OFFICE OF SPECIAL MASTERS
No. 99-546V
August 31, 2006
Not to be Published

DONALD H. SIMMONS, Petitioner, v. SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, Respondent.	*	Entitlement; hepatitis B vaccination; 9- to 15-month onset interval too long for causation; does not have CIDP; Dr. Andrew Campbell not trustworthy in test results, diagnosis, or opinion

Altom M. Maglio, Sarasota, FL, for petitioner.
Glenn A. MacLeod, Washington, DC, for respondent.

MILLMAN, **Special Master**

DECISION[1]

Petitioner filed a petition initially pro se, dated July 30, 1999, under the National Childhood Vaccine Injury Act, 42 U.S.C. §300aa-10 et seq., on his own behalf, alleging that hepatitis B vaccine administered on August 31, 1993 caused him symptoms of chronic fatigue

[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 is filed, 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.

syndrome (CFS), liver disorders, and immune disorders beginning in September 1993. Petitioner at ¶¶ 3, 4. Petitioner does not mention any further hepatitis B vaccinations in his petition.

FACTS

Petitioner was born on December 28, 1950.

Petitioner filed a page with a list of names and dates on Cooper Family Medical Center stationery. Med. recs. at Ex. 12, p. 300. Next to petitioner's name is the date August 31, 1993. In handwriting is another date, September 30, 1993. *Id.* Next to that is another handwritten note reflecting "3rd" and March 1994. There is no connection to hepatitis B vaccine mentioned on this record.

Petitioner's earliest dated medical record is August 1, 1995 when petitioner was admitted to Singing River Hospital for a laparoscopic cholecystectomy (gall bladder removal). Med. recs. at Ex. 1, p. 1. His admission history was that he had developed right upper quadrant pain and tenderness. He saw Dr. McKell who diagnosed gall bladder disease. Petitioner was unable to tolerate pizza and greasy foods, and he was tender in the right upper quadrant. Dr. William T. Avara discussed with petitioner that he probably had biliary tract disease. On physical examination, petitioner was well-nourished and well-developed in no acute distress. He was alert and oriented. His extremities were within normal limits and he was grossly intact neurologically. *Id.* In surgery, Dr. Avara not only took out petitioner's gall bladder, but also resected a callus or corn on his left great toe. Med. recs. at Ex. 1, p. 3. The pathology report of Dr. James L. Stith states chronic cholecystitis as well as laminated keratin consistent with clavus from left great toe. Med. recs. at Ex. 1, p. 4. Petitioner was discharged on August 1, 1995. He had done quite well. Med. recs. at Ex. 1, p. 5.

On October 19, 1995, petitioner went to Ocean Springs Hospital ER, complaining of headache, nausea, and photophobia. He stated he was taking it easy for two weeks. If he did anything to increase his heart rate, his head throbbed. He felt as if something had popped in his head when it first started. Med. recs. at Ex. 11, p. 256.

On October 25, 1995, petitioner returned to the Ocean Springs Hospital ER, complaining of a headache for one to two weeks. Med. recs. at Ex. 11, p. 257.

On November 16, 1995, petitioner was admitted to Ocean Springs Hospital. Petitioner complained of chest pain in the left precordial region with some involvement of the substernal region. In the ER, he was felt to have significant epigastric abdominal tenderness and pain, although he denied this to Dr. James A. Swenson when he met him the next day. Med. recs. at Ex. 11, p. 259. On admission, petitioner had a lipase level of 1300 and was admitted with a diagnosis of pancreatitis. The next morning, his lipase level was completely normal. He was admitted with an alcohol level of about 117. He denied a previous history of alcoholism. He was a heavy smoker and his mother had coronary artery disease. His past medical history included pancreatitis several years ago, and a cholecystectomy that summer for epigastric and abdominal pain. He was told his gallbladder was abnormal. He had headaches and chronic low back pain. *Id.*

On physical examination, he was healthy, well-developed, with epigastric tenderness that was gone the next morning. His admission lipase was 1306, alcohol level was 177, amylase 134. Liver enzymes were markedly elevated with alkaline phosphatase rising as high as 239, and SGPT high at 400-600. The alkaline phosphatase peaked at 309. ERCP confirmed markedly dilated bile duct. *Id.* He was evaluated neurologically for complaints of left hand numbness. He

also complained of chronic low back pain and leg pain. A lumbosacral spine x-ray showed some changes in the L4-5 disc space. Dr. Swenson diagnosed him with idiopathic pancreatitis, chronic hepatitis of uncertain etiology, hypertriglyceridemia (his triglyceride level was over 800). unexplained left hand numbness, and chronic low back pain. Petitioner was discharged November 24, 1995. Med. recs. at Ex. 11, p. 258.

On November 17, 1995, petitioner had a hepatitis A & B diagnostic profile performed. It was negative for hepatitis B surface antigen (which is normal). It was negative for anti-hepatitis B core antibody. It was negative in all other respects (including for hepatitis A antibody). Med. recs. at Ex. 8, p. 178. In a pancreatic panel dated November17, 1995, petitioner had an elevated lipase of 371 (normal being between 23 and 208). Med. recs. at Ex. 8, p. 197.

On the same date, petitioner had an MRI of his brain. His clinical history was acute pancreatitis. The MRI was normal except for sinusitis. Med. recs. at Ex. 8, p. 179. On November 18, 1995, petitioner's lipase level was normal at 52. Med. recs. at Ex. 8, p. 198. On November 21, 1995, the ERCP test showed the common bile duct to be dilated, but the pancreatic duct was normal. *Id.* A long cystic duct remnant was identified and the peripheral biliary radicals were slightly dilated. *Id.* A lipid A/B performed on November 28, 1995 showed triglycerides of 376. Med. recs. at Ex. 8, p. 180. A pathology report, dated November 29, 1995, showed multiple hyperplastic polyps. Med. recs. at Ex. 8, p. 181. An endoscopy on the same date showed multiple colon polyps. Med. recs. at Ex. 8, p. 182.

Mr. Simmons was admitted to Ocean Springs Hospital on November 29, 1995 under the care of Dr. James A. Swenson because of blood in his stool. He was recently hospitalized for

pancreatitis. On physical examination, he was well-developed and in no distress. His vital signs were normal. Med. recs. at Ex. 8, p. 183.

On December 6, 1995, petitioner had blood chemistries performed which showed elevations of his SGOT, SGPT, and SGTP. He had a positive antinuclear antibody (ANA) titer of 1:80 (normal being less than 1:40), whose pattern was speckled. Med. recs. at Ex. 8, pp. 184, 187.

