In the United States Court of Federal Claims

No. 00-181V
April 27, 2007

JENNIFER DUNCAN,	*	
	*	
Petitioner,	*	
v.	*	Hepatitis A and B vaccine; pre-existing joint pain, fibromyalgia; leg numbness, blurry vision; somatization; significant aggravation?
	*	
SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,	*	
	*	
Respondent.	*	

ORDER

Petitioner filed a petition on April 3, 2000 under the National Childhood Vaccine Injury Act, 42 U.S.C. §300aa-10 et seq., alleging that she suffered an adverse reaction after receiving hepatitis B vaccine on April 23, 1998. (The medical records show she also received hepatitis A vaccine on that day.)

In an affidavit dated July 28, 2003, petitioner claims that 14 days post-vaccination, she had knife-like pains in the side of her face, flu-like symptoms, numbness in her legs and right arm, and anxiety. P. Ex. 25. She states she was diagnosed with myofascial pain syndrome and went to see Dr. Andrew Campbell. *Id.* Dr. Campbell is well-known in this Program and is currently being evaluated for suspension of his medical license in Texas for misdiagnosing and mistreating (prescribing the incorrect treatments) the people who come to him. Texas State Board of Medical Examiners v. Andrew William Campbell, MD, SOAH Docket No. 503-04-5717 (Oct. 10, 2006).

FACTS

Petitioner was born on August 2, 1959.

On March 16, 1982, petitioner saw her doctor, complaining of headaches for five to six years which started in high school. Med. recs. at Ex. 17, p. 5. It usually was in the left cervical but, if really bad, it was all over her head. She had rare throbbing. She was shaky in the morning. She had lightheadedness with cold. She was very dizzy. She was grinding her teeth with stress. She had tingling in the left ulnar associated with tightening of the trapezius on the left four to five years earlier. *Id.* On examination, petitioner had some tenderness over the cervical spinus processes of C7 and C8 and a slight click with movement of the neck in that region. Pin prick was diminished over the mesial left arm, forearm, small finger, and the mesial fourth finger. Med. recs. at Ex. 17, p. 7. Her nose had a deviated septum slightly to the left with some mucous discharge. *Id.*

On March 29, 1982, petitioner was diagnosed with cervical disc syndrome and tension headaches. Med. recs. at Ex. 17, p. 6. Petitioner was diagnosed with left occipital neuropathy tension with a possible lower cervical radiculopathy and severe right pain brachia and numb brachia. Med. recs. at Ex. 17, p. 8.

On April 13, 1982, petitioner had less tenseness. *Id.*

On June 21, 1982, petitioner still had pain in the left mid scapular. She was best on the floor for sleep. *Id.*

On July 12, 1982, she still had spasms and a bad left trapezius, but tolerated neck traction. *Id.*

On July 24, 1987, petitioner was diagnosed with anxiety neurosis. Med. recs. at Ex. 17, p. 10. She also had allergies, bronchitis, gastritis and spastic gastrointestinal tract. *Id.*

On December 28, 1988, petitioner saw her doctor, complaining of back pain and recent urinary frequency. Med. recs. at Ex. 20, p. 22. She had a history of allergic asthma but no severe attacks. She occasionally used ethanol. She stated she had possible rheumatic fever in the past. The diagnosis was an upper respiratory infection. *Id.* Petitioner also complained of right lower quarter pain. She had a low-grade temperature. Med. recs. at Ex. 20, p. 23.

On December 28, 1988, petitioner had a laparascopy for pelvic pain and metorrhagia. The pain was worse on the right side. Med. recs. at Ex. 20, p. 26. Petitioner had early secretory phase edometrium and mild chronic endocervicitis. Med. recs. at Ex. 20, p. 29.

On December 30, 1988, petitioner went to The Deaconess Hospital with a racing heart and brief shortness of breath. Med. recs. at Ex. 20, p. 9. Dr. F. Mushkat diagnosed mitral valve prolapse. She had a history of having intermittent episodes of shortness of breath and heart palpitations over the prior couple of days which was worse when she lay down and relieved by rest. She stated she was diagnosed with a heart murmur a couple of weeks earlier during pre-admission testing before a laparoscopy December 28, 1988 for endometriosis. She described the shortness of breath as pressure. She had a prior history of asthma. *Id.* Petitioner described feeling like her heart was racing that day for 10-15 minutes associated with anxiety. Med. recs. at Ex. 20, p. 16. She could not calm down and developed shortness of breath. She was on Vicodin and Triphasil. She had normal sinus rhythm with Grade 1/6 systolic murmur in the left sternal border at the fourth intercostal space. *Id.*

On December 30, 1988, petitioner had a chest x-ray which showed no acute cardiopulmonary disease. It also showed free intraperitoneal air probably related to petitioner's recent laparoscopy. Med. recs. at Ex. 20, p. 14.

On January 5, 1989, petitioner had an electrocardiographic reading from a Holter monitor. The scan lasted for 14 hours and one minute. During that time, petitioner complained of being tired, somewhat short of breath, having heaviness in the chest which was thought to be indigestion, and backache. Dr. George Krevling's impression was that there was no positive correlation between petitioner's complaints and electrocardiographic changes. There were three isolated premature atrial contractions and premature ventricular contractions during the scan. She had mild sinus arrhythmia more noted during sleep. Med. recs. at Ex. 5, p. 129.

On January 6, 1989, petitioner had an echocardiography done. Dr. David Tondow found it to be normal. Med. recs. at Ex. 5, p. 130.

On May 21, 1991, petitioner had a gall bladder ultrasound because of abdominal pain and diarrhea. Her ultrasound was normal. Med. recs. at Ex. 19, p. 16.

On September 2, 1992, petitioner saw her doctor with chronic sore throat. Med. recs. at Ex. 19, p. 21. She had had a sore throat for one week. On examination, her throat was clear. Dr. Mason diagnosed pharyngitis, possibly secondary to allergies. *Id.*

On January 26, 1993, petitioner saw her doctor and gave a history that she had a possible mitral valve prolapse 10-12 years earlier. She had chronic headaches and still complained of pain on the right side. *Id.*

On May 14, 1993, petitioner saw Dr. Robert R. Burger, an orthopedic surgeon, because of complaints of intermittent achy pain along the anteromedial aspect of the right knee with

associated symptoms of catching and popping. Med. recs. at Ex. 19, p. 17. She also had some tenderness along the posterior aspect of the right knee. Examination showed findings consistent with lateral patellar subluxation and inflamed synovial plica with significant weakness of the hip abductor and vastus medialis obliquus muscle groups. Dr. Burger recommended petitioner engage in aggressive rehabilitation. She might have some specialized taping for the knee subluxation. *Id.*

On August 15, 1993, petitioner complained of chronic headaches and sinus problems. She had had problems with her right wrist for two months. She had pain with movement, some nausea and some headache. Med. recs. at Ex. 17, p. 44. She was diagnosed with fibromyalgia. *Id.*

On August 30, 1993, petitioner complained her head was swimming and she was dizzy when she moved suddenly. She complained of some right wrist pain which was longstanding. Her dizziness was probably due to labyrinthitis, possibly an otitis media. Dr. Francis P. Kohrs thought she may have overused her right wrist. Med. recs. at Ex. 17, p. 43.

On August 31, 1993, petitioner complained that her head was swimming. She was dizzy while lying or with sudden movement. Med. recs. at Ex. 17, p. 42.

On October 15, 1993, petitioner complained of an ear infection. She had pain the day before. She had intermittent dizziness since August 1993 which was worse the past two days. Antivert helped the dizziness and nausea. Head movements made them much worse. On examination, her tympanic membranes looked normal. Her throat was slightly red without exudate. She was diagnosed with labyrinthitis as residua from her prior ear infection and eustachian dysfunction. She was prescribed Sudafed. Med. recs. at Ex. 17, p. 41.

On April 9, 1994, petitioner called to report leg pain from the top of her thigh to her knee and tingling sometimes in the foot which was constant. Med. recs. at Ex. 17, p. 37.

On November 1, 1994, petitioner called, complaining of joint pain for the past five weeks which had increased the past weekend. Med. recs. at Ex. 17, p. 35. She noticed joint pain since having a baby, especially at night. She used Ibuprofen with some relief. *Id.*

On November 14, 1994, petitioner complained of continuing joint pain in her thumbs. Med. recs. at Ex. 17, p. 36.

On February 27, 1995, petitioner complained of dizziness for the prior two days when lying down or getting up. It nauseated her. She had this from August to October 1993. She actually got it every August for years. She had hay fever symptoms. She had pressure in her ears. She had constant tinnitus. *Id.*

On May 2, 1995, petitioner telephoned for Dr. T. Dryer. She had numbness over her body for the past three nights. Her legs tingled and she felt cold all over. That day, the symptoms were still occurring. She wondered if it were due to the Ibuprofen. The doctor advised her to stop taking the drug and restart it in 48 hours to see if the symptoms were related. Med. recs. at Ex. 17, p. 32.

On May 22, 1995, petitioner saw Dr. Rodney F. Hochman. Med. recs. at Ex. 5, p. 46. Petitioner had an eight-month history of increasing pain in both wrists. She had previously been diagnosed as having fibromyalgia, but had noted specifically joint pains for several years. She was generally worse in the morning with some significant morning stiffness lasting generally one hour. She denied joint swelling. She had been using Ibuprofen 800 mg. twice a day with some mild improvement in her symptoms. During the last pregnancy which was completed eight

months previously, she noted marked improvement in her joint symptoms. On neurologic examination, petitioner had some slight delay in the reflexes in the extremities. The wrists showed tenderness on extreme range of motion. *Id.* There was tenderness over the abductor tendons of the thumb. Med. recs. at Ex. 5, pp. 46-47. The knees showed some tenderness along the medial joint line bilaterally. The ankles showed some tenderness on extreme range of motion. Dr. Hochman's impression was that petitioner might have an early inflammatory arthritis. Another possibility was hypothyroidism. Another possibility was sarcoidosis given her age and the nature of her joint symptoms, particularly involving the ankles and wrists. Med. recs. at Ex. 5, p. 47.

On May 23, 1995, two out of three thyroid studies were normal. Sensitive TSH was low at 0.30 (normal range being 0.47-6.90). Med. recs. at Ex. 5, p. 204.

On May 31, 1995, petitioner saw Dr. Joseph E. Temming, an arthritis specialist. Med. recs. at Ex. 5, p. 72. He thought she had mild DeQuervain's tenosynovitis of the right wrist and possible mild synovitis of the right wrist itself. He was treating the tenosynovitis with anti-inflammatories, Ibuprofen, moist heat, and avoidance of overuse. *Id.*

On July 10, 1995, petitioner saw Dr. Temming again for her DeQuervain's tenosynovitis. Med. recs. at Ex. 5, p. 71. She altered her habit of lifting and the pain in her medial wrist resolved completely. However, she was having some pain and stiffness now in her right ankle. There was also some discomfort on the bottom of her foot. This was most symptomatic the first thing in the morning and resolved after about 30 minutes. On examination, the right ankle was not swollen. She had mild plantar fascia tenderness. Dr. Temming diagnosed possible mild inflammatory arthritis of the right ankle and some fasciitis. She could have sarcoidosis. *Id.*

On August 10, 1995, petitioner saw Dr. J. Temming. She had a history of DeQuervain's tenosynovitis and right ankle arthralgia and possible plantar fasciitis. She had good range of motion in her right ankle and no synovitis. The heel was nontender. Dr. Temming's impression was transient arthralgia of the right ankle and mild plantar fasciitis, now mostly resolved. Med. recs. at Ex. 17, p. 31.

