In the United States Court of Federal Claims

OFFICE OF SPECIAL MASTERS
No. 07-303V
November 23, 2009
To be Published

BRETT GLASSBERG,	*	
	*	
Petitioner,	*	
	*	
v.	*	Entitlement; influenza vaccine and CIDP; onset
	*	
SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,	*	
	*	
Respondent.	*	

Thomas P. Gallagher, Somers Point, NJ, for petitioner.
Heather L. Pearlman, Washington, DC, for respondent.

MILLMAN, Special Master

RULING ON ENTITLEMENT[1]

Petitioner[2] Brett Glassberg (hereinafter, "Brett") sues under the National Childhood Vaccine Injury Act, 42 U.S.C. §300aa-10 et seq., alleging that an influenza (flu) vaccination caused his chronic inflammatory demyelinating polyneuropathy (CIDP).

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[1] Vaccine Rule 18(b) states that all decisions of the special masters will be made available to the public unless they contain trade secrets or commercial or financial information that is privileged and confidential, or medical or similar information whose disclosure would clearly be an unwarranted invasion of privacy. When such a decision, petitioner has 14 days to identify and move to delete such information prior to the document's disclosure. If the special master, upon review, agrees that the identified material fits within the banned categories listed above, the special master shall delete such material from public access.

[2] Initially, the current petitioner's mother Dr. Beth Pletcher was petitioner, filing the petition on May 15, 2007. When Mr. Glassberg reached his majority, he became the named petitioner on the granting of petitioner's oral motion on May 20, 2009.

A hearing was held on May 27, 2009. Testifying for petitioner were petitioner's mother, Dr. Beth Pletcher, petitioner, and Dr. Marcel Kinsbourne, a pediatric neurologist. Testifying for respondent was Dr. John T. MacDonald, a pediatric neurologist. The sole issue was whether onset was within six weeks (around Christmas 1998) or 75 days (January 30, 1999).

FACTS

Brett was born on April 20, 1990.

On November 16, 1998, at the age of eight, he received flu vaccine.

On May 27, 1999, Dr. Zachary Simmons wrote that the onset of Brett's CIDP was January 30, 1999 when his parents noticed he had weakness of his hands and wrists. Ex. 2, p. 1. (That would put onset 75 days after his flu vaccination.)

Other Submissions

Petitioner filed an article entitled "An Epidemiologic and Clinical Evaluation of Guillain-Barré Syndrome Reported in Association with the Administration of Swine Influenza Vaccines" by A.D. Langmuir, et al., 119 *Amer J Epidem* 6:841-79 (1984), as Exhibit 23 (also filed as Exhibit 38). The authors analyzed data from GBS patients who had received swine flu vaccine compared to GBS patients who had not, and found an eight-week period for a relationship to the vaccine.

Petitioner filed an article entitled "Clinicopathological features of chronic inflammatory demyelinating polyradiculoneuropathy in childhood" by N. Hattori, et al., *J Neur Sci* 154:66-71 (1998), as Exhibit 28. The authors followed 10 children who had CIDP, six with a subacute progression for up to two months after onset and four with a chronic insidious progression for more than three months. *Id.* at 70. The level of cerebrospinal fluid (CSF) protein ranged from

27 mg/dl to 240 mg/dl elevating over 35 mg/dl in eight cases. *Id.* at 68. They found corticosteroids more effective in patients with a subacute progression in the initial phase than for those with a longstanding insidious chronic progression. *Id.* at 70. They describe another study with patients whose initial progression took from four to eight weeks, designated as subacute inflammatory demyelinating polyradiculoneuropathy or SIDP. *Id.*

Petitioner filed an article entitled “”The Guillain-Barré Syndrome and the 1992-1993 and 1993-1994 Influenza Vaccines” by T. Lasky, et al., 25 *NEJM* 339:1797-1802 (1998), as Exhibit 31. (This is also respondent’s Exhibit F.) The authors found a causal relationship of GBS with flu vaccine within six weeks of vaccination.

Petitioner filed an article entitled “Guillain-Barre Syndrome Following Vaccination in the National Influenza Immunization Program, United States, 1976-1977" by L.B. Schonberger, et al., 2 *Amer J Epidem* 110:105-23 (1979), as Exhibit 39. The period of risk for GBS following swine flu vaccine was nine or 10 weeks.