On December 15, 1995, petitioner was at Ocean Springs Hospital, where he was diagnosed with chronic hepatitis of unclear etiology. Med. recs. at Ex. 11, p. 266. A liver biopsy showed fragments of liver with focal mild chronic portal inflammation and focal mild steatosis. Med. recs. at Ex. 8, p. 189. In the admission and history at Ocean Springs, Dr. Swenson states that petitioner's elevated liver enzyme panel was consistent with hepatocellular disease. His past history was pancreatitis, and chronically elevated liver enzymes for probably two years. Med. recs. at Ex. 8, p. 190. On physical examination, his vital signs were normal. His extremities had no edema. The impression was chronic hepatitis. Med. recs. at Ex. 8, p. 190.

On February 28, 1996, petitioner went to Singing River Hospital ER, complaining of severe muscle pain all over for three weeks. He had seen the doctor that day for pain medication which did not help. Med. recs. at Ex. 11, p. 270.

On March 6, 1996, petitioner saw Dr. J. Lee Harwell, complaining of sleep disturbance, with a suggestion of fibromyagia. Petitioner did not have any significant muscle tenderness. Med. recs. at Ex. 3, p. 113.

On March 15, 1996, petitioner saw Dr. Harwell, complaining of muscle aches. Petitioner's EMG was essentially negative. Med. recs. at Ex. 3, p. 107. On physical

examination, petitioner was in no acute distress. Dr. Harwell diagnosed myalgias most consistent with fibromyalgia. *Id.*

On April 16, 1996, petitioner saw Dr. Harwell, who diagnosed him with fibromyalgia and hyperlipidemia. Med. recs. at Ex. 3, p. 108. On August 9, 1996, Dr. Harwell diagnosed hyperlipidemia, gastroesophageal reflux, and fibromyalgia. He also filled out a form that petitioner's history was unremarkable for scuba diving. Med. recs. at Ex. 3, p. 110.

On October 24, 1996, Dr. Heather H. North, a rheumatologist, states in a letter to Dr. J. Lee Harwell that she saw petitioner who was diagnosed with fibromyalgia one year previously. Med. recs. at Ex. 7, p. 153. Dr. North quotes petitioner as follows:

> **He reports that he was in good health until he had to have a cholecystectomy** [removal of his gall bladder] **for acute cholecystitis in July of 1995.** After that he had some complications with elevated liver function tests and clinical jaundice. **He underwent some endoscopic procedure as well as a liver biopsy** and he reports that his liver function tests are falling back toward normal. **He feels** that [he] **did not ever recover fully from these hospitalizations**. **He developed diffuse aching and stiffness in his muscles. He has predominantly left sided joint pain; the joints involved are his left shoulder, left hip, and left knee. He has seen a rheumatologist in Mobile in consultation who ruled out inflammatory muscle disease.** ... [H]e did have a nerve conduction in March which revealed a mild left median distal latency. His EMG was essentially normal with possible borderline changes in a few muscles including the triceps. He **denies a history of injury one year ago** [1995] **or any other life stressors that might have precipitated his fibromyalgia.** [Emphasis added.]

Id.

Petitioner had two maternal aunts with fibromyalgia. Med. recs. at Ex. 7, p. 155. Petitioner reported he had increased pain lately in his legs, arms, and around his thorax, and his

muscles hurt everywhere. Med. recs. at Ex. 7, p. 153. On examination, petitioner's deep tendon reflexes were 1+ in the upper extremities, at the knees, and at the right ankle. Dr. North could not elicit a left ankle jerk. Med. recs. at Ex. 7, p. 156. Dr. North's impression was that petitioner had had a major change in his ability to function and sense of well-being since Fall 1995. *Id.*

On November 6, 1996, petitioner went to Dr. Harwell, complaining of pain all over. Med. recs. at Ex. 3, p. 111.

On January 30, 1997, petitioner had a lumbar spine x-ray which showed degenerative disc disease at L5-S1 with associated vacuum disc, mild degenerative disc disease at L4-5, and previous surgery in the pelvis and cholecystectomy. Med. recs. at Ex. 9, p. 218.

On February 10, 1997, petitioner saw Dr. Harwell, complaining that he was tender all over. He did not have any evidence of joint swelling, warmth, or redness. Med. recs. at Ex. 3, p. 112.

On March 4, 1997, petitioner had a lumbar MRI which showed mild, broad-based annulus bulge at L4-5 without evidence of nerve root compression. The L3 vertebral body showed a focus consistent with hemangioma (mass of blood vessels). Med. recs. at Ex. 9, p. 219.

On March 7, 1997, petitioner saw Dr. Harwell, complaining of easy fatiguability. Med. recs. at Ex. 3, p. 114. Dr. Harwell found no objective weakness in petitioner's muscles. *Id.*

On March 27, 1997, petitioner was admitted to Ocean Springs Hospital under the care of Dr. Harwell. Med. recs. at Ex. 3, p. 115. Petitioner had a history of pancreatitis, fibromyalgia, and fatigue. He stated he was in his usual state of health until March 26, 1997 evening when around 10:00 p.m., he had substernal/left pectoral chest pain radiating toward the left shoulder, with shortness of breath and diaphoresis. He took Tagamet and Rolaids without relief. The pain

lasted three to four hours. He went to the emergency room. Nitroglycerin relieved the pain. He had a recurrence of pain that day at noon without EKG changes. The pain was relieved with Maalox. He had no other complaints. *Id.*

Dr. Harwell recorded that petitioner had a history of pancreatitis secondary to biliary obstruction in November 1995. He had colonoscopic polypectomy for multiple polyps. He had a cholecystectomy and endoscopic sphincterotomy. Both his parents had coronary disease. Petitioner quit smoking in 1995 and occasionally used ethanol. *Id.* He was in no distress. *Id.* His affect was somewhat flat. Med. recs. at Ex. 3, p. 116. His EKG on admission and that day was unremarkable. *Id.* Dr. Harwell's impression was chest pain, differential including esophagitis, gastritis, pancreatitis, and angina. Because petitioner was on nonsteroidals, he was at risk for gastritis or esophagitis. He had elevated liver enzymes, most likely due to Zocor. He had significant hyperlipidemia, chronic fatigue, and fibromyalgia. *Id.*

On March 31, 1997, petitioner saw Dr. Harwell, complaining of muscle pain. Med. recs. at Ex. 3, p. 121. The examination of his muscles was unchanged. Med. recs. at Ex. 3, p. 122.

