In the United States Court of Federal Claims
OFFICE OF SPECIAL MASTERS

No. 09-150V
Filed: July 19, 2012
Reissued with redactions: September 26, 2012
Unpublished

VALERIE SOTO, as parent and legal guardian of Y.D., a minor,	*	
Petitioner,	*	Fact ruling; Reliance upon contemporaneous medical records
v.	*	
SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,	*	
Respondent.	*	

Lorraine J. Mansfield, Law Office of Lorraine Mansfield, Las Vegas, NV, for Petitioner.
Lisa Ann Watts, U.S. Department of Justice, Washington, D.C., for Respondent.

FACTUAL RULING[1]

GOLKIEWICZ, Special Master.

The undersigned presented orally this ruling to the parties immediately following the fact hearing in this matter and again at subsequent status conferences. This written ruling memorializes those oral rulings that the factual portion of this case is governed by the contemporaneous medical records.

The issue presented for decision is the credibility of petitioner's allegations that certain neurological symptoms, especially staring, lethargy and poor visual contact, began immediately following vaccination and continued until [Y.D.] was sent for a neurological examination in December 2006. The issue arises because there is no mention of these symptoms following immunization until the pediatrician's visit on December 6, 2006. In addition, the medical records evidence histories from the parents indicating that the symptoms began in July 2006,

[1] This Fact Ruling was originally filed on July 19, 2012. On August 7, 2012, petitioner requested redactions to the caption for publication. Thereafter, the undersigned granted in part and denied in part petitioner's request in an Order, filed on September 26, 2012. In this reissued version, the minor child's name is redacted to initials throughout, the minor's birth date is omitted and this footnote is changed to reflect the redaction. The remainder of the Decision is unchanged.

which is approximately four months after the immunizations. Even these histories are questionable given the pediatrician's records during this time period, which not only do *not* record neurological symptoms, but note in positive terms [Y.D.]'s general health, eye contact and neurological status.

To address these issues, a fact hearing was conducted on November 3, 2011. Testimony was taken from petitioner, [Y.D.]'s mother, and her grandmother. The undersigned found both witnesses to be intelligent, well-spoken and making their best efforts to accurately report the facts from memory. However, despite their best efforts, the testimony cannot be accepted. At no point were the witnesses able to offer a logical explanation for how a doctor, who petitioner stated she has known for years and with whom she has an open relationship, could examine [Y.D.] on multiple occasions and not report any neurological abnormalities. In addition, the doctor did not record any complaints from petitioner regarding [Y.D.]'s medical condition. For example, the testimony was of a lethargic child with lifelessness in her eyes which began the day after the vaccination and worsened. Dr. Hom makes no notation of this. This does not make sense and petitioner was unable to offer any persuasive reason for the absence of notation. When Dr. Hom was told of the staring in December, Dr. Hom recorded the staring episode. That is expected and logical; petitioner's assertions are not. In short, the contemporaneous medical records do not substantiate in any way petitioner's allegations.

The Federal Circuit and logic teach us to give great weight to contemporaneous medical records as the importance of the information and the recent memory combine to reflect the most accurate information. Cucuras v. Sec'y of the Dept. of Health & Human Servs., 993 F.2d 1525, 1528 (Fed. Cir. 1993). These records are "generally contemporaneous to the medical events," and "accuracy has an extra premium" because a patient's proper treatment is "hanging in the balance." Id. That is not to say that medical records are sacrosanct. They are sometimes incomplete and even contradictory. However, there is no indication that the medical records in this case are incomplete, inaccurate, or otherwise unreliable. Thus, it is found that the medical records form the factual predicate for analyzing and resolving this Petition.

In brief, the medical records show as follows:

[Y.D.] was born on [redacted]. P Ex 1. She was seen numerous times by her pediatrician for normal infant sick visits. P Ex 3 at 41-61. [Y.D.] received immunizations at two, five, seven, and nine months without any apparent adverse reactions. Id. [Y.D.] presented to her pediatrician on March 13, 2006, for a sick visit. Id. at 66. She had a low grade fever, was pulling at her ear for the past 3-4 days and had a runny nose. Id. The assessment was bilateral otitis media, for which she was given an antibiotic. Id. [Y.D.] received Prevnar and MMR vaccines that day. Id.; P Ex 4. Petitioner claims that the MMR vaccine caused [Y.D.] to suffer an encephalopathy, seizure disorder and leg injury. Petitioner at 7, ¶ 26. The medical records do not support that contention.

A notation on [Y.D.]'s chart indicates that a prescription for amoxicillin, another antibiotic, was called in to the pharmacy on March 14 for [Y.D.]. P Ex 3 at 66. There is no indication of any complaint that [Y.D.] was suffering any reaction to her March 13 immunizations. [Y.D.]'s next treatment was nearly two months following her immunizations on May 15. Id. at 67. The complaint was concerns about [Y.D.]'s legs. The assessment was tibial torsion. Id. Respondent's expert, Dr. Gerald Raymond, describes tibial torsion as a

"developmental orthopedic issue and results in in-toeing while walking. It rarely requires more than observation." R Ex A at 5. Again, there is no indication of any symptoms of neurological injury following immunization. [Y.D.]'s next medical intervention was on July 10 when she was seen for ringworm and constipation. Id. at 68. Once again, the records do not indicate any neurological concerns, and in fact good eye contact is noted. Id.

