12
King's Bench Walk

Next Talk: 10:00 – 10:40

Painful medico-legal issues in Chronic Pain & CRPS & how to deal with them.

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This talk will not….

- Repeat lectures you have heard before about what Chronic pain/CRPS is;
- Tell you that Chronic pain does not exist;
- Tell you that all Claimants with CP/CRPS are lying.

This talk will……

- Look at some new issues arising in CP cases
- Help you to identify issues that arise in these cases
- Give you pointers as to how to deal with issues that arise
- Hopefully be of assistance to those representing Claimants and Defendants

- We will cover:
  - NICE guidelines
  - Specific issues in CRPS
  - New category of pain
  - Dishonesty
  - Causation
  - Care and rehabilitation


IMPROVED
PAIN SCALE
1 IT MIGHT BE AN ITCH
2 I JUST NEED A BANDAID
3 ITS KIND OF ANNOYING
?#$!
4 THIS IS CONCERNING
BUT I CAN STILL WORK
5 BEES?
BEES!
6
I CANT STOP CRYING
7
I CANT MOVE
IT HURTS SO BAD
8
MAULED BY A BEAR
OR NINJAS
9
UNCONSCIOUS
10

What's that coming over the hill.....?

- Early identification of CP cases is key for C and for D
  - Are they still off work?
  - High pain levels on the VAS
  - Catastrophising
  - Early offers of rehab
  - Early access to medical records
  - Seeing claimant's face to face – understanding them

NICE National Institute for Health and Care Excellence

7th April 2021

Chronic primary pain

Examples include:

- Fibromyalgia
- Chronic primary headache and orofacial pain
- Chronic primary musculoskeletal pain
- Chronic primary visceral pain

Chronic primary pain has no clear underlying condition, or symptoms may seem to be out of proportion to any observable injury or disease

The clinical presentation is consistent with the ICD-11 definition

ICD 11 Chronic Pain (Code MG 30)

- *"Pain is an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage. Chronic pain is pain that persists or recurs for longer than 3 months.*
- *Chronic pain is multifactorial: biological, psychological and social factors contribute to the pain syndrome".*

Chronic Widespread Pain (MG 30.01)

- A wider term than "**Fibromyalgia**"
- *"Chronic widespread pain (CWP) is diffuse pain in at least 4 of 5 body regions and is associated with significant emotional distress (anxiety, anger/frustration or depressed mood) or functional disability (interference in daily life activities and reduced participation in social roles)."*

Chronic Widespread Pain

- *[1]. CWP is multifactorial: biological, psychological and social factors contribute to the pain syndrome. The diagnosis is appropriate when the pain is not directly attributable to a nociceptive process in these regions and there are features consistent with **nociplastic** pain*

- *[2] and identified psychological and social contributors*

Complex Regional Pain Syndrome *(Code 8D8A) Autonomic disorder*

- Note the separate coding & Categorisation
- Not categorised in the same section as chronic pain
- Often wrongly (even by some medical experts) referred to as "**Chronic Regional Pain Syndrome**" but no such condition is known to medicine.
- This is **WRONG** and a clear sign the "expert" may not be so expert in this area

CRPS

- *"a chronic pain condition in an extremity with a variable course over time. It is characterised by continuing regional pain (not in a specific nerve territory or dermatome), usually with distal predominance or distal-to-proximal gradient. It typically arises after tissue trauma and is seemingly disproportionate in magnitude or duration to the usual course of pain after such tissue trauma. CRPS is characterized by signs indicating autonomic and neuro-inflammatory changes in the affected body region varying between patients and over time. Often, CRPS is accompanied by significant emotional distress or functional disability. CRPS is multifactorial." ICD 11 8D8A*

Is CRPS is different to Chronic Pain?

