In the United States Court of Federal Claims

OFFICE OF SPECIAL MASTERS
No. 99-464V
May 23, 2007

BLACKBIRD WILLOW,	*	
	*	
Petitioner,	*	
	*	
v.	*	hepatitis B vaccine and
	*	relapsing/remitting MS;
SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,	*	no proof of significant aggravation
	*	
Respondent.	*	

ORDER TO SHOW CAUSE[1]

Petitioner filed a petition dated November 7, 2000, under the National Childhood Vaccine Injury Act, 42 U.S.C. §300aa-10 et seq., alleging that hepatitis B vaccine she received on November 21, 1998 significantly aggravated her pre-existing multiple sclerosis (MS).

[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.

In petitioner's Response to February 8, 2006 Order, filed March 8, 2007, petitioner stated that not only did hepatitis B significantly aggravate her relapsing-remitting MS, but also caused alopecia (baldness) and fatigue. Petitioner requested 90 days or June 6, 2007 to file an expert report. Having reviewed the medical records, the undersigned finds that petitioner is unlikely to prove that hepatitis B vaccine significantly aggravated her MS and gives petitioner until **July 13, 2007** to SHOW CAUSE why this case should not be dismissed.

FACTS

Petitioner was born on July 18, 1971. Her original name was Wendy Sayre. Med. recs. at Ex. 1, p. 55.

From November 8 to 11, 1988, petitioner was at Olive View Medical Center to rule out cerebellar dysfunction. She was diagnosed with possible MS. Med. recs. at Ex. 11, p. 14. She was 17 years old with a three-week history of loss of coordination and weakness. She had flu-like symptoms one week prior to her neurologic symptoms. She had been walking to the bus stop and noticed decreased sensation to her feet. Sensory deficit progressed with involvement of the upper extremities. She stated she must concentrate when moving her arms. Otherwise, the movements were disjointed. She was obese. On examination, she had patchy deficits involving the distal upper extremities and lower extremities. She had 1+ reflexes. *Id.*

MRI showed lesions in the periventricular white matter, the corona radialis on the left, suggestive of MS. Med. recs. at Ex. 11, p. 18. Petitioner gave a history of having generalized weakness, tingling and numbness and no strength in her hands. Med. recs. at Ex. 11, p. 17. Petitioner did not have objective signs of clear motor dysfunction currently and no clear posterior

column-type sensory deficits. However, her overall fatigue and paresthesia might be consistent with MS. Her current complaints did not warrant steroid treatment. Med. recs. at Ex. 11, p. 21.

On November 22, 1988, petitioner went to Olive View Medical Center, complaining of difficulty with fine motor control. She had four positive oligoclonal bands in her spinal fluid. Med. recs. at Ex. 11, p. 22. Her MRI showed multiple plaques consistent with MS. Petitioner satisfied the criteria in time and space for a diagnosis of MS. *Id.* She had a three-week history of numbness and burning of her left leg, then her arms, and abdomen. Med recs. at Ex. 11, p. 23.

On November 22, 1988, the clinic nursing notes stated that petitioner complained of her hand for two months. She had numbness and pressure. She had dizziness and difficulty with speech. She had no coordination of her hands. Med. recs. at Ex. 11, p. 43.

On January 24, 1989, petitioner went to Olive View Medical Center to rule out MS. Her CSF showed oligoclonal bands. Her MRI showed multiple plaques. Petitioner first presented in November 1988 with body numbness and decrease in fine coordination. Med. recs. at Ex. 2, p. 35. That day, petitioner stated she was better but still had difficulty picking up small objects, writing, and numbness of her hands. She denied difficulty walking. She complained of difficulty finding the right word at times. She was diagnosed with probably MS. *Id.* She had a history of cocaine and LSD abuse. *Id.* Petitioner weighed 153.6 pounds. She stated she had no normal control of her right hand and was always dropping things. Med. recs. at Ex. 11, p. 43.

On February 1, 1989, petitioner had an MRI of her cervical spine done. There was a high signal mass in the cervical cord at T2-3 which did not enhance with gadolinium, suggestive of an MS plaque. Med. recs at Ex. 11, p. 35.

On March 2, 1989, petitioner went to Midway Hospital Medical Center with a displaced fracture of the right radial head of her arm. Med. recs. at Ex. 2, p. 7. She had fallen the week before. Med. recs. at Ex. 2, p. 8. Her mother said she had a history of MS. Her right elbow was swollen. *Id.* Petitioner had surgery on March 2, 1989 for a comminuted intra-articular fracture of the right radial head. Med. recs. at Ex. 2, p. 17.

On May 29, 1990, petitioner went to the USC Medical Center ER, complaining of fatigue, tingling in both feet, difficulty walking, and decreased coordination. Med. recs. at Ex. 47, p. 9. She stated she had been admitted for an MS work-up at Olive View one year previously. Now she was having a relapse. She wanted disability parking. Her sensory examination was patchy and inconsistent. The diagnosis was anxiety and, by history, MS. *Id.*

On June 22, 1990, petitioner returned to the USC Medical Center ER, complaining of pain, weakness, and tingling whose onset was May 2, 1990. She stated that three weeks previously, she had numbness and tingling in her feet and hands which traveled progressively upward. She had been in pain for one week, had decreased sensitivity which traveled to the thorax, and she was having much difficulty breathing. She had slurred speech. Writing was difficult. Gross motor movement was easier. She had an unbalanced gait. She had the same symptoms one year previously. Med. recs. at Ex. 47, p. 10.

On June 22, 1990, petitioner saw Dr. Richard Macko at UCLA Neuropsychiatric Hospital. Med. recs. at Ex. 1, p. 55. She had recurrent episodes of hypesthesia and problems of incoordination in all four extremities. This most likely began at age 15 years (four years previously) when she experienced diplopia lasting about two weeks. She did not recall if the diplopia were of sudden onset or insidious. This resolved and did not recur. In 1988, at 17 and

½ years of age, petitioner experienced a gradual onset of bilateral lower extremity hypoesthesia which evolved over weeks to the thorax and, in a patchy manner, the entire body below the neck. She did not have paresthesia or dysesthesia. The hypoesthesia which began in the bilateral lower extremities began to improve there while persisting in the upper extremities. Over five months, the hypoesthesia completely resolved. *Id.* During the same five months, petitioner had mild difficulty with gait and discoordination of the bilateral upper extremities. She was more distractible and had difficulty concentrating. Old records indicated a concern of paraphasic error. She had occasional stuttering. She had itching intermittently during the same five months which resolved. *Id.*

Examination at Olive View was remarkable for subjective decreased hypoesthesia in the bilateral lower extremities and distal bilateral upper extremities and the impression of mild discoordination. Her reflexes were normal. An MRI at Olive View indicated T2 signal in the periventricular and left corona radiata. Petitioner was fine until May 1990 when she felt a recurrence of the hypoesthesia in the bilateral lower extremities. This again evolved but more rapidly this second time to include patchy hypoesthesia greater in the distal extremities including everything below the neck. She began to have some discoordination of gait initially with some gradual improvement, and then discoordination of the bilateral upper extremities. She began acupuncture for these symptoms. She had mild fatigue. *Id.*

At the current time, petitioner felt she continued with mild gait problems, discoordination of the bilateral upper extremities, and hypoesthesias in the bilateral upper extremities. She described what might be Lhermitte's sign. Med. recs. at Ex. 1, p. 56. She used cocaine, occasional LSD, and marijuana until mid-1988. On examination, petitioner's affect was mildly

blunted with one episode of near tearfulness when describing medical problems. Mood was euthymic. Writing was very sloppy and showed discoordination in the bilateral upper extremities. She had difficulty copying three-dimensional figures due to discoordination of the bilateral upper extremities which had a mild-to-moderate cerebellar component. She had a mild horizontal gaze nystagmus on the far lateral and upgaze. There was a hint of mild optic disc pallor. *Id.*

On motor examination, she had mild cerebellar type dysmetria, mild discoordination and slowing of rapid alternating movements, and left upper extremity greater than right upper extremity. Med. recs. at Ex. 1, p. 57. She had decreased subjective sensory to touch, pin, and temperature in the bilateral upper extremities, distal greater than proximal, mild in a stocking distribution as well. Graphesthesia was mildly decreased concomitant with decreased general sensory in the bilateral upper extremities. Deep tendon reflexes were 1+ and equal. Dr. Macko's impression was possible MS with exacerbation in May, now resolving. *Id.*

On June 26, 1990, petitioner went to UCLA Medical Center for an Occupational Therapy Evaluation. She had recent onset of decreased sensation in both hands starting in January 1989. Med. recs. at Ex. 9, p. 33. She had a history of lower extremity weakness, decreased trunk control, and fatigue. *Id.* She had difficulty using a steering wheel, with cutting food, with tying shoes, with donning jewelry, and with handwriting. Med. recs. at Ex. 9, p. 34.

On June 26, 1990, petitioner had an addendum to her physical and occupational therapy evaluation at UCLA Medical Center. Med. recs. at Ex. 9, p. 32. She claimed her fingers would not stay in place when she played the guitar. She expressed difficulty performing fine motor activities, i.e., handwriting, typing, buttoning shirts, and in differentiating textures. This might

be due to decreased bilateral hand sensation. Petitioner also reported decreased concentration and also fatigue. *Id.*

On September 19, 1990, petitioner went to UCLA Medical Center with a history of possible intermittent relapsing/remitting MS. Med. recs. at Ex. 11, p. 50. Her first attack was in November 1988 with total resolution. In March 1989, she had symptoms of fatigue and heaviness in all four limbs which progressed distally to proximally over her whole body. She had hypoesthesia and problems with memory. The second relapse was in May 1989 which was much more rapid. *Id.*

On October 5, 1990, petitioner had an patterned visual evoked potential test done. Drs. David Blum and Marc R. Nuwer noted an abnormal patterned visual evoked potential test because of mildly delayed potentials in each eye, worse on the right. This was consistent with a bilateral dysfunction of the optic tracts or nerves, suggesting a demyelinating lesion. Med. recs. at Ex. 1, p. 93.

On October 5, 1990, petitioner had a median nerve somatosensory evoked potential test done. Med. recs. at Ex. 9, p. 36. Dr. David Blum and Dr. Marc R. Nuwer noted the test was abnormal because of absent cervical potential upon right arm stimulation and delayed central conduction bilaterally. This suggested somatosensory dysfunction at or above the cervical level. *Id.*

On October 5, 1990, petitioner had spinal and cortical lower extremity somatosensory evoked potential tests. Med. recs. at Ex. 9, p. 37. Dr. David Blum and Dr. Marc R. Nuwer noted the test was abnormal because of mildly delayed cortical potential upon right leg stimulation. This abnormality suggested central delay in somatosensory conduction. Combined with the

upper extremity somatosensory evoked potential study of the same date, petitioner had a lesion at or above the cervical level. *Id.*

On July 27, 1991, petitioner went to UCLA Medical Center, Physical and Occupational Therapy, and reported trouble typing. Med. recs. at Ex. 9, p. 32.

On December 24, 1991, petitioner saw Dr. Gary B. Niditch, a neurologist. Med. recs. at Ex. 1, p. 52. She had been seen previously nine days before. She had an ophthalmologic evaluation including visual fields without significant abnormalities seen. She was continuing treatments with Dr. Yeser. She noted that her neck seems a little tighter recently. Her lower back had not been too bad. Her midback had been bothering her. She had been getting headaches, but not as intense recently. She had a heavy tired feeling. She still experienced problems with her memory and concentration. She reported difficulties falling asleep. Her main problem was fatigue and a tired feeling during the day. She did not notice any benefit from taking Doral to help her sleep and be more alert during the day. *Id.* On examination, she appeared mildly subdued. *Id.* Dr. Niditch felt petitioner was still symptomatic. Med. recs. at Ex. 1, p. 53. She had a combination of spinal pain, memory and concentration disturbance, and a tired feeling during the day. He believed her fatigue was multifactorial: the amount and quality of sleep, the distraction of her pain, and a component of depression. He prescribed Naprosyn and relaxation exercises. She would undergo an EEG study. *Id.*

On May 20, 1992, petitioner saw Dr. Jesus Muro. Med. recs. at Ex. 1, p. 48. On November 9, 1988, petitioner had two weeks of diplopia, incoordination, decreased sensitivity, mild aphasia, bilateral leg numbness, nystagmus and slow motor function. *Id.* Petitioner was

using cocaine and LSD. Med. recs. at Ex. 1, p. 49. Petitioner weighed 160 pounds. Med. recs. at Ex. 2, p. 31.

On May 26, 1992, petitioner saw Dr. Clarke D. Espy, a neurologist, on recommendation from Dr. Muro. Med. recs. at Ex. 1, p. 50. Petitioner had been diagnosed with MS. She had some diplopia at age 15, and some numbness of extremities at age 17. She had intermittent Lhermitte's phenomenon in recent years. UCLA evaluated her in 1990. An MRI of her brain at Olive View Hospital showed patchy white matter disease. Evoked response studies at UCLA were abnormal. Presently, petitioner complained of numbness in her arms and legs, difficulty writing, legs feeling heavy, difficulty with prolonged walking, easy fatiguability, and intermittent difficulty in getting words out. *Id.* She was in an auto accident in December 1991. X-rays of the cervical spine showed congenital fusion at C2-C3. Med. recs. at Ex. 1, pp. 50-51. She once tried Impramine as an antidepressant. Med. recs. at Ex. 1, p. 51. She did not like the side effects. She worked as a massage therapist but had difficulty because of her hand numbness. She was on disability for a week. On examination, she was moderately obese, had some gaze nystagmus, soft speech, flat affect, slight anisocoria, right greater than left, slightly bizarre and slow gait, and bizarre ataxia on finger-nose and heel-shin testing bilaterally. *Id.* Her deep tendon reflexes were trace to 1+. Plantar response was flexor bilaterally. Dr. Espy's impression was probably MS. There was "a definite suggestion that there is a functional contribution to her symptomatology." *Id.* He wanted to try petitioner on Prednisone since she never took steroids. *Id.*

On June 29, 1992, petitioner weighed 162 pounds. Med. recs. at Ex. 2, p. 31. She saw Dr. Jesus Muro and said she felt better and stronger since being on medication. Med. recs. at Ex. 2, p. 34.

