Info** | www.crea-helb.be / crea@helb-prigogine.be<br>www.anfe.fr / sfc.secretariat@anfe.fr |

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| **21–24 novembre 2012** | **12ème congrès national de la Société Française d'Etude et de Traitement de la Douleur (SFETD)** |
| **Lieu** | Lille, Grand Palais, France |
| **Info** | http://www.congres-sfetd.fr |

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| **4-8 March 2013** | **2013 IFSHT Triennial Congress**<br>**12th Triennial Congress of the IFSSH**<br>International Federation of Societies for Surgery of the Hand |
| **Place** | New Delhi, India |
| **Info** | http://www.ifssh-ifsht2013.com |

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| **18–19 avril 2013** | **Certificat en rééducation sensitive de la douleur : Module 1 Troubles de base I & II – Comment traiter les syndromes du canal carpien, algodystrophies et hémiplégies.** |
| **Lieu** | Université de Montréal, Canada |
| **Info** | http://www.readap.umontreal.ca/ |
| **Formateur** | Claude SPICHER, BSc erg, rééducateur de la main certifié SSRM<br>Collaborateur scientifique universitaire<br>Ces formations peuvent être comptabilisées pour :<br>Le Certificat en rééducation sensitive de la douleur |

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| **22–23-24 avril 2013** | **Certificat en rééducation sensitive de la douleur : module 2 Complications douloureuses I, Analyse de pratique & Anatomie clinique I** |
| **Lieu** | Université de Montréal, Canada |
| **Info** | http://www.readap.umontreal.ca/ |
| **Formateur** | Claude SPICHER, BSc erg, rééducateur de la main certifié SSRM<br>Collaborateur scientifique universitaire<br>Ces formations peuvent être comptabilisées pour :<br>Le Certificat en rééducation sensitive de la douleur |

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| **15-17 mai 2013** | **Certificat en rééducation sensitive de la douleur: module 2 Complications douloureuses I, Analyse de pratique & Anatomie clinique I 5ème volée** |
| **Lieu** | CREA-HELB, Campus ERASME, Bruxelles |
| **Info** | www.crea-helb.be / crea@helb-prigogine.be<br>www.anfe.fr / sfc.secretariat@anfe.fr |

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| **23-26 May 2013** | **4th International Congress on Neuropathic Pain** |
| **Place** | Toronto, Canada |
| **Info** | http://www2.kenes.com/neuropathic/ |

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|---|---|
| **20–22 novembre 2013** | **Certificat en rééducation sensitive de la douleur : module 3 Gestion du lien thérapeutique, Anatomie clinique II & Complications douloureuses II 5ème volée** |
| **Lieu** | CREA-HELB, Campus ERASME, Bruxelles, Europe |
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## Formation en rééducation sensitive de la douleur
### Module 2

Aux médecins
Aux patients
Aux scientifiques en neurosciences
Aux thérapeutes

# A. RUEF[11]

Cette formation nous a apporté de nombreuses informations. Voici, en quelques points, l'essentiel des sujets abordés:

- Les rappels anatomo physiologiques ;
- La passation de différents tests ;
- L'utilisation de l'atlas cutané;
- Des conseils sur la gestion de nos dossiers et la transmission d'informations au médecin et à l'équipe soignante;
- L'approche auprès des patients ;
- La littérature complète et précise sur laquelle nous pouvons nous appuyer ;
- Les rencontres et le soutien.

**1er jour de formation**

Lorsque nous arrivons au CREA-HELB où se passe la formation, nous retrouvons des personnes connues et nous en découvrons de nouvelles. Après avoir fait connaissance, nous nous découvrons un point commun : beaucoup de questions à poser à Claude Spicher. Car en effet, après le 1er module de formation, nous avons tous essayé d'appliquer la méthode mais, en tant que débutants, cela s'est avéré difficile.

Après s'être présenté, nous nous sommes mis au travail. Nous avons commencé par des petits rappels anatomo-physiologiques pour redonner les bonnes bases aux participants.

Ensuite, nous nous sommes attardés sur des études de cas présentés par différents participants. Cela nous a permis de faire des parallèles avec notre pratique et de corriger nos erreurs. Enfin, nous avons fini notre journée en nous intéressant à l'importance du Questinaire de la Douleur St-Antoine (QDSA), de l'Echelle Visuelle Analogique (EVA), et à leur mode de passation.

