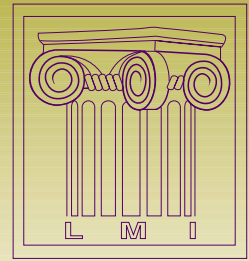


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R E P O R T E R



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MEDICAL INFORMATION MANAGEMENT IN NURSING HOME LITIGATION

Pressure Ulcers (Part I of II)

By: Elizabeth B. Juliano and James R. Fell

Introduction

Decubiti—pressure sores—dermal ulcers—bedsores. Although historically they have been known by different names, until recently pressure ulcers have, unfortunately, been regarded as an inevitable outcome of aging and nursing home confinement. Such a complacent attitude is no longer the norm. For many nursing home residents, the development of this potentially life-threatening condition now should be regarded as highly preventable, given the implementation of proper nursing and medical care. Accordingly, failure to anticipate and forestall pressure ulcer development in a resident can expose a nursing home, its staff, and attending physicians to allegations of negligence.

In the past, pressure ulcer litigation involving geriatric clients failed to produce awards comparable to those delivered in other types of medical lawsuits, i.e. “breadwinner” loss or “bad baby” cases. Pressure ulcer lawsuits were not looked upon as glamorous cases to argue in trial. Juries were perceived as less

sympathetic to geriatric cases because nursing home residents were stereotyped as outside the mainstream of society. Even when a plaintiff verdict was returned, issues of death or quality of life translated into limited monetary compensation.

This too has changed. As society increasingly values the worth of the elderly, and as the overall U.S. population ages, juries are less apt to discount an

“Many suspected pressure ulcers later turn out not to be pressure ulcers, once a knowledgeable review of the nursing home records is completed.”

- *Ronald E. Bush & Dale R. Sisco
Bavol Bush & Sisco, P. A.*

award in a nursing home negligence case. Pressure ulcers and their sequelae have now garnered impressive verdicts in lawsuits predicated on nursing home negligence. One organization advocating pressure ulcer litigation has even

requested plaintiff attorneys to post information on its web site message board relating successes in these types of cases.

All Skin Sores Are Not Alike

Attorneys Ronald E. Bush and Dale R. Sisco of the Tampa, Florida firm, Bavol Bush & Sisco, comment that pressure ulcer cases can be difficult to defend given the graphic photographs generally involved. We have all heard the statement “a picture is worth a thousand words,” or in long-term care litigation, “a million dollars.” However, according to Bush and Sisco, pressure ulcer cases are subject to several defenses. In choosing the defense to a pressure ulcer case, the attorney should never accept the “picture is worth a thousand words” or “a million dollars” at face value. In their experience many suspected pressure

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This newsletter was prepared by the Corporate Communications Division of Litigation Management, Inc. For more information about any of the articles in this newsletter please contact James Fell, Editor, at (440) 484-2000 or 1-800-778-5424; Fax: (440) 484-2020. Questions may also be directed to the newsletter e-mail address at contactlmi@litigation-mgmt.com.



From the President:

Dear Readers:

This month I had the privilege to speak during a breakfast meeting of the Products Liability Litigation Committee at the annual conference of the American Bar Association. Following my presentation on the subject of reviewing medical records for litigation, I was approached by several attorneys who either partner with Litigation Management, Inc. (LMI) for the provision of medical information management, or who are otherwise acquainted with my company and its services.

I was struck by the fact that a frequent comment made by listeners in my audience was that they were under the impression Litigation Management, Inc. only provides medical support services in the mass tort arena. Although LMI's experience has spanned asbestos, diet drug, breast implant, pedicle screw, chemical exposure, and other class actions, our work products are by no means limited to these fields. The lead article in this issue of *The M.I.M. Reporter* is a case in point.

