12-26-90

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December 12, 1990

Doc. 377

Mr. Edward L. Bettendorf
The Ohio Bell Telephon Company
Suite 1400
45 Erieview Plaza
Cleveland, OH 44114

Re: Leon Usyk, et al. v. Edward Lapp, et al., Case No. 90-182301 (Cuy. Co. Com. Pl.) in re Defense Medical Examination of Leon Usyk

Dear Mr. Bettendorf:

Thank you for allowing me to see Mr. Leon Usyk December 12, 1990. As you know, I had the opportunity to review the large, 4-inch, 3-ring binder of information supplied by his counsel as well as his deposition of August 21, 1990. Today Mr. Usyk came to the examination along with his attorney, Mr. John Canala. Mr. Usyk and I spoke and I took a history lasting well over an hour, and then a medical examination was performed. Following that examination, X-rays of the left ribs and left knee were ordered.

So that we may better understand this difficult case, I will give a detailed vocational history, medical history, and then I will discuss the accident of March 20, 1986, as well as the medical history since that time. Following this background information, I will detail the results of my examination and give my opinion regarding Mr. Usyk's current status relative to the injury sustained on March 20, 1986.

Mr. Usyk is a 43-year old male who worked as a builder in the Navy from 1965 to 1969. Following that, he worked as a bartender from 1969 to 1973. He denies any history of any injuries while in the Navy, however he did sustain a gunshot wound in approximately 1971 while working as a bartender when he pulled out a pistol and dropped it to the floor. A bullet went into the mid portion of his left leg and he states that it fractured the fibula. Part of that bullet still remains as does the scar from the bullet wound. This was treated at Metropolitan General Hospital and the leg was casted due to the fracture for approximately six weeks. He still complains of some tenderness over the site of that injury. The patient's medical history is important,

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as he admits to a problem with alcohol abuse from approximately 1968 to 1974. He states the problem got worse over time, to the point that he was drinking a case of beer per night. During this period of time he had approximately 12 hospitalizations for acute pancreatitis, being hospitalized at Parma Hospital, Lutheran Hospital, Grace Hospital and Deaconess Hospital. I have none of those medical records available, although they would be of interest. In 1974 the patient entered Rosary Hall at St. Vincent Charity Hospital for treatment of his alcohol problem. He states that following that he went to AA meetings for about two years, was abstinent for another 7 years and then began drinking intermittently.

While working as a bartender from 1969 to 1973 the patient did quite a bit of heavy lifting, such as lifting cases of beer, etc. He denies any history of injury to his back during that time. The patient began working at the Ford Motor Company in 1973 as an assembly line worker. He worked there from 1973 to 1976 and he stated that he may have had an injury to his hand while there, but denies any back injuries. In 1976 he began working as a carpenter and worked as a carpenter for U-Haul, until about 1978.

In 1978 he began working for Winslow Homes, a part of Forest City, doing repair work in new homes. He states that on September 26, 1978 he sustained his first back injury while digging up around the foundation of a house he swung a shovel full of dirt over his left shoulder, twisted and felt a pain in his back. At this time his wife was working for a chiropractor, Dr. Gordon Charboneau, and the patient began treatment with him. Reviewing Dr. Charboneau's records, we find that he treated the patient continuously from 1978 until 1985. In reviewing these same records, I was unable to determine what exactly that claim was allowed for under the Ohio Workers Compensation System and much of the writing by Dr. Charboneau was illegible. Nevertheless, it appears that he treated the patient approximately once a week continuously up until August 8, 1985. The patient states that his wife changed from the employ of Dr. Charboneau at about that time to the employ of the chiropractor Daniel P. McFadden, in 1985. Accordingly, the patient then began treatment with Dr. McFadden continuously from September of 1985 up until early 1990. The patient recalls the treatment for the 1978 injury to be chiropractic manipulation with the chiropractor doing a "crush". technique on his chest with his hand behind the patient's back. The patient at that time had lumbosacral pain at the belt line.

