PRACTICE POINTS

Complex regional pain

Andrew Campbell and Hywel Evans consider the circumstances in which injuries first considered as innocuous can turn into a catastrophic injury claim

» Complex regional pain syndrome (CRPS) is a widely misunderstood condition. Lawyers can find themselves in a difficult position when attempting to quantify an injury that is frequently misunderstood by medical practitioners.

CRPS has an unpredictable prognosis. The cause of CRPS is unknown. Medical experts often fail to agree on diagnosis, cause, treatment, prognosis and presentation. Often, the terms 'malingerer' or 'exaggerator' are used to describe the claimant. It is sometimes evident that an inappropriate reaction or description is provided by the claimant, but this can often be explained as an unconscious secondary outcome owing to and compounding the CRPS itself, causing a vicious cycle of organic and psychological interplay. Defendants will seek to blame the underlying cause on some psychosomatic illness, if not exaggeration. Claimants will search for the often non-existent organic change to prove the symptoms and injury. Even where liability is admitted, causation remains highly contested.

What is CRPS?

CRPS is a multifactorial, progressive and often debilitating and painful condition associated with sensory, motor, autonomic, skin and bone abnormalities. It is a chronic pain condition that can affect one limb or, in 7% of cases, more than one limb, often but not necessarily resulting from direct trauma. Despite the cause of CRPS being unknown it is widely considered to be as a result of damage to, or malfunction of, the central nervous system (the brain and spinal cord) and peripheral nervous systems (nerve signalling to the rest of the body).

The National Institute of Neurological Disorders and Stroke states that in 90% of cases, CRPS is triggered by a clear history of trauma or injury. This can involve fractures, sprains, soft tissue injuries (such as burns, cuts, or bruises), limb immobilisation (such as being in a cast), or surgical or medical procedures. There is no relationship between the severity of the trauma and the degree of CRPS experienced. The European incidence rate is 26/100,000 person-years. CRPS is an abnormal neurological and pain response that magnifies the effects of injuries. It causes an excruciating (defendants may say implausible) level of pain as a reaction to what would usually be considered small stimuli.

Dr Rajesh Munglani, consultant in pain medicine, put it perfectly when addressing the court: 'If one takes one's thumb and hits it with a hammer, the thumb will be painful, will swell, become red and hot and one will not want to move it. However, with time, as healing occurs all these symptoms will resolve themselves and the thumb will heal and move again. Unfortunately, in a complex regional pain syndrome, the body does not ever switch off the initial phases of redness, swelling, pain and lack of movement.'

Two or three types of CRPS?

Traditionally, CRPS has been subdivided into two types based on the absence (type 1 – much more common) or presence (type 2) of a lesion to a major nerve. In terms of management the distinction has no relevance but it can be important in medico-legal cases. Recent evidence suggests that even type 1 may be associated with sub-clinical neurological change. A third diagnostic sub-type called CRPS-NOS (not otherwise specified) is recommended for patients who have abnormalities in fewer than three Budapest symptom categories (see below), or two sign categories, including those who had more documented signs and symptoms in the past, if current 'signs and symptoms' are still felt to be best explained by CRPS.

Diagnosis

The correct diagnosis of CRPS is incredibly important. Pain in general is misunderstood, and differential diagnoses must be considered to ensure treatable ailments are not incorrectly labelled as CRPS and go untreated (for example, carpal tunnel syndrome). Unfortunately, diagnosing CRPS can be difficult, not least because often there is no organic marker to account for the pain. It is, therefore, sometimes referred to as a 'diagnosis of exclusion'. Further, other causes can be attributable to CRPS. We recently acted in a case in which it was agreed the claimant suffered from CRPS, but the road traffic accident was merely a coincidence and the underlying cause was likely degeneration around the spine. This is the sort of thing the lawyer wants to find out at an early stage before high five- or six-figure costs are incurred.

