ISY ARAN MORRIGAN – TIMELINE

Date	Event	Comments
12/15/00	Reported wrist pain.	Bilateral wrist pain, always worse after work. Reported it to supervisor and HR.
12/00-10/01	Diagnosis of RMS with possible tendonitis. OT and noninvasive measures.	Moved trackball to left hand. Improved typing habits. Seen by Dr at Workplace Health. Wrist did not respond adequately. Referred to Dr K.
10/01-12/01	Process of discovery: X-ray and MRI.	X-ray showed right wrist has widened scapholunate gap. MRI showed volar ganglion. Scheduled surgery. Gave up drumming, weightlifting, and motorbike riding.
1/4/2002	Surgery: right wrist ganglion resection.	Surgery uneventful.
1/15	First post operative visit.	Summary of findings: Improved as expected. Returned to work with no limitations. Next scheduled visit 3/5.
1/21	First complication: infection.	Localized redness, swelling, pain at left incision, the slower-healing incision. Treated it with warm saline compresses initially.
1/24	Called Dr. K's office and reported the infection to office nurse.	Made appointment for 1/29, earliest available. Started Cipro, 500 mg BID x 10d.
1/29	First complication visit: infection.	Summary of findings: Improved, but slower than expected. Returned to work with limited use of right hand. Started using a wrist splint. Next scheduled visit 3/14.
2/25	Second complication: reinjured in my sleep.	Woke to find operative wrist and hand bruised and swollen from wrist to the first knuckle of the fourth finger inclusive. Doctor away. Got an appointment for Tuesday.
3/5	Second complication visit: reinjury.	Summary of findings: Worsened. Operative wrist and hand bruised and swollen as above. Signs/symptoms worse with repetitive motion. Work status: Manual work restricted to four hours daily. Next scheduled visit 4/2. Gave up jewelry making and recreational writing. Manual tasks limited to essentials.
4/11	Follow-up visit: tendonitis.	Summary of findings: Minor decrease in wrist pain. Pain remains worst over the back of the wrist. Redness over medial wrist @ radial extensor. Bruising over dorsal lateral wrist. Intervention: Injection of Marcaine and Kenalog given into medial tendon. Hurt like hell, confirming a screaming case of tendonitis. Work status: <= 4 hours typing/writing per day. Limit use of right hand. Wear splint intermittently.
5/7	Next visit: 2 wks disability.	Summary of findings: Worsened: persistent generalized swelling and pain, bruising around right incision, redness over radial tendon under the left incision, and a bleb-like swelling under the left incision. This swelling feels like an encapsulated form loosely attached to the scar. Its size varies between 4-6 mm in diameter. Plan: Repeat MRI to assess for new/recurring ganglion or other

		changes. Work status: temporary total disability from 5/7 to 5/21. Next exam to be scheduled after the MRI. Gave up flute playing and self-prep cooking.
5/14	Called office: expedite requested MRI.	Developed new swelling and pain in the right dorsal wrist. No erythema; persistent ecchymosis. Getting the MRI approved has been problematic. The adjuster took over a week to return my messages. Once contacted, she didn't understand why postsurgical "carpal tunnel" would need a repeat MRI. I corrected her as to the diagnosis, and explained the need for the study. Acupuncture helps a lot at the time, somewhat over time. My acupuncturist never speaks against anyone, but apparently this adjustser was awful to her. Can't work efficiently, can't work out effectively, can't engage in hobbies, can't do anything I enjoy except walk. In pain 90% of the time.
5/25	Repeat MRI, right wrist.	Summary of findings: MRI is negative, according to radiologist. Med note: Off Lodine. Too hard on my GERD. Slept on 4 pillows.
6/13	Post-MRI re-evaluation visit.	Summary of findings: Wrist still failing to heal. Dr. K and I agree to seek outside help: he will consult with Dr. J, head of hand and microsurgery at UCLA and his former fellowship supervisor, and I will see Dr. Q, head of Acute Rehab at the local hospital, for a nonsurgical perspective. Work status: return to modified duty: <= 3 hours of keyboard/writing per day.
6/20	Phone consultation with Dr. K: 4 wks disability. *See hand image from 6/24*	Summary: Dr. J's thoughts: while there are several possible causes of these continued problems, he feels that the best way to investigate is to open the wrist up surgically and look inside. I commented that I was very anxious at the prospect of another surgery. Dr. K was perfectly understanding. Since rest has historically reduced the signs and symptoms, we agreed to rest my wrist, more thoroughly and for a longer time, and see if that resolves the problem. If not, we will revisit the prospect of surgery, and possibly discuss other alternatives, if any. Dr. Q could not see me before Aug. 29. Work status: 4 weeks total disability (6/24-7/22), with wrist immobilized except for several stretch periods throughout the day. The aim is to rest the wrist as completely as possible without losing mobility in the joint. Follow-up appointment 7/13.
6/27	Phone conversation with cross-cover nurse case manager, re: disability.	This was a long conversation. She was unhappy that he did not see me in person before putting me on disability. I explained, at great length, that the decision was made not on the basis of any change in my condition, because there wasn't any, but because we had decided to approach things differently. I retailed the entire substance of my phone conversation and previous visit with Dr. K, as well as providing an overview of my care to date and the assurance that we were soliciting highly-qualified outside opinions. She agreed that total rest was a good intervention, and said she'd discuss the matter with the

		adjuster and see if she could be persuaded to approve it.
7/3	Disability denied: received a letter from adjuster Jane Cunningham dated 6/27.	(In her letter denying the claim, Ms. C referred to "Ms. Jones" as the patient. ???) Called her and left a message stating that I expected her to call me back as soon as possible. I called Dr. K's office to say that the disability claim had been denied.
7/8	Phone conversation with adjuster re: disability denial.	I elicited Ms. C's present understanding of the situation. She felt that the surgeon did not communicate well with her and she complained that he didn't always return her calls. She stated that the specific reason she denied the claim was because the doctor had not seen me in person on the day that he decided to put me on disability. I conveyed to her the same substance that I had conveyed to her cross-cover about my course of treatment and the unforeseen complications, and explained the rationale of Dr. K's decision to put me on disability. Ms. C said that, in light of our conversation, ***she now thought this leave was a good idea***, especially as we were meanwhile pursuing more information. Surprisingly, she stated that the documentation she had received said nothing about infection or reinjury. I'm certain that both injury and infection were noted, because I certainly received appropriate medications and saw some of this documentation being written. However, since I can't access the chart without legal counsel, I can't negotiate this misunderstanding without raising the stakes. She is proceeding with the QME process although she now agrees with the disputed intervention. Med note: off Vioxx. Too hard on my GERD. Coping with pain using comfort measures and gritted teeth. GI discomfort 40% of the time.
7/13-7/16	Research arthroscopy, complications and sequelae.	Online search and in the stacks at Stanford's Lane Medical Library yield very little. Wrist arthroscopy has been SOP only for about two years. Rate of complications is extremely low. More extensive notes in my laptop. Repeat surgery begins to seem sensible.