On October 27, 1995, petitioner saw her doctor because she could not get a deep breath. She felt tight. She had severe posterior nasal drainage. The doctor diagnosed allergic rhinitis and allergies. Med. recs. at Ex. 5, p. 45.

On March 15, 1996, petitioner saw her doctor, complaining of recurrent back pain in the mid-back. *Id.* She thought it was due to lifting her 26-pound child out of the crib. She had a burning sensation around the spine which did not radiate down the spine or into the legs. It hurt when she twisted or touched her chin to her chest. On examination, she had tenderness over the spinal process T8-10. *Id.*

On May 14, 1996, petitioner saw her doctor, complaining of chronic itching on her skin and a racing heart beat. Med. recs. at Ex. 12, p. 92. The doctor wondered if her palpitations were due to an anxiety disorder. *Id.*

On May 23, 1996, petitioner telephoned Dr. Hochman. Med. recs. at Ex. 5, p. 44. Petitioner said she saw Dr. Stegman the prior week. She had itching (but no rash) on her face, jaw line, and leg. It was a deep, penetrating itch. It was not the eczema that Dr. Stegman treated. *Id.*

On June 5, 1996, petitioner saw the doctor with pruritis of sudden onset. *Id.*

On July 15, 1996, petitioner phoned her doctor, complaining of fluid in her ears and wanting a prescription. Med. recs. at Ex. 12, p. 93.

On August 23, 1996, petitioner saw her doctor, complaining of left leg numbness which started about one month previously. Med. recs. at Ex. 5, p. 43. The numbness was located on the left lateral leg between her knee and ankle. She had some sensation, but when she touched the leg, it felt as if she were touching through a "wet suit." *Id.* The area of numbness had been increasing. She did not have weakness, bowel or bladder symptoms, or back pain. On examination, petitioner had decreased pinprick and light touch in the left lateral leg between her knee and ankle. Her deep tendon reflexes were normal. Her strength was normal. She had normal straight-leg raising. The assessment was neuropathy. The doctor discussed the case with Dr. Fitz. There were two possible causes: (1) radiculopathy from the spine; or (2) perineal nerve dysfunction. An EMG would help sort this out. Petitioner wanted this done as she had symptoms for four to six weeks. *Id.*

On September 4, 1996, petitioner had an electromyography because she complained of left leg numbness. The EMG was to rule out neuropathy. Med. recs. at Ex. 5, p. 6. There was no evidence of neuropathy. *Id.*

On September 13, 1996, petitioner returned to her doctor after Dr. Crubbs informed her that her EMG was normal. She stated she was still having a problem, but learned she is pregnant and doubted anything else could be done. Med. recs. at Ex. 5, p. 43.

On July 27, 1997, petitioner had her blood tested, whose results were normal. Med. recs. at Ex. 5, p. 69.

On July 28, 1997, petitioner saw her doctor with right tympanic membrane fluid. She also had hemorrhoids. Dr. Hochman diagnosed petitioner with fibrocystic disease, chronic sinusitis, and headaches. Med. recs. at Ex. 12, p. 115. She was recently seen for joint symptoms during her last pregnancy. She had sinusitis and occasional headaches. Med. recs. at Ex. 12, p. 116. She also had dizziness. *Id.*

On February 3, 1997, petitioner saw Dr. Hochman with a change in her skin lesion on her back and a new lump in her right breast. Med. recs. at Ex. 5, p. 41.

On July 28, 1997, petitioner complained of dizziness. Med. recs. at Ex. 5, p. 30. She also complained of joint symptoms during her last pregnancy. She was not exercising regularly. *Id.*

On August 21, 1997, petitioner saw her doctor, complaining of an elbow in the ribs from her husband four to five hours earlier. Med. recs. at Ex. 5, p. 40. She said she had pain with movement and respiration and this was getting worse. On examination, she was comfortable. Her thorax had tenderness on palpation of the lower left ribs. There was no evidence of abdominal injury. *Id.*

On August 21, 1997, petitioner had an x-ray of her ribs because she complained of left lower thoracic pain. Med. recs. at Ex. 5, p. 4. She had normal left ribs. *Id.*

On August 24, 1997, petitioner called her doctor because of a recent elbow to her ribs. Dr. Voica saw her on August 21st. She felt as if she could not get a deep breath due to the pain but she did not have shortness of breath and spoke normally. Med. recs. at Ex. 5, p. 21.

On September 4, 1997, petitioner went to the doctor complaining of rib pain on her left side. It hurt with certain movements and deep breaths. *Id.*

On September 10, 1997, petitioner went to Christ Hospital ER, complaining of right abdominal pain for three months. Med. recs. at Ex. 7, pp. 34. 35. The pain increased with inspiration. She was diagnosed with acute exacerbation of right upper quadrant pain, unclear etiology, and dehydration. Med. recs. at Ex. 7, p. 36. She had an x-ray study which was negative. Med. recs. at Ex. 7, p. 37. Dr. Sabrina D. Leach wrote the ER report. Petitioner stated her right upper quadrant pain had occurred almost daily since June 18, 1997. At that time, she was traveling in a car with her husband. Med. recs. at Ex. 7, p. 39. She experienced nausea but no emesis. On September 10, 1997, the pain was worse especially when she breathed deeply. She had run low grade fevers the last two weeks. She had diarrhea every other day. She was seeing Dr. Gail L. Bongiovanni for these complaints and had a right upper quadrant ultrasound which was negative. She had a recent esophagogastroduodenoscopy and colonoscopy without significant findings. *Id.* On examination, petitioner was tearful at times. Med. recs. at Ex. 7, p. 40. She had some tenderness to palpation in the right upper quadrant without guarding or rebound. Dr. Leach's impression was acute exacerbation of right upper quadrant pain, unclear etiology, and dehydration. *Id.*

On September 15, 1997, petitioner saw Dr. Dunn, stating that her niece had head lice. She herself noted itching for ten days but had no knowledge of any problem in her own room. Dr. Voica and her sister looked but did not see anything. She had a lump excised from her right breast , but petitioner noticed that the lump returned under the scar. Dr. Dunn carefully searched petitioner's scalp and hair for head lice and nits but did not find any. The lump under the scar tissue felt fibrous but not like breast tissue. Dr. Dunn recommended no further action with the scalp. The incisional lump should be benign. Med. recs. at Ex. 5, p. 39.

On October 22, 1997, petitioner went to the doctor, complaining of pain in mid-lumbar spine. Med. recs. at Ex. 5, p. 22.

On October 24, 1997, petitioner had an x-ray of her lumbosacral spine because she complained of a back injury. Med. recs. at Ex. 5, p. 3. The x-ray was unremarkable. *Id.*

On January 17, 1998, petitioner called her doctor to say the back pain improved. Med. recs. at Ex. 5, p. 22.

On February 21, 1998, petitioner saw Dr. Pragalos, complaining of a five-day history of sore throat, achiness, and fatigue. Med. recs. at Ex. 5, p. 38. She stated her children had strep throat recently, and her husband was just diagnosed with strep throat and mononucleosis and was receiving penicillin injections. She denied fever or cough. On physical examination, her tympanic membranes were clear, and her throat was red without exudate. Her sclera were clear and there was no sinus tenderness. She did not have lymphadenopathy. Dr. Pragalos diagnosed pharyngitis and rule out mononucleosis. *Id.*

On March 27, 1998, petitioner saw Dr. Pragalos, complaining of lightheadedness for one to two weeks. Med. recs. at Ex. 5, p. 23. She noticed the symptoms when doing daily activities but she could also get lightheaded when sitting. She also complained of blurriness when trying to read. She had her vision checked one to two months previously and was normal. She also complained of intermittent periods of increased head pressure and stated it was unrelated to sinus pressure or headache. She had positive increased fatigue for the prior weeks. She also had increased heat tolerance than in the past. Dr. Pragalos determined to check her thyroid and do a complete blood count. She prescribed Antivert. *Id.*

On March 31, 1998, petitioner saw Dr. Pragalos to follow up for her dizziness and chest tightness. Med. recs. at Ex. 5, p. 37. She described it as pressure in her upper chest that went into her neck into her head. She felt she might be having palpitations with it. She denied specific chest pain. Blood work drawn for thyroid function and CBC were both normal. *Id.*

On March 31, 1998, petitioner had a chest x-ray because of palpitations. The x-ray was normal and unchanged from the x-ray of August 22, 1997. Med. recs. at Ex. 5, p. 159.

From March 31, 1998, for 24 hours and 57 minutes, petitioner had a Holter monitor. On April 4, 1998, a doctor interpreted it as showing sinus rhythm with periods of sinus bradycardia and sinus tachycardia. Heart rates ranged from 46 to 120 beats per minute with an average of 74 beats per minute. A 10-beat run of supraventricular tachycardia (SVT) at 142 beats per minute correlated with petitioner's diary entry of heart fluttering. Sinus tachycardia correlated with several of petitioner's diary entries of head pressure, chest discomfort, fast heart beat, and heart jumping. No other abnormalities were noted. Med. recs. at Ex. 5, p. 161.

On April 4, 1998, petitioner telephoned Dr. Pragalos to say that she still had shortness of breath. Dr. Pragalos said, if she had extreme shortness of breath, to go to the ER. *Id.*

On April 4, 1998, at 5:15 p.m., petitioner went to Christ Hospital ER. Med. recs. at Ex. 7, p. 15. She complained of chest pain and shortness of breath. *Id.* She stated she had had chest discomfort over the prior several weeks. She was placed on a Holter monitor. She complained now of continued chest pain, shortness of breath, and weakness. Med. recs. at Ex. 7, p. 17. She complained of being easily fatigued and winded. She took the Holter monitor off within the prior few days. She had some abnormalities but nothing worrisome. Her husband had had recent strep. She denied recent illness. She was nauseated, weak, and had dyspnea on exertion with

pain radiating through to her back between her shoulder blades. She had had indigestion recently. Leaning forward helped the pain. *Id.* Dr. John M. Keefe wrote the ER report. Med. recs. at Ex. 7, p. 21. Dr. Kortekamp stated there was no evidence of any ischemic changes or ventricular dysrhythmia on the recent Holter monitor. Petitioner got quite lightheaded while at church that day and hit the wall, sliding down it, although she did not faint or hurt herself. She stated she had been under some stressors in her life recently especially regarding the day care center for one or more of her children. An echocardiogram nine years previously showed no significant heart pathology. She had a previous history of headaches. *Id.* On examination, petitioner continued to complain of pressure or a heavy sensation in the anterior chest which movement did not affect. She had regular rate and rhythm without murmur, gallop, or rub. Med. recs. at Ex. 7, p. 22. Dr. Keefe's impression was atypical chest pain, possible underlying anxiety disorder, no evidence of any acute coronary, myocardial, pericardial, pleural, pulmonary, or aortic disease or pulmonary embolus. *Id.* A chest x-ray taken April 4, 1998 showed no acute cardiopulmonary process or significant interval change from March 31, 1998. Med. recs. at Ex. 7, p. 32.

On April 4, 1998, petitioner again telephoned Dr. Pragalos that she had been seen in the ER. Her EKG was normal. The doctor would arrange a stress echocardiogram. Med. recs. at Ex. 5, p. 24.

