Jennifer Guldin
Gardasil Injury Timeline/Diary

August 29, 2008: My only child, Gracyn, was born.

Sept.-Oct. 2008: Left knee surgery

Sept.-Oct. 2009: Right knee surgery

February 10, 2010: Appt. with PCP; diarrhea; hurts to cough; sore throat; cough; congestion and chest pains from coughing; began February 8 (2 days ago); taking OTC Cold Medicine; abdominal pain; cramping; denies nausea and vomiting; swallowing is painful; bilateral ear pain when swallowing; postnasal drip frequently; bilateral facial pain; chest pain WITH DEEP BREATH; shortness of breath worse with exertion, relieved with rest; headache; chest congestion; loss of appetite; no weakness; fatigue; headache; no tingling or numbness; no seizures; no insomnia; no memory loss; no dizziness; no gait abnormality; no tremor; no syncope; no myalgias; hoarseness. Treated for **upper respiratory infection** and diarrhea; prescribed Omnicef, Hycodan syrup, magic mouthwash, Continue Antivert 25 mg (NEVER TAKEN); injection Depo-Medrol; 1 ml of methyl prednisone 80mg/ml IM to right glut; Stop tamiflu capsule, zyrtec D (NOT TAKING), Veramyst spray (NOT TAKING), Demerol HCl (NOT TAKING), Phenergan (NOT TAKING), stool softener (NOT TAKING).

April 23, 2010: Appt. with PCP; **left elbow pain**; holding a younger cousin who broke away from I and hyper extended my left arm; heard cracking noise; x-ray; pain in posterior upper arm; no weakness; no fatigue; treated for strain; start zipsor 25 mg; samples; continue Antivert 25 mg (NEVER TAKEN).

July 2010: Pap smear

February 18, 2011: Appt. with PCP; sore throat; ears hurt; started feeling bad 2/17/13; exposed to flu over the weekend; no known fever; started as sore throat; now cough; body aches; headache and congestion; nasal congestion; cough very little productivity; post nasal drip frequently; chest pain due to cough; headache pressure, like sensation; took zicam this morning; loss of appetite; fever; fatigue; nausea; myalgias; treated for **viral infection**; flu screen negative; start Allegra D

April 10, 2011: Period

April 18, 2011: Appt. with PCP; tired; fatigue; I explained that I have suffered from fatigue for the past 2.5 years since the birth of my daughter; daughter has never been a good sleeper and typically wakes her up 4-5 times a night. No other symptoms – **only fatigue** – requesting blood work be performed; only finding was that iron was at the top of normal; remaining labs fine; Allegra D 60-120 mg daily and multi-vitamin.

May 3, 2011: Period

May 12, 2011: Appt. with PCP; knot on right side of neck near collarbone; no pain; noticed about 3 weeks ago after a massage; swollen gland; periods irregular; treated for **lymphadenitis**; apply moist heat and gentle massage; continue Allegra D and multi-vitamin.

August 16, 2011: While on vacation, I visited a walk-in clinic presenting with symptoms of stomach pain and nausea. Although I tested negative and have no history of UTI, I was treated for a **UTI**. However, I was told it could be the start of appendicitis so if my symptoms worsened to return immediately. (Pennsylvania)

September 9, 2011: Annual Exam – positive for **chest pains, constipation**; *negative for fatigue, migraines, palpitations, abdominal pain, nausea, diarrhea, weakness, vaginal pain, no tenderness in abdomen*. Nurse practitioner recommended Gardasil injection. I first declined stating that I was 25, married, and had a child and didn't feel this injection was needed. Nurse practitioner bullied me by stating "what if your husband cheats on you or you get divorced or he dies." I relented and agreed to return on September 16 for the first injection.

September 16, 2011: First Gardasil injection given; left arm

September 21, 2011: I returned to OB/GYNfor a "problem visit." I complained of constant nausea, constipation, heavy periods, decreased energy, bloating, lower back pain, pelvic pain, achiness, intermittent stabbing pain, period came 14 days early. **Transvaginal Ultrasound** and a **Pelvic Exam** were conducted and found to be normal.

