OFFICE OF SPECIAL MASTERS

(No. 90-1729V)
(Filed April 17, 1998)

JOHN KEVIN O'LEARY	*	
Petitioner,	*	**TO BE PUBLISHED**
v.	*	
SECRETARY OF HEALTH AND HUMAN SERVICES,	*	
Respondent.	*	

Rodney A. Klein, of Sacramento, California, for petitioner.

Mark W. Rogers, of the United States Department of Justice, Washington, D.C., for respondent.

DECISION ON REMAND

French, Special Master.

On September 27, 1990, petitioner filed a claim under the National Childhood Vaccine Injury Compensation Act (Vaccine Act or Program).[(1)] The petition alleges that John Kevin O'Leary

(Kevin) received a diphtheria-tetanus (DT) vaccination on June 6, 1983, and as a result, sustained chronic relapsing inflammatory demyelinating polyradiculoneuropathy (CIDP).[(2)]

The special master did not convene a hearing in this matter and issued a decision on April 3, 1997, based on the filings of record. The special master found petitioner was not entitled to compensation because he

was unable to demonstrate, by a preponderance of the evidence, that the vaccination in question actually caused his CIDP. On May 2, 1997, petitioner filed a motion for review of the special master's decision. On September 24, 1997, Judge Horn issued an order remanding the case to the special master to conduct further proceedings. Pursuant to Judge Horn's order, a hearing was held in San Diego, California on December 9, 1997. At the hearing, petitioner presented the testimony of Kevin O'Leary (petitioner herein) and Dr. Charles K. Jablecki, petitioner's treating neurologist. Respondent presented the testimony of Dr. W.C. Wiederholt, a neurologist.

The initial issue in this case is a factual one concerning the time of the onset of petitioner's condition. There are contradictions in the petition, affidavits, medical records, and testimony regarding when Kevin's symptoms of CIDP first appeared. For this reason, within the presentation of the factual background, below, I include portions of the medical records, petition, affidavits, and testimony pertaining to the issue of onset. In the discussion section, I highlight the inconsistencies between those representations of fact.

FACTUAL BACKGROUND

The following evidence is contained in the medical records in this matter:

In June 1983, at the age of 31, petitioner cut his foot on a metal object in shallow water while surfing. He received a DT shot on June 26, 1983 from his health care provider, Kaiser Permanente (Kaiser). Petition (Pet.) at 145.

On November 1, 1983, petitioner was seen at Kaiser for numbness in his lip and toe. The record documents "1 w[ee]k hx [(history)] of [(decreased)] sensation L side of lower lip." Pet. at 144. The record notes petitioner had no history of injury or dental problems and attributed the toe numbness to shoe compression. Id. On January 11, 1984, Kevin was seen by Dr. Novak at Kaiser who noted "31 y.o. , board surfer; no acute injury ~ 3 days ago noted upper R back pain, soreness in area with shoulder motion." Pet. at 142. Dr. Novak's impression was a muscle strain and possible muscle tear. Id. Kevin called Kaiser on January 23, 1984, complaining of an inability to lift two fingers of his left hand and was seen by Dr. Fisher the next day who noted petitioner had numb toes and lip "several mo[nths] ago" that resolved. Pet. at 140, 141.

Kevin was seen by Dr. Flippin on January 26, 1983. Dr. Flippin recorded the following history:

The patient is a single 31-year-old computer programmer for the United States Navy. He has no past history of any serious medical illnesses. He is a very athletic individual who actively participates in surfing, weightlifting and other vigorous physical exercise. He was in his usual state of health until approximately one week ago when he noted weakness of the left hand and wrist when he had difficulty "setting" while playing volleyball. He paid no attention to it at that time, but the next day he became aware that the left hand was weak and the hand and the wrist had been weak since the onset of symptoms for at least the past 2 days. He does note that the third and fourth fingers of the left hand feel somewhat numb in that he tends to drop objects held in that hand unless he pays close attention to it. . . . He has no history of trauma to the elbow, he's had no neck or radicular symptoms. He's not had symptoms of this nature involving the right upper extremity. . . . He has had recurrent dislocation of his left shoulder, for which he received treatment in the Orthopedic Department.

