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FIBROMYALGIA: TRAUMA AND DISABILITY

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Since 1990, Fibromyalgia has been recognized as a distinct diagnosis by the American College of Rheumatology. At that time, rheumatologists came up with diagnostic criteria for identifying patients with Fibromyalgia. These criteria included wide-spread pain for three months or more, and 11 of 18 tender points when palpated with up to 9 pounds of pressure. Prior to 1990, Fibromyalgia patients were diagnosed with a number of ailments with a number of different names. The American College of Rheumatology came up with diagnostic criteria for both research and clinical purposes. Since that time considerable literature has developed showing a relationship between Fibromyalgia and trauma and showing that Fibromyalgia appears to be a permanent conditions. Nevertheless, many physicians and other health care providers have not kept abreast of the developing literature on Fibromyalgia and have failed to recognize it in practice.

The relative recency of the diagnostic criteria and developing literature combined with the unfortunate considerable range of disability that can accompany the diagnosis, makes handling cases of clients with Fibromyalgia difficult. The epidemiologic data indicates that as much as 2-5% of the population has Fibromyalgia.

The effects of Fibromyalgia range from a mere nuisance to total disability preventing the Fibromyalgia sufferer from getting out of bed. The more disabled the client, the more potentially valuable the case, but also the more difficult.

Many of these clients had extremely active lifestyles that gradually diminished sometimes despite Herculean efforts to maintain a level of function. Without the diagnosis, many patients refuse to acknowledge their limitations and try to push through them. This often makes the condition worse. Even with the diagnosis, many, many individuals with Fibromyalgia push hard to maintain their lives as they were prior to coming down with Fibromyalgia. The lack of understanding in the medical community also creates problems as it can take sometimes as much as five years before Fibromyalgia is diagnosed. In the meantime, the client has gone from one health care provider to another trying to find an explanation for the symptoms. The client looks fine and often family members and health care providers encourage them to ignore their symptoms and get on with their lives. Often, family members and health care providers suggest there is a psychological explanation for the problems. Finally, absent frequent jury awards acknowledging the significance of the disability, insurance companies refuse to acknowledge the severity of these clients' injuries.

WHAT IS FIBROMYALGIA?

In 1990, the American College of Rheumatology set up criteria defining Fibromyalgia as widespread pain more than three months in duration in

combination with objectifiable tenderness at 11 or more of 18 specific sites. According to the American College of Rheumatology:

“Widespread pain was identified when all of the following were present: Pain on the left side of the body, pain on the right side of the body, pain above the waist, and pain below the waist.

In addition, exoskeletal pain (cervical spine or anterior chest or thoracic spine or low back) had to be present.

In this definition, left or right shoulder and buttock pain was considered as pain for each involved side.

Low back (lumbar) pain was considered lower segment pain. Thus, pain in three sites (e.g. right shoulder, left buttock, thoracic spine) qualifies as widespread pain.”

The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia, Report of the Multicenter Criteria Committee, Wolfe, et al.; Arthritis and Rheumatism, Vol.33, No.2 February 1990 at 163.

In addition to widespread pain, the 1990 Multicenter Study explored other discriminating criteria for making the diagnosis of Fibromyalgia. After considerable study, although many other symptoms frequently occur with patients who have Fibromyalgia, the Committee identified 18 specific sites, which if palpated up to 9 pounds of pressure hurt in fibromyalgics, but did not hurt in controls. Patients may hurt at many other sites, but the 18 identified provided the best consistent accuracy. If a patient had 11 of 18 of these tender points with any report of pain on palpation, then that patient would have Fibromyalgia providing the patient also met criteria for widespread pain. The tender points were not points that necessarily hurt without being touched. They differ from trigger points in that the pain does not usually radiate, but is specific to the point. Any point in which there is any positive report of pain is a positive point for the diagnosis of Fibromyalgia. The tenderness scoring typically can be made with (0) equaling no pain report or no grimace response; (1) equaling positive pain report and no grimace response; (2) equaling positive pain report and positive flinch or grimace response; (3) positive pain report and dramatic flinch or grimace response; and (4) patient is untouchable at that site. A report of at least level (1) tenderness makes for a positive tender point.