On April 9, 1997, petitioner saw Dr. North, complaining of losing his balance and choking on food over the last month or so. He continued to complain of diffuse pain and stiffness. He complained of intermittent diarrhea. On physical examination, his muscles were fairly tight, but petitioner did not have the tender points of fibromyalgia that day. In fact, he was not very tender at all to palpation. Sensation was intact throughout. His deep tendon reflexes were 2+ throughout. His muscular strength was fair and symmetric throughout. He did not have any synovitis. Med. recs. at Ex. 7, p. 165. Dr. North's impression was that petitioner experienced 18 months (onset would then be October 1995) of increased aching, diffuse pain,

and stiffness. Initially, this seemed to be fibromyalgia, but as time went on and his symptoms progressed, Dr. North doubted fibromyalgia was the only cause of petitioner's discomfort. She was concerned about a possible neuromuscular or neurologic etiology for his symptom complex. There was a large functional component to petitioner's illness. *Id.*

On April 24, 1997, petitioner saw Dr. Greg A. Redmann, a neurologist. Petitioner dated the onset of his symptoms to a gallbladder operation which he had two years previously (or 1995). Med. recs. at Ex. 9, p. 220. He complained of diffuse muscle weakness and muscle pain, which initially started in his legs, with arthralgias, and then developed into calf and thigh muscle pain, becoming generalized to his shoulders, arms, and trunk bilaterally. He had mild balance problems. His symptoms were worse in cold weather but not in the morning on awakening. He had no sensory symptoms except for diffuse myalgia-type pains. An MRI of the lumbar spine appeared normal except for mild degenerative joint disease. *Id.*

On physical examination, petitioner appeared slightly fatigued. Motor exam showed no drift. He was able to hold his arms lifted for about two minutes. Motor exam showed intact strength in his trapezius, deltoids, wrist, extensors, and finger extensors. He had intact strength in his iliopsoas, quadriceps and anterior tibialis bilaterally. Reflexes were 2 and symmetric in biceps, triceps, and brachioradialis. They were also 2 and symmetric at the knees and ankles. Finger-nose-finger was intact. He had a normal tandem gait and a negative Romberg. His normal gait showed a normal base. Med. recs. at Ex. 9, p. 221.

Dr. Redmann's impression was that petitioner had either chronic fatigue syndrome or myopathic type symptoms. He suggested petitioner take an EMG to rule out inflammatory myopathy. Med. recs. at Ex. 9, p. 222. An EEG performed on April 30, 1997 was normal.

Petitioner complained of memory loss and migraines. A prior EEG done in November 1995 was also normal. Med. recs. at Ex. 9, p. 224.

On April 30, 1997, testing done at Ocean Springs Hospital showed petitioner was nonreactive to hepatitis B surface antigen, hepatitis B surface antibody, and hepatitis B core antibody. He was also nonreactive to hepatitis A and C. Med. recs. at Ex. 3, p. 124; Ex. 9, p. 226.

On May 8, 1997, petitioner had an EMG which showed slightly increased amplitudes and polyphasics but normal duration. Med. recs. at Ex. 9, p. 233. Also on May 8, 1997, petitioner saw Dr. Redmann. The EMG showed no evidence of denervation. He had no evidence of myopathic type potentials. He did have mildly increased amplitudes between 300 and up to 600 microvolts with normal duration of motor unit action potentials. There was some mildly increased polyphasia. Dr. Redmann concluded these results were essentially normal. These included a normal EEG, normal liver panel, normal hepatitis screen, normal ANA, and normal anti-DNA. He concluded that petitioner most likely had chronic fatigue syndrome. Dr. Redmann thought it unlikely that petitioner had a motor neuron type of disorder because petitioner did not have the picture electromyographically that would be typical for it. Med. recs. at Ex. 9, p. 234.

On May 9, 1997, petitioner saw Dr. Harwell, who diagnosed irritable bowel in addition to fibromyalgia with chronic fatigue, and hyperlipidemia. Med. recs. at Ex 3, p. 125.

On May 19, 1997, Dr. North wrote that she had been seeing petitioner since October 1996 for diffuse pain, aching, stiffness, and poor sleep and that his symptoms began in the summer of

1995. Med. recs. at Ex. 7, p. 166. He had not only fibromyalgia but also chronic myofascial pain. *Id.*

On May 30, 1997, Dr. F. Steven Orleans, a gastroenterologist, wrote that petitioner had a history of a fatty liver, but his liver function tests were not totally normal. Med. recs. at Ex. 8, p. 208.

On June 4, 1997, petitioner filled out an application for disability retirement. In answer to the question when he first consulted a physician for his present illness, petitioner wrote December 1994.[2] Med. recs. at Ex. 12, p. 303.

On June 10, 1997, Dr. North filled out a Statement of Examining Physician for petitioner to apply for disability benefits under the Public Employees Retirement System of Mississippi. Dr. North stated on the form, under "History of Disability," that petitioner had a cholecystectomy in July 1995 for acute cholecystitis. This was followed by gradual development of aching and stiffness in his muscles diffusely. His cholecystectomy was complicated by elevated liver function tests and clinical jaundice by Mr. Simmons' report, which resolved. His muscular symptoms continued. He had poor sleep, elevated fatigue, and decreased mobility. Often, his symptoms flared, necessitating rest. His gait at these times was slow and stiff. He had difficulty with stairs and getting in and out of a car or chair. He was on medications to help control his symptoms, but he continued to have moderate to severe pain on a daily basis. His concentration was decreased. Neurologic evaluation was not revealing of any other etiology. EMG and nerve conduction tests were accomplished and essentially normal. Med. recs. at Ex. 7, p. 170. Under

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[2] Petitioner has not filed any medical records for the period 1990-July 31, 1995. The Vaccine Act, section 13(a)(1) does not permit the undersigned to rule for petitioner based solely on his assertions unsubstantiated by medical records or medical opinion.

"Diagnosis," Dr. North wrote chronic myofascial pain syndrome and fibromyalgia. Dr. North stated she considered petitioner's disability to be permanent because his symptoms had been present for two years (i.e., since 1995), and he had no lasting improvement with any treatment. Med. recs. at Ex. 7, p. 171.

On June 11, 1997, petitioner saw Dr. Redmann who said his symptoms had minimally improved. He complained of chronic fatigue. His EMG study did not show evidence of a primary myopathy although he had mild increase in amplitude and polyphasics. On physical examination, petitioner seemed upset, but well-developed. His strength was essentially intact. His reflexes were 2 and symmetric. Dr. Redmann's impression was petitioner had possible chronic fatigue syndrome. Med. recs. at Ex. 9, p. 235.