Respondent filed an article entitled “Review. Chronic inflammatory demyelinating polyneuropathy” by F. Said, *Neuromuscular Disorders* 16:293-303 (2006), as Exhibit E. Said states that CIDP’s “clinical presentation and course are extremely variable.” *Id.* at 293. He states a preceding vaccination or infection has been observed within six weeks of onset, obtaining a history of vaccination in 32% of their patients. *Id.* at 294. Although an elevation in CSF protein has been regarded as a mandatory criterion of CIDP diagnosis, in Said’s series, 14% of patients had a normal CSF protein. *Id.* Said cites another series in which the CSF protein content was normal in half the patients. *Id.*

Respondent filed an article entitled "Guillain-Barre syndrome after vaccination in United States. A report from the CDC/FDA Vaccine Adverse Event Reporting System" by N. Souaya, et al., *Vaccine* 25:5253-55 (2007), as Exhibit G. The authors found an association within six weeks.

Respondent filed an excerpt from chapter 37 entitled "Neuromuscular disease" by G.M. Fenichel, et al., from the text The practice of pediatric neurology, vol. II, eds. K.F. Swaiman and F.S, Wright (1975), as Exhibit J. Fenichel states in a section devoted to GBS that elevated CSF protein occurs in all patients some time during the illness. *Id.* at 4. He also states that the protein elevation is usually maximal during the second week of the GBS but may rise for several weeks and then return to normal over a period of months. *Id.*

TESTIMONY

Dr. Beth Pletcher, Brett's mother, testified first for petitioner. Tr. at 4. She is a pediatrician and geneticist. Tr. at 5. On January 30, 1999, Brett's violin teacher came running out of the music lesson room, saying something was terribly wrong with Brett because he kept dropping his bow and his hands were like noodles. Tr. at 8. Brett later told her that he had had some problems roller skating beforehand, but did not tell her at the time. Tr. at 10. He went roller skating in the beginning of January 1999. Tr. at 10-11.

Petitioner testified next on his own behalf. Tr. at 30. After the flu vaccination, before Christmas break, he had trouble with small objects and some loss of feeling. He did not think of mentioning it. Tr. at 32. These small objects were pencils and spoons. *Id.* In early January 1999, his nanny took her daughter, Brett, and Brett's little sister to the roller rink. Tr. at 33. He was a fairly good rollerblader. *Id.* On that day, he struggled to stay on his feet and to balance on

the rollerblades. He sat out a great deal of the time. *Id.* He was also slower at getting writing work done because he had difficulty holding a pencil. Tr. at 35. He would be up late at night working on homework. *Id.* He also had some loss of feeling in his hand. *Id.* He also had trouble turning pages. *Id.* He even had trouble fastening his velcro shoes. Tr. at 36. He had trouble negotiating stairs. *Id.* He remembers the problem with holding the pencil and other small objects occurred before Christmas because he can remember Christmas break. Tr. at 40.

When Brett saw a developmental doctor on January 8, 1999, he did not tell her anything about his problems. Tr. at 43.

Dr. Marcel Kinsbourne testified next for petitioner. Tr. at 49. He is a child neurologist. Tr. at 52. If the onset of petitioner's CIDP were 75 days, he would not testify that flu vaccine caused it. *Id.* He would only go as far out as 10 weeks or 70 days. *Id.* CIDP is a very insidious gradually increasing condition. Tr. at 53. Dr. Kinsbourne, relying on petitioner's and his mother's testimony, thinks that the onset was less than 10 weeks, and that the flu vaccination caused or triggered Brett's CIDP. Tr. at 54.

Dr. Kinsbourne stated that CIDP is a chronic form of Guillain-Barré syndrome (GBS). Tr. at 55. It is an immune-mediated neuropathy, demyelinating in most cases. *Id.* The onset of CIDP should take at least two months of increasing disability and symptomatology. *Id.* Brett had IVIG at some point when the condition was still worsening, cutting short the two months of development. Tr. at 55-56. The onset of Brett's CIDP sounds like December 20, 1998. Tr. at 57. The type of symptoms Brett described on the witness stand is consistent with CIDP. Tr. at 58.

Respondent's expert Dr. MacDonald pointed out in his report that Brett's cerebrospinal fluid (CSF) taken right after his Feb. 3, 1999 admission did not show the typical elevation of protein. Tr. at 60. In GBS and CIDP, in CSF, protein rises while white cells do not. This is called albuminocytological dissociation. *Id.* No further spinal tap was done and we do not know if the protein would have risen or did rise. *Id.* To Dr. MacDonald, that indicated that Brett was early in his syndrome because of the lack of protein level elevation. *Id.* But Dr. Kinsbourne stated that, in a minority of GBS and CIDP cases, there never is any elevation of protein level. *Id.* One of respondent's articles mentions that 16 percent of patients do not show this protein elevation, and refers to another article showing a higher percentage not showing the protein elevation. Tr. at 60-61. Without a second lumbar puncture, we do not have enough information to understand the significance of Brett's initial and only lumbar puncture protein finding. Tr. at 61.