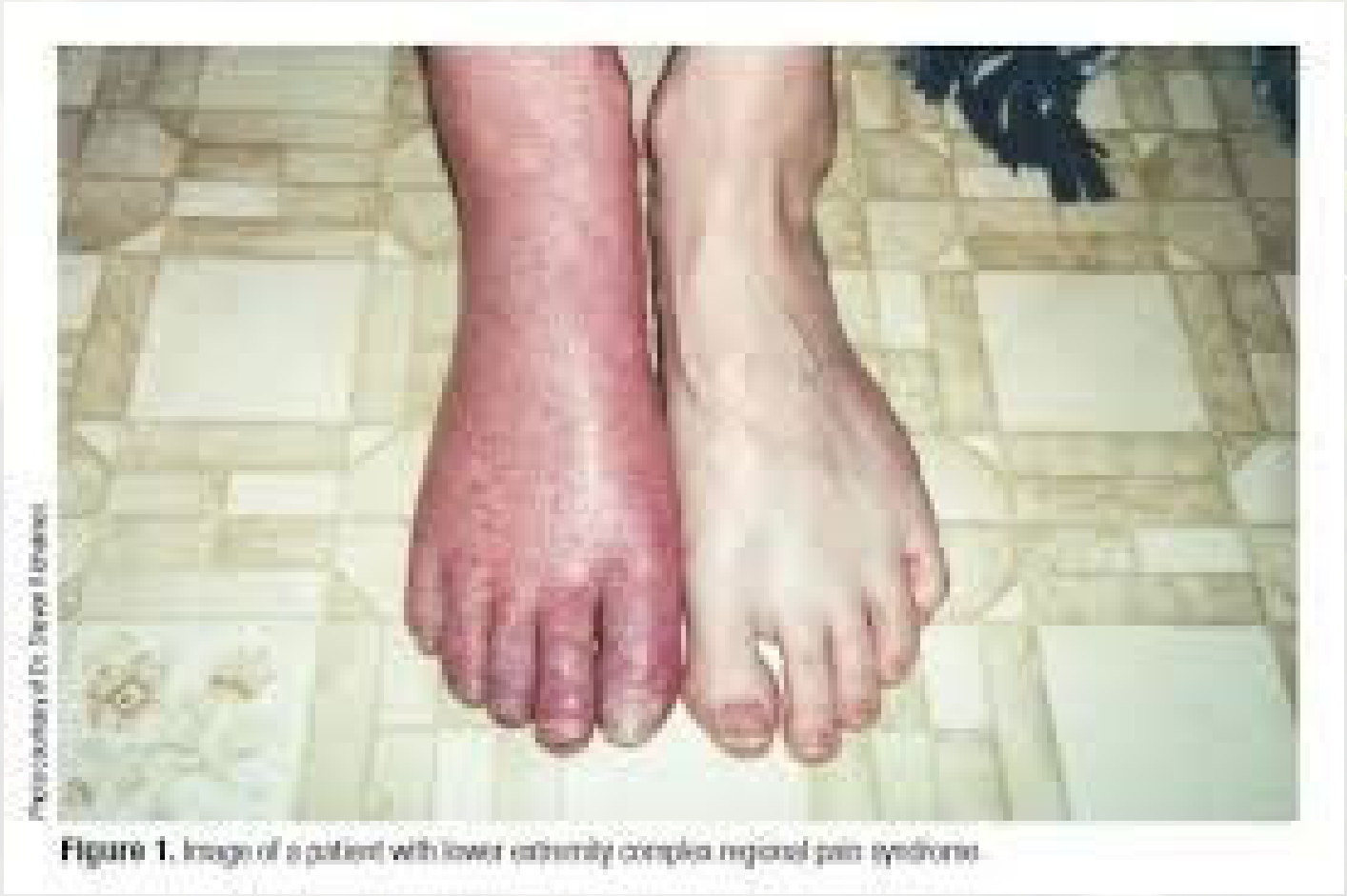
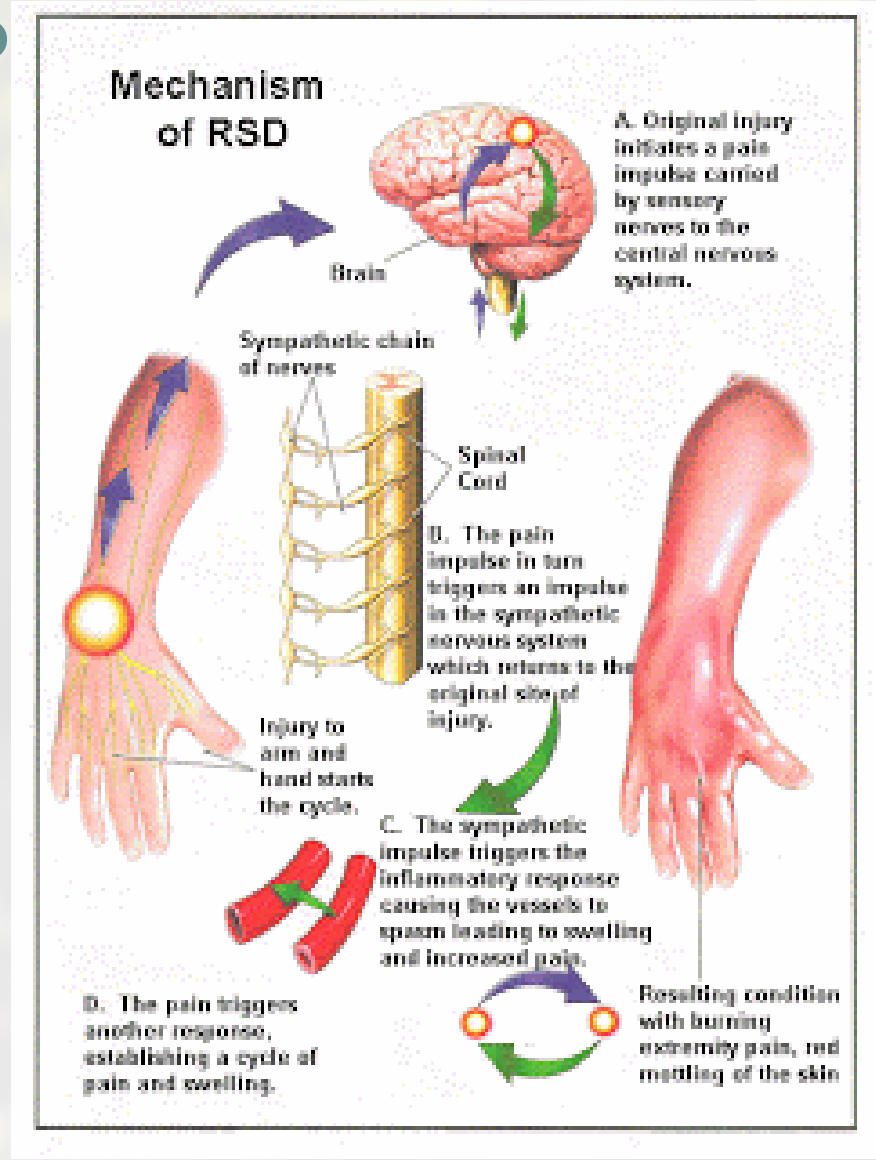