Pet. 136. Dr. Flippin followed up with Kevin on February 24, March 27, June 1, June 26, and June 29, 1984. Pet. at 132-35. Kevin was seen again on July 6, 1984, and it is noted at that time that he demanded to be referred to Physical Medicine. Pet. at 125-26. He saw Dr. Goetz, on August 1, 1984, and the

following was recorded:

This 32-year-old computer programmer is seen for evaluation of numbness in his body. The patient presented to Family Practice in January of this year with the spontaneous onset of weakness in the 4th and 5th fingers and turned out subsequently to have bilateral slowing across the ulnar tunnel. The patient has slowly improved in this respect but states that in the last several months he has been aware of the fact that his arm seemed to be weak and he is somewhat clumsy. He tried to play tennis the other day and he felt that he could not make the quick moves that he is accustomed to making. He feels that he may be losing a little strength in his legs but predominantly in his arms. He's also had patchy numb-like sensations such as over the right breast, temporarily over the left eye, and sometimes in his legs. He is concerned that he might have a serious neurological disease.

Pet. at 120.

On August 10, Dr. Goetz, referred Kevin back to neurology with the suggestion that Kevin could have multiple sclerosis. Pet. at 123. Dr. Flippin saw Kevin again on August 10, 1984, and expressed concerns about the possibility that Kevin was suffering from an organic central nervous system process, a demyelinating disease, or a brain stem glioma. Pet. at 117-18. In September, Dr. Flippin ordered a series of studies to be performed on Kevin. Pet. at 96-112.

On October 24, 1984, Dr. Devors saw Kevin and recorded a "one year history of gradually progressive distal numbness and weakness . . . ." Pet. at 94. Dr. Devors' impression at that time was "chronic progressive demyelinating polyradiculoneuropathy" for which he prescribed prednisone. Pet. at 95.

Dr. Richard Smith next examined Kevin on November 2, 1984. The following is an excerpt of the history recorded by Dr. Smith:

The patient, a 32 y/o left-handed male, is self referred for neurological consultation. According to the patient's report he was in excellent health until October of 1983 when he noted numbness about the left lower lip and right foot. The former symptom resolved over about a two week period but his foot remained numb. He felt this might be due to ill fitting shoes. In January he sustained a right shoulder injury while surfing. For some time after that his right arm seemed weak. He dismissed this as being due to his injury. A month later he noted that his left hand was clumsy. He would drop his fork or other utensils and he appreciated the onset of numbness involving the left middle and ring fingers, also he noticed a left wrist drop. He consulted Dr. Flippen [sic] (Kaiser/neurologist) who made a diagnosis of entrapment neuropathy. Follow up was advised. There was mention that the patient might ultimately benefit from surgical translocation of the ulnar nerve. As time went on the patient noted increased weakness in the left upper extremity. Whereas he had been able to lift weights he noted a marked reduction of strength. For the first time (May) he also began to note a weakness of the right "ankle". In the ensuing months he noted patchy numbness over the right chest, forehead, etc. These sensory symptoms would come and go although at the present time he notes sensory loss over the lower extremities, abdomen and the right side of his neck and scalp. Both arms are weak although the left is more affected than the right. He also reports that his voice is raspy and he has some difficulty clearing his throat.

Pet. 68. Dr. Smith noted that in July 1983, prior to taking a trip to Mexico, Kevin took an antibiotic and that Kevin sprained his ankle in July 1983 while playing volleyball. Dr. Smith commented, "[i]t is of more than passing interest that he received a diphtheria-tetanus shot on June 6, 1983 -- several months before the onset of his illness." Pet. at 69. "Reviewing the record carefully it is noted [Kevin] received a

diphtheria-tetanus injection approximately three months before the onset of his symptoms. One can't help but wonder whether there is not a relationship between this and his subsequent illness." Pet. at 71.

On November 6, 1984, Kevin first saw Dr. Charles Jablecki, his current neurologist. Dr. Jablecki recorded the following history:

This is the first office visit for Mr. O'Leary, a 32-year-old married man, who worked for the government as a computer programmer and systems design analyst. While at sea, about a year ago, the patient noticed the onset of numbness in the third, fourth, and fifth toes of the right foot. The patient has been in good health before this, had not had any viral illnesses, although he had a tetanus shot two months before the symptoms began. On his return to San Diego, he arranged for evaluation at Kaiser.