From June 21 to 25, 1993, petitioner was at Harbor-UCLA Medical Center. Med. recs. at Ex. 1, p. 22. Dr. A. Djenderedjian, a psychiatrist, wrote the discharge summary. Petitioner's chief complaint was depression, suicidal ideation, auditory hallucinations, and the belief that evil spirits were setting her up. Petitioner's MS was diagnosed in 1991 at Cedars-Sinai Medical Center by MRI and lumbar puncture. She had a history of prior substance abuse and a recent suicide attempt. *Id.* She was uncooperative and unclear and would not provide any clear collateral information. She claimed a lack of memory due to MS and would not provide phone numbers and addresses. She ran away at 14 and her parents locked her away in two cults. She was emancipated from her parents at age 16 with the purported help of foster patients and lived in her car for a few years. She had been receiving intermittent SSI benefits, but had recently run out of her benefits. She claimed to live with Imogene Bump but provided no details or a phone number. *Id.*

She had been on Prozac, Haldol, and Cogentin for about one to two years, given by a purported Dr. Wenstein. Petitioner said he was on vacation and would not give details. She had no income and had not been able to pay her rent. She could not get refills on her medications which ran out a few weeks earlier. She refused steroid treatment for her MS because she said it made the evil voices more powerful. Without Prozac, she felt depressed and recently attempted suicide by jumping off a bridge but a man talked her out of it. *Id.*

Petitioner came to Harbor-UCLA for follow-up care for multiple trauma, multiple rib injuries and left wrist fracture with a cast because she had fallen off a horse, necessitation chest tube drainage. While in the ER, she was observed to be psychotic with depression, positive suicidal ideation, auditory hallucinations and delusions. Med. recs. at Ex. 1, p. 23. Petitioner

had positive delusions of grandeur and special powers such as the ability to tell the future and to set fires. She had positive auditory hallucinations. She said evil voices were "trying to screw me up or maybe it is due to my M.S." *Id.* She had positive ideas of reference, i.e., the television, radio, and newspaper were referring to her. She believed that her dead father was watching her. *Id.*

Petitioner saw the UCLA psychiatrist Dr. Wenstein (?) and was given Imipramine which was "bad." She did not give details. She then was given Prozac, Haldol, and Cogentin for the prior one to two years. She claimed she had a prior suicide attempt at 15 or 16 years of age when her parents put her into a cult. She did not graduate from high school. She claimed she spent two years at UCLA studying religion. Her father would hit her and her mother terrorize her. She said her mother was all powerful. Petitioner had used cocaine, stopping at age 17. She also used LSD and mushrooms, but denied present drug use. She occasionally drank. *Id.*

Both parents were alcoholics. Med. recs. at Ex. 1, p. 24. Petitioner had been using Vicodin for pain, but the prescription ran out. *Id.* On physical examination, petitioner had decreased strength of 4/5 in motor function bilaterally throughout, decreased sensation to pinprick and light touch bilaterally throughout, a positive Romberg, poor balance, a wide and ataxic gait, 3+ reflexes in her knees, and 1+ in her ankles, biceps, and brachioradialis bilaterally. Med. recs. at Ex. 1, p. 25. On toxicology screen, petitioner was opiate positive. *Id.* In appearance and behavior, petitioner had lethargic/retarded motor activity. She was uncooperative and refused to answer certain questions claiming memory loss secondary to MS. Her mood was depressed. She had decreased range and blunted affect. Her speech had decreased volume. *Id.* Petitioner did not know the specific date or month. She had a poor to fair fund of knowledge.

She had poor abstraction ability. She had poor recent recall. She had poor insight/judgment, stating, "I am kept here for no reason." Med. recs. at Ex. 1, p. 26.

Petitioner was put on Haldol 5 mg. p.o. two times a day and qHS and Cogentin 1 mg. p.o. two times a day. She greatly improved with negative suicide ideation and disappearance of the evil voices. She continued to have delusions of special powers but based that on Indian culture. *Id.* Petitioner was diagnosed with schizophrenia, undifferentiated type. "Correlations have been noted between multiple sclerosis and psychosis in some patients." *Id.* She had MS. *Id.*

On August 17, 1992, petitioner had a neurology work-up showing both moderate and mild disturbance of speech with a change in reflexes. She had trace to 1+ deep tendon reflexes. Her gait was slightly bizarre and slow and she had up gaze nystagmus. Med. recs. at Ex. 10, p. 10. The doctor concluded petitioner had probable MS. Med. recs. at Ex. 10, p. 11.

On November 29, 1993, petitioner had an x-ray taken of her chest. Med. recs. at Ex. 9, p. 3. Petitioner had left rib pain. She had a friend step on her sternum five days earlier to crack the ribs. She had a history of seven rib fractures on the right side in May 1993. The conclusion was a negative examination. *Id.*

On March 1, 1994, petitioner went to Daniel Freeman Memorial Hospital ER, having been stung by bees. She stated she had a history of MS for five years. She had some right-sided numbness for three weeks. She felt feverish. She was prescribed Prednisone, but she refused to take it. Med. recs. at Ex. 1, p. 96.

On May 25, 1994, petitioner went to the UCLA Medical Center Neurology Clinic where Dr. Sanjay Banerji and Dr. F.L. Yan-Go examined her. Med. recs. at Ex. 9, p. 12. Her MS symptoms started at age 15, consisting of two weeks of diplopia, which completely resolved. In

November 1988, petitioner was numb from the neck down, starting with her feet and progressively ascending over the next few weeks, accompanied by incoordination of all four limbs. This lasted three to five months. She was examined at Olive View and found to have mild discoordination and subjective paresthesia with questionable increased T2 signal in the periventricular area and left corona. In May 1990, petitioner had a recurrence of the gradual hypesthesia in the same pattern as 1988. She also complained of Lhermitte's phenomenon with an electric shock-like sensation going down her back and around her chest on bending her neck. She also had mild discoordination with her gait and both upper extremities. She complained of mild fatigue which heat worsened, such as when she took a hot shower. She also noticed nystagmus and had eye, arm, and leg muscle spasms lasting about one to two minutes. In 1992, she had another bout of diplopia. This time the objects were vertically oriented. *Id.* The diplopia lasted one week and resolved. Med. recs. at Ex. 9, p. 13. She also noticed difficulty with her handwriting. She received oral steroids. In 1993, she lost her balance, both leg and truncal, and the symptoms lasted two weeks and resolved. In June 1993, petitioner fell and fractured six ribs and had a pneumothorax. In January 1994, she had dysesthesia below the neck and "felt like she was on fire." *Id.* This lasted two weeks. She underwent bee sting therapy and took more of it than recommended, developing a mild fever. Presently, she was having transitional dysesthesias diffusely which were painful and not correlated to any change in situation except possibly with heat. She also experienced some urgency with very occasional incontinence. She had had difficulty walking for the past five weeks. She had increased fatigue and stated her thinking might be unclear. She complained of occasional visual blurring without any diplopia. *Id.* She stated her illness affected her ability to study at school. Med. recs. at Ex.

9, p. 14. On examination, she had an afferent pupillary defect. She had horizontal, torsional, and vertical nystagmus. *Id.* Fine finger movements were decreased bilaterally. Med. recs. at Ex. 9, p. 15. She had decreased proprioception and vibration in bilateral lower extremities, toes greater than ankles, greater than knee. She had patchy subjective deficits of pinprick and temperature in bilateral lower extremities and trunk. She had impaired heel to shin coordination bilaterally, left greater than right. Her gait was slightly wide-based. She had a positive Hoffmann's[2] bilaterally. Visual evoked potentials done in 1990 were abnormal. *Id.* Median nerve SSEPs were also abnormal. Med. recs. at Ex. 9, pp. 16. There was the suggestion of somatosensory dysfunction at or above the cervical level. The doctors concluded petitioner had relapsing-remitting MS. She was an appropriate candidate for Betaseron therapy. *Id.*

On June 6, 1994, petitioner had an x-ray done of her left forearm. Med. recs. at Ex. 9, p. 5. She had a contusion because a five-pound shower head filter fell on her left arm. The result was no abnormalities were noted. *Id.*

On January 27, 1995, petitioner went to Tahoe Forest Hospital ER after an automobile accident in which she rearended. She was not wearing a seat belt and hit her head on the windshield. She did not lose consciousness, but complained of pain in her head, neck, chest, arm, mid low back, and both knees. Med. recs. at Ex. 1, p. 81. She had a history of MS diagnosed in 1987. Petitioner had been driving to Elko, Nevada, to see a medicine man for some medical advice. Med. recs. at Ex. 1, p. 83. She had recently completed a course of Prednisone.

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[2] Hoffmann's phenomenon is "increased excitability to electrical stimulation in the sensory nerves; the ulnar nerve is usually tested. Called also *Hoffmann's sign*." Dorland's Illustrated Medical Dictionary, 30th ed. (2003) at 1419.

Id. She was diagnosed with neck and back pain, acute muscular, cervical, and thoracic spine strain, and status post-MS. Med. recs. at Ex. 1, p. 84.

On November 6, 1996, the Ventura County sheriff's office responded to a call from petitioner's parents that she had taken several Vicodin in an attempt to kill herself. She had been depressed because of family problems, wrote a suicide note, and swallowed a handful of Tylenol with codeine. Med. recs. at Ex. 38, p. 14. She was 5 foot 2 and ½ inches and weighed 149 3/4 pounds. Med. recs. at Ex. 38, p. 17.

From November 7 to 13, 1996, petitioner was a mental health inpatient at Ventura County Medical Center. Med. recs. at Ex. 38, p. 10. Petitioner was diagnosed with major depression, dysthymia, an overdose of Tylenol with codeine. She had feelings of self-harm. *Id.* She was prescribed Paxil and Valium. Med. recs. at Ex. 38, p. 11. Dr. Frances O'Sullivan was the admitting physician. Med. recs. at Ex. 38, p. 18. Petitioner's admitting diagnosis was adjustment disorder with mixed disturbance of emotions and conduct, dysthymic disorder, rule out mixed personality traits, history of cytomegalovirus, hepatitis, normal liver enzymes, and MS. Her discharge diagnoses were major, recurrent, and severe depression, dysthymic disorder, overdose of Tylenol with codeine, MS, cytomegalovirus, left brow laceration, TMJ syndrome, whiplash syndrome, and family medical concerns. Petitioner said she needed a new family and could not get along with her mother. *Id.* She said she had been depressed all her life. Med. recs. at Ex. 38, p. 19. She had made three suicide attempts since she was 14 years old. She had psychiatric hospitalization in the past but would not discuss it. She was depressed, angry, and bitter. She had flat affect, depressive thought content, death wishes, and vague auditory hallucinations. She stated she could hear her mother's voice. She had moderate insight and

impaired judgment. *Id.* On November 11, 1996, another psychiatric patient assaulted her and she had a 1.5-cm laceration above her left eyebrow. Med. recs. at Ex. 38, p. 20. Petitioner's liver tests were negative on her having a cytomegalovirus-induced hepatitis. Med. recs. at Ex. 38, p. 22. They were going to screen her for tuberculosis, but she stated that a vaccine had set off her MS. She had positive nystagmus in the left eye. *Id.*

On November 26, 1996, petitioner saw Dr. John M. Larsen, an orthopedic surgeon, having been assaulted on November 10, 1996, resulting in a laceration to her left brown and nose bleeding. She was seen at Ventura County Medical Center ER. She received three sutures to the brow and was given a prescription for Valium. Med. recs. at Ex. 1, p. 34. Petitioner was unemployed, had MS, and was on Social Security benefits because of permanent disability. *Id.* Her MS caused fatigue and weakness in her muscles. This was diagnosed eight years before. Med. recs. at Ex. 1, p. 35. In January 1995, she was in a car accident which injured her head, neck, shoulders, back, right knee, and right ankle. She was in chiropractic care for 10 months and recovered fully. In 1993, she fractured seven right ribs and her left wrist from a horse accident. She had a pneumothorax and required surgery. She fully recovered. Nine years previously, she had a right ankle fracture. At age 18, she had right elbow surgery due to a fracture. in 1991, she had a right knee fracture due to an automobile accident. She had depression for which she took Paxil. She also took Valium and Motrin. *Id.* She was a smoker. As a child, she had many inner ear problems, croup, and allergies. She had hepatitis in the past. She was told she had anemia. *Id.*

Petitioner complained of frequent headaches that started at the top of her head and radiated downwards. Med. recs. at Ex. 1, p. 36. She also had bilateral jaw pain that caused

shooting pain. Her nose was tender. Her neck was tight and painful. The pain radiated into her shoulders, worse on the right. She had occasional numbness in her both hands, more on the right. Her entire back was painful, worse in the upper back. She felt the pain when lifting and raising her arms. She felt pain extending diagonally from the right shoulder to the left low back region. She had some numbness in her feet which could be from the MS. Dr. Larsen's diagnosis was cervical and lumbar strain. *Id.*

On November 27, 1996, petitioner visited a chiropractor Adam Story and gave a history that she had been diagnosed with MS eight years previously. She had broken her right ankle in 1987, after jumping off a ledge. Med. recs. at Ex. 1, p. 3. She broke her right elbow in 1989. She broker her right knee in 1991. In May 1993, petitioner broke ribs 5-11 on her right side because of a horse accident. In January 1995, petitioner had an automobile accident. She received soft tissue manipulation. Petitioner had viral hepatitis in September 1996. *Id.* On November 10, 1996, petitioner was assaulted by a mental patient in the ward where she worked. The patient hit petitioner numerous times in the face. Petitioner was in shock, pain, fear, and was upset. Med. recs. at Ex. 1, p. 2. Later, her pain increased and she felt anxious, restless, and depressed. She had cuts to her face and required stitches over her left eyebrow. Her left cheek and nose were swollen, black and blue. Her neck was injured as was her low back. *Id.*

Petitioner came to the chiropractor because of low back pain, upper back pain, neck pain, headaches, stiff neck, sleeping problems, nervousness, tension, irritability, head seeming too heavy, pins and needles in her arms, numbness in her fingers and toes, fatigue, depression, photosensitivity, loss of memory, ringing in her ears, loss of balance, facial scarring, bruising, and jaw pain. Med. recs. at Ex. 1, p. 3. She complained that physical activity of a simple nature

hurt and she had difficulty falling asleep. She could not concentrate and was not motivated. She did not want to interact socially, lift, bend, and noted that twisting her spine increased her pain. *Id.*

On physical examination, the chiropractor noted a two-inch scar above petitioner's left eyebrow and swelling and discoloration of her left cheek. *Id.* Her range of motion was 80% decreased extension of the lumbar spine, 60% decreased right lateral bending, and 70% decreased left rotation. *Id.* The chiropractor did anterior-posterior full-spine and cervical, thoracic, and lumbar lateral x-rays. He found retrolisthesis of L5, antalgic to the left beginning with the lumbar spine, curvature of the thoracic spine in the coronal plane, reversal of the cervical spine curve, congenital fusion of C2-C3, and posterior pontical of C1. Med. recs. at Ex. 1, p. 4. The chiropractor diagnosed petitioner with lumbar strain and sprain, cervical strain and sprain, facial lacerations, swelling of the left eye and nose, TMJ syndrome, cervicogenic headache, and rib strain and sprain. Med. recs. at Ex. 1, pp. 4-5. The chiropractor attributed her photosensitivity, dizziness, fatigue, and feet numbness to her MS. Med. recs. at Ex. 1, p. 5.

On December 24, 1996, petitioner came to Cedars-Sinai Medical Center because of a motor vehicle accident. Med. recs. at Ex. 23, p. 43. She had a patellar fracture with no significant displacement. Med. recs. at Ex. 23, p. 48.

On January 24, 1997, because petitioner moved, she switched chiropractors and saw Jeffrey E. Ptak. Med. recs. at Ex. 1, p. 8. Petitioner had difficulty concentrating, increased anxiety, inability to sleep, constant generalized headaches, left jaw pain and muscle spasms with clicking and difficulty chewing, generalized stiffness and joint pain, forgetfulness, confusion,

depression, and an increase in anxiety and fatigue. Med. recs. at Ex. 1, p. 9. She was diagnosed with MS in 1987. Med. recs. at Ex. 1, p. 10.

