

HANDLING AND DEFENDING TBI AND CRPS CASES

By Meade W. Mitchell and Margaret Z. Smith



Every litigator who handles personal injury cases is aware that the value of these cases is largely determined by the type of injury alleged by a plaintiff. In many cases, this can be determined by relatively objective methods. Did the x-ray demonstrate a broken bone? Did the MRI show a bulging disc? The more difficult cases are ones in which a plaintiff alleges an injury that is based primarily on subjective complaints and less on objective diagnostic tests. These types of injuries can turn a case with seemingly minor injuries into a high-exposure claim, or take a case with serious injuries and significantly increase the exposure for a defendant.

What makes many of these claims difficult to value is that much of the diagnosis and symptoms are based on the subjective statements of the plaintiff. The symptoms from these injuries, such as memory loss and pain, can be tempting to exaggerate, especially if the plaintiff understands that embellishment of the symptoms could add value to his or her claim. Additionally, defense of these claims is costly, both in terms of time and resources, as it takes significant investigation by both defense counsel and retained experts to uncover the true severity of the injury or whether the injury even exists.

These types of injuries can also create a delicate situation for the presentation and defense of the claims at trial. A defendant must be careful when suggesting that a plaintiff is exaggerating or fabricating an injury due to the risk of appearing unsympathetic, which can be costly in front of a jury. On the other hand, proper investigation and credible evidence that cast doubt on a plaintiff's claims and alleged injuries can create disfavor toward the plaintiff, winning the case for the defense.

This article addresses how to handle and defend these types of claims. While the discussion focuses on two examples of these types of injuries—traumatic brain injury and complex regional pain syndrome—the information can be applied to any claim where an injury with subjective complaints is alleged.

WHAT ARE TRAUMATIC BRAIN INJURY AND COMPLEX REGIONAL PAIN SYNDROME?

Traumatic brain injury. A traumatic brain injury (TBI) occurs when an external mechanical force causes brain dysfunction.¹ Approximately 1.5 million people in the United States sustain a TBI each year. A TBI typically arises from a violent blow or jolt to the head or body.² This type of injury could be caused from a motor vehicle

collision, a fall, or when two opponents collide during a sporting event.³ However, not all blows or jolts that result in head injuries result in TBIs.

Injury to the brain can be direct or indirect.⁴ In cases of direct injury, a TBI can be caused when an object, such as a bullet, penetrates the skull and enters brain tissue, producing bruising, bleeding, and neurological damage.⁵ An indirect injury, on the other hand, occurs when there is no obvious trauma to the head, making this type of injury difficult to diagnose.⁶ As with most personal injuries, a TBI can range from mild to severe, with the severity typically based on the following: duration of loss of consciousness and/or coma score, posttraumatic amnesia, and brain imaging results. The good news is that 80 percent of TBIs that occur in the United States are mild and do not result in long-lasting symptoms.⁷

A mild TBI, commonly known as a concussion, is most often characterized as a brief loss of consciousness, usually limited to a few seconds or minutes, posttraumatic amnesia for less than one hour, normal brain imaging results, and a Glasgow Coma Scale score of 13–15.⁸ A moderate TBI is characterized as a loss of consciousness for 1–24 hours, posttraumatic amnesia for 1–24 hours, abnormal brain imaging results, and a Glasgow Coma Scale score of 9–12.⁹ This category accounts for approximately 10 percent of all TBIs.¹⁰ Severe TBIs, representing an additional 10 percent of all TBIs, are characterized as loss of consciousness or coma for more than 24 hours, abnormal brain imaging results, and a Glasgow Coma Scale score of 3–8.¹¹ In these rare cases, recovery and return to full consciousness, if at all, may take days to weeks.¹²

After a concussion, patients usually describe mental, physical, and behavioral symptoms that can be evidence of a TBI.¹³ Although there are certain objective tests that can aid in evaluating the severity of a TBI, such as CT scans or the Glasgow Coma Scale, in the majority of mild TBI cases these tests appear normal. It is here that diagnosis often relies solely on symptoms that tend to be more subjective than other personal injuries and, therefore, can be exaggerated.¹⁴ Moreover, it is not uncommon for the symptoms to occur days, weeks, or even months following the initial injury.¹⁵ There are generally three components to a TBI injury: cognitive-communicative symptoms, psychological/emotional symptoms, and physical symptoms.¹⁶



TIP

Do not assume a claim involving a traumatic brain injury or complex regional pain syndrome is a high-exposure case. Aggressive and tactical investigation can win the day for the defense.

