J.H. Ennis MSW, MD, FRCP[C]

Ennis Centre for Pain Management

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This is a summary of a non-traumatic case. The issue has been non-payment of long term disability.

Date

INDEPENDENT MEDICAL EVALUATION

Patient:	**Ms. XXXXX**
Date of Birth:	**Date**
Date of Report:	**Date**
Your File No.:	**11-11111**
Evaluator:	**Dr. J.H. Ennis, Psychiatrist**

QUALIFICATIONS:

I am a duly qualified medical practitioner licensed to practice by the College of Physicians and Surgeons of Ontario. I obtained my MSW degree at the University of Toronto in 1982, and my MD degree at McMaster University in 1988. Following my residency in psychiatry, I participated in an additional three years of supervised training in the treatment of patients with chronic non-cancer pain. I am a Consultant in Psychiatry and certified as a Fellow of the Royal College of Physicians and Surgeons of Canada in this specialty. I was an examiner for the College of Physicians and Surgeons of Ontario. I held the position Associate Director of the Chronic Pain Management Unit at Chedoke Rehabilitation Services. I was the Director of the *HSO Pain Management Group* and the *East End Multidisciplinary Pain Management Program.* Currently, I am the director of *The Ennis Centre for Pain Management,* located in Hamilton, Ontario. I hold cross appointments in the Department of Physical Medicine and Rehabilitation, and the Department of Psychiatry and Neurobehavioural Sciences. I am a part-time clinical Assistant Professor in the Faculty of Health Sciences at McMaster University in Hamilton, Ontario, Canada. My clinical practice is devoted to the assessment and treatment of patients with chronic non-cancer pain.

Patient: Ms. XXXXX
Date of Birth: 1900/00/00
Date of Report: Date
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CONSENT*:*

At the outset of the assessment I did have Ms. XXXXX complete a form 14 consent for disclosure of information. I also spent time with the patient reviewing the role of the expert witness. She did sign a document indicating that she understood this role. Finally, Ms. XXXXX did sign a document which outlines the limits of confidentiality in the context of this assessment.

The disclosure of information allows this documents to be distributed to the following:

Mr. ZZZZZ

Ms. XXXXX was seen for an independent psychiatric evaluation at the request of her legal representative. If a physical examination is carried out it is carried out in the presence of my secretary, Ms. GGGGG. The nature of the examination was explained. Ms. XXXXX understood that she could stop the examination at any point for any reason. If pain was produced by any test or other aspect of the examination it should be brought to my attention and test would be discontinued. The patient understood that she could make such a request without jeopardizing her situation and had no objection to the copy of this letter being forwarded to her family physician.

Ms. XXXXX understood that I have been asked by her legal representative to provide an unbiased response to the following questions/issues:

1. **What symptoms are noted on interviewing and testing?**
2. **What are the results of interview, testing and examination?**
3. **What is your diagnosis?**
4. **What, if any, impact does Ms. XXXXX's condition have on her ability to return to work in her former occupation.**
5. **What, if any, impact does Ms. XXXXX's condition have on her ability to return to work at any occupation within her training, education or background?**
6. **In addition, I will also provide treatment recommendations.**

Patient: Ms. XXXXX
Date of Birth: 1900/00/00
Date of Report: Date
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SOURCE OF DATA:

Reports:

- Primary Care Physician Notes
- Report by LLLLL (nephrologist) dated
- Right Knee Ultra Sound dated
- Report by LLLLL (nephrologist) dated
- Report by LLLLL (nephrologist) dated
- Tissue Biopsy dated
- Report by LLLLL (nephrologist) dated
- Report by LLLLL (nephrologist) dated
- X-ray of the Lumbar Spine dated
- Report by QQQQQ (physiotherapist) dated
- Report by LLLLL (nephrologist) dated
- Report by QQQQQ (physiotherapist) dated
- MRI of the Spine dated
- Report by LLLLL (nephrologist) dated
- Report by MMMMM (rheumatologist) dated
- Report by NNNNN (anaesthetist) dated
- Report by LLLLL (nephrologist) dated

Clinical Assessment:

A clinical assessment was conducted at the Medical Arts Building in Hamilton, Ontario on date.

Patient:	**Ms. XXXXX**
Date of Birth:	**Date**
Date of Report:	**Date**
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SECTION I

The information contained within this section derives solely from the subjective verbal history provided by the patient.

IDENTIFYING DATA:

Ms. XXXXX is a 50-year-old woman. She is married. The patient's husband works as a manager for ZZZZZ.. Prior to date Ms. XXXXX was working on the line at LLLLL as a packer.

Ms. XXXXX has a history of Lupus Erythremitosis first diagnosed in 1987 which has been associated with a remitting relapsing Lupus Nephritis. However, she had been working at LLLLL for nine years prior to the onset of her current cluster of symptoms that resulted in her reduction in function.

HISTORY:

Ms. XXXXX indicated that in 2010 she had a gradual onset of back pain and chest wall pain. Over time the pain spread to involve other joints. She started to become fatigued. She continued to work for about four months in spite of being symptomatic. However by date she was unable to manage in the workplace and she has not returned to work since that time.

Ms. XXXXX was referred for physiotherapy by her disability insurance provider. She reported that the physiotherapy was not particularly helpful although the physiotherapist recommended that she be assessed by a rheumatologist.

Ms. XXXXX has been under the care of Dr. YYYYY. (nephrologist). In 2010 the patient had a renal biopsy indicating the presence of Lupus Nephritis. She began treatment with immuno-suppressants which included the use of Prednisone and Imuran.

Ms. XXXXX indicated that she does not like to take these medications. The Prednisone is associated with mood swings and significant weight gain. According to the patient these medications do not make her feel physically better.