Figure 1. Image of a patient with lower extremity complex regional pain syndrome.

Signs of CRPS

Mechanism of CRPS?



CRPS Types

Table 2

Comparison of CRPS Types

Signs and Symptoms	CRPS Type 1	CRPS Type 2
Precipitating event	Sometimes	Yes
Single peripheral nerve involvement	Sometimes	Yes
Physiologic changes in affected limb	Yes	No
Cardinal signs	◗ Spontaneous pain ◗ Swelling ◗ Different skin temperatures	◗ Burning pain ◗ Allodynia ◗ Hyperalgesia
Progressive	Yes	Sometimes
Bone atrophy	Yes	No

Nociplastic Pain

- A new category of type of pain
- Previously thought pain was either:-
  - Nociceptive- arising from damage to tissues normally dull or thudding type pain
  - Neuropathic- arising from damage to nerve tissue- often burning, electric shocks

Nociplastic Pain

- November 2021 Volume 162 Number 11


Commentary

PAIN®

Nociplastic pain: helping to explain disconnect between pain and pathology

David A. Walsh[a,b]

Nociplastic pain

- Helps to explain why tissues not injured can be perceived as painful
- Also associated with hypersensitivity, fatigue, sensitivity to sound, light, odours, sleep disturbance, cognitive problems
- Good news is that the pain is not necessarily permanent. It is reversible
- Mechanisms behind it remain poorly understood. Central mechanisms in all probability.

