Keegan v. Middlebury College (February 16, 2005)

STATE OF VERMONT
DEPARTMENT OF LABOR AND INDUSTRY

Karen M. Keegan	)	Opinion No. 17-05WC
	)	
	)	By: Margaret A. Mangan
v.	)	Hearing Officer
	)	
Middlebury College	)	For: Laura Kilmer Collins
	)	Commissioner
	)	
	)	State File No. R-50476

Pretrial conference held on July 19, 2004
Hearing held in Montpelier on December 14 and December 15, 2004
Record Closed on January 27, 2005

APPEARANCES:

William E. Leckerling, III, Esq., for the Claimant
Frank E. Talbott, Esq., for the Defendant

ISSUE:

Does claimant have Reflex Sympathetic Dystrophy (RSD), also known as Complex Regional Pain Syndrome Type I, (CRPS) and, if so, is it causally related to her work related injury?

What degree of permanent partial disability benefits are due claimant?

EXHIBITS:

Joint I:	Medical Records
Claimant 3 through 16:	Photographs
Claimant 17:	Prescriptions
Claimant 18 to 20:	Photos 2002
Claimant 21:	Somatization disorder criteria
Claimant 22:	CV of Dr. Puttlitz
Claimant 23:	CV of Dr. Brigham
Claimant 24:	CV of Dr. Solomon
Defendant A:	CV of Dr. Youngjohn
Defendant B:	CV of Dr. Powers
Defendant C:	Report by Dr. Youngjohn
Defendant D:	Report by Dr. Powers

FINDINGS OF FACT:

1. Claimant injured her right knee while working as a security guard at Middlebury College on November 19, 2000.

2. Following the injury claimant treated with Benjamin Rosenberg, M.D., an orthopedist, who at first prescribed a knee stabilizer and crutches. By November 28th, she had difficulty bearing full weight on her right knee and had what Dr. Rosenberg described as an "usual" area of ecchymosis on the side of her knee that looked like a contusion. An examination led him to the diagnosis of patellar subluxation of the right knee. She was prescribed physical therapy.

3. By January 18, 2001, Dr. Rosenberg noted that claimant was walking with an unusual limp, unlike an expected antalgic gait. Dr. Rosenberg documented what he determined was her pain magnification. He explained that she did not have a structural lesion of the knee.

4. Claimant later moved to Chittenden County and treated with Dr. Abate. On June 14, 2001, Dr. Abate operated on her knee after determining that conservative treatment had failed. With the exception of some scar tissue, the knee surgery revealed no pathology.

5. Claimant's pain increased postoperatively and she continued to complain that the knee was buckling. At one point she fell down a flight of stairs. Yet Dr. Abate reported on an essentially normal objective examination. The surgical site was healing well; she had little pain, and was taking no pain medication. He made no mention of instability in her knee.

6. Claimant had several photographs taken of her knee at various times before and after surgery.

7. By December 2001 Dr. Abate noted that claimant had regained full range of motion, she was feeling no patellar instability and the patella was not dislocating.

8. Claimant continued to treat with Dr. Abate and also saw Dr. Schneider in 2002. She reported having fallen down stairs and injuring her hand because her knee gave out. Yet the range of motion in her knee remained normal and it was stable when examined.

9. On March 25, 2002, Dr. Johansson, who performed an assessment for the carrier, determined that she had had patellar subluxation and had a whole person permanent partial impairment of 5%.

10. In May of 2002, Dr. Brigham performed an examination for the claimant. He diagnosed "right knee dysfunction" with an 18% whole person impairment. Dr. Johansson later accepted Dr. Brigham's rating because of the muscle atrophy in the claimant's leg and loss of strength.

11. Claimant moved to Arizona where she saw Michael Creaseman, M.D. on June 16, 2002. Dr. Creasman expressed concern about atrophy and weakness in the leg and suggested that she might have RSD. Therefore, he recommended a bone scan, referred her to Dr. Michael Powers, a neurologist, and to an RSD support group.

12. The bone scan was normal, except for a mild increase in uptake suggestive of a normal anatomical variant. The scan did not reveal signs of RSD.

13. Nerve conduction studies were also normal, ruling out nerve involvement.

14. On November 14, 2002, Dr. Creasman determined that claimant had a permanent condition "secondary to patellofemoral osteoarthritis and surgery" with a 15% impairment.

15. Rather than see the neurologist Dr. Creasman recommended, claimant obtained the name of Dr. Puttlitz from the RSD support group. She saw him because of his experience treating patients RSD, although up to that point she had not been diagnosed with RSD.

16. Claimant reported to Dr. Puttlitz that she was experiencing signs and symptoms of RSD including burning pain in her knees, intermittent knee swelling, pale color of the knee, and skin dryness on the knee. On examination, Dr. Puttlitz found that her knee was pale and somewhat cyanotic; it was cool to touch; she had allodynia (pain with light touch) and hyperpathia (pain with pressure).

17. Dr. Puttlitz diagnosed RSD, a diagnosis he confirmed when claimant reported relief with a sympathetic nerve block. However, he was not able to determine the probable cause of the syndrome.