The lack of response to immunosuppressants suggests that there are more than physical factors associated with the patient's experience of pain.

Ms. XXXXX is aware that Dr. YYYYY. had commented that she was capable of work from a nephrological perspective only but Dr. YYYYY. was not commenting on whether the patient was capable of working as a result of the wide spread joint pain and fatigue

that she experiences.

Ms. XXXXX has also been under the care of Dr. YYYYY. (rheumatologist). According to Ms. XXXXX she does not feel that the therapeutic relationship has been optimal. She states that she typically will see a resident and rarely sees Dr. YYYYY. and she describes him as not communicating very clearly with her. As best as I can tell, there has been no specific active treatment involved with the consultation by Dr. YYYYY. .

Ms. XXXXX has also had a consultation with Dr. YYYYY.(anaesthetist). It was Dr. YYYYY.opinion that Ms. XXXXX's back pain has a significant myofascial component and he did not feel that she would respond to intervention.

Current Symptoms:

Ms. XXXXX has pain affecting her neck and back, with wide spread arthralgias and myalgias affecting most aspects of her body. She reports that there is no where that she does not have pain. Bowel and bladder function are maintained and there are no long track signs.

***Level of Function*:**

Prior to the onset of the patient's current difficulties she worked 12 hour shifts at LLLLL. She would take care of her home. She did the cooking and shopping and she would socialize with friends.

Now, Ms. XXXXX reports that she does very little. She will get up between 9:30 and ten in the morning and take a bath. She does some light housework. She reports that she cannot stand for very long and therefore she will stand and sit, stand and sit and stand and sit in order to complete the tasks.

She spends most of the day doing very little. Her mother helps a great deal. Her husband does the shopping and the mother does cooking on the weekend. The patient reported that she will sometimes do cooking during the week. She no longer socializes and intimacy between herself and her husband is significantly reduced because of low libido.

PAST MEDICAL HISTORY:

As noted Ms. XXXXX has a history of Lupus with recurrent Lupus Glomerulonephritis associated with hypertension.

PAST PSYCHIATRIC HISTORY:

The patient does not report any formal psychiatric history.

MEDICATIONS:

Cymbalta 60 mgs. It is the patient's understanding that she is taking Cymbalta for pain only and not for mood. She reports that the Cymbalta is not helpful.

Apo-HyDr. YYYYYoxyquine 200 mgs two tablets per day

Ergo-calciferol Vitamin D2 one tablet per week

Tiazac KC 240 mgs one tablet per day before bedtime for hypertension.

Teresa-Irbesartan 150 mgs OD

Ratio-Lenoltec #3 300-30-15 m codeine one tablet every 6 hours

The patient is allergic to Tramadol and Tide detergent. She does not smoke or use substances.

FAMILY MEDICAL AND PSYCHIATRIC HISTORY:

The patient reports no significant family medical or psychiatric history.

PERSONAL HISTORY:

Ms. XXXXX was born in location. She has one brother. She describes her family as close. Her father is retired from working in a car factory. Both of her parents are originally from location. There is no developmental trauma. Ms. XXXXX was uncertain as to how far she went in school but settled on having completed grade 11. She did state that she has been thinking about returning to school at some point. She has always had to work in physical labour and she regrets having not gone further in her own education. The patient describes her husband as very supportive.

MENTAL STATUS EXAMINATION:

Ms. XXXXX presented as a moderately well-groomed obese woman. She demonstrated significant pain behaviours throughout the assessment. She sat hunched over to the left because of chest wall pain. Episodically she would grunt and moan. The patient describes herself as feeling restless but not depressed. She does feel frustrated. She described herself as a very private individual who does not like to talk about her problems or worry other people. Her appetite is reported as poor but she has not had any change in weight. Her sleep is normal. She is not anhedonic but rather has a physical incapacity to do things. Her energy is poor but her concentration is intact. She has a positive self image and stated that it is "not my fault". She denied suicidal ideation or intent. There was no evidence of mania or hypomania.

Ms. XXXXX described herself as having "claustrophobia". By this she means that she gets extremely anxious when she is in small spaces such as elevators. A good example of this was found in the medical legal brief. The patient was scheduled for an MRI that had to be cancelled because she had a panic attack when put in to the MRI machine without sedation. She does not have anxiety or panic attacks outside of the situation described. She does not have obsessive thinking or compulsive behaviours. Her thought form and content were normal and there was no evidence of perceptual disturbance. Cognitive examination was grossly normal.

BRIEF PHYSICAL EXAMINATION:

A brief physical examination was conducted. The patient demonstrated functional range of motion of the neck. In terms of the back, she moved about two degrees in flexion with 0 extension. Lateral bending was about 5 degrees to either side. Palpating fibromyalgia tender points resulted in reports of pain on palpation of 14 out of 18 tender points. However, less than feather light touch was utilized in the examination. There is significant non-organic findings present.

It is important to note that the presence of non-organic findings is not indicative of malingering. Rather, a review of the literature demonstrates that the presence of non-organic findings means that the clinical outcome is more likely to be poor and clinicians are more likely to meet with treatment resistant symptoms.