The Multicenter Study looked at a number of other symptoms typically associated with Fibromyalgia. The list of symptoms includes the following:

1. Widespread pain;
2. Sleep disturbance;
3. Fatigue;
4. Morning stiffness;
5. Anxiety;
6. Irritable bowel syndrome;
7. Irritable bladder;
8. Headaches;
9. Cold hands and/or feet;
10. Dry mouth, eyes;
11. Depression;
12. Numbness, tingling;
13. Allergies;
14. Hypoglycemia;
15. Excessive mucus;
16. Fluid retention;
17. PMS;
18. Painful menstruation;
19. Adversely affected by heat or cold;
20. Adversely affected by weather change;
21. Recurring family stress regarding symptoms;
22. Family history of similar symptoms.

Finally, to understand Fibromyalgia, it is important to note that Fibromyalgia is not a diagnosis of exclusion. It is a diagnosis that can be made on its own and can coexist with other conditions. This distinguishes Fibromyalgia from Chronic Fatigue Syndrome, which at present is a diagnosis of exclusion.

Patients who have fewer than the required number of tender points may also be diagnosed as having FM provided they have widespread pain and many of the characteristic symptoms of the syndrome. These symptoms include fatigues, sleep disturbance, mood disturbance, headache, irritable bowel symptoms, among others. Tenderness in sites not specified by the ACR criteria does not exclude diagnosis. . . .

FM may be associated with concurrent medical or psychiatric illness, but the diagnosis of one disorder does not exclude the other. *The Fibromyalgia Syndrome: A Consensus Report on Fibromyalgia and Disability*, Wolfe, The Journal of Rheumatology 1996; 23:3 at 536.

Research continues and there may be objective tests to document changes in patients with Fibromyalgia. Most notably, as seen on Good Morning America, there are studies involving brain SPECT scans that show decreased

blood flow in specific areas of the brain in patients with Fibromyalgia compared to controls. These were discussed most recently in Mohammed B. Yunus, et al., *Fibromyalgia Consensus Report: Additional Comments*, Journal of Clinical Rheumatology, Vol.3, No.6, December 1997 at 325.

“While no specific laboratory testing is currently available in FMS (as in many other rheumatologic diseases), objective laboratory abnormalities often do exist in this condition. Abnormal sleep electroencephalographic test, a three fold increase in cerebral spinal fluid substance P, a reproducible abnormality and serum serotonin, decreased imipramine bindings on platelets as compared with depression, a highly significant decrease IGF-1 (somatomedin C) and a decrease in cerebral blood flow in the hypothalamus and the caudate nucleus of the brain by single-photon-emission-computed tomography (SPECT) are examples. These abnormal tests also provide important information on the biophysiological mechanisms in FMS. We agree that these tests should not be routinely ordered, but in the presence of suspected concomitant or associated conditions (such as a sleep disorder), some of the laboratory or imaging tests mentioned in the report may be indicated.”

Yunus et al. at 325.

TRAUMA CAUSES FIBROMYALGIA

Any physician who has treated a large number of Fibromyalgia patients will perceive the association between trauma and Fibromyalgia. There are also anecdotal and case reports in the literature. *Reactive Fibromyalgia Syndrome*, Greenfield, et.al., Arthritis and Rheumatism, Vol.35, No.6 (June, 1992). The Vancouver Consensus Report has been used to argue that trauma cannot cause Fibromyalgia. *The Fibromyalgia Syndrome: A Consensus Report on Fibromyalgia and Disability*, Wolfe, The Journal of Rheumatology 1996; 23:3. A careful reading of this report indicates that the major concern was the lack of epidemiologic studies linking trauma to the development of Fibromyalgia. Nevertheless, in the consensus statement in that report, those participating determined:

“Causality: The cause(s) of FM are incompletely understood. There may be events reported by the patient as precipitating and/or aggravating, including physical trauma, emotional trauma, infection, surgery,

and emotional or physical stress. In determining the relationship between FM and antecedent events [trauma], the physician should consider the patient's opinion, review the events and pertinent collateral information, including current and past medical and psycho social history. The chronology of symptoms should be documented.”

