In the United States Court of Federal Claims

OFFICE OF SPECIAL MASTERS
No. 99-519V
December 15, 2006

ANNE E. OTTENWELLER,	*	
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Petitioner,	*	
	*	
v.	*	Hepatitis B vaccine; no neurological condition;
	*	
SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,	*	Dr. Andrew Campbell about to have his medical license suspended
	*	
Respondent.	*	

ORDER TO SHOW CAUSE[1]

Petitioner filed a petition on July 28, 1999, under the National Childhood Vaccine Injury Act, 42 U.S.C. §300aa-10 et seq., alleging that she received hepatitis B vaccine on January 5, 1995, February 17, 1995, and August 2, 1995 and experienced an adverse reaction. Petitioner submitted proof of vaccination. Med. recs. at Ex. 14, p. 1.

[1] Because this order contains a reasoned explanation for the special master's action in this case, the special master intends to post this order 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). 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 or designated substantive order 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.

The undersigned strikes pages 74-77 of Ex. 2 which deal with a patient who is not petitioner.

Petitioner is ORDERED TO SHOW CAUSE by **February 16**, **2007** why this case should not be dismissed.

FACTS

Petitioner was born on March 5, 1952.

On March 27, 1987, petitioner telephoned Dr. John Cowan's office. She had spotting and occasional cramps. She was sure she had an early miscarriage and stated it was her eighth miscarriage. Med. recs. at Ex. 3, p. 67.

On August 22, 1988, petitioner saw Dr. Cowan, a gynecologist. She had not had a menstrual period for two years and was still nursing. She complained of bloating, backaches, headaches, nervousness, mild cramps, pain in the side similar to ovulation pains, and stated she experienced all these symptoms when she was pregnant except she did not have nausea or fatigue which she normally had during pregnancy. On August 8, 1988, her pregnancy test was negative. She requested a repeat test. Med. recs. at Ex. 3, p. 69.

On May 10, 1989, petitioner had bilateral breast augmentation. Med. recs. at Ex. 6, p. 2.

On June 1, 1989, petitioner went to Dr. Donald Giant because of an automobile accident the day before. She had whiplash. Med. recs. at Ex. 11, p. 83. She had neck pain. *Id.*

On June 2, 1989, petitioner telephoned Dr. Cowan's office and complained of a bladder infection. Med. recs. at Ex. 3, p. 70.

On June 15, 1989, petitioner saw Dr. Giant complaining of pain radiating down the arms with tingling. Med. recs. at Ex. 11, p. 83.

On December 29, 1989, petitioner telephoned Dr. Cowan's office and stated her hormones had been "unbalanced" since her last delivery three years before. Med. recs. at Ex. 3, p. 71. She complained of her hair falling out, nausea, cramps, chills, and diarrhea. *Id.*

On January 16, 1990, Dr. Cowan's office telephoned petitioner to advise her that her tests were normal. *Id.*

On April 30, 1990, petitioner went to Dr. Giant with palpitations. She had recurrence of palpitations through the weekend. Her EKG was normal. Dr. Giant thought she might have mitral valve prolapse syndrome. Med. recs. at Ex. 11, p. 82. She complained her heart beats hard and then her head felt funny. Med. recs. at Ex. 11, p. 83.

On April 30, 1990, petitioner called Dr. Cowan's office and wanted her pulse rate. She was advised that blood pressure and weight were checked at examinations. *Id.*

On May 4, 1990, petitioner was tested for mitral valve prolapse. She did not have the condition. Med. recs. at Ex. 11, p. 65.

On March 9, 1991, petitioner called Dr. Cowan's office and complained of a bladder infection. Med. recs. at Ex. 3, p. 72.

On May 9, 1991, petitioner called Dr. Cowan's office and said she has felt pregnant for three weeks. Her husband had a vasectomy in November. She was nursing. She was not having a menstrual period. She felt she had ovulated two times. She had the same signs when she was pregnant but not as severe. She got a false negative pregnancy test until six or seven weeks. On testing, petitioner was not pregnant. Med. recs. at Ex. 3, p. 72.

On May 13, 1991, petitioner called Dr. Cowan's office and said she still felt pregnant. She thought she was about five weeks pregnant. She wanted an ultrasound by the end of May and Dr. Cowan said yes. Med. recs. at Ex. 3, p. 73.

On May 20, 1991, petitioner called Dr. Cowan's office and said the symptoms of pregnancy were getting stronger. She wanted to schedule an ultrasound that week. *Id.*

On June 4, 1991, petitioner went to Dr. Giant, complaining of cough, headache, and stomach pains. Her blood pressure was 90/70. Med. recs. at Ex. 11, p. 82. She told Dr. Giant that she was also having blackout spells suggestive of orthostatic hypotension. He diagnosed an upper respiratory infection. Med. recs. at Ex. 11, p. 82.

On June 4, 1991, petitioner called Dr. Cowan's office and said she was still having vertigo, cramping, fatigue, and sore breasts. She had a negative beta and ultrasound. She had been dieting. She had bronchitis and was advised to increase rest and fluids, increase proteins, and eat small frequent meals. *Id.*

On June 24, 1991, petitioner went to Dr. Giant to review lab results of her thyroid which were all normal. She continued with hair loss. Med. recs. at Ex. 11, p. 82.

On September 19, 1991, petitioner telephoned Dr. Giant's office to complain of back ache, stomach ache, and headache. She did not have fever. Med. recs. at Ex. 11, p. 81.

On November 5, 1991, petitioner went to Dr. Dankaert because of hair loss that began in April 1991. Med. recs. at Ex. 2, p. 4. The diagnosis was postpartum alopecia. She had aunts with thin hair. *Id.*

On January 30, 1992, petitioner went to Dr. Giant, complaining of dysuria for 24 hours. She had recurrent cystitis. Med. recs. at Ex. 11, p. 81.