SYMPTOMS ASSOCIATED WITH TBIs

| | Cognitive-Communicative | Psychological/Emotional | Physical |
|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mild TBI | <ul style="list-style-type: none"> • Decreased attention and concentration • Decreased speed of processing • Memory problems • Increased confusion • Decreased awareness and insight regarding difficulties | <ul style="list-style-type: none"> • Irritability • Depression and anxiety • Emotional mood swings | <ul style="list-style-type: none"> • Headache • Fatigue • Sleep disturbance • Visual disturbance • Dizziness • Nausea • Balance problems |
| Moderate to Severe TBI | <ul style="list-style-type: none"> • Decreased attention and concentration • Distractibility • Memory problems • Decreased speed of processing • Increased confusion • Perseveration • Impulsiveness • Decreased interaction skills • Decreased executive function abilities (e.g., planning, organization, problem-solving) • Decreased awareness and insight regarding difficulties | <ul style="list-style-type: none"> • Dependent behaviors • Apathy • Decreased lack of motivation • Irritability • Acting out • Depression • Denial of difficulties | <ul style="list-style-type: none"> • Difficulty speaking and being understood • Physical paralysis, weakness, or spasticity • Difficulties with sense of touch, temperature, movement, or position • Chronic pain • Decreased bowel and bladder control • Sleep disorders • Loss of stamina • Appetite changes • Partial or total loss of vision • Weakness of eye muscles and/or double vision (diplopia) • Blurred vision • Problems judging distance • Involuntary eye movements (nystagmus) • Intolerance of light (photophobia) • Decreased or loss of hearing • Ringing in the ears (tinnitus) • Increased sensitivity to sounds • Diminished or loss of sense of smell (anosmia) • Reduced or loss of sense of taste |

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From a defense perspective, a number of concerns result from relying on symptoms to diagnose a TBI. For example, evidence of a TBI is generally presumed when an individual complains of symptoms he or she claims did not exist before the head injury.¹⁷ However, these accounts are not always dependable due to the potential of overlooking prior existing conditions and attributing these symptoms to the head injury when something else is actually responsible.¹⁸ Other factors such as mental fatigue, depression, illness, and headache or other bodily pain can also affect an individual's perception of the severity of the symptoms and their source.¹⁹ Furthermore, many kinds of psychiatric disturbances can result in similar symptoms, such as inattention and concentration difficulties, memory impairment, and slowed thinking, which are

commonly associated with a TBI.²⁰ Thus, without definitive diagnostic tests, relying on symptoms alone to diagnose a TBI is uncertain.

Additionally, the symptoms associated with a TBI are commonly known to the general public. Hence, along with objective tests and subjective complaints, motivational and effort tests can also be used to diagnose a TBI. These tests use cognitive tests and questionnaires in an attempt to identify malingering or to infer that an individual is endeavoring to appear impaired. Similarly, in instances where an individual endorses or claims a curiously high number of symptoms, administrators may be able to infer exaggeration.²¹

Thus, in cases where a TBI is alleged, a party should be mindful that while complaints of symptoms associated with a TBI should be adequately considered, they are not

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conclusive evidence for a diagnosis. The lack of diagnostic screenings and objective tests to confirm the existence or severity of a claimant's TBI should be addressed during discovery and settlement negotiations in order to achieve a more realistic idea of the injuries and damages at stake.

Complex regional pain syndrome. Complex regional pain syndrome (CRPS) is an abnormal form of chronic pain that usually affects an arm or a leg.²² Although the cause of CRPS is not well known, it is thought to be caused by damage to, or malfunction of, the peripheral and central nervous systems.²³ CRPS typically develops after an injury to a limb, such as a crush injury to an arm or a leg, but it can also develop after a surgery, stroke, heart attack, or infection.²⁴ CRPS is characterized as severe persistent pain that is out of proportion to the severity of the initial injury.