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He stopped working at Winslow Homes and next began working at Krehel Partitions. Employment with Krehel started in approximately 1980 and on January 19, 1981 he admits to his second back injury, ai? allowed Workers Compensation injury while working for them. At that time he was standing and trying to move a loaded file cabinet and lifted the cabinet and then pushed it with his left knee. When doing this he felt a pain in his left buttock. The patient was again treated by Dr. Charboneau, the chiropractor, and the allowed diagnosis for this Workers Compensation claim was a paravertebral muscle strain with secondary left sciatic neuralgia, meaning that he had a radiation of pain along the sciatic nerve going from the buttock down the left lower extremity. In addition to being treated by a chiropractor, he also sought treatment by his family physician, Dr. Rosemann. We note in the file that he was treated by Dr. Rosemann on September 17, 1981 for left sided low back pain. He was treated by him again in 1983 for the left sided back pain with Phenaphen with Codeine and received that again in 1984 as well. The patient was seen by Dr. Ljuboja on March 25, 1982, at which time she noted that he was complaining of left leg pain and lower back pain. On the examination she found the reflexes on the left to be sluggish, again suggesting a sciatic nerve component. The patient was wearing a back brace. She recommended a permanent partial disability of 30% of the whole person. We note that according to the records, the patient was off work from April 22, 1982 until March 15, 1984 while under the care of Dr. Charboneau for the lumbosacral and paravertebral muscle strain with secondary left sciatic neuralgia. When questioned regarding this, the patient does not recall being off work for that two year period of time, however the records clearly show this.

Mr. Usyk states that he next began to work for Marana Construction, first as a carpenter and then in 1986 he began to work as a field supervisor. A motor vehicle accident occurred on March 20, 1986. We should note that the patient denies any other low back injury from January 19, 1931 until this date. The patient was in a Toyota pickup, not wearing his seatbelt and states that he was struck in the driver's door by a car from Ohio Bell Telephone. He was knocked to the other side of his truck, but remained conscious. He was taken to Parma Community General Hospital where he was seen in the Emergency Room. Arterial blood gases on room air were normal, and a chest X-ray revealed fractures of the left sixth, seventh, eighth and ninth ribs. There was no pneumothorax or hemothorax, nor were their any flail segments. An X-ray of the pelvis revealed a small avulsion of the cortex of the superior pubic ramus at the symphysis. X-rays of the left knee revealed a joint effusion but no fracture. The patient was in the hospital for

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one week and released. He returned to the care of Dr. McFadden, the chiropractor who he had switched to in September of 1985, as he noticed that he was having low back pain as well. At this time we should note that the patient had chiropractic treatment on February 19, 1936, March 4, 1986, March 7, 1986, and March 10, 1986, all of these treatments being just prior to the March 20, 1986 injury. The patient describes these treatments as being manipulation with a "crush" technique as well. Dr. McFadden referred the patient to the orthopedist, Dr. Zaas. X-rays taken on April 8, 1986 by Dr. Zaas revealed X-rays of the pelvis to be normal without any sign of fracture. Nevertheless, X-rays of the left knee revealed a fine vertical line through the tibial plateau without displacement. They also showed a pre-existing osteochondroma, or a benign bone tumor, which was into the medial collateral ligament of the left knee. The patient does not recall having this benign bone tumor previously, and he denies having any treatment for this previously. X-rays taken on May 7, 1986 revealed the knee fracture to be well-healed, without deformity and the left ribs were shown to be healing well. On March 14, 1987, Dr. Zaas advised that no further orthopedic treatment was needed for his low back or left knee pain.

