In the United States Court of Federal Claims

OFFICE OF SPECIAL MASTERS

No. 07-472V
Filed: June 26, 2009
NOT TO BE PUBLISHED

ANDREA HODGES,	)	
	)	
Petitioner,	)	
	)	Fact Ruling; Brachial Neuritis;
v.	)	Influenza Vaccine
	)	
SECRETARY OF	)	
HEALTH AND HUMAN SERVICES,	)	
	)	
Respondent.	)	
	)	

FACT RULING AND ORDER[1]

The initial issue presented in this case is a factual one, more specifically when did the symptoms of Ms. Hodges' brachial neuritis begin? To resolve this issue, a fact Hearing was conducted at which petitioner and her mother testified. As discussed with counsel following the Hearing and confirmed by an examination of the Record, the undersigned finds that the lay witness testimony was not credible. Thus, the factual predicate for any expert report and testimony is the medical records for Ms. Hodges.

A brief explanation of the undersigned's ruling follows. The explanation will not discuss each pertinent medical record, which are numerous, but will highlight the records related to the time period in question - October 2003 through January 2004.

Petitioner filed her Petition on June 29, 2007. She alleges that she suffered a post-vaccinal brachial neuritis resulting from a Trivalent Influenza vaccination given on October 29, 2003. Petition at para. 3. The alleged vaccination record was unsigned and undated. P Ex 3 at 1. Petitioner alleged and testified to the vaccination date of October 29, 2003.[2] Ms. Hodges was

[1] The undersigned intends to post this decision on the United States Court of Federal Claims's website, in accordance with the E-Government Act of 2002, Pub. L. No. 107-347, 116 Stat. 2899, 2913 (Dec. 17, 2002). As provided by Vaccine Rule 18(b), each party has 14 days within which to request redaction "of any information furnished by that party (1) that is trade secret or commercial or financial information and is privileged or confidential, or (2) that are medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of privacy." Vaccine Rule 18(b). Otherwise, the entire decision will be available to the public. Id.

[2] Significant issues were presented regarding the actual receipt and date of the flu immunization. While a close call, the undersigned finds that the testimony and various references to petitioner having received a flu

seen on November 19, 2003 for work exposure to epoxy dust. P Ex 9I at 5. The note states that she "Looks well. No distress." Id. The next medical record was from January 7, 2004. Id. at 6. The history states as follow:

> This 36 yr old female presents with these symptoms: Has a kink in her neck at xmas, and then came back, then started to get, chills and sick to stomach and feels ichy. Had a cold at Christmas time had sinus infection and took a zpac and took this, and got better. She now is complaining of the neck/left scapular pain and the left shoulder region, that she is unable to lift the left arm upward. It is sharp and stabbing pain and radiates to the shoulder and hand. Hurt to take a deep breath, but no sob noted.

Id. The duration was noted as "5" days. Id. at 7. It is noted that "She states she has had this before and gets a kink but normally resolves." Id.; see also id. at 8-10.

The next meaningful medical records concern a workers compensation claim filed by petitioner on March 16, 2004. In referring Ms. Hodges for a medical evaluation, the referring examiner gives the following history:

> Ms. Hodges admits to a history of seeking medical treatment for complaint of neck stiffness and pain. She denies any specific work related injury involving her left shoulder or neck. While on vacation in December 2003, she experienced increased left sided neck stiffness. While on vacation, she also developed flu-like symptoms and began to experience left shoulder and chest pain.

P Ex 9V at 508. The questionnaire Ms. Hodges filled out indicates "increasing stiffness neck shoulder - woke 12/23/03 couldn't move neck/Head." Id. at 513. The evaluating doctor, Dr. Zeller gives in pertinent part this history:

> She stated that while on vacation in December 2003, she started to get left-sided neck stiffness and pain into her shoulder. She does recall that she almost had flu like symptoms at that time, but she had a flu shot several weeks before that.

Id. at 502. Based upon this incorrect history of the timing of Ms. Hodges' flu shot - Dr. Zeller understood the shot to be given "several weeks" before, when the alleged shot was given two months prior, P Ex 3 at 1 - Dr. Zeller stated that the flu shot may have caused Ms. Hodges' medical issues. P Ex 9V at 506. Ms. Hodges' workers compensation claim was denied on May 12, 2004. P Ex 16 at 8. The denial includes the statement that "[t]he onset of your injury/illness occurred while you were on your Christmas vacation." Id. The claim form also includes the date of onset as "12/24/03." Id. at 9.