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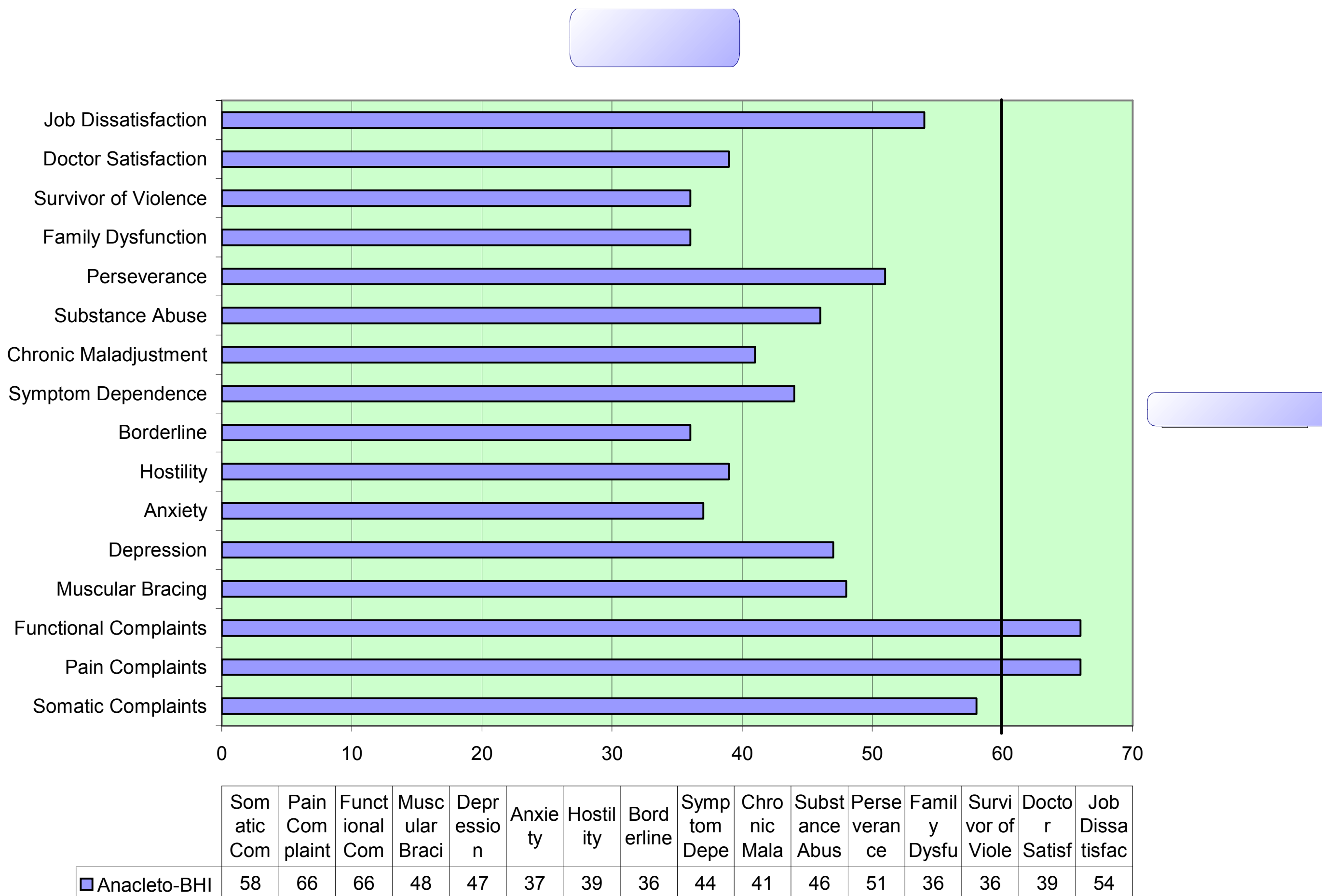
SECTION II

The information in this section derives solely from objective psychometric testing.



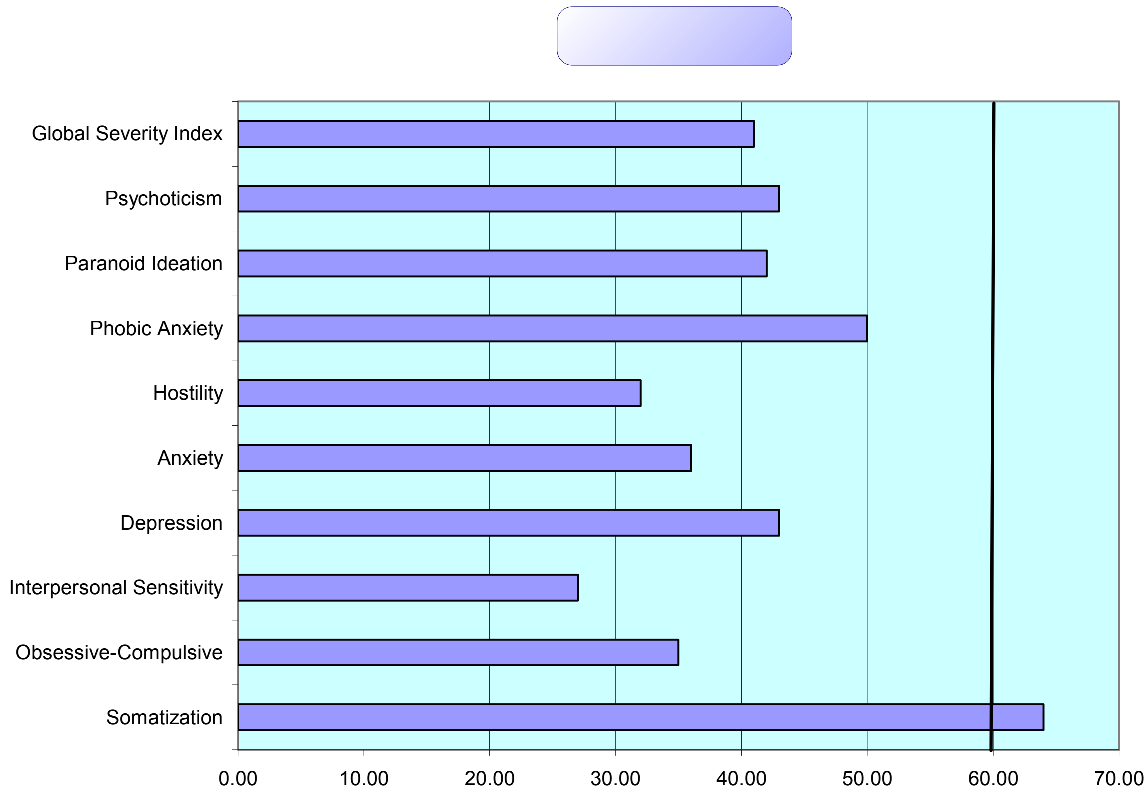
	Som atic Com	Pain Com plaint	Funct ional Com	Musc ular Braci	Depr essio n	Anxie ty	Hostil ity	Bord erline	Symp tom Depe	Chro nic Mala	Subst ance Abus	Perse veran ce	Famil y Dysfu	Survi vor of Viole	Docto r Satisf	Job Dissa tisfac
Anacleto-BHI	58	66	66	48	47	37	39	36	44	41	46	51	36	36	39	54