Wolfe, et al. *The Fibromyalgia Syndrome: A Consensus Report on Fibromyalgia and Disability*, The Journal of Rheumatology 1996; 23:3 (Report of a June 1994 meeting in Vancouver, Canada) at 536.

Since the 1994 meeting, there has been an epidemiologic study done that shows an increased risk of developing Fibromyalgia after trauma. Specifically, the study concludes that there is a 13 times greater risk of a person developing Fibromyalgia following a neck injury than following a broken leg. This study, performed in Israel was also evaluated by Dr. Wolfe. It should be noted that the Israeli study only followed people for up to one year following their trauma. *Increased Rates of Fibromyalgia Following Cervical Spine Injury*, Buskila, et al., Arthritis & Rheumatism, Vol.40, No.3, March 1997.

Recently there have been two federal cases that prohibited evidence that Fibromyalgia can be caused by trauma. *Black v. Food Lion, Inc.*, 171 F.3d 308 (5th Cir. 1999); *Hultberg v. Wal-Mart Stores, Inc.*, 1999 WS 244030 (E.D. La. 1999). These cases applied a *Daubert* analysis to exclude expert testimony on causation. Do not accept the holding of these cases on face value. The testimony in *Black* offered that a fall in a store caused hormonal damage which led to the development of fibromyalgia. The only literature cited by the court is the 1996 Consensus Report authored by Fred Wolfe, MD. The court focuses on Dr. Wolfe's comments and not the consensus statement. Importantly, at FN3 the court writes: “Although Black attempted to admit into evidence more recent studies allegedly demonstrating a causal link between physical trauma and fibromyalgia, the trial court excluded the evidence because the studies had not been properly produced to opposing counsel during discovery.” *Black*, 171 F.3d at 313. The court then went on to seriously criticize Dr. Reyna who had testified that he “did not find the cause of Black's fibromyalgia”. *Id.* The court also found, “it follows from the scientific literature that Dr. Reyna's theory has failed to gain acceptance within the medical profession. Experts in the field conclude that the ultimate cause of fibromyalgia cannot be known, and only an educated guess can be made based on the patient's history.” *Id.* The court did, however, observe from the 1996 Vancouver report: “Overall...data from the literature are insufficient to indicate whether causal relationships exist between trauma and [fibromyalgia]. The absence of evidence, however, does not mean that causality

does not exist, rather appropriate studies have not been performed.” *Id.* at 312. The court never considered the considerable supportive literature that does exist, such as the Buskila study and the Yunus et al rebuttal to the Consensus report. More recent articles by Bennett and others also will help. So far no study has debunked the findings that trauma can cause fibromyalgia. The literature since 1996 is strong. Do not go to court without it.

The *Hultberg* case relies on *Black*, but very importantly notes at FN5: “The Fifth Circuit’s analysis relied heavily on the Daubert factors. However, the Fifth Circuit did note that ‘[t]he absence of evidence, however, does not mean that causality does not exist, rather that appropriate studies have not been performed.’ Unfortunately, the Plaintiff has not offered the Court with any evidence to indicate that studies have been conducted other than stating in their opposition that ‘[s]uch studies may now be available.’ This evidence might have supported an argument that the testimony would be reliable under Daubert. Without such evidence, however, this Court must follow the clear mandate set forth by the Fifth Circuit in *Black v Food Lion, Inc* less than a month ago.” Again the court did not have good evidence from the available medical literature to rely on. This just underscores the importance of using the studies in the medical bibliography attached to this paper.

FIBROMYALGIA CAUSES WORK AND QUALITY OF LIFE DISABILITY

Numerous studies document the disabling affects of Fibromyalgia. The results of the Six Center Longitudinal Study were reported in September 1997. This study concludes:

“This study shows that the prognosis and outcome of Fibromyalgia are unsatisfactory. Patients with Fibromyalgia have substantial and clinically significant abnormalities and all important outcome measures. These results are in accordance with the finding of continuing high rates of service utilization and work disability and we have shown in other analyses from this longitudinally studied cohort.”

Health Status and Disease Severity in Fibromyalgia, Wolfe, et.al., *Arthritis & Rheumatism*, Vol.40, No.9, September 1997 at 1577-1578.