On June 26, 1997, petitioner had an abdominal ultrasound which showed fatty infiltration of the liver, previous cholecystectomy, dilatation of the common bile duct measuring about 10 mm., slightly larger than the previous examination of March 29, 1996, and a cortical mass in the upper pole of the left kidney. Med. recs. at Ex. 8, p. 209.

On July 2, 1997, petitioner saw Dr. North. Petitioner and his wife reported he had increased pain, and decreased mobility and strength. He had not had any joint swelling. On physical examination, there was no warmth or erythema to the joints or obvious swelling. His muscle bulk was unchanged. His muscle strength was intact 4+/5 throughout. His reflexes were 2 to 3+/4 throughout. Petitioner had not had any abnormal labs to suggest inflammatory disease. Dr. North stated petitioner was unchanged since his last visit. Med. recs. at Ex. 7, p. 172.

On July 10, 1997, petitioner had a nuclear medicine bone scan. Dr. Barret P. Young noted symmetrical arthritis in the acromioclavicular joints, elbows, wrists, knees, and ankles. Petitioner

also had posterior bowing of the left mid-tibia with increased activity in the mid-tibia, probably representing a healed or healing fracture. Med. recs. at Ex. 3, p. 129.

On July 21, 1997, petitioner saw Dr. Redmann. He was taking up to 60 pills of Paxil daily. He still felt somewhat tired although also somewhat better. Dr. Redmann conferred with Dr. McKinley who concurred on the diagnosis of chronic fatigue syndrome and recommended increasing petitioner's Prozac. Petitioner's bone scan showed symmetric osteoarthritic changes at the acromioclavicular area and an old healing fracture on the left tibia. He continued to complain of arthritic pains in his joints, particularly his right elbow and back and shoulders. On physical examination, petitioner was well-developed and in no apparent distress. His right elbow had mild tenderness to range of motion movement. He did not have frank erythema, swelling, or tenderness. His reflexes were 2 and symmetric. Dr. Redmann's conclusion was chronic fatigue syndrome. Med. recs. at Ex. 9, p. 238.

On July 24, 1997, petitioner had a CT scan of his abdomen. Dr. Jeffrey L. Sauls noted status post-cholecystectomy, mild dilatation of the common bile duct without demonstration of abnormality of the pancreatic head, and a small, irregular mass within the upper pole of the left kidney which enhanced post-contrast administration. Possible etiologies were renal cell carcinoma and angio-myolipoma. Petitioner also had a small round mass within the upper pole of the right kidney seen only on the post-contrast examination. Med. recs. at Ex. 3, p. 128.

On July 25, 1997, petitioner saw Dr. Orleans who noted he continued to have a fatty liver. The ultrasounds showed a question of some masses in the kidney. Med. recs. at Ex. 8, p. 213.

On August 5, 1997, petitioner saw Dr. Frances Selman. On physical examination, he was well-developed, seemingly chronically depressed, but in no acute distress. He walked with a

cane. Dr. Selman was not really sure exactly why but petitioner told her it was related to his chronic fatigue syndrome. His extremities initially had some limitation of motion on exam, but when Dr. Selman asked him to move about, he did so reasonably well. He was grossly intact bilaterally neurologically. Med. recs. at Ex. 10, p. 250. Dr. Selman's impression was that he was taking duplications of his medicines and had to cut down. Dr. Harwell agreed. Med. recs. at Ex. 10, p. 251.

On August 7, 1997, petitioner had a bilateral renal sonography. Med. recs. at Ex. 10, p. 253. Dr. Charles P. Stroble stated petitioner had a normal left kidney and a right upper pole nodular lesion. Med. recs. at Ex. 10, p. 254.

Also, on August 7, 1997, petitioner saw Dr. Harwell. Petitioner's joints seemed somewhat stiffer. He had some difficulty flexing his digits. The rest of his exam was unchanged. Med. recs. at Ex. 3, p. 131. Dr. Harwell diagnosed hyperlipedemia, possible polyarthritis rather than fibromyalgia due to the results of the bone scan, a possible renal mass, and gastrointestinal problems. *Id.*

On August 8, 1997, Dr. Selman telephoned Dr. Harwell. She states in her records: "This is a perplexing case of a gentleman who has very little in the way of objective findings for a disease and the fibromyalgia seems to be the central diagnosis rendered by Dr. Heather North and very little else." *Id.*

On August 12, 1997, Dr. Selman telephoned petitioner and told him that the x-rays showed no malignancy or renal mass. He really did not need to come back in six months. *Id.*

On September 2, 1997, petitioner told Dr. Redmann that he did not feel therapy had improved his condition and that he was always in pain. The pain medications were not working.

He was concerned about muscle twitching. Med. recs. at Ex. 9, p. 241. Petitioner described recurrent pain in the posterior calf bilaterally. Med. recs. at Ex. 9, p. 242. On physical examination, petitioner was well-developed and slightly sad, but in no apparent distress. He had no tenderness to range of movement activities, including straight leg raise, pronation, and extension of his arms. His reflexes were 2 and symmetric in all four extremities. Dr. Redmann's impression was that petitioner appeared "to present with chronic fatigue syndrome type of complaint, without any bonafide basis." *Id.* Petitioner complained of insomnia. *Id.*

On September 9, 1997, petitioner went to the Ocean Springs Hospital ER, complaining of pain all over. Med. recs. at Ex. 3, p. 133. He stated that his legs, head, arms, back, and neck hurt. He stated he had fibromyalgia syndrome that had been worked up for years and doctors never found the actual cause associated with irritable bowel syndrome. Petitioner's physical examination was completely unremarkable except that he appeared uncomfortable. Dr. Patrick Booth saw no focal findings other than multiple trigger point tenderness. Petitioner had no joint swelling, rash, or redness. Petitioner's vital signs appeared normal. His pulse was in the 70's and Dr. Booth noted that he would expect a little bit higher response if petitioner were actually having the degree of pain he related. *Id.*

On September 10, 1997, petitioner complained to Dr. Redmann that he went to physical therapy two days previously and had been hurting all over his body since then. He went to the hospital emergency room on Friday night with headache and received an injection for pain. Med. recs. at Ex. 9, p. 245.