There are two categories of CRPS: Type I and Type II. The categories are distinguished by the cause of the CRPS rather than signs and symptoms of the condition, which are similar for both categories.²⁵ Type I, also known as reflex sympathetic dystrophy syndrome, is the category assigned to individuals without confirmed nerve injury.²⁶ Type II, also known as causalgia, is the category assigned to individuals with a specific injury to a nerve.²⁷

The difficulty in evaluating cases involving CRPS is that there is no single diagnostic test that can confirm or rule out CRPS. Accordingly, the diagnosis is primarily based on a plaintiff's subjective complaints rather than objective findings. This can lead to overdiagnosis by medical providers as well as the temptation to exaggerate the symptoms on the part of the plaintiff. With the absence

of an objective test, the International Association for the Study of Pain (IASP) developed the following diagnostic criteria for CRPS in 1994:

1. The presence of an initiating noxious event, or a cause of immobilization;
2. Continuing pain, allodynia, or hyperalgesia that is disproportionate to any known inciting event;
3. Evidence at some time of edema, changes in skin blood flow, or abnormal sudomotor activity in the region of pain; and
4. The exclusion of other conditions that would otherwise account for the degree of pain and dysfunction.²⁸

Ten years later, an international consensus held a closed meeting in Budapest to review issues related to diagnosing CRPS, and the modified diagnostic criteria known as the "Budapest Criteria" were proposed.²⁹

An individual who claims to suffer from CRPS may experience the following signs or symptoms:

- Continuous burning or throbbing pain, usually in the arm, leg, hand, or foot;
- Increased skin sensitivity, particularly to touch or cold;
- Swelling of the painful area;
- Changes in skin temperature—at times the skin may be sweaty, and at other times it may be cold;
- Changes in skin color, which can range from white and mottled to red or blue;
- Changes in skin texture, which may become tender, thin, or shiny in the affected area;
- Changes in hair and nail growth;
- Joint stiffness, swelling, and damage;
- Muscle spasms, weakness, and loss (atrophy); and/or
- Decreased ability to move the affected body part.³⁰

The signs and symptoms of CRPS vary from person to person and may change over time. A person does not have to exhibit any or all of these signs or symptoms in order to be diagnosed with CRPS. Moreover, under

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| 1 | <p style="text-align: center;">Sensory</p> <p style="text-align: center;">Allodynia (aka pain in normally not painful situations such as touch, temperature, or movement) Hyperalgesia (heightened pain intensity)</p> |
| 2 | <p style="text-align: center;">Vasomotor</p> <p style="text-align: center;">Differences in skin temperature (greater than 1°C) Differences in the skin coloration between sides of the body</p> |
| 3 | <p style="text-align: center;">Sudomotor/Oedema</p> <p style="text-align: center;">Changes or asymmetry in swelling Changes or asymmetry in sweating</p> |
| 4 | <p style="text-align: center;">Motor/Tropic</p> <p style="text-align: center;">Decreased movement Motor symptoms (weakness, tremors, etc.) Changes in hair/skin/nails</p> |

the IASP diagnostic criteria, any other condition that might account for the degree of pain and dysfunction *must* be excluded in order for there to be a CRPS diagnosis.

INVESTIGATION AND DISCOVERY IN TBI AND CRPS CLAIMS

Prompt and thorough investigation is crucial to defending claims involving subjective injuries. Particularly with regard to TBIs, warning bells should go off for a claims handler who learns that a claimant lost consciousness—no matter how brief. The retained experts, discussed below, will need as many details as possible in order to assess the plaintiff's injury and offer a credible opinion that undermines the plaintiff's claims. Accordingly, it is fundamental to seek details of the plaintiff's injury. Focus should be placed not only on the incident/occurrence that caused the injury, but also on the plaintiff's life prior to sustaining the injury. It is important to establish the plaintiff's level of function prior to the incident/occurrence. For example, was the plaintiff having performance issues, such as poor academic performance or problems at work, prior to sustaining the injury? Did the plaintiff have psychological issues prior to the incident/occurrence, evidenced by prior prescription medication for anxiety or depression or prior alcohol or drug abuse?