On April 7, 1998, petitioner had a stress echocardiography because she complained of chest pain and palpitations. Med. recs. at Ex. 5, p. 8. Dr. J. Mashny wrote that the ECG was negative for ischemia. Petitioner had an abnormal heart rate response to exercise secondary to

deconditioning. She had normal blood pressure response to exercise. She had fair functional aerobic capacity for her age. *Id.*

On April 8, 1998, petitioner saw Dr. Pragalos, complaining of ongoing shortness of breath and chest pain. Med. recs. at Ex. 5, p. 37. She described problems with her heart fluttering associated with dizziness. She had to leave work twice for these symptoms. She had a Holter monitor showing one short episode of atrial fluttering with a fast heart rate associated with the symptoms. Petitioner called Dr. Kortekamp through the weekend while he was on call with complaints of this on two separate occasions. Dr. Pragalos referred petitioner to Dr. Henthorn, a cardiologist, for further evaluation. *Id.*

On April 10, 1998, petitioner saw Dr. Richard W. Henthorn, a cardiologist. Med. recs. at Ex. 2, p. 10. She had an episode of syncope when she was in church at 10 years of age. Nine years before this visit (1989), she had an episode of fatigue and palpitations, but had a normal echocardiogram and the symptoms resolved spontaneously. She was married with two children, the younger being 10 months old. Petitioner was stressed by the usual events of life. For several years, she has not been getting a good night's sleep. She woke in the morning not feeling well and this had been so for longer than three weeks. She stated she did not feel particularly well over the last three weeks. She had chest discomfort which was variable. She had difficulty inhaling. Pain might start in the epigastric area and go up and other times down, sometimes radiating into the back. She felt short of breath putting down a load of laundry and had difficulty standing up when bending over, but no difficulty climbing a flight of steps. *Id.* She was dizzy more than previously, particularly when bending over and standing up. She had palpitations and fluttering. On a Holter monitor, she had a 10-beat episode of atrial tachycardia. Her

echocardigram was normal. *Id.* Her cardiovascular exam was negative. Med. recs. at Ex. 2, p. 11. Her EKG was entirely normal. The one episode of atrial flutter was not alarming and did not explain the major symptoms about which petitioner was concerned. Some sort of sleep disorder was a possible explanation. Some strange viral illness, a chronic fatigue-type syndrome, or the stresses of life with poor sleep, poor nutrition, and lack of exercise might be explanations. Dr. Henthorn and petitioner and her husband decided the latter was the likely cause. He prescribed more rest over the school vacation, mild exercise progressing to moderate exercise, and an attempt to sleep better. *Id.*

On April 16, 1998, petitioner again saw Dr. Pragalos, complaining of chest pain and shortness of breath. Dr. Henthorn evaluated her and felt that there was not a cardiac etiology for her symptoms. Med. recs. at Ex. 5, p. 24. Petitioner complained of palpitations, and tightness and radiation of the chest tightness into her throat. She was concerned she was getting diabetes because her mother had it. She said she felt faint in the morning and felt better after eating. Petitioner was concerned about anxiety. She was trying to remain calm and was getting more rest as Dr. Henthorn recommended. On physical examination, her pulse was 60. Her blood pressure was 108/60. Dr. Pragalos diagnosed petitioner with palpitations, possible gastroesophageal reflux disease, and anxiety. She prescribed Xantac and would check her for diabetes. *Id.*

On April 23, 1998, petitioner received hepatitis A and hepatitis B vaccinations. *Id.*

On May 15, 1998, petitioner saw Dr. Pragalos to follow up on her complaints of palpitations and chest pain. Med. recs. at Ex. 5, p. 36. She stated that the chest pain and palpitations were improving. She now complained of diffuse arm and leg numbness. She said it

was more like tingling as the sensation of her hands and legs fell asleep. It was painful to walk, especially on her right foot. Petitioner stated that several years ago she saw a rheumatologist prior to seeing Dr. Hochman and, at that time, the rheumatologist considered a diagnosis of scleroderma. She did not have any further respiratory symptoms or difficulty swallowing or any upper gastrointestinal symptoms. Petitioner asked Dr. Pragalos if her symptoms were due to allergies. She said that in August and the spring of every year, she had very unusual symptoms and she felt they could be related to allergies. *Id.* Dr. Pragalos examined petitioner and found that she had 2+, brisk, and symmetrical reflexes. She had normal sensation to light touch throughout. She did not have edema. She prescribed Zyrtec for possible allergies and a check of petitioner's ANA. *Id.*

On May 15, 1998, at noon, petitioner telephoned Dr. Hochman's office to say she now had a "bruise" on the back of her left leg and an increase in tingling in the leg as well. The working diagnosis was deep vein thrombosis (DVT). Petitioner was unable to be reassured. She went to the ER but the ER never called. *Id.*

On May 16, 1998, at 1:07 a.m., petitioner went to Christ Hospital ER. Med. recs. at Ex. 7, p. 5. She gave a several-day history of generalized numbness. Her right leg was worse than her left. Her foot push was equal and strong. A provisional diagnosis was paresthesias. Med. recs. at Ex. 7, p. 7. Dr. Jeffrey Stuckert wrote the ER report. About one month previously, petitioner had onset of paresthesias. She had brief episodes of tingling in both hands lasting only a few seconds. She had been having fairly persistent paresthesia in the right lower extremity which she described as heaviness in the leg. She felt decreased sensation. At times, she had pain in the plantar aspect of the foot near the first MTP joint, particularly in the morning with weight-

bearing. She had occasional paresthesias in the left leg. She had some paresthesias in the right leg which felt as if she were wearing a wet suit, and had an EMG about one year previously which was reportedly negative. She denied any motor weakness or incoordination. She denied any back pain or limited range of motion of the spine. She denied any urinary symptoms or incontinence. She denied any visual symptoms or ear, nose, or throat problems other than usual sinus symptoms. She took large doses of Ibuprofen. Sometimes, three or four times a week, she too up to 1800 mg per day. She used it more frequently recently because of sinus headaches which she typically got in the spring. Dr. Pragalos started her on Zyrtec the day before. She got frequent headaches which she attributed to migraines. She denied diplopia, nausea, vomiting, fevers, or chills. Med. recs. at Ex. 7, p. 8. In April 1998, petitioner experienced tightness in the chest and palpitations. A stress echo was performed which was negative. Med. recs. at Ex. 7, p. 9. On examination, petitioner had good muscle strength and tone. She had full range of motion of all joints. Her gait was normal. She did not have ataxia. She had a negative Romberg sign. Her reflexes, motor and sensory, were all fully intact. She had good heel and toe walking. She could touch her toes. *Id.* Dr. Stuckert thought the cause of petitioner's paresthesias could be medication-induced by Ibuprofen. There were no motor or cerebellar findings suggestive of MS. Recent ANA test and thyroid studies were negative. He asked petitioner to stop taking Ibuprofen to see if her symptoms resolved. She was to use Tylenol as needed for headaches. *Id.*

On May 19, 1998, petitioner phoned her doctor with ongoing complaints of bilateral symptoms. She complained of lower extremity weakness and numbness. Her upper extremities had no symptoms. She had gone to the ER for the symptoms. Her work-up was negative. Her ANA was negative. She was told of normal results. She was not able to be reassured and was

now concerned that she had MS. The note-taker said she would schedule a lower extremity EMG and a follow-up with Dr. Randy F. Hochman. Med. recs. at Ex. 5, p. 35.

On May 20, 1998, petitioner saw Dr. Hochman, complaining of numbness in the right foot in the second and third toes, pain down the lower extremity and arms, and blurry vision. She had no bladder or bowel dysfunction. Dr. Hochman gave her a sensory examination which was normal, and a motor examination which was normal. He found her reflexes to be 2+ and symmetrical, and she had normal straight-leg raising, and regular coronary rate and rhythm. Her musculoskeletal systems were normal. He recommended she have a neurological consultation. *Id.*

On May 21, 1998, petitioner had an electromyography. Dr. Richard Watson found no evidence of neuropathy. Med. recs. at Ex. 5, p. 135.

On May 26, 1998, Dr. Pragalos's staff called in a Xanax prescription. Med. recs. at Ex. 5, p. 25.

On May 28, 1998, petitioner had a brain MRI. Dr. Roger Vithalani noted no findings to suggest MS. There was a very subtle region of high signal intensity within the left cerebellar hemisphere which he said was compatible with artifact. His impression was a normal brain MRI. Med. recs. at Ex. 5, p. 64.

On June 1, 1998, petitioner saw her doctor, complaining of worse tremor in her hands and electric shocks in her lower back. She was to see Dr. Kanter. She had normal reflexes and normal motor testing. Med. recs. at Ex. 5, p. 25.

On June 3, 1998, Dr. Hochman reviewed petitioner's laboratory tests. They were normal. He also found her MRI to be normal. Med. recs. at Ex. 12, p. 120.

On June 4, 1998, petitioner saw Dr. Daniel S. Kanter, a neurologist. Med. recs. at Ex. 4, p. 8. She told Dr. Kanter she was neurologically normal until a couple of months previously (putting onset in early April 1998) when she had tingling over her anterior chin. She then developed numbness of the plantar surface of her right foot. She has also had fatigue and palpitations. She reported episodic tremors and electric shocks in her buttocks and down her low back and groin. She stated her right leg felt heavy and numb and somewhat rigid. She reported some numbness in the toes of her right foot. She stated her left arm was heavy and numb. She had difficulty focusing on near objects. She had an MRI of the brain which was normal. There was a single area of bright T2 signal on one cut in the cerebrum on the left with a hypodense area just above that. This was an unusual pattern not suggestive of any known pathology. She had an EMG on May 21, 1998 of her right leg which was normal. Testing for ANA, liver function, and thyroid were normal. *Id.*

Petitioner's recent medications were Ibuprofen and Xanax. Med. recs. at Ex. 4, p. 9. She worked as a grade school teacher. A paternal aunt had cerebellar ataxia and a paternal great aunt had multiple sclerosis. Dr. Kanter examined petitioner and concluded that her neurologic examination was normal except for possible slight weakness of her right hip flexors. Her sensory complaints had no clear etiology. Her MRI looked normal to him despite the presumed artifact in the left cerebellum. He explained to petitioner that there was no obvious illness to explain her symptoms. What concerned Dr. Kanter was "the strong component of anxiety and depression that she currently manifests. This is interfering with her life functioning and I feel strongly that she should have a psychiatric intervention to help her cope with her current psychological

problems." Med. recs. at Ex. 4, pp. 9-10. Petitioner was to call Dr. Hochman to arrange psychiatric intervention. Med. recs. at Ex. 4, p. 10.