Budapest – the diagnostic criteria for CRPS

(A-D must apply; 'sign' is where the medical practitioner can see or feel a problem; 'symptom' is where the patient reports a problem.)

A) The patient has continuing pain which is disproportionate to any inciting event.

B) The patient has at least one sign in two or more of the categories.

C) The patient reports at least one symptom in three or more of the categories.

D) No other diagnosis can better explain the signs and symptoms.

1. 'Sensory' – allodynia (to light touch and/or temperature sensation and/or deep somatic pressure and/or joint movement) and/or hyperalgesia (to pinprick).

2. 'Vasomotor' – temperature asymmetry and/or skin colour changes and/or skin colour asymmetry. The medical practitioner must notice a temperature asymmetry of > 1°C.

3. 'Sudomotor/oedema' – oedema and/or sweating changes and/or sweating asymmetry.

4. 'Motor/trophic' – decreased of motion and/or motor dysfu (weakness, tremor, dystonia) a trophic changes (hair/nail/skir

The sceptical defendant

The defendant's solicitor will have a psychiatrist go throug claimant's medical notes and ine the claimant seeking to ex the condition by virtue of unre (to the negligent act that is th ject of the claim) psychiatri sentation and history. A frequ encountered argument is that a few sessions of cognitive behavi therapy (CBT), the claimant w back to normal, but only if th gested treatment takes place aft litigation has ceased. Alternat that the claimant was pre-dis to CRPS and would in any event gone on to develop it in absence negligent act.

A review of the recent me thinking on the subject confirm

Continued on pa

PRACTICE POINTS

Complex regional pain

ontinued from page 21

s now clear that CRPS is not associ-ed with a history of pain-preceding ychological problems, or with som-zation or malingering. If a patient esents with such problems, these ould be addressed where appropri-, as would be good practice in other edical situations. Claimants still port being stigmatised by health ofessionals who do not believe that eir condition is 'real'.

If a claimant's own treating doctor is eptical about the condition (through ack of understanding of the condi-n) one can immediately see the oblems facing the claimant lawyer: nvincing the defendant that CRPS ists; that the claimant is suffering m it; and that it has been caused by e (sometimes seemingly innocuous) pact. As in all cases, the choice of pert is imperative. Consideration eds to be given to the expertise of ecific experts and whether they have fact ever come across patients with PS. Neurologists and orthopaedic rgeons will be required to consider fferential diagnosis and can some-nes diagnose CRPS.

There are many 'old school' med-l experts wheeled out by defen-nts who are simply unbelievers. A nsultant in pain medicine will be quired to comment on the neurol-y and orthopaedic report, and con-m a diagnosis of CRPS. Quantum d prognosis will me later and can dealt with in fferent reports, cluding, in the ore severe cases, n p l o y m e n t, commodation d care costs ports. Indeed, o g n o s i s will ed to be dealt th sometime er as CRPS dif-s widely in its esentation and effects from person person.

Experience suggests that causation ll remain in issue until settlement or al. The defendant will seek reliance their own expert evidence, usually m a psychiatrist, to suggest that, as s historically believed, it is 'all in e's head'. Defendants often attack imants' credibility, and the accusa-ns of malingering and over-exagger-ng will be free-flowing. Surveillance idence will undoubtedly be a must any defendant. CRPS cases can be luable (as shown by our recent six-d seven-figure settlements) and the cost of surveillance will likely be proportionate. If surveillance evidence is disclosed, requests should be made for unedited evidence and any accompanying statements of truth to verify the footage. Appropriate advice should be given to the claimant with regard to surveillance and mitigation.

CRPS incorporates pain, loss of function, association with the 'emotional' limbic system and psychosomatic issues that, while not causative, can amplify the problems already experienced (Bruehl, 2001). Indeed, findings of observational studies have given credence to arguments in favour of a psychogenic origin of movement disorders in CRPS (Verdugo & Ochoa, 2000).

