Behind the scenes of a pain report

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Compass Chambers

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Objectives

- Assessing the pursuer
- Case presentations (4)
- Instances and observations inconsistent with chronic pain

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Aim of a pain report

Assist the court

Preserve medical reputation

Answer the question

Ref 1 Muyepa v Ministry of Defence (2022) EWHC 2648 (KB);
Ref 2 Ruffell v Lovatt (2018) HHJ Hughes

Answer the questions asked

Do they have pain?

- Yes

Was it caused by the accident?

- No: end
- Yes: diagnosis and prognosis

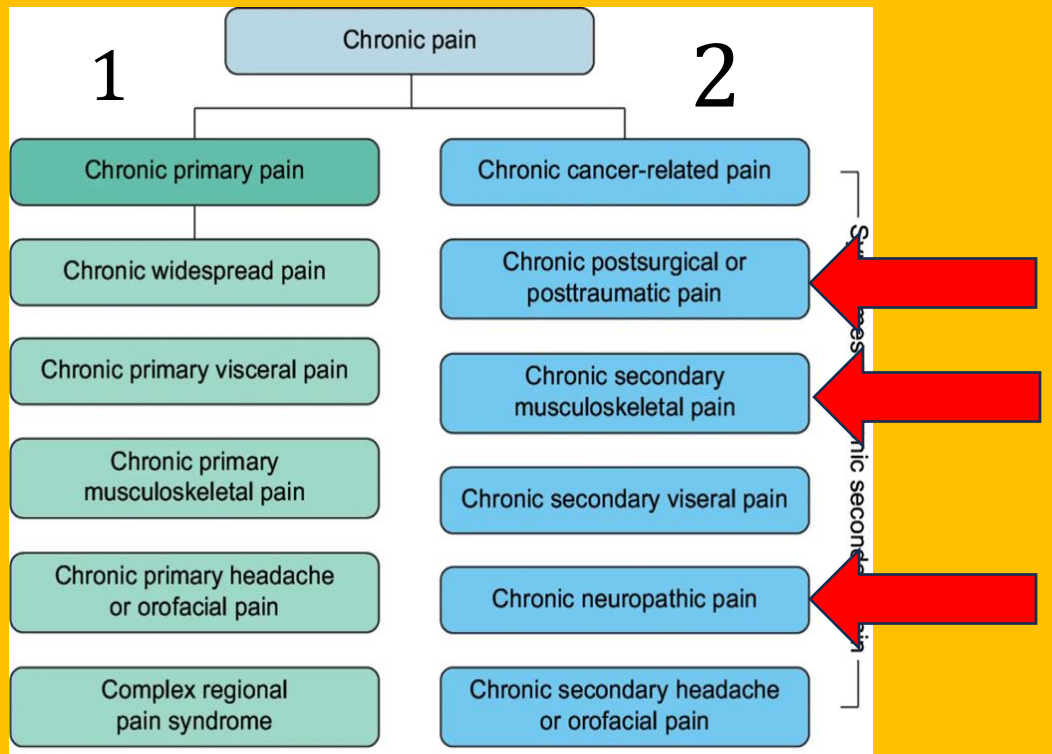

Figure 1. Chronic pain in the ICD-11. The classification distinguishes between conditions of *Chronic primary pain* and syndromes of known etiology or established pathophysiology that are associated with chronic (secondary) pain. Figure created by author, modified from Reference 5.

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Why pain is a problem

- No tests
- Not visible
- No signs
- No scans
- No verification

- Subjective vs objective
- No lie detector test
- No special training
- (Honesty vs malingering)
- (Believing the pursuer)

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Believing the pursuer (or not)

‘Be aware that chronic pain patients can present with signs and symptoms that are incongruent with medical expectations based on anatomical and physical knowledge. Appreciate that these cannot be considered cases of malingering.’

‘Recognise that malingering and deception are possible…. as well as our limitations to accurately assess malingering.’

Core Curriculum for Professional Education in Pain, IASP press. 2005 P50.

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Believing the pursuer (or not)

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Accept the account

Test the evidence for fit

Compare findings with ‘normal’ and ‘normal expected’

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What is normal?

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University	• 2 years' pre-clinical
Clinical practice	• 9 years' training • 20 years' consultant
Medicolegal practice	• 6 years

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What is normal?