In Brett's case, there is no other event to which one could attribute cause. Tr. at 62. Dr. Kinsbourne stated that had Brett not received the flu vaccine, he would not have had CIDP. Tr. at 63. There were no other triggers occurring in those 10 weeks. *Id.* CIDP is an autoimmune disease. Some aspect of the influenza vaccine antigen produces an attack on the myelin sheath of peripheral nerves. *Id.* One has to assume Brett must have some susceptibility to the antigen. One of the articles that respondent filed discusses a possible genetic susceptibility factor in CIDP. Dr. Kinsbourne stated, "By susceptibility factor one means some predisposition which then awaits a triggering factor to bring the disorder to a clinical level. I think this is what happened in Brett's case." Tr. at 64.

Dr. Kinsbourne testified that most GBS cases occur within the first four weeks or certainly within the first six weeks. Tr. at 71. However, articles written about the swine flu vaccine association with GBS in 1976 indicated a period of time of eight weeks (Langmuir) or even 10 weeks (Schonberger) after vaccination. *Id.* With CIDP and its indolence in developing, a longer interval is justified. Tr. at 73. It takes longer for the subclinical process to reach a clinical level than GBS. *Id.*

A typical onset interval for an immune-mediated neurologic injury is five to 42 days. Tr. at 75. This is a minimal estimate of time, not a maximal one. *Id.* It is also the classical time frame. Tr. at 77. He thinks a reasonable estimate is up to 10 weeks. *Id.* The bell curve indicates fewer cases at weeks six to seven. Tr. at 78. Both CIDP and GBS are immune-mediated demyelinating diseases. Tr. at 79. The time frames for acute diseases such as GBS do not have to be the same as for diseases like CIDP which have insidious or gradual onsets. Tr. at 79-80.

Dr. Kinsbourne placed Brett between a CIDP onset and a GBS onset. Tr. at 85. Brett's onset was shorter than a CIDP onset would typically be, but, on the other hand, it was not as acute and explosive as the more typical acute GBS is. *Id.* Dr. Kinsbourne adopts the 10-week limit from the Schonberger article (Exhibit 39), written in 1979. Tr. at 87. CIDP can occur in the absence of any known cause. Tr. at 89.

Dr. John MacDonald testified for respondent. Tr. at 93. He is a pediatric neurologist. *Id.* He agrees that Brett had CIDP. Tr. at 95. The cause is usually some provoking factor such as vaccination or illness. Tr. at 96. The cause triggers the immune system. *Id.* Dr. MacDonald's understanding is that individuals with CIDP may have an innate problem with

their T-cells that predisposes them to the chronic nature of the disorder although the acute presentation is still GBS. Tr. at 97. Dr. MacDonald agrees with the five- to 42-day (six-week) interval as the appropriate time between instigator and disease. Tr. at 98. He disagrees with the 10-week limit Dr. Kinsbourne accepts. *Id.* Anecdotal evidence or case reports discuss the 10-week limit, but Dr. MacDonald would rather stick to more classical studies. *Id.*

Dr. MacDonald stated that Brett's description of difficulty occurring in late December holding objects with difficulty rollerblading in early January and then the incident at the end of January with the violin bow was not the normal progression for CIDP. Tr. at 99. His reason is he expects GBS to be acute. *Id.* When Brett saw Dr. DeSouza on February 1, 1999, he had mild weakness and retained some reflexes in his upper extremity although they were absent in the lower extremities. Tr. at 102-03. Typically, all the reflexes are lost as weeks go by, indicating to Dr. MacDonald that Brett had a fairly recent onset. Tr. at 103, 104. Dr. MacDonald thinks that the onset of Brett's CIDP was a couple of weeks before his abnormal EMG done February 10, 1999 (maybe an onset of January 27, 1999). Tr. at 105-06.

Dr. MacDonald did not disagree with the standard definition of CIDP as having an indolent beginning over weeks if not months. Tr. at 107. The first two-month period is quite variable and there are cases where there is a slowly progressive pattern. Tr. at 108. Early in the disease, the protein in the cerebrospinal fluid is normal. Tr. at 113. If Brett's onset of CIDP were 10-12 weeks earlier than his spinal tap, Dr. MacDonald would have expected his protein to have been elevated and it was not. Tr. at 113-14. Dr. MacDonald does not believe that Brett's flu vaccine caused his CIDP because of the temporal interval between vaccination and onset. Tr.

at 114. If Brett's onset were before Christmas, which is within six weeks after vaccination, then he would accept there was causation. Tr. at 115.