On March 15, 1997, Dr. Michael A. Gould, a dentist at the Oral Facial Pain Center, wrote to Dr. William Sobel about petitioner's injuries after the assault of November 11, 1996. Med, recs, at Ex. 1, p. 63. Petitioner complained of facial pain, mouth discomfort, painful and restricted jaw movement, and pain in the jaw/cheek/temple areas upon chewing resistant foods, jaw joint noises, inability to open the mouth smoothly, inability to find her bite, clenching, jaw deviation to one side when opening, headaches, neck aches, ear symptoms (ringing, pain, decreased hearing, clogging, itchiness), dizziness, eye symptoms (pain, photosensitivity), throat symptoms (soreness, swallowing difficulties, feeling of a foreign object), numbness or pain in the arms and fingers, shoulder aches, and back aches. Med. recs. at Ex. 1, p. 63-64.

A mental patient attacked petitioner's face, neck, and jaw area by punching her several times. Med. recs. at Ex. 1, p. 64. Petitioner was treated for TMJ from a car accident she had in January 1995, which resolved in October 1995. Chiropractor Jeffrey Ptak referred petitioner to Dr. Gould. *Id.* Her symptoms have caused petitioner moderate difficulty in sleeping, with exhausting during the day, impaired ability to concentrate, and moderate irritability, depression, frustration, and severe anxiety. Med. recs. at Ex. 1, p. 66. Dr. Gould found that petitioner had a temporomandibular disorder. Med. recs. at Ex. 1, p. 67. EMG of the four muscle groups associated with the temporomandibular joint revealed neuromuscular and skeletal imbalance between the mandible and the cranium. Med. recs. at Ex. 1, p. 69.

On March 20, 1997, petitioner saw Dr. Alvin Reiter, a facial plastic surgeon and otolaryngologist. Med. recs. at Ex. 1, p. 88. Petitioner developed multiple scar deformities as a

result of lacerations to the left upper eyelid area and abrasions to the left upper lip due to the assault. *Id.* The scars caused pain, pressure, and tightness as well as sensitivity to touch. *Id.*

On April 3, 1997, petitioner went to the Los Angeles Free Clinic, complaining of abdominal pain and pain in her lower back. The assessment was a possible urinary tract infection. Med. recs. at Ex. 1, p. 47.

On April 10, 1997, petitioner went back to Los Angeles Free Clinic, complaining of high fever, and sharp side and lower back pain. Her temperature was 98.5º. She had possible pelvic inflammatory disease or pylenephritis. Med. recs. at Ex. 2, p. 1.

On April 29, 1997, petitioner returned and was diagnosed with resolving PID. Med. recs. at Ex. 2, p. 3.

On August 22, 1997, petitioner had a head CT scan done because of a fall and subsequent decreased range of motion, confusion, and dizziness. Med. recs. at Ex. 20, p. 30. She had a normal CT scan. *Id.*

On August 29, 1997, petitioner saw Dr. Barbara Clure at SeaMar Community Health Centers, for follow-up on her confusion and headache after a fall from a horse. Med. recs. at Ex. 23, p. 287. A CT scan done the prior week was benign. She had severe frontal headache. Deep tendon reflexes were 1+ in the brachial, brachioradialis bilaterally, in the knees, and the ankles, and 2+ in the left knee. Dr. Clure's impression was probably concussion, but perhaps a mild exacerbation of her MS. *Id.*

On September 2, 1997, petitioner went to SeaMar Community Health Centers for re-evaluation of headache and low back/tailbone pain. Med. recs. at Ex. 23, p. 288. She is no worse than when she was see four days previously. She did not think Ibuprofen helped and

wanted Vicodin. Dr. Adams and the nurse practitioner agreed that they would like not to use narcotic pain medication but continue anti-inflammatories. *Id.*

On September 4, 1997, petitioner saw Dr. Clure at the SeaMar Community Health Centers, complaining of pain in her hips, neck, and jaw. The headache and TMJ pain had been occurring since November 1996 when she was assaulted in a hospital. The hip and neck pain were related to her recent fall from a horse. Med. recs. at Ex. 23, p. 290. She came to Dr. Clure for pain medication. She reported that Daypro and Flexeril did not help her pain. She also reported some trouble concentration since she fell from the horse. She had some mild symptoms of this prior to the incident but now reported it was much worse. She said that sometimes she forgot words in mid-sentence. On September 3, 1997, she was driving on the wrong side of the road. She had trouble falling asleep because she clenched her jaw. She noted decreased appetite and fatigue. She weighed 156 pounds. She said she felt jittery and could not carry on a conversation. *Id.* Dr. Clure explained to petitioner that she did not feel comfortable giving petitioner a narcotic pain medication because this would worsen her confusion. Med. recs. at Ex. 23, p. 291. She also discussed with petitioner the importance of not using narcotic pain medication for chronic pain. She recommended using antidepressants for chronic pain, but petitioner was against using antidepressants because she thought they made her feel too strange. Dr. Clure recommended physical therapy, Daypro and Flexeril. *Id.*

On September 18, 1997, petitioner saw Dr. Clure at SeaMar Community Health Centers, to follow up on her concussion and chronic neck and back pain. *Id.* Physical therapy was helping her a lot and her low back pain was almost completely resolved. Her confusion was mostly resolved. *Id.*

On October 16, 1997, petitioner saw Dr. Clure. Two days previously, she again fell off a horse onto her left hip area. Med. recs. at Ex. 23, p. 292. Petitioner had tried Prozac, Imipramine, and Paxil in the past but felt they made her too "amped up" and out of control. Med. recs. at Ex. 23, p. 293. Dr. Clure explained to her that they were not stimulating types of antidepressants and she should not have those side effects. *Id.*

On November 24, 1997, petitioner saw Dr. Clure. Med. recs. at Ex. 23, p. 294. She had some bladder control problems. She was to have five more sessions of physical therapy. Dr. Clure offered her a flu vaccination but she said that previous vaccines had set off her MS so she preferred not to have the vaccination. *Id.*

On February 5, 1998, petitioner Dr. Clure, complaining of a three-week history of feeling very fatigued, having an overwhelming sensation of dread. Med. recs. at Ex. 23, p. 295. She had been feeling feverish (her temperature in the office was 98.6º) and she had achy joints. For the last two days, she had headache, stiff neck, and pressure behind her eyes. She noted decreased appetite. Her weight was 162 pounds. Her urine had been dark. She felt slightly weak and dizzy. She had hepatitis A in September 1996 when she was in Costa Rica. Petitioner said she felt like she did when she had hepatitis. Her symptoms came on the week after she started her nicotine patch. On examination, her weight was nine pounds higher than her last visit in October 1997. She was afebrile. Her nose was mildly erythematous. Her throat was erythematous without exudate. She had sinus tenderness. *Id.* Dr. Clure's assessment was diffuse complaints of fatigue, headache, decreased appetite, abdominal pain, and nausea of unclear etiology. Dr. Clure would check her thyroid. Med. recs. at Ex. 23, p. 296.

Also on February 5, 1998, at 7:30 p.m., petitioner telephoned SeaMar Community Health Centers to report that her muscles were seizing up and her chest was heavy. She was shivering and having hallucinations, seeing "patterns" and "bits of blue." Med. recs. at Ex. 23, p. 298.

On February 10, 1998, petitioner saw Dr. R. Emil Hecht to resolve the scar and laceration over her left eye and eyebrow area and various other changes including the otomandibular syndrome in the right jaw region. Med. recs. at Ex. 1, p. 110.

On February 12, 1998, petitioner saw Dr. Clure. She stated that after she left on February 5th, she got worse, had shaking chills, and hallucinations. She still had fatigue but was otherwise back to normal. Med. recs. at Ex. 23, p. 297. She wanted to know why she had chills, fevers, hallucinations, and other problems. Her lab work including thyroid was completely normal. She remembered taking some herbal products prior to the episode, including horse tail, sage, licorice root and various fruits from other countries and wondered if some of these preparations caused her symptoms. *Id.*

Petitioner had 24 physical therapy treatments from March 12 to June 12, 1998 with Northwest Physiotherapy Associates. Med. recs. at Ex. 8, p. 32. In the initial visit, petitioner reported that she had pain and tightness in the bilateral region, right greater than left, as well as pain in the scalp and external ear area, sternocleidomastoid, scalenes, levator, scapula, and suboccipitals bilaterally. She reported intermittent headaches. She said her symptoms were aggravated by eating, sleeping, driving, and stress increase. Her symptoms began after an assault in November 1996 when she was punched in the face. She had been treated so far with acupuncture, dental treatment, massage, and chiropractic treatment with only limited success. Med. recs. at Ex. 33, p. 59.

On April 15, 1998, petitioner saw Dr. Herbert P. Gordon, a dentist, regarding her complaints about a temporomandibular joint disorder. Med. recs. at Ex. 2, p. 42. Since her assault on November 11, 1996, petitioner had limited mouth opening, pain when moving her jaw, pain when eating, daily headaches involving the lateral and supraorbital areas of the head; pain during sleep which caused her to have restless sleep, occasional clicking in both temporomandibular joints, and need to avoid certain foods because of pain arising when she chewed them. She also had constant tightness in her neck and shoulders. *Id.* Dr. Gordon diagnosed traumatic arthropathy involving her TMJ and jaw-movement muscles. Med. recs. at Ex. 2, p. 43.

On April 28, 1998, Dr. Hecht performed scar excision after laser ablation and subsequent peel. Med. recs. at Ex. 1, p. 111.

On May 11, 1998, petitioner's physical therapist noted that petitioner continued to have both increase and decrease in her symptoms and the physical therapist was uncertain why she had these flare-ups and improvements. Med. recs. at Ex. 8, p. 33. When petitioner was in a car accident in 1994, she had treatment for whiplash and TMJ. Med. recs. at Ex. 8, p. 34.

On September 9, 1998, petitioner went to Dennis C. Littleton, a doctor of naturopathy. Med. recs. at Ex. 7, p. 42. Her health concerns were pain, anxiety, neck and should tightness which was worsening on simple activities such as turning head, chopping vegetables, lifting as little as five pounds. Sometimes she had burning. *Id.*

On September 9, 1998, petitioner told naturopath Littleton that she had hepatitis A illness in October 1996 and was hospitalized in November 1996. Med. recs. at Ex. 7, p. 40. She was assaulted by a mental health patient. The beating reactivated her TMJ pain. The right side of her

head got tight. She had sensitive ears. She might get tight behind the eyes. MS was diagnosed 10 years ago. She had had eight motor accidents. She had good response with magnet therapy. *Id.* She had anxiety from the attack. Med. recs. at Ex. 7, p. 41. She felt hypervigilant about being attacked. She had occasional headaches. She had surgery in April over the left eye and right forehead from the assault. *Id.*

In a health questionnaire for naturopath Littleton that petitioner filled out on September 16, 1998, she wrote that she had pain in her neck and jaw. Med. recs. at Ex. 7, p. 46. She was on Flexeril and Daypro. She said she was allergic to Prednisone. *Id.* She said she had hepatitis in September 1996. Med. recs. at Ex. 7, p. 47. She checked off her past symptoms: insomnia, poor appetite, night sweats, heavy sensation in head or limbs, allergies, dizziness, blurred vision, numbness/tingling, imbalance, muscle weakness, head felt heavy, photosensitivity, loss of balance, dizziness, loss of hearing, buzzing in ears, pain in neck and with movement, stiff neck, anxiety or worry, depression, pain around ribs, low back pain when sitting, mid back pain between shoulder blades, ringing in ears, jaw tight or sore, difficulty with hearing ear pain, grinding teeth, neck pain, shoulder pain, arm pain, ankle weakness, joint pain which moved from one joint to another, pain across shoulders, tension in shoulders, muscle spasms in shoulders, change in appetite or change in eating habits. nausea, vomiting diarrhea, constipation, ball bladder concerns, abdominal pain/cramps, bloody stools liver trouble, pain in hip joint, pins and needles in legs, and numbness of legs, feet and toes. Med. recs. at Ex. 7, pp. 49-50.

Petitioner checked off her present symptoms: sleep problems, actively dreaming, nervousness, fatigue, frequent headaches, weight gain, loss of coordination, memory loss, intermittent headache in the temples, photosensitivity, hearing loss, pain in ears, pain in neck,

neck pain with movement, stiff neck, grinding, grating, and popping sounds in the neck, anxiety or worry, tension, fear, restlessness, depression, panic attacks, low back pain when sitting, pain between shoulder blades, muscle spasms, burning (which she wrote in), earache, tight or sore jaw, grinding teeth, neck pain, shoulder pain, arm pain, hip pain, ankle weakness, pain across shoulders, tension in shoulders, muscle spasms in shoulders, gall bladder concerns, pain in hip joint, easy bruising, dry skin, hair changes, and wounds which healed slowly. *Id.*

On September 17, 1998, petitioner saw naturopath Littleton and received acupuncture. Med. recs. at Ex. 7, p. 39.

On September 24, 1998, petitioner saw naturopath Littleton. She was still tired and not sleeping well. He prescribed acupuncture and magnets. *Id.* Her memory was okay but not good with data and trivia. She was good with concepts. Med. recs. at Ex. 7, p. 38. She was pretty sensitive to light. She might awaken at 3:00 - 5:00 a.m. and return to sleep. A falling sensation might awaken her. *Id.*

On September 29, 1998, petitioner went to SeaMar Community Health Centers, complaining of severe fatigue and slow healing process. Med. recs. at Ex. 23, p. 272. She wanted her thyroid tested. The assessment was to question the etiology of petitioner's malaise. Petitioner had normal thyroid studies done in February 1998 when she had the same complaint of fatigue. *Id.*

On October 2, 1998, petitioner saw naturopath Littleton. Med. recs. at Ex. 7, p. 36. She had lost the magnet on the shoulder. She felt really stressed now. Her temple and jaw tension was due to this stress. She slept okay. She felt like she was on fire last night. She worried about an MS attack. Littleton prescribed acupuncture. *Id.*

On October 7, 1998, petitioner saw naturopath Littleton. *Id.* Things at home were a little better. Her jaw felt somewhat better. Her temple area was very tight. The back side of her right thigh was pretty tight. *Id.*

On October 14, 1998, petitioner saw naturopath Littleton. Med. recs. at Ex. 7, p. 37. Her left jaw seemed to be hurting recently. She was feeling attacked by other people on all sides. Littleton referred her to a psychologist. He gave her acupuncture. *Id.*

On October 21, 1998, petitioner saw naturopath Littleton. *Id.* She was feeling weak. She had a cold the last couple of days and was coughing. Her anger increased lately. She did not have much sleep because of stress. Her left jaw had no improvement at all. She saw the chiropractor but had no improvement. She had pulsing muscle spasms in the right temple area. Littleton gave her acupuncture. *Id.*

On October 29, 1998, petitioner saw naturopath Littleton. Med. recs. at Ex. 7, p. 34. Her left jaw shifted without much pain. Her cold was tailing off. She quit smoking. She was losing some weight and did not have much appetite. She felt a dagger action in the right shoulder blade. Her temples were contracting. She wanted homeopathic treatment. She was afraid when she was in a car that another car would hit her. She was afraid of getting too close to people. She was an active person but had a lack of confidence and no balance. Rubbing her fingers on a textured surface might sedate her. Her parents leaving her at a fundamentalist camp was a longstanding torment. The group mesmerized her for hours. She fought this. She felt that she did not have control and had been in many vulnerable situations. She had anxiety. Her family drank alcohol. *Id.* She was afraid of intimacy because people close to her had manipulated or violated her.