On June 5, 1998, petitioner saw Dr. Geraldine N. Wu of Integrated Behavioral Services, Inc. Med. recs. at Ex. 5, p. 55. Petitioner developed some anxiety in March in the middle of several stresses. Her medical work-up was negative, but petitioner did not address the psychological stressors she was facing. She subsequently developed numbness and tingling in her extremities and began, at that point, focusing "pathologically on her somatic symptoms in spite of the fact that her medical work up was once again negative. She has been fearful, anxious, agitated, obsessing over somatic complaints, having severe sleep disturbance, feeling unsure of herself in every way." *Id.* Dr. Wu asked petitioner to continue taking Xanax and started her on Buspar and Serzone. *Id.*

On June 6, 1998, Dr. Wu did a diagnostic evaluation of petitioner. Med. recs. at Ex. 5, p. 57. Petitioner reported she began having some palpitations and chest pain in March 1998. Work-up was negative. In April 1998, she began having some neurological symptoms, but work-up did not show MS. She had numbness and tingling in her right leg which went to her left arm. She had pain in the bottom of her right foot, and pins and needles in her lower back. MRI, EMG, blood work-up, creatine phosphokinase (CPK), and thyroid testing were all negative. In April, she started to worry and became afraid of MS. She nursed her baby until mid-January. Her husband was ill with symptoms that resembled rheumatic fever. The baby sitter whom she loved was going to Europe and she worried about this. She had never been a good sleeper. She was up nursing in the middle of the night. She did not usually have trouble falling asleep, but usually had trouble waking up through the night. She felt that Xanax was causing her symptoms. By

June 5, 1998, she felt she was not able to cope with anything and was crying a lot. She felt desperate and completely depressed and joyless. She had been anxious and nervous most of her life. She felt she could not go on any more. She had not been eating well and had lost eight to ten pounds. Her concentration was really bad. Her sister and brother had psychiatric illness. *Id.*

When petitioner broke up with a boyfriend of six years, she took Triavil. She had a history of headaches. Med. recs. at Ex. 5, p. 58. She said she had never been this depressed. She was concerned about her parents' health and her children's safety. She had always been concerned about health issues. She had high anxiety, somatic focus, crying spells, agitation, fearfulness, decreased energy, low appetite, social withdrawal, panic attacks, and obsessional ruminations. Her somatic symptoms were: numbness; tingling; pins and needles in her hands, arm, and leg; chest pain; shortness of breath; palpitations; weakness; inability to walk and ambulate okay; clumsiness; and tremors. Her concentration and memory were diminished. She had no insight. *Id.*

Dr. Wu's assessment was that petitioner had always been anxious and tended to somatize most of her life. Med. recs. at Ex. 5, p. 59. She had one episode of anxiety and depression in her 20's and was treated with Triavil. Her current symptoms of anxiety and depression followed several significant stresses in her life: (1) she just completed nursing her baby in January; (2) her one-year-old child was still not sleeping well; therefore, she had not been able to sleep well; (3) her husband developed a severe strep throat; and (4) the baby sitter whom she trusted and on whom she depended was leaving the country. Petitioner had not had time to address her psychological concerns and fears, and tended to focus on her somatic problems. Thus, her emotional symptoms progressed. Petitioner had a significant element of vegetative signs of

depression. Dr. Wu believed she would require not only an anti-anxiety drug, but also an anti-depressant. Serzone was good to reduce anxiety and help with sleep disturbance. She reassured petitioner that Xanax did not cause her problems and she could continue to take it until Buspar took effect. *Id.*

Dr. Wu diagnosed somatoform disorder, panic disorder, rule out general anxiety disorder, dysthmic (despondency) disorder, and concerns about her health. Her goals were to eliminate anxiety and depression and refocus on psychological issues. *Id.*

On June 9, 1998, petitioner saw Dr. Wu. Med. recs. at Ex. 9, p. 13. Petitioner felt a little better each day. She was out of school. She was taking Xanax. The weekend was hard. She kept thinking about the sense of shock in her back. Her arm numbness was better. Shaking continued and worried her constantly. Right leg numbness was the same. *Id.*

On June 13, 1998, petitioner saw Dr. Wu. Med. recs. at Ex. 9, p. 12. She still shook without Xanax. She felt better with a massage. *Id.*

On June 16, 1998, petitioner saw Dr. Wu. Med. recs. at Ex. 9, p. 11. Petitioner's husband entered the session to say that they argued in a verbally violent fashion. Petitioner had less shakiness on Inderal, but it lasted only eight hours. *Id.*

On June 30, 1998, petitioner saw Dr. Wu. Med. recs. at Ex. 9, p. 10. Her shaking improved on a vacation cruise. Massage really helped her. *Id.*

On July 1, 1998, petitioner saw her doctor, complaining of left shoulder pain. Med. recs. at Ex. 5, p. 34. She was using massage therapy with good results. The pain did not radiate. She had right foot and ankle pain which was worse in the morning, but no other symptoms. On physical examination, petitioner's metatarsophalangeal (MTP) second and third toes were tender,

but she had no other joint abnormality. She had a left upper tender trigger point with movement. The doctor recommended petitioner see Dr. Eisley to rule out Morton's neuroma.[1] *Id.*

On July 9, 1998, petitioner saw Dr. Wu, the psychiatrist. Med. recs. at Ex. 9, p. 9. Petitioner could not tolerate Serzone. She was quivering everywhere. Dr. Wu decided to try her on Prozac. *Id.*

On July 13, 1998, at 10:30 a.m., petitioner telephoned her doctor (Dr. Hochman). She still had facial pain, and hot and cold tingling in her legs, feet, and hands. She asked if she should continue with the hepatitis B series of vaccinations. Dr. Hochman noted to hold the hepatitis B vaccinations for now. Petitioner also asked for the name of the doctor's daughter's acupuncturist. *Id.*

On July 16, 1998, petitioner saw Dr. Wu, the psychiatrist. Med. recs. at Ex. 9, p. 8. Petitioner and her husband were having arguments. *Id.*

On July 28, 1998, petitioner saw Dr. Wu. Med. recs. at Ex. 9, p. 7. She was doing pretty well, but shook more at night. She slept better. She was tired from Klonopin. *Id.*

On August 4, 1998, petitioner saw Dr. Wu. Med. recs. at Ex. 9, p. 6. Petitioner and her husband had been having arguments. Her shakiness and twitching were ongoing and she felt very tired. The real issues between herself and her spouse were not resolved. *Id.*

On August 10, 1998, petitioner saw Dr. Sandra A. Eisele, an orthopedist. Med. recs. at Ex. 5, p. 53. She consulted Dr. Eisele regarding her feet. She had had some pain in her feet since March 1998 (one month prior to the vaccinations at issue). Med. recs. at Ex. 5, p. 54. She

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[1] Morton's neuralgia is "a form of foot pain, metatarsalgia caused by compression of a branch of the plantar nerve by the metatarsal heads; chronic compression may lead to formation of a neuroma." Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 1251.

also had a lot of fatigue. A neurologist was going to do a work-up for possible fibromyalgia. She had been having pain in both arches when she got up in the morning, and in the right forefoot which worsened when she got up in the morning. She had to wear loose shoes. Bare feet or high heels worsened her right foot pain in the forefoot. She was taking Paxil, Klonopin, Xanax, and Triphasil. On examination, petitioner had very high arches and tenderness along the plantar fascia bilaterally. In the right foot, she had tenderness between the first and second metatarsal heads. Dr. Eisele thought she had a neuroma in the second interspace. Petitioner had increased pain with compression of the metatarsal heads and under the base of the second and third toes between them. Otherwise, distal sensory and motor examinations were essentially normal. Dr. Eisele's impression was bilateral plantar fasciitis and right second interspace neuroma with bilateral pes cavus. She recommended physical therapy and orthotics. She started petitioner on Daypro. *Id.*

On August 11, 1998, petitioner saw Dr. Kanter again. Med. recs. at Ex. 4, p. 5. Petitioner had switched physicians to Dr. Antoinette Pragalos. Petitioner reported significant improvement in her anxiety and depression. Her paresthesias and numbness improved a great deal. She had occasional prickly and hot and cold feelings in her feet, and some electric shocks up her back. Her main complaint was fatigue which she had all the time and trembling which occurred frequently. Her current medication included Paxil, Klonopin, and Xanax. She had occasional twitching. *Id.* On examination, petitioner remained neurologically normal. Med. recs. at Ex. 4, p. 6. Dr. Kanter's impression was fatigue and trembling of unclear etiology. There were no physical examination features to suggest MS. Petitioner demonstrated some slight trembling of her outstretched arms, but this looked like an enhanced physiologic tremor rather

than a cerebellar tremor, essential tremor, or parkinsonian tremor. Her anxiety and depression might be contributing to her trembling or this could be medication-related. Trembling by itself was rarely due to any primary neurologic problem. *Id.*

On August 12, 1998, petitioner had an MRI of her brain with and without contrast and an MRI of her cervical cord without contrast. Med. recs. at Ex. 21, p. 3. Her brain was essentially normal with no findings to suggest MS and no cerebellar lesion. She had a linear focus of T2 hyperintensity on the left lateral ventricle likely representing a perivascular space. Her cervical cord and spine were normal. *Id.*

On August 13, 1998, petitioner saw Dr. Wu, the psychiatrist. Med. recs. at Ex. 9, p. 5. Petitioner noticed a connection between eating and shakiness. After she ate, she did not seem to shake at all. She had fatigue unrelated to Paxil. Dr. Wu diagnosed somatoform disorder, panic disorder, and dysthymic disorder. *Id.*

On August 17, 1998, petitioner saw Dr. Susan E. Kindel, a dermatologist, for multiple lesions on her face, trunk, and extremities about which she was concerned. Med. recs. at Ex. 5, p. 50. Petitioner had a fibrous papule on the left knee which was a benign lesion that did not require treatment. She had a seborrheic keratosis on her right cheek that was a benign lesion that did not require treatment. She had several dermatofibromas in various areas of her trunk which were benign lesions that did not require treatment. She had a possible atypical nevus on her left lower abdomen which Dr. Kindel removed. Pathology showed a very mildly dysplastic nevus. Dr. Kindel requested petitioner make yearly appointments. *Id.*

On August 19, 1998, petitioner had a lumbar puncture. Med. recs. at Ex. 4, p. 4. Reports of her recent MRI of the brain and of the cervical spine showed no abnormalities. *Id.* The results of the LP showed no oligoclonal bands. Med. recs. at Ex. 4, p. 12.

In a patient questionnaire dated September 10, 1998, petitioner stated that she had had headaches for 25 years. Med. recs. at Ex. 5, p. 89. She was seeing the doctor for tremors and possible fibromyalgia. *Id.*

On September 10, 1998, petitioner saw her doctor with possible fibromyalgia and tremors since April. She had had an extensive work-up for the prior six months for tremor, numbness, weakness, and chest pain with palpitations. MRIs, EMG, EKG, and echocardiography were negative. Dr. Wu diagnosed her with anxiety and prescribed Serzone, Prozac, Xanac, and Paxil. Also, she prescribed Klonopin for tremor. Overall, petitioner felt better. She complained of chronic diffuse pain especially in the left neck area, chronic fatigue, and insomnia with frequent nighttime awakening. Med. recs. at Ex. 5, p. 87. On examination, her motor, tone, and reflexes were normal. Sensation was grossly intact. She had very mild fine tremor in the third, fourth, and fifth digits of both arms with extension of the hands. She did not have intention tremor or resting tremor. She had marked tenderness at trigger zones typical of fibromyalgia in the upper neck, lower neck, mid back, lower back, anterior chest wall, and at her elbows and knees. Med. recs. at Ex. 5, p. 87. The doctor diagnosed fibromyalgia with improvement in symptoms. Med. recs. at Ex. 5, p. 86.

On October 1, 1998, petitioner saw her doctor, complaining of left shoulder and neck pain. The doctor's impression was fibromyalgia with some improvement in overall symptoms. Acupuncture into tender trigger points resulted in complete relief. Med. recs. at Ex. 5, p. 88.

On October 15, 1998, the doctor noted in follow-up that petitioner's neck pain and headaches were 50% improved since the last time. She was coping much better. Her allergies were controlled on Nasonex. She had some episodes of fatigue. *Id.*

On November 11, 1998, petitioner saw her doctor with acute bronchitis. Med. recs. at Ex. 5, p. 86.

On November 16, 1998, petitioner saw her doctor with acute bronchitis. Med. recs. at Ex. 5, p. 85.

On November 18, 1998, a chest x-ray was positive for pneumonia. *Id.*

On November 23, 1998, petitioner was coughing less but continued to have shortness of breath. She had fatigue and heart palpitations. *Id.* The doctor suspected the heart palpitations were secondary to the pneumonia. Med. recs. at Ex. 5, p. 84.