**2ème jour de formation**

Les bases étant bien remises en place précédemment, le rythme fût plus rapide. Les

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e-mail : Alice.Ruef@erasme.ulb.ac.be

informations fusaient. La journée était beaucoup plus orientée sur la prise en charge des patients atteints de CRPS et de névralgie. Nous avons de nouveau fait de nombreux liens avec des cas pratiques.

L'utilisation de l'atlas cutané fut expliquée afin de nous permettre de bien cibler les branches des nerfs lésés et ainsi de proposer une intervention précise auprès de nos patients. Un parallèle avec le module 1 fut à chaque fois proposé.

L'après-midi, Claude nous a proposé de faire un atelier pratique ayant pour but de comprendre l'atlas et d'apprendre d'une manière ludique les territoires de distribution cutanées et les territoires autonomes. Nous avons donc dessiné sur le corps de nos voisins. Nous sommes rentrés bariolés de cette 2ème journée.

### 3ème jour de formation

Différents sujets ont été abordés ce jour là : l'éducation thérapeutique, les mécanismes de l'allodynie mécanique, l'utilisation du Vibralgic™ et du Vibradol®, les traitements des fibromyalgies, l'hyposensibilité sous-jacente…

Les questions qui étaient restées en suspens jusqu'alors eurent réponse ce jour par des réponses précises de Claude.

Pour conclure, nous ressortons de cette formation avec des réponses à certaines de nos questions mais aussi avec de nouveaux questionnements. Cette formation nous a offert des rencontres de toutes parts. En premier lieu, ce sont les personnes qui, comme nous, apprennent en essayant d'appliquer la rééducation sensitive auprès de leurs patients. Leur expérience, avec leurs difficultés et leurs réussites, est enrichissante et rassurante. En second lieu, il y a le forum, où chacun peut poser ses questions et où d'autres tentent d'y répondre. Cela nous permet d'être moins seul dans notre pratique et de partager/diffuser nos observations. Et, petit à petit, à force de rencontres, notons que des collaborations se mettent en place. Enfin, la lecture du *e-news Somatosens Rehab* et des références nous permettent aussi d'approfondir et de spécifier nos connaissances. Mais n'oublions pas les acteurs principaux : Claude Spicher et Isabelle Quintal qui, en collaborant d'une manière optimale, on pu nous transmettre leur expérience d'une manière continue entre les modules 1 et 2.

# Who are you?

**You are 36'375 neuroscientists, medical doctors, therapists & patients all over the world on the 5 continents, in 138 countries**

Albania, Algeria, Argentina, Armenia, Australia, Austria, Azerbaijan, Bahamas, Bangladesh, Barbados, Belarus, Belgium, Bermuda, Bosnia & Herzegovina, Botswana, Brazil, Brunei, Bulgaria, Cambodgia, Cameroon, Canada, Cayman Islands, Chile, Colombia, Costa Rica, Cote d'Ivoire, Croatia, Cuba, Cyprus, Czek Republic, Denmark, Dominican Republic, Ecuador, Egypt, Estonia, Ethiopia, Finland, France, Gabon, Georgia, Germany, Ghana, Greece, Guatemala, Hong Kong, Haïti, Hungary, Iceland, India, Indonesia, Irak, Iran, Ireland, Israel, Italy, Jamaica, Japan, Jordan, Kenya, Korea, Kosovo, Kuwait, Kyrgyzstan, Latvia, Lebanon, Libya, Lithuania, Luxemburg, Macau, Madagascar, Malawi, Malaysia, Mali, Malta, Mauritania, Mauritius, Mexico, Moldova, Mongolia, Montenegro, Morocco, Mozambique, Namibia, Nepal, Netherlands, New Caledonia, New Zealand, Niger, Nigeria, Northern Ireland, Norway, Pakistan, Paraguay, Palestine, Panama, Peru, Philippines, Poland, Portugal, Republic Democratic of Congo, Republic of Fiji, Republic of the Union of Myanmar, Romania, Russian Federation, Rwanda, Saudi Arabia, Seychelles Islands, Senegal, Serbia, Singapore, Slovakia, Slovenia, South Africa, South Korea, Spain, Sri Lanka, Sudan, Sultanate of Oman, Sweden, Switzerland, Taiwan, Tanzania, Thailand, Togo, Trinidad, Tunisia, Turkey, Uganda, Ukraine, United Arab Emirates, United Kingdom, United States of America, Uruguay, Venezuela, Viet Nam, Zambia, Zimbabwe.


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