On the **BEHAVIOURAL HEALTH INVENTORY II**

Subscales scores above 60 are considered of clinical significance. Elevations are noted for functional complaints and pain complaints in keeping with chronic noncancer pain.

<u>Psychopathology:</u>

On the **SCL90-R**



	Somatization	Obsessive-Compulsive	Interpersonal Sensitivity	Depression	Anxiety	Hostility	Phobic Anxiety	Paranoid Ideation	Psychoticism	Global Severity Index
Anacleto-SCL90R	64.00	35.00	27.00	43.00	36.00	32.00	50.00	42.00	43.00	41.00

On the SCL-90-R, subscales with T-Scores above 60 are considered to be clinically significant. An elevation is noted on the somatization subscale.

On the **PTSD CHECKLIST** Ms. XXXXX's profile did not meet criteria for PTSD.

On the **ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)**, Ms. XXXXX scored 0 indicating no issues related to alcohol use.

On the **DRUG USE DISORDERS QUESTIONNAIRE** Ms. XXXXX scored 0 indicating no issues related to drug use.

On the **COMM,** scores above 9 indicate risk of addiction in patients who are opioid naive. Ms. XXXXX scored 4.

On the **PAIN CATASTROPHIZING SCALE** scores above the 75th percentile are considered to be of clinical significance. Ms. XXXXX's total score was in the 97th percentile. On the rumination subscale she scored in the 91st percentile. On the magnification subscale she scored in the 98th percentile and on the helplessness subscale she scored in the 97th percentile. This profile does indicate significant catastrophic thinking.

On the **EPWORTH SLEEPINESS SCALE** Ms. XXXXX scored 2 indicating no evidence of sleep disorder.

The patient was unable to complete the **DAPS**. She reported that a number of the questions did not apply to her.

Patient: **Ms. XXXXX**
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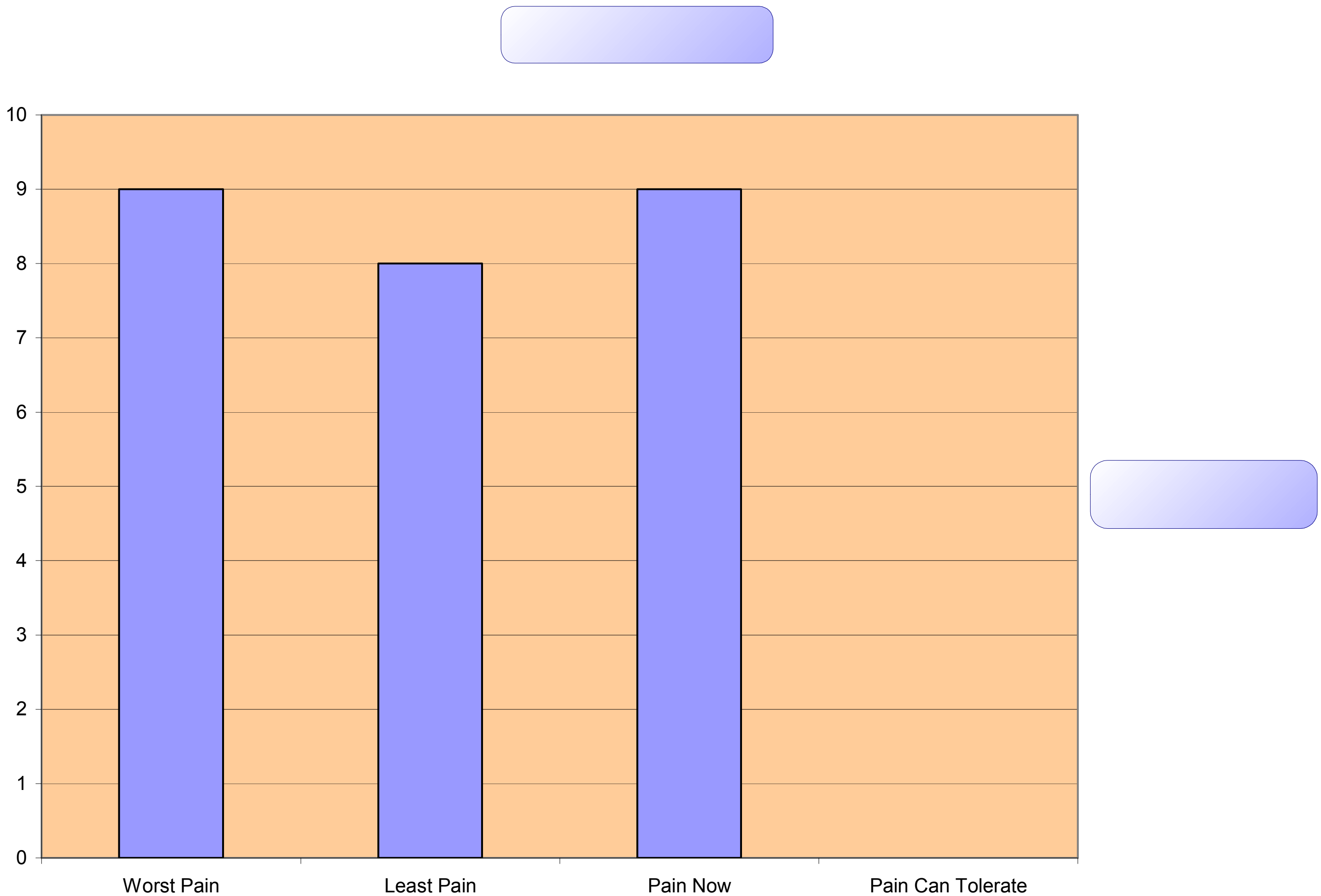
Pain and Disability:

On the **PAIN RATING SCALE:**



This patient has reported that she can tolerate no pain. This is a poor prognostic indicator.

On the **PAIN DISABILITY INDEX** Ms. XXXXX scored 54. For the family and home responsibilities subscale she scored 10 out of 10 with 10 being total disability and 0 being no disability. For the recreation subscale she scored 10. Social activity was scored at 9, occupation at 10, sexual activity at 0, self care at 8 and life support activities at 7. The patient's overall score is somewhat above scores typically seen in

patients with chronic pain involved in litigation.

On the **HAND SORT**, Ms. XXXXX's total score put her in the 20th percentile indicating that this is below sedentary capacity.

On the **SPINAL SORT,** Ms. XXXXX's total score put her in the 2nd percentile which is well below sedentary capacity.

On the **OSWESTRY BACK PAIN AND DISABILITY QUESTIONNAIRE** the patient scored 82. This score indicates that she is either presenting with symptom magnification or is bed bound.

On the **OSWESTRY NECK DISABILITY QUESTIONNAIRE** the patient scored 54 indicating that she perceives herself as severely impaired as a result of neck pain.

The patient's **KARNOFSKY** score is 60 indicating that she requires occasional assistance but is able to care for most of her own needs.

On the **HEADACHE IMPACT TEST** Ms. XXXXX scored 55 indicating that headaches are interfering with some aspects of her life.

On the **OREBRO MUSCULOSKELETAL PAIN QUESTIONNAIRE** scores above 130 indicate an extremely high likelihood of chronic disablement and an extremely low likelihood of return to work. Ms. XXXXX scored 133.

On the **TAMPA SCALE FOR KINESIOPHOBIA** Ms. XXXXX scored 48. This score does indicate that this patient has fear of movement.

On the **TIME TO GET UP AND GO TEST** Ms. XXXXX scored 23 indicating that she has "variable mobility".

On the **FEAR AVOIDANCE QUESTIONNAIRE** Ms. XXXXX's work subscale was 18 which indicates clinically significant fear. On the physical subscale the patient scored 33 which is also above scores typically seen indicating that this patient has fear related to physical activity.

Patient: Ms. XXXXX
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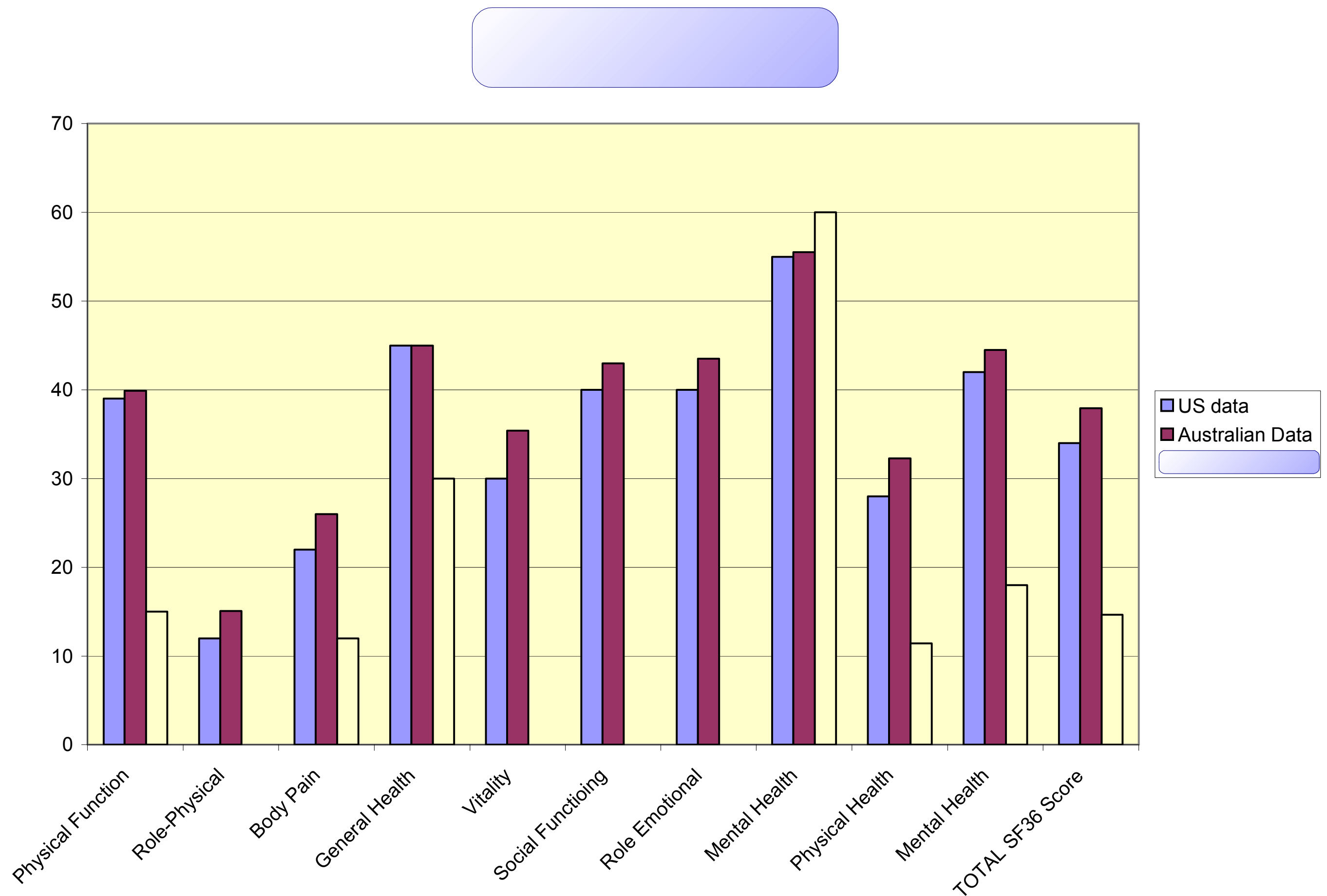
Ms. XXXXX's score on the **SF36** is:



