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That Can't Be Right! - Addressing Controversial Diagnoses and Controversial Treatments: Fibromyalgia; Post-Concussion Syndrome; CRPS; Neuropathic Pain

Ever looked at a medical record and thought "no way that is work-related"? Ever feel like workers' compensation has become the dumping ground for the medical problems which cannot be explained? Ever received a request for surgery of pain management and thought "that will never work"? You may be right, particularly for controversial diagnoses such as Fibromyalgia, Neuropathic Pain, CRPS/RSD, and Post-Concussion Syndrome. The clinical standards for medical causation are receiving closer scrutiny and the spread of objective medical guidelines is providing a broader range of tools for claims professionals and lawyers. While it may appear causation standards are in a state of transition, the protocols for addressing causation objectively and clinically remain constant. What may actually be undergoing change is how the workers' compensation tribunals approach the issue of causation in an age of expanding research and objective data. Learn how to harness the latest clinical research and use objective diagnostic protocols to gain the leverage needed to eliminate or mitigate controversial medical "diagnoses". Learn how to identify and respond to requests for controversial treatments which remain standard practice despite the fact that the latest clinical research shows they do not improve outcomes and will likely do more harm than good. Hear about outcomes-based approaches involving ancillary providers. Participate in a discussion about how to advocate treatments which are not only more cost effective for the employer/carrier but are more likely to result in better outcomes and improved function for the injured worker.

Opioids

Deaths - drug related deaths are confirmed by CDC and double those of Traffic deaths in 2016. They are probably an understatement, as death certificates are notoriously inaccurate, but the trend is remarkable, almost doubling from 2014.

Science of Opioids

We can measure BP, pulse, pulmonary/cardiac function, which may provide more objective indicators regarding the presence or absence of pain and the degree of pain; the Visual Analogue Pain scale (VAS) and Oswestry are all simply self-reports of pain by the patient and are unreliable.

Polypharmacy

Polypharmacy is quite simply, the prescription and/or taking of many different medications. This is often the result of a medical approach known as "Semiotics", which is the medical treatment of symptoms. Prescription medications often produce side effects and, polypharmacy may occur when the patient complains to their doctor of additional symptoms or side effects, often caused by the initial medication, for which additional symptoms the physician prescribe additional medications. This process can build upon itself as the claimant is given additional medication to address additional symptoms in a repeated process of symptom complaints for which medications are provided, which medications produce more side effects, for which more medication is provided, …., you get the point. The situation can become even more problematic in situations where the claimant is receiving medication from more than one physician, who may be unaware of the other physician's involvement and prescriptions being provided. Another difficult variation on this situation arises where the claimant is taking additional drugs from non-medical sources such as family members or friends. These may be prescription drugs or illegal drugs. In any event, the authorized treating physician is generally not notified by the patient of the additional drug use.

Pain, Iatrogenesis, Recent Trends & Syndromes

Pain is generally defined as "An Unpleasant Subjective Experience…." Efforts to quantify or objectify pain include the analog pain scale (i.e. reported pain on a scale of 1 to 10). Pain can be associated with some generally objective indicators such as blood pressure and heart rate. We do know certain things about efforts to confirm the presence of pain and to quantify the level of pain:

•Pain cannot be measured;

•We can measure BP, pulse, pulmonary/cardiac function, which may provide more objective indicators regarding the presence or absence of pain and the degree of pain;

•The Visual analogue pain scale (VAS) and Oswestry are all simply self-reports of pain by the patient and are unreliable;

•The VAS undertakes to quantify pain by rating: mild (1-3), mod (4-6), severe (7-10);

•"Severe pain" inconsistent with the ability to perform activities of daily living (drive, dress yourself, eat, etc.) AMA 4th Ed. Guides, pg. 315)

•Severe pain and normal BP, pulse, resp. rate reflect a physiologic inconsistency.

Iatrogenesis refers to harm resulting from actions of health care providers, starting with inducing patients to believe something untrue about themselves early on; that they may suffer from serious or disabling conditions when they do not. This "elephant in the room," too long ignored in "polite" circles, is a prolific cost driver – and more importantly – often results in harm including, in these 'overly medicated' times, death. Without accurate diagnoses, neither appropriate treatment nor positive outcomes can be achieved.

Syndromes as attempt to name a collection of subjective symptoms. Recent Trends and Controversial "Diagnoses" - Complex Regional Pain Syndrome (RSD) Discussion about the history and evolution of CRPS\RSD. Identifying the diagnostic protocols - Failed Back Syndrome Discuss the subjective nature of this condition - Carpal Tunnel Syndrome. Discussion of information from the AMA Guides - Neuropathic Pain (Neuropathy) Discuss data regarding conditions labeled as "neuropathy" - Fibromyalgia

Identify the subjective complaints which underlie this "diagnosis". Discuss the lack of any objective diagnostic protocol - Chronic Pain Syndrome. Discuss the subjective nature of this "diagnosis"

Address the absence of any objective diagnostic protocol. - Post Concussion Syndrome. Discuss the objective science associated with head injuries in general and specifically with concussions

Opiate Risk Factors and Common Pitfalls

The use of opioids has increased without rational explanation. As use has increased, the unintended death rate has also increased. However, outcomes for opioid users and survivors are not better.

The typical path to polypharmacy involves a relatively minor accident and injury followed by unusually high reports of pain. The health care provider seeks to address and diminish the pain complaints and prescribes medications to address symptoms. The patient's pain complaints escalate for reasons which most often cannot be rationally explain or objectively diagnosed. More often than not the medical providers fail to properly and thoroughly investigate the complaints. These lapses often include either no physical examination of the patient or only a cursory exam which failed to measure and record relevant physical information which could confirm or exclude possible causes. Most common are situations where the subsequent medical visits and corresponding records continue reflect subjective complaints without identifying or recording relevant physical information. Side effects, additional symptoms and increasing levels of pain are reported by the claimant, which results in additional prescriptions and increasing quantities of medication to address the blossoming complaints. The frustrated medical provider often hands off the patient to "Pain management". The claimant has become another victim of Polypharmacy.

The most common causes of death are respiratory suppression and cardiac issues. Many narcotics, especially at higher doses and in combination with anxiolytic/sedative hypnotic drugs such as Ambien, Xanax, and Valium, suppress the respiratory drive in the brain stem. Unless a thorough post mortem exam is done (including toxicology) a drug related death could be easily missed, and Coroners may sign off on cause of death due to "natural causes". For this reason, drug related deaths are likely under reported. Fentanyl has become an increasingly more prevalent and deadly drug.

A problematic pattern of opioid use that causes clinically significant impairment or distress. A diagnosis is based on specific criteria such as unsuccessful efforts to cut down or control use, as well as use resulting in social problems and a failure to fulfill obligations at work, school, or home. Opioid use disorder has also been referred to as "opioid abuse or dependence" or "opioid addiction." The Diagnostic and Statistical Manual for Mental Health Disorders, Fifth Edition, (DSM V) classifies this under the heading" SUBSTANCE USE DISORDER".