Med. recs. at Ex. 7, p. 35. She had nervous tremors. She had dreams of not getting to the bathroom on time. *Id.*

On November 12, 1998, petitioner saw naturopath Littleton. Med. recs. at Ex. 7, p. 30. She got really sick and was getting over a cold. She started a new job at the Battered Women's Shelter. The right side of her head felt really tight. The pinching on her cheek was over. Littleton prescribed acupuncture. *Id.*

On November 19, 1998, petitioner saw naturopath Littleton. *Id.* She had a fight with her roommate. She burned incense. Petitioner had menstrual cramps. She quit smoking and felt more emotional for this. She had anxiety especially when driving a car. She was somewhat more comfortable with herself. She was making baskets. She had somewhat less tightness in the TMJ area. She had a low appetite. She had some tightness behind the right eye. She had stress from the navel to the neck and the left chest. Littleton recommended acupuncture. *Id.*

On November 21, 1998, petitioner received hepatitis B vaccine.

On December 9, 1998, petitioner saw Dr. Robert Luby at SeaMar Community Health Center for her workmen's compensation claim that hepatitis B vaccine had caused a burning sensation from her hips to her feet and seemed to be rising in her body. Also, she was weak and tired. Med. recs. at Ex. 23, p. 268. Petitioner was still able to work. Since the vaccination, she had decreased lower extremity light sensation, and weakness of arms, legs, and stomach muscles. On examination, she had 5/5 strength in all four extremities, and decreased sensation from T-7 and below. He diagnosed paresthesias, burning sensation, and subjective weakness. He thought this was probably related to the vaccination based on the time course. *Id.*

On December 9, 1998, petitioner saw naturopath Littleton. Med. recs. at Ex. 7, p. 31. Hepatitis B vaccine made her feel as if she were on fire. She had fatigue and brain fog. She had some speech problems. She filled out a workmen's comp claim for this. She saw another doctor that morning. Her jaw was cramping up. Her muscles and joints were a little tight. This was aggravated from the vaccine. Her depression persisted. Her pulse at sleep was weak. Littleton recommended acupuncture. *Id.*

On December 16, 1998, petitioner saw naturopath Littleton. She was somewhat more fatigued. *Id.* She had an almost unbearable vaccine reaction. She was trying not to lose muscle tone. Her muscles fatigued very severely. Her nerves still burned from the vaccine. Her jaw and neck were both tight. She wanted to live on the reservation. She felt very stressed. She wanted to deal with the neck and jaw. She had fallen several times. She was depressed. She had weird dreams. Littleton recommended acupuncture. *Id.*

On December 23, 1998, petitioner saw Dr. Walter N. Ruf, a neurologist. Med. recs. at Ex. 23, p. 33. She was hospitalized at age 17 at UCLA for vague neurologic symptoms: a feeling of heaviness, decreased coordination, difficulty writing, and aphasia. Her diagnosis was possible MS. Five months later, petitioner had an episode of nystagmus. She had blurring of vision and occasional diplopia. She was diagnosed with MS after she developed a positive Lhermitte's sign associated with numbness and fatigue. Over the last 10 years, she has had 10 or fewer attacks. At one point, she had rubella and mumps vaccinations, followed by burning paresthesias and dysesthesias in all four extremities. She treated herself with bee stings and eventually her symptoms resolved. She was working at the women care shelter and received a hepatitis B vaccination on November 21, 1998. After this, she had burning dysesthesias from the waist

distally. The question was whether the hepatitis B vaccination caused these dysesthesias or might have exacerbated her MS. Petitioner participated in a study with magnets at the University of Washington. *Id.* Petitioner's height was five foot four inches. Her weight was 160 pounds. Med. recs. at Ex. 23, p. 34. On examination, the visual fields were full to confrontation testing. The fundi showed sharp optic discs bilaterally. She had a few beats of nystagmus on vertical gaze. She had symmetrical strength in the four extremities and tone was normal. *Id.* Her reflexes were 2+ in both biceps, 1+ in both triceps, 2-3+ in both knees, and 2+ in both ankles. Med. recs, at Ex. 23, p. 35. She could walk without difficulty. She could toe walk, heel walk, and tandem walk without difficulty. Romberg test was normal. She did not have dysmetria or dyssynergia in the four extremities. There was no intentional tremor. Her sensory examination was unremarkable. However, she reported burning dysesthesias from the wait distally. Dr. Ruf's impression was that petitioner was in complete remission with regard to objective neurologic signs and symptoms of MS. She did have subjective paresthesias. "With regard to burning dysesthesias and MS, it is extremely unusual for MS to cause any painful symptoms." *Id.* Petitioner appeared to be fully functional and reported she had improved somewhat. Dr. Ruf did not recommend any treatment for her. *Id.*

On December 24, 1998, petitioner saw naturopath Littleton. Med. recs. at Ex. 7, p. 28. She had moved and felt she would be living on the reservation for a while. She had a shared living arrangement. The burning was decreasing some. Her jaw was kind of tight. She was tense because she had to drive in snow. She also had to move a couple of other people. Littleton prescribed acupuncture. *Id.*

On January 5, 1999, petitioner saw Dr. Patrick A. Delaney, a neurologist. Med. recs. at Ex. 11, p. 7. Within a couple of days after receiving hepatitis B vaccine in November 1998, she had increased fatigue and a diffuse burning sensation from the waist down. She was not able to lift as much weight or do as many repetitions. She had transient white flashes in the periphery of her vision. She did not have fever, chills, nausea, vomiting, diarrhea, myalgias, or arthralgias following the vaccination. *Id.* Dr. Delaney started petitioner on Neurontin. Med. recs. at Ex. 11, p. 5. On examination, speech and cognitive testing were entirely normal. Med. recs. at Ex. 11, p. 8. Motor examination revealed no upper extremity drift. Muscle strength, tone, and bulk were symmetric throughout all four limbs. Distal sensory examination revealed a subjective alteration in pinprick level at about T9. All other modalities were intact distally. Graphesthesia was normal in the hands. There was no pain to palpation over the cervical, thoracic, or lumbosacral spine. Cerebellar testing revealed normal finger-to-nose and heel-to-shin testing with no rebound and no dysdiadochokinesia. Cranial nerve examination revealed full visual fields. Ocular motility was full, without nystagmus. The pupillary reflexes were symmetric and the optic disc margins sharp. Facial movement and sensation were symmetric. The examination was largely unrevealing, aside from the subjective alteration in pinprick sense in the thoracic region. *Id.* Available studies have consistently failed to disclose any relationship between immunizations and specifically hepatitis B vaccination and consistent worsening of symptoms or physical findings. Med. recs. at Ex. 11, pp. 11, 5. He discussed this with petitioner in depth. Med. recs. at Ex. 11, p. 5.

On January 13, 1999, petitioner telephoned Dr. Delaney, feeling "wasted" on Neurontin. She was instructed to maintain the dose until she felt better. Med. recs. at Ex. 11, p. 7.

On January 15, 1999, petitioner telephoned Dr. Delaney because she had a sharp chest pain which lasted about five minutes after she drank a Pepsi and she wanted to know if Neurontin caused this. Dr. Delaney said that Neurontin should not cause chest pain. *Id.*

On January 22, 1999, petitioner saw naturopathy Littleton. *Id.* She had been experiencing shortness of breath. She had plenty of anger about work. Her jaw was very tight especially now with work problems. Littleton prescribed acupuncture. *Id.*

From February 1-26, 1999, petitioner received outpatient rehabilitation for otomandibular syndrome. Med. recs. at Ex. 8, p. 30. She had TMJ pain and tightness and complaints of pain in the scalp, right ear, and cervical musculature. The symptoms were the result of an assault in November 1996. She had intermittent headaches. Her symptoms were aggravated by eating, sleeping, driving, and increased levels of stress. She had hypertonicity of her cervical muscles with marked tenderness on palpation. *Id.*

On February 11, 1999, petitioner saw naturopath Littleton and discussed jaw pain. Med. recs. at Ex. 7, p. 29. Petitioner claimed TMJ was not a problem before the assault. She was angry and anxious about the California State crime organization not following through with more original commitment. Apparently, what they said was not what they were doing in disbursements to health care providers. Petitioner had not had much sleep. Her right cheek had tightness which led to jaw discomfort. Her temples were okay that day. Her tongue had red edges. Littleton prescribed acupuncture. *Id.*

Also on February 11, 1999, Dr. Ruf wrote a letter to Dr. Warren B. Howe, Chairman of the Grievance Committee for the Whatcom County Medical Society related to a grievance petitioner filed. Med. recs. at Ex. 39, p. 5. Petitioner had seen Dr. Ruf on December 23, 1998 at

Dr. Luby's request. Petitioner requested from Dr. Ruf during the course of the prolonged office visit on December 23, 1998 validation that she had MS. Dr. Ruf could find no direct objective evidence on her clinical examination that she had any manifestations of MS. Her examination showed full normal function. Petitioner wanted treatment for MS but Dr. Ruf, because he had no confirmation that she had MS, regarded such treatment as inappropriate. Petitioner wanted validation from Dr. Ruf that hepatitis B had exacerbated her MS, but Dr. Ruf stated this could not be confirmed. Petitioner wanted validation from Dr. Ruf that her magnet therapy and bee sting therapy benefitted her MS. Dr. Ruf could not validate this. Petitioner wanted Dr. Ruf to validate that the women's shelter required she receive hepatitis B vaccine which caused her MS exacerbation and that the Washington Department of Labor and Industries was liable, but Dr. Ruf could not engage in such speculation. Petitioner clearly did not like Dr. Ruf's answer. Petitioner insisted Dr. Ruf accept that she had MS purely on her verbal history, but he would not do that because her clinical examination and he would need clear objective past evidence to confirm the diagnosis. *Id.*

On February 16, 1999, petitioner saw Dr. Delaney. Med. recs. at Ex. 11, p. 5. Petitioner's physical examination was entirely normal. She had no focal neurological deficit to motor, sensory, cerebellar or cranial nerve testing. She had excellent improvement in her paresthesias and dysesthesias on Neurontin. *Id.*

On February 18, 1999, petitioner saw naturopath Littleton. *Id.* Petitioner had influenza virus and was extremely congested. She had jaw pain now and persistent temple contraction. Littleton prescribed acupuncture. *Id.*

On February 22, 1999, petitioner saw naturopath Littleton with right jaw discomfort. She was meditative and feeling positive. Med. recs. at Ex. 7, p. 26. Her bronchial cough persisted. She had received antibiotics for TMJ. He prescribed acupuncture. *Id.*

On March 11, 1999, petitioner saw naturopath Littleton, *Id.* She wondered about cytomegalovirus. She had been sleeping very hard and wondered about bladder infection. She was not eating much. She had to move again. Her neck was bothersome because it felt tight. Her jaw was not too bad that day. He prescribed acupuncture. *Id.*

On March 18, 1999, petitioner saw naturopath Littleton, with a possible yeast problem. *Id.* She was using suppositories. She was avoiding sugar. She recently had hearing loss with the right worse than the left. There was no heat at home now. She ran out of propane. Her jaw was very tight. She was considering returning to physical therapy. Her energy levels had gone up. She did not feel exhausted at that point. Her neck had been popping and cracking lately. She had a pattern of numbness around her waistline which began a couple of weeks earlier. The ridges of her tongue were red. Littleton prescribed acupuncture for TMJ. *Id.*

On April 1, 1999, petitioner saw naturopath Littleton, complaining of a cervical biopsy which was followed by bleeding and some cramping. She had boyfriend problems. Her housing situation was going downhill. Med. recs. at Ex. 7, p. 25.

On April 9, 1999, petitioner saw naturopath Littleton, looking tired. She was sleeping in a new home now. She was still distressed over having to move. She felt cold and had thrust symptoms. She was congested and very busy. She did not work this week. Her tongue had red edges. Her right ear was still plugged. She had very limited revenue which had to go into her car. She had sharp pains in her jaw. Was this connected to her ear? She was involved in

ceremonies. Her energy levels were moving around. Her stomach had been tight for the last six days. Med. recs. at Ex. 7, p. 25.

On April 28, 1999, petitioner saw Dr. Hecht with concerns about her general health. There was still some redness in the facial area. Med. recs. at Ex. 1, p. 106. Petitioner was excited about her upcoming trip to Mexico. She wanted Laramine medication and samples of Cellex-C or hydroxy acid for the skin. *Id.*

On May 5, 1999, petitioner saw naturopath Littleton. Her jaw tension was pretty severe. Med. recs. at Ex. 7, p. 13. She had been seeing a chiropractor for care. Her jaw stress seemed to be aggravated by financial matters concerning victims of crime. She was up for review for Social Security benefits. She had neck and shoulder tension. *Id.*

On May 8, 1999, Dr. Patricia Sparks wrote to nurse Barbara Salnitzer, regarding petitioner's workmen's compensation claim. Med. recs. at Ex. 23, p. 63. Dr. Sparks wrote that petitioner complained of burning from her hips to her feet, weakness, and fatigue after receiving hepatitis B vaccine during her employment. Dr. Walter Ruf saw her in December 1998 and noted she had no neurologic signs on examination. Dr. Delaney also saw her and did not note any focal neurologic findings. *Id.*

On May 14, 1999, petitioner saw naturopath Littleton, saying her jaw really acted up over the prior three days. She had an episode of anger and kicked it into gear. She was doing self-love meditation. She was going for acupuncture. *Id.*

On May 20, 1999, the Whatcom County Medical Society Grievance Committee, per Dr. James R. Lohse, wrote petitioner that the Committee was unable to resolve her differences with Dr. Ruf. Med. recs. at Ex. 39, pp. 10-11.

On June 8, 1999, the State of Washington, Department of Labor and Industries, Division of Industrial Insurance, sent a Notice of Decision to petitioner, denying her claim because hepatitis B vaccine did not cause her condition, her condition pre-existed the alleged injury and was not related to it, and petitioner did not sustain a personal injury. Med. recs. at Ex. 23, p. 64.

On June 17, 1999, petitioner saw Dr. James Erhardt, an ear, nose, and throat specialist, complaining of ear discomfort and hearing loss since her assault in November 1996. She said that more recently, she had sharp, stabbing pain in the right ear. Med. recs. at Ex. 1, p. 100. She felt pressure in her left ear and fluid in both ears. Some of her symptoms might be due to her chronic TMJ problems. She was also bothered by bilateral clicking in the ears which she thought was wax moving. She has used Q tips or tools in her ear and wax candles in the past. She had scar revisions by Dr. Hecht. She felt a plane trip in March 1999 worsened her hearing. *Id.* Dr. Erhardt diagnosed neuralgia (recent sharp stabbing pain), possible stapedial tendon tic which was benign, possible low-grade chronic eustachian tube dysfunction, potentially related to allergy, history of allergies, possible progressive hearing loss, chronic pain syndrome following assault, and MS. *Id.*

On June 18, 1999, petitioner saw the naturopath Littleton. She was wiped out from legal stuff and bureaucratic nonsense. Pain was beating her down. Her right ribs hurt. Her right shoulder was tight. Her ears were clogged. Her workmen's compensation claim was being reviewed. Med. recs. at Ex. 7, p. 13.

