

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. Donald Randall acknowledged that Dr. Martin found redness and coldness to Ms. Jones's right upper extremity. That is *not* a *normal* finding. He totally 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. 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 clearly biased. He was quick to state that physicians at the University of Florida 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.

Regarding Dr. Randall's note that Dr. Martin agreed there were no clinical findings, I cannot help but wonder whether or not this assertion is actually legitimate. On December 16, 2007, and December 19, 2007, Dr. Martin 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 suggest a letter from Dr. Martin indicating that it was not correct and pointing out 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 times¹. 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. What were they hiding? 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 of Ms. Jones's hand would have provided clear, objective data of symmetry. 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.

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 can be purchased for as little as ninety dollars (\$90.00), is non-invasive and does not require touching the extremity. 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" laser thermometer. An example can be found at www.montanatest.com).

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 terrific 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 the 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 hanging the hand down rather than holding it, 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/PhD². 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

¹ 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, p 41-42. This can be purchased by going to the IASP website. Page 42 states: "symptoms sometimes fluctuate at times."

² 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."

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 myopic examination. All he needed to use was a hand dynamometer which would tell if, in fact, the grip strength is full effort by the 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. He 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.

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, the Sixth Edition has come out but I haven't read it).³

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

³ 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.

of side effects of the medications she might be taking. A really good site for this would be www.epocrates.com. 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 restriction, then there is no scientific measure.

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.⁴ 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.***"⁵ (bold and italics added). Ojemann et al (2001) found significant verbal and language disturbances as a side effect of topiramate.⁶

I am enclosing 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,

⁴ Micromedex.com, citing article by Kellett et al, 1999; Harden, 1994; Rosenfeld et al, 1992; Rak & Isacoff, 1993; Ben-Menachem, 1992; Britton & So, 1995.

⁵ 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.

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

stating she “had a questionable head injury unrelated to this accident, so *I’m not going to 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 October in Minnesota 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 the sweater, which unfortunately, I see all the time.

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. I did a search regarding Dr. Finn and I am just sending that report including the case which we found in which he has testified.

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. 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?

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 constitute multiple fatal flaws.

Sincerely,
Sims, Stakenborg & Henry, PA

Claudeth Henry
For the Firm