

Sample Medical Analysis on LTD/ERISA Case
File reviewed including claims file: 300 pages.
Time spent: 8 hours total. (note: Names/facts changed)

Tom Smith

Re: Susan Jones

Dear Tom:

Pursuant to your request, I have reviewed the materials you provided including the reports of Dr. Randall and Dr. Finn on Ms. Jones. I have grave concerns regarding the validity of their conclusions that Ms. Jones does not suffer from Reflex Sympathetic Dystrophy (RSD) and exhibits symptom magnification.

To begin, it is quite noteworthy that Dr. Randall acknowledged that Dr. Morley found redness and coldness to Ms. Jones's right upper extremity. That is *not* a *normal* finding. He completely ignored the July 25, 2002, report of Medical Advance Pain Specialist documenting atrophy of the right hand when compared to the left. Measurement around the main part of the hand was 7 ½ inches on the right compared to 7 7/8 inches on the left. As such, Ms. Jones had a smaller right hand than left hand. Assuming she is right handed, her right hand should actually be *larger* than the left, so the measured atrophy is really greater than it appears. In fact, if the hands were of equal bulk, that would still be evidence of atrophy of the right hand.

Further, she had decrease finger flexion in mp joints 2-4 as well as hypersensitivity in the index area of the palm and thumb, and some discoloration of the right fingertip of the index finger. Yet he failed to mention them in his report, stating that Dr. Harris acknowledged no objective findings and that was consistent with all the other physicians' findings.

Dr. Randall's review was biased and incomplete. He was quick to state that physicians at the University of Georgia Medical Center were of the opinion that Ms. Jones's symptoms were *not* consistent with Complex regional pain syndrome (CRPS). However, he failed to mention that Dr. Perry's impression was neuropathic pain in the median nerve distribution with involvement of the right thenar and palm which suggest injury to the carpal tunnel region. He also failed to mention Dr. Perry's recommendation for increased medications to include long acting opioid to improve pain control. While Dr. Perry felt that CRPS was less likely, he clearly felt there was objective pathology to support her pain complaint. Yet this was omitted from Dr. Randall report.

His claim that your client's complaints are more consistent with Somatoform Disorder vs CRPS/RSD is unscientific and just plain wrong. He alleged your client was intentionally exaggerating yet by definition, if you have Somatoform disorder you cannot be malingering.¹ Furthermore, he is not a psychologist nor did he refer her to one for

¹ APA Diagnostic and Statistical Manual, 4TR at 485

psychological testing to support this psychological diagnosis. He also failed to take a psychiatric history yet claims her depression is due to her husband's affair 4 years prior to any symptoms of depression.

This expert has authored nothing on the topic of CRPS/RSD and is clearly not aware of published diagnostic standards which were followed by the treating doctor as set forth in the International Association for the Study of Pain. Please note that this condition is so painful that one of the published side effects is "Suicide"²

Regarding Dr. Randall's note that Dr. Morley agreed there were no clinical findings, this is questionable at best. On December 16, 2007, and December 19, 2007, Dr. Morley responded to the carrier's inquiry, advising that he disagreed with the findings of the IME. Since I do not see a letter sent to Dr. Harris confirming their telephone discussion, I would speaking with Dr. Morley to determine if this is a misrepresentation of his conclusions and discuss all the clinical findings supporting the diagnosis.

Dr. Finn made much of the fact that there was no clinical finding of RSD during his one hour and twenty minute visit with Ms. Jones. The gold standard for diagnosing reflex sympathetic dystrophy is the International Association for the Study of Pain. It provides that symptoms fluctuate at times³. Therefore, the fact that she doesn't have the same symptoms every visit is not at all inconsistent with the standard of traditional reflex dystrophy. It is of interest to note that the records of Dr. Harris provided to Dr. Finn by the carrier began in July 2004, even though Ms. Jones treated with Dr. Harris since 2001. Dr. Finn acknowledged in his report that those records are important, yet there is no evidence they were supplied. Why not? Why didn't he ask for them? Doctors have a duty to reach conclusions only after they have the relevant facts. In fact, his own code of ethics, the link which I forwarded to you earlier by email, compels him to make an effort to obtain that information in a forensic case. Could it be those earlier records contain objective clinical evidence of RSD?

Often times, the defense expert will claim that nothing is wrong with an individual by avoiding any kind of *accurate* physical examination. That appears to be what we are dealing with currently. Rather than Dr. Finn's blatant suppositions, a simple measurement using a tape measure, comparing left to right would have provided clear, objective data of asymmetry. However, he failed to perform this simple examination. One can infer the reason he did not do so was his fear of identifying the obvious asymmetry. Remember, WNL doesn't always mean "within normal limits." It is also referred to by doctors in the profession as "*We never looked.*"

I find it interesting to note that he failed to measure the temperature of the extremity question, which could be accomplished with a simple laser thermometer, which

² Classification of Chronic Pain, Descriptions of Chronic Pain Syndromes and Definitions of Pain Terms, International Association for the Study of Pain, Taxonomy, on Chronic Pain.,²nd Ed IASP Press 2002, at 41.