In most situations, nursing home litigation tends to consist of single case lawsuits. For quite some time, LMI has analyzed medical records implicated in nursing home liability actions. On LMI's medical staff are health care professionals selected for their educational preparation and clinical expertise in the provision of care to the elderly in nursing home, home health, and geropsychiatric settings. Other medical specialists on the LMI team are engaged in the review of individual personal injury, Workers' Compensation, and medical malpractice cases. Indeed, LMI is much more than a provider of medical support services exclusively for class actions.

Later this month I will be attending the annual meeting of the Federation of Insurance and Corporate Counsel in California. If you will be present at this meeting, please stop by the Litigation Management, Inc. display to discuss the medical information challenges confronting your law firm or corporation. And as always, if any readers have comments regarding *The M.I.M. Reporter*, please feel free to contact me by telephone at (440.484.2000) or by email at ebjuliano@litigation-mgmt.com.

Very truly yours,
Elizabeth B. Juliano
President

ulcers later turn out not to be pressure ulcers, once a knowledgeable review of the nursing home records is completed.

When preparing the medical defense of a pressure ulcer case, Bush and Sisco recommend ruling out other potential types of sores, such as *venous ulcers*, *arterial ulcers*, *diabetic ulcers*, etc. In order to establish the alternative causation defense, a thorough review of medical records should seek to establish underlying disease processes potentially responsible for causing other types of skin sores. In the event that the sore is found to be a pressure ulcer, Bush and Sisco advise that the defense attorney always explore the "clinically unavoidable pressure sore" defense. Once again, a thorough review of the medical record will be necessary to establish the basis of this defense.

In contrast to the aforementioned alternative causation in these cases, true *pressure ulcers* represent tissue damage and/or death stemming from external application of intense pressure for a short time or low pressure for a long time. Pressure ulcers usually develop over bony prominences of the body in such areas as the sacrum, hips, ankles, heels, and toes. However, a pressure ulcer can manifest in other body locations, if conditions are conducive. A pressure ulcer may form over the cartilage of the ear and/or the dorsum of the head in a resident who lies excessively in one position on a sweat-soaked pillow. A pressure ulcer also can form over the bony aspect of the cheekbone where a feeding or nasogastric tube has been too tightly secured without periodic repositioning.

Pressure ulcer development is often associated with insufficient turning and poor body alignment while the resident is confined to bed. Likewise, long periods of sitting in one position while in a wheelchair can cause such skin breakdown. Malnutrition, dehydration, continual skin wetting from lying in stool or urine, and skin abrasion from being dragged across rough bedsheets heighten the occurrence of pressure ulcers. Proper nursing care is one of the fundamental interventions for the prevention and restoration of pressure ulcers. As could be expected, the incidence of pressure ulcers in a nursing home population is highly correlated with low staffing levels. In Ohio in 1998, one out of every five annual nursing home inspections resulted in a citation for bed-sore incidence. This statistic was often noted to characterize circumstances of insufficient staffing in nursing homes struggling to maintain profitability.¹

Economics of Pressure Ulcers

The combination of large numbers of nursing home residents who develop pressure ulcers, coupled with the staggering costs for their treatment, demonstrate why pressure ulcer litigation is proving to be a fertile field for plaintiff attorneys. A few statistics will substantiate this statement. The Agency

for Health Care Policy and Research (AHCPR) reports that the prevalence of pressure ulcers in nursing homes is as high as 23%.² Referencing the *National Long-Term Study*, Bergstrom and Braden (1992) note that 35% of residents in skilled care institutions are reported to have developed pressure ulcers.³

Accurate expenditures for treatment of pressure ulcers are difficult to compute; however, all studies estimate that these figures are high. At the upper end of the range, according to a National Decubitus Foundation equation, additional costs related to the extended hospital stay of the average pressure ulcer patient are \$50,976. Nationally, this translates into an annual expenditure of health funds amounting to over \$55B, and this is a conservative estimate according to the Foundation.⁴ *The Merck Manual of Geriatrics* places the additional cost per patient of pressure ulcer care between \$2,000 and \$10,000.⁵ A study by Yakellis and Frantz (1996) of 30 nursing home patients revealed that treatment costs, including those of hospitalization, were \$2,731 greater per ulcer.⁶