Pet. at 63. Dr. Jablecki confirmed the diagnosis of chronic, progressive inflammatory polyradiculoneuropathy. Pet. at 64.

On November 27, 1984, Kevin saw Dr. Jablecki again. At that time, Dr. Jablecki noted Kevin's symptoms "were present for about one year, prior to initiation of steroids, . . . the second week of November, 1984." Pet. at 54. On August 20, 1987, Dr. Jablecki wrote a letter to petitioner as follows:

This letter is to confirm that you have a chronic inflammatory polyneuropathy for which you were first evaluated in November, 1984. You had been symptomatic for about one year prior to that evaluation. At that time, you had moderately severe weakness of the muscles of both extremities, primarily distal, greatly reduced tendon reflexes, and some sensory symptoms in both the hands and feet. You responded very well to prednisone, 60 mg every other day, following completion of laboratory studies, including an EMG and nerve conduction studies, and a CSF examination, which confirmed the diagnosis.

Pet. at 28.

PETITIONER'S ALLEGATIONS

The petition

The petition in this matter was filed on September 27, 1990. In it, petitioner alleges he received a DT vaccination on June 6, 1983, at Kaiser Hospital in San Diego, California. Regarding the onset and progression of petitioner's neurological symptoms, the petition states:

In late 1983 after the DT shot, Petitioner began experiencing an onset of numbness of the lower lip which spread to his toes on the right foot. In the Spring and Summer of 1984 petitioner began to note a weakness in his left hand and as a result was dropping items, i.e. silverware while eating. Petitioner also experienced some wrist drop. Later on, petitioner experienced weakness in his upper extremity and a noted weakness in his right ankle. In the ensuing months, petitioner noted patchy numbness over the chest and forehead, lower extremities, abdomen and right side of his neck and scalp.

Pet. at 2.

The affidavits

Kevin O'Leary affidavit

Kevin's affidavit was filed on May 6, 1993. In it he avers that his health was good prior to June 1983. He explained that he cut his foot while surfing in June 1983 for which he received a tetanus shot. He described the onset of his neurological symptoms as follows:

Shortly after receiving this shot I began to experience occasional numbness in the fourth and fifth fingers of my left hand. I attributed this to normal circumstances or the possibility that I had pinched a nerve or something similar to that. The tingling sensation in my fingers was the same as if they had been asleep and were just waking up. These symptoms persisted on an intermittent basis. The following week I noticed that the ball and forth [sic] and fifth toes of my right foot had become numb. During this period of time the symptoms that I was experiencing would seem to improve and go away and then inexplicably reoccur. In the first week of July the left side of my lower lip and chin became numb. Up to this time the symptoms I was experiencing were a slight nuisance but I just attributed them to either tight shoes or excessive physical exercise.

Pet. ex. 5 at 2.

Kevin claimed he attempted to schedule an appointment at Kaiser for July or early August, but, because this was not an emergency, the earliest appointment he could get was November 1, 1983. Id. On November 1, the Kaiser doctor advised Kevin that his mouth numbness was likely due to dental problems and suggested his foot numbness was due to tight shoes. Kevin claimed his symptoms were cyclical in their severity, and over time more symptoms developed and increased in severity to the point where he could barely walk. "By April, the numbness and strength loss was spreading up both of my legs, my arms and into my shoulders. My hands were without feeling and extremely weak. I could not write which created major problems for me at work and at school. . . . I quit taking night classes because it was very embarrassing to hand in work that was barely legible." Id. at 4-5.

Kevin explained that by late summer his physical condition seemed to be deteriorating at a more rapid pace. By July, Kevin was frustrated and dissatisfied with Kaiser's treatment. He continued to receive treatment from Kaiser and it was not until late October that Dr. Devors diagnosed him with CIDP and prescribed prednisone therapy. Id. at 7-8. Kevin then scheduled an appointment with Dr. Jablecki to get another opinion about the diagnosis and treatment. By late November 1984, Kevin was much improved on the prednisone therapy. At the time of his affidavit, Kevin remained on prednisone and has had to make lifestyle changes to accommodate the side effects of long-term prednisone use. Id. at 8-9.