On October 14, 1997, petitioner stated he had to use a wheelchair occasionally due to pain in his legs. He had rested well the prior two nights. Med. recs. at Ex. 9, p. 246. Dr. Jeffrey

T. Laseter had been giving him pain treatment. Med. recs. at Ex. 9, p. 247. Petitioner again complained of pain in his hips, knees, and ankles. This was worse in the morning. It was occasionally so disabling that he had difficulty walking. On physical examination, petitioner was slightly tired and very depressed. He was not in apparent distress. He had full strength in neck flexors and extensors. He had no drift on straight arm test. His extraocular movements were intact. Petitioner was able to hold his hands out for about two minutes. Reflexes were symmetric in all four extremities. He had intact strength in his wrist and finger extensors. Dr. Redmann's impression was chronic fatigue syndrome with a possible superimposed arthritic complaint. He agreed with Dr. Laseter's treatment of Amphetamines. Since petitioner's work-up had been negative to date, Dr. Redmann recommended treatment of symptoms as Dr. Laseter recommended. *Id.*

On October 31, 1997, petitioner saw Dr. Orleans. He still had a fatty liver. He also had irritable bowel syndrome. Some stones were removed in 1995. Med. recs. at Ex. 8, p. 214. A liver panel study done on November 4, 1997 showed a normal SGOT and a mildly elevated SGPT of 61 (the normal range being 7-56). Med. recs. at Ex. 8, p. 215. A biliary scan on November 4, 1997 showed a normal bile duct and liver. Med. recs. at Ex. 8, p. 217.

On November 21, 1997, petitioner saw Dr. Orleans. He still had a fatty liver and irritable bowel syndrome. He did not have any stones. Med. recs. at Ex. 8, p. 216.

On November 24, 1997, petitioner saw Dr. Laseter with chronic fatigue syndrome and arthritic pain. Med. recs. at Ex. 4, p. 139. He stated his whole body was in pain, mainly in his joints. He also had migraine headaches. Ritalin resulted in a 10% decrease in his chronic fatigue. Petitioner had diffuse and exquisite tenderness around the right elbow and bilateral

wrists. Sensory was intact to light touch and pinprick. Motor was intact. He was starting to develop some weakness of his biceps and triceps. Bilaterally, they were 4/5. Otherwise, he had 5/5 strength in all groups. *Id.* Dr. Laseter commented in a note dated December 11, 1997 that petitioner had a non-reactive hepatitis profile. Med. recs. at Ex. 4, p. 140.

On January 5, 1998, petitioner told Dr. Redmann he was depressed through Christmas and New Year. Ritalin helped his chronic fatigue, but he was still in severe pain. His wife had to help him out of bed. He had to take pain medications before getting out of bed. He could not pick up heavy items because he had no strength and because of severe pain. Cold and wet days were his worst. He wanted a letter to help him get Social Security. He put a lift in his left shoe because his left leg was shorter than his right leg. Med. recs. at Ex. 9, p. 248.

On February 2, 1998, petitioner told Dr. Redmann he was unchanged since his last visit. Dr. Laseter agreed with Dr. Redmann's suggestion of having a muscle biopsy done. Med. recs. at Ex. 9, p. 249.

On February 4, 1998, petitioner saw Dr. John J. McCloskey, a neurosurgeon, giving a history that petitioner was well until about four years previously (or about 1994) when he developed pancreatitis and gastrointestinal problems. He ended up having a cholecystectomy and a liver biopsy. He continued to have difficulties. About two years previously (about 1996), petitioner developed muscle pain and stiffness which had progressed and he had developed numbness and tingling in his fingers, as well as carpal tunnel syndrome. Med. recs. at Ex. 5, p. 142. On examination, petitioner looked chronically ill. His muscles were firm and tender. His arms and legs were functional. His knee reflexes were present and his plantar response

downgoing. Dr. McCloskey suspected myopathy and diagnosed chronic fatigue syndrome and gastrointestinal problems. *Id.*

On February 9, 1998, Dr. Donald E. Dore did a pathologic analysis of a muscle biopsy of petitioner's right quadriceps. There was no inflammation. Dr. Dore diagnosed myofiber atrophy with Type II myofiber predominance.[3] Med. recs. at Ex. 5, p. 145. Dr. Dore stated the changes seen in the biopsy suggested neurogenic atrophy. *Id.*

On February 10, 1998, Dr. Selman wanted to follow up with the bilateral superior pole renal masses. Petitioner's physical examination was not otherwise unusual. Med. recs. at Ex. 10. p. 252. On February 16, 1998, petitioner had an abdominal CT scan which showed a small mass within the anterior aspect of the upper pole of the right kidney, unchanged since August 7, 1997. Med. recs. at Ex. 10, p. 255.

On February 17, 1998, petitioner saw Dr. Harwell, complaining of weakness and fatigue. Med. recs at Ex. 3, p. 134. Dr. Harwell assessed tobacco use, hyperlipidemia, weakness, and fatigue. *Id.*

On February 26, 1998, Dr. McCloskey sent a letter to petitioner, telling him that his muscle biopsy showed neurogenic atrophy. Med. recs. at Ex. 5, p. 146. Also, on February 26, 1998, Dr. Selman telephoned petitioner and told him that the results of his last CT scan showed his upper pole right renal mass unchanged. Med. recs. at Ex. 10, p. 252.

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[3] "Immobilization or disuse of muscle causes atrophy of type 2 fibers. Type 2 fiber atrophy is also seen with prolonged use of corticosteroids (steroid myopathy) and in polymyalgia rheumatica." http://neuropathology.neoucom.edu/chapter13/chapter13bDenervation.html

On March 2, 1998, petitioner saw Dr. Terry J. Millette, a neurologist and neuro-ophthalmologist. Med. recs. at Ex. 6, p. 150. Petitioner had apparently had myalgias in his arms and legs over the last two years (or since 1996). Petitioner complained that, over the last 18 months, he felt subjectively weak globally and had been using a cane for about six months. He had some tingling in his hands. *Id.* Dr. Millette examined petitioner and found he had normal tone and power on motor examination and his sensory examination was intact to light touch. *Id.* Petitioner's deep tendon reflexes were symmetric. Med. recs. at Ex. 7, p. 151. His cerebellar examination revealed normal gait with no appendicular ataxia. Dr. Millette's impression was myalgias with subjective weakness. *Id.*

On November 3, 1998, Dr. Millette described petitioner as having a symptom complex whose etiology was somewhat inscrutable. He primarily complained of muscular pain with some arthralgias. Dr. Millette could not detect any obvious weakness on physical examination. Petitioner did not have any abnormal reflexes. Dr. Millette diagnosed petitioner with an obscure neurologic, neuromuscular syndrome. Med. recs. at Ex. 6, p. 149.

On September 2, 1998, petitioner saw Dr. Harwell with poorly controlled depression, hyperlipidemia, a mild contusion of his left elbow, and chronic pain secondary to a poorly-defined myopathic illness. Med. recs. at Ex. 3, p. 135.