The SF-36 contains 36 items that, when scored, yield 8 domains. Physical functioning assesses limitations in physical activities, such as walking and climbing stairs. The role physical and role emotional domains measure problems with work or other daily activities as a result of physical health or emotional problems. Bodily pain assesses limitations due to pain, and vitality measures energy and tiredness. The social functioning domain examines the effect of physical and emotional health on normal social activities. Mental health assesses happiness, nervousness and depression. The general health perceptions domain evaluates personal health and the expectation of changes in health. All domains are scored on a scale from 0 to 100, with 100 representing the best possible health state. Summary scores for a physical component (physical functioning, role physical, bodily pain and general health perceptions) and a mental component (vitality, social functioning, mental health and role emotional) can also be derived.

The patient's score is compared to a large, cross country cohort of patients with chronic non-cancer pain. Ms. XXXXX's score was below that of other patients with chronic noncancer pain across all subscales except mental health. This indicates a low level of function even for a patient with chronic noncancer pain.

On the **REHABILITATION CHECKLIST** Ms. XXXXX indicated that the five most important issues that are acting as barriers to her function are as follows, in the order of importance: fear or re-injury or worsening condition, pain, lack of energy and feeling fatigued, physical restrictions and difficulty engaging in social activities. Her score is such that her emotional subscale is greater than four and risk factor subscale is greater than 13. On the Rehabilitation Checklist these elevations indicate risk of disability.

On the Degree of Life Role Disability the patient reports 100% disability for household chores, parental activity and volunteer work in the community. 100% disability is noted for participation in hobbies, social activities and in regular employment. She scored self sufficiency in Dr. YYYYYessing and eating as 60% disabled and learning and studying as 70% disabled. Her total LR score is 86% which is well above cut off of 50% again indicating high risk.

In regards to condition change it is the patient's opinion that her condition has worsened by 80% since the onset of the problems from a physical point of view only. Emotionally she had also worsened by 80%. She expects her overall condition to improve by 50%.

Overall, this profile indicates fear of injury, and a significant self perception of profound disability.

<u>Cognitive Ability:</u>

On the **MONTREAL COGNITIVE ASSESSMENT SCALE** Ms. XXXXX scored 30 out of 30 indicating no issues related to cognitive capacity.

<u>Malingering:</u>

On the **REY 15 ITEM MEMORY TEST** Ms. XXXXX scored 15 out of 15 indicating no issues related to malingering.

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Summary of Findings:

Psychometric testing does not show evidence of a mood or anxiety disorder. This is consistent with the clinical examination. There is evidence of somatization. This patient perceives herself as very impaired. Her level of function is below that typically seen in patients with chronic noncancer pain. She has clinically significant catastrophic thinking. Her capacity to work, based on self perception, is below sedentary capacity. She rates her level of disability in day-to-day life as between 70-100%. She has clinically significant catastrophic thinking.

Patient: Ms. XXXXX
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SECTION III

The information in this section derives solely from the available medical-legal brief.

REVIEW OF AVAILABLE DOCUMENTATION:

Notes that are handwritten and photocopied will be commented on if they are completely legible only. Documents will be commented on only if they are complete and are not missing any pages.[1]

Primary Care Physician Notes:

A note from date states that an MRI report is reviewed. The patient has had 16 sessions of physiotherapy without positive results and he referred the patient to Dr. YYYYY. .

A note from date states that Ms. XXXXX is diagnosed with multiple joint pain related to Lupus. Her kidney is stable. She is being treated with Tridural titrated to 300 mgs.

A note from date states the Tridural has not been helpful and Ms. XXXXX has had rashing which stopped after the Tridural was discontinued.

A note from date states that Ms. XXXXX had a fall down a flight of stairs twisting the right knee. The knee was tender to palpation with reduced range of motion. Reduced strength is noted. The diagnosis is to rule out a meniscal tear.

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[1] Please note: All of the author's (Dr. YYYYY. Ennis) comments in regards to consultation reports will be in italics and 'border filled' in light grey.

A note from date states there is evidence of ligament tear to the right knee. The patient was off work until further notice.

A note from date states that Ms. XXXXX is using a brace but it is not helping. The patient's insurance benefits had been cancelled. She was referred to physiotherapy and for a Venus Doppler.

A note from date states that Ms. XXXXX has problems with knee pain and back pain. She is diagnosed with myofascial back pain and they are awaiting the MRI of the knee.