18. Dr. Christopher Brigham testified that a sympathetic nerve block plays no role in the diagnosis of RSD.

19. In a second report to the claimant, Dr. Brigham adopted Dr. Putllitz's diagnosis of RSD based on that physician's notes.

20. On February 11, 2004 Michael Powers, M.D., a board certified neurologist, examined claimant for the defense in this case. Dr. Powers observed and documented the following: without a crutch and knee brace, claimant walked in an erratic fashion, buckling her knee. With support she could stand and take a step or two before her knee buckled and gave way. Motor testing was inconsistent. For example, when asked to extend her knee, she reported that it was too weak. But when the doctor held her leg up then let go, she slowly lowered it, a movement that required strength she denied she had.

21. Dr. Powers is thoroughly familiar with the diagnosis and treatment of RSD/CRPS. His examination of the claimant revealed no objective neurologic abnormality. He determined that claimant made no effort to perform functions she is capable of performing and attributes the atrophy in her leg to disuse.

22. Dr. Powers also noted that when one develops RSD after an injury, it typically manifests itself within a few weeks. Yet, no one who had treated claimant in Vermont had suspected that diagnosis or made any of the observations Dr. Putllitz recorded at her first visit with him, a visit that occurred after claimant had met with the RSD support group.

23. On referral from Dr. Powers, claimant next saw James Youngjohn, Ph.D., certified in Neuropsychology at the Neuropsychology Clinic in Phoenix, Arizona. Dr. Youngjohn also testified for the defense in this case. After reviewing the records and testing the claimant, Dr. Youngjohn diagnosed claimant with a somatoform disorder unrelated to her work-related injury. That diagnosis is based on a history that included claimant's having fallen six times before the work related injury, injuring herself and requiring medical treatment. Also, before the injury in this case, claimant developed a tendonitis in her foot and relied on a foot brace to the point that her extremity atrophied somewhat. Only after a strong recommendation from her physician did she stop using the brace.

24. Dr. Youngjohn's report verified Dr. Powers's opinion that claimant lacks an organic explanation for her chronic pain complaints, chronic atrophy and give-way weakness. On the basis of his expertise in neurology, Dr. Powers recommended that claimant stop treating for RSD, stop using a brace and crutch, and return to physical therapy to help her regain normal ambulation.

25. For the claimant, psychologist Paul Solomon, Ph.D., rejected Dr. Youngjohn's opinion because claimant does not meet the diagnostic criteria under DSM-IV 300.81 for Somatization Disorder. However, Dr. Youngjohn's opinion is that claimant meets the criteria for Undifferentiated Somatoform Disorder, DSM-IV 300.82, a well-supported diagnosis.

CONCLUSIONS OF LAW:

1. In workers' compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. *Goodwin v. Fairbanks*, 123 Vt. 161 (1962). The claimant must establish by sufficient credible evidence the character and extent of the injury and disability as well as the causal connection between the injury and the employment. *Egbert v. Book Press*, 144 Vt. 367 (1984).

2. There must be created in the mind of the trier of fact something more than a possibility, suspicion or surmise that the incidents complained of were the cause of the injury and the inference from the facts proved must be the more probable hypothesis. *Burton v. Holden & Martin Lumber Co*., 112 Vt. 17 (1941).

3. In cases such as this one where there is a dispute among the various experts, the following criteria are relevant: 1) the length of time the physician has provided care to the claimant; 2) the physician's qualifications, including the degree of professional training and experience; 3) the objective support for the opinion; and 4) the comprehensiveness of the respective examinations, including whether the expert had all relevant records. *Miller v. Cornwall Orchards*, Op. No. WC 20-97 (Aug. 4, 1997); *Gardner v. Grand Union* Op. No. 24-97WC (Aug. 22, 1997).

4. Dr. Puttlitz has the advantage as the treating physician, but he did not treat the claimant soon after her injury and his assessment is based almost entirely on the claimant's subjective complaints. Even this supportive physician was not able to opine with the requisite degree of probability that claimant's condition is work related. Dr. Puttlitz has expertise in pain management, Dr. Brigham in impairment ratings, Dr. Powers in neurology and Doctors Youngjohn and Solomon in psychology. Dr. Brigham's first opinion is a reliable opinion, based on objective evidence when he arrived at an 18% impairment rating. Dr. Powers's expertise in neurology places his opinion above all others in terms of the diagnosis in this case. His assessment was thorough, objective and well reasoned. Together with the testing from Dr. Youngjohn, the opinion from Dr. Powers that claimant does not have RSD and that her pain condition is not related to her work related injury is the most convincing.

ORDER:

Therefore, based on the foregoing findings of fact and conclusions of law, claimant is awarded permanency based on an 18% whole person rating. All other claims are DENIED.

Dated at Montpelier, Vermont this 16th day of February 2005.

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Laura Kilmer Collins
Commissioner

Appeal:

Within 30 days after copies of this opinion have been mailed, either party may appeal questions of fact or mixed questions of law and fact to a superior court or questions of law to the Vermont Supreme Court. 21 V.S.A. §§ 670, 672.