On February 25, 1992, petitioner went to Dr. Giant because of recurrent dysuria. *Id.*

On March 13, 1992, petitioner returned to Dr. Giant to recheck her urinary tract infection. *Id.*

On April 1, 1992, petitioner filled out an informational form for Dr. Cowan. Med. recs. at Ex. 3, p. 74. She had some vulvar and vaginal discomfort. A urinary tract infection was recently treated. She had cyclical head hair loss. She got subjective pregnancy symptoms that then cleared. She had headache and occasional nausea. *Id.*

On May 8, 1992, petitioner saw Dr. Cowan, complaining of problems with false pregnancy symptoms, three times in 12 months. *Id.* She had nausea, fatigue, and headaches. Her husband had a vasectomy. She felt she had the symptoms with ovulation. Her hair fell out. *Id.*

On November 20, 1992, petitioner saw Dr. Giant with a febrile illness. She had a temperature of 101-102° and body aches, chills, and sweats. She had a dry cough, nausea, and stomach ache. She had a history of recurrent urinary tract infections. Her blood pressure was 100/60. Examination showed injection of the pharynx. She had possible mycoplasma. Med. recs. at Ex. 11, p. 80.

On December 8, 1992, petitioner saw Dr. Giant with chest pain. She had to go home from work the prior week due to chest pains early after starting work. She also had some shortness of breath. Dr. Giant diagnosed slowly resolving bronchopneumonia with secondary pleurisy. Med. recs. at Ex. 11, p. 80.

On April 28, 1993, petitioner telephoned Dr. Giant's office complaining of sinus congestion, headache, and cough. *Id.*

On October 3, 1993, petitioner filled out an informational form for Dr. Cowan. Med. recs. at Ex. 3, p. 76. She recently had a urinary tract infection and has three to four urinary tract infections a year. *Id.*

On November 22, 1993, Dr. Nancy M. Hockley of Fort Wayne Urology Corporation wrote a letter to Dr. Giant regarding petitioner. Petitioner gave a long history of recurring urinary tract infections. Petitioner linked her infections to drinking coffee, tea, colas, ethanol, and citrus fruits. She believed that each time she had one of these substances, she became infected. Med. recs. at Ex. 10, p. 32.

On December 1, 1993, petitioner saw Dr. Cowan. She was not feeling well on antibiotics for a urinary tract infection. She had antibiotics two weeks earlier for the same reason. She complained of back and abdominal aching, nausea, her head screwed up, problems in her vagina and urethra, and discharge. Med. recs. at Ex. 3, p. 76.

On December 16, 1993, petitioner saw Dr. Hockley. Med. recs. at Ex. 11, p. 51. She felt her urethra was inflamed. She had some side effects from Septra including nausea, vomiting, and fatigue. A cystoscopy revealed some evidence of urethritis. *Id.*

On January 22, 1994, petitioner saw a urologist at Fort Wayne Urology Corporation, complaining of having burning frequency, fatigue, headache and possible temperature. Med. recs. at Ex. 10, p. 2.

On June 13, 1994, petitioner telephoned Dr. Giant's office, complaining of sore throat and dry cough. Med. recs. at Ex. 11, p. 80.

On October 10, 1994, petitioner saw Dr. Hockley. Med. recs. at Ex. 11, p. 50. On September 18, 1994, she had the sudden onset of dysuria. She got better but then, on October 4,

1994, her symptoms became severe. She requested a cystoscopy. Cystoscopy was unremarkable. There appeared to be no active bladder infection. *Id.*

On November 9, 1994, petitioner telephoned Dr. Giant's office to request a prescription to stay awake at night while she was working. Med. recs. at Ex. 11, p. 80.

On December 14, 1994, petitioner had a cystoscopy, hydro-distention of the bladder, and random bladder biopsy. Med. recs. at Ex. 11, p. 44. Dr. Hockley was the surgeon. Petitioner had irritative voiding and the operation was to rule out interstitial cystitis. *Id.*

On December 20, 1994, petitioner saw Dr. Hockley. Pathology showed no evidence of interstitial cystitis. Med. recs. at Ex. 11, p. 46. Her urine appeared mildly infected.

On January 5, 1995, petitioner saw Dr. Giant for a preschool physical. She was starting clinical nursing. Med. recs. at Ex. 11, p. 79.

On January 5, 1995, petitioner had her first hepatitis B vaccination. On February 17, 1995, petitioner had her second hepatitis B vaccination. Med. recs. at Ex. 14, p. 1.

On March 6, 1995, petitioner telephoned Dr. Giant's office. She had a sinus infection, headache, dizziness, and nausea. She was prescribed Keflex and Entex. Med. recs. at Ex. 11, p. 79.

On March 9, 1995, petitioner saw Dr. Giant with cold symptoms. Med. recs. at Ex. 11, p. 78. Petitioner had had cold symptoms for about a month. She had occasional nausea, dizziness, and headache ever since the weekend. She had episodes of almost near syncope when getting up too quickly. She had chills and diarrhea two nights previously, but this resolved. She stated she always felt cold, but during this episode, she felt quite hot. Her blood pressure was 110/70. Ear, nose, and throat exam showed mild tenderness to percussion over the sinuses. Dr. Giant

diagnosed petitioner with sinusitis and noted that she had recently started on Keflex and Entex. She had been on them only for three days and was gradually improving. *Id.*

On April 3, 1995, petitioner filled out an informational form for Dr. Cowan. Med. recs. at Ex. 3, p. 77. She had not felt well for the prior two months with nausea and lightheadedness. She felt this was likely due to stress. *Id.*

On June 2, 1995, petitioner saw Dr. G. Randolph, the doctor who had performed breast implantation. Med. recs. at Ex. 6, p. 4. She wanted him to evaluate an injury she sustained to her right chest. She had sudden pain when she was involved in a pile up with her family in a wrestling match. *Id.*

On June 3, 1995, petitioner returned to Dr. Randolph with redness in her right breast that he suspected was an infection. *Id.*

On June 7, 1995, petitioner returned to Dr. Randolph after seeing Dr. Borenstein over the weekend. The Toradol she was taking upset her stomach. Dr. Borenstein placed her on Keflex. *Id.*

On July 11, 1995, petitioner went to Parkview Memorial Hospital Emergency Care Center because she was in an automobile accident and had arm and knee pain. Med. recs. at Ex. 11, p. 41. She was discharged with diagnoses of multiple abrasions, knee contusion, and biceps strain. Her past medical history was none. *Id.* Neurologically, Dr. Jeffrey R. Nickel stated there were no focal, sensory, or motor deficits. Deep tendon reflexes were symmetric at 2+. Her gait was normal. Med. recs. at Ex. 11, p. 42.