Chronic pain (primary and secondary) – using NICE guidelines for assessment and management

NICE National Institute for Health and Care Excellence

Assessment for people aged 16 years and over with any chronic pain

Recommendations in the NICE guideline on chronic pain for patient-centred assessment, thinking about possible causes, talking about pain, providing advice and information, developing a care and support plan and flare-ups

Chronic pain and a NICE guideline for the condition

Management options in the NICE guideline for the condition (for example, NICE guidelines on endometriosis, headaches, irritable bowel syndrome, low back pain and sciatica, neuropathic pain, osteoarthritis, rheumatoid arthritis, spondyloarthritis)

Use clinical judgement:

- **to assess whether the pain or its impact is out of proportion to the underlying condition and would be better managed as chronic primary pain**
- **to inform shared decision making about options in the NICE guideline for the underlying condition and the NICE guideline for chronic pain if chronic secondary pain and chronic primary pain coexist**

Chronic primary pain (no clear underlying condition or impact of pain is out of proportion to any observable injury or disease)

Management options in the NICE guideline on chronic pain:

- **Exercise programmes and physical activity**
- **Psychological therapy**
- **Acupuncture**
- **Pharmacological management**

Chronic primary pain

Examples include:

- Fibromyalgia
- Chronic primary headache and orofacial pain
- Chronic primary musculoskeletal pain
- Chronic primary visceral pain

Chronic primary pain has no clear underlying condition, or symptoms may seem to be out of proportion to any observable injury or disease

The clinical presentation is consistent with the ICD-11 definition

Chronic pain persists for more than 3 months. Chronic primary pain has no clear underlying condition or is out of proportion to any observable injury or disease. Chronic secondary pain is a symptom of an underlying condition. Chronic secondary pain and chronic primary pain can coexist.