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Weekly caseload		
	New patients	Desk-based reviews
Clinical practice	8–10	50
Medicolegal	2	3

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Normal exaggeration

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Common and expected

Present extreme of range of symptoms

Convince (in clinical practice) vs deceive (medicolegal expert)

Malingering is rare

- Chronic pain not otherwise specified
- Chronic pain not otherwise categorised
- '*Not a pain condition I recognise …*'
- *'Not a pain condition I can attribute to the index event'*

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Abnormal aspects of presentations

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- No red flags
- But …
- Confidence (e.g. driving, attending alone)
- Softer signs
- General observations of circumstances
- Contradictions

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Case 1

Traumatic amputation

Background

32-year-old female

Traumatic amputation tip of right index finger and post-traumatic stress disorder (PTSD)

Background: chronic pain conditions, anxiety and depression

Condition and prognosis, consider diagnosis of complex regional pain syndrome (CRPS)

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Diagnosis

- (Secondary) chronic post-amputation pain
- CRPS not applicable:
  - There is a diagnosis that better explains symptoms
  - Symptoms restricted to injured finger
  - No signs on clinical examination

1. Budapest criteria for complex regional pain syndrome[5,6]

- Continuing pain, which is disproportionate to any inciting event
- Must report at least one symptom in three of the four following categories:
  - sensory – hyperaesthesia or allodynia
  - vasomotor – temperature asymmetry, skin colour changes or skin colour asymmetry
  - sudomotor and oedema – oedema, sweating changes or sweating asymmetry
  - motor and trophic – decreased range of motion, motor dysfunction or trophic changes
- Must display at least one sign at the time of evaluation in at least two of the following categories:
  - sensory – evidence of hyperalgesia or allodynia
  - vasomotor – evidence of >1°C temperature asymmetry, skin colour changes or skin colour asymmetry
  - sudomotor and oedema – evidence of oedema, sweating changes or sweating asymmetry
  - motor and trophic – evidence of decreased range of motion, motor dysfunction or trophic changes
- No other diagnosis better explains the signs and symptoms

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Making the diagnosis

- Typical presentation with expected features
- Pain restricted to areas supplied by nerves that are known or can be assumed to have been injured
- Nature of pain is typical of neuropathic pain paroxysms, with descriptions of '*strange, stinging, sore, pins and needle-y*'
- Worse with activity but still present at rest
- Worse at night
- Finger can change colour: red or white

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Treatment

- Engaged with physiotherapy
- Psychotherapy for PTSD
- Actively trialing fingertip prostheses
- Proactively changed job and workplace, and changed working hours

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Findings and controversies

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Confirmatory findings

Examination findings typical; reported avoidant behaviour expected

GP records and expert reports largely consistent with account given to me and examination findings

Potential controversies

Pre-existing chronic pain

- including fibromyalgia
- rheumatological conditions affecting hands

Pre-existing mental-health difficulties

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Assisting the court

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My pain report

- 24 pages
- 6 pages of opinion (25%)
- 7 references, signposted

Defender's pain report

- 70 pages
- 5 pages of opinion (16%)
- 53 references, not cross-referenced
- No diagnosis offered
- Psychosomatic symptoms discussed repetitively and at length

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Areas of agreement identified

- *A chronic pain condition which was caused by the index event*
- *Criteria for a diagnosis of neuropathic pain were met*
- *Previous pain conditions co-exist and persist*
- *While opinions differ as to their exact nature they do not detract from event-related injury and findings*