[Y.D.] was seen on August 9 for a well-child visit. Id. at 69. She is noted to be doing well. She received varicella, hepatitis A, DTaP and HIB vaccines at this visit with no noted complaints. Id.; P Ex 4. [Y.D.] was seen on September 25 for a sick visit. P Ex 3 at 70. The concerns were vomiting and diarrhea for two days and pulling at the ears. Id. There are no concerns expressed regarding any reactions to her immunizations. [Y.D.] was not seen again until December 8. Id. at 71. This was a sick visit with complaints of a runny nose and pulling at her ears. It is noted in the record that [Y.D.] "stares." Id. There is no elucidation of this notation. The assessment includes, in addition to otitis media, speech delay and seizures. Id. [Y.D.] was referred to early intervention and neurology. Id.

[Y.D.] was seen on December 13 for her first neurologic consultation with Dr. Maller for evaluation of possible seizures. P Ex 5 at 116-119. Petitioner, [Y.D.]'s mother, gave a history of staring episodes lasting one to two minutes in duration occurring on a daily basis. Id. at 118. The staring began about five months ago, which would place it in July 2006. Id. On an intake questionnaire completed the same day, petitioner indicated that she did not know when [Y.D.]'s "first seizure ever" occurred. Id. at 112. The parents also expressed concern over [Y.D.]'s speech development, her interaction with other children and poor eye contact. Id. at 118. Dr. Maller's examination was inhibited by [Y.D.]'s lack of cooperation. Id. at 119. Dr. Maller noted that [Y.D.] was very active, exhibited no verbal expression, and did not have dysmorphic features. Id. Her diagnostic impressions were infantile autism and recurrent episodes of alteration of awareness; seizures versus behavioral staring. Id. [Y.D.] was seen on January 30, 2007, for a follow-up with Dr. Maller. Id. at 111. Petitioner reported that [Y.D.] had been seen by Nevada Early Intervention Services and started therapy for autism. Id. Dr. Maller indicated no need to see [Y.D.] on a regular basis. Id.

[Y.D.]'s medical records continue covering her ongoing care. Of interest here, her pediatric records note a call on February 27, 2007, indicating that "vaccines have been thimerosal free, no flu vaccines given." P Ex 3 at 75. On June 4, 2007, which is slightly 14 months after the vaccines at issue in this Petition, [Y.D.] was seen by her pediatrician. P Ex 3 at 80. On examination, a slight nodule was noted on [Y.D.]'s left thigh. Id. The pediatrician noted a discussion with petitioner about possible causes of autism. Id. The assessment was autism and "nodule? from vaccines," and to the left of that notation is written "?hepA, Vz." Id. [Y.D.] was seen at the Center for Children's Surgery on February 5, 2008, for a "lump on her left thigh." P Ex 10 at 170. The examining physician noted that the lump was noticed by [Y.D.]'s mother about six months ago – which is roughly consistent with the June 4, 2007, record which is the first recordation of the nodule on the left thigh – and mom reported an immunization given in the same vicinity about a year ago. Id. Diagnostic impression was a "subcutaneous scar possibly secondary to a previous immunization in the mid-left thigh." Id. No surgical intervention was deemed necessary. Id.

On March 10, 2008, [Y.D.] was seen by Dr. Dipple at the UCLA Genetics service to rule out a metabolic disorder associated with her autism. P Ex 12 at 183-86. [Y.D.]'s parents

reported that [Y.D.]'s problems started at the age of one year five months – approximately June of 2006, which is consistent with the history the parents gave to Dr. Maller on December 13, 2006, that [Y.D.]'s staring episodes began about five months ago, or July 2006 – when she lost all of her acquired skill and regressed in speech. Id. The parents reported that [Y.D.] developed staring spells at this time. Id. Dr. Dipple's diagnostic impression was autism, seizure disorder and developmental regression. Id. [Y.D.] was seen for a follow-up at UCLA Genetics service on June 9, 2008. Id. at 181-82. She was seen by Dr. Cederbaum. Dr. Cederbaum commented that "[t]oday, the mother is really looking for a validation of her belief that there is an association with the immunizations, and she points particularly to the very high level of rubella antibody measured initially." Id. Dr. Cerderbaum's diagnostic impression was that [Y.D.] has autistic spectrum disorder with hyperbeta-alaninemia. Id.