Litigation Trends

While the actual incidence of pressure sores in nursing home residents appears to be decreasing, the number of lawsuits is increasing. Berlowitz, *et al* (2000) studied 30,510 residents in 107 nursing homes. Findings revealed that from 1991 to 1995 there was a 25+% rate decline for pressure ulcers, with the proportion of new pressure ulcers of the most severe category types declining from 30% to 22%. The authors concluded that these nursing homes evidenced a substantial improvement in pressure ulcer preventive care.⁷

Monetary compensation for nursing home pressure ulcer cases is growing. Citing a report in *The Wall Street Journal*, Begley (1999) notes that in the period from 1987 to 1994, the average award in a nursing home negligence case increased from \$238,285 to \$525,853. In addition, while personal injury litigation produces punitive damages in only 5% of cases, the figure is 20% for nursing home lawsuits.⁸ Reporting on a study of nursing home jury verdicts from 1996 to 1998, Rowe (1999) notes that in 28 out of 30 plaintiff verdicts/settlements in pressure ulcer lawsuits, compensation averaged \$973,340.92.⁹ In a review of pressure ulcer cases cited in legal databases, Bennett, *et al* (2000) identified 173 cases from 1937 through 1997. Numbers of cases were noted to surge in the years surrounding the publication of the 1987 Omnibus Budget Reconciliation Act (OBRA) and again in 1992 when the Health Care Financing Administration published the OBRA-87 regulations. For all years, the judgment/settlement range was \$2,200 to \$65,000,000, with a median of \$250,000.¹⁰ The looming specter of awards such as these clearly mandate that an informed, objective review of nursing home records be undertaken when preparing the pressure ulcer case.

Structuring Medical Information Management

For mass torts in which hundreds or thousands of plaintiffs may claim medical damages, strategic planning for medical information management may be founded on a tiered evaluation process. Initially, the medical claims of each plaintiff can be evaluated using the 1-2 page *medical abstract*, organized according to designated diagnostic criteria. Records of claimants whose symptoms/diagnoses match the specified parameters may subsequently undergo a more in-depth analysis as the *medical summary* or *medical chronology* is developed.

In contrast, strategic planning for medical information management in most nursing home litigation is founded on the individual action. Accordingly, the most cost-effective approach to medical information management in these cases would not utilize a tiered formula. Instead, analysis of the case would be accomplished directly through the development of the medical summary/chronology.

Bush and Sisco indicate that the most cost effective and efficient manner in which to stay on top of the mountains of medical records often encountered in the pressure ulcer case is through the use of medical information management services. The prompt, professional review and analysis provided by such services allow for early establishment of the defense strategy. The databases of information created by medical information management services allow for cross-referencing of records and permit the building of the defense position.

Elements of the Review

Medical records for nursing homes are structured somewhat differently than those maintained by hospitals and clinics. Familiarity with these differences will expedite the medical information management aspects of record selection, acquisition, review, and analysis. The following sections will delineate those medical documents, which should be evaluated when preparing the nursing home pressure ulcer case:

Hospital Records: Entry to the nursing home for many individuals begins with a hospital admission. In most cases, these patients sought hospitalization for some medical disorder which may have rendered them susceptible to pressure ulcer formation. For example, Versluisen (1985) investigated the formation of pressure ulcers in elderly populations hospitalized for treatment of hip fractures, a relatively common problem in the aged. In a population of 283 elderly patients admitted to the hospital for hip fracture or elective hip surgery, 90 developed pressure ulcers. Mortality was 27%.¹¹

In a similar study of 100 subjects, Versluisen (1986) discovered that 66 patients ultimately developed pressure ulcers, with 83% of these forming by only the fifth day

of hospitalization.¹² Although these are now older studies, the authors cite such reports because of their noteworthy statistics. While the technology, prevention, and treatment of pressure ulcers have certainly changed, the implications for nursing home liability are still very clear. Given the constraints imposed by managed care upon duration of hospitalization, it is reasonable to conclude that elderly patients who have undergone operative regimens may be transferred to the nursing home for rehabilitation with an incipient pressure ulcer whose full extent is yet to be appreciated.