On December 2, 1998, petitioner saw her doctor with an increased cough for the prior three days. *Id.*

On December 7, 1998, petitioner saw Dr. Hal S. Blatman, a pain management physician, giving him a long history of headache and upper body pain which greatly worsened in April 1998. Diagnostic work-up had been negative. Med. recs. at Ex. 5, p. 128. Physical examination showed neck and shoulder range of motion to be grossly within normal limits. Straight leg raise and deep tendon reflex testing were unremarkable. Myofascial trigger points were palpable and most active in masticatory, cervical trapezial, shoulder girdle, lower back and lower extremity musculature. Dr. Blatman's impression was that petitioner had chronic myofascial pain syndrome. She met the diagnosis of fibromyalgia. He started treating her with nutritional recommendations, stretching exercises, and myofascial release techniques. *Id.*

On December 17, 1998, petitioner saw her doctor with an upper respiratory infection. Med. recs. at Ex. 5, p. 83. She had emesis after coughing. Med. recs. at Ex. 12, p. 129.

On December 26, 1998, petitioner called her doctor to report recurrent chest pain in the right chest wall behind the scapula, mild shortness of breath, and a non-productive cough. She was worried about a recurrence of pneumonia. Med. recs. at Ex. 12, p. 127.

On December 30, 1998, petitioner had a chest x-ray for a pneumonia follow-up. Med. recs. at Ex. 12, p. 77. She had a normal x-ray. The left lower lobe pneumonia was completely resolved. *Id.*

On December 31, 1998, petitioner had a chest x-ray which was normal. The pneumonia had completely resolved. Med. recs. at Ex. 12, p. 128.

On January 26, 1999, petitioner saw Dr. Blatman for neck and shoulder pain. Med. recs. at Ex. 10, p. 5. She was doing pretty well, having less frequent headaches. She got off Ibuprofen. She took Tylenol or Excedrin. The ball and stretches helped. Her joints were a little achy sometimes. She took vitamins, stretched, and used the ball three to five times a day. He injected petitioner's trigger points with procaine in six sites followed by stretch with myofascial release techniques. Petitioner improved. *Id.*

On February 9, 1999, petitioner saw Dr. Blatman for her neck and shoulder pain. Med. recs. at Ex. 10, p. 6. The day before, her left arm went numb down to her hand on the ulnar side. She felt lightheaded too. Using the ball got rid of the numbness, but it came and went. She thought she was coming down with something. She was trembling and asked about cranial work. Dr. Blatman discussed mercury with petitioner. He gave her procaine injections in her trigger points. *Id.*

On February 26, 1999, petitioner went to Light Touch Physical Therapy for an initial evaluation with physical therapist Vickie M. Fairchild. Med. recs. at Ex. 13, p. 45. Dr. Blatman referred petitioner for evaluation and treatment of her fibromyalgia. Petitioner had neck, shoulder, and back pain, headaches, and myofascial pain syndrome. Petitioner stated she had had these symptoms since high school, and then began to experience tremors and shaking, and the symptoms got worse. *Id.* No activities increased or decreased the pain. She saw a psychiatrist, Dr. Wu, from July to October for anxiety disorder. Petitioner felt her shaking was secondary to some kind of illness. She felt her anxiety was secondary to the tremoring. She stated the tremoring had been constant since May. She had also had chiropractic adjustments, acupuncture, physical therapy, and massage therapy in the summer. Today, petitioner described her pain as 4-5 out of 10. She described cramping throughout the neck, shoulders, left side of her trunk, lumbar, gluteals, gastroc, left and right sides of her legs, and right frontal. She also complained of numbness in the left ulnar side of her right upper extremity. She had burning in the soles of her feet around the first two metatarsals in the morning for two to three minutes which vanished. She stated she had constant achiness and tightness which lasted for hours which was a dull pain. Tests have ruled out MS and any other neurological or hormonal problem. *Id.*

On March 16, 1999, petitioner saw her doctor with a sore throat and an elevation in temperature. *Id.* He diagnosed her with an upper respiratory infection. *Id.*

On March 22, 1999, petitioner saw her doctor with an increased cough and some pain between her shoulder blades with cough. He diagnosed her with bronchitis. *Id.*

On March 22, 1999, petitioner saw Dr. Wu, the psychiatrist. Med. recs. at Ex. 9, p. 3. Petitioner was a little stressed out, shaking, and not sleeping well. *Id.* Dr. Wu kept petitioner on Klonopin. *Id.*

On March 23, 1999, petitioner saw Dr. Blatman for neck and shoulder pain. Med. recs. at Ex. 10, p. 6. She had been doing well. She had been going for physical therapy and that really helped. She was not in any pain but got tight in her neck and back. She did not have severe headaches. *Id.*

On March 23, 1999, petitioner had a chest x-ray because of her cough. Med. recs. at Ex. 12, p. 78. The x-ray was normal. *Id.*

On April 8, 1999, petitioner saw Dr. Blatman for neck and shoulder pain. She had cycle headaches again but not as intense. Menstruation made her achy. Med. recs. at Ex. 10, p. 7.

On April 22, 1999, petitioner saw her doctor. She was concerned about having had a hepatitis B vaccine reaction. She had her first vaccination April 23, 1998. She developed facial tingling 10 days later, followed by tingling in her legs with fatigue and tremor. She had done research into adverse reactions to hepatitis B vaccine and felt that she fit this profile. Her chronic pain was well-controlled with regular physical therapy. She always felt as if she had a tremor in her entire body. Klonopin relieved this somewhat. She had chronic pain with shooter sensation in the lumbar area. Med. recs. at Ex. 5, p. 82. The doctor diagnosed her with adjustment disorder with depression. *Id.* Her rheumatoid panel on April 26, 1999 was normal. *Id.*

On April 22, 1999, petitioner had a negative ANA. Med. recs. at Ex. 5, p. 138. The doctor decreased her Paxil from 20 mg. daily to 10 mg. daily. *Id.* On examination, petitioner had full range of movement, her DTRs were 2+ and equal, her sensation was intact, she had a

negative straight-leg raise, no weakness, negative Romberg, and tremor of the hands aggravated with concentration on that area. *Id.* The doctor diagnosed an adjustment disorder with depression. *Id.*

On May 20, 1999, Dr. Sandi Amoils wrote a "To Whom It May Concern" letter to obtain permission for petitioner to see Dr. Andrew W. Campbell to see if she had a reaction to hepatitis B vaccine. After her vaccination on April 23, 1998, about 30 days later, petitioner went to the ER for tingling and a large bruise. She currently had tremors, fatigue, numbness with tingling in her legs as well as visual changes. Dr. Kanter, a neurologist, saw her. Petitioner had negative EMGs as well as a negative brain MRI. Petitioner saw Dr. Geraldine Wu, a psychiatrist, and was currently taking Paxil and Klonopin with persistence of tremors, fatigue, numbness, tingling, and diffuse pain. Dr. Amoils had evaluated her and all laboratory tests were negative, including sedimentation rate, ANA, rheumatoid factor, CBC, and liver function tests. X-rays of cervical and lumbar spines were normal. Petitioner had done extensive reading into possible adverse reactions to hepatitis B, and discussing her symptoms with Dr. Campbell, Dr. Amoils wrote it was "very likely that she has had an adverse reaction to hepatitis B vaccine." *Id.*

On May 26, 1999, petitioner told physical therapist Vickie M. Fairchild that she was much improved since she started therapy. Med. recs. at Ex. 13, p. 31.

On June 3, 1999, petitioner saw her doctor, complaining of pharyngitis. Med. recs. at Ex. 5, p. 81. Petitioner was fatigued and achy with pain in all her joints. She had been exposed to strep. Med. recs. at Ex. 12, p. 130.

On June 11, 1999, petitioner saw her doctor, complaining of pharyngitis. Med. recs. at Ex. 5, p. 80. She had white spots on the throat and under the tongue with headache. Med. recs. at Ex. 12, p. 131.

On June 18, 1999, petitioner saw Dr. Blatman for neck and shoulder pain. She had hepatitis B and reacted to it neurologically. She had a back headache, left-sided face pain, left shoulder traps, and low back shocking. Intravenous vitamins made a huge difference. Trigger points were identified and procaine injected into four sites followed by stretch and myofascial release techniques. Her condition improved. Med. recs. at Ex. 10, p. 7.

On June 24, 1999, petitioner saw Dr. Blatman for neck and shoulder pain. She was fighting a virus. He injected procaine in two sites of her trigger points followed by stretch and myofascial release. Med. recs. at Ex. 10, p. 8.

On June 29, 1999, petitioner filled out a form for Dr. Andrew W. Campbell who runs the Center for Immune, Environmental, and Toxic Disorders in Houston, TX. Med. recs. at Ex. 6, p. 39.

On July 1, 1999, petitioner saw Dr. Campbell. Med. recs. at Ex. 6, p. 31. Petitioner claimed her right eye did not focus. She complained of electric shocks on her back and upper neck, numbness in her right leg, sleep disturbances, tremors, fatigue, muscle pain, and low resistance to getting sick. *Id.* Petitioner stated that within two weeks of receiving hepatitis A vaccine and hepatitis B vaccine, she started to feel shooting pain on her face and numbness on her chin. After this, she felt like she had the flu. She had new symptoms daily. She felt numbness in her right leg, then in her left. Then it went to her left arm and finally to her right arm. The symptoms followed in a circular pattern and eased somewhat in one area as a new area

was affected. She had pins and needles in her hands and feet and shock-like electric current in her lower back. She had extreme fatigue and tremors. She started having bruising and shortness of breath. She developed anxiety from having these symptoms. She was tested and found to be normal. She went on an anti-depresssant and anti-anxiety medication. She started having sleeping problems with muscle pain. Her hormone levels were tested. She had an EMG and two MRIs, including a cervical spine and a lumbar puncture. All test results were normal. A neurologist told her she did not have MS. Her symptoms improved on multiple vitamins and intravenous therapy, but they were still there. *Id.*

On July 1, 1999, Dr. Campbell diagnosed petitioner with a hepatitis B vaccine reaction and charged her $12,123.00. Med. recs. at Ex. 6, p. 29.

On July 7, 1999, petitioner saw Dr. Blatman for intravenous vitamins. Med. recs. at Ex. 10, p. 8. Dr. Campbell believed she had chronic inflammatory demyelinating polyneuropathy (CIDP), although the official results were not back yet. Her pain was more diffuse. Her shoulders were doing better. Dr. Blatman discussed mercury detoxification with petitioner. She had some left foot pain and had stubbed her toe. The IV vitamins consisted of: ascorbic acid, 25,000 mg; vitamin B-6, 15,000 ucg; B complex, 100 mg; calcium gluconate, 2,000 mg; glutathione, 1,000 mg; magnesium sulfate, 2,000 mg; mineral mix (copper, chromium, manganese, molybdenum, selenium, vanadium, zinc), Nutripan 750 mg; and taurine, zinc, 5 mg. *Id.*

On July 8, 1999, petitioner telephoned Dr. Campbell and said that her physician in Cincinnati, Dr. Blatman, strongly recommended she remove her mercury fillings. Circled next to

that statement is the word "yes" in a circle. Med. recs. at Ex. 6, p. 27. Petitioner had 10 mercury fillings. *Id.*

On July 8, 1999, petitioner saw a foot doctor, complaining of an at least two-month history of worsening exacerbated pain in the left first MPJ. She stated she had had it for some time, but that while walking through the airport, she jammed it and had worse pain. Med. recs. at Ex. 18, p. 2. She had a hard time touching the top of it. The pain radiated into her arch when the toe bent, extending to the top of her foot. She also complained of a neuroma to the second intermetatarsal space of the right foot, involving the second and third toes. She had generalized foot pain frequently which was chronic. On examination, she had good proprioception and a positive Mulder's sign of right second intermetatarsal space. She had limited ankle joint dorsiflexion. Otherwise, the range of motion and muscle strength were normal. She had a partially compensated pes cavus deformity (high arch) and hypertrophic spurring. *Id.* He recommended orthotics strongly. Med. recs. at Ex. 18, p. 3.