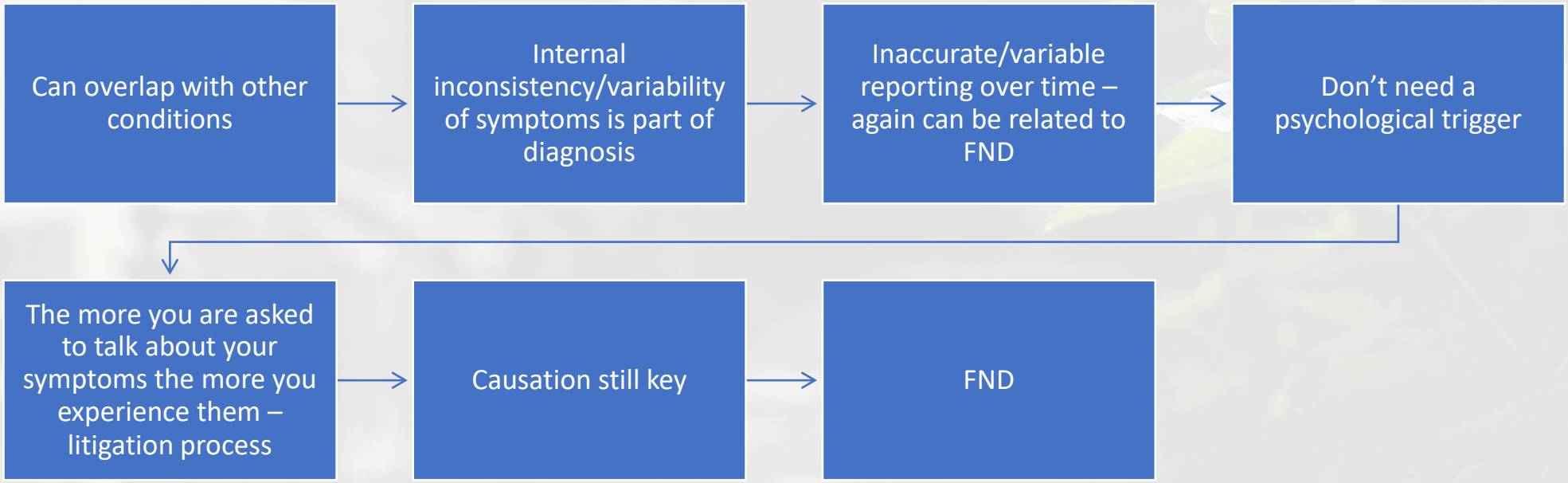
Pathway for Chronic Pain

- Exercise- 23 studies showed exercise reduced pain. 22 studies- improved quality of life
- Psychological therapy- ACT & CBT
- Acupuncture-27 studies showed that reduced Pain and Increased Quality of life (Short-term)
- Pharmacological management

No evidence of benefit

- TENS
- Ultrasound
- Interferential therapy
- Anti-epileptic drugs e.g. Gabapentin, Pregabalin (Clinical trials & after careful evaluation- maybe)
- Anaesthetics
- Cortico-steroids
- NSAIDS
- Paracetamol
- Opioids

FND – particular challenges



FND and CRPS

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Complex regional pain syndrome – Autoimmune or functional neurologic syndrome

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FND and CRPS

- Paucity of evidence to support that CRPS is an autoimmune disease
- Diagnostic criteria virtually identical to current DSM 5 FND and proposed ICD 11, FND diagnosis
- Possibility is that CRPS is another “functional disorder” a subset of FND
- Dystonia primary movement disorder is reported in 90% of CRPS cases

FND

- Genuine movement disorders or seizures not related to a defined disease
- Some argue that but for the “invention” of CRPS as a diagnosis it is better explained as an FND by the DSM 5 criteria.
- That explains disproportionate pain
- Cannot be explained by a neurological pathway or medical condition

Litigation

In a study of 50 CRPS patients involved in litigation in the UK

Somatoform disorders found in 42 of the 50

21 showed FND symptoms such as a “claw-hand”

In 19, the diagnosis of CRPS was questioned

Depression and panic attacks were common 30/50 and 10/50

32 of the 50 were on opiates

Are symptoms being reinforced and prolonged by litigation?

Limitation

Of medical knowledge that is

Medicine just doesn’t yet know why some people suffer these maladies

CRPS label may not help - mechanism not discernible

Reassurance and helping a patient to return to function as in an FND diagnosis is likely to be beneficial

Litigation should be settled as soon as possible

Dishonesty

- You cannot have a talk about Chronic Pain without considering dishonesty
  - Genuine cases of CP exist
  - CRPS if properly diagnosed more likely to be genuine – but not always
  - Subjective symptoms can always be feigned or exaggerated
  - Unconscious exaggeration
  - Pain behaviour and cycle of belief/disuse

- 2 Types of Claimant
  - Long pre-accident history; Depression – the Red Flag case
  - No history of somatising, no history of mental health issues – the clean slate

The Red Flag case

Clear history of somatising or of frequent GP trips for generalised ailments such as stomach problems.

Depression/anxiety or history of marital problems or other negative life events.

Likely in a low paid or stressful job e.g. public sector job.

Exaggeration is less likely to be conscious

If dishonest these are less likely to be about faking CP symptoms but about failing to disclose relevant history.

This is the Claimant where efforts best directed to challenging ***causation.***

The clean slate case

There is no obvious vulnerability to developing chronic pain

The stakes are high if there is a reduced earning capacity

All or nothing case

More likely to be CRPS? What if CRPS is Functional?

This is the Claimant who you should scrutinise

Evidence – C

SCRUTINISE RECORDS AND CROSS REFERENCE – DWP/EMPLOYMENT

ASK THE DIFFICULT QUESTIONS

PREPARE ON THE BASIS THAT THERE WILL BE SURVEILLANCE

LOOK FOR EVIDENCE TO SUPPORT THE CHRONOLOGY/NARRATIVE

PICK YOUR EXPERTS WISELY – CHALLENGE THEM

MAKE SURE WHOLE PICTURE CONSIDERED

CONFERENCE WITH EXPERTS

Evidence – D

Scrutinise records and cross reference – DWP/employment

Plan surveillance properly – ‘good day/bad day’ argument

Get orthopaedic experts to take footage of gait or movement at exam

Earlier the better with social media profiling

Conference with experts

Walkden v Drayton Manor [2021]
EWHC 2056 (QB)