Begin with analyzing the facts surrounding how the incident that caused the injury occurred. The plaintiff's deposition is an important time to get as many details as possible on the plaintiff's version of the incident. Instruct the plaintiff to physically demonstrate how the injury occurred. With TBI claims in particular, inquire as to how exactly the force occurred that allegedly caused the TBI. As to CRPS claims, investigate whether there was an inciting event that led to the alleged injury. If there was an inciting event, find out exactly how the initiating injury occurred and what

the plaintiff alleges is the source of the continued pain and sensitivity. Consider recording the deposition to capture the plaintiff's demonstration on video. At the very least, the video demonstration will aid the defense experts in formulating their opinions as to the existence or severity of the injury. At most, it can be a powerful impeachment tool if the plaintiff presents a much more dramatic and forceful incident at trial.

It is essential to obtain all of the claimant's records, including all past

was the duration of the plaintiff's loss of consciousness? Then confirm whether the plaintiff's allegations are corroborated by a medical record or witness. Also for TBI claims, inquire as to whether the plaintiff had or has any memory loss that he or she associates with the TBI. If yes, then at which specific parts of the incident does the plaintiff not remember? Is it just minor details lost or blocks of time during the incident/occurrence? At what point during or after the incident/occurrence did the plain-

Defense counsel should consult experts as soon as a TBI or CRPS claim is suspected.

medical records and films as well as school records, military records, and employment records. But the investigation should not stop there. The plaintiff's records should be reviewed, reviewed, and then reviewed again. Undoubtedly, there are gems that can add value to the defense of the claims. Also consider whether the plaintiff doctor-shopped or sought medical treatment following consultation with counsel.

As to the injury itself, inquire as to when the onset of symptoms first began. Also inquire into what specific symptoms the plaintiff experienced that he or she relates to the TBI or CRPS. For TBI claims, evaluate in which category of severity the symptoms fit. Are they consistent with the diagnosis? For example, a plaintiff may allege a severe TBI but his or her symptoms may be more consistent with a mild TBI. For CRPS claims, consider whether the plaintiff's symptoms are consistent with the symptoms typically experienced by persons alleging CRPS.

For TBI claims, did the plaintiff ever lose consciousness? If yes, what

tiff's memory return?

Because conditions that would otherwise account for the degree of pain and dysfunction must be ruled out for CRPS claims under the IASP diagnosis criteria, consider whether the diagnosing physician investigated possible alternative explanations, such as diabetes, obesity, Lyme disease, HIV, chronic alcoholism, Crohn's disease, lupus, ulcerative colitis, etc.

Inquire as to whether the plaintiff's symptoms have subsided. If yes, then when did the symptoms begin to subside? Does the plaintiff consider himself or herself fully recovered? If not, follow up with inquiring as to what specific lasting symptoms the plaintiff relates to the TBI or CRPS. Consider whether these symptoms are any different than what the plaintiff experienced before the incident/occurrence. Also consider whether there could be an alternative explanation for the symptoms. For example, if continued memory loss is claimed, get specific details of the degree of the memory loss: Is it losing car keys? Walking into a room and

forgetting why he or she entered the room in the first place? Or is it more significant memory loss, such as forgetting where he or she lives? Always consider whether the memory loss could be due to age rather than the subject incident/occurrence.

Have the plaintiff confirm whether there is anything he or she cannot do today that he or she could do before the incident/occurrence and that the plaintiff relates to the TBI or CRPS. Follow up with confirming whether a medical physician has instructed the plaintiff on the alleged disability. If the plaintiff alleges that he or she cannot perform routine tasks or if it is suspected that the plaintiff is not as limited in activities as he or she claims, consider whether to conduct physical surveillance on the plaintiff. If the plaintiff is caught performing a task that he or she testified he or she could no

longer do, this can become a persuasive tool at trial.