Other useful studies showing the long-term problems with Fibromyalgia are listed in the bibliography. The occupational environment study by Waylonis is particularly useful in looking at the types of work activities that cause problems for people with Fibromyalgia.

In looking at the disabling effects of Fibromyalgia, it is important to recognize that Fibromyalgia has a range of effects on people. Given the high prevalence of Fibromyalgia (as much as 2-5% of the population), not everyone

with Fibromyalgia is unable to work. In fact, in light of the numbers of people that have Fibromyalgia, a minority are unable to work.

What prevents people from working in addition to the pain with activity is the fatigue which can be profound. It can be described as a severe flu, but not the type of flu where you “gut it out” and go to work. It is more like the flu that afflicts you and keeps you from getting out of bed. In addition, the other symptoms in combination with the widespread pain can prevent routine work activity and interfere with daily living activities. Most important, repetitive tasks cause problems. On any given day a Fibromyalgia patient may be able to do a given task. It is then necessary to look at the effect of doing that task over the next couple of days. Very typically, the Fibromyalgia patient will push to do the task on a given day, then will need to spend the next three days in bed. The unpredictability of symptoms, the waxing and waning of symptoms, and adverse effects of changes in weather or temperature or degree of activity make it very difficult for someone with severe Fibromyalgia to maintain any employment and to participate in life as they had before developing Fibromyalgia.

TREATMENT OF FIBROMYALGIA

Currently, there is no cure for Fibromyalgia. Once people develop Fibromyalgia, they have it for the rest of their lives. The symptoms seem to plateau, meaning once they stabilize, absent some other trauma or other intervening event, the symptoms remain about the same. There are typically good days and bad days, but the symptoms wax and wane around the plateau.

Since treatment cannot cure Fibromyalgia, it is designed to mitigate the symptoms increase the good days, decrease the bad days and decrease the variance in symptoms around the plateau. One of the most important elements of treatment is for the individual to understand that pacing life becomes necessary. Typically, people with Fibromyalgia are real “go-getters” before the condition sets in. They have a hard time letting go of life as well as difficulty with their adjustment to life as they can do it. Finally, their bodies require them to change their lifestyle.

In addition, a variety of other modalities are offered. None of these modalities has been proven in double blind testing to create a significant difference. However, these modalities are used on a patient by patient, case by case basis. Physicians experienced in managing patient with Fibromyalgia will look at multidisciplinary treatment and encourage a variety of treatment modalities including prescription drugs, physical therapy, massage therapy, acupuncture, biofeedback, hot tubbing, and light exercise.

HOW TO DEVELOP AND PRESENT A FIBROMYALGIA CASE

Because Fibromyalgia is a largely invisible condition, preparing the case requires significant attention. There are several musts which may be basic with every case, but become ever so important in a Fibromyalgia case.

In the initial client interview, explore the symptoms. Often the diagnosis of Fibromyalgia has been missed by health care providers. We have seen it take up to five years to make the diagnosis even though symptoms have been present throughout that time. If you are able to identify symptoms which make you suspicious, then coordinate a referral to a rheumatologist who can properly evaluate the client and make an appropriate diagnosis. Managing the medicine becomes a very important aspect of the case. If you anticipate trying a case, then it is useful to have health care providers in a variety of different specialties recognize and accept the diagnosis of Fibromyalgia. Ideally, it would be helpful to have physicians in several specialties actually make the diagnosis. It is also important to have at least one witness who can use literature to help educate the jury.

To help prepare the witnesses, it is important to obtain all medical records that predate the diagnosis of Fibromyalgia, as well as all medical records from the date of diagnosis of Fibromyalgia. The prediagnosis records must be examined to determine when the symptoms appeared. Since Fibromyalgia is not often diagnosed promptly, it is important to look at the prediagnosis records to see if the symptoms indicate that the diagnosis was present at any time prior to the diagnosis being made. Fibromyalgia is usually present after three months, but can manifest as late as 18-24 months. The best clue will be finding evidence of widespread pain. Because of a lack of understanding by health care providers, the diagnosis can sometimes remain missed for as much as five years. The patients have gone to numerous health care providers generating considerable records. All of these records need to be examined to determine the types of witnesses that will be necessary to counter the predictable arguments.