On cross-examination, Dr. MacDonald was asked if he agreed with Said's article "Chronic Inflammatory Demyelinating Polyneuropathy" (Exhibit E), page 2, in which Said states that in 14 percent of CIDP cases, spinal fluid protein was normal. Tr. at 117-18. Dr. MacDonald's response is that Said does not say when they did the spinal taps. Tr. at 119. In Dr. MacDonald's experience, protein elevation depends on when you do the tap. *Id.* He quoted Swaiman's The practice of pediatric neurology, vol. II, "Neuromuscular disease," by Dr. Gerald Fenichel, page 961 (Exhibit J), stating that if the protein in the spinal fluid is normal, that probably reflects more the timing of the spinal tap. Tr. at 120. The authors state there is an elevation of CSF protein in all CIDP patients at some time during their illnesses. *Id.* The protein elevation is usually maximal during the second week of illness. But, it may rise for several weeks and then gradually return to normal over a period of months. *Id.*

The undersigned asked Dr. Kinsbourne how he put together Said's statement that 14% of CIDP patients had no rise in CSF protein with Dr. Fenichel's statement in Swaiman's text that all CIDP patients have an elevation in CSF protein. Tr. at 123-24. Dr. Kinsbourne said he would rely on Said because this was an empirical study whereas Dr. Fenichel did not give a reference for his point. Tr. at 124. Dr. MacDonald did not think Said and Fenichel were in conflict because the protein normally comes down over months. Tr. at 126. He said it makes sense that the protein rises after a few weeks and than in a few months comes down. Tr. at 126-27.

The following colloquy occurred:

> THE COURT: So are you saying that if Brett's onset of his CIDP were around Christmas, and if somebody had done a lumbar puncture at the time of the actual onset, assuming it was around Christmas, they would have seen an elevated protein, but that a couple of months later, or maybe six weeks later, when it was done after he was hospitalized it had already come down to normal?
> THE WITNESS: Yeah. That's what Dr. Fenichel's [sic[and that's our experience, that the up-phase is usually in the first weeks or two. It stays up for weeks, or occasionally a couple of months, and then it comes down. So if for some reason there had been a spinal tap at Christmas and you believe that was closer to the, well, we're saying onset then is November [sic] 30, I wouldn't have been surprised then that the spinal fluid protein had been elevated. If you for some reason choose to repeat it in February 10, it had been 16, now it's 40, so it's coming down to the normal range. That seems very consistent with Dr. Fenichel's article, and also with the report of the change in the spinal fluid protein with the chronic nature of the illness. So I see no incompatibility.

Tr. at 127-28.

DISCUSSION

This is a causation in fact case. To satisfy his burden of proving causation in fact, petitioner must offer "(1) a medical theory causally connecting the vaccination and the injury; (2) a logical sequence of cause and effect showing that the vaccination was the reason for the injury; and (3) a showing of a proximate temporal relationship between vaccination and injury." Althen v. Secretary of HHS, 418 F. 3d 1274, 1278 (Fed. Cir. 2005). In Althen, the Federal Circuit quoted its opinion in Grant v. Secretary of HHS, 956 F.2d 1144, 1148 (Fed. Cir. 1992):

> A persuasive medical theory is demonstrated by "proof of a logical sequence of cause and effect showing that the vaccination was the reason for the injury[,]" the logical sequence being supported by "reputable medical or scientific explanation[,]" *i.e.*, "evidence in the form of scientific studies or expert medical testimony[.]"

In Capizzano v. Secretary of HHS, 440 F.3d 1317, 1325 (Fed. Cir. 2006), the Federal Circuit said "we conclude that requiring either epidemiologic studies, rechallenge, the presence

of pathological markers or genetic disposition, or general acceptance in the scientific or medical communities to establish a logical sequence of cause and effect is contrary to what we said in Althen...."

Without more, "evidence showing an absence of other causes does not meet petitioners' affirmative duty to show actual or legal causation." Grant, supra, at 1149. Mere temporal association is not sufficient to prove causation in fact. *Id.* at 1148.

Petitioner must show not only that but for the vaccine, he would not have had CIDP, but also that the vaccine was a substantial factor in bringing about his CIDP. Shyface v. Secretary of HHS, 165 F.3d 1344, 1352 (Fed. Cir. 1999).