Elizabeth Gramoy affidavit

Elizabeth Gramoy, petitioner's long-time girlfriend, signed an affidavit on August 1, 1993, recounting the following:

I remember when Kevin cut his foot surfing in June 1983. He was concerned about infection so he made arrangements to go to Kaiser to get it checked out. I remember that towards the middle of June 1983 we were sitting in our backyard talking. Kevin kept tapping his fingers on the arm of his chair and said something to the effect that he had been sitting for too long because his hand fell asleep. A few days later while watching TV, he again commented that his hand must be tired because it fell asleep again. Around this time he also mentioned that there was a numb spot on his arm that he noticed while drying off with a towel. . . . [B]y the end of June he started complaining that his toes were also tingling and feeling like they had fallen asleep. . . . Around the 4th of July he commented that his lower lip was numb and made and [sic] appointment with Kaiser. Because it normally takes a long time to set up a non-emergency type of appointment at Kaiser, we did not think it unusual, albeit frustrating, to have to wait several months to

see his family practitioner. Between the 4th of July and the time of his appointment on November 1, his numbness and weakness progressively got worse and we commented about looking forward to his appointment. . . . Each day I would ask how he felt, in the hopes he would say better.

Pet. ex. 6.

The testimony

Petitioner testified that prior to his vaccination, he was very physically active and participated in a number of outdoor activities on a regular basis. Transcript (Tr.) at 9. He testified that he was vaccinated with DT on June 26, 1983, after cutting his foot while surfing. Tr. at 9-10. According to Kevin, nothing happened immediately after the shot, but "[a]bout a week later, I began to notice a numbness and tingling in my fourth and fifth fingers of my left hand." Tr. at 10. He testified he had been sitting in his backyard with his elbow on a chair and thought his hand had fallen asleep. Id. "Then on July 4th, we were at a picnic. I was playing volleyball in my bare feet on the grass, and I noticed a numb spot on the bottom of my right foot." Tr. at 11; *see also* Tr. at 33-34. He testified that over the next couple of weeks, he noticed a patch of numbness in his forearm and developed a patch of numbness in his chin and lip. Tr. at 12-13. Kevin's symptoms were cyclical from week to week--the numbness would persist and then seem to resolve, only to reoccur. Tr. at 13.

Kevin testified that he contacted Kaiser in the first part of September.(3) Tr. at 14. The earliest he could get an appointment was November 1, 1983. Kevin recalls describing his symptoms to the doctor on November 1 and being told the numbness in his feet was due to tight shoes and the numbness in his lip to a dental problem. He testified he told the doctor that he had been symptomatic "over the past few months." Tr. at 19. The doctor instructed Kevin to get wider shoes and to return in a couple months if the problems had not resolved. Kevin did not seek a second opinion at that time. He explained, "I think it's one of those things I had heard what I wanted to hear and was hoping they were right and went off and hoped it would resolve itself like they seemed to indicate . . . ." Tr. at 20.

Kevin testified that his problems did not resolve. While some of the areas of numbness waxed and waned in severity, he developed weakness in his upper body, and new patches of numbness. Tr. at 21-24. He returned to Kaiser and underwent neurological studies. Tr. at 24. His problems persisted, the weakness increased, and he continued to return to the doctor. In July 1984, Kevin demanded a referral to the physical medicine department because he felt the neurology department was not treating his problem. At the end of July, Kevin testified, he was diagnosed with a chronic demyelinating disease. Tr. at 26-27.

Kevin testified he sought a second opinion from Dr. Smith who confirmed the diagnosis of chronic demyelinating polyradiculoneuropathy. Tr. at 27. About three days later, Kevin sought the opinion of Dr. Jablecki, a prominent and reputable neurologist in San Diego. Tr. at 28. According to Kevin, Dr. Jablecki reviewed the Kaiser records, conducted neurological tests and recommended steroid treatment. Id. Kevin began steroid treatment in November 1984 and saw a dramatic improvement in his condition over the next six months. Tr. at 29-30. He testified the effects of the steroids have lasted until the present, although attempts to stop the steroids altogether have been unsuccessful, and decreasing the dosage of steroids has been a slow process. Tr. at 30-31.