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immunization in the medical records support the finding that petitioner received a flu vaccine on October 29, 2003.

On March 22, 2004, Ms. Hodges was evaluated by Dr. Kenneth Wiesner for "possible chronic inflammatory demyelinating syndrome secondary to a flu vaccine." P Ex 12 at 1. The history given indicates the onset of symptoms following a flu vaccine given in 2002,[3] which included burning sensation in the chest, muscle tightness on the left side of petitioner's neck and shoulder and a very stiff neck. Id. These symptoms eventually resolved. However, "[i]n 2003, she unfortunately had another flu vaccine and this became associated with similar symptoms that did not go away and got progressively worse." Id. Based upon this history, Dr. Wiesner stated that "the vaccine is quite responsible for what is going on to her clinically." Id. at 2.

Petitioner saw Nurse Roque on May 5, 2004 and asked whether her problems were due to the flu vaccine received at work. P Ex 9IV at 460. Nurse Roque notes that she did not see a mention of the flu vaccine in petitioner's medical records. Id. She noted further that it was "questionably resultant" from the flu shot. Id. at 463. Petitioner was then seen by neurologist Dr. Stephen Knox on May 13, 2004. Notably in the history it states "[i]n the end of November about a month or so after a flu shot, she developed difficulties with her left arm and shoulder." P Ex 9IV at 407-08. This is the first reference in the contemporaneous medical records of the onset of symptoms in November of 2003.

It is not disputed that petitioner suffered "brachial plexus type symptoms" as of January 7, 2004. Tr at 3. The issue is when did the symptoms of petitioner's brachial plexus begin? The medical records, including histories given by petitioner herself to treating doctors, indicate that the symptoms began around Christmas of 2003. Petitioner, however, claims that the symptoms began shortly following the flu immunization and worsened to the point that "[b]y December 18th, the start of my Christmas vacation, I was unable to turn my head from side to side and had a difficult time getting in and out of bed and getting dressed." P Ex 19. Petitioner presented testimony of petitioner herself and her mother in support of her allegations of temporal onset with the flu vaccination. In short, the undersigned did not find the lay testimony persuasive or credible and finds the contemporaneous medical records far more reliable for the factual information in this case.

The first witness was Ms. Whitman, petitioner's mother. She testified to her frequent conversations with her daughter. Tr. at 6. Petitioner related that she received a flu shot and felt achy and hurt. Id. at 7. This conversation took place prior to a visit at Thanksgiving. Id. At Thanksgiving, the symptoms had progressed. Id. at 8. While cooking dinner, petitioner "could not do much with her left side" and had to lay down. Id. She experienced pain and symptoms throughout the visit. Id. at 9. Through continued conversations, Ms. Whitman testified that petitioner's symptoms worsened. Id. At Christmas, petitioner traveled to her domestic partner's family's house and was "sick during travel, sick when she got there, [and] had to go lay down at their home." Id. at 10. The symptoms worsened to the point that petitioner "couldn't function" and the symptoms "wiped out her holiday." Id.

[3] Petitioner testified that this information is incorrect. Tr. at 39-40. It is unnecessary to resolve the issue of the correctness of this medical record.

However, there are a number of significant reasons to discount Ms. Whitman's testimony. First, there is no mention of the Thanksgiving events in her affidavit. P Ex 21. Second, Ms Whitman, while explaining her memory of the events surrounding the 2003 flu immunization based upon her frequent telephonic communications with her daughter, was unaware of several other significant events. For example, she was unaware that petitioner received a flu vaccination in 2002, tr. at13, she could not recall when her daughter had surgery, id. at 17-18, and she was unaware that her daughter filed a Workers Compensation claim for exposure to epoxy dust. Id. at 22. These gaps in knowledge were despite talking "constantly" to her daughter. Id. at 24. Ms. Whitman's rather selective knowledge of her daughter's medical information does not make sense when viewed in isolation. Viewed in comparison to the contemporaneous medical records Ms. Whitman's testimony is found unreliable.