On April 28, 1999, five and six years after his alleged hepatitis B vaccinations, petitioner saw Dr. Andrew W. Campbell, telling Dr. Campbell that after his first hepatitis B vaccination on August 31, 1993, he started feeling ill with nausea and vomiting which he felt led to a cholecystectomy (removal of his gall bladder) in 1995. He had different gastrointestinal problems and problems with his bile duct after the vaccination. He had liver problems and

elevated liver enzymes which necessitated a liver biopsy in 1996 that showed fatty degeneration of the liver. In September 1993, he received his second hepatitis B vaccination which worsened his symptoms so that he had a mixture of chronic fatigue, joint pains, and muscle pains. He was diagnosed with fibromyalgia in 1997. He had a nerve biopsy on March 2, 1998 and was told he had myalgias with subjective weakness and neurogenic changes. He said he received his third hepatitis B vaccination in March 1994 and continued getting sick. He stated most of his problems were on the left side of his body. He had needle and pinprick sensations in his left hand. His vision deteriorated and was blurry. He had intermittent ringing in his ears and severe memory loss. Med. recs. at Ex. 2, p. 16 (filing of Feb. 6, 2001).

Petitioner told Dr. Campbell he had seen many doctors who could not figure out what was wrong with him. Med. recs. at Ex. 2, p. 17 (filing of Feb. 6, 2001). Petitioner complained of severe fatigue, usually made worse by physical exercise, for about four years (or since 1995) as well as severe muscle weakness and lower back pain. He stated he had memory disturbances and attention deficit disorder over the last four years (or since 1995). He complained he could not do calculations over the past four years (or since 1995). He complained of spatial disorientation and frequently saying the wrong word. He stated he had been depressed for the past three or four years (or since 1995 or 1996). He complained of headaches and changes in his visual acuity over the past four years (or since 1995) and photophobia. He complained of numbness or tingling on his left side for the last four years (or since 1995) and dysequilibrium for the past two years (or since 1997). He stated he had lightheadedness and feeling spaced out as well as having blackouts. He noted difficulty moving his tongue. He stated he had tinnitus since three or four years ago (or since 1995 or 1996). He complained of joint and muscle aches as well as muscle

twitches beginning four years ago (or since 1995). He noted recurrent flu-like illnesses often with chronic sore throat over the past four years (or since 1995). He stated he had abdominal pain, diarrhea, nausea, intestinal gas or irritable bowel syndrome, and frequent urination. He complained of low-grade fevers or feeling hot often over the past four years (or since 1995) in addition to night sweats. He noted frequent canker sores, rashes of herpes simplex or shingles for the last four years (or since 1995) and various other rashes. He stated he had hair loss starting within the last four years (or since 1995). He claimed he suffered from impotence for the past two years (or since 1997). He noted he had chest pains for the past four years (or since 1995). He had suffered from dry eyes and dry mouth for the past three to four years (or since 1995 or 1996). He had cold hands and feet as well as carpal tunnel syndrome for the last four years (or since 1995). He noticed he got out of breath too easily for the last four years (or since 1995). He noted these symptoms worsened with extreme temperatures. *Id.*

Dr. Campbell concluded that petitioner's symptoms began eight years previously (which would put onset in 1991 or two years before petitioner's first hepatitis B vaccination) with an increase in symptoms within the last four to five years (or 1994 or 1995). Dr. Campbell stated that petitioner has severe abnormalities on his nerve conduction studies, presumably his own testing since petitioner's prior nerve conduction studies (done by neurologists) did not show severe abnormalities. Unlike in petitioner's prior physical examinations, Dr. Campbell found petitioner's deep tendon reflexes abnormal and petitioner to have a complete loss of sensation to pinprick and vibration in all four extremities. Med. recs. at Ex. 2, p. 19 (filing of Feb. 6, 2001).

Dr. Campbell attributed petitioner's condition to delays in treatment due to inappropriate denial of medically necessary treatment by his health insurance company. *Id.* Dr. Campbell

stated that immune system testing showed immune dysregulation with significant abnormal antibody formation. Dr. Campbell also noted malnutrition on Spectra cell analysis. Mr. Simmons weighed 162 pounds. (In 1998, his height was 5'8". Med. recs. at Ex. 5, p. 142.) Dr. Campbell stated that petitioner's IgM and DHEA levels were decreased, his T and B cell functions were abnormal, and his NK cell activity decreased. His nerve conduction studies showed multiple abnormalities consistent with neurological damage. (Dr. Campbell is not a neurologist.) Med. recs. at Ex. 2, p. 20 (filing of Feb. 6, 2001.)

Dr. Campbell stated that petitioner's muscle pain, compatible with myaglia, began after receiving hepatitis B vaccine. Elevated muscle antibodies were isolated during serologic testing. Since petitioner did not have these problems prior to vaccination, and petitioner had neurologic damage following vaccination plus serologic abnormalities consistent with formation of antibodies similar to patients with adverse reactions to hepatitis B vaccine, which worsened after subsequent vaccinations, the hepatitis B vaccine caused his condition. Med. recs. at Ex. 2, pp. 23-24 (filing of Feb. 6, 2001). Dr. Campbell stated that petitioner had the immediate onset of his symptoms following his initial vaccination. Med. recs. at Ex. 2, p. 24 (filing of Feb. 6, 2001).

On January 20, 2002, Dr. North wrote a "To Whom It May Concern" letter, stating that petitioner's symptoms began following hepatitis B vaccinations beginning in August 1993. (No medical record that petitioner filed shows petitioner giving a history to Dr. North that his symptoms began following hepatitis B vaccinations beginning in August 1993.) Dr. North concluded that petitioner suffers from post-hepatitis B vaccine syndrome. Med. recs. at Ex. 4, p. 1 (filing of May 2002.)

On February 14, 2002, petitioner saw Dr. Richard T. Furr.[4] Petitioner stated he was in good health until about 1994 when he had to take hepatitis B vaccine. (Petitioner must have forgotten that his alleged first hepatitis B vaccination was August 31, 1993.) Following vaccination, his health went downhill and he had muscle pain and atrophy related to autoimmune antibodies induced by hepatitis B vaccine. He has fibromyalgia.

Dr. Furr stated we know very little about fibromyalgia and do not know its cause except we do know its cause in petitioner's case. Petitioner had definite demonstrable autoimmune antibodies and actual nerve conduction studies producing solid evidence of nerve dysfunction.

Dr. Furr stated that petitioner has a documented case of chronic inflammatory demyelinating polyneuropathy most likely precipitated by hepatitis B vaccine which he received in 1994. Dr. Furr stated there is no evidence that petitioner's serum has hepatitis B antibodies despite his receiving three hepatitis B vaccinations. His illness began in 1995 following vaccination in 1994. Med. recs. at Ex. 5, p. 2 (filing of May 7, 2002).