On July 21, 1995, petitioner saw Dr. Giant with a left eye infection. She also complained of sore throat and fever. She had mild adenopathy. He diagnosed pharyngitis and persistent conjunctivitis. Med. recs. at Ex. 11, p. 78.

On August 2, 1995, petitioner had her third hepatitis B vaccination. Med. recs. at Ex. 14, p. 1.

On August 18, 1995, petitioner had an x-ray taken because she had an automobile accident on July 11, 1995, and had medial ankle and knee pain. Med. recs. at Ex. 11, p. 39. There was no fracture in the foot although petitioner held the foot in a slight plantar flexion. The left knee showed mild degenerative changes. *Id.*

On August 25, 1995, petitioner saw Dr. Giant because of ankle and knee pain due to the automobile accident. Med. recs. at Ex. 11, p. 77.

On September 6, 1995, petitioner saw Dr. Hockley. Med. recs. at Ex. 11, p. 38. This was a follow-up of her recurrent urinary tract infections and irritative voiding symptoms. Since the doctor saw her in December, she had done extremely well. She had no voiding symptoms whatsoever unless she drank soda or consumed ethanol. She took Macrodantin for prevention. Dr. Hockley refilled her Macrodantin. Petitioner would often take an antibiotic if she cheated on her diet. Petitioner should pay attention to the foods that irritated her bladder as well as the Ditropan. *Id.*

On September 26, 1995, petitioner called Dr. Cowan's office and said she saw a urologist for recurrent urinary tract infections. She had vaginal discharges and the urologist asked for her to get a check-up with a gynecologist to see if vaginal infection was causing ureteritis. Her four-year-old daughter was also seeing the urologist for infection. Med. recs. at Ex. 3, p. 78.

On September 29, 1995, petitioner saw Dr. Cowan. She had had urinary tract problems since age 21. *Id*. On an altered diet, she usually did well. The prior week, she had discharge when she was not feeling well. She felt dizzy and lightheaded, and had urinary irritation. Dr. Cowan's impression was vaginal discharge and urethral irritation. *Id.*

On October 2, 1995, Dr. Cowan called petitioner to tell her all her cultures were negative. *Id.*

On October 10, 1995, petitioner saw Dr. Cowen who did a pelvic examination. She was in good health, with a left ovarian tumor on ultrasound. Med. recs. at Ex. 3, p. 79.

On October 10, 1995, petitioner called Dr. Cowan's office to tell them that she forgot to tell Dr. Cowan that she had not felt well for the past four to six weeks with extreme fatigue and lightheadedness. She also had intermittent nausea. *Id.*

On October 11, 1995, petitioner had a chest x-ray, showing a right breast prosthesis. Med. recs. at Ex. 19, p. 56.

On October 13, 1995, petitioner had a laparoscopy for a left ovarian mass. Dr. Michael Amorini diagnosed her with a normal left ovary and endopelvic adhesions. Med. recs. at Ex. 19, p. 53.

On October 14, 1995, petitioner had an analysis of a left ovary biopsy done. The pathologist, Dr. Blandine Bustamante, stated the tissues showed peritoneal fluid cytology and were negative for malignancy. Med. recs. at Ex. 19, pp. 47, 51.

On October 18, 1995, petitioner called Dr. Cowan's office, stating she felt quite well and resumed normal activity. Med. recs. at Ex. 3, p. 80.

On December 15, 1995, petitioner saw Dr. William B. LaSalle, an orthopedist. Med. recs. at Ex. 11, p. 6. Petitioner had had some problems for several months in her right hip area. When she carried her books, she would have a little occasional twinge. Recently, this had become more pronounced and the pain was radiating down her right leg to the knee. She did not have any problems sleeping. She had no bowel or bladder symptoms. Physical examination showed a very healthy female, walking without a limp. She could heel and toe walk with difficulty. Muscle stretch reflexes were normal. She had excellent range of motion of her low back. She had pain with internal rotation of the right hip and Dr. LaSalle pinpointed the area as the superior/posterior aspect of her trochanter. X-rays were normal. Dr. LaSalle concluded petitioner had trochanteric bursitis. He prescribed Medrol with a follow-up of Advil. *Id.*

On January 4, 1996, petitioner saw Dr. LaSalle. She was improved. Med. recs. at Ex. 11, p. 7.

On June 13, 1996, petitioner saw Dr. Dankaert with herpes zoster on the right side. She also had an open sore on the nasal apex which might also be herpes, but she had a history of perioral dermatitis and the possibility of acne rosacea. Med. recs. at Ex. 2, p. 3.

On June 18, 1996, petitioner returned to Dr. Dankaert. She was doing well. She did not have any cough or shortness of breath. There were no lesions other than in the dermatomal distribution on the trunk. She did have acne rosacea lesions. The tip of the nose was improved. Med. recs. at Ex. 2, p. 3.

On September 10, 1996, petitioner saw her doctor, stating she had shingles in the spring of 1996 and, at that time, a positive tuberculosis test. Three weeks later, she had a negative TB test when the shingles were about gone. Med. recs. at Ex. 24, p. 16. She had no problems with

her bladder now. She took Prozac. She complained of depression and fatigue, especially one week before her menstrual cycle. Prozac helped. Petitioner just did not feel well. *Id.*

On September 10, 1996, Dr. Cowan did an ultrasound of petitioner's uterus which proved to be normal. She had a 3 mm endometrial stripe. Med. recs. at Ex. 24, p. 21. She was diagnosed with a small follicle/cyst 9 x 8 mm on the left ovary and fatigue. Med. recs. at Ex. 24, p.22.