In hospital transfer situations, review of medical records from this period of confinement should identify the degree to which skin breakdown may have already been present prior to entry into the nursing home environment. Medical and nursing discharge summaries and any patient transfer reports are the primary documents to evaluate for this evidence. Note should be taken of the location(s), stage(s), treatment, etc. for these lesions at the time of patient transfer for comparison with subsequent admission documentation contained in the nursing home record.

An important caveat to bear in mind when reviewing hospital discharge records in pressure ulcer litigation is that such documentation may or may not list this problem among the discharge diagnoses. In a review of hospital administrative databases Berlowitz, *et al* noted that in a sample of patients with pressure ulcers transferred to nursing homes, the discharge diagnosis only listed pressure ulcers in 30.8% of the cases. Almost 50% of Stage 4 pressure ulcers (the most severe) were not recorded.¹³ In case preparation where such medical evidence is lacking, it becomes critical that the medical legal reviewer establish the pre-existence of the pressure ulcer when analyzing admission assessment records of the nursing home.

Risk Assessment Scales: The nursing home record should contain documentation that the resident was initially and periodically evaluated for risk factors which could contribute to the development of pressure ulcers. (See the discussion on the Minimum Data Set [MDS] in Part II of this series.) Assessment information may be recorded on a facility-specific form, or on a standardized instrument such as the Norton or Braden Scale. The *Norton Scale*¹⁴ is a pressure sore rating system founded upon five risk factors: physical condition, mental condition, activity, mobility, and incontinence. Each variable is rated on a scale ranging from “1” (least functional) to “4” (most functional). The lower the composite score, the more the resident is at risk for development of pressure ulcers. Similarly, the *Braden Scale*¹⁵ is organized according to six risk factors for pressure ulcer formation: sensory perception,

activity, mobility, moisture, friction, and nutrition. All of the predictive factors are rated from “1” (least favorable) to “4” (most favorable), with the exception of the friction variable, which is rated from “1” to “3.” In the Braden scheme, the maximum number of points potentially achievable is 23. As with any numeric rating system, documentary evidence offered by these instruments should be analyzed in conjunction with other aspects of the medical record. At least one study has shown that in some instances, the Braden Scale and the Norton Scale can over-predict the risk (36% and 64%, respectively) for development of pressure ulcers.¹⁶

Pressure Ulcer Staging System: The severity and development of a pressure ulcer is indicated by its numerical stage evaluation. Shea (1975) designed a taxonomy for classifying pressure ulcers based upon a 4-tier gradation.¹⁷ Since that time, this categorization has been modified by the National Pressure Ulcer Advisory Panel (NPUAP) and is now termed the NPUAP Pressure Ulcer Staging System. In 1998, this standard was further refined to better reflect assessment parameters required for patients with varying ranges of skin pigmentation.¹⁸ Within this system, pressure ulcers are characterized as:

Stage I: An observable pressure-related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature, tissue consistency, and/or sensation. The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

Stage II: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III: Full thickness skin loss involving damage to, or necrosis (death) of, subcutaneous tissue that may extend down to, but not through, underlying fascia (the sheet of fibrous material overlying muscles). The ulcer presents as a deep crater with or without undermining of adjacent tissue.

Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (tendons, joint capsule). Adjacent tissue undermining and sinus tracts (an abnormal cavity into the tissue) may also be associated with this stage.¹⁹

The NPUAP advises against the use of reverse staging to evaluate healing of pressure ulcers. Instead the NPUAP recommends that a pressure ulcer staging system should only be

utilized to document the maximum anatomic depth of the ulceration, after any dead tissue has been removed.²⁰ Elaboration on this cautionary advice is available from the NPUAP at www.npuap.org/positn2.htm. The reader's attention is directed to this instruction for its implications in case management of the pressure ulcer claim. Because of the potential for misuse of a pressure ulcer staging system, medical and nursing geriatric care experts should be consulted to properly evaluate this aspect of the medical lawsuit.