DISCUSSION

Statutory requirements

Petitioner may establish causation in one of two ways. First, petitioner may demonstrate what is

commonly referred to as a Table case. The Vaccine Injury Table lists vaccines covered by the Act and certain injuries and conditions that may stem from the vaccines. §14. If the special master finds that a person received a vaccine listed on the Table, and suffered the onset or significant aggravation of an injury listed on the Table, within the time period prescribed by the Table, then the petitioner is entitled to a presumption that the vaccine caused the injury. §13(a)(1)(A). The petitioner must then show that the injury for which he seeks compensation is a sequela of a Table injury. §14(a)(I)(E). The respondent may rebut the presumption of causation with a preponderance of the evidence that the injury or condition was due to factors unrelated to the administration of the vaccine. §13(a)(1)(B).

Second, petitioner may establish causation by proving by a preponderance of the evidence that the vaccine actually caused the alleged injury. Actual causation requires proof of a "logical sequence of cause and effect showing that the vaccine was the reason for the injury." *Strother v. Secretary of HHS*, 21 Cl. Ct. 356, 370 (1990), *aff'd without opinion*, 950 F.2d 731 (Fed. Cir. 1991). The mere temporal relationship between a vaccination and the injury, and the absence of other obvious etiologies for the injury, are patently insufficient to prove actual causation. *Wagner v. Secretary of HHS*, No. 90-1109V, 1992 WL 144668, at *3 (Cl. Ct. Spec. Mstr. June 8, 1992). Rather, petitioner must show a medical or scientific theory causally connecting the vaccination and the injury. *Strother*, 21 Cl. Ct. at 370 (*citing Hasler v. United States*, 718 F.2d 202, 205-06 (6th Cir. 1983)).

Petitioner's condition, CIDP, is not one listed on the Vaccine Injury Table. Therefore, petitioner is pursuing a cause-in-fact claim, asserting the DT vaccination he received on June 26, 1983, actually caused his CIDP which allegedly had its onset six days later. In support of this allegation, petitioner provided the expert report and testimony of his treating neurologist, Dr. Jablecki. Dr. Jablecki's opinion that DT caused petitioner's CIDP, however, is conditioned on the onset of CIDP occurring within six weeks of vaccination. He designated August 7, 1983, as the cut-off date by which onset must occur in order for the CIDP to be causally linked to the vaccination. Therefore, the initial issue is a factual one, namely, did the onset of petitioner's CIDP occur within six weeks of his June 26, 1983, DT vaccination. If the answer is affirmative, the next query is whether the DT shot actually caused petitioner's CIDP. That query would be broken down into a two-part inquiry: (1) can DT cause CIDP and (2) did DT cause CIDP in this case.

A special master may not find in favor of petitioner based on the claims of petitioner alone, unsubstantiated by medical records or medical opinion. §13(a)(1). "Medical records, in general, warrant consideration as trustworthy evidence. The records contain information supplied to or by health professionals to facilitate diagnosis and treatment of medical conditions. With proper treatment hanging in the balance, accuracy has an extra premium. These records are also generally contemporaneous to the medical events." *Cucuras v. Secretary of HHS*, 993 F.2d 1525, 1528 (Fed. Cir. 1993). The Supreme Court counsels that oral testimony in conflict with contemporaneous documentary evidence deserves little weight. *United States v. United States Gypsum Co.*, 333 U.S. 364, 396 (1947); *see also Montgomery Coca-Cola Bottling Co. v. United States*, 615 F.2d 1318, 1328 (Ct. Cl. 1980). However, the Act recognizes that medical records are not always accurate. In cases where medical records are devoid of any mention of onset or contain a date or dates that are inconsistent with petitioner's allegations it has been held that the fact finder must closely scrutinize the conflicting testimony. In order to meet his burden of persuasion, petitioner must present thoroughly credible and persuasive testimony and/or documentary evidence to explain omissions or errors in the medical records. *Buckert v. Secretary of HHS*, No. 90-1605V, 1994 WL 26302 (Fed. Cl. Spec. Mstr. Jan. 11, 1994) (petitioners' burden particularly heavy where there are no contemporaneous medical records indicating Table injury). It is against these standards that the undersigned considered the evidence presented in this case.