On October 23, 2002, petitioner saw Dr. Edward F. Aldridge of OnCall Medical Clinic of Ocean Springs. Med. recs. at p. 405 (filing of Aug. 9, 2004). Dr. Aldridge stated petitioner has CIDP, "a condition where the patient's immune system attacks its own body and causes demyelination of nerves." *Id.* According to petitioner's doctor in Houston (Dr. Aldridge must be referring to Dr. Campbell), petitioner's CIDP was caused by hepatitis B vaccine. Petitioner rated his pain as 7 out of 10. On physical examination, petitioner lifted his left and right legs straight

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[4] Dr. Furr was an internist and family practice physician. He closed his practice on July 1, 2006, after nearly 50 years. http://www.oceanspringsarchives.com/os_chronology.htm

and was negative for pain at 45 degrees. On bringing the right leg down, he had pain in his lateral left hip. Med. recs. at p. 406. There was minimal tenderness in the lumbar spine, thoracic spine, and cervical spine on palpation. His knee tendon and Achilles tendon reflexes were absent bilaterally. Dr. Aldridge diagnosed petitioner as having CIDP, myofascial neck and back pain, migraine headaches, chronic fatigue syndrome, and fatty liver. *Id.*

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 1274, 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. Hasler v. US, 718 F.2d 202, 205 (6th Cir. 1983), cert. denied, 469 U.S. 817 (1984).

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

In Gilbert v. Secretary of HHS, No. 04-455V, 2006 WL 1006612 (Fed. Cl. Spec. Mstr. Mar. 30, 2006), the undersigned ruled that hepatitis B vaccine can cause CIDP and did so in that case. The onset interval after Adam Gilbert's second hepatitis B vaccination was 21 days, a medically-appropriate temporal period for an immune reaction.

In this case, there are two problems: onset and diagnosis. In petitioner's application for retirement, he stated that the onset of his malady was December 1994. Petitioner alleges that his third hepatitis B vaccination occurred some time in March 1994 (although petitioner has not filed documentation for either his second or third hepatitis B vaccination, and the documentation for his first hepatitis B vaccination lists a date without any notation that the list of names is for receipt of hepatitis B vaccination.)

Assuming, arguendo, that petitioner did receive a third hepatitis B vaccination in March 1994, his claimed onset of symptoms in December 1994 is nine months later, far too long to be an appropriate temporal relationship for an immune adverse reaction. Petitioner has not provided any medical support from a medical doctor giving the basis for an opinion that hepatitis B vaccine can cause his malady nine months later.

Moreover, petitioner told Dr. Campbell and later Dr. North that his illness began after his initial hepatitis B vaccination which is presumably August 31, 1993. There is at least a 15-month

hiatus between August 31, 1993 and December 1994 when petitioner asserted the onset of his illness began when he applied for disability. Petitioner has not filed any medical opinion justifying causation from hepatitis B vaccination 15 months later. Petitioner's history to Dr. Campbell and Dr. North that his symptoms began after his initial hepatitis B vaccination is not credible because it conflicts with all his earlier histories which were contemporaneous with the onset of his symptoms.

The earliest medical record petitioner filed is dated August 1, 1995 when petitioner was going to have his gall bladder removed (cholecystectomy). If petitioner's symptoms actually began in December 1994, petitioner did not provide substantiating medical records for that period of time. In the August 1, 1995 hospitalization, petitioner did not give a history of symptoms of pain, achiness, or stiffness to the medical personnel at that hospitalization that preceded his visit to them.

The first medical record noting petitioner having pain is on February 28, 1996 when petitioner went to Singing River Hospital ER, complaining of severe muscle pain all over for three weeks. That would put onset of his pain in the first week of February 1996, or 11 months after his alleged third hepatitis B vaccination and two years and five months after his first hepatitis B vaccination on August 31, 1993.

On October 24, 1996, when petitioner saw Dr. North, a rheumatologist, he told her he was in good health until his cholecystectomy (which was August 1995, 17 months after his purported third hepatitis B vaccination and almost two years after his purported first hepatitis B vaccination). Dr. North must have forgotten this history when she wrote her "To Whom It May

Concern" letter in 2002 stating petitioner had symptoms immediately after receiving hepatitis B vaccine. Perhap she did not look at her records for October 24, 1996.

In 1997, when petitioner saw Dr. Redmann, a neurologist, he told the doctor that the onset of his symptoms occurred two years earlier (i.e., 1995) after his gall bladder was removed.

In 1998, when petitioner saw Dr. McCloskey, a neurosurgeon, he told him he was well until he developed pancreatitis and gastrointestinal problems about four years previously. He told Dr. McCloskey that about two years previously (i.e., 1996), petitioner developed muscle pain and stiffness which had progressed, and that he had developed numbness and tingling in his fingers, as well as carpal tunnel syndrome.

In 1998, when petitioner saw Dr. Millette, a neurologist, he told him he had had myalgias in his arms and legs over the prior two years (i.e., 1996). Dr. Millette could not detect any obvious weakness or abnormal reflexes on physical examination. Dr. Millette concluded petitioner had a symptom complex whose etiology was somewhat inscrutable.

Only when petitioner saw Dr. Campbell in 1999, the same year in which he filed his petition, did petitioner give a history of symptoms beginning soon after receipt of his first hepatitis B vaccination on August 31, 1993. Yet, in detailing all of his numerous symptoms, petitioner gave an onset of 1995 for most of them to Dr. Campbell, which is two years after his first hepatitis B vaccination. Those symptoms which petitioner stated to Dr. Campbell did not begin in 1995 began after 1995.

Dr. Campbell, who is not a neurologist, performed neurological and immune tests on petitioner and decided petitioner had CIDP caused by hepatitis B vaccine. The undersigned and her colleagues have seen Dr. Campbell appearing in numerous cases and he always gives

opinions that are contrary to those of the treating physicians in those cases. Dr. Campbell's opinions inevitably are that petitioners have neurologic illnesses, based on his own tests, even though petitioners' own neurologists have found them not to have neurologic illnesses and their test results have been normal. Dr. Campbell has a decided bias in concluding neurologic illness and vaccine causation. His opinion is untrustworthy and his test results and diagnoses not credible..

Dr. Furr, now retired after 50 years in practice in family medicine, alluded to Dr. Campbell's test results and opinion in stating petitioner has CIDP caused by hepatitis B vaccine. Dr. Furr was not a neurologist. Dr. Furr's opinion is no better than the basis (Dr. Campbell's opinion) on which he relies. Since Dr. Campbell is untrustworthy and his test results and diagnosis not credible, Dr. Furr's opinion similarly fails to provide appropriate evidentiary support for petitioner's allegations.