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Case 2

Chronic post-traumatic pain

Background

55-year-old male polytrauma

Defender instruction

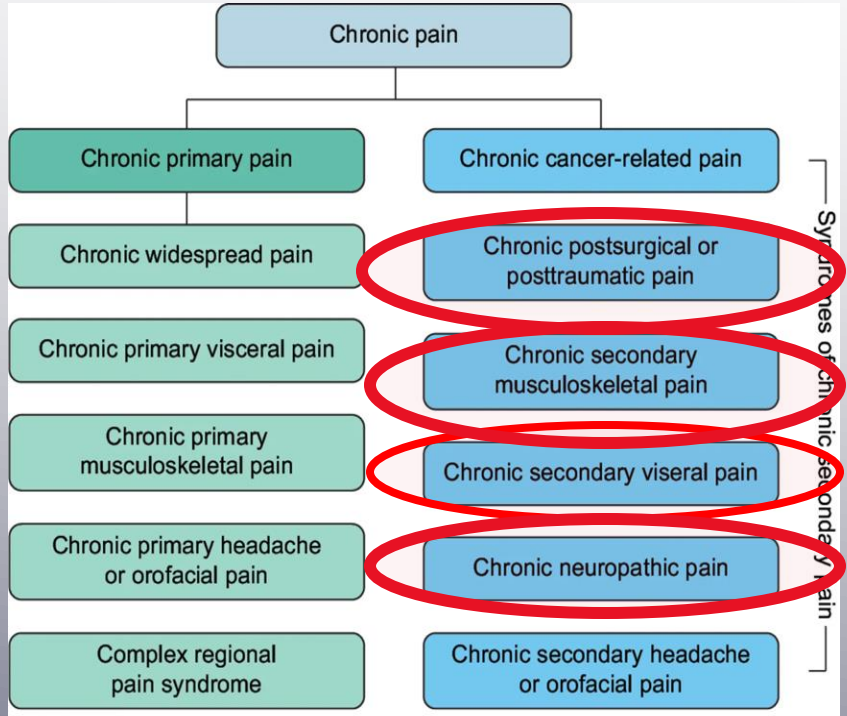
May 2018: crushed between two double decker buses

Multiple injuries: chest, pelvis, lower limbs, intra-abdominal bleeding

Developed PTSD

Diagnosis

- Secondary chronic post-traumatic pain
- Neuropathic pain
- Musculoskeletal pain
- Visceral pain
- Post-surgical pain



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Confirmatory features

Severity of injury: soft tissues and viscera

Combination of injuries

Typical subsequent unravelling of psychosocial aspects relating to, and modifying pain

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Consultation in 2019: one year later

- No history of pain problems
- Chronic widespread chronic pain
- Disabled physically and psychologically
- Unable to work

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Treatment and prognosis

Treatment

Compliance with physiotherapy

Good regimen of pain medications

Engagement with psychotherapy

Prognosis

Full potential likely to be achieved

Benefit to legal process of further review at two years?

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Case 3

Mixed-pain presentation

Background

19-year-old male

2019: back seat passenger: high-energy rear-end shunt

Fracture of right thigh bone (femur), soft-tissue injuries neck and lower back, PTSD

2022: ongoing right thigh pain and back pain

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Diagnosis

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Right thigh pain

- Musculoskeletal
- Neuropathic
- Somatic

Back pain

- Somatic

Somatic symptoms:

genuine symptoms perceived as described without physical or organic cause for them being identified

All pain attributable to index event

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Causation of pain in 2022

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Right thigh

- Serious injuries, air transfer to hospital, intensive care
- Recalled pain all over his body
- Three operations over 18 months for femoral fracture (non-union)

Back

- Neck and lower back soft-tissue injuries
- Prolonged convalescence, slow progress, then defaulted physiotherapy

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But …

Right thigh

- Orthopaedic records detail good recovery by October 2021
- Deterioration between first and second orthopaedic expert reports
- Symptoms worse when sitting or contact with outer thigh
- Self-report of pain vague

Back pain

- Pre-accident low back pain (pain now different: midback)
- Post-accident back pain not mentioned (anaesthetic charts)
- Examination apprehensive, verbalising pain behaviour, widespread hypersensitivity

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Inconsistencies

- Back pain report: *‘Immediately on discharge when painkillers stopped’*
- ‘*He doesn’t even go out to the back garden because of the stairs’* vs *‘I bought a chair for me to sit on when I sit in the back garden’*
- Needle phobia: conflicting statements: no morphine given because of this vs report it developed due to index event
- ‘*Happy person before; now down all the time’* vs *‘I suffer from depression and severe anxiety; I suffered from this before the accident*’
- *‘I cannot run … I can play football but only for a short period of time’*

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Observations

- Catastrophic language, exaggeration
- Chaotic lifestyle, disordered sleep, toxic home environment
- Ongoing mental-health difficulties – untreated
- Illness behaviours:
  - ‘*My mum has to get my tablets for me’*
  - *‘I do not need help with getting dressed; my mum just puts my clothes out for me’*
- False assumptions: *‘The bone in my leg has been permanently weakened’*