In deciding whether petitioner's onset of CIDP occurred within six weeks of his DT vaccination, the special master must determine whether the factual allegations are believable in light of the

contemporaneous medical records. On of the biggest dilemmas facing the undersigned in this case is the stark contrast that exists between the time of onset, unambiguously and consistently recorded in the medical records, and the current claims of petitioner. In the past, the undersigned has found instances where petitioners' clear, cogent and convincing testimony was sufficient to overcome the absence of contemporaneous medical documentation and discrepancies in the medical records. *See Eng v. Secretary of HHS*, No. 90-1754V, 1994 WL 67704 (Fed. Cl. Spec. Mstr. Feb. 18, 1994); *Stevenson v. Secretary of HHS*, No. 90-2127V, 1994 WL 808592 (Fed. Cl. Spec. Mstr. June 27, 1994). In this case, however, the special master finds petitioner's recollections of the events are unreliable and cannot be accepted as fact.

Petitioner urges the court to accept on or about July 1, 1983, as the date of onset of his CIDP. He claims his symptoms began about one week after the DT vaccination, around the first of July, a few days prior to a July 4th picnic that stands out in his mind. Petitioner made it clear that his memory of the onset is tied to the July 4 holiday. It is the court's experience that people tend to recall events in connection with holidays or days of special significance such as birthdays or anniversaries. In fact, a recollection tied to such an event often lends credibility to the particular remembrance.

There are a number of problems, however, accepting petitioner's current version of the events as fact. One aspect of this case that is particularly troubling, is the inconsistency between petitioner's early allegations, set forth in his affidavit and in the petition, and his later claims provided at the hearing. Petitioner testified that upon further factual investigation after filing his claim, he discovered the DT vaccination was not administered on June 6, but June 26, 1983. Petitioner does not refer to a specific date of vaccination in his affidavit, but, rather, mentions June 1983 as the time of the shot and chronicles a progression of symptoms into the first week in July:

Shortly after receiving the shot I began to experience occasional numbness . . . . These symptoms persisted on an intermittent basis. The following week I noticed [new symptoms]. . . . During this period of time the symptoms that I was experiencing would seem to improve and go away and then inexplicably reoccur. In the first week of July . . . my lower lip and chin became numb. Up to this time the symptoms I was experiencing were a slight nuisance . . . .

P. ex. 5 at 2. Petitioner's *testimony*, on the other hand, was that several days prior to the July 4th picnic, he first noticed some numbness in his fingers. Then, on July 4, he became aware of a numb patch on his foot.

The problem with the testimony versus the affidavit is that they *seem* to describe two considerably different time periods during which petitioner noticed the onset of symptoms--several weeks in the affidavit and three days in the testimony. Petitioner insists, however, that the time

period referred to in his affidavit (excerpted above) represents the same three-day period to which he testified, i.e., the period from July 1 to July 4th:

Q So "up to this time" referred to three days --

A That's correct.

Q -- worth of symptoms?

A Right.

Tr. at 35.

I cannot easily accept that assertion. A common sense reading of the affidavit strongly suggests a process that took place over a period of *several weeks* following vaccination, not three days. It is reasonable to assume that, at the time of the filing of his affidavit, petitioner was relying on the June 6th date of vaccination as submitted in the petition.[(4)] That being the case, his reference, in the affidavit, to the period of time from "shortly after" the vaccination to the first week in July, would cover a period of several weeks and not a matter of days as petitioner submits. This significant shift in time frames in petitioner's factual recitation, from the affidavit to the testimony, diminishes my confidence in the accuracy of petitioner's current allegations.

Ms. Gramoy's affidavit indicates that the first incident occurred in the middle of June and worsened by the end of June. In her affidavit, she specifically relates the onset of lip and toe numbness to July 4. In this regard, Ms. Gramoy's affidavit is consistent with petitioner's affidavit. If the recollections are correct in their affidavits, this would place the onset *prior* to the vaccination. Petitioner testified that he and Ms. Gramoy did not consult with each other in the preparation of their affidavits, but drafted them independently based on their own recollections of the events. If that is the case, then there exist two *independent* recollections of onset *predating* the vaccination.