On September 26, 1996, petitioner saw Dr. Giant, complaining of fatigue since May 1996. She slept more than eight hours a day and still felt tired. She had been on Prozac 10 mg and took it almost every day. This helped her depression but not her energy level. She denied any unusual aches or pains. She wondered if part of the reason for her extreme lethargy were environmental allergies because she had a very strong family history of this. Her blood pressure was 104/60. Ear, nose, and throat exam showed minimal postnasal drip and slightly reddened eyes. He tried petitioner on a non-sedating antihistamine. Med. recs. at Ex. 11, p. 75.

On November 11, 1996, petitioner saw her doctor, complaining of low grade menstrual pain in the abdomen and back all the time. Her bowels were okay. Med. recs. at Ex. 24, p. 17.

On November 26, 1996, petitioner saw her doctor, complaining of menstrual pain for the entire cycle. *Id.*

On December 3, 1997, petitioner saw Dr. Dankaert. She had been feeling bad for one week and had a patch on her torso, a papule on her nose, and a past history of shingles. She did

not have any fever. Med. recs. at Ex. 2, p. 3. She had a furuncle[2] anterior abdomen that started that day. Med. recs. at Ex. 2, p. 2.

On December 3, 1997, petitioner phoned her doctor to schedule her annual gynecologic examination and complained of fatigue for three years (making onset 1994, before she had her first hepatitis B vaccination). She also complained of periods of feeling blue. Med. recs. at Ex. 24, p. 17.

On December 5, 1997, petitioner saw Dr. Giant, complaining of neck ache, headache, tender ears, tender neck, and increasing fatigue. Med. recs. at Ex. 11, p. 73. She had three near-syncopal spells that resolved when she lay down and elevated her feet. (Petitioner's initial complaint of near syncope was June 4, 1991, four years before she received hepatitis B vaccine.) She had not had chills, fevers, or night sweats. She had no other unusual aches and pains. She stated she had a history of depressions in the fall. Her blood pressure was 92/60 supine and 88/60 sitting. *Id.*

On December 10, 1997, petitioner had a CT scan done of her right lower quadrant because she complained of pain there. She had a negative abdomen and pelvic CT scan. Med. recs. at Ex. 19, p. 43.

On January 20, 1998, petitioner saw Dr. Giant. Med. recs. at Ex. 11, p. 72. She had persistent fatigue, episodes of low blood sugar with sinking spells, and a history of depression. Her blood sugars had run as low as the 40s and 50s at work. She felt quite weak at those times. This resolved with eating. He tried raising her dose of antidepressants to treat her lethargy. She

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[2] Furuncle is "a painful nodule formed in the skin by circumscribed inflammation of the corium and subcutaneous tissue.... It is caused by staphylococci, which enter through the hair follicles...." Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 745.

stated her mood improved, but she still felt tired all the time. She looked pale and excessively thin. She had lost some weight. There were no other significant physical findings. *Id.*

On January 21, 1998, petitioner saw Dr. Mark Tartara. Med. recs. at Ex. 8, p. 10. She complained of three years of fatigue. Dr. Tartara suspected hypothyroidism vs. hypoglycemia. *Id.* Petitioner was a registered nurse and worked the night shift. Med. recs. at Ex. 8, p. 11. Over the past three to four months, her fatigue had been worse. She could sleep 18 hours a day if allowed. She had a blue mood about one year before and went on Zoloft. This worked initially but she stopped the drug. She felt she had no further problems with blue mood. She had three episodes of feeling she would pass out. This was not associated with palpitations or dizziness. She felt a warm sensation. Her last two episodes occurred at work. Her blood glucose was found to be in the 50s the first time and in the 40s the second time. She did not take any carbohydrate at the time. She lost ten pounds in the fall, but that was due to less appetite. She had wanted to lose weight. She took one to two ounces of ethanol a week. On examination, she had no muscular pains, strains or weakness. Her strength was not changing. She had no weakness and no paresthesias. She had no gait disturbance. She had no recurrent dizziness. She had no history of syncope. She had been working nights for the past five years. She was going to school at night and got her nursing degree one year previously. *Id.* She worked 4:00 p.m. to 4:00 a.m. and then went back home to sleep for an hour before getting up to get her children to school. Then she went back to sleep. Lately, she had not been able to stay awake in the morning and had her 18-year-old get the younger children to school and drive herself and her sister to school. Med. recs. at Ex. 8, p. 12. She had some seasonal rhinitis and some morning forehead congestion. She appeared depressed and a bit worried. She had good insight. She had no joint

effusions or erythema. She had adequate range of motion without pain. She had no joint instability. She had normal muscle tone and strength was grossly normal for age. Her deep tendon reflexes were symmetric and not pathologic. Sensation to light touch, pinprick, vibration, and proprioception were normal. She had normal relatedness and affect. Her memory was intact to short and long term functions. There was no suggestion of overt depression, anxiety, or agitation. She was alert and oriented to person, time, and place. *Id.* Dr. Tartara's impression was that her fatigue and spells of profound fatigue may be related to hypoglycemia. He thought her symptoms were most likely multifactorial related to her change of lifestyle to working as a registered nurse two to three nights weekly in addition to taking care of her children, accompanied by some allergic rhinitis and possibly sinusitis and depression. She might have hypoglycemia. He wanted to rule out hypothyroidism and cortisol deficiency although she had normal electrolytes. Med. recs. at Ex. 8, pp. 112-13.

On January 26, 1998, petitioner saw D. William Smits, an allergist. Med. recs. at Ex. 7, p. 28. She had fatigue and was feeling poorly. Hear ears had been popping for six weeks and were full. Her eyes itched. She had rhinorrhea and sneezing. The age of onset was 30 years of age. (That would be 15 years earlier.) When she ate, she was nauseated. She stated she was always sick as a child. She complained of dizziness and possible hypoglycemia. She had low blood pressure, heart rate, and body temperature. She saw Dr. O'Brien about 11 years before. She had pneumonia in 1992. Her symptoms were better when she was on an allergy diet years ago. The symptoms had been present for two years. She had trouble in April and felt weak. *Id.* She was on Zoloft. Med. recs. at Ex. 7, p. 29. She was sensitive to corn, milk, wheat, and refined sugar. Some family members had seasonal allergies. *Id.* She had chronic urinary tract

infections as a child. Med. recs. at Ex. 7, p. 30. Dr. Smits diagnosed allergic rhinitis caused by dust and dander, and hay fever, as well as food allergy and dyspepsia. Med. recs. at Ex. 7, p. 31.