Mr. Usyk began having a problem with chronic headaches in November of 1985. He was originally treated by Dr. Rosemann or Dr. Joseph Baker who took over Dr. Rosemann's practice. The patient does not recall when this change of practices occurred. Nevertheless the records reveal that the patient had treatment for headaches on November 11, 1985 at which time he was given the strong pain medication Fiorinal. He was seen again on November 14, and was given Darvocet-N. The patient was referred to the neurologist, Dr. Good, and the diagnosis was "Cephalgia of unknown etiology". The patient does not recall how many times he saw Dr. Good for this, Nevertheless, in the history and physical which was done following admission to the hospital, he did not only admit to the problem with alcohol, but also gave a history of chronic headaches for four months prior to the accident and mentioned he had been treated by Dr. Good. We also note that there was no loss of consciousness following the accident. Nevertheless, following the accident the patient did see Dr. Good again on May 1, 1986 and a diagnosis of "Cephalgia" was made again. The patient does not recall how he was referred to Dr. Tucker, but Dr. Tucker did see him on June 3, 1986 and June 10, 1986, just one month after seeing Dr. Good. When questioned regarding his symptoms at that time, he states that he was having some dif-

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ficulty with memory, that is not recalling what he was to do that day, or where he was to go when in his car. In a letter to the attorney, Dr. Tucker stated that the neurological examination was normal with the exception of some hypalgesia in the left lower extremity L-5 dermatome. He also mentioned that there was some hesitation when trying to think of names. He gave the diagnosis of a "Cerebral concussion". Dr. Tucker appears unaware of the patient's past history. The patient states that the memory loss cleared after approximately **4-6** months and he has had no further problem with that.

In 1987 the patient began working for Gallo Displays. Here he had lay-offs from time to time, but was able to do his regular work. On June 30, 1987 while working at Gallo Displays, he was climbing a ladder and states that he fell down two rungs when his left knee gave way. We should note that this was at the same time that Dr. Zaas thought that the patient needed no further treatment for his left knee and discharged him. He also denies having any further treatment for his left knee. On March 5, 1989 while at home, the patient states that he fell down the steps to his basement. When questioned further, we find that he states that his knee gave out and he stumbled down only 2-3 steps and sustained a fracture to his foot. When questioned again regarding his knee giving out, he again denies having any further treatment or evaluation for this. We should note that the patient has never had an arthrogram of the knee nor any other special diagnostic tests, and the knee examinations have been normal. He denies sustaining any injury to his lower back at that time of either fall.

The patient began treatment with the orthopedist, Dr. Marsolais on September 30, 1988. This was due to his low back pain, and he was referred there by the chiropractor. In reviewing Dr. Marsolais' letters, we find that he appears to be quite unaware of the patient's weekly chiropractic treatments dating back to approximately 1978, and also appears to be unaware of the patient's left sciatica dating from 1981. Treatment was tried with an exercise program, medication, and later a set of injections, but the patient states that the pain in his left leg continued, and therefore he had **L-3/4** and L-4/5 discectomies on January 5, 1989. When questioned regarding this, he states that when he woke up following the surgery he continued to have the same pain in the left lower extremity. This would certainly indicate that the problem was no corrected. The patient went home after a few days in the hospital, but returned to the hospital on January **14,** 1989 as the pain continued. A diagnosis was made by Dr. Marsolais of recurrent herniation of L-4/5. The patient denies any incident occurring after being discharged from

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the hospital. In a letter to Dr. McFadden dated January 7, 1989, Dr. Marsolais stated that there was a major herniation at L-3/4 with impingement on the left L-4 root. Earlier tests revealed the nerve conduction velocity of the left leg to be negative, but the EMG was slightly positive. An earlier MRI prior to the surgery revealed bulging of the L-3/4 area and they recommended ruling out a central disc herniation. We should also note that Dr. McFadden had diagnosed a spondylolisthesis at L-5, meaning that there was a chronic instability in the patient's lower back, and this was found prior to the motor vehicle accident of March 20, 1986. Degenerative arthritis was noted as well. There is some discussion in Dr. Marsolais' records of a possible need for future fusion of the lumbosacral spine. The only reasons that one might do this in Mr. Usyk's case are for the diagnosis of spondylolisthesis and degenerative arthritis. As these are pre-existing to the motor vehicle accident of March 20, 1986, one would certainly recognize that a possible fusion would not be related to the motor vehicle accident.