Report by LLLLL (nephrologist) dated

Ms. XXXXX was initially hospitalized with flu-like symptoms in 1996 with a creatinine of 170 and active urine sediments. She had sclerosis and glomerulonephritis class II and class III Lupus nephritis treated with Prednisone and Azathioprine. She was completely off medication and in remission since 1999. She was re-referred with the onset of hypertension. In terms of diagnosis it was thought that the hypertension may be related to the patient's significant weight gain. Her blood pressure has been controlled on Diltiazin. They spoke about postpartum related issues and antipartum flare-ups of Lupus.

Right Knee Ultra Sound dated :

Two areas of partial tear of the medial collateral ligament and a tear to the medial meniscus could not be excluded.

Report by LLLLL (nephrologist) dated:

Apparently Ms. XXXXX had not done the necessary blood work and it was pointed out to her that she must do this. She will then be followed up to determine if she requires a biopsy.

Patient:	**Ms. XXXXX**
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Report by LLLLL (nephrologist) dated:

Ms. XXXXX was seen in follow up. She has increased blood pressure and hematuria and it is possible she is getting a glomerulonephritis again and the plan is for a percutaneous renal biopsy.

Tissue Biopsy dated :

This is Lupus glomerulonephritis with mesangial proliferative class II.

Report by LLLLL (nephrologist) dated:

Ms. XXXXX was given a reduced dose of Prednisone and the plan is to slowly withDr. YYYYYaw her from Prednisone.

The patient's symptoms are considered minimal. She has a lot of chest wall pain. X-rays did not show any significant abnormality. The plan is to reduce Prednisone.

Report by LLLLL (nephrologist) dated:

Ms. XXXXX is on minimal amounts of Prednisone. The plan is to wean her off the Prednisone.

X-ray of the Lumbar Spine dated:

There is osteoarthropathy at the lowest three sets of facet joints. Disc space is considered normal.

Report by B. ZZZZZ (physiotherapist) dated:

Ms. XXXXX presents with back pain, intermittent neck pain, bilateral shoulder pain and leg pain. The plan is for physiotherapy with education, aerobic exercise, stretch and strengthening exercises and core exercises.

Report by LLLLL (nephrologist) dated:

Ms. XXXXX does not appear to be having any active Lupus symptoms. From a renal point of view she is doing well. The plan is to discontinue the Azathioprine.

Report by B. XXXXX (physiotherapist) dated:

Ms. XXXXX's movements are described as slow and guarded. She has musculoskeletal pain in multiple areas. It was noted that the patient had also stopped taking her immuno-suppressants and this may have resulted in what he describes as a flare up. It was felt it would be difficult to progress to a work hardening program until the patient's symptoms are better managed.

MRI of the Spine dated:

Small annular fissure is noted at L4-5 and L5-S1 with mild disc bulging at L4-5 without compromise to the spinal canal or neural foramina.

Report by LLLLL (nephrologist) dated:

The assessor had taken care of Ms. XXXXX for ten years previously with her first episode of Lupus nephritis. She was seen again in 2008 and had a kidney biopsy which showed mesangial proliferative glomerulonephritis class II. She has been treated with Prednisone and Azathioprine as well as Fosamax. The nephritis went into remission and she was weaned off Prednisone and has been off of it since 2010. Her

creatinine is 92 which for her age is considered slightly elevated. Urinalysis was negative. It was stated there was no reason why the patient could not return to work from a renal point of view.

Report by A. KKKKK (rheumatologist) dated:

Ms. XXXXX has been diagnosed with Lupus since 1996 and has had renal involvement. She had been in denial of the disease and had not done anything in regards to follow up until 2010 when she was found to be hypertensive with some impairment of renal function. There has been a renal biopsy. It is noted she does have Raynode's phenomenon and a recurrent malar rash. She was allergic to Tide detergent and Tramadol. She has diffuse tenderness even on dermal palpation which is not characteristic of Lupus. She has been started on Plaquenil.

Report by GGGGG (anaesthetist) dated:

It was his opinion that Ms. XXXXX's pain is secondary to a mild disc bulge at L4-5 and a large component of myofascial pain as well. It was his opinion that she would not benefit from interventional pain management. He has initiated treated with Nortriptyline 25 mgs po qhs which can be increased to 75 mgs. The only concern was of weight gain. The patient has already gained 40 pounds over the previous five months.

Ms. XXXXX is 40 years old and had worked as a candy packer for nine years. She stopped working in date because of the onset of bilateral low back pain. She is able to stand ten minutes and sit for half an hour. She does not have a radiculopathy. She scored 76% on the Oswestry Disability Index.

Past medical history is for chronic renal failure in 1996 secondary to systemic Lupus, systemic Lupus since 1996, hypertension. He diagnosed her with chronic low back pain not yet diagnosed. He recommended the patient exercise.

Patient: Ms. XXXXX
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Report by LLLLL (nephrologist) dated:

The patient appeared to be in remission. Prednisone was discontinued.

Patient:	**Ms. XXXXX**
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SECTION IV

This section is Dr. YYYYY. Ennis' formulation of the data contained in Section I, II, and III.

DIAGNOSIS:

Axis I	Pain Disorder Associated with Both Psychological Factors and a General Medical Condition.
Axis II	Deferred.
Axis III	Lupus Erythremitosis, Lupus Nephritis currently in remission, Fibromyalgia, glomerulonephritis class II and class III Lupus nephritis -in remission, mild disc bulge at L4-5 and a large component of myofascial pain (based on review of medical brief)
Axis IV	Ms. XXXXX describes stress related to financial concerns.
Axis V	Current GAF 50/100.

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Global Assessment of Functioning (GAF) Scale (DSM - IV Axis V)

Note: The complete GAF scale on page 32 of the DSM - IV and should be consulted for clinical use.