The second witness was petitioner, Ms. Hodges. She testified that she received the flu vaccine from her employer on October 29, 2003. Tr. at 43. She stated that she had an ache and feverish feeling in her arm for the next several days, and it never went away. Id. at 45. She stated that it would "recede" a little bit and then come back stronger. Id. She stated the stiff neck issues began close to Thanksgiving. Id. at 46. She thought it might be due to the flu shot, but did not go to the doctor. She explained that she was busy at work and with her freshman child who was active in sports and attributed the problem to a kink in the neck. Id. She explained that she did not tell the Workers Compensation doctors in November because that dealt with epoxy dust exposure and she "didn't think to tell" the doctor and "I wouldn't have confused the issues." Id. at 52. Ms. Hodges stated that her symptoms worsened after Thanksgiving. Id. at 54. However, she did not miss any days at work. Id. at 53. She described her Christmas trip which ended with her neck being so painful and stiff that she "literally could not even pick [her] head up off the bed." Id. at 56.

Ms. Hodges first saw a doctor upon her return from vacation. Her affidavit and testimony differ on the events surrounding this doctor's visit and her returning to work. Her affidavit states that she first called in to work sick on the day of her expected return, January 4, 2004, but was told that she had to come in due to a shortage of workers. P Ex 19. She states that after her bosses' firsthand observation of her condition, and after a short meeting, she was sent home. Id. She then called for a doctor's appointment, which she got for January 7. Her testimony was slightly different. She stated that when she returned home from vacation, "prior to the New Year," she called for a doctor's appointment and got the January 7 appointment. Tr. at 59. She then called in sick on the 4th, her scheduled return-date for work. Id. However, she was called into work, not because of a shortage of workers, but because her investigation team had to respond to a power outage. Id. at 59-60. She stated that she went into work for part of the day, "probably around 8:00 o'clock, attended the meeting, went to a lunch meeting and went home in mid-afternoon." Id. She added in her testimony that she was sent home because "you look terrible." Id.

The above summary discusses the relevant portions of the testimony regarding the issue of onset of Ms. Hodges' symptoms. There are many more medical records and testimony

regarding those records. However, it is not necessary to discuss them given the ruling on the factual testimony. The essence of the ruling is that the undersigned did not believe that Ms. Hodges' testimony was accurate. This is not to say that she lied, but it is clear to the undersigned that her memory of events is highly questionable. Contemporaneously recorded medical symptoms are frequently accorded more weight by Special Masters than later recounted medical histories, affidavits and oral testimony. Binding precedence supports this approach;

> 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. Sec'y of HHS, 993 F.2d 1525, 1528 (Fed. Cir. 1993)(citing United States v. United States Gypsum Co., 333 U.S. 364 (1947).) The Federal Circuit decision in Cucuras clearly supports the view favoring medical records over oral testimony, especially in situations where there is a conflict between the former and the latter. Id. This is not to say that notations should be blindly accepted. Medical records are often incomplete or in error. However, in this case there is no apparent issue with the medical records. In fact, Ms. Hodges testified several times that the records correctly record the events. However, Ms. Hodges attempts through her testimony to rewrite history, and that is what was particularly unpersuasive. The undersigned will give several examples of testimony that was found highly questionable.

Ms. Hodges was seen for exposure to epoxy dust on November 19, 2003. P Ex 9I at 5. The history notes that she "doesn't feel sick - feels really 'dry'" and "looks well. No distress." Id. Ms. Hodges stated that this was accurate. Id. This was during the period of time that she stated she experience flu-like symptoms that never went away. Tr. at 45. The symptoms would "recede," but then they "would come back stronger." Id. She would wake up in the "middle of the night and my arm would be really sore and achy again." Id. She attempted to explain not mentioning these symptoms to the doctor by stating that she did not "correlate" the flu-like symptoms with the epoxy dust. Tr. at 85. But that does not explain how she could report that she did not feel sick or how a doctor could note that she looked well and was in no distress. Her feeble effort to say that the symptoms had "receded" that day and that the exam lasted about "five minutes" are desperate attempts to spin very damaging records. Tr. at 85-7. In the effort, it was her credibility that was damaged.

Ms. Hodges faced the high hurdle of information that she herself provided to doctors. On March 16, 2004, Ms. Hodges filled out a Workers Compensation form for a left shoulder problem. P Ex 16 at 10. The date given for the onset of the injury is 12/24/03. Id. The Occupational Nurse recorded the history as follows:

> Emp. recalls waking up one morning with a stiff neck and sore L shoulder. Pain in shoulder kept getting worse to the point of being unbearable. Went to see PMD

who asked if she had a repetitive job.