³ Id at, p 41-42. This can be purchased by going to the IASP website. Page 42 states: "symptoms sometimes fluctuate at times."

can be purchased for as little as \$31.00, is non-invasive and does not require touching the extremity. See:

http://www.google.com/products/catalog?hl=en&q=laser+thermometer&bav=on.2,or.r_g.c.r_pw.&wrapid=tlif130340878911710&um=1&ie=UTF-8&cid=15744087931737453081&sa=X&ei=mnCwTZDKBofv0gHmve3mAg&ved=0CDoQ8gIwAA#

When the laser thermometer is aimed at the body parts of a person with RSD, you can see there is a clear temperature difference. (I suggest you actually buy one... you can get by just “Google” it. They were originally created to determine the temperature of air vents).

Dr. Finn criticizes Ms. Jones for moving and gesturing with her right hand. It is important to note that there is a difference in using the right hand to gesture to someone versus actually being *touched* by an individual. While RSD can cause significant hypersensitivity and pain when touched by something even as light as a cloth, one cannot conclude that by the simple act of moving the hand thru the air there would be no pain in the affected extremities or no experience of pain when touched. That appears to be Dr. Finn’s claim on page 4 of his report.

On one hand, he is claiming she is exaggerating, and on the other hand he criticizes her for no facial grimacing during the time she was clasping her hand, indicating she felt no discomfort. I would point out that the activity of having her hand hang down rather than holding it up, actually makes symptoms worse. *See:* The International Research Foundation for RSD/CRPS has promulgated the Clinical Practice Guidelines, Third Edition by Dr. Anthony Kirkpatrick, MD/PhD⁴. By holding her hand she is actually guarding it, instead of letting it swing loose, where it can bump into something or something can bump into it. Therefore, the behavior of holding her hand is actually more consistent with true and legitimate reflex sympathetic pain. (I think you could probably find some articles on this).

Moreover, the records show that Ms. Jones has had extensive physical therapy and instructions on range of motion to keep her hand mobile. Her doctor probably told her to move her hand as much as possible to minimize the atrophy, and by following that advice she is being penalized by the defense expert. Someone who has RSD is basically operating from the standpoint of fear. The action he is describing was that of her *protecting* her arm. She likely didn’t want the doctor to touch it because she knew that he was not hired to help her. Frankly, I wouldn’t either. He claims the observations of this behavior continued for an hour and twenty minutes, which, frankly, is difficult to believe.

There is no mention that Dr. Finn checked her grip strength. I’d like to know exactly what he earned for this minimal examination. All he needed to use was a hand dynamometer which would tell if, in fact, the grip strength is full effort by the

⁴ International Research Foundation for RSD/CRPS, Clinical Practice Guidelines – Third Edition, pg. 11. “Hand hangs down and the blood goes to the hand is actually more painful than holding it up.”

consistency of three grip strengths in each hand within a certain number of degrees of each other. In other words, if an individual is trying to fake it, then the three measurements wouldn't be similar in nature. But, if they are not trying to fake it, it would be fairly similar, and it appears as though he didn't even test her for grip strength, but simply presumed it to be appropriate. The treater measured grip strength and reported it as abnormal which Dr. Finn conveniently left out of his report.

Dr. Finn claims that he couldn't see any discoloration or atrophy in her hands. I would suggest that you photograph her arm the next time you see it, and even videotape the use of the laser thermometer on her extremities. I believe that an x-ray or a triple-phased bone scan would reveal demineralization of the bones, since she hasn't used her hand much and has been wearing a wrist brace. You might wish to consult with her treater about this.

The one examination of the right extremity performed by Dr. Finn was not properly documented. He states that Ms. Jones's reflexes are limited on the right upper extremity. That is important because one cannot *fake* reflexes, and he doesn't even bother to grade them 1+, 2+, 3+. Which is it? To say that an individual has limited (translation abnormal) reflexes, and yet say that the individual has reported pain complaints not supported by objective findings, doesn't make sense. He is basically saying there are no objective findings, while at a minimum, ignoring his own result of reflex testing.

He also states that he measured range of motion, but I don't see whether he utilized an inclinometer or goniometer. The AMA Guides for Evaluation for Permanent Impairment specifically states one needs to be used and suggests the use of the inclinometer (this is the Fifth Edition, please note, there is now a 6th edition).⁵

Dr. Finn completed a physical capacities form, advising that Ms. Jones was capable of performing light duty, but he gave no basis for his assertion, no reproducibility of his conclusion, and there appears to be no discussion whatsoever on the combination of side effects of the medications she might be taking. I entered her medications by going to www.epocrates.com and, unfortunately, when you log on and do same (It's free) you will find the side effects of the combinations of her medications include:

- a. Profound sedation
- b. Significant psychomotor retardation.
- c. Confusion

That being the case, the fact that he releases her to work and operate heavy machinery is of great concern. Please provide the attached link to the results to your treater so he is aware of the effects of the combinations of medications your client must take and its resulting effects on employment.