The patient returned to work three months after the low back surgery by Dr. Marsolais and continued to work there up until just about a month ago, when he found a better job offer. He therefore quit Gallo Displays. His current medication consist of Voltaren, a non-steroidal anti-inflammatory agent, and he states that he takes this "once in awhile". He is not on any other current medication. When questioned regarding the injury sustained on March 20, 1986, he states that he continues to have some discomfort from the rib fractures and states that it hurts occasionally when he pulls with the left arm, also he may have some discomfort in the left ribs. He complains of discomfort when lifting his left arm overhead. He admits that he has had no treatment for this since the original injury, When questioned regarding the left knee, he states that he has pain below the kneecap and he rates this as a 0-8 on a scale of 1-10 with 10 being the greatest amount of pain. He admits to having no treatment since seeing Dr. Zaas last in 1987. When questioned regarding the possible avulsion fracture of the pubic symphysis, he states that this no longer bothers him. When questioned regarding the diagnosis of concussion by Dr. Tucker, he admits to the memory loss occurring for approximately 4-6 months after the incident, but states that he is no longer having a problem with this. When questioned regarding the lower back pain he states that when just sitting he has a pain which he would rate at 4 and at other times when working he may have a pain rating from 3-8. He describes this feeling as being in the lumbosacral area with radiation to the left buttock. When questioned if these symptoms now are the same as they were in 1981, he stated "I guess." His last treatment for this by Dr. McFadden was in early 1990. He has been able to perform his regular work at Gallo Displays up until a month ago with no history of further lost time due to the injury.

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One other medical problem that the patient has had, which has not been clearly brought out in the previous reports, is a psychiatric problem. This has been diagnosed by the Psychiatrist, Dr. May, on January 23, 1990 as depression with schizoaffective disorder. The patient states he began seeing Dr. May in approximately 1988 for a problem with depression due to several personal problems including his wife's illness, etc. He was treated with an anti-depressant, and he states that he last saw Dr. May about six months ago. We should note that a schizoaffective disorder is a quite serious illness, and the diagnosis can only be made if the patient has had serious problems with his thought process with delusions or hallucinations lasting for at least two weeks (see attached Reference DSM III American Psychiatric Association). Accordingly, it is quite understandable that during the history which was done for over an hour, that the patient had quite a difficult time remembering different events.

On examination this was a 43-year old, healthy-appearing, muscular, 6'2", 234-lb. male who was able to get up and down from his chair with ease and who walked in a brisk and uninhibited fashion. On examination of the ribs where the fractures were, there was no tenderness, nor was there any palpable nodular deformity. chest expansion and contraction were completely normal and the breath sounds were normal to auscultation as well. The patient admitted to being a smoker. There was no costovertebral tenderness, nor was there any intercostal tenderness found. The patient appeared to have full range of motion of the thoracic spine in all directions without any complaint or discomfort. The arms moved freely as well, without any complaint of discomfort. On examination of the pelvis, the patient had no tenderness to compression over the pubic symphysis and was able to move the hips about normally. He was able to stand on one foot and then the other, and hop on one foot and then the other, without any complaint of discomfort. On the neurological examination, the cranial nerves appeared to be intact. Romberg testing was normal and there was no sign of any vertigo or dizziness. On examination of the left knee, there was full flexion and extension of the knee. The patient was able to walk about in a normal, brisk and uninhibited fashion, without favoring one leg over the other. He was able to walk easily on his heels and toes, and as noted above he was able to hop on one foot and then the other and squat down fully and duck walk as well. Circumferential muscle measurements revealed the quadriceps muscles to measure equally at 45 cm. bilaterally when measured at 10 cm. above the patella. The knees measured equally at 41 cm. in circumference, and the calf measurements revealed no significant difference when measured at their maximum. Lachman's Test was negative and there was no sign of any instability found

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in the knee. McMurray's Testing was negative and no tenderness was found about the joint line. There was no tenderness found over direct pressure at the tibial plateau. There was no significant difference found between the left or the right knee. The bullet wound and exit hole were found with a large 1-inch scar over the lateral calf. On examination of the spine we noted the well-healed, non-tender, non-erythematous 4-inch, midline incision. Flexion was to approximately 70-80 degrees when standing and extension, lateral flexion and rotation were full and normal. There was no tenderness in the sacroiliac or sciatic notch areas. The paravertebral muscles relaxed normally as the patient walked in place. Straight leg raising in the sitting position was a 90 degrees, and when supine was limited only by hamstring tightness. The Achilles and patella reflexes were brisk and equal bilaterally, as was foot dorsiflexion. The sensory examination revealed some decreased sensation just distal to the bullet wound. The vascular examination on the left was normal. The patient was able to sit up on the table, flexing his spine to 90-100 degrees without any apparent discomfort.