On June 23, 1999, Dr. Daniel Berg, a dermatology surgeon, wrote to Dr. R. Emil Hecht. He saw petitioner who had done well after facial surgery in April 1998, but was concerned about erythema around the brows. Med. recs. at Ex. 8, p. 23. He discussed with her pulsed dye laser.

Petitioner stated that she had MS diagnosed at age 21 with numbness, fatigue, and aphasia associated with that. She complained about a reaction to hepatitis B vaccine resulting in "burning over her lower body." *Id.*

On June 24, 1999, petitioner wrote the State of Washington, responding to the denial of her workmen's compensation claim. Med. recs. at Ex. 23, p. 65.

On July 6, 1999, petitioner saw Dr. Delaney. He planned to begin petitioner on Amantadine. Approximately 90% of the visit was spent with petitioner reviewing her various reasons for opening a claim and/or bringing law suits regarding a hepatitis vaccination. While Dr. Delaney was sympathetic, he had not seen "any convincing evidence that this agent consistently causes such a health issue, and I have discussed this quite candidly with her." Med. recs. at Ex. 2, p. 28. Petitioner stopped taking Neurontin because it impaired her concentration. She mainly complained of fatigue. Med. recs. at Ex. 11, p. 6. Petitioner's neurological examination remained unrevealing with no focal weakness to confrontational testing, symmetric deep tendon reflexes, flexor plantar responses, no cerebellar abnormalities on finger-to-nose testing, and a normal cranial nerve examination including full visual fields, full ocular motility without nystagmus, symmetric pupillary reflexes and sharp optic disc margins. *Id.*

On July 7, 1999, petitioner saw Dr. Erhardt again. She had some recurring discomfort in the right infra-auricular area. The examination was quite benign. She had mild, flat, low- and high-sensorineural hearing loss in the right ear. Med. recs. at Ex. 1, p. 100. It was slightly worse than in March. *Id.*

On July 27, 1999, petitioner saw a naturopath Littleton. Med. recs. at Ex. 7, p. 12. She needed to move again and was living in a friend's condo. She was severely depressed. Her last

living situation turned abusive. She had bad dreams and her hair was falling out. She had underlying paranoia. Homelessness was clearly aggravating her health. She stopped taking Amantadine because she felt it was contributing to her depression. She wondered if her hair loss and burning sensations were due to hepatitis vaccine. There was a recent death in the family. *Id.*

On August 3, 1999, petitioner went to SeaMar to discuss hair loss, depression, and fatigue. She felt these symptoms were due to hepatitis B vaccine, but her neurologist did not support her on that and she was quite frustrated. Her workmen's compensation claim was denied and all these things were extremely stressful for her. Med. recs. at Ex. 35, p. 32. She was tearful intermittently through the examination. She had flattened affect. She had extremely long hair that she reported was extremely thick before. There were no distinct patches of scalp baldness noted and no significant amount of hair breakage noted. *Id.*

On August 10, 1999, petitioner went to Care Medical Group, after having a motor vehicle accident on August 5, 1999. Med. recs. at Ex. 26, p. 10. She had no pain at the time and had not sought any medical advice before that day. She weighed 142 pounds. *Id.*

On August 25, 1999, petitioner saw Dr. Susan Douglas, a neurologist, at UCLA Medical Center. Med. recs. at Ex. 9, p. 9. Petitioner complained of depression, difficulty concentration, memory loss, and visual flashes in front of her eyes since a hepatitis B vaccination in November 1998. *Id.* She was diagnosed with MS in November 1998. Her symptoms began when she was 16 with an episode of diplopia of sudden onset with objects appearing horizontally to each other. This completely resolved. In November 1998, she had numbness in her feet which ascended over the following few weeks, accompanied by incoordination in all four extremities. This lasted three to five months and resolved without sequelae. She also complained of electric shock

sensation going down her back and around her chest on bending her neck. She complained of fatigue which was worse with heat such as taking a hot shower. When treated with steroids, she had complete resolution within one week. She said her baseline was two episodes a year when she experienced symptoms from whole body numbness, heavy limbs, decreased coordination, weakness, fatigue, aphasia, and shooting pains. The symptoms could last two to three months and then resolve. She also had occasional incontinence. *Id.* Shortly after the hepatitis B vaccination, she had an exacerbation where she felt like she was on fire from the waist down. She was treated with Neurontin which helped and this episode resolved in about four months. She now stated that she had residual depression, difficulty concentrating, memory loss, and flashes in front of her eyes. She stated her depression waxed and waned. She had suicidal ideation without a plan at times and said that at times, she wished she were dead but would not hurt herself. She had decreased appetite and had been losing hair. She had cytomegalovirus and hepatitis A disease in November 1996. She had exacerbation with MMR vaccine in 1994. She had numerous accidents causing fractured left capitulum and seven broken ribs and a pneumothorax in June 1993, right patellar injury in December 1991, right humerous injury in 1990, and fractured ankle in 1986. She graduated from UCLA and had worked at a battered women's shelter but not in the prior month. *Id.* She had been smoking since age 14. Med. recs. at Ex. 9, pp. 9-10. On examination, petitioner had vertical nystagmus on upgaze. Med. recs. at Ex. 9, p. 10. She had decreased vibration, light touch, and pinprick in the right lower extremity in a stocking distribution. She had an upgoing toe on the right. Dr. Douglas's conclusion was that petitioner had relapsing, remitting MS. Petitioner had subjective sensory loss in the right lower extremity, vertical nystagmus, and upgoing toe on the right. The rest of her neurological

examination was normal. Her hair loss may be related to depression due to the stress of having a workmen's compensation claim pending. *Id.* Dr. Douglas told petitioner there was no statistically significant scientific evidence to relate hepatitis B vaccine to MS exacerbations. Med. recs. at Ex. 9, p. 11. There were however anecdotal reports. *Id.*

On September 3, 1999, petitioner went to Care Medical Group, requesting more Vicodin. She had an automobile accident on August 5, 1999. Med. recs. at Ex. 26, p. 8. Her grandfather died recently and this affected petitioner's ability to concentrate on her therapy. She still had pain along her neck, jaw, shoulders, and back. She had some depression but felt that the car accident triggered anxiety and depression on its own, making her more emotionally labile. *Id.*

On September 14, 1999, the State of Washington responded directly to petitioner's request for an explanation for the denial of her workmen's compensation claim since petitioner's attorney had withdrawn from representing her. Med. recs. at Ex. 23, p. 84. These were the reasons for rejecting her claim: the hepatitis B injection did not cause an MS condition and the objective medical findings did not support petitioner's claim that her MS was being worsened. There were no abnormal objective findings to support petitioner's claim that her symptoms were consistent with a vaccine reaction and no specific treatment was given for a possible reaction.

On September 15, 1999, petitioner saw a Dr. Mark J. Doherty for evaluation of diffuse alopecia of approximately one year's duration. Med. recs. at Ex. 2, p. 29. She stated it occurred immediately after hepatitis B vaccination at Womencare Shelter in November 1998. She lost 30 pounds and had been feeling weak with a history of optic neuritis and a sense her body was on fire. She attributed all these problems to the hepatitis B vaccination. She had a history of MS diagnosed in 1990 and again in 1988 after an MRI and spinal tap. Her MS was manifested by

fatigue, flashes, and dysfunctional bladder. She was taking amantadine but discontinued on her own. She was on Baclofen for muscle spasm because of an automobile accident two weeks ago. She was also taking Vicodin and Vioxx. She stated she was allergic to Prednisone because it created nightmares of her body parts being cut up. She stated when she had MMR in 1994, she had the same sensation of body burning. Before the hepatitis B vaccination, she had a healthy body of hair. Examination showed a very healthy head of hair with voiced thinning. On examination, there was a very slight amount of bitemporal hair loss, but the pull test was absolutely negative. There were no patches of baldness, and no signs of alopecia areata. There was fine facial hair which petitioner said was normal. She had a few pigmentary changes suggestive of melasma. The doctor's diagnosis was telogen effluvium attributed to significant weight loss, stress, and a sundry of other nonspecific complaints. The doctor doubted telogen effluvium associated with hepatitis B vaccination, but the only way to tell was to eliminate all other potential and more likely causes, such as standing voiced history of MS, 30-pound weight loss, fatigue, and neurologic problems. *Id.* The doctor (whose initials are MJD) said he or she would be happy to see petitioner back in clinic but did not have much to offer in light of "this very unusual presentation and complaints." The office visit lasted more than 30 minutes. *Id.*

On October 1, 1999, petitioner went to an unidentified ER because of on-going back pain. Med. recs. at Ex. 20, p.21. On August 8, 1999, she was in a car accident. Her boyfriend fell asleep and drove the car into a ditch. Petitioner did not seek medical attention immediately. A few days later, she became sore and stiff. On examination, she had a full range of motion and full motor strength. *Id.* She was diagnosed with cervical, thoracic, and lumbar strain. Med. recs. at Ex. 20, p. 22.

On October 14, 1999 and November 11, 1999, Dr. Ronald A. Pinson, a TMJ specialist, and Dr. Alan G. Brobeck, an orthopedic surgeon, performed an IME on petitioner for the State of Washington. Med. recs. at Ex. 23, p. 139. The examination was at the request of the Victims of Crime Program. She complained chiefly of pain in the face and jaw. The IME was in relationship to her assault on November11, 1996. Med. recs. at Ex. 23, pp. 140-41. She said her pain was constant and burning, going down her neck and also stabbing. Med. recs. at Ex. 23, p. 141. She initially had TMJ symptoms after a car accident in 1994 which resolved completely. *Id.* An x-ray was taken to evaluate the jaw and TM joints. There was no pathology in the main part of the jaw. Med. recs. at Ex. 23, p. 141. The doctors concluded that her injuries were consistent with trauma from the assault. Med. recs. at Ex. 23, p. 142. Petitioner was five foot four inches tall and weighed 135 pounds. Med. recs. at Ex. 23, p. 147. In the orthopedic examination, there was no evidence of a dermatomal sensory loss in the upper or lower extremities. Med. recs. at Ex. 23, p. 149. She did not appear to be exerting full effort with any muscle testing in the lower or upper extremities. *Id.* Petitioner presented with ongoing subjective complaints that were not substantiated by objective findings with regard to her cervicodorsal, dorsolumbar, and sacral areas. She did not appear to be exerting maximal effort with muscle testing or with range of motion. Med. recs. at Ex. 23, p. 150. There was no focal sensory loss or focal muscle weakness. Reflexes were symmetrical. The orthopedist did not recommend an further ongoing active treatment. *Id.*

On October 29, 1999, petitioner saw Dr. B. Clure, complaining of severe pain after an assault by a girl who was jealous because petitioner got a ride home with the girl's boyfriend. She had no cuts, scrapes, or significant bruising. She was also involved in a motor vehicle

accident on August 5th. She did not have any obvious bruises, scrapes or abrasions but her neck was sore since then. She wanted stronger pain medication than Celebrex. Also, her grandfather died. Med. recs. at Ex. 35, p. 102. Petitioner weighed 144 pounds, down one pound from her last visit. Med. recs. at Ex. 35, p. 103. Dr. Clure gave petitioner a prescription for Vicodin. *Id.*

On November 3, 1999, petitioner returned to Dr. Doherty, the dermatologist, with continued complaints of diffuse alopecia of the scalp. She stated that with Rogaine, after six weeks, she had reduction in hair loss. Med. recs. at Ex. 2, p. 30. Dr. Doherty examined petitioner and found she had a full head of hair. The diagnosis was subjective complaint of diffuse alopecia, not seen on examination. *Id.* Petitioner had mild vascular rosacea. *Id.*

On December 7, 1999, petitioner saw Dr. S. Drasnin for a refill of Vicodin. Med. recs. at Ex. 35, p. 35.

On January 14, 2000, petitioner went to Dr. Peter V.V. Hewitt, referred by Dr. Drasnin for pain in the neck, jaw, and shoulders after multiple traumas. Med. recs. at Ex. 32, p. 49. Petitioner weighed 135 pounds. Med. recs, at Ex. 32, p. 50. She was diagnosed with MS in 1988 but remained pain-free until 1993 when she fell from a horse, breaking three ribs, and incurring a pneumothorax. In 1994, she was in an automobile accident and her neck and jaw became painful. In 1996, petitioner had hepatitis A and was hospitalized for three weeks. Later that year, someone assaulted her in a hospital. In 1998 and 1999, she had two to three facial surgical procedures to deal with the assault in 1996. In August 1999, petitioner was in another automobile accident. Her neck had been increasingly sore since that period. In October 1999, she was assaulted by a jealous woman whose boyfriend had given petitioner a ride home. Her pains became markedly aggravated after that assault. Petitioner attributed aggravation of her MS

to a hepatitis B vaccination in 1998 and she had stress over legal issues regarding liability. Med. recs. at Ex. 32, p. 49. Her sister had chronic pain problems and chronic illness. Med. recs. at Ex. 32, p. 50. Petitioner was taking Vicodan. She had no abnormality in hair distribution. She had 5/5 muscle strength and her sensory examination was within normal. *Id.* Dr. Hewitt diagnosed cervical neuropathic myofascial pain, primarily C3-5, especially on the right side, lumbar neuropathic myofascial pain, primarily L1-3, MS, a history of hepatitis A, and involvement in legal issues which might be setting back her self-management skills and keeping her from work. Med. recs. at Ex. 32, p. 51. He allowed her Oxycodone.