On January 27, 1998, petitioner had a CT scan done of her sinuses. No abnormalities were noted. Med. recs. at Ex. 19, p. 41.

On February 13, 1998, petitioner was examined as part of a pediatric nursing specialists employee health examination. She was in general good health. Med. recs. at Ex. 11, p. 23. In a form that petitioner completed on January 14, 1998, petitioner denied allergies, headaches, injuries, and other serious illness. Med. recs. at Ex. 11, p. 22.

On February 19, 1998, petitioner returned to Dr. Smits for a recheck. She had overwhelming fatigue and weakness. She had headaches, jaw discomfort, and her ears hurt. She finished the Prednisone and had more energy. She did not have headaches while she was on the Prednisone. She was very frustrated. Med. recs. at Ex. 7, p. 25.

On March 20, 1998, petitioner told Dr. Smits that the Claritin-D really helped. She had not felt that good in a while. In the last four to five days, she felt like her old self and she could actually go back to work. Med. recs. at Ex. 7, p. 19.

On April 6, 1998, Dr. Smits, the allergist, wrote a letter to Dr. Giant. Med. recs. at Ex. 7, p. 66. He said he had diagnosed petitioner with allergic rhinitis, asthma, and a history of fatigue. Allergic work-up confirmed sensitivities to trees, weeds, molds, and certain foods. Petitioner was aware that she was allergic to cats but, despite this, she had two pet cats, a pet dog, and one guinea pig. *Id.* She was on Claritin-D, Allegra, Singulair, and Volmax. Petitioner stated she felt she had responded well to the current medication and had found energy which she had not had for quite a while. *Id.* Dr. Smits administered shots to petitioner. Med. recs. at Ex. 7, p. 11.

Also on April 6, 1998, petitioner received the following allergy serums from Dr. Smits: vial A for trees, weeds, roaches, cats, feathers, and corn; vial B for molds. Med. recs. at Ex. 7, p. 58.

On August 25, 1998, Dr. Paul E. Later, a neurologist, wrote a letter to Dr. William Smits that he had recently seen petitioner. Med. recs. at Ex. 5, p. 3. Her primary complaint was severe fatigue. She also complained of dysequilibrium, general malaise, body aches, and joint aches. About three years ago, she had an episode of severe tiredness all the time. In April 1996, she noted shingles on her left flank. In October 1997, she had an episode of syncope at work and had documented low blood sugar in the 40s. In January 1998, she had waves of excessive sleepiness that would last for 20 hours a day, and poor concentration. In June 1998, she had episodes of a hypersensitive patch on her scalp. About two weeks prior to her visit with Dr. Later, petitioner had episodes of dysequilibrium. She did not have diplopia or a sense of band-like tightness of the extremities or thorax. She had chronic bladder control changes without any real changes recently and no incontinence. She had no history of optic neuritis or symptoms of migratory myalgia. *Id.* She was checked for allergic causes of her symptomatology. *Id.* Petitioner was allergic to many environmental allergens. Med. recs. at Ex. 5, p. 4. Her family history was significant for multiple sclerosis, cardiac disease, miscarriages, and migraines. On physical examination, petitioner was alert and oriented with normal speech and language function. Motor examination was normal. Deep tendon reflexes were 3+ throughout. Fine motor control was normal. Individual muscle strength testing was full. Cerebellar examination showed normal finger-to-nose and rapid alternating movements. She showed normal light touch and double

simultaneous stimulation. Her gait was normal straight, heel, toe, and tandem walk. *Id.* Dr. Later wondered if petitioner had demyelinating disease and recommended a brain MRI. *Id.*

On October 5, 1998, petitioner saw Dr. Kenneth A. Smith, a rheumatologist. Med. recs. at Ex. 7, p. 61. He wrote a letter to Dr. Smits, dated October 20, 1998. He evaluated her for arthralgias and myalgias and discussed her three-year history of fatigue, noting her history of disturbed sleep pattern. Dr. Smith thought she had fibromyalgia and not an underlying inflammatory disease process. Her physical examination was normal. *Id.* Dr. Smith suggested Elavil and other anti-depressants. Med. recs. at Ex. 7, p. 62. He also suggested a regular aerobic exercise program. Stretching and strengthening exercises should be continued. All narcotics and potentially addictive drugs should be avoided. *Id.*

On October 21, 1998, petitioner filled out an immune dysfunction questionnaire for Dr. Andrew W. Campbell of Houston, TX, who is neither an immunologist nor a neurologist. Med. recs. at Ex. 1 (page number indecipherable). She stated that she had three years of fatigue, one year of attention deficit disorder, one year of memory disturbance, one year of spatial disorientation, one year of frequently saying the wrong word, two years of depression, two years of mood swings, six months of sleep disturbance, one year of dysequilibrium, one year of lightheadedness, one year of severe muscular weakness, two years of decreased libido, one year of muscle and joint aches, six months of weight gain, 25 years of abdominal pain, diarrhea, nausea, intestinal gas or irritable bowel syndrome, three years of rash of herpes simplex or shingles, 12 years of hair loss, 25 years of cold hands and feet, 20 years or longer of multiple sensitivities to food and other substances, and ten years of low blood sugars, worsening in the past year.

Also on October 21, 1998, petitioner filled out a personal and family health history for Dr. Campbell. Med. recs. at Ex. 1 (page numbers indecipherable). She marked positive for allergies, anemia, miscarriage, hay fever, positive test for TB followed two weeks later by a negative test, fainting, spells of dizziness, ear pain, shortness of breath climbing a flight of stairs, irregular heartbeat, burning when urinating, loss of control of bladder, blood in urine, trouble holding urine (mostly 1974-94), varicose veins, phlebitis or inflamed leg veins, which started in 1990, constant thirst, coldness, sluggishness or fatigue, jumpiness, joint pain, loss of muscle strength, back pain, worry over her job and money, and drinking coffee and alcohol. She had numerous miscarriages before 12 weeks from 1978 to 1985.