It is no wonder that, on occasion, defendants argue that (with CBT or a quick settlement) the claimant's condition will vastly improve. However, clients have often explained to us that the problem they experience with movement is like 'your brain telling your foot to move but it doesn't listen'. That is not to say that this is always the case. Psychiatric overlay associated with CRPS can lead to the perception of increased disability as opposed to an attempt to mislead or exaggerate (see *Connery v PHS Group Ltd* [2011] EWHC 1685).

The outcome and prognosis of CRPS is even less understood. De Mos *et al.* (2009) opine that, of those diagnosed with CRPS, around one-third will improve, one-third will show an undulating response and one-third will become worse. This can cause litigation problems if, during assessments or settlement negotiations, the claimant is going through a long quiescent patch with few problems. There is no current cure and recurrence is likely. Provisional damages ought always to be considered in the event that settlement occurs during a period of few or no symptoms.

> **The consequences of CRPS can be devastating, including wheelchair dependence and significant care requirements. With time, many clients will undoubtedly become worse and no amount of money will compensate them for their injuries. Early intervention is key**

While there is no cure, early intervention is considered vital. At the mere suggestion of reflex sympathetic dystrophy or causalgia (early nomenclatures for CRPS – there are many more) or chronic pain, treatment should be put in place. The claimant lawyer should attempt to agree rehabilitation with the defendant under the 'rehab code' or otherwise at the earliest point.

Experts often fail to agree on diagnosis, cause, treatment and prognosis

Initial treatment is often in the form of physiotherapy to target movement disorders, medication to treat and combat pain (opiates, anti-depressants and neuropathic pain medication) and counselling (CBT). These methods may assist in alleviating some of the pain or at least assisting the claimant in understanding CRPS and thus attempting to live with it. If initial treatment fails, the alternative options are costly and incredibly invasive. They include spinal injections, dorsal column or spinal cord stimulators (requiring a foreign body to be placed in situ, usually directly on the spine to try and alleviate pain) or, in severe cases, amputation (which can also lead to CRPS in the form of phantom limb pain).

Claimant solicitors should make this clear to defendants at the first opportunity to attempt to agree rehabilitation at the earliest intervention. Otherwise, pending liability, the defendant could face paying for incredibly costly treatment and, most importantly, the claimant will be put through even more excruciating pain.

What the claimant lawyer can do

The role of the lawyer is not to diagnose CRPS. It is, as always, to work in the best interests of the client and to ensure they are put in the position they would have been but for the accident. This will not be possible in cases of CRPS. The consequences of CRPS can be devastating, including wheelchair dependence and significant care requirements. With time, many clients will undoubtedly become worse and no amount of money will compensate them for their injuries. Early intervention is key. The appropriate treatment and litigation experts need to be in place and must work together for the benefit of the client. A close relationsh with the defendant will be needed try and agree funding and the be course of action, based on eviden at the earliest point possible. Cauti is advised, however, so that eviden is not disclosed too hastily, allowi the defendant to make offers th put the claimant at risk witho understanding the full extent of t injuries.

Unfortunately, understanding t full extent of the injuries is not alwa possible in CRPS cases. Approach ought to be made to experts and, the event that evidence needs to disclosed to agree funding, a date c be set for an appointment and rece of their initial, often draft, report that any offer can be considered a advised upon correctly.

CRPS cases are difficult. They u ally take years, due to the progress and sometimes deteriorative nature the symptoms and disorder. A deg of hand-holding will be requir but a firm approach will be need to ensure there are no unattainal expectations. These cases will b long process. Sometimes the outco and prognosis will not be clear a this will be a difficult concept for client to fathom. As the lawyer, y will be the catalyst attempting to or nise, arrange and bring together best outcome for the client, whet it is long periods between recurren or simply trying to better understa their own condition. Compensat will help, but it will not be claima main objective. This will often be unattainable recovery, which j adds to the psychological trau these cases often present.

Andrew Campbell is a partner a Hywel Evans a solicitor at Bikelaw Motorcycle Accident Solicitors