On July 1, 1999, Dr. Campbell had petitioner's blood tested and the result was a positive rheumatoid factor (even though when Dr. Amoils tested her, her rheumatoid factor was negative). Med. recs. at Ex. 5, p. 125. He also found her IgG Benzene ring positive. *Id.* When Dr. Campbell tested petitioner's rheumatoid factor on October 19, 1999, it was normal. Med. recs. at Ex. 6, p. 117.

Dr. Campbell put petitioner on DHEA. Med. recs. at Ex. 6, p. 21. The test result for DHEA on July 1, 1999 was 61, the normal range being 35-430. It is unclear why Dr. Campbell thought petitioner's DHEA was low. Med. recs. at Ex. 6, p. 134. The same test on July 1, 1999 found petitioner had positive antibody to hepatitis A, but no reaction to hepatitis B. The

conclusion of the report was that petitioner's blood had no evidence of past exposure to or current infection with hepatitis B virus. Med. recs. at Ex. 6, p. 135. One of petitioner's thyroid tests (T4) showed petitioner was over the normal range, i.e., 12.8 when the normal range was 4.4-12.5. Med. recs. at Ex. 6, p. 136. A nutritional test dated July 2, 1999 showed petitioner had vitamin B1 and glutathione deficiencies. (Since petitioner was receiving IV vitamins from Dr. Blatman, including 1,000 mg of glutathione and 100 mg of a B complex, it is hard to know why she was deficient in glutathione and vitamin B1.) She had average antioxidant function. Med. recs. at Ex. 6, p. 137. Symptoms for vitamin B1 deficiency included fatigue, mental depression, loss of appetite, weakness, and peripheral neuropathy. Med. recs. at Ex. 6, p. 143.

On July 14, 1999, petitioner saw Dr. Blatman for neck and shoulder pain. Med. recs. at Ex. 10, p. 9. She had a headache on the left side and twitching in her left hamstring region. She had pain in her left shoulder trap and neck region. IV therapy was helpful. He injected six sites with procaine. *Id.*

On August 17, 1999, petitioner saw Dr. Blatman for neck and shoulder pain. *Id.* She had joint pain the last few days. She had menstrual headaches. He discussed mercury detoxification with her. She was scheduled for dental filling changes. She had a sharp pain over her left ear over the prior four weeks. He injected procaine in four sites. *Id.*

On August 20, 1999, petitioner telephoned Dr. Campbell. She had an environmental specialist come to her home because of her positive Benzene ring result. She wanted to have her carpet and air ducts cleaned, and air washed with a HEPA filter. She needed a statement from Dr. Campbell stating this was medically necessary for tax purposes. Med. recs. at Ex. 6, p. 20.

On September 21, 1999, petitioner saw Dr. Blatman for neck and shoulder pain. Med. recs. at Ex. 10, p. 10. An injection for ear pain helped and she has no more ear pain. She had been taking DHEA since mid-August. *Id.*

On October 4, 1999, petitioner saw her doctor with a sore throat, headache, and diarrhea. She had been in contact with those with strep. Med. recs. at Ex. 5, p. 80. She was diagnosed with an acute viral illness. Med. recs. at Ex. 5, p. 79.

On October 4, 1999, petitioner telephoned Dr. Campbell to say that she had had her DHEA tested and it was 160 (it had increased from 60). Med. recs. at Ex. 6, p. 19.

On October 18, 1999, petitioner saw Dr. Campbell. Petitioner noticed more tremors and more lumps on her breasts, but less tingling in her hands and feet. Med. recs. at Ex. 6, p. 17. She was going to have the mercury fillings removed from her teeth. *Id.*

On October 18, 1999, Dr. Campbell diagnosed abnormal involuntary muscle movement, abnormal reflex (first time anyone diagnosed this), arthralgia/joint pain, arthritis, autoimmune thryoiditis, demyelinating disease (first time anyone diagnosed this), fatigue, hepatitis B vaccine reaction, immune mechanism disorder (first time anyone diagnosed this), multiple vitamin deficiency (first time anyone diagnosed this). Petitioner owed a balance of $650.00. Med. recs. at Ex. 6, p. 16.

On October 21, 1999, petitioner saw Dr. Blatman for neck and shoulder pain. Med. recs. at Ex. 10, p. 10. She had two bouts of neck tightening which almost led to migraine on the left. She had calf cramping once a week. Dr. Blatman injected two sites with procaine. He explained mercury detoxification to petitioner. She had two more quadrants to do. *Id.*

On October 29, 1999, petitioner saw Dr. Blatman for neck and shoulder pain. Med. recs. at Ex. 10, p. 11. She had been pretty good since she started sleeping on a magnet pad. She had been using it for three weeks and she had more energy. Petitioner had chronic inflammatory demyelinating neuropathy. She was on immune therapy once a week until blood tests showed all the antibodies were gone. DHEA had been increased. Dr. Blatman palpated petitioner's myofascial trigger points. Dr. Blatman prescribed evening primrose oil and lecithin. *Id.*

On November 2, 1999, Dr. Campbell prescribed intravenous immunoglobulin (IVIG) therapy for petitioner, in addition to diet, chemical avoidance, and regular medications. He instructed her to take Daypro 600 mg twice, and to increase her DHEA to 50 mg.. She was also to take Serine 500 mg. three times a day. Med. recs. at Ex. 6, p. 12.

On December 13, 1999, petitioner had a chest x-ray done because of rapid heartbeat. The x-ray was normal. Med. recs. at Ex. 5, p. 152.

On December 13, 1999, petitioner saw Dr. Campbell again. Med. recs. at Ex. 6, p. 9. She was there for follow-up on IVIG. She took the fifth dose of 12 treatments the previous Friday. The only side effect was headache. Petitioner had CIDP and immune muscle disorder. Overall, she had more energy but was still not normal. Her tremors continued to increase in severity. Her numbness and tingling disappeared. She still had intermittent joint pain. She still had muscle pain. She had heart palpitations and a forceful beat with lightheadedness. The notetaker listened to her heart beat and noticed three episodes of irregularity. *Id.*

On December 13, 1999, Dr. Campbell diagnosed petitioner with abnormal reflexes, CIDP, generalized pain, heart palpitations, hypomagnesemia, immune mechanism disorder, and

severe muscular weakness (the first time anyone had found this). Med. recs. at Ex. 6, p. 8. She owed $12,067.00. She was charged $2,171.00 for that day's visit. *Id.*

On December 14, 1999, petitioner took a GXT (graded exercise test) treadmill test because of chest pain. The result was a negative GXT. Med. recs. at Ex. 12, p. 79.

Also on December 14, 1999, petitioner had a chest x-ray because of pain and rapid heart beat. The x-ray was normal. Med. recs. at Ex. 12, p. 80. Petitioner had gone to St. Elizabeth Medical Center ER for rapid heartbeat and chest pressure. Med. recs. at Ex. 14, p. 6. On examination, she had no focal motor or sensory deficits. Med. recs. at Ex. 14, p. 7. She was given an aspirin. Her discharge diagnosis was chest pain (myocardial infarction ruled out). Med. recs. at Ex. 14, p. 50.

On December 27, 1999, petitioner saw her doctor, complaining of atypical chest pain. Med. recs. at Ex. 5, p. 78. The doctor suspected gastroesophageal reflux disease and discussed dietary lifestyle modifications. Petitioner also complained of heart palpitations. Her stress test was negative. Her EKG has non-specific ST & T changes, sinus rhythm. *Id.*

On January 10, 2000, petitioner saw Dr. Blatman for neck and shoulder pain. She had been under a lot of stress because of her mother's heart attack. Med. recs. at Ex. 10, p. 11. She had cramping in her shoulder traps and tight chest muscles. She had chest pain on December 13, 1999 before getting on a plane. She had borderline abnormal electrocardiogram when she got off the plane. A stress EKG was normal. She was taking IV gammaglobulin. He discussed with petitioner chest pain, butter, carbs, pasta, bread, eggs, the immune system, Xantac, acid, and digestive enzymes. He injected six separate sites with procaine. He gave her prescriptions for physical therapy and digestive enzymes. *Id.*

On January 24, 2000, petitioner told Dr. Campbell that a week ago, at the school where she worked, they painted her classroom lockers with an oil-based paint. The students, teachers, and petitioner were getting sick from the fumes. She reported burning eyes and nose, and watery eyes. Some other people got headaches and stomach sickness. Opening the windows did not seem to work. She wanted Dr. Campbell to write an order for medical leave. Dr. Campbell ordered that petitioner take one week off from school. Med. recs. at Ex. 6, p. 227. On January 26, 2000, he mailed the letter to petitioner. *Id.* The letter is at Ex. 6, p. 402 of the medical records.

On February 1, 2000, petitioner returned to Dr. Henthorn, the cardiologist, because of recurrent symptoms of feeling her heart pounding and having some intermittent atypical chest discomforts. Med. recs. at Ex. 5, p. 91. She said that stretch maneuvers related to fibromyalgia relieved her chest discomfort. On December 13, 1999, there was an EKG with V3 and V1 apparently identical. It was unclear to Dr. Henthorn whether that could have been due to lead placement. In Dr. Henthorn's office February 1, 2000, her EKG was essentially within normal limits and really unchanged from April 10, 1998. She had a negative exercise study recently. She had a normal exercise stress echocardiogram in April 1998. Because of one brief episode of atrial tachycardia on Holter monitor, it was possible she was having recurrent episodes of atrial tachycardia. However, the atrial tachycardia documented was not fast. Her cardiovascular examination was within normal limits. *Id.* Dr. Henthorn did not believe petitioner had any significant cardiac condition. The EKGs could be attributable to lead placement or sometimes thin females have variations in their ST-T wave segment not associated with any underlying cardiac condition. Med. recs. at Ex. 5, p. 92.

On February 4, 2000, petitioner saw Dr. Campbell. He diagnosed her with abnormal involuntary muscle movement, abnormal reflex, arthritis, autoimmune thyroiditis, CIDP, fatigue, heart palpitations, immune mechanism disorder, multiple vitamin deficiency, and numbness/tingling. Her balance owed was $16,050.00. Med. recs. at Ex. 6, p. 224. Petitioner said that, since she had been receiving IVIG, she had headaches. She was lately stressed because her mother had a heart attack before Christmas. Petitioner had occasional tachycardia. Her heart beat was irregular. She had an increase in tremors in her whole body. She had tingling in her back. Her hands and feet had shooting pains. She was easily prone to throat infections. She had an increase in muscle spasms. Overall, she felt worse since her last visit due to much stress. Her last IVIG treatment was January 28, 2000. Her cardiologist tested her but made no diagnosis. Med. recs. at Ex. 6, p. 226.