Pressure Ulcer Healing Record; Pressure Ulcer Healing Graph: Given their potential for infection, disability, and death, Stage IV cases present the gravest threat in nursing home pressure ulcer litigation. The NPUAP indicates that Stage IV ulcers will not progressively resolve through the development of replacement muscle, fat, and dermis. Rather, "healing" takes place through the incorporation of granulation tissue, which is inferior to the more vital tissue elements lost during the original formation of the pressure ulcer. According to the NPUAP, resolution of pressure ulcer damage should be evaluated using criteria such as size, depth, amount of necrotic tissue and drainage, degree of granulation, etc.²¹

The NPUAP (1997) formulated the Pressure Ulcer Scale for Healing (PUSH) as a research-validated instrument which nursing staff can employ to assess progression of pressure ulcers. The actual incorporation of the PUSH Tool into a revised MDS is reportedly under consideration. Within the PUSH system, assessments of ulceration length and width, amount of exudate (drainage), and tissue type are each scored and noted on the Pressure Ulcer Healing Record. Summation of the individual scores produces a total PUSH Score, which can then be plotted on the Pressure Ulcer Healing Graph timeline. A negative slope on the graph reveals that the pressure ulcer is resolving; conversely, a positive slope indicates that the ulcer's condition is deteriorating. Information on the PUSH Tool 3.0, Pressure Ulcer Healing Chart, and Pressure Ulcer Healing Graph, as well as instructions for their clinical application, can be accessed via the NPUAP web site at www.npuap.org/push3-0.htm and www.npuap.org/pushins.htm. The NPUAP advises that the PUSH system be applied at "regular intervals," while the Agency for Health Care Policy and Research (AHCPR) indicates pressure ulcer assessments be conducted "at least weekly" and "if the condition of the patient or wound deteriorates."²²

Although a given nursing home may not have yet implemented the PUSH evaluation system with its nursing staff, sufficient data may be available in the medical record that the medical legal reviewer can construct a graphic depiction of pressure ulcer progression as one component of the medical information management. Subsequently, these illustrations can be expanded into instructive case exhibits for trial use by the attorney.

Summary

There are a number of other aspects of the nursing home record which must be considered in medical information management in the pressure ulcer case. Information from the Minimum Data Set, Quarterly Assessment, nursing notes, nursing care plan, multidisciplinary team meetings and other documents can cast a critical light on the true nature of the pressure ulcer claim. In part II of this series, *The M.I.M. Reporter* will identify the facts a review of these records can uncover in the pressure ulcer lawsuit and how the attorney can incorporate such findings into a strategic plan for optimum case resolution.

The authors wish to thank Ronald E. Bush, Esq. and Dale R. Sisco, Esq. of Baval Bush & Sisco for their kind assistance in the preparation and review of this article.

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USE AND MISUSE OF RAST IN EVALUATING OCCUPATIONAL ASTHMA

by: Elizabeth B. Juliano and James R. Fell

Understanding Occupational Asthma

Occupational asthma has been defined as a "diffuse, intermittent, reversible airway obstruction caused by a specific allergen encountered in the workplace."¹ According to the definition of the British Industrial Injuries Advisory Council, occupational asthma can be differentiated from non-occupational asthma because it "develops after a variable period of symptomless exposure to a sensitizing agent at work."²

While exposure to chemicals, dust, and fumes may worsen symptoms in an individual with pre-existing asthma, this does not mean that the person is an occupational asthmatic. In reality, it takes at least 1.5 to 5 years of industrial exposure to the provocative agent before a worker is sufficiently sensitized to evidence disease. In cases involving a new employee hire, symptoms of occupational asthma will *not* appear after only a first-time exposure.³ An appreciation of the concept of this "latency" period, which exists between the time of exposure and first exhibition of symptoms, is a critical element in occupational asthma litigation.