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Evidence

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Evidence of causation

- Severe injuries
- Complicated fracture
- Poor progress with physiotherapy
- Back pain: mentioned pre-accident in records but not post-accident
- Untreated mental-health illness
- Adverse social circumstances

Evidence for alternative cause

- Later self-reports to experts conflicting and unclear
- Inconsistencies in witness statements
- Back pain was '*different*': not low back, not musculoskeletal; sensory changes but no neuropathic injury
- Learned helplessness and illness behaviour

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Other considerations

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- Consider somatoform condition
  - Explains inconsistencies
  - Many psychosocial risk factors
  - History of similar symptoms: tingling, drop attacks

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On the balance of probabilities…

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Back pain

Somatic symptoms

Exacerbation related to accident via worsening untreated mental-health conditions and social circumstances

Thigh pain

Recovery by October 2021 but ongoing symptoms still related to accident via deconditioning

Exacerbated by worsening untreated mental-health conditions and social circumstances

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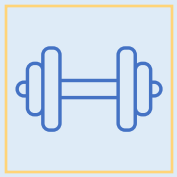
Case 4

Low-back pain

Background

42-year-old male



Gym fit

Active job

No past pain conditions

October 2021: minor road traffic accident (RTA)

2023: persisting, debilitating back pain

Orthopaedics: whiplash-type back pain 3-6 months

Diagnosis

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Ongoing pain: low mechanical back pain

Not related to accident

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Revisiting the history

- Diagnosis is key:
  - 90% history, 9% examination, 1% investigation
- If the diagnosis is wrong, the treatment will be incorrect and the patient will not get better
- *'Clinical mystery, return to the history'*

PC
HPC

PMH
DH

FH
SH
Systems enquiry

DDx
Rx
Px

History

October 2021

Gradual return to exercising back: *'Felt tired'*

No time off work

November 2021

Back to running 10km twice per week

Back to gym

December 2021

Increased hours at work as busy festive period

January 2022

Covid-19 infection and hospital admission

Investigations

- January 2022: Covid-19 infection; prolonged hospital admission
- March 2022: CT scan of chest showed fractures to T9,10
- Assumptions
  - Fractures had likely occurred in accident in October 2021
  - Fractures explained persisting pain

Causation of back pain

Evidence for RTA causation

- Back pain affecting lower spine recognised following RTA
- Expect to get worse if inactive with another illness
- Psychological effect of discovery of fractures

Evidence for alternative cause

- Fractures identified at T9,T10 and back pain lower (L3,L4)
- Initially improved and recovered in 2021
- Getting progressively worse in 2022

Conclusions

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Causation

- Prolonged convalescence, deconditioning of lower back muscles
- Reframing of accident: increased significance
- Expectation of recovery unrealistically high
- Stress and worry heightening pain

Opinion

- Low back pain from accident better by December 2021 (8-12 weeks)
- Current low back pain developed after this period
- No chronic pain condition developed because of the index event

Conclusion

- Back pain attributable to RTA as per orthopaedic opinion

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If we have time…

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Behavioural inconsistencies

- Observations: before and after appointment
- Driving
- Neck pain: carrying open can of fizzy drink, coloured hair
- Foot pain: ?CRPS crossed legs, bouncing foot, kicking handbag
- Need help with personal care: in bathroom at appointed time
- Working overtime
- General poverty of movement absent

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Raised suspicions

- Lack of GP records provided
- Changing GP practice without moving home
- Create confusion and blame others (records, pharmacy)
- Inconsistent record of site of pain (foot/ankle, arm/shoulder/elbow)

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Small talk

- What are you doing now?’
  - ‘*Nipping up to …*’
  - *‘Going for a wander*’
  - ‘*Weekend away without the kids’*
- *I might not get anything but it’s worth a try*’

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Soft signs

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Long-sleeved, layered or close-fitting clothing

Button-fly jeans

Carrying car keys, list of errands, in a rush

Summary

- Pain is complex and presentations are wide-ranging
- Please do ask
- Always happy to have an informal chat and give free advice
- Feedback is good
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