Dr. Aldredge relied on petitioner's history of pains and aches after hepatitis B vaccine and Dr. Campbell's test results and opinion in forming his own opinion that petitioner has CIDP caused by hepatitis B vaccine. Dr. Aldredge is not a neurologist. Dr. Aldredge's opinion is no better than the basis (Dr. Campbell's opinion) on which he relies. Since Dr. Campbell is untrustworthy and his test results and diagnosis not credible, Dr. Aldredge's opinion similarly fails to provide appropriate evidentiary support for petitioner's allegations.

The undersigned cannot accept the histories that petitioner gave later on to Dr. Campbell and others that the onset of his pain occurred directly after vaccination. Well-established case law holds that information in contemporary medical records is more believable than that produced years later at trial. United States v. United States Gypsum Co., 333 U.S. 364, 396

(1948); Burns v. Secretary, HHS, 3 F.3d 415 (Fed. Cir. 1993); Ware v. Secretary, HHS, 28 Fed. Cl. 716, 719 (1993); Estate of Arrowood v. Secretary, HHS, 28 Fed. Cl. 453 (1993); Murphy v. Secretary, HHS, 23 Cl. Ct. 726, 733 (1991), aff'd, 968 F.2d 1226 (Fed. Cir.), cert. denied sub nom. Murphy v. Sullivan, 113 S. Ct. 263 (1992); Montgomery Coca-Cola Bottling Co. v. United States, 615 F.2d 1318, 1328 (1980). Contemporaneous medical records are considered trustworthy because they contain information necessary to make diagnoses and determine appropriate treatment:

> Medical records, in general, warrant consideration as trustworthy evidence. The records contain information supplied to or by health professionals to facilitate diagnosis and treatment of medical conditions. With proper treatment hanging in the balance, accuracy has an extra premium. These records are also generally contemporaneous to the medical events.

Cucuras v. Secretary, HHS, 993 F.2d 1525, 1528 (Fed. Cir. 1993).

The undersigned relies upon the histories petitioner gave to Dr. North, Dr. Redmann, Dr. McCloskey, and Dr. Millette (as well as all the hospital personnel) before he saw Dr. Campbell in 1999 in determining the onset of his symptomatology. Presuming that petitioner had a third hepatitis B vaccination in March 1994, by petitioner's own admission in applying for disability, the onset of his symptoms occurred no sooner than nine months later.

Dr. Campbell did a series of tests purportedly showing that petitioner has autoimmune antibodies (contrary to all petitioner's prior tests with his reputable treating physicians) and that petitioner has CIDP (also contrary to petitioner's prior tests and diagnoses with his reputable treating neurologists). Dr. Campbell's test results and opinions are suspect not only because they directly contradict the test results and opinions of petitioner's treating neurologists, but also because his determination that petitioners must have vaccine injuries appears to be the

predominant motive for his diagnoses and test results. The undersigned questions Dr. Campbell's conclusions in diagnosing and treating his patients.[5] The undersigned has had occasion in the past to reject Dr. Campbell's opinion and does so now.

Dr. Redmann who is a neurologist never diagnosed petitioner with CIDP. Petitioner's nerve conduction tests and EMG were basically normal. In order to have CIDP, petitioner must have demyelination, but none of his nerve conduction tests showed demyelination.

A muscle biopsy of petitioner's quadriceps in 1998 showed myofiber atrophy with type 2 myofiber predominance (neurogenic atrophy). Immobilization or disuse of muscle can cause atrophy of type 2 fibers, and petitioner herein was using a wheelchair. Also overuse of steroids can cause type 2 fiber atrophy and petitioner herein has been on multiple, duplicative therapies, such that Dr. Selman had to inform his other doctors to cut back on his medication. Type 2 myofiber atrophy is not CIDP.

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[5] The Texas Medical Board has filed two complaints against Dr. Campbell of the Center for Immune and Toxic Disorders in Spring, TX, in the context of toxic mold injuries, charging Dr. Campbell with the following: operating below the standard of care, relying on unproven science when making a medical diagnosis, reaching medically unreasonable conclusions regarding a diagnosis that is not recognized or generally accepted in the medical and scientific community, ordering tests that are not appropriate, making medically and scientifically unsupported jumps in logical conclusions which betray a standard of care that is scientifically and medically unsound, making medically unsupported findings and conclusions of "abnormal neurological examination" based on incomplete examinations and failure to perform medically necessary diagnostic testing, making medically and unsupported findings and conclusions of "demyelinating polyneuropathy" without meeting the medical and diagnostic criteria required before arriving at such a diagnosis, ordering treatment without meeting the appropriate medical and diagnostic criteria, requesting payment at a higher level than warranted, and unprofessional conduct in double billing, all constituting grounds for the Board to revoke or suspend Dr. Campbell's Texas medical license. The Texas Medical Board accused Dr. Campbell of unprofessional and dishonorable conduct that was likely to deceive, defraud, or injure the public. See Second Amended Complaint, page 33, paragraph 5. Both the First Amended Complaint and the Second Amended Complaint are available at: http://www.casewatch.org/board/med/campbell/complaint.shtml.

Dr. Selman, Dr. Redmann, Dr. Booth, and Dr. Millette noted in their records that petitioner had very little objectively wrong with him. Dr. Redmann agreed with Dr. Laseter to treat petitioner symptomatically since, other than dealing with his subjective complaints, there was no objective illness to treat.

On June 30, 2006, the undersigned issued an Order to Show Cause by August 11, 2006 why this case should not be dismissed unless petitioner could provide an expert opinion from a neurologist that hepatitis B vaccine caused him to have symptomatology from nine to 15 months after vaccination, and that he has CIDP or some other illness from hepatitis B vaccine.

On August 10, 2006, petitioner made an oral motion for a 14-day extension of time to respond to the undersigned's Order to Show Cause. On August 11, 2006, the undersigned granted petitioner's motion and gave petitioner until August 25, 2006 to answer the Order to Show Cause.

On August 24, 2006, petitioner's counsel telephoned the undersigned's law clerk to inform her that petitioner wished to dismiss this case.

CONCLUSION

This petition is dismissed with prejudice. In the absence of a motion for review filed pursuant to RCFC, Appendix B, the clerk of the court is directed to enter judgment in accordance herewith.[6]

IT IS SO ORDERED.

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[6] Pursuant to Vaccine Rule 11(a), entry of judgment can be expedited by each party's filing a notice renouncing the right to seek review.

August 30, 2006
DATE

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