On January 18, 2000, petitioner returned to Dr. Hewitt with a pain diary. Med. recs. at Ex. 32, p. 48. Her affect, speech, and ideation were within normal. *Id.*

On January 20, 2000, Dr. Sparks of the State of Washington wrote to nurse Sainitzer that petitioner had a family history of autoimmune disease and her sister had been diagnosed with lupus and a thyroid disorder. Med. recs. at Ex. 23, p. 138. Petitioner filed a claim for paresthesias, weakness, fatigue, and MS reported due to hepatitis B vaccination. She contended that hepatitis B vaccine exacerbated her MS. Dr. Walter Ruf indicated she was in complete remission regarding objective neurologic signs and symptoms. Dr. Sparks was not sure what would be accomplished by an IME. *Id.*

On January 25, 2000, petitioner returned to Dr. Hewitt. She was seeing a counselor one day a week for post-traumatic stress disorder. Med. recs. at Ex. 32, p. 48. She was involved in a hit and run accident where she was hit from behind. Her affect was constricted. She received initial cervical segmental injections. *Id.*

On January 31, 2000, petitioner saw Dr. Charles H. Walter, a dentist, for a second opinion regarding therapy for her temporomandibular joint problems. Med. recs. at Ex. 20, p. 23. Her problems began when she was mugged about four years previously in California. She had an increase in stress since moving to Bellingham. Her TMJ symptoms were much greater on the right than on the left. She declined physical therapy. *Id.*

On February 1, 2000, petitioner returned to Dr. Hewitt, reporting soreness following her neck treatment but she had also moved in the prior week. Med. recs. at Ex. 32, p. 47. She now reported pain scores of 9/10 in all regions. She was unable to lift items such as her bed and boxes of books which she had been able to lift in the past. She had been taking extra OxyContin and using Vicodin. Her affect was constricted. Dr. Hewitt diagnosed cervical, lumbar, and thoracic neuropathic myofascial pain aggravated by poor pacing and overactivity. He emphasized her adhering to their opioid agreement. *Id.*

On February 9, 2000, petitioner saw Dr. Hewitt, stating she ran out of OxyContin two days before and had since had significant increase of pain. Dr. Hewitt began lumbar segmental nerve injection treatments. He continued her on OxyContin. *Id.*

On February 11, 2000, Dr. Hewitt had a telephone conversation with Dr. Barbara Clure who was unaware that petitioner was attending his clinic. Dr. Clure said that petitioner was the type of patient who typically jumped from primary care physician to primary care physician when she heard something from the first physician that she did not like. There was no convincing diagnosis of proof of her MS. The plan was to discontinue her opioid medications, encourage consistent visits to a primary care physician, and to acquire her old medical records. Med. recs. at Ex. 32, p. 46.

On February 17, 2000, petitioner saw Dr. Hewitt, reporting soreness for one day and then decreased pain for one week. He performed segmental nerve injections. He discussed petitioner's past medical history. She claimed her past medical records regarding her MS were destroyed in the 1994 Northridge earthquake. She broke into tears and spoke of great distrust by the medical community and of her stress over her legal claims. Med. recs. at Ex. 32, p. 45.

On February 17, 2000, petitioner saw Dr. Patrick A. Delaney. Med. recs. at Ex. 30, p. 11. He last saw her in July 1999. She returned to plead her case for a letter documenting that her demyelinating disease was in some way related to hepatitis B vaccine. He showed her an article from *Annals of Neurology* in 1999 entitled "Assessment: Neurologic Risk of Immunization" which did not support any causal relationship between hepatitis vaccination and the subsequent development of demyelinating disease. She continued to report some fatigue. She also complained of persisting but intermittent small dark spots in her visual fields. On physical examination, she had full ocular motility without nystagmus, her pupillary reflexes were symmetric, and the optic disk margins were sharp with no temporal pallor of the optic nerve heads. Motor examination revealed no upper extremity drift, tone and muscle strength were symmetric throughout the upper and lower extremities, deep tendon reflexes were symmetric, plantar responses were downgoing. Her neurologic examination remained entirely normal as have her previous examinations. Dr. Delaney said, "some qualities of her description appear functional...." *Id.*

On February 24, 2000, petitioner saw Dr. Hewitt and reported no change following her cervical injections at the last visit. She stayed in bed for three days after the treatment. Med. recs. at Ex. 32, p. 45. She had been taking 100 mg daily of Celebrex and was not certain of its

benefit. She expressed great frustration over having to be her own lawyer and now gave Dr. Hewitt several of her past medical records. She declined to take a test to follow up on her MS due to cost, but spoke two weeks previously of serendipitously coming upon thousands of dollars. She will not consider any employment because of stress and jaw pain. Her affect was frustrated, angry, and teary. She did not exhibit pain behavior. She moved smoothly. She was seen outside the clinic to move her neck easily. Dr. Hewitt spent 20 minutes with petitioner discussing her past medical history and record of honesty. Considering the great discrepancy between her observed range of movement outside the clinical setting as compared to her range of movement during examination, "it appears that she is not being truthful." *Id.* He recommended psychotherapy to assist with her traumatic physical and emotional past. *Id.*

On March 3, 2000, petitioner returned to Dr. Hewitt, stating she had significant stress regarding her medical history and was trying to collect all her records from past physicians. He gave her segmental nerve injections. He prescribed a 30-minute cognitive behavioral session discussing the issue of trust and her employment. Med. recs. at Ex. 32, p. 44.

On March 10, 2000, petitioner returned to Dr. Hewitt, reporting her pain now sharper in the mid-back. She reported nightmares from Ultram. She said two of her roommates had died recently, one being given the wrong medication by her doctor and the other having been stabbed. Med. recs. at Ex. 32, p. 43. On examination, she had no pain behavior. Her affect was constricted. He diagnosed her with poor self-management and fixation on medications. *Id.*

On March 17, 2000, petitioner returned to Dr. Hewitt, stating she could not turn her head to the right. She cried as she described nightmares which seemed to be coming true. Med. recs.

at Ex. 32, p. 42. Her affect was constricted and often teary. He administered segmental nerve injections from C3-T1 bilaterally. *Id.*

On March 23, 2000, petitioner saw Dr. Hewitt with a 30% decrease in pain. She said Methadone made her groggy and caused urinary frequency. *Id.*

On March 28, 2000, petitioner saw Dr. Hewitt on an emergency basis because of 10/10 pain in the left side of her neck. Her affect was constricted. He administered segmental nerve injections. Med. recs. at Ex. 32, p. 41.

On April 6, 2000, petitioner saw Dr. Hewitt, reporting better range of movement and 40% decreased pain. She complained of fatigue and was sleeping approximately 11 hours a day. Her affect was constricted. She was to resume Methadone as OxyContin was too sedating for her. *Id.*

On April 13, 2000, petitioner saw Dr. Hewitt, experiencing sedation on Methadone and now wishing to switch to MS Contin. She had been evicted from her last apartment and was living with a former boyfriend who had no telephone, electricity, or running water. Med. recs. at Ex. 32, p. 40.

On April 27, 2000, petitioner saw Dr. Hewitt, very distressed over not feeling as if she belongs anywhere, including her current residence. She recently slipped in a bathtub and was hurting all over. Her affect was blunted and occasionally teary. *Id.*

On May 9, 2000, petitioner was brought in involuntarily to an unidentified ER because of depression. Med. recs. at Ex. 20, p. 19. The police department brought her in after she called her sister and left a message about giving her sister her car, insinuating that she was going to commit suicide. Upon arrival at the ER, petitioner was tearful and not wanting to be there. She had been

having a difficult time establishing a permanent residence and was living intermittently with a boyfriend. Psychiatric examination showed manipulative behavior, but she was not acutely psychotic or suicidal. On neurologic examination, she was alert and oriented. It was a nonfocal examination. The discharge diagnosis was borderline personality disorder with underlying depression. *Id.*

On May 9, 2000, petitioner had an MRI done of her temporomandibular joint. Med. recs. at Ex. 20, p. 13. She had a long history of difficult range of motion and pain in her TMJ. *Id.* Dr. David G. Ashley's conclusion was that her TMJ appeared within the range of normal. She had a question of some degeneration of the posterior band of the left meniscus. Med. recs. at Ex. 20, p. 14.

On May 11, 2000, petitioner saw Dr. Philip E. Zeidner. She indicated she had reasonable pain control and was slightly sedated on Methadone. Her affect was flattened. Med. recs. at Ex. 32, p. 39.

On June 1, 2000, petitioner saw Dr. Zeidner, wanting to discuss Methadone which she said made her scatterbrained. She complained of losing things and had urinary frequency and lack of bladder control. She stated that Dr. Hewitt did not believe her. *Id.*

On June 6, 2000, petitioner saw Dr. David E. Wisner, a rheumatologist, on referral from Dr. Barbara Clure. Med. recs. at Ex. 41, p. 15. Sometime after age 17 when she fractured her right elbow, she began to experience chronic pain. The pain was widespread and varied from one area to the next. She had a sense of fatigue. She found short-acting narcotics such as Vicodin or Percocet more helpful than long-acting narcotics such as Oxycontin. She did not have consistently poor sleep patterns. The severity of her pain varied. Brushing her teeth might

develop neck pain. She had a history of MS aggravated by MMR and hepatitis B vaccinations. Her weight was 129 pounds. *Id.* On examination, she had diminished rotation and flexion of her neck. Med. recs. at Ex. 41, p. 14. She had intent strength and reflexes. Dr. Wisner thought fibromyalgia was the best diagnostic fit considering her muskuloskeletal pain and lack of other objective findings and laboratory normality. He recommended aerobic exercises, stretching, and psychiatric care. She had a history of MS. Dr. Wisner did not make a return appointment. *Id.*

On June 15, 2000, petitioner saw Dr. Zeidner, having good response from nerve injections with decreased pain. Med. recs. at Ex. 32, p. 38.

On June 19, 2000 and June 28, 2000, petitioner was given an IME by Dr. Barbara Jessen, a neurologist, and Dr. Reynold M. Karr, a rheumatologist, for the State of Washington. Med. recs. at Ex. 23, p. 163. The rheumatologist noted petitioner's complaint of visual changes and hair loss. She contended that hepatitis B vaccine either caused a new neurologic condition or aggravated her pre-existing MS. Med. recs. at Ex. 23, p. 164. She stated since the vaccination, she had experienced significant hair loss, lost 40 pounds, and had an episode of severe burning sensation of her skin. Currently, she described visual changes consisting of a black dot or squiggly structure in her right field of vision. *Id.* On examination, petitioner was tender in all 18 of 18 characteristic fibromyalgia locations. Med. recs. at Ex. 23, p. 166. She walked normally. Dr. Karr detected no peripheral sensory deficit or motor impairment. Her deep tendon reflexes were equal bilaterally without pathologic reflexes. *Id.* Dr. Karr diagnosed petitioner with fibromyalgia syndrome with associated sleep disorder, chronic fatigue, and situational depression, unrelated to hepatitis B vaccination. Med. recs. at Ex. 23, p. 167. The record available to Dr. Karr did not provide any objective evidence of a physical reaction to hepatitis B

vaccine. Dr. Karr could not identify any objective evidence of physical limitations and/or restrictions preventing petitioner from employment. *Id.* Petitioner's visual complaint of a dot and curled linear structure in the right visual field suggested the possibility of floaters. Med. recs. at Ex. 23, p. 168. On the neurological examination, petitioner stated that she had increased hair loss about three months after receiving hepatitis B vaccine. Med. recs. at Ex. 23, p. 169. She described huge quantities of hair coming out and held her fingers apart in an area bout two by four inches. She also had less appetite. *Id.* Petitioner stated the burning pain lasted about four or five months and disappeared. Med. recs. at Ex. 23, p. 170. When Dr. Jessen told petitioner that her complaints were similar after she was assaulted December 10, 1996, petitioner indicated she had been assaulted again in October 1999. *Id.* Petitioner was five foot four and one-half inches tall and stated she weighed 119 pounds. Med. recs. at Ex. 23, p. 182. On examination, heel walking, toe walking, and tandem walking were normal. Med. recs. at Ex. 23, p. 183. She had nystagmus in the upper gaze. She had grossly normal visual fields. Sensory examination to light touch was symmetrical. *Id.* Motor examination revealed 5/5 on testing of the deltoid, biceps, triceps, brachioradialis, wrist extensors and intrinsics. Med. recs. at Ex. 23, p. 184. Dr. Jessen's diagnosis was MS, pre-existing and not affected, and status post-two incidents of assault, resulting in discomfort from cervical and thoracic straining injuries. *Id.* Dr. Jessen stated, "There is no evidence of a physical reaction to the injection itself on a more probable than not basis." Med. recs. at Ex. 23, p. 285. Petitioner's examination did not reveal any objective findings except for nystagmus on vertical gaze and some patchy areas of sensory loss as well as a right upgoing toe sign. She had no other abnormalities on examination.

Petitioner had minimal symptomatology attributable to MS. *Id.* Dr. Jessen found that hepatitis B vaccine had no effect on petitioner's condition. Med. recs. at Ex. 23, p. 186.

On June 29, 2000, petitioner saw Dr. Zeidner, doing very well with overall pain management. Med. recs. at Ex. 32, p. 38.

On July 19, 2000, petitioner saw Dr. Zeidner, complaining of high level of pain in her neck and shoulders. He gave her trigger point injections. Med. recs. at Ex. 32, p. 37.

On August 17, 2000, petitioner saw Dr. Zeider, complaining of continued high level of pain in her neck and shoulders. She had an exacerbation secondary to stresses related to her sister's wedding and to her recent breakup with her boyfriend. She discontinued Trazodone because of fears related to muscle dystonia. Dr. Zeidner recommended cognitive behavioral therapy to establish a physical mechanism to relieve stress. He gave her trigger point injections. *Id.*

On August 17, 2000, petitioner saw Dr. Way Yin, medical director of Interventional Medical Associates of Bellingham. Med. recs. at Ex. 20, p. 8. Her chief complaint was right-sided facial pain, headaches, and shoulder pain. She was assaulted on November 11, 1996. She had been in a hospital ER, waiting evaluation for hepatitis A. Petitioner suffered lacerations and multiple contusions and underwent reconstructive surgery involving the left eyebrow in 1997. Since her assault, she complained of chronic right jaw temporal and frontal pains and right-sided neck pain. She also complained of pain in the mid-scapular regions. She was diagnosed with MS 12 years previously. She had experienced multiple exacerbations and remissions over the past 12 years. Her exacerbations occurred every 18 months. Her exacerbations of MS were typically manifested by numbness below the neck. Her primary complaint involved constant

aching pain and tenderness starting in the right TMJ region and radiating into the right temporal regions. She stated her pain was a tightness and drawing sensation, that the supraorbital region on the right became sensitive to touch, and the right side of her face felt like a balloon. She said when the pain was sever, her right eyelids twitched. The pain was like a needle sticking in her right TMJ and she had pain in her right air. She said the pain worsened with chewing and eating crunchy foods. She also complained of pain in the suboccipital region on both sides, worsened with neck movements. She had a constant band-like sensation across the back and both shoulders. *Id.* Coughing, sneezing or Valsalva maneuvers did not worsen her pain. She reacted to hepatitis B and MMR vaccines with several months of her body being on fire. Med. recs. at Ex. 20, p. 9. An MRI was done of her temporomandibular joints. According to Dr. Walters, her joints were structurally normal. She was not felt to be a surgical candidate. *Id.* Petitioner was five feet four inches tall and weighed 127 pounds. Med. recs. at Ex. 20, p. 10. Petitioner was alert, appropriate, and oriented in all spheres. She had 5/5 strength in all areas tested. *Id.* There were no pathologic reflexes. Med. recs. at Ex. 20, p. 12. Dr. Yin's assessment was atypical facial pain and MS currently in remission. *Id.*

On September 14, 2000, petitioner saw Dr. Zeidner, stating that she had improved range of motion following the August 17th treatment. Currently she had recurrent pain in her neck and mid-shoulders and problems with her lower back. She was barely able to walk without possibly pulling a muscle. Med. recs. at Ex. 32, p. 36. Petitioner was unhappy with her current neurologist. *Id.*

On September 18, 2000, petitioner had an MRI done of her cervical spine because of back and neck pain. Med. recs. at Ex. 35, p. 67. The cord signal suggested demyelinization.