Code	Description of Functioning
91 - 100	Person has **no problems** OR has superior functioning in several areas OR is admired and sought after by others due to positive qualities
81 - 90	Person has **few or no symptoms**. Good functioning in several areas. No more than "everyday" problems or concerns.
71 - 80	Person has symptoms/problems, but they are **temporary, expectable reactions to stressors**. There is no more than slight impairment in any area of psychological functioning.
61 - 70	**Mild symptoms in one area** OR difficulty in one of the following: social, occupational, or school functioning. BUT, the person is generally functioning pretty well and has some meaningful interpersonal relationships.
51 - 60	**Moderate symptoms** OR moderate difficulty in one of the following: social, occupational, or school functioning.
41 - 50	**Serious symptoms** OR serious impairment in one of the following: social, occupational, or school functioning.
31 - 40	**Some impairment in reality testing** OR impairment in speech and communication OR serious impairment in several of the following: occupational or school functioning, interpersonal relationships, judgment, thinking, or mood.
21 - 30	**Presence of hallucinations or delusions which influence behavior**
11 - 20	There is **some danger of harm to self or others**

Patient: Ms. XXXXX
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Evaluator: Dr. J.H. Ennis, Psychiatrist

CONCLUSION:

Ms. XXXXX is a 41-year-old woman who has a diagnosis of Lupus dating back to 1996. According to the patient, after she was first diagnosed, she denied the presence of the Lupus and therefore she did not follow up with her nephrologist for a number of years until she began to have a relapse. By 2010 the patient had low back pain with wide spread generalized joint pain associated with fatigue and reduced function. At that time she was diagnosed with a relapse of the lupus nephritis. With treatment the nephristis went into remission. However, the wide spread pain and fatigue continued. The end result is that the patient was unable to continue to work as of date.

Psychometric testing does not show evidence of a mood or anxiety disorder. This is consistent with the clinical examination. There is evidence of somatization. This patient perceives herself as very impaired. Her level of function is below that typically seen in patients with chronic noncancer pain. She has clinically significant catastrophic thinking. Her capacity to work, based on self perception, is below sedentary capacity. She rates her level of disability in day-to-day life as between 70-100%. She has clinically significant catastrophic thinking. Ms. XXXXX has kinesiophobia and fear and avoidance. She is bed ridden much of the day. In my opinion this patient is presenting with a *pain disorder associated with both psychological factors and a general medical condition.* This does not negate Dr. YYYYY diagnosis of mechanical low back pain with myofacial pain. The pain disorder is a co-morbid diagnosis. The presence of the somatoform disorder does help to explain why this patient's level of function is so poor and why currently she is not responding to the Duloxatine in regards to pain control.

In regards to the assessment questions:

Patient: Ms. XXXXX
Date of Birth: Date
Date of Report: Date
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1. What symptoms are noted on interviewing and testing?

As described above.

2. What are the results of interview, testing and examination?

As described above.

3. What is your diagnosis?

Axis I	Pain Disorder Associated with Both Psychological Factors and a General Medical Condition.
Axis II	Deferred.
Axis III	Lupus Erythremitosis, Lupus Nephritis currently in remission, Fibromyalgia, glomerulonephritis class II and class III Lupus nephritis -in remission, mild disc bulge at L4-5 and a large component of myofascial pain (based on review of medical brief)
Axis IV	Ms. XXXXX describes stress related to financial concerns.
Axis V	Current GAF 50/100.

4. What, if any, impact does Ms. XXXXX's condition have on her ability to return to work in her former occupation.

In my opinion, Ms. XXXXX is disabled from being able to return to work in her former occupation. Central to the diagnosis of a pain disorder is the patient's perception of themselves as profoundly disabled as a result of disabling pain. The patient believes that increased activity will lead to irreparable harm to themselves. This is consistent with Ms. XXXXX's perception of herself.

5. What, if any, impact does Ms. XXXXX's condition have on her ability to return to work at any occupation within her training, education or background?

In my opinion, Ms. XXXXX is unable to return to work at any occupation within her training, education or background. As noted above, central to the diagnosis of a pain disorder is the patient's perception of themselves as profoundly disabled as a result of disabling pain. The patient believes that increased activity will lead to irreparable harm to themselves. This is consistent with Ms. XXXXX's perception of herself. The end result is that her day-to-day activity is minimal. She is doing very little in her own home and therefore she would be unable to manage any form of remunerative employment.

6. In addition, I will also provide treatment recommendations.

1. Currently Ms. XXXXX is being treated with Cymbalta at 60 mgs. She reports no effect. The only option left that Dr. YYYYY has not tried as yet is Effexor. Cymbalta (Duloxetine), effexor and lyrica are indicated for the treatment of wide spread nonarticular pain. It is my understanding that the patient has had trials of Gabapentinoids without positive results. She is also allergic to Tramadol and anti-inflammatory medications are ill-advised given her Lupus Nephritis.

2. In my opinion the "best" treatment available for this patient is a multidisciplinary pain management program.

3. Another alternative to consider is a specialized exercise program for patients with chronic noncancer pain.

Patient: Ms. XXXXX
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OPINION OF THE EXAMINER:

The opinions expressed in this report are based upon the examination(s), interviews, records and/or reports described above. They are based upon the subjective complaints and history provided to the examiner, the medical records and tests provided and the physical findings. It is assumed that the material provided is correct.

The author reserves the right to alter an expressed opinion, to modify, and/or amend this report should further information come to light which would warrant reconsideration of our opinion. The opinions expressed in this report have been rendered independent of the requesting party and are based upon our professional assessment. This report is not to be copied, distributed or used by other than the requesting party without the consent of the author.

J.H. Ennis, MSW MD FRCP (C)

Evaluating Psychiatrist

JHE:sac

date