The Petition in this case alleges that [Y.D.]'s March 16, 2006 MMR immunization caused in fact an encephalopathy, seizure disorder and leg injury. Petition at 7, ¶ 26. Relying on the mother's affidavit, the Petition alleges that on the night of the immunization, [Y.D.] suffered "fever and crying and had staring episodes and was 'absent' for short periods." Id. at 4, ¶ 10. The Petition states that due to [Y.D.]'s worsening condition, the doctor was contacted the next day and [Y.D.] was prescribed Amoxicillin and Tylenol. Id. at ¶ 11. [Y.D.]'s condition worsened over the next several weeks. Id. at ¶ 12. She was diagnosed with tibial torsion on May 15, 2006. Id. at ¶ 13. The nodule on [Y.D.]'s leg is palpable to date. Id. at ¶ 14. [Y.D.] was diagnosed with a seizure disorder on December 8, 2006. [Y.D.]'s grandmother and mother testified in support of these allegations. As stated above and discussed below, this testimony is found not credible in the face of the contemporaneous medical records.

While the undersigned found the witnesses to be truthful, they were not found to be credible regarding the facts of the case. First, as [Y.D.]'s grandmother, Ms. Mactier, stated, a timeline of events was constructed from the medical records. Tr at 9, 25. However, the allegations of vaccine reactions are not in the medical records. This information was added to the timeline after discussing with petitioner how [Y.D.] was feeling at the various visits. Tr at 63. Thus, information that does not appear in the contemporaneous medical records is now being proffered more than five years after the period in question. Ms. Mactier had to reference these notes repeatedly to refresh her memory. See Tr at 52. This is understandable given the passage of time, but it undermined the confidence in her independent recollection of the events in question. The same can be said for [Y.D.]'s mom, petitioner.

In response to questions regarding what occurred the day of the vaccination, March 13, 2006, Valerie responded "I don't remember. . . . Five years ago, I don't remember my children staying up abnormally late." Tr at 117. That is an honest answer and it reflects reality; remembering a timeline of events from five years ago is nearly impossible. But that is what petitioner is asking the court to accept, that memories are more reliable than documents created at the time in question. Petitioner is also asking the court to accept that Dr. Hom did not note the medical complaints correctly. Valerie testified that she told Dr. Hom that [Y.D.] was lethargic and in pain following the immunization. Tr at 124. She described [Y.D.] as having staring spells and being lifeless in late March. She said she called Dr. Hom repeatedly about these concerns. Id. at 131. Valerie had known Dr. Hom for six years as he treated Valerie's older children. She still sees Dr. Hom. Id. at 24. There is no indication in the medical records of the phone calls or of the described symptoms. In fact, as opposed to a lifeless child, Dr. Hom indicates at the July 10, 2006 visit that [Y.D.] exhibits good eye contact. P Ex 3 at 68. [Y.D.]

was taken to Dr. Hom on May 15 for concerns about her legs, id. at 67, on July 10 for patches on her skin, id. at 68, on August 9 for a well visit, and on September 25 for vomiting and diarrhea. Id. at 70. The undersigned explored these records with the mom trying to determine if there is a logical explanation for the chasm between the contemporaneous records and petitioner's allegations. Tr at 137– 145. No persuasive explanation was forthcoming. Mom attempted to explain the absence of mentioning of the symptoms in the medical records due to a gradual worsening of the symptoms. Tr at 145. However, she had already testified that her level of concern over [Y.D.]'s health in March was a nine on a scale of ten and that she contacted Dr. Hom repeatedly over those concerns. Tr at 130-31. The fact is that Dr. Hom saw [Y.D.] on multiple occasions following the March immunization and yet the records are devoid of parental complaints of neurological symptoms and of Dr. Hom assessing the same.[2] It is not until December of 2006, over eight months following immunizations, that the first reference to staring appears. Records thereafter point to approximately July as the onset point, more than three months following the immunizations. No treating doctor viewed the vaccinations as the causative agent.

As stated above, the undersigned finds that the medical records provide the facts for this case. Petitioner provided the medical opinion from Dr. Grout. However, Dr. Grout's opinion is premised upon [Y.D.] suffering seizures dating from March 13, 2006. This is factually incorrect. The Federal Circuit has found that an expert's opinion is only as good as its factual predicate. Perreira v. Sec'y of DHHS, 33 F.3d 1375, 1377 n. 6 (Fed. Cir. 1994). Since Dr. Grout's factual predicate is incorrect, it follows that her opinion fails as well.[3] As discussed above, the medical records do not provide that support. Thus, as discussed with petitioner at the close of the hearing and in status conferences, petitioner must either dismiss this case for lack of proof, or petitioner must provide an opinion from a qualified doctor which discusses the medical records and how the information in the medical records supports petitioner's allegation that the March 13, 2006 immunization caused in fact [Y.D.]'s medical condition.

The undersigned's Order filed June 8, 2012, continues to govern future proceedings in this case.

IT IS SO ORDERED.

s/ Gary J. Golkiewicz
Gary J. Golkiewicz
Special Master

[2] Following the fact hearing, the undersigned gave petitioner an opportunity to inquire of Dr. Hom whether the doctor had any information that would assist the court in understanding the medical records and [Y.D.]'s medical history. Petitioner filed a status report stating that no testimony from the treating physician would be presented. P STR filed December 5, 2011.

[3] Respondent filed the expert report from Dr. Raymond, which took strong exception to Dr. Grout's analysis and opinion of the case. R Ex A.