Id. at 9. The date of onset of the injury was recorded as "12/24/03." Id. There is no mention of the vaccine causing this injury, but the nurse records "CTD Left Shoulder from changing filter housings, lifting above shoulder." Id. Petitioner saw Dr. Zeller for an examination related to this claim. Dr. Zeller records a history, attributed to petitioner, that the onset of symptoms began "while on vacation in December 2003." P Ex 9V at 502. Interestingly, he also records that "she had a flu shot several weeks before that." Id. Based at least upon that mistaken time line, Dr. Zeller concluded that "[s]he unfortunately had a flu shot and probably developed this from that or from some other etiology." Id. at 506. Based upon Dr. Zeller's report, Ms. Hodges' claim was denied because the "onset of your injury/illness occurred while you were on your vacation." P Ex 16 at 8. This information is consistent with the history of illness from Ms. Hodges' first visit to the doctors on January 7, 2004. That record records that she had "a kink in her neck at xmas, and then came back, then started to get, chills and sick to stomach and feels ichy." P Ex 9I at 6. The record also notes the duration of her illness was "5 DAYS." Id. at 7. When asked about these records, Ms. Hodges declined to say that they are wrong, but that "when I went into the doctors and I was describing my pain, I would say that when I was in significant pain, it was during Christmas time." Tr. at 112. She explained further that she "got used to saying that my onset was at Christmas time." Id. at 113.

Unfortunately for petitioner, this explanation simply does not make sense. The records clearly state that the onset of Ms. Hodges' symptoms began at Christmas time of 2003. This information came from petitioner herself, at the time in question. It defies reasonable belief that petitioner would not relate to treating medical professionals the alleged prior two months of waxing and waning symptoms that got progressively worse each time they arose. Petitioner's testimony simply was not believable. Petitioner's effort to modify the content of the contemporaneous records five years later was to put it nicely unconvincing.

The undersigned has reviewed the entire record and finds that the facts are accurately depicted by the medical records. The witness testimony was simply not credible. Ms. Whitman's testimony was highly suspect due to her selective recall of events. Ms. Hodges' efforts to rewrite history, history for which she was the source, was wholly unpersuasive. Ms. Hodges had the motive and means to seek medical attention and did not. Her explanation of being busy at work and with her family rings hollow. The undersigned was particularly unimpressed with her many and varied explanations of why clear statements in the medical records that contradicted or called into question her testimony should be modified to take into account her factual testimony coming five years after the events in question. In the end, the witness testimony presented no persuasive reason for rewriting what petitioner concedes are accurate contemporaneous medical records.

Accordingly, the lay witness testimony is rejected. The factual predicate for this claim is the contemporaneous medical records. Thus, at this stage of the proceedings, it is incumbent upon petitioner to produce an expert medical opinion opining more likely than not based upon

the factual information contained in the medical records that Ms. Hodges' brachial neuritis was caused by her October 29, 2003 flu vaccine. Accordingly;

-Petitioner shall file **within sixty (60) days, by no later than August 25, 2009**, petitioner's expert report.

-With regard to an expert report any opinion from an expert may be more persuasive if supported by medical articles. An expert is not required to cite any literature supporting his theory. Althen v. Sec'y of HHS, 418 F.3d 1274, 1281 (Fed. Cir. 2005). However, medical articles may be considered in evaluating an expert's opinion. Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579, 593-94 (1993); Terran v. Sec'y of HHS, 195 F.3d 1302, 1316 (Fed. Cir. 1999) (affirming special master's use of Daubert in vaccine program cases).

-If medical literature is filed in support of the expert opinion, the undersigned requests that petitioner's counsel or petitioner's medical expert **specifically highlight** the particular sentences, paragraphs or pages that are relevant or of special significance in support of petitioner's case.

-If petitioner is **unable to file** petitioner's expert report **by August 25, 2009**, petitioner shall confer with respondent and contact the court **within ten (10) days** with three proposed dates and times for scheduling a status conference.

Any questions regarding this Order may be directed to my law clerk, Catherine Olin, at (202) 357-6343.

IT IS SO ORDERED.

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Gary J. Golkiewicz
Chief Special Master