Abnormal signal extended from about C3 through C6. There was no evidence of spinal or foraminal stenosis or focal disc lesion. *Id.*

On September 28, 2000, petitioner returned to Dr. Yin. Med. recs. at Ex. 20, p. 26. He reviewed her cervical MRI study performed on September 18, 2000 which showed left paracentral disc protrusions at C3-C4, C4-C5, and C5-C6. Her cervical MRI was remarkable for scattered cord signal abnormalities consistent with MS. On examination, her short-term memory was normal. Her neurologic examination revealed no cranial nerve deficits and no upper extremity motor or sensory deficits. *Id.* Dr. Yin would perform occipital nerve injections of local anesthetic and corticosteroid on October 10, 2000. Med. recs. at Ex. 20, p. 27.

On October 5, 2000, the State of Washington wrote petitioner that her IME on June 19, 2000 (with Dr. Jessen) reaffirmed the State's prior medical opinions that hepatitis B vaccine did not affect her MS and the State was reaffirming its rejection of her workmen's compensation claim. Med. recs. at Ex. 23, p. 192.

On October 19, 2000, petitioner saw Dr. Zeidner, using stinging nettles as an adjunct to her treatment with him. Med. recs. at Ex. 32, p. 36. He had a short discussion of cognitive dysfunction secondary to MS. *Id.*

On October 23, 2000, petitioner saw Dr. Yin. Med. recs. at Ex. 20, p. 28. The diagnostic injection procedure on October 10, 2000 was made more difficult by the unexpected finding of a congenitally-fused C2-C3 segment. Petitioner reported that her TMJ region was 50% improved following the diagnostic injections in C4 and C5 medial branches. Her temporal headache was totally relieved. Her neck pain was moderately improved. Her cervical range of motion was

markedly improved. *Id.* Dr. Yin was to perform bilateral cervical medial branch injections on November 17, 2000. Med. recs. at Ex. 20, p. 29.

On November 16, 2000, petitioner saw Dr. Zeidner, with decreased pain lasting two weeks followed by gradual recurrence. Med. recs. at Ex. 32, p. 35.

On November 17, 2000, Dr. Yin performed confirmatory bilateral C2 through C5 cervical medial branch and third occipital nerve local anesthetic and corticosteroid injections on petitioner under fluoroscopic imaging. Med. recs. at Ex. 20, p. 45.

On December 14, 2000, petitioner saw Dr. Zeidner, having done well since the November 16th nerve injections. She currently had pain in her neck. Her sleep cycle was good at 8-10 hours. Med. recs. at Ex. 32, p. 35.

On January 11, 2001, petitioner saw Dr. Zeidner, saying the last cervical nerve injections were effective in relieving pain for about three weeks. She was sick of Methadone and wanted to return to OxyContin. Med. recs. at Ex. 32, p. 34.

On January 30, 2001, Dr. Yin performed percutaneous stereotactic mapping of the bilateral C2, C3, C4, and C5 cervical medial branch, posterior primary ramus nerves (cervical facet nerves) and radiofrequency neurotomy of the right C2, third occipital, and C6 medical branch nerves and radiofrequency neurotomy of the left C2 medial branch nerves on petitioner. Med. recs. at Ex. 20, p. 47.

On February 12, 2001, petitioner saw Dr. Zeidner, doing reasonably well. Med. recs. at Ex. 32, p. 34.

On March 12, 2001, petitioner saw Dr. Zeidner for continued management of cervical pain with medication and segmental nerve injections. They would not be following petitioner any further because of discontinuation with Medicare. *Id.*

On April 27, 2001, petitioner had an abdominal ultrasound for abdominal pain and the question of stones. Her ultrasound was negative. Med. recs. at Ex. 35, p. 65.

On December 11, 2001, petitioner saw Dr. Marilyn Nayan, an occupational medicine specialist, at Harborview Medical Center, for a toxicology evaluation, referred by Dr. David Drobnicki. Med. recs. at Ex. 9, p. 61. Petitioner claimed she had never had a burning sensation from the waist down distally accompanied by weakness before she received hepatitis B vaccine. She complained of increasing hair loss, depression, anxiety, more fatigue, and decreased memory or absent-mindedness. She stated that mercury in the vaccine could also cause neurologic symptoms. *Id.* A car had hit her dog and killed it, depressing petitioner. *Id.* She lost 50 pounds in a year. Med. recs. at Ex. 9, p. 62. She weighed 132 pounds. She was oriented to time, place, and person. She had good strength in all extremities. She had decreased sensation in her right upper extremity. *Id.* She had good coordination. In the lower extremities, sensation was intact. Her deep tendon reflexes were 2+ in the lower extremities. She had a slight decrease in the right upper extremity. Dr. Nayan's assessment was that petitioner had MS but no signs of exacerbation. Her hair loss had a questionable etiology. *Id.*

Also on December 11, 2001, petitioner saw Dr. Carl Brodkin, an occupational medicine specialist at Harborview Medical Center, for evaluation of possible mercury exposure as well as exacerbation of MS following hepatitis B vaccine. Med. recs. at Ex. 9, p. 64. She stated she was in her usual stated of health with intermittent numbness and fatigue, occasional word-mixing,

and bladder "dripping" when she received hepatitis vaccine in November 1998. Shortly afterwards, she had prominent exacerbation in her MS characterized by painful paresthesias. She brought to Dr. Brodkin product information about hepatitis B vaccine which described exacerbations of MS. She stated she had experienced hair loss, absent mindedness, anxiety, depression, fatigue, difficulty in concentration, and visual changes. She was worried about mercury toxicity. *Id.*

On examination, petitioner had trigger point tenderness in the shoulder, neck, and sacroiliac consistent with fibromyalgia. Med. recs. at Ex. 9, p. 65. She had some mild blurring of the optic disk margin. Dr. Brodkin felt it unlikely that the dose of mercury in hepatitis B vaccine would be associated with significant systemic toxicity including hair loss, central neurologic disorders and/or peripheral neurologic disorders. Med. recs. at Ex. 9, pp. 65-66. There was low likelihood of mercury exposure. He recommended that petitioner strictly avoid chelation procedures. There was no evidence of mercury toxicity based on the current examination. Her hair loss was mild. Med. recs. at Ex. 9, p. 65.

On January 7, 2002, Karen A. Summers, a domestic violence advocate at Womencare Shelter, wrote a "To Whom It May Concern" letter. Med. recs. at Ex. 4, p. 1. She supervised petitioner. In late November or early December 1998, petitioner spoke of not feeling well. She had problems with her eyes and a whole body sense of illness. She felt as if her body were on fire. She lost weight over time. Another staff member with MS who also received hepatitis B vaccine began to feel unwell and said her symptoms were an activation of her MS. Both petitioner and this other woman with MS did research to find out information about hepatitis B vaccine causing problems for others with MS. *Id.*

On January 13, 2002, Lorna Mackowiak, a coworker at Womencare Shelter with petitioner, wrote a "To whom it may concern" letter. Med. recs. at Ex. 6, p. 1. Ms. Mackowiak also had MS and she received hepatitis B vaccine. Both she and petitioner had symptoms consistent with an exacerbation of MS. Her neurologist confirmed she had optic neuritis which lasted for six months and left her with significant cognitive dysfunction, decreased energy levels, and hair loss. Petitioner experienced optic neuritis and burning sensation of her extremities, weight loss, and increased fatiguability. She had loss of hair. The package insert stated hepatitis B vaccine could exacerbate MS. *Id.*

On January 24, 2002, petitioner returned to Dr. Doherty, complaining she still had hair loss. She was using Rogaine without response. Med. recs. at Ex. 23, p. 218. On examination, she had very mild bitemporal hair loss. He evaluated her entire scalp which showed a good healthy head of hair, possibly a Ludwig's type 1 thinning which was very mild. There were no signs of alopecia areata. The pull test was unremarkable. He diagnosed most likely idiopathic androgenic alopecia in a female. *Id.*

On February 15, 2002, the State of Washington again affirmed the rejection of petitioner's workmen's compensation claim based on the medical information dated December 11, 2001 from Dr. Carl Brodkin, indicating he could not substantiate petitioner's claim. Med. recs. at Ex. 23, p. 216.

On February 20, 2002, an acupuncturist named Judy Chiasson wrote a "To Whom It May Concern" letter, stating that she first saw petitioner on June 22, 2000 at which time petitioner said she had a reaction to hepatitis B vaccine with MS and fibromyalgia. Med. recs. at Ex. 3, p. 1. After the vaccination, her whole body felt on fire for several months even though her

temperature was normal. She attributed a lot of the problems she had to the lingering effects of hepatitis B vaccine: fatigue which was worse in the afternoons, lack of strength, sleep problems, feeling cold, low appetite with recent weight loss, hair loss, poor hearing, painful periods, frequent urination with difficulty holding, bruising easily, cervical strain, neck and shoulder pain, muscle pain, and upper back, lower back, and right rib pain. *Id.* After a number of acupuncture treatments, petitioner's symptoms began to improve. She would have flare-ups. On July 27, 2000, she had numbness in her legs which spread upward with trouble walking. With treatment, she had improved by August 22, 2000. On May 15, 2001, she had a flare-up where her left leg had electric sensations and she had difficulty moving it and shuffled when she walked. She had major fatigue, balance problems, and hair falling out creating bald spots. By May 23, 2000, she walked better. Her legs felt really stiff, wooden, and painful. She did not have a lot of energy but was not exhausted. Her hair was still falling out and she had bad cramps when she menstruated. By May 30, 2000, she could do more but became exhausted easily. Her legs felt dead. By June 6, 2000, she walked better and her legs no longer felt fatigued, but she had overall fatigue and her neck bothered her. On June 20, 2000, she another flare-up with the other leg. In January, her back bothered her after she had a high temperature for a few days. Over several weeks, that improved. *Id.*

On February 23, 2002, Kirsten Hammer, an acquaintance of petitioner from the Womencare Shelter, wrote a "To whom it may concern" letter. Med. recs. at Ex. 5, p. 1. Shortly after petitioner's hepatitis B vaccination, petitioner had severe physical symptoms and said she felt as if she were on fire. She had severe weight loss. In August 2000, petitioner moved in with Ms. Hammer for several months. Before the vaccination, petitioner was healthy, vibrant, and

worked out at the local gym daily. After the vaccination, it was hard for her to walk. Sometimes, she would appear spacy and forgetful. *Id.*

On April 16, 2002, petitioner appealed the State of Washington's denial of her workmen's compensation claim. Med. recs. at Ex. 23, p. 220.

On April 29, 2002, petitioner saw Dr. W.T. Longstreth, Jr., a neurologist, at Harborview Medical Center. Dr. Carl Brodkin of the Occupational Medicine Clinic referred her for evaluation of MS and symptoms following hepatitis B vaccine. Med. recs. at Ex. 9, p. 44. Petitioner related her current problems to hepatitis B vaccine, including hair loss, decreased memory, and weight loss. Her sister has lupus. On examination, her mental status was clear despite her complaints. Her motor and sensory examinations were grossly symmetric. Coordination and gait were normal. Her reflexes were symmetric. "The patient is most concerned about the role hepatitis B vaccine has played in her current symptoms. We indicated that we could not say, on a more probable than not basis, that the vaccination had anything to do with her current symptoms. Clearly this is an opinion she did not want to hear." *Id.*

For petitioner's April 29, 2002 visit with Dr. Longstreth, petitioner filled out a questionnaire, checking "yes" for every neurologic or psychiatric symptom except for fainting spells, loss of consciousness, headaches, and crying spells. Med. recs. at Ex. 9, p. 52.

On April 29, 2002, petitioner also saw Dr. Richard Peterson and Dr. Longstreth. Med. recs. at Ex. 9, p. 58. Between 1988 and 1998, petitioner had 10 exacerbations of her MS which would last for a few weeks to a couple of months, mostly consisting of numbness and weakness in an extremity. Since her hepatitis B vaccination in 1998, petitioner felt her MS had worsened, specifically, visually, sensorily, and cognitively. She complained of increased frequency of

urination. She also lost weight and had significant alopecia. She wanted to know how much mercury was in hepatitis B vaccine. She felt use of bee stings in the past improved her symptoms and that magnets improved her symptoms. *Id.* Her past medical history included fibromyalgia, cytomegalovirus, hepatitis A, multiple bone fractures, depression, and anxiety. *Id.* Her medications included Oxycodone, bee pollen, caffeine, bilberry, and St. John's wort. Med. recs. at Ex. 9, p. 59. On examination, her toes were downgoing bilaterally. The doctors noted that it was currently felt that MS patients can safely undergo vaccination. *Id.*

On May 11, 2002, petitioner had a brain MRI done with and without contrast. Med. recs. at Ex. 9, p. 46. She had extensive white matter lesions distributed in a pattern consistent with MS. One of these lesions enhanced. *Id.* In particular, she had patch regions of high T2/FLAIR signal present in the white matter throughout the brain, primarily periventricular with some subcortical sites noted. There was involvement of the temporal white matter, corpus callosum, brainstem, and deep white matter of the cerebellum and brachium pontus. One left periatrial lesion showed enhancement with gadolinium. No other enhancement was seen. There was mild diffuse volume loss without extra-axial fluid collections or midline shift. *Id.*

On June 13, 2002, petitioner went to Harborview Medical Center for a neuropsychological evaluation by Dawn M. Ehde, a clinical psychologist. Med. recs. at Ex. 9, p. 38. Dr. William Longstreth of the Neurology Clinic at Harborview referred petitioner for neuropsychological evaluation. Petitioner demonstrated moderate to severe impairments in most of the neuropsychological domains assessed in the evaluation: attention, learning, memory, information processing speed, motor speed, visuospatial processing, and executive functioning. She was quite distressed and met the criteria for post-traumatic stress disorder. She also

experienced depressive symptoms. Chronic pain and other physical impairments compounded her overall suffering. Ehde recommended cognitive rehabilitation, psychotherapy, medicine , an MS support group, and alternative pain interventions. *Id.*

On June 13 and 24, 2002, petitioner told the psychometrists Tammy Boag Whitley and Hamid Nazemi that since her November 1998 hepatitis B vaccination, her MS had been exacerbated. She was concerned that she had experienced mercury toxicity as a result of the vaccine. Dr. Carl Brodkin in the Occupational Medicine Clinic at Harborview Medical Center recently evaluated petitioner and did not feel as though her past or current symptoms were necessarily related to mercury toxicity. He did not recommend chelation therapy. Dr. Longstreth of the HMC Neurology Clinic also evaluated petitioner and was of a similar opinion regarding the association between her worsening of MS symptomatology and hepatitis B vaccine. *Id.*

Petitioner barely passed her courses in college due to multiple stressful life events, including several deaths, MS exacerbations, extreme poverty, and homelessness. Med. recs. at Ex. 9, p. 41. Petitioner reported a long-standing history of depression and anxiety. She described significant psychosocial stressors growing up, including significant abuse and being forced into a cult by her parents. At various times, she has been in psychotherapy for her anxiety and depression. She lacked social support. She arrived 45 minutes late for testing because she said she had gotten lost en route. She was very distressed and appeared overwhelmed. Affect was depressed and anxious. No overt memory deficits were evident during the evaluation. She had difficulty sustaining attention during testing. She was easily distracted by internal stimuli. She asked that test instructions be repeated on several occasions because she had been inquiring

about the time, was taking pain medication, or requesting to make a phone call, which distracted her from the task at hand. *Id.* Verbally, petitioner was in the average range of functioning. *Id.*