- This was more of a ‘clean slate’ type case
- Chronic (back) pain resulting in loss of a business claimed
- Defeating it required detailed analysis of records/social media and quality surveillance
- The judge found he suffered mild and even ongoing injury but was entitled to reject the claim of a ‘chronic pain syndrome’
- Disclosure here included evidence of an application for financial support to a friendly society
- Good example of a case where small pieces built up to a bigger picture of dishonesty

Odewale v LB Tower Hamlets HHJ Baucher 10/10/19

- Fibromyalgia/Myofascial pain case
- Extremely high levels of disability (unable to hold a cup)
- Key to defeating this claim:
  - Surveillance on same day as expert examination
  - Footage taken at the examination
  - Careful trawl through DWP records

Causation

- Occupational Health/Personnel –
  - Were they happy at work?
  - Is this someone who was engaged in their career?
  - Amount of sick leave – adaptations at work
  - Had they raised grievances etc.

RESEARCH ARTICLE

Sick Leave within 5 Years of Whiplash Trauma Predicts Recovery: A Prospective Cohort and Register-Based Study

Tina Birgitte Wisbech Carstensen[1]*, Per Fink[1], Eva Oernboel[1], Helge Kasch[2], Troels Staehelin Jensen[3], Lisbeth Frostholm[1]

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Conclusions

Sick leave before the collision strongly predicted prolonged recovery following whiplash trauma. Participants with acute whiplash trauma had weaker attachment to labour market pre-collision compared with the general population. Neck pain at inclusion predicted future neck pain. Acute whiplash trauma may trigger pre-existing vulnerabilities increasing risk of developing whiplash-associated disorders.

Causation

- Medical records
  - Is there a history of investigation for illness with no cause found?
  - Mental health issues
  - Adverse life events
  - Retrospective identification of somatic symptom disorder
  - Response to previous life events

Causation

- DWP
  - Do the symptoms worsen after a refusal of a benefit?
  - Was the person claiming a benefit pre-accident? – applications
  - Findings on assessment correlate with symptoms claimed?
  - Carer for a partner/child?

Exacerbation

If we start by assuming that a claimant has a pre-existing condition or vulnerability,

an accident may cause that to become symptomatic for a period of time and thereafter the symptoms will subside with no noticeable long term effects on the claimant.

In such a situation the claimant may claim **damages only for the period of exacerbation.**

Acceleration

- It is often the case that a claimant has a pre-existing condition which is rendered symptomatic for a period of time
- but the underlying condition is also brought forward by a period of years.
- In such a case the **damages** are awarded for the **initial period of exacerbation** and **also** for the **period by which the underlying condition is brought forward**

Vulnerability

Ignore vulnerability (take victim as find them)	
Assess 100%	Damages

↓

Discount % chance of happening anyway	
Ignore tortious events	Take into account non-tortious events

↓

Clinician- Tell the Court what sort of event	
Judge	Assesses chance of that event happening