On October 26, 1998, Dr. Campbell examined petitioner. Med. recs. at Ex. 1 (page numbers indecipherable). In his examination, he found her deep tendon reflexes normal. He diagnosed her with demyelinating disease.

On October 29, 1998, Dr. Campbell wrote that petitioner's balance was $10,230.00. Med. recs. at Ex. 1 (page number indecipherable).

On November 19, 1998, petitioner saw Dr. Dankaert. She had perioral dermatitis. This occurred twice a year and lasted about six weeks. Med. recs. at Ex. 2, p. 2.

On November 24, 1998, Dr. Campbell wrote that petitioner's balance was $10,230.00. Med. recs. at Ex. 1 (page number indecipherable).

On February 1, 1999, Dr. Campbell diagnosed petitioner with abnormal reflex, CIDP, demyelinating disease, lymphadenopathy, and Raynaud's syndrome. Med. recs. at Ex. 1 (page number indecipherable). Petitioner's previous balance was $10,230.00.

On March 19, 1999, petitioner had a right breast hematoma which Dr. Joseph Mlakar drained. Med. recs. at Ex. 19, p. 37. Petitioner underwent capsulectomies and removal of breast implants with immediate reconstruction a week previously. She presented at that time with growing swelling of her right breast secondary to hematoma. She was taken to surgery for evacuation. *Id.*

On March 23, 1999, petitioner had an evacuation of a seroma and excision of a pseudocapsule of the right breast. Med. recs. at Ex. 19, p. 34. Dr. Brian J. Lee stated she had removal of implants, a capsulectomy, and mastopexy approximately two weeks before. Subsequently, she had a hematoma of the right breast which was drained four days previously. That morning the right breast increased in size. She had not had fevers, chills, nausea, vomiting, or any other symptoms. *Id.*

On March 29, 1999, petitioner saw Dr. Campbell. Med. recs. at Ex. 1 (page number indecipherable). She had completed six IVIG treatments, the last one on March 15 or 18, 1999. On March 9, 1999, petitioner had bilateral implant removal. Two weeks after March 9, 1999, petitioner had two to three days of great energy and normal cognitive function. She felt normal again, especially after IVIG treatment. She was much improved. Her fatigue and weakness improved. Her cognitive function improved after each IVIG treatment and with the implants removed. Sleep was not a problem.

Also on March 29, 1999, Dr. Campbell diagnosed abnormal reflex, CIDP, and immune mechanism disorder. He charged $422.00. Med. recs. at Ex. 1 (page number indecipherable).

On April 4, 1999, petitioner had biopsies of her breasts. Med. recs. at Ex. 4, p. 4. Dr. Rahim Karjoo, a pathologist, diagnosed fibrous capsule from the right breast showing laminated

fibrous tissue, presence of abundant crystalloid material (silicone) in the wall of the capsule, and presence of the silicone beyond the surface capsule in the scar tissue adjacent to the breast. He also diagnosed a laminated fibrous capsule containing a small number of silicone, mostly in the histiocytes, from the left breast showing fibrosis, scar formation and vascularization of the breast adjacent to the capsule and inflammatory changes of the breast tissue. Med. recs. at Ex. 4, p. 3. Dr. Karjoo commented that this particular case had extensive calcification extensions and leaking of the silicone in both breasts, with the right more prominent with severe calcification. *Id.*

On April 12, 1999, Dr. Cowan did an ultrasound of petitioner's uterus, showing small fibroids, the largest being 1.3 cm in diameter, intramural in nature. There was a well-demarcated 9 mm endometrial stripe. Petitioner had a small uterine leimyomata (benign tumor).[3] Med. recs. at Ex. 24, p. 19.

On April 13, 1999, petitioner had a biopsy of her endometrium showing a proliferative endometrium with focal mild stromal breakdown changes, negative for hyperplasia, atypia, and malignancy. Med. recs. at Ex. 24, p. 18.

On June 29, 1999, petitioner saw Dr. Campbell. She had had a total of eight IVIG treatments. There were 12 IVIG treatments ordered. She had two IVIG doses ordered April 29, 1999. Med. recs. at Ex. 1 (page number indecipherable). Petitioner said she had fatigue for the past two months. She felt better after six weeks of IVIG. She slept without problem. Her joint/muscle pain resolved since receiving IVIG. Dr. Campbell diagnosed CIDP, fatigue, hepatitis B vaccine reaction, immune mechanism disorder, and charged petitioner $5,228.00.

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[3] Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 1011.

On August 3, 1999, Dr. Campbell diagnosed petitioner with polyclonal gammopathy[4]. Med. recs. at Ex. 1 (page number indecipherable). He stated she had an abnormal nerve conduction test.

On September 16, 1999, petitioner filled out an Immune Dysfunction Questionnaire Update for Dr. Campbell. Med. recs. at Ex. 1 (page number indecipherable). She stated she had, on a scale of severity from 0-10: fatigue (7), attention deficit (7), calculation difficulties (7), memory disturbance (9), frequently saying the wrong word (6), mood swings (2), sleep disturbances (2), headaches (2), numbness or tingling (1), dysequilibrium (3), lightheadedness (8), severe muscular weakness (6), near blackouts (6) intolerance of alcohol (4), decreased libido (4), muscle and joint pains (from 4-5 to 7-8), abdominal pain (3), recurrent flu-like illnesses (5-6), twitching muscles (2), severe nasal or other allergies (5), weight gain (3), night sweats (3), heart palpitations (2), one episode of shingles, uncomfortable urination (4), rashes (5), hair loss (7), frequent canker sores (5-6), cold hands and feet (7), shortness of breath (8), symptoms worsened by extremes in temperature (7), sores that will not heal (7), multiple sensitivities to food, medicine, and other substances (3), and under other symptoms weakness, fatigue, mental decline and lightheadedness. Petitioner denied anxiety and depression.

Also on September 16, 1999, Dr. Campbell examined petitioner. She had normal deep tendon reflexes. Med. recs. at Ex. 1 (page number indecipherable). Petitioner was concerned about her mental status and energy level. She stated that her cognitive function was not what it used to be. She was disoriented while driving for moments and then was able to find her way.