Consider having the plaintiff undergo an independent medical exam. Do not assume that an independent medical exam is always the best option, however. If the plaintiff's expert seemingly performed a complete and thorough history of the plaintiff and has a reputation for integrity and honesty, an independent assessment could result in the same findings as the plaintiff's expert's. In this situation, it is probably best to forgo the independent assessment. However, if the plaintiff's expert did not fully evaluate the plaintiff's history and/or incorporate the plaintiff's history into his or her findings, or the expert has a reputation for overdiagnosing, then an independent evaluation may be a wise investment.

Always perform an Internet

search of the plaintiff, including (and especially on) all social media platforms. This task should be performed as soon as possible and ideally before the plaintiff's counsel advises him or her to restrict any privacy settings. Be sure to keep documentation of all photographs or posts that could be relevant to the plaintiff's claim and alleged damages.

EXPERTS ARE ESSENTIAL

Defense counsel should consult experts as soon as a TBI or CRPS claim is suspected. In most cases, fact investigation will not be enough to defend the claims. These types of claims are complex in nature and require qualified experts to review and analyze the plaintiff's medical records and witness testimony, and perhaps reconstruct the incident and offer credible opinions that cast doubt on the existence or severity

of the claimant's injuries. Careful consideration must be given to experienced experts who will present well in front of a jury.

A neurologist/neurosurgeon/neuropsychologist³¹ (for ease of reference, "neurologist") can be essential to defending a TBI or CRPS case. This expert will review the plaintiff's treating neurologist's findings and evaluate the nature of the injury to determine whether the alleged injury is as severe as the plaintiff claims. It is paramount that the defendants obtain the raw data generated by the plaintiff's neurologist. Although the plaintiff will allege that these tests are objective, in reality they are subject to interpretation. It is quite possible that the plaintiff's neurologist over-interpreted the data. The defense can counter this issue by having its retained neurologist review and analyze the raw data.

In both TBI and CRPS cases,

the plaintiff will likely allege emotional distress as a result of the injury. Consideration should be given to the retention of a psychiatrist to opine as to the plaintiff's emotional state following the incident/occurrence, especially if the plaintiff has a past history of emotional distress. It is important for the defendants to obtain the plaintiff's full set of prior medical records, including psychiatric records. Physicians are routinely prescribing medication for anxiety and depression, making it a strong possibility that there is a prior prescription in the plaintiff's medical history. A psychiatrist is particularly important in CRPS cases, where the entire injury is based on a subjective feeling that is not consistent with the injury. A psychiatrist may be able to uncover a consistent pattern of emotional issues that would cast doubt on the plaintiff's allegations.

A biomechanical engineer

should not be overlooked and could be the key to a defense verdict, especially in cases alleging a TBI. Biomechanical engineering is the combined use of mechanical engineering principles and biological knowledge. With this combined expertise, a biomechanical engineer can determine the amount of force sustained by the skull during the incident/occurrence and evaluate whether the alleged injury, or alternatively the severity of the injury, could have been caused by the incident/occurrence. To illustrate, if a plaintiff alleges a severe TBI with long-term effects resulting from a motor vehicle collision, a biomechanical engineer may be able to opine that the force of the subject collision was not great enough to have caused a severe TBI.

In cases alleging a TBI or CRPS, defendants should

anticipate that the plaintiff will claim long-term disabilities as well as future medical treatment. Normally, the plaintiff's counsel will retain a life care planner to opine as to the plaintiff's future condition and needs. Do not wait for the plaintiff's counsel to reveal that they retained a life care planner before consulting your own. Life care planners can call into question the reasonableness and necessity of a plaintiff's expert's opinions as to the plaintiff's future care. But these opinions regularly vary a great deal. Often the plaintiff's life care planner inflates the need for and cost of numerous line items. This expected variance as to a plaintiff's future care often significantly affects the value of a case. It is therefore paramount that defendants have their own life care planner who can scrutinize the plaintiff's expert's opinions and challenge the plaintiff's alleged damages.

With any life care plan, it is also normally important to retain an economist to formulate the numbers into present-day value. Consider retaining an economist who is credible and who can easily explain the numbers to a jury. If the defense counsel cannot understand how the numbers were generated, then you can expect a jury will not either.