Based on these findings and the patient's treatment and work history, it is my opinion that Mr. Wsyk has had a good recovery from the injury sustained on March 20, 1986. In the summary of diagnoses supplied by his attorney, on Page 3 we find that there are several concerns expressed:

1. They note that the patient sustained fractures to the left sixth, seventh, eighth and ninth ribs, and that is certainly true. At this time there are o objective findings of any residual problem from the rib fractures. X-rays taken following the examination revealed just the old, well-healed fractures with no signs of ongoing pathological process. The patient has some complaints at this time, but again there were no positive findings on the examination.

2. The patient was initially found not to have a fractured left tibial plateau in the Emergency Room, but later when Dr. Zaas X-rayed the knee there was a simple linear fracture found. This healed quite nicely after a few months and there was no further treatment recommended by the orthopedist. The patient did have a pre-existing chondroma going into the medial collateral ligament, and this certainly may be the cause of some of his present complaints, but the examination today was negative, with the patient being able to squat down fully and stand up again and there was no instability found in the knee or any joint line tenderness. X-rays taken today failed to reveal any evidence of a past fracture, but did show the osteochondroma. The joint was otherwise normal.

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3. The patient may or may not have sustained a cracked pelvis on the right side. X-rays in the Emergency Room revealed a small avulsion or chip fracture of the pubic symphysis. However, this was not found on the follow-up X-rays taken by Dr. Zaas. The patient no longer has any symptoms relative to this possible fracture and the examination today was negative as well.

4. Following the injury and in the Emergency Room, there was no suggestion of a cerebral concussion. Also following the injury the patient did see his regular neurologist, Dr. Good and he was again found to have cephalgia, something he was found to have prior to the injury and dating back to 1985. Nevertheless he appears to have been referred by his attorney to Dr. Tucker, who diagnosed a "Cerebral concussion". When questioned regarding this, the patient stated that he had some difficulty with memory for 4-6 months following the incident, and the problem went away after that period of time. He is no longer complaining of any memory difficulties. It is quite possible that the patient's memory difficulties may be due to his past alcohol abuse as well. His pre-existing headaches as well as the psychiatric diagnosis cloud any further investigation of any residual problems in this area. Nevertheless, the patient himself denies any further difficulties since 1987.

5, The patient was found to have bulging back discs on a CT scan of April 18, 1988 ordered by Dr. McFadden at Southwest General Hospital. He was also found to have a mild degree of degenerative arthritis. Some bulging of the discs is completely normal and physiologic, but this patient has had serious back problems dating back to 1978 with symptoms of left-sided sciatica dating back to 1981. He also was found to have spondylolisthesis and a chronic instability in his back, and he was manipulated on almost a weekly basis for nearly 8 years prior to the motor vehicle accident of March 20, 1986. It is recognized that such frequent chiropractic manipulation would have caused some looseness or instability in the lumbosacral spine. The patient had subsequent surgery, and now states that he continues to have pain in the lumbosacral area with pain in the left

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buttock, which is the same thing he had in 1981, and he admits to this. We recall that the patient required on-going chiropractic care just a few days prior to the motor vehicle accident. If the patient in fact does need further surgery with fusion, then this would be for the pre-existing spondylolisthesis and degenerative arthritis and would not be related to the incident of March 20, 1986. The examination of the low back today revealed the surgical scar, but there were no real positive physical findings suggesting any continuing problem at this time. It is my opinion that the patient has had a good recovery.

Should you have any further questions relating to this examination, please do not hesitate to contact me.

Sincerely,

Arlen J. Rollins, D.O., M.Sc.