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[4] Gammopathy is "a condition marked by disturbed immunoglobulin synthesis." Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 751. "Polyclonal" means "derived from different cells." Dorland's, at 1479.

She experienced less fatigue, but still had fatigue. She functioned at a low level of energy. She slept okay. Her body aches were a lot better. She had limited levels of joint and muscle pain. Dr. Campbell diagnosed CIDP, fatigue, hepatitis B vaccine reaction, and immune mechanism disorder. Petitioner owed a balance of $175.00.

On October 1, 1999, Dr. Campbell noted that petitioner had polyclonal gammopathy, an increase in her cholesterol, an increase in her SGOT, abnormal although improved nerve conduction studies, positive myelin basic protein antibodies, and positive ganglioside GM-1, and he diagnosed CIDP. Med. recs. at Ex. 1 (page number indecipherable).

On October 7, 1999, Dr. Campbell diagnosed petitioner with CIDP, fatigue, hepatitis B vaccine reaction, and immune mechanism disorder. Med. recs. at Ex. 1 (page number indecipherable).

On February 8, 2000, petitioner went to a doctor and stated that she had had chronic urinary problems since she was 20 (27 years ago). Med. recs. at Ex. 18, p. 9. She stated that her aunt had chronic bladder problems. *Id.*

On March 7, 2000, petitioner had a cystoscopy which showed a normal bladder with mild vaginitis. Med. recs. at Ex. 18, p. 8. She had a renal and bladder ultrasound on that date because of chronic cystitis with frequency since age 20. She had normal kidneys and bladder with 98% evacuation of the bladder. Med. recs. at Ex. 18, p. 33.

On September 6, 2000, petitioner had a history of interstitial cystitis and had discomfort. A urinalysis was negative. Med. recs. at Ex. 18, pp. 22, 29.

On March 22, 2001, petitioner saw Darlene Noble, a nurse practitioner for a gynecological examination. Med. recs. at Ex. 24, p. 9. Petitioner thought she was menopausal.

She did not have hot flashes, but she was more emotionally labile and specifically had depression. NP Noble stated that petitioner's examination was normal. She tried to reassure petitioner that everything she was experiencing as far as cycle change was very normal. *Id.*

On March 6, 2002, petitioner went to Northeast Indiana Urology with a longstanding history of interstitial cystitis. Med. recs. at Ex. 18, p. 15. The doctor's assessment was pelvic pain, possible interstitial cystitis. *Id.*

On August 7, 2002, petitioner had a hysterosalpingogram. Dr. Christopher Wing stated petitioner had complete occlusion of the endometrial cavity and/or obstruction at the level of the internal cervix. Med. recs. at Ex. 19, p. 20.

On December 4, 2002, petitioner had a chest x-ray because of coughing and fatigue. She did not have significant cardiopulmonary disease. Med. recs. at Ex. 19, p. 17.

On April 10, 2006, petitioner saw Dr. Madhav H. Bhat, a neurologist. Med. recs. at Ex. 25, p. 20. Petitioner complained of memory disturbance for 10 years, starting in 1995, and fatigue for several months. Despite having short-term memory disturbance and confusion, her performance in the hospital CCU has not declined. She has not made any mistakes. She did not have headaches, nausea, vomiting, or dystaxia. Petitioner said her symptoms came after a hepatitis B vaccination which she had in 1995 when she had fatigue, tiredness, concentration difficulties, and generalized weakness. She saw the neurologist Dr. Later and a local allergist. She saw Dr. Campbell and received IVIG once a week for almost a year for presumed chronic inflammatory demyelinating polyneuropathy. *Id.* She did not have a neurological evaluation then. She never had proximal or distal leg weakness, arm weakness, or persistent hand or feet paresthesia then. Med. recs. at Ex. 25, p. 21.

In past medical history, Dr. Bhat wrote "questionable diagnosis of CIDP and significant fatigue." *Id.* Her family history is positive for coronary artery disease. Neurological examination showed an alert, oriented woman who followed simple commands. Her fund of knowledge was adequate. Insight was normal. Repetition of three words was normal with a recall of three out of three objects on the first try. Judgment, similarities, and abstraction were normal. There were no constructional or ideational apraxias. Strength was normal in all extremities. Coordination was normal. Sensory evaluation was normal. Tendon reflexes were normal in all extremities. Plantar reflex was flexor bilaterally. She walked well. She had no difficulties rising from a chair. Romberg sign was absent. Dr. Bhat's impression was that petitioner's subtle short-term memory disturbance and concentration difficulties may be secondary to underlying anxiety and depression. Dr. Bhat did not find clinical evidence of Alzheimer's disease or encephalopathy. The symptoms petitioner reported 10 years earlier are not typical for a diagnosis of CIDP. *Id.*

On April 19, 2006, petitioner had an EEG done. Dr. Bhat stated it was normal. Med. recs. at Ex. 25, p. 16.

Also on April 19, 2006, petitioner had a brain MRI. Petitioner gave a history of gradual memory loss over several years. Med. recs. at Ex. 25, p. 18. There were multiple scattered T2 signal hyperintensities in the frontal and parietal occipital deep white matter and subcortical white matter. Dr. John R. Kim stated that he did not see any immediate periventricular white matter lesions. These areas were not associated with abnormal restriction or abnormal enhancement. The differential for this finding would include chronic small vessel ischemic/occlusive disease, vasculitis, and less likely demyelination. *Id.*

On June 28, 2006, petitioner saw Dr. Bhat as a follow-up. Med. recs. at Ex. 25, p. 3. Petitioner continued to have subtle short-term memory disturbance and trouble concentrating at work as well as at home, although she continued to perform activities of daily living skills independently. Petitioner did not have trouble driving or handling her financial duties. She did not have any deterioration of her work performance as a critical nurse. When asked, petitioner denied depression although she admitted to occasional anxiety. *Id.* Petitioner was fatigued and tired all the time. Dr. Campbell treated her with IV gamma globulin. Her history included a "questionable diagnosis of immune dysfunction and CIDP," and fatigue. *Id.*

On August 9, 2006, nurse Anita Lough noted that Dr. Bhat reviewed the CSF studies which showed no evidence of demyelinating disease. Med. recs. at Ex. 25, p. 6.