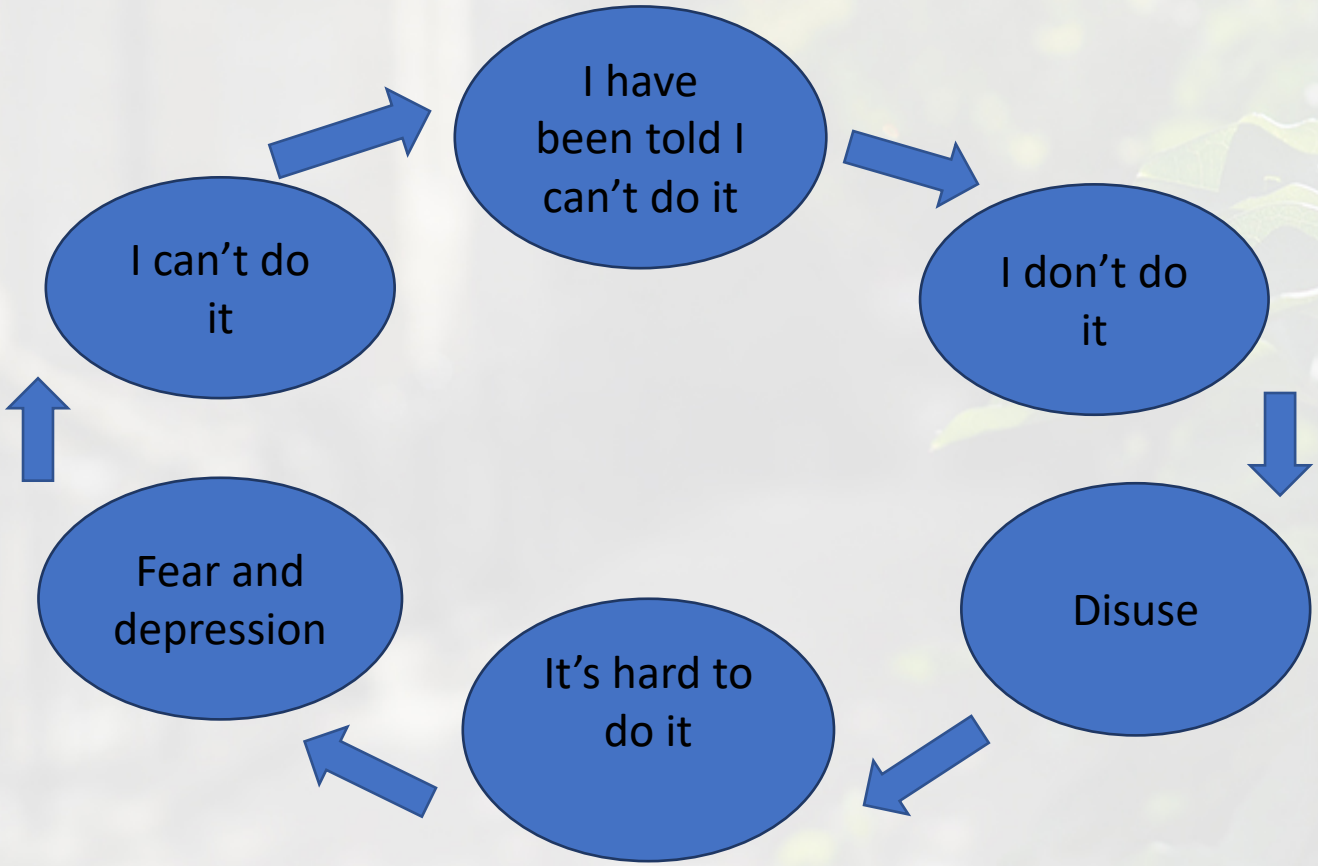
Discounts

- In Heil v Rankin – 50%
- Malvicini v Ealing -10%
- Discounts vary and factors include the characteristics of the Claimant, medical history and seriousness of the inciting event

Rehabilitation/Care

- Does the care/rehab package proposed help or hinder?
- In seeking to maximise damages – is this hindering progress in recovery?
- Dependency on care/aids/equipment a real issue – entrenches behaviour – can physically decondition
- Vicious circle
- Physiotherapy – pro's and con's

Cycle


I have been told I can't do it
I don't do it
Disuse
It's hard to do it
Fear and depression
I can't do it

Neuroplasticity

The brain is not a one-trick pony

If your neural pathways can become conditioned to ‘pain’ the opposite is true

Like breaking an addiction

Takes time to form new ones and the more trappings of the ‘pain’ lifestyle a party has (and the more incentive to maintain that lifestyle) the harder it is

Points to remember

Diagnosis and attribution of CP in a medico-legal context requires multi-discipline approach

Pain Management evidence is not (always) the answer

Address causation head on

Keep an open mind and explore all avenues

Conclusions

Circles back to NICE guidelines	Move away from pain medication	Get people exercising
Support mental health	Get in with rehabilitation at an early stage	Be on the look out for signs of CP early on

Thank you

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