On February 10, 2000, petitioner saw Dr. Blatman for neck and shoulder pain. Med. recs. at Ex. 10, p. 12. She also had pain in her upper back mostly on the left at the shoulder blades. She had burning in her lower back. She was taking digestive enzymes. She was injected in two places with procaine. *Id.*

On February 28, 2000, petitioner saw Dr. Blatman for neck and shoulder pain. Med. recs. at Ex. 10, p. 13. Two days after her last visit, she had flu symptoms and her bowels were most irregular with burning and cramping. She was fatigued and had muscles aches. She had total body pain. Test results from Houston said she needed more thyroid. *Id.*

On March 13, 2000, petitioner telephoned Dr. Campbell. She wanted to discuss benzene in gas. She wanted to know if she should go back to work because her classroom had been

recently painted with a petroleum-based paint. She was not interested in buying an air purifying system. She had an increase in headaches and was nauseated. Med. recs. at Ex. 6, p. 221.

On March 13, 2000, petitioner saw Dr. Blatman for neck and shoulder pain. Med. recs. at Ex. 10, p. 13. She said that Dr. Blatman's injections into her C-section scars and gall bladder really helped. Dr. Campbell was giving her weekly IV vitamins. Dr. Blatman injected two sites with procaine. He administered Novocain to her gall bladder. *Id.*

On March 20, 2000, petitioner saw Dr. Campbell. He diagnosed arthritis, autoimmune thyroiditis, CIDP, fatigue, hepatitis B vaccine reaction, multiple vitamin deficiency, and numbness/tingling. Petitioner's balance was $22,977.20. The charge for that visit was $475.21. Med. recs. at Ex. 6, p. 217. Petitioner stated her body tremors, tingling, and numbness had decreased. She had occasional headaches when she menstruated. Her hands and feet were not painful. Sometimes, in the early morning, when she stepped on the floor, she felt numbness in the tips of her toes with tingling. She was a little stressed out since her mother had a heart attack before Christmas. Overall, petitioner was very grateful for the IVIG. Some of her symptoms had disappeared. Med. res. at Ex. 6, p. 218. Dr. Campbell measured petitioner's deep tendon reflexes as 4++++. Med. recs. at Ex. 6, p. 219.

On April 10, 2000, petitioner saw Dr. Blatman for neck and shoulder pain. Med. recs. at Ex. 10, p. 14. Her gall bladder was doing better. Dr. Blatman injected four sites with procaine. *Id.*

On April 25, 2000, petitioner telephoned Dr. Campbell to ask if she could have Lasik surgery. Her eye doctor had approved it. Med. recs. at Ex. 6, p. 214. Dr. Campbell's staff called petitioner and said Dr. Campbell said not to have the surgery yet because she had CIDP. *Id.*

On May 9, 2000, petitioner saw Dr. Blatman for neck and shoulder pain. Her gall bladder had settled down. Good massage helped her neck. Her right palm and little finger became numb. Her knees bothered her. Dr. Blatman injected two sites with procaine. Med. recs. at Ex. 10, p. 14.

On May 12, 2000, petitioner saw Dr. Campbell. He diagnosed autoimmune thyroiditis, CIDP, fatigue, hepatitis B vaccine reaction, and numbness/tingling. Petitioner had a balance due of $8,057.68 and she owed $5,602.00 for that day's visit. Med. recs. at Ex. 6, p. 211. Petitioner completed 12 rounds of IVIG treatment on April 26, 2000. Petitioner stated that, since March 20, 2000, she started getting shaky and had body tremors, tingling in her upper neck, occasional headache, and felt more frequent restlessness. Her right toe felt numb when she first stepped out of bed. She had good and bad days. Some numbness disappeared. Med. recs. at Ex. 6, p. 213.

On June 3, 2000, petitioner telephoned her doctor to report the sudden onset of dizziness that morning. Med. recs. at Ex. 12, p. 134. She had an episode 20 years ago. She had nausea which was worse with movement. *Id.*

On June 5, 2000, petitioner saw Dr. Blatman for intravenous H2O2 (hydrogen peroxide). Med. recs. at Ex. 10, p. 15. Petitioner was still using her oils, lavender, and frankincense. Her nausea had gone but her vertigo came back. The IV drip consisted of 2.5 cc of hydrogen peroxide, 5.0 cc of manganese, and 2.0 cc of magnesium sulfate. *Id.*

On June 5, 2000, petitioner saw her doctor, complaining of positional dizziness. Med. recs. at Ex. 12, p. 135. She had congestion in her ear. She had the onset of vertigo for 20 minutes three days previously. This was associated with nausea. She felt off balance and had

fullness in her ears. She had ringing. On examination, her tympanic membranes were clear. The doctor diagnosed acute vertigo, probably labyrinthia. *Id.*

On June 13, 2000, petitioner saw Dr. Blatman for neck and shoulder pain. She had an inner ear infection and could not lie down. *Id.* She just saw Vicki Fairchild who did cranial work on her. Dr. Blatman injected three sites with procaine. He discussed H2O2 therapy with her. *Id.*

On June 21, 2000, petitioner saw her doctor, complaining of dizziness which started June 3, 2000. The doctor suspected the dizziness was secondary to viral illness. She might have benign positional vertigo, but not true vertigo. Med. recs. at Ex. 12, p. 134.

On July 10, 2000, petitioner saw Dr. Campbell. He diagnosed abnormal reflex, autoimmune thyroiditis, CIDP, hepatitis B vaccine reaction, immune mechanism disorder, and numbness/tingling. He charged petitioner $5,763.00. She owed him a balance of $124. Med. recs. at Ex. 6, p. 203. Petitioner had finished her sixth round of IVIG on June 27, 2000. About a month previously, she had an inner ear infection which caused constant ringing in her ears. She had taken Antivert for the infection, which helped but made her tired and she stopped taking it. She continued to have some tingling in her upper neck and some numbness in her right toe. She complained of body tremors and was shaky most of the time. She had a little bit more energy because she could rest since school was out. Some numbness had disappeared in some body areas. She had good and bad days. Petitioner had questions about vitamin B. *Id.*

On July 12, 2000, petitioner saw Dr. Blatman for neck and shoulder pain. Med. recs. at Ex. 10, p. 17. That day she felt good. She was achy the day before. She could eat red meat, organic eggs, and a few sweets, according to Dr. Campbell's diet for her. He stopped her Xantac.

Her dizziness was 90% gone. She could take Claritin as needed. She still had tinnitus. They discussed cilantro, DMPS, and mercury. She was taking MSM. *Id.*

On July 14, 2000, petitioner telephoned Dr. Campbell. She was very concerned regarding IVIG. She had been without IVIG treatment for about three weeks and felt very fatigued and restless. She slept 11 hours a day. She had muscle and joint aching. Med. recs. at Ex. 6, p. 202.

On July 17, 2000, petitioner saw Dr. Blatman for DMPS IV (to remove methylmercury). Med. recs. at Ex. 10, p. 16. She had been feeling bloated lately. She had changed birth control pills recently. She was on a juice fast that day and dropped her pre-heavy metal test off. Med. recs. at Ex. 10, p. 16. After the IV drip, she felt a little lightheaded and orange juice was given to her. She felt better. *Id.*

On July 21, 2000, petitioner saw Dr. Blatman for DMPS mineral replacement IV. She did not feel any different after the last DMPS IV. Her heart was skipping some. It did this once in a while. *Id.* After the IV was started, petitioner had a muscle spasm in her right bicep that worked its way to her neck. *Id.*

On July 26, 2000, petitioner saw Dr. Suzanne Matunis, complaining of dizziness for three months, ringing in her ears, and bright, flashing lights from her left eye. Med. recs. at Ex. 12, p. 136. Her tympanic membranes were clear. Dr. Matunis diagnosed vertigo and tinnitus, possible early Meniere's disease, but her symptoms were much better. She was unsure what was causing the flashing lights in her eye. Petitioner's examination was unremarkable. *Id.*

On August 17, 2000, petitioner telephoned Dr. Campbell. She was having an exacerbation of her symptoms. She had a dear friend who died that past weekend. Petitioner

wanted to start IVIG then instead of waiting for the eight-week break. Med. recs. at Ex. 6, p. 200.

On September 25, 2000, petitioner saw Dr. Campbell. He diagnosed arthritis, autoimmune disease, autoimmune thyroiditis, nest pain, CIDP, tremor, fatigue, generalized pain, hepatitis B vaccine reaction, immune mechanism disorder, multiple vitamin deficiency, and numbness/tingling. Med. recs. at Ex. 6, p. 195. Petitioner complained of chest pain unrelated to activity and palpitations which occurred separately from her chest pain. Med. recs. at Ex. 6, p. 197. Petitioner complained of constant ringing in her ears and dizziness. Med. recs. at Ex. 6, p. 198.

On September 28, 2000, petitioner saw Dr. Myles L. Pensak, an ear, nose, and throat specialist. Med. recs. at Ex. 12, p. 83. She stated she had paroxysmal onset of debilitating vertigo in June 2000 with associated tinnitus and aural fullness. Before the vertigo, she had an upper respiratory infection and sinonasal tract congestion, which exacerbated if her head hung in the left dependent position. She described her vertigo as a true spinning sensation with nausea and diaphoresis. Since the resolution of the acute vestibulopathy, she had spacial disorientation, lightheadedness, and disequilibrium. Although she told Dr. Pensak that she was diagnosed with demyelinating polyneuropathy presumably due to hepatitis vaccine, Dr. Pensak noted that, "Interestingly, an MRI done in 1998 revealed no evidence of a central demyelinating process." *Id.* On physical examination, petitioner's external auditory canals and tympanic membranes were benign. Her facial response was symmetric and equal. Her head and neck were non-revealing for inflammatory change or mass lesion. Neurologic testing was entirely unremarkable. All cranial nerves were intact. Gross motor and sensory function was normal. Petitioner

underwent ABR (auditory brainstem response) and ENG (electronystagmogram) testing. The ABR was normal. The ENG demonstrated findings consistent with peripheral vestibulopathy associated with cupulolithiasis or positional vertigo. *Id.* Dr. Pensak thought petitioner might have a post-viral hydrops and suggested petitioner keep a diary of exacerbators and mollifiers, and engage in an aggressive course of exercises. Med. recs. at Ex. 12, p. 82.

On November 1, 2000, petitioner saw Dr. Blatman for neck and shoulder pain. Med. recs. at Ex. 10, p. 17. She had ringing in both ears and her digestive system was off. Dr. Blatman injected procaine in four sites. Shoulder traps continued to be problematic. *Id.*

On November 27, 2000, petitioner saw Dr. Campbell. He diagnosed abnormal reflex and demyelinating disease. Petitioner's previous balance was $1,954.00. Med. recs. at Ex. 6, p. 190. Petitioner had been off IVIG for two weeks and still had ringing in her ears and some tingling in her right leg. She had chest pain for the prior three days which started with fluttering and a thunderous feeling, then pain. She denied any sensation in the left arm at the time of her chest pain. She had some burping after taking meals but still had chest pain. She did not have any chest pain yet that day. Med. recs. at Ex. 6, p. 192.

On February 5, 2001, petitioner tested at 2,055.00 mg/dl of IgG immunoglobulins while the normal range was 680-1445. Med. recs. at Ex. 6, p. 257. She had a normal rheumatoid factor of 9 IU/ml in a normal range of 0-20. Med. recs. at Ex. 6, p. 261. She had adrenal antibodies of 15.0 while normal was between 0-10. Med. recs. at Ex. 6, p. 263. She had low thyroid stimulating hormone (TSH) with reflex to FT4 of 0.32 when the normal range is 0.40-5.50. Med. recs. at Ex. 6, p. 265.