Causation Issues

On the other hand, if a newly hired employee has been exposed to an implicated agent in prior jobs or in the non-work environment, sensitization to the substance may have already occurred. In this case, appearance of occupational asthmatic symptoms might be observed soon after the new hire begins work and is re-exposed to the particular allergic stimulus. Causation might then be erroneously attributed to the new job site when actual sensitization took place elsewhere. To further complicate matters, once the worker has become sensitized to a particular industrial element, much lower concentrations of this provocative agent may be sufficient to elicit an asthmatic response.^{4 5}

Substantiating or refuting allegations of a causal association between a given agent and occupational asthma can be difficult in many exposure cases. Various diagnostic evaluations and tests will often be employed in an effort to identify such an association, or lack thereof. One such study, radioallergosorbent testing (RAST), may or may not be helpful in this determination.

The RAST Procedure

RAST has been in clinical usage for over twenty years. In this laboratory study, allergens are first chemically bound

to some form of insoluble matrix, such as a paper disk. Next, a sample of the patient's serum is introduced, and any allergen-specific IgE* present binds to the immobilized allergen. Following this, radioactively labeled anti-IgE is then added, which attaches to the specific IgE already bound to the allergen. Determination of the level of allergen-specific IgE in the patient's serum is derived from measurement of bound radioactivity. Allergen levels are scored 0-4, with "0" indicating no IgE present, "1" a borderline finding, and "2-4" a rising IgE against the allergen.^{6 7 8} RAST results can be influenced if the patient has recently undergone other studies which may have involved ingestion of radioactive preparations, i.e. diagnostic radioactive scanning.⁹

RAST and Evaluation of Occupational Asthma

Treatment of an allergic type of asthma is facilitated if the irritant(s) provoking respiratory symptoms can be identified. In routine office practice, this is accomplished by taking a complete exposure and symptom history, and through allergen diagnostic studies, such as skin testing and RAST. Although the more expensive of the two, RAST has proven to be a useful diagnostic study in cases where skin testing cannot be performed. Textbooks define the utility of RAST determinations in assessing the role of plant pollen, animal dander, house dust, and food allergens in asthma, eczema, and other allergic conditions.¹⁰

However, the use of RAST to evaluate some types of occupational asthma can be controversial, particularly those types of exposures involving low molecular weight chemical compounds, which may be encountered in the industrial setting. Sandler (1996) indicates that a limitation of RAST in evaluation of occupational asthma is the loss of "sensitization" (presumably a time-associated phenomena dependent upon removal from the provocative agent). Sandler also indicates that RAST is less predictive than bronchoprovocation challenge testing in determining any relationship between occupational asthma and a suspected etiologic agent. He notes, "there may be antibodies to anything, but that does not mean that there is a clinical disorder. Some laboratories commonly perform antibody testing for

* Immunoglobulins are produced by lymphocytes in the blood and other body fluids. They perform antibody functions. There are five types of immunoglobulins that differ on the basis of composition and antigenic activity: IgE, IgG, IgA, IgD and IgM. IgE is produced by lymphoid cells of the bronchial mucosa. It plays a role in the development of an allergic response to inhaled irritants.

Analysis of RAST reports is one aspect of comprehensive medical information management in a case alleging occupational asthma.

a range of chemicals, but the *clinical significance of such test results is indeterminate without medical and exposure evaluation.*" (emphasis added)¹¹

Evaluating RAST Reports

RAST measurements are useful to evaluate exposure and subsequent sensitization to certain industrial agents. However, RAST cannot:

- ❖ Be relied on as the only criteria used to render a diagnosis of occupational asthma; rather, a medical specialist should conduct a wholistic battery of studies to rule out other potential disorders and to clarify causal factors for the alleged condition.
- ❖ Define the severity of medical impairment resulting from the chemical exposure when attempting to quantify a claim for disability payment. Other measures of pulmonary impairment should be consulted, such as pulmonary function testing.
- ❖ Target one industrial origin as the offending culprit in the development of occupational asthma; other potential sources for sensitization should also be assessed.
- ❖ Precisely delineate the point in time a particular exposure may have occurred. A positive RAST simply indicates that exposure may have occurred.
- ❖ Retrospectively define air concentration levels for a named chemical suspected as a causal agent in the development of occupational asthma. This should be evaluated by means of ongoing industrial hygiene monitoring.