Another inconsistency between petitioner's testimony and his affidavit brings into question the reliability of petitioner's current factual account. In his affidavit, petitioner claims that he attempted to schedule an appointment in July or early August when he experienced the numbness on his face. Ms. Gramoy also represented in her affidavit that petitioner called Kaiser for an appointment around July 4 when Kevin's lip and chin became numb. At the hearing, however, petitioner was insistent that he did not call for an appointment until September. Petitioner could not explain why he is now certain it was September and not July or August as he indicated in his affidavit:

Q Okay. In 1993, you couldn't remember when you scheduled the appointment? That's when you signed the affidavit?

A Right. Exactly. No I'm assuming at that stage, that's what I thought I recalled.

Q Okay. At that point, that's when you remembered.

A. Right.

Q But that wasn't true?

A Well --

Q Let me put it a different way. That wasn't correct.

A Well, I guess at this stage, on thinking back, I don't really remember doing that. I certainly have no evidence that I made that call, so it's very difficult for me to --

Q Okay. You've testified that it was in September --

A Right.

Q -- that you called.

A Right.

Q Is it fair to say you don't remember when it was?

A I do not know the specific date in September when I called.

Q Okay. Could it have been in July or August or are you sure now it was in September?

A I'm sure it was in September.

Tr. at 35-36.

The most compelling evidence weighing against petitioner, however, is the fact that the most contemporaneous medical records consistently report that Kevin did not begin to suffer symptoms until October 1983, approximately *four months* after his DT vaccination of June 26, 1983. Kevin first received medical attention for his condition on November 1, 1983. The record of that visit documents a *one week history* of symptoms, placing the onset in late October 1983. Pet. at 144. Another record, prepared on January 24, 1984, reports a history of numb toes and lip "several mo[nths] ago." Pet. at 140. Other records, of October and November 1984, specifically refer to an onset of about one year earlier, i.e., October or November 1983. Pet. at 68 ("was in excellent health until October of 1983"); Pet. at 63 (November 6, 1984 record notes good health until about a year ago). One record actually refers to the critical time frame, July and August 1983, but is conspicuously void of reference to any symptoms of CIDP. That November 2, 1984 record provides a detailed medical history, places the onset of CIDP in October 1983, and reports that "[i]n July of 1983, prior to taking a trip to Mexico, the patient took an antibiotic." Pet. at 69. Also reported is the fact that Kevin sprained his ankle in July 1983 playing volleyball. Id.

Even Dr. Jablecki, petitioner's expert and treating physician, reported in several instances that Kevin's symptoms had their onset around November 1983. Pet. at 54 (November 27, 1984 record); Pet. at 28 (August 20, 1987 letter to petitioner). As well, Dr. Jablecki's expert report, written on September 30, and filed on October 1, 1993, states that "[t]he illness began with primarily sensory complaints in the fall of 1983." Pet ex. 8 at 1. There is one record of Dr. Jablecki's, however, dated November 6, 1984, that refers to the onset of symptoms while petitioner was "at sea about a year ago." Pet. at 63. That same record also notes that Kevin had a tetanus shot two months before the symptoms began. Id. Kevin testified he does not recall telling Dr. Jablecki about being at sea, but he does recall that he took a trip to Mexico in 1983 from August 11 to the 17th or 18th, during which he spent time sport fishing but did not go out to sea at any other time in the fall of 1983. Tr. at 48-50.

There is ambiguity within this one record that seems to establish a November 1983 onset, but *could* also implicate August 11-18. Regardless, even if I were to accept that the onset of Kevin's CIDP occurred on August 11, this is still outside the time frame petitioner's expert would require for DT to be considered causally linked to CIDP.[(5)]

Dr. Jablecki testified that, after reviewing additional material and talking with petitioner further, he is now willing to accept an onset date of July 4 or a few days prior despite the notations in Dr. Jablecki's own medical records and expert report. It is significant to him that petitioner ties the onset to a holiday. Tr. at 65-66. Also, Dr. Jablecki explained that at the time he took a history from petitioner, Dr. Jablecki was not particularly interested in the exact date of onset. Rather, he testified, he was more concerned about making a diagnosis. Tr. at 69.