Petitioner had bothersome pain in her jaw, neck, shoulders, low back, and legs. Med. recs. at Ex. 9, p. 43. She also had fatigue, photophobia, phonophobia, poor balance, decreased strength, decreased coordination, sleep disturbance, forgetfulness, concentration difficulties, irritability, and anxiety. Med. recs. at Ex. 9, pp. 43, 39. She had a possible panic disorder and other anxiety symptoms. Med. recs. at Ex. 9, p. 39. She was worried about her health and finances. She said her legal battle over the vaccination was the most stressful thing in her life at that time. *Id.*

On June 15, 2002, naturopath Littleton, wrote a letter entitled, "Agent of Inquiry." Med. recs. at Ex. 7, p. 4. He states petitioner had an undeniable adverse reaction to hepatitis B vaccine administered in June 1999 (petitioner alleges she received hepatitis B vaccine on November 21, 1998 in her petition). Petitioner visited Mr. Littleton for treatment of her TMJ on July 27, 1999, but he saw that her body symptoms and expression of illness had changed. He states she never had these symptoms before, including nightmares with themes of paranoia and fear, hair loss, and whole body burning sensations. Her depression was aggravated, and she had persistent neck pain, shoulder pain, and flared TMJ pain. Mr. Littleton placed the blame on mercury (thimerosal) in the vaccine which cause weakened memory, mistrustful thought forms, fatigue, hair loss, burning sensations, ulcers, alterations in appetite and thirst, weakness, variations in neurologic sensation, and a variety of pain patterns. *Id.*

On June 24, 2002, petitioner returned to Dr. Longstreth who with Dr. Richard Peterson, noted that petitioner stated that many of her symptoms varied on a day-to-day basis. Petitioner's

last MRI showed white matter lesions in periventricular fashion as well as the corpus callosum, brainstem, cerebellum, and brachium pontis. Med. recs. at Ex. 9, p. 54. Petitioner was concerned that the MRI was much worse than her prior MRIs and the doctors informed her that this is often the case in MS. But the changes on MRI may not correlate with any clinical change. *Id.*

On June 24, 2002, petitioner returned to Dr. Longstreth and Dr. Peterson, for concerns about her MS and its relationship to hepatitis B vaccine. On examination, she had clear mentation, relatively full strength in her limbs, and increased tone in her lower extremities. Petitioner also carried a diagnosis of fibromyalgia. Med. recs. at Ex. 9, p. 56.

On July 12, 2002, petitioner saw Dr. James D. Bowen, a neurologist, and Dr. Melanie Walker. Med. recs. at Ex. 23, p. 248. Petitioner stated she had 11 exacerbations of MS in the past five years, and four exacerbations in the past one year. They involved the right leg limited to paresthesias. She stated both legs were numb. She noted significant cognitive difficulties, including mental blackouts, numbness in her right arm and chest, and optic neuritis. *Id.* Petitioner weighted 124.6 pounds. Med. recs. at Ex. 23, p. 250. On examination, petitioner was alert and oriented. Her concentration and attention did not appear grossly impaired. Her speech was fluent and spontaneous. She was able to name and repeat without difficulty. There was no evidence of aphasia. Her fund of knowledge was normal. There was no afferent pupillary defect, no intranuclear ophthalmoplegia, and no nystagmus. Her visual fields were grossly intact. Her ophthalmoscopic examination was normal. Her motor strength was normal. She had upgoing toes. *Id.*

On July 18, 2002, petitioner saw Dr. Sherman. She had diffuse pain in her low back and neuropathic pain shooting all over her body in different places and at different times due to her MS. Med. recs. at Ex. 35, p. 49. She was concerned about mercury poisoning which she felt strongly was related to the development of her MS, depression, anxiety, and ADD. Med. recs. at Ex. 35, p. 50.

On August 8, 2002, petitioner saw Dr. L. Gober with multiple complaints, including considerable hair loss for which she saw the dermatologist Dr. Doherty in the past. "He was very not to her liking and did not provide any helpful suggestions to her; she felt that he did not listen to her or evaluate her well." She wanted a referral to another dermatologist. Med. recs. at Ex. 35, p. 52. She complained of optic neuritis which she thought secondary to hepatitis B vaccine. She had a recent upper respiratory infection and wondered if she needed antibiotics. She complained of MS and chronic pain. *Id.*

On September 4, 2002, petitioner saw Dr. Lydia Chwastiak, an instructor in psychiatry and behavior sciences. Med. recs. at Ex. 23, p. 253. Dr. Bowen referred her for treatment of depression and anxiety. Petitioner believed that hepatitis B vaccine gave her mercury poisoning. Dr. Brodkin's examination did not support a diagnosis of mercury poisoning. Petitioner had a lifelong history of depression and anxiety. She reported significant physical, sexual, and emotional abuse during her childhood. She had a long history of narcotic use for fibromyalgia pain. *Id.* She believed her functioning was quite impaired due to her anxieties and she had been self-medicating with marijuana, which was the only intervention that had been helpful in managing her anxiety. Med. recs. at Ex. 23, p. 254. Her major complaint was cognitive difficulty. She felt unable to work. Dr. Chwastiak diagnosed petitioner with generalized anxiety

disorder and post-traumatic stress disorder. *Id.* Petitioner was willing to try Wellbutrin for depression and anxiety. Dr. Chwastiak recommended discontinuing Oxycodone because it was not appropriate for fibromyalgia and might have exacerbated petitioner's depression. She also advised abstinence from marijuana. Med. recs. at Ex. 23, p. 255.

On October 25, 2002, petitioner saw Dr. Bowen. Med. recs. at Ex. 23, p. 246. Her MS was stable. *Id.*

On March 10, 2003, petitioner saw Dr. Sherman with significant dysmenorrhea. She felt as if her cramps lasted three weeks out of the month. She had decreased libido. She had difficulty remembering pills. She had chronic neck and upper back pain. Med. recs. at Ex. 35, p. 54.

On March 23, 2003, petitioner went to the University of Washington Medical Center MS Clinic. Her MS was clinically stable although she complained of vision problems and difficulty sleeping. She had long-standing issues with depression. Med. recs. at Ex. 37, p. 23.

On April 18, 2003, petitioner saw. Dr. Sherman, complaining of having to urinate all the time. She wanted to be tested for ovarian cancer. She had profound fatigue, hair loss, dry skin, and wanted her thyroid tested. She got a rash on her chest in January which was itchy. She was profoundly sad the prior week. She was breaking up with her boyfriend and was out of sorts with her family. She was sad, overwhelmed, with low energy and fatigue. Dr. Sherman suggested increasing her Paxil. Med. recs. at Ex. 35, p. 56.

On June 26, 2003, petitioner saw Dr. Sherman. She had crossed the border after visiting Canada and was arrested for having Cylert, medication prescribed for her fatigue. Med. recs. at Ex. 35, p. 59. She was jailed and charged with assault at the same time. She had more energy

and felt better. In jail, she was off her medications and felt she was hallucinating. Her affect was dysthymic. Her mood was mildly depressed and her thought process linear. She felt low energy and fatigue. *Id.*

On August 15, 2003, the State of Washington ruled on petitioner's appeal of its denial of her workmen's compensation claim. Med. recs. at Ex. 23, p. 256. The State of Washington affirmed its denial. Med. recs. at Ex. 23, p. 258. Petitioner said she had lost 50 pounds after hepatitis B vaccination. She also said she lifted weights daily and had been trying to lose weight. Med. recs. at Ex. 23, p. 260. Petitioner quit her job in November 1999, almost one year after hepatitis B vaccination, to reduce her stress level. Med. recs. at Ex. 23, p. 261. Dr. Lori Sherman first saw petitioner on October 18, 2001 and testified that she found no objective evidence relating petitioner's complaints to the 1998 inoculation. *Id.* Dr Patrick A. Delaney first saw petitioner on January 5, 1999 and found no evidence of a flare-up in petitioner's MS. Med. recs. at Ex. 23, p. 262. Dr. Jessen concluded that hepatitis B vaccine did not affect petitioner's MS. Med. recs. at Ex. 23, p. 263. Diane Wood worked at the Womencare Shelter in the administrative office while petitioner was working there and testified that petitioner had not missed any work from the time of vaccination until petitioner quit almost a year later. *Id.* Judge Thomas W. Merrill, Industrial Appeals Judge, ruled that petitioner failed to provide evidence that she sustained an injury on November 21, 1998, and that hepatitis B vaccine exacerbated her pre-existing MS. Med. recs. at Ex. 23, p. 265.

On September 12, 2003, petitioner went to see Dr. James. D. Bowen, a neurologist. Med. recs. at Ex. 37, p. 20. She had had no recent exacerbations of MS but continued to complain of visual loss. She had not seen an ophthalmologist. She had a lot of difficulty with stiffness and

fatigue. She had long-standing depression. On examination, her cranial nerves were normal, her motor was 5/5 throughout, coordination, finger-to-nose, fast finger movements, rapid alternating movements were slightly slowed, right more than left. Reflexes were brisk, right slightly more than left. Her gait was normal. *Id.* Her legal concerns were a major stressor for her. Med. recs. at Ex. 35, p. 21.

On November 26, 2003, petitioner saw Dr. L. Sherman, having gained quite a lot of weight. She weighed 171 ½ pounds. Med. recs. at Ex. 35, p. 63. She had been in the 120s earlier in the year. She wondered if her thyroid were abnormal. She had been taking multiple herbal medicines including chlorella, conflaxin, and flower pollen. Over the last two days, she had a fear of food and some nausea. She had been on Paxil since March and on birth control pills. She felt Ditropan made her feel speedy. Dr. Sherman thought she had subclinical hypothyroidism and would check her TSH and T4. They had put her on a low dose of thyroid to help her energy level and fatigue, but she continued to gain weight. *Id.*

DISCUSSION

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[.]"

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 hepatitis B vaccine, she would not have had significant aggravation of her MS, but also that the vaccine was a substantial factor in bringing about significant aggravation of her MS. Shyface v. Secretary of HHS, 165 F.3d 1344, 1352 (Fed. Cir. 1999).

Dr. Vera Byers, petitioners' immunologic expert in the Omnibus proceeding on hepatitis B vaccination and demyelinating diseases, including MS, stated in answer to a question about hepatitis B vaccine exacerbating MS that she had to give "the caveat that the rechallenge cases with MS are more difficult to interpret than the rechallenge cases with the monophasic [course] because MS does have a relapsing and remitting course." Stevens v. Secretary of HHS, No. 99-594V (October 13, 2004), tr. at 77. Petitioner in the instant action has a relapsing and remitting course of MS. She went to four neurologists after receiving hepatitis B vaccine and they did not diagnose her with an exacerbation of her MS. They did not even find her neurologically abnormal. Although she lost weight briefly, she gained it back. Three months after the vaccination, she had slight hair loss which was not diagnosed as alopecia areata. She told doctors that her burning sensation after the hepatitis B vaccination lasted four or five months.

Petitioner's complaints echo complaints she has had since she was diagnosed as a teenager with MS.

But even assuming arguendo that petitioner had significantly aggravated MS after hepatitis B vaccine, the Vaccine Act requires that her injury last more than six months. 42 U.S.C. §300aa-11(c)(1)(D)(i).

The first neurologist petitioner saw after she received hepatitis B vaccine on November 21, 1998 was Dr. Walter N. Ruf on December 23, 1998, just one month later. Dr. Ruf examined her and concluded that she was in complete remission with regard to objective neurologic signs and symptoms of MS. Petitioner complained of burning below the waist, but Dr. Ruf thought it extremely unusual to have burning dysesthesia related to MS. Because Dr. Ruf would not agree based on his examination that petitioner even had MS, he would not prescribe MS medication for her or assist her in attempting to prove that hepatitis B vaccine exacerbated her MS. Consequently, petitioner filed a grievance against Dr. Ruf with his county medical society.

Petitioner was also diagnosed as normal neurologically when Dr. Delaney, another neurologist, saw petitioner six weeks post-vaccination on January 5, 1999.

On June 8, 1999, the State of Washington denied petitioner's workmen's compensation claim on the ground that hepatitis B vaccine did not cause her condition, her condition pre-existed the alleged injury and was not related to it, and petitioner did not sustain a personal injury. After petitioner requested an explanation for the denial, the State of Washington responded that these were the reasons for rejecting her claim: the hepatitis B injection did not cause an MS condition and the objective medical findings did not support petitioner's claim that her MS was worsened. There were no abnormal objective findings to support petitioner's claim

that her symptoms were consistent with a vaccine reaction and no specific treatment was given for a possible reaction.

On August 25, 1999, petitioner saw Dr. Susan Douglas, a third neurologist, and told her that her hepatitis B vaccine exacerbation lasted four months. Except for some subjective sensory loss, Dr. Douglas found petitioner neurologically normal.

On September 15, 1999, petitioner saw Dr. Mark J. Doherty, a dermatologist, for her alleged alopecia areata. He concluded petitioner did not have alopecia areata. She had minimal hair loss and no loss of hair on pulling. The doctor concluded petitioner had instead telogen effluvium which he attributed to significant weight loss, stress, and a sundry of other nonspecific complaints. The doctor doubted telogen effluvium was associated with hepatitis B vaccination.

On February 24, 2000, Dr. Peter V.V. Hewitt, a pain specialist, found petitioner dishonest and untruthful because her range of movement which was observed outside the clinical setting was clearly better than what she portrayed inside his office.

On June 19, 2000, petitioner told Dr. Barbara Jessen, a fourth neurologist, that her burning pain after hepatitis B vaccine lasted four or five months and disappeared. She also told Dr. Jessen that her hair loss began three months after hepatitis B vaccination. Dr. Jessen concluded, after reviewing petitioner's records and examining petitioner, that her MS was not affected by the vaccination. Not only did the hepatitis B vaccine not cause a physical reaction in petitioner, but also petitioner had minimal symptomatology attributable to her MS.

On December 11, 2001, petitioner saw Dr. Marilyn Nayan, an occupational medicine specialist, who examined petitioner and found petitioner had MS but no signs of exacerbation.

Even assuming that four neurologists, a dermatologist, a pain specialist, and an occupational medicine specialist are wrong, i.e., that petitioner actually had significant aggravation of her MS, the Vaccine Act requires this aggravation to last more than six months. She told two neurologists that the burning pain lasted four or five months and disappeared. Her minimal hair loss, which began three months after the vaccination, is not alopecia areata and, as such, is unrelated to the vaccination. Although petitioner lost weight initially, she went back to obesity weighing 172 pounds.

Petitioner continued working at the women's shelter where she received the vaccination for another year before leaving. She never missed any work from the time of the vaccination until she quit almost a year later due to stress.

The undersigned ORDERS petitioner TO SHOW CAUSE by **July 13, 2007** why this case should not be dismissed.

IT IS SO ORDERED.

May 23, 2007
DATE

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