Neurological examination showed an alert, oriented woman who followed simple commands. Petitioner's language function was normal. *Id.* Motor, sensory, and tendon reflex evaluations were normal. Med. recs. at Ex. 25, p. 4. She walked well. Neuropsychological testing that Dr. Williams performed was within normal limits. The symptoms were attributed to underlying stress. A brain MRI was unremarkable other than a subtle nonspecific white matter signal lesion in the left parieto-occipital head region that was more suggestive of a gliosis[5] than demyelination. *Id.* A multiple sclerosis panel and cerebrospinal fluid were normal. EEG was normal. Dr. Bhat concluded that a large portion of petitioner's neurological symptoms were

[5] Gliosis is an excess of astroglia. Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 778. Astroglia are astrocytes. Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 170. Astrocytes are neuroglial cells of "ectodermal origin, characterized by fibrous, protoplasmic, or plasmatofibrous processes." Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 169.

secondary to underlying anxiety and possible depression. After a lengthy discussion with petitioner, Dr. Bhat decided to treat petitioner with Prozac. *Id.*

Other Submitted Material

Petitioner filed a statement from her sister Elizabeth M. Bode, dated November 26, 2002. Pe. Ex. 20. Although Ms. Bode does not specify which hepatitis B vaccination to which she is referring, she states that before the vaccination, petitioner was like the Energizer bunny. But after the vaccination, she became more and more ill. P. Ex. 20, p. 1. After Dr. Campbell started treating her, Ms. Bode saw small improvements. P. Ex. 20, p. 2.

Petitioner filed a statement from Janet A. Zoll, a registered nurse, dated January 10, 2003, who administered intravenous immunoblobulin to petitioner. P. Ex. 21.

Petitioner filed a statement from Ruth Miley, a registered, nurse, undated, who used to work with petitioner. She stated that petitioner would become very pale and nearly faint. She also mentioned that petitioner had low blood sugar which was not corrected by giving her juice. P. Ex. 22.

Petitioner filed a statement from another sister, Teresa M. Gigli, undated, saying that before her first hepatitis B vaccination in 1995, petitioner was extremely active. Some time in the fall of 1995, petitioner felt faint or lightheaded a lot. This worsened over the winter and spring. In the fall of 1998, petitioner told Ms. Gigli that she had fibromyalgia. Another sister and Ms. Gigli found Dr. Andrew Campbell for petitioner and she began to improve slowly after starting treatment with him. P. Ex. 23.

DISCUSSION

This is a causation in fact case. To satisfy her 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, she would not have had whatever she has, but also that the vaccine was a substantial factor in bringing about whatever she has. Shyface v. Secretary of HHS, 165 F.3d 1344, 1352 (Fed. Cir. 1999).

Petitioner has been complaining since 1991 about blackout spells. She worked five years on the night shift in intensive care as a nurse. She worked from 4:00 p.m. to 4:00 a.m., had low blood sugar, low blood pressure, and low weight. She complained often of urinary tract infections and colds. She complained of palpitations without a cause found for them. She is allergic to cats and has two cats as pets. She has allergies to many foods. These symptoms preceded her 1995 vaccinations. Although she told some doctors that she had sleeping problems, she told others that she slept well. No doctor diagnosed petitioner with a demyelinating condition, much less CIDP, until she went to Dr. Andrew Campbell, who makes a profession of diagnosing patients with serious illnesses so that he can charge them thousands of dollars. He is not a neurologist or an immunologist. Dr. Campbell diagnosed petitioner not only with CIDP but also with an immune-mediated disorder and vaccine reaction to hepatitis B.

Dr. Campbell is the subject of proceedings that will at the least suspend his medical license in the State of Texas. The Texas State Office of Administrative Hearings per Administrative Law Judges Sarah G. Ramos and Paul D. Keeper ruled in a 138-page Proposal for Decision on October 10, 2006 that, inter alia:

> 6. Dr. Campbell is subject to disciplinary action by failing to practice medicine in an acceptable professional manner consistent with public health and welfare. Act §164.051(a)(6).
>
> 7. Dr. Campbell [sic] failure to practice medicine in an acceptable manner consistent with public health and welfare includes the failure to treat a patient according to the generally accepted standard of care. 22 TAC §190.8(1)(a).
>
> 8. Dr. Campbell engaged in a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(5) of the Act by prescribing or administering a drug or treatment that is nontherapeutic in the manner the drug or treatment is administered or prescribed.

9. Dr. Campbell engaged in a prohibited act or practice within the meaning of Section 164.052(a)(5) of the Act in engaging in unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public.

10. Dr. Campbell committed a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(1) of the Act by the commission of an act that violates any law of this state if the act is connected with Respondent's practice of medicine.

11. Dr. Campbell committed a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(7) of the Act by violating Section 311.0025 of the Texas Health and Safety Code, which provides that a health care professional may not submit to a patient or a third party payor a bill for a treatment that professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.

12. Dr. Campbell committed a prohibited act or practice, and is subject to discipline pursuant to Section 101.203 of the Act, which provides that a health care professional may not violate Section 311.0025 of the Health Care and Safety Code.

13. The Board is authorized to take disciplinary action if a physician commits unprofessional or dishonorable conduct that is likely to deceive or defraud the public, as provided by Section 164.053, or injure the public. Act §164.052(a)(5).

14. Section 164.051(a)(6) of the Act authorizes the Board to take disciplinary action based on a physician's failure to practice medicine in an acceptable professional manner consistent with public health and welfare.

Page 137 of the opinion which may be retrieved at:

http://www.soah.state.tx.us/PFDSearch/Search.asp

Dr. Campbell is totally devoid of medical professionalism. His opinion that petitioner has an immune-mediated disorder and CIDP due to hepatitis B vaccine is worthless. Petitioner is ORDERED TO SHOW CAUSE why this case should not be dismissed by **February 16, 2006**.

IT IS SO ORDERED.

December 15, 2006
DATE

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