Seek Expert Consultation

Published reports have revealed somewhat variable findings and differing interpretations regarding the utility of RAST in judging occupational exposure issues. Therefore, cautionary acceptance or rejection of RAST test results

should be followed in evaluating the occupational asthma claim. For a given chemical exposure, it is recommended that an experienced medical legal researcher conduct a thorough review of peer-reviewed scientific, toxicologic, and epidemiologic literature to better ascertain the utility of RAST in evaluating the plaintiff's medical allegations.

Interpretation of RAST studies in appraisal of occupational asthma claims is best undertaken by specialists in the areas of immunology, pulmonology, toxicology, and allergy medicine. Review of the medical and scientific literature pertaining to applications of RAST in occupational asthma is one source which can be utilized to locate these experts. Additionally, nationally recognized medical centers, which support research and treatment of occupational asthma, present further options for identification of these experts. For more information on this and other aspects of medical information management in litigation involving occupational exposures, contact the Litigation Management, Inc. help line at contactlmi@litigation-mgmt.com.

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NEW MEDICAL GUIDANCE ON LATEX REACTIONS

Abstracted by: Elizabeth B. Juliano and James R. Fell

In March, a task force of the American Academy of Allergy, Asthma, and Immunology, in collaboration with the National Institute of Allergy and Infectious Disease and 20 other organizations, released *The Allergy Report*, a consensus statement containing allergy diagnosis and treatment recommendations. According to one Task Force co-chairperson, this 600-page, three volume report has integrated contributions from all the medical specialties which treat allergies and is the only single-source document providing this type of comprehensive patient management tool.

Of particular interest to legal professionals is one section in Volume III addressing medical aspects of latex exposures. Manufacturers and health care professionals are increasingly cognizant of the need to limit the extent to which patients, medical personnel, as well as the general public, come into contact with latex-containing products. However, in some applications no acceptable alternatives to latex yet exist. Consequently, latex allergy litigation can be expected to persist.

When analyzing medical records of the latex claimant, it is critical that the reviewer ascertain if the party manifests a true latex allergic reaction or an otherwise nonallergic reaction. For example, *The Allergy Report* notes that latex allergic reactions constitute a range of conditions, from a minor skin rash or contact type

of eczema to a full-blown, life-threatening anaphylactic reaction. On the other hand, the more common, nonallergic reactions to latex-containing products are identified as irritant forms of responses often caused by non-latex agents involved in the product manufacturing process. An understanding of such clinical distinctions has important implications in both product liability and Workers' Compensation cases.

Medical information analysis of latex reactions should be predicated on focus areas in the patient's medical history and physical examination as defined by this report. Specific studies and laboratory tests indicated for the diagnosis of latex reactions are also listed, as are medical management practices for the patient diagnosed with latex allergy.

Although many people associate the development of latex allergy with

exposure to latex-containing surgical/examination gloves, there are many other potential incriminating etiologies. When analyzing medical records in latex litigation, the investigator should be alert to these sources of possible alternate causation. While the report contains tables listing some sources and products which may be implicated in latex exposure, the lists are by no means exhaustive. Therefore, medical record reviewers should consult supplemental references for other likely avenues of alternative causation when preparing latex case evaluations.

Individual copies of the report are priced at \$22.00 and can be obtained by calling 1-800-822-2762. The report can also be located through the web site of the American Academy of Allergy, Asthma, and Immunology at www.aaaai.org.

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