On February 5, 2001, petitioner saw Dr. Campbell. She stated she was doing well. She occasionally had numbness on her right foot as soon as she stepped down from bed to the floor. Her chest pains were gone. She had occasional headaches. She continued with body tremors. Petitioner said that when she followed the diet, she had more energy. She felt better on IVIG. She had more energy and was able to work. Med. recs. at Ex. 6, p. 360.

On February 5, 2001, Dr. Campbell diagnosed petitioner with abnormal reflex, autoimmune thyroiditis, demyelinating disease, fatigue, immune mechanism disorder, and numbness/tingling. Petitioner's previous balance was $4,324.00. The charge for that day's visit was $5,928.00. Med. recs. at Ex. 6, p. 362.

On February 5, 2001, Dr. William L. High, Jr., a neurologist, administered somatosensory evoked potential report (SEPT) to petitioner. She had a normal somatosensory evoked response study with tibial stimulation. The waveforms were well-developed bilaterally and within normal limits. Med. recs. at Ex. 6, p. 341.

On April 19, 2001, petitioner saw Dr. Campbell. For the prior four days, she had been really achy and had extreme fatigue. She had a fine rash on her arms, face, and chest that morning, but it went away. Med. recs. at Ex. 6, p. 367.

On April 19, 2001, Dr. Campbell diagnosed autoimmune thyroiditis, fatigue, hepatitis B vaccine reaction, and polyneuropathy due to a toxic agent. Petitioner's previous balance was $253.45. Current charges were $250.00. Med. recs. at Ex. 6, p. 368.

On April 25, 2001, petitioner telephoned Dr. Campbell. She had joint pain and swollen hands which were worse in the morning. She had severe muscle aches and bloating. She still had tremor. She was worried about her kidneys. She wanted to know if she should receive a

tetanus vaccination. She was worried about symptoms because she was released from the doctor's care. Med. recs. at Ex. 6, p. 369.

On April 30, 2001, petitioner telephoned Dr. Campbell because she was concerned she was declining in health. In a lengthy discussion, petitioner was concerned because she continued to be fatigued for two weeks. She had tremor and twitching and felt as if she were falling backward. She said she was very moody again and had trouble sleeping. She had numbness and tingling. She had an increase in muscle and joint pain. She complained of more headaches although less severe than when she initially began treatment. Petitioner was worried. She filled out a questionnaire that day (April 30, 2001) which she would repeat in two weeks. Med. recs. at Ex. 6, p. 370.

In that April 30, 2001 questionnaire, petitioner wrote that she had constant whole-body tremor, continued ringing in her ears, muscle and joint pain which lessened through the day, bloating and swelling of her abdomen and hands which got better through the day, lots of gas, and headaches which were less severe but more constant because of neck tightness. Med. recs. at Ex. 6, p. 371.

In her May 23, 2001 questionnaire, petitioner wrote that she had definite improvement since the prior questionnaire. Her tremors continued regularly as did her ear ringing. She wondered if her fatigue were due to stress, work or some other reason. Overall, she was holding her own, but could not sleep without Paxil and Klonopin. She stopped taking DHEA. Med. recs. at Ex. 6, p. 373.

On May 30, 2001, petitioner telephoned her doctor to report intermittent chest pains for three days. That day she had tightness in the chest with left arm pain. She was going to the ER. Med. recs. at Ex. 12, p. 137.

On July 2, 2001, petitioner took tests of her thyroid. Her TSH was lower than normal (0.23 instead of being between 0.35 and 5.5). Med. recs. at Ex. 12, p. 89. Dr. Mary Mosko diagnosed petitioner with hyperthyroidism, CIDP secondary to hepatitis vaccine, PMS, sleeping difficulties, allergies, and chest tightness with questionable history of asthma. Med. recs. at Ex. 12, p. 138.

On July 18, 2001, petitioner spoke with Dr. Campbell's staff to question why she was not on IVIG therapy any longer. She wanted to know if she was going to restart it. The staffer explained that, on April 19, 2001, petitioner had been doing better and Dr. Campbell discontinued the IVIG. Med. recs. at Ex. 6, p. 375.

On October 8, 2001, Dr. Campbell released petitioner from treatment. She was to come in for a follow-up on January 21, 2002. Med. recs. at Ex. 6, p. 376.

On October 9, 2001, petitioner called Dr. Campbell. She wanted to discuss the family living in a house with mold and her having hepatitis B vaccine. Med. recs. at Ex. 6, p. 377.

On October 26, 2001, petitioner telephoned Dr. Campbell to say she had recurrent symptoms of joint pain, burning pain, and some bruising. She wanted to know if she should come in. Med. recs. at Ex. 6, p. 379.

On October 30, 2001, petitioner complained of increased nerve pain, muscle tenderness, and increased fatigue. She made an appointment for December 13, 2001. She requested lab and neurologic testing with the appointment. *Id.*

On December 13, 2001, petitioner filled out a questionnaire, stating that she had dizziness and ear ringing, memory disturbance, and muscle and joint aches all over. Med. recs. at Ex. 6, p. 380. Dr. Campbell found her deep tendon reflexes to be 3+++ in her lower extremities and a decrease in vibratory sensation in her right lower extremity. Med. recs. at Ex. 6, p. 381. Petitioner was concerned because her symptoms returned after going back to work and the school had a mold inspection with results to be given in two to three weeks. Her short term memory was poor. She could not remember children's names in class. Med. recs. at Ex. 6, p. 382. Petitioner presented with body tremors. She stated that they had worsened since she went off Klonopin. She complained of tingling in her lower extremities which increased in severity since she discontinued IVIG treatment. She stated she was active but had episodes of fatigue. She slept seven to eight hours a night with difficulty. She questioned the appropriate dosage of thyroid medicine. She had difficulty with vision in her right eye which was fuzzy. She had seen an eye doctor. In addition, she complained of memory disturbances for four months. She was unable to remember names. She was concerned about possible mold exposure leading to her symptoms. She had little electric shocks in her toes. Med. recs. at Ex. 6, p. 383.

On December 13, 2001, Dr. Campbell diagnosed petitioner with abnormal involuntary muscle movement, abnormal reflex, allergies, arthralgia/joint pain, blurred vision, fatigue, hypothyroidism, memory loss, numbness/tingling, and tinnitis. He charged petitioner $3,125.00 for that day's visit. Med. recs. at Ex. 6, p. 384.

A month later, petitioner telephoned Dr. Campbell to request the results of her tests. She had become increasingly forgetful. She began Klonopin which helped tremendously. The school

did not have mold but did have bacteria. On January 14, 2002, a staffer called petitioner and reviewed the test results from December 13, 2001. Med. recs. at Ex. 6, p. 385.

On May 28, 2002, petitioner reported to Dr. Campbell that she had bouts of abdominal bloating and a frequent gassy feeling. She was greatly improved since her first visit to his office. She was concerned about residual symptoms. She had itching mostly at school. She also had spells of dizziness and went through entire audio testing. Her itching and vertigo seemed to be exacerbated when she taught in school. She noted dizziness especially starting in August when it was the high allergy season. The itching went away on Claritin. She had whole-body tremor which felt like a vibrator. Tremors began right after she received hepatitis B vaccine and never really subsided. Med. recs. at Ex. 6, p. 389.

On June 3, 2002, Dr. High performed a visual evoked potential (VER) test on petitioner which was normal. The waveforms were well-developed bilaterally. Med. recs. at Ex. 6, p. 351.

Also on June 3, 2002, Dr. High performed a brainstem auditory evoked response (BAER) on petitioner which was normal. The waveforms were well-developed bilaterally and all absolute and interpeak latencies were within normal limits. Med. recs. at Ex. 6, p. 352.

On June 3, 2002, petitioner saw Dr. Campbell. She reported continued body tremors. She had them most of the night while lying still. They started before she began Paxil. Klonopin helped the tremors. She continued having tingling in the bottoms of her feet. She had continued muscle and joint aches. She reported her lower back and legs constantly ached and she had joint pain in her knees, elbows, and wrist which came and went. She had continued fatigue. She had bouts of intermittent itching, with changes in the area of itching. She had such severe itching that it caused bruising. She had headaches which occurred three to four times a week and a lot of

tension in her neck and shoulders. She had nasal drainage, frequent sore throats, dry eyes, blurred vision, short term memory loss, foggy head, and a feeling of unbalance. Klonopin helped with these symptoms. She had frequent difficulty with word recall. She had continued ringing in her ears. Med. recs. at Ex. 6, p. 390.

On July 24, 2002, petitioner telephoned Dr. Campbell to report an increase in dizziness, tingling and cramping in all extremities, especially the left leg. Med. recs. at Ex. 6, p. 399. The symptoms were the worst in the morning. *Id.*

On July 31, 2002, petitioner telephoned Dr. Campbell to report dizziness, but a decrease in leg cramping since starting a vitamin and mineral supplement. *Id.*

On August 2, 2002, Dr. Campbell diagnosed petitioner with abdominal pain, abnormal involuntary muscle movement, allergies, anxiety, arthralgia/joint pain, blurred vision, fatigue, generalized pain, headache, hepatitis B vaccine reaction, memory loss, numbness/tingling, severe muscular weakness, and vertigo/dizziness. He charged her $4,024.00 for the visit. Med. recs. at Ex. 6, p. 393.

DISCUSSION

Although petitioner asserts that hepatitis B caused her neurological symptoms (including, but not limited to tingling and numbness in her extremities), fatigue, joint pain, and possible fibromyalgia (see petitioner's Response to Order of February 8, 2007, filed March 8, 2007), the neurologists petitioner saw did not diagnose her with any neurological disease. All of her tests, including MRIs, EMGs, nerve conduction studies, physical examinations (but not Dr. Campbell's examinations), sensory evoked potentials, and BAERS have been normal.

Moreover, petitioner has been complaining of fatigue, joint pain, numbness, tingling, and headaches for years before she received the vaccinations at issue. She has repeatedly dated her symptoms to high school. Although Dr. Campbell diagnosed petitioner with CIDP, he diagnoses every vaccinee who comes to him with CIDP. He is not board-certified in neurology. He is not board-certified in immunology. He went to medical school in Mexico. But, his lack of neurologic training does not impede his recommendation to each vaccinee that the vaccinee receive IVIG. This case does not concern a demyelinating disease, regardless of Dr. Campbell's diagnosis.

Because this case does not deal with a demyelinating disease, the holdings of the Omnibus proceedings concerning hepatitis B vaccine and demyelinating diseases do not apply to it. Moreover, since petitioner was complaining about joint pain, lightheadedness, blurry vision, headaches, and leg numbness years before she received hepatitis A and B vaccinations, the undersigned assumes she is alleging that these vaccinations significantly aggravated these conditions. Petitioner was diagnosed with fibromyalgia in 1993, five years before her hepatitis A and B vaccinations. The undersigned assumes petitioner is also alleging that the vaccinations significantly worsened her fibromyalgia. Underlying all of these complaints are longstanding diagnoses of anxiety neurosis (since 1987) and somatization.

Section 300aa-33(4) defines "significant aggravation" as "any change for the worse in a preexisting condition which results in markedly greater disability, pain, or illness accompanied by substantial deterioration of health." Petitioner's pre-vaccination symptoms are identical to her post-vaccination symptoms.

The undersigned does not believe that petitioner will find a medical expert to opine that hepatitis A vaccine and/or hepatitis B vaccine significantly aggravated her pre-vaccination headaches, numbness, tingling, joint pain, fibromyalgia, headaches and anxiety neurosis. The petitioner is ORDERED TO SHOW CAUSE by **June 15, 2007** why this case should not be dismissed.

IT IS SO ORDERED.

April 27, 2007
DATE

s/ Laura D. Millman
Laura D. Millman
Special Master