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AJR/bc

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DRS. SACHS, ROSS AND ASSOCIATES

INTERPRETATION:

LEFT RIBS;

There are remote healed fracture deformities involving the posterior or posterolateral aspect of the left 6,7,8,9th and perhaps 10th ribs and anterolateral or anterior aspects of the left 6 and 7th ribs. No acute fracture is seen. The left ribs are otherwise unremarkable.

LEFT KNEE;

There appears to be a small osteochondroma projecting from the superomedial portion of the medial femoral condyle at the diametaphyseal junction. There is no evidence of fracture or dislocation or other significant bony abnormality. The joint spaces appear to be well maintained without joint effusion or joint calcification.

RAB:pp
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X-RAY REPORT 200

Radiologist

Last Name	First	Middle	Age	Sex	Room Number	X-Ray No.
USYK	LEON		43	M	MOB	298-40-384
Regions X-Rayed						Emergency Room Number
LEFT RIBS, LEFT KNEE						
Attending Physician			Date			Hosp. No.
ROLLINS			12-12-90			01109768-0346

721 003 2/86

PHYSICIAN'S COPY

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

(THIRD EDITION - REVISED)

DSM-III-R

Published by the
American Psychiatric Association
Washington, DC
1987

diagnosis should be qualified as "provisional," because there is no certainty that the person will actually recover from the disturbance within the required six-month period. (The diagnosis should be changed to Schizophrenia if the clinical picture persists beyond six months.)

Differential diagnosis. Since the diagnostic criteria for **Schizophrenia** and Schizophreniform Disorder differ primarily in terms of duration of the illness, most of the discussion of the differential diagnosis of Schizophrenia (p. 192) applies also to Schizophreniform Disorder, except that the clinical picture in Schizophreniform Disorder is more often characterized by emotional turmoil, fear, confusion, and particularly vivid hallucinations.

Brief Reactive Psychosis usually does not present with the characteristic psychotic symptoms of the active phase of Schizophrenia. However, in those rare instances in which the criteria for both Brief Reactive Psychosis and Schizophreniform Disorder are met (e.g., three weeks of bizarre delusions apparently triggered by a markedty stressful event, without any of the prodromal symptoms of Schizophrenia), the diagnosis of Brief Reactive Psychosis preempts the diagnosis of Schizophreniform Disorder.

Diagnostic criteria for 295.40 Schizophreniform Disorder

A. Meets criteria **A** and C of Schizophrenia **(p.** 194).

B. An episode of the disturbance (inciuding prodromal, active, and residual phases) lasts less than six months. (When the diagnosis must be made without waiting for recovery, it should be qualified as "provisional.")

C. Does not meet the criteria for Brief Reactive Psychosis, and it cannot be established that an organic factor initiated and maintained the disturbance.

Specify: without good prognostic features or **with good prognostic features,** i.e., with at least two of the following:

(1) onset of prominent psychotic symptoms within four weeks of first noticeable change in usual behavior or functioning

(2) confusion, disorientation, or perplexity at the height of the psychotic episode

(3) good premorbid social and occupational functioning

(4) absence of blunted or flat affect

295.70 Schizoaffective Disorder

The term *Schizoaffective* Disorder has been used in many different ways since it was first introduced as a subtype of Schizophrenia, and represents one of the most confusing and controversial concepts in psychiatric nosology. The approach taken in this manual emphasizes the temporal relationship of schizophrenic and mood symptoms. This diagnostic category should be considered for conditions that do not meet the criteria for either Schizophrenia or a Mood Disorder, but that at one time have presented with both a schizophrenic and a mood disturbance and, at another time, with psychotic symptoms but without mood symptoms. The diagnosis is made only when it cannot be established that an organic factor initiated and maintained the disturbance.

Although far from definitive, this description of Schizoaffective Disorder appears to have tentative validity from prognostic, treatment, and family studies as delimiting an

entity that appears to be distinct from Mood Disorder. The relationship of Schizoaffective Disorder, as described here, to Schizophrenia remains unclear. Family studies suggest that this disorder may bear a close relationship to Schizophrenia. The distinction between Bipolar and Depressive Types of Schizoaffective Disorder may be important. Several lines of evidence suggest that Schizoaffective Disorder, Bipolar Type, may be more closely related to a Mood Disorder than is Schizoaffective Disorder, Depressive Type.