While I found Dr. Jablecki to be an impressive witness--clear, articulate, knowledgeable, and forthright--I am troubled by this aspect of his testimony. It is true that remembering a particular event in connection to a holiday can be persuasive. However, Dr. Jablecki's willingness to now change his *own records*

documenting the onset of the disease for which he currently treats petitioner, based on petitioner's much later connection of the events to a holiday, is puzzling. I have heard many treating physicians testify under the Program, and it has come to be my understanding that knowing the time of onset of a disease can be a particularly important and relevant tool in making a diagnosis. Furthermore, not only did Dr. Jablecki change his mind about the time of onset, he changed significantly his medical opinion from the time of his medical expert report to the time of his testimony. Dr. Jablecki was initially willing to support a causal link between DT and CIDP based on no less than three months separating the two. *See* Pet. ex. 8 (recognizing June 6, 1983 immunization and Fall 1983 onset). By the time of the hearing, however, Dr. Jablecki had condensed that necessary time period considerably to six weeks at the most. It is understandable that Dr. Jablecki has since done research and educated himself further about CIDP. However, these significant adjustments to Dr. Jablecki's medical records and expert opinions undermine Dr. Jablecki's credibility and make the court hesitant to rely on his current convictions.

To summarize, petitioner's burden was particularly difficult in this case in the face of conflicting contemporaneous medical documentation. Petitioner was unable to provide adequate explanation for the discrepancy between his current recollections and those entries recorded in the medical records. More specifically, petitioner did not offer a persuasive explanation why the contemporaneous medical records refer consistently to a late 1983 onset. He conveyed in his testimony that he was concerned about his early symptoms, although he attempted to ignore or minimize their significance. He claimed, in fact, to have called Kaiser for an appointment between July and September because his symptoms were so worrying. Ms. Gramoy's affidavit also conveyed concern for petitioner's condition when the symptoms began. Indeed, she claimed that every day between July 4 and November 1, 1983, she would ask Kevin how he felt. Considering petitioner's

and Ms. Gramoy's professed concern during the summer months, it is difficult to understand how the medical records failed consistently to reflect an onset earlier than October 1983.

Petitioner's own account of the events, given at the December 1997 hearing, contradict significantly his written affidavit and Ms. Gramoy's affidavit, as well as the medical records and the petition. Petitioner initially believed his vaccination was given on June 6. Later, through the course of investigation for purposes of litigation, he came to learn the shot was actually administered on June 26. Consequently, there was a shift in the recitation of facts that was inconsistent and irreconcilable with those originally alleged. There was no consistency in the story in terms of petitioner remembering the fact of vaccination and the progression of symptoms from that time. I am not confident that the time frame petitioner would have the court accept is the actual time frame for the onset of CIDP.

I want to make it clear that I do not believe petitioner lied to the court. Petitioner appeared confident in his assertions under examination and impressed me as forthright and sincere. To overcome discrepancies in medical records, however, prudence requires a high level of consistency in eyewitness recollections of critical facts. Petitioner was simply unable to provide the clear, cogent explanation needed to persuade the court that the medical records should be disregarded and his assertions accepted as fact.

CONCLUSION

Based on the foregoing, after considering the entire record in this case, the undersigned recommends that compensation be denied.

IT IS SO ORDERED.

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E. LaVon French

Special Master

1. The statutory provisions governing the Vaccine Act are found in 42 U.S.C. §§ 300aa-1 et seq. (1991 & Supp. 1998). Reference will be to the relevant subsection of 42 U.S.C. § 300aa.

2. Petitioner later amended the date of vaccination to June 26, 1983.

3. He recalls that his grandfather passed away at the end of July and he took a vacation with friends in the middle of August. Tr. at 14. Kevin testified that he decided to call for an appointment if the problem persisted when he returned from his vacation. Tr. at 15.

4. It was not until 1994 that respondent even brought into issue the fact that the vaccination record was not legible enough to rely on June 6 as the date of vaccination. *See* Respondent's Report filed March 23, 1994.

5. Dr. Jablecki testified that if the CIDP began after August 7, 1983, he would not believe it was caused by the DT vaccine. Tr. at 93-94.