Since there is no reproducibility measure, nor is there any standardized measure from which he extrapolates what the claimant can do, other than to simply say there is no

⁵ The reference to the AMA requires that an individual is to rely upon range of motion. The utilization of inclinometer is noted on Page 402 of the Guide.

restriction, then there is no scientific measure. This is not a standard functional capacity evaluation I am used to assessing. [I am enclosing one that I have done for another lawyer for you to review].

Ms. Jones mentions a number of medications that she has been taking, but I couldn't tell from Dr. Finn's report if he even determined what medications she was currently taking at the time she saw him. She was taking Topamax, Amytriptylene and Lexapro, Vicodin, Tylenol Codeine, among others. Most of these have research-proven deleterious cognitive effects. To perform a transferable skills analysis to highly cognitive jobs without taking into consideration effects of cognitively impairing medication is a fatal flaw, which invalidates the subsequent conclusions that she is capable of sedentary work involving highly cognitive functioning.

Regarding the Topamax, according to Micromedex, central nervous systems effects of Topiramate at doses of 200 - 400mg/day include: somnolence, dizziness, ataxia, speech disorders and related speech problems, psychomotor slowing, nystagmus, and paresthesia. The most common dose related adverse events at doses of 200 - 1000 mg/day include: fatigue, nervousness, difficulty with concentration or attention, confusion, depression, language problems, anxiety, mood problems, cognitive problems and tremor. It is also noted that "cognitive impairment" is a relatively common adverse effect of Topiramate.⁶ Such symptoms would also clearly interfere with her ability to perform jobs requiring cognitive skills.

Salinsky et al (2005) stated, "Topiramate (TPM) impaired cognitive test performance, where as gabapentin had minimal effects. *The effects of TPM were of sufficient magnitude potentially to affect daily and occupational function.*"⁷ (bold and italics added). Ojemann et al (2001) found significant verbal and language disturbances as a side effect of topiramate.⁸

I am enclosing links to articles concerning the major effect that Topamax plays on cognition, even at dosages prescribed for Ms. Jones. To conclude, ability to work without taking into consideration the potential adverse effects of Xanax and Topamax on cognition and performance is to blatantly ignore important potential contributory factors in the pursuit of a predetermined conclusion.

Relevant to this issue, Dr. Finn also neglected to take into account the reports of post traumatic headaches as possibly reflecting *head trauma*. This is important to potential cognitive effect on her ability to perform other occupations. Ms. Jones suffered a fall, striking her head. That portion of the assessment was dismissed by Dr. Finn, stating she "had a questionable head injury unrelated to this accident, so *I'm not going to*

⁶ Micromedex.com, citing article by Kellett et al, 1999; Harden, 1994; Rosenfeld et al, 1992; Rak & Isacoff, 1993; Ben-Menachem, 1992; Britton & So, 1995.

⁷ Effects of topiramate and gabapentin on cognitive abilities in healthy volunteers, M.C. Salinsky, M.D., et al, *Neurology*. 2005 Mar 8;64(5):792-798.

⁸ Language Disturbances as Side Effects of Topiramate and Zonisamide Therapy, Ojemann, LM, et al, *Epilepsy Behav*. 2001 Dec;2(6):579-584.

deal with it any further except to say she has some post traumatic headache not related to the accident”. So it does not appear that he took into consideration her post traumatic headaches and medications used to treat her headaches on her ability to perform cognitive occupation.

I don't see in the report when she was actually lying down, and since the examination took place in December in Florida one might presume that she was wearing a sweater. Why does that matter? Because in the report, he states that she has no significant muscle spasms, but he doesn't indicate if he even tried to palpate them *over* a bulky sweater. Since she was not gowned, his claim there was no spasm is not supported since he conducted his palpation, if at all, over thick clothing. Imagine a ob/gyn conducting a breast examination in this fashion and then concluding no lumps.

Tom, unless your client has lied for a number of years (I would demand surveillance because if they have it, and it's negative, that speaks volumes), I frankly can't believe this doctor.

Unanswered Questions:

1. Why didn't the doctor actually measure the range of motion suggested by the Guide?
2. Why didn't he measure the client's bulk to see if there was atrophy which was present a number of years ago?
3. Why didn't he admit the prior findings consistent with CRPS/RSD in reports of other doctors?
4. Why didn't he measure her temperature using a laser thermometer before claiming it was normal?
5. How does the fact that Ms. Jones didn't get up and move around while he was taking her history for an hour and 20 minutes equate to the individual being capable of working an entire eight-hour day?
6. Why does the doctor blame her condition on a psychological condition for which he did not inquire, is not trained to opine and then fail to send her out for a proper psychological examination? That is like concluding someone has Leukemia but knowing nothing about it, doing no blood work and not referring the patient to a specialist.

In conclusion, there is overwhelming evidence of Dr. Finn's neglect of very simple clinical tests, such as temperature, grip strength, or measurement for symmetry, as well as his own reflex results. He also neglected to incorporate the potential adverse effects of the medications Ms. Jones was taking on her cognitive ability to do work. To wholeheartedly endorse symptom magnification in the face of so much contradictory (or at least contributory) data and medication information suggests bias on Dr. Finn's part, and raises questions concerning his impartiality. Overall, I believe his data and conclusions are suspect and invalid for the many reasons cited above and suggest you have these addressed with her treating doctor.