Since the DSM-III-R term *Mood Disorders* has replaced the DSM-III term *Affective Disorders*, the name of this category should more properly be "Schizomood Disorder." However, the term *Schizoaffective Disorder* is retained for the sake of historical continuity.

Age at onset. Detailed information is lacking, but the typical age at onset is probably in early adulthood.

Course. Studies have suggested that there is some tendency toward a chronic course. The prognosis appears to be somewhat better than that for Schizophrenia, but not nearly so good as that for Mood Disorder.

Prevalence. Detailed information is lacking here as well, but this disorder appears to be less common than Schizophrenia.

Sex ratio. No information.

Familial pattern. Several studies have suggested that there is an increased risk of Schizophrenia in first-degree biologic relatives of people with this disorder. There may also be an increased risk of Mood Disorder in relatives of some people with this disorder, although this has not been firmly established.

Differential diagnosis. The diagnosis is made only when it cannot be established that an organic factor initiated and maintained the disturbance. **Organic Mental Disorders** can present with both bizarre psychotic symptoms and a prominent mood disturbance. (See also discussions of etiologic factors of Organic Delusional Syndrome, p. 110, and Organic Mood Syndrome, p. 112.)

When a disturbance involves both the characteristic symptoms of the active phase of **Schizophrenia** and prominent mood symptoms, the differential diagnosis depends on the temporal relationship of the mood and the psychotic symptoms. In Schizophrenia, either the total duration of all episodes of mood disturbance is brief relative to the total duration of the disturbance, or the mood disturbance occurs only during the residual phase of the disorder.

In **Mood Disorder with Psychotic Features**, there is never a period of at least two weeks in which delusions or hallucinations are present without prominent mood symptoms.

In **Delusional Disorder** the psychotic features are limited to nonbizarre delusions.

Diagnostic criteria for 295.70 Schizoaffective Disorder

A. A disturbance during which, at some time, there is either a Major Depressive or a Manic Syndrome concurrent with symptoms that meet the **A** criterion of Schizophrenia.

B. During an episode of the disturbance, there have been delusions or hallucinations for at least two weeks, but no prominent mood symptoms.

C. Schizophrenia has been ruled out, i.e., the duration of all episodes *of* a mood syndrome has not been brief relative to the total duration *of* the psychotic disturbance.

D. It cannot be established that an organic factor initiated and maintained the disturbance.

Specify: bipolar type (current or previous Manic Syndrome) or
depressive type (no current or previous Manic Syndrome)

297.30 Induced Psychotic Disorder

The essential feature of this disorder is a delusional system that develops in a second person as a result of a close relationship with another person (the primary case) who already has a psychotic disorder with prominent delusions. The same delusions are at least partly shared by both persons. This diagnosis *is* not made in people who present evidence of a psychotic disorder (or the prodromal symptoms of Schizophrenia) immediately before onset of the delusion.

The content of the delusion is usually within the realm of possibility, and often is based on common past experiences *of* the two people. Occasionally, bizarre delusions may be induced. Usually the primary person with the psychotic disorder is the dominant one in the relationship and gradually imposes his or her delusional system on the more passive and initially healthy second person. These people usually have lived together a long time, and are isolated from contact with other people.

Associated features. If the relationship with the primary person who has the psychotic disorder is interrupted, usually the delusional beliefs in the second person will diminish or disappear. Although most commonly seen in relationships of only two people (known as Folie à deux), cases have been reported involving up, to twelve people in a family. People with this disorder rarely seek treatment, and secondary cases are usually brought to light when the primary person receives treatment.

Age at onset. Variable.

Course. The course is usually chronic in that this disorder occurs almost invariably in relationships that are longstanding and resistant to being altered by external forces.

impairment. Impairment is generally less severe than for Delusional Disorder or Schizophrenia, as often only a portion of the primary person's delusional system is adopted.