CONCLUSION

TBI and CRPS claims, where the injury is often largely based on the subjective claims of the claimant, should not be underestimated. These injuries can be costly to defendants if not handled properly. Conversely, diligent investigation and an aggressive defense strategy can significantly mitigate the plaintiff's damages. Until the medical field develops diagnostic tests that can objectively identify the existence and/or severity of these types of claims, defense

counsel and claims handlers should continue to expect these types of claims and the uncertainties associated with each type. It is paramount that claims handlers and defense counsel aggressively defend these claims with thorough investigation and retention of proper experts. ■

NOTES

1. *Traumatic Brain Injury: Definition*, MAYO CLINIC (May 15, 2014), www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/basics/definition/con-20029302.

2. *Id.*

3. *Traumatic Brain Injury: Causes*, MAYO CLINIC (May 15, 2014), www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/basics/causes/con-20029302.

4. Albert M. Drukteinis, *A Head Injury Is Not a Brain Injury*, NEW ENG. PSYCHODIAGNOSTICS, www.psychlaw.com/LibraryFiles/HeadInjury.html (last visited Nov. 2, 2017).

5. *Id.*

6. *Id.*

7. 72 AM. JUR. PROOF OF FACTS 3D *Traumatic Brain Injuries* § 363 (2003).

8. *Severity of TBI*, NE. U., www.northeastern.edu/nutraumaticbraininjury/what-is-tbi/severity-of-tbi/ (last visited Nov. 2, 2017); *What Is the Glasgow Coma Scale?*, BRAINLINE, www.brainline.org/content/2010/10/what-is-the-glasgow-coma-scale.html (last visited Nov. 2, 2017).

9. *Severity of TBI*, *supra* note 8; *What Is the Glasgow Coma Scale?*, *supra* note 8.

10. 72 AM. JUR. PROOF OF FACTS 3D *Traumatic Brain Injuries* § 363.

11. *Id.*; *Severity of TBI*, *supra* note 8; *What Is the Glasgow Coma Scale?*, *supra* note 8.

12. 72 AM. JUR. PROOF OF FACTS 3D *Traumatic Brain Injuries* § 363.

13. Drukteinis, *supra* note 4.

14. *Id.*

15. CTNS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUM. SERVS., HEADS UP: FACTS FOR PHYSICIANS ABOUT MILD TRAUMATIC BRAIN INJURY (MTBI), www.brainline.org/sites/default/files/mtbi.pdf (last visited Nov. 2, 2017).

16. *Severity of TBI*, *supra* note 8.

17. Drukteinis, *supra* note 4.

18. *Id.*

19. *Id.*

20. *Id.*

21. *Id.*

22. *Complex Regional Pain Syndrome: Definition*, MAYO CLINIC (Apr. 12, 2014), www.mayoclinic.org/diseases-conditions/complex-regional-pain-syndrome/basics/definition/con-20022844.

23. *Complex Regional Pain Syndrome: Causes*, MAYO CLINIC (Apr. 12, 2014), www.mayoclinic.org/diseases-conditions/complex-regional-pain-syndrome/basics/causes/con-20022844; *Complex Regional Pain Syndrome Fact Sheet*, NAT'L INST. OF NEUROLOGICAL DISORDERS & STROKE (Jan. 2017), www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Complex-Regional-Pain-Syndrome-Fact-Sheet.

24. *Complex Regional Pain Syndrome: Causes*, *supra* note 23.

25. *Id.*

26. *Id.*

27. *Id.*

28. Anthony H. Wheeler, *Complex Regional Pain Syndrome*, MEDSCAPE (July 15, 2016), <http://emedicine.medscape.com/article/1145318-overview>.

29. See Rosie Morland, *CRPS Animal Models Explained*, SPEAKING OF RES. (June 18, 2015), <https://speakingofresearch.com/2015/06/18/guest-post-crps-animal-models-explained/>.

30. *Complex Regional Pain Syndrome: Symptoms*, MAYO CLINIC (Apr. 12, 2014), www.mayoclinic.org/diseases-conditions/complex-regional-pain-syndrome/basics/symptoms/CON-20022844.

31. Each of these experts' field of expertise is unique, although they do overlap. Consider the plaintiff's treating/diagnosing physician and analyze what expert testimony will be needed to counter the plaintiff's claims before deciding which type of expert to retain.