Close calls are to be resolved in favor of petitioners. Capizzano, supra, at *8; Althen, supra, at 1280. *See generally*, Knudsen v. Secretary of HHS, 35 F.3d 543, 551 (Fed. Cir. 1994).

The Federal Circuit stated in Althen, supra, at 1280, that "the purpose of the Vaccine Act's preponderance standard is to allow the finding of causation in a field bereft of complete and direct proof of how vaccines affect the human body."

As the Federal Circuit stated in Knudsen, supra, at 548, "Causation in fact under the Vaccine Act is thus based on the circumstances of the particular case, having no hard and fast *per se* scientific or medical rules." The undersigned's task is to determine medical probability based on the evidence before the undersigned in this particular case. Althen, supra, at1281 ("judging the merits of individual claims on a case-by-case basis").

The only issue in this case is onset. The medical records do not depict an onset earlier than 75 days after Brett's flu vaccination, which is too long for petitioner's expert Dr. Kinsbourne to agree to causation from the flu vaccine. But Brett's mother, who gave the

histories after the violin lesson difficulties of January 30, 1999, testified she was unaware that her eight-year-old son Brett was having gradually worsening difficulties for over a month. Considering that Brett's mother, a busy doctor, and his father, equally busy, were not with Brett and his younger sister, and that their nanny was around, it is not surprising that neither parent was aware of Brett's gradually developing problems. Brett was an active eight-year-old, practicing karate and soccer, with attention deficit disorder that already made doing his homework more time-consuming. That he did not reflect, as an older child might, that his difficulties with small instruments such as pencils before Christmas was something to report to his mother sounds like a normal child to the undersigned. That he did not tell his mother or father that he had to sit out the rollerblading in early January 1999 because he could not balance is consistent with his independent attitude. To the undersigned, Brett just sounds like a normal little boy who had some problems which he was not going to fuss about. He had had earlier problems in life from cerebral palsy and ADD.

On January 30, 1999, when Brett could not fasten his velcro shoes, his mother fastened them for him and hustled him off to his violin lesson. She thought he was just acting out by being late. It was his violin teacher who rushed from the practice room to alert her that something was wrong with Brett. Then the process of getting a correct diagnosis began.

The undersigned accepts Brett's testimony that the onset of his symptoms was around Christmas 1998, which is within six weeks after his flu vaccination, which both experts accept as being causally related to the flu vaccination.

Dr. MacDonald was concerned that Brett's lumbar puncture on February 10, 1999 which showed normal protein indicated that he was just beginning his CIDP. But he admitted that if

Brett's onset were around Christmas, which was six weeks before the LP, then Brett's protein level could have been elevated earlier and dropped to normal by the time of the February 10th LP. Studies show that either in 14% or in half of CIDP cases, there is no elevation of CSF protein.

As for Brett still retaining some of his upper extremity reflexes when he was diagnosed, both medical experts and the literature the parties filed agree that the pace and symptomatology of CIDP can vary greatly.

The undersigned does not agree with Dr. MacDonald's testimony that Brett's course was of the acute GBS type, even though Brett was initially diagnosed with GBS. With a gradual course of symptoms spreading out over six weeks, Brett had the classic picture of CIDP, the first word of which is "chronic." Dr. Kinsbourne thought Brett had a hybrid type of demyelinating illness, partly GBS and partly CIDP (which one author in the literature filed referred to as subacute inflammatory demyelinating polyradiculoneuropathy or SIDP). The distinction is not important for our purposes here.

Dr. MacDonald agreed that immunizations can cause CIDP and that, if Brett's onset were within six weeks of his flu vaccination, the vaccination caused it. Dr. Kinsbourne was in agreement. The undersigned holds that onset was around Christmas 1998, which is within six weeks of Brett's flu vaccination.

Petitioner has prevailed in proving that flu vaccine caused his CIDP and, but for the vaccination, he would not have had the CIDP. The experts have agreed on the first and second prongs of Althen, i.e., that vaccination can cause CIDP and, if onset in this case were within six weeks, flu vaccination did cause Brett's CIDP. There is no alternate factor which caused it.

Petitioner has proved the third prong of Althen that his onset of CIDP occurred within a medically appropriate time frame to conclude that flu vaccine caused his CIDP.

CONCLUSION

Petitioner is entitled to reasonable compensation. The undersigned hopes that the parties may reach an amicable settlement, and will convene a telephonic status conference soon to discuss how to proceed to resolve the issue of damages.

IT IS SO ORDERED.

November 23, 2009
DATE

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