The predictable arguments are (1) Fibromyalgia doesn't exist; (2) if this person has Fibromyalgia, it didn't come from the collision; (3) they don't have Fibromyalgia, really they have a psychological condition; (4) they are malingering and not disabled as they want everyone to think.

In addition to physicians in various specialties, but especially rheumatology, it is useful to get a psychologist or psychiatrist familiar with chronic pain and Fibromyalgia, a vocational counselor, and importantly a physical capacities examiner experienced in evaluating patients with fibromyalgia. The physical capacities examiner should follow up on the client several days after doing the physical capacities examination to document the effects of the day long testing on their patient. In people with severe fibromyalgia, the testing often produces a significant aggravation of symptoms requiring at least several days to recover. Also, a competent human performance evaluator doing a set protocol for physical capacity testing can document biomechanical abnormalities

including a significant fatigue effect. These findings can be presented as objective findings of the disability caused by severe fibromyalgia.

Finally, to cement the case, you should identify as many lay witnesses as possible. These witnesses should be able to testify to the changes in the client's function before and/or after the collision. They may also be able to provide evidence of widespread pain. If there is no traumatic incident at issue, and the purpose of evidence is simply to document disability, then lay witness testimony about the limitations evident from observing the client can be very useful. These witnesses can be family members, co-workers, friends and acquaintances. Ideally, these witnesses will know the client both before and after the development of Fibromyalgia and any resulting disability. To be most effective, they will need to be able to relate very specific anecdotes to tell about the client whether it is climbing Mount McKinley, exercise or sports routines, special trips, day long shopping, witnessing the client play with children, or any other work or daily living activities. The testimony should be specific and paint a picture rather than provide the conclusion that the person just plain can't work. Witnesses need to be able to give examples of what they saw.

The key to the successful case comes from strong, integrated medical expert testimony, deftly using the literature, combined with good client and lay witness testimony chronicling the destruction (gradual or quick) of the ability to work and ability to enjoy daily living. The literature and records and lay witness testimony become very useful weapons to use to neutralize most defense experts brought in to debunk FM or the client.

RESULTS

The success in using this approach can be seen in the results our firm has had in representing people with severe fibromyalgia in the context of post-traumatic fibromyalgia or in the context of wrongful denial of long term disability insurance benefits under ERISA or non-ERISA insurance plans.

On March 1, 2000, a King County, Washington jury assessed total damages for one of our clients with severe fibromyalgia following traumatic neck injury at \$2,742,571. (The verdict actually entered was for \$2,372,323.92 after damages were reduced by 13.5% for fault of the injuries attributed to the plaintiff. (We were associated on the case with Rob Kraft, an experienced maritime attorney at the Levenson Freedman firm in Seattle.) In May 1998, a Chelan County jury awarded one of our clients \$361,000 for fibromyalgia stemming from a car accident. In September 1999, a Federal District Court Judge ordered Paul Revere Insurance Company to reinstate long term disability insurance benefits to one of our clients, requiring Paul Revere to also pay attorney fees and prejudgment interest. In each of these cases, the Defense tried to argue that the condition was purely psychological and not as disabling as the client's found it to be. We used the approach described above to counter these arguments. In the two cases involving fibromyalgia as a result of trauma, the Defense argued

that there was no legitimate link. We used the medical literature, expert testimony, and lay witness testimony to counter this argument. In the most recent case, the defense presented testimony from a psychiatrist, an anesthesiologist specializing in treating patients with chronic pain, a University of Washington rheumatologist, and an addiction medicine specialist. We countered with two rheumatologists, a psychiatrist, an addiction medicine and chronic pain treatment specialist, a human performance evaluator (physical capacities examiner), a vocational expert, and an acupuncturist. We presented and discussed at trial many of the articles in the attached bibliography. We had numerous lay witnesses including several supervisors from work, the plaintiff's girlfriend, and several other friends who could all testify to the significant change in our client following his injury leading to the ultimate development of fibromyalgia. They also could testify to observable disabling effects of his condition. Needless to say, to properly present a case, there can be considerable expense incurred.

Nevertheless, people truly living with severe fibromyalgia have profound and documented disability that warrants very significant compensation, and therefore full preparation of their case.