September 23, 2011: I went to the ER complaining of severe abdominal pain (upper right quadrant). Intermittent abdominal pain for a long time; has been in constant pain for 2-3 hours; same thing happened about the time of cycle and went to PA walk-in clinic; was told to watch for appendicitis. Nausea but no vomiting. Crampy. Sharp and stabbing. Abdomen tender. Feels very weak. Nausea 6 times this month. They did a **CT of the abdomen** with IV and P.O. contrast (to check my appendix), which was normal. They noted that the probable cause of my discomfort was constipation because a moderate amount of air and stool were present in my colon. Minimal dependent changes are noted the lung bases; the liver, spleen, pancreas, adrenal glands, and kidneys are unremarkable. Appendix is unremarkable. Trace nonspecific pelvic free fluid is present. The bladder is nondistended. Moderate amount of air and stool are present in colon. Probable constipation

November 18, 2011: Second Gardasil injection given; left arm

December 23, 2011: Appt. with PCP for bad cough, congestion, chills, body aches and drainage; fatigue; myalgias; nasal congestion; sore throat; cough; postnasal drip; headache; fatigue; cough; sore throat; nasal congestion; nausea; cough; nausea; treat for bronchitis, dysfunction Eustachian tube, allergic rhinitis Nose, IBS, Mitral valve regurgitation, Tricuspid valve regurgitation, Anxiety Disorder, GERD; prescribed Albuterol HFA, 2 puffs, 4-6 hours; Zutripro 5mg/4mg/60 mg (Z-pak); continue Allegra D and multi-vitamin.

January 2, 2012: Period

January 17, 2012: Appt. with PCP with left shoulder/chest pain from left side of neck to shoulder blade and throughout; hurts worse laying down; not shooting pains, just achy; no shortness of breath; chest pain radiating into her back and left upper extremity; Pain started around noon yesterday and persisted throughout the night, finally falling asleep around 4:30 this morning; did not take anything for symptoms; gets anxious when she has left chest pains; abdominal pain; cramping; heartburn last night; nausea; sick to stomach nightly; pain; radiation of pain to left arm into back; numbness and tingling; chest pain; nausea; heartburn; abdominal pain; normal EKG; esophageal spasm/reflux; refer to gastroenterologist; stop albuterol HFA; Stop Zutripro; finished z-pak; continue Allegra D and multi-vitamin.

February 2, 2012: Appt. with Gastroenterologist– atypical chest pain, abdominal pain, constipation; intermittent episodes of chest pain since high school. Pain is intermittent sharp pain in my chest without any precipitating factors including her meals. The pain does radiate to the left side of my neck and shoulder blades and through my arm. The pain is worse when I am lying down. The pain is not associated with any diaphoresis (excessive sweating), nausea, or vomiting. I also have some intermittent lower abdominal pain at night like cramps. I described my abdominal pain as achy pain. Gastroenterologist claims this appears to be related to anxiety and stress. I am frequently constipated and have a bowel movement every three days.

February 13, 2012: I had an **Upper Endoscopy with esophageal biopsies and gastric biopsies for a rapid urease test (H pylori) performed** by Gastroenterologist, which came back normal. My stomach issues continued on and off until April/May of 2012, then my stomach issues, primarily nausea, became constant EVERY day. This was to rule out anything heart related due to chest pains that I was experiencing. No reflux esophagitis or eosinophilic esophatitis (inflammation). Duodenum normal.

February 17, 2012: Called Gastroenterologist; has not had a bowel movement all week. Cannot go; suggested a bottle of magnesium citrate.

April 17, 2012: Third Gardasil injection given; left arm

May of 2012: I returned to my PCP with my stomach issues. They did blood work, which was normal (pancreas, liver, kidney, sugar, potassium, sodium, calcium, CBC, WBC, and RBC). They sent me for an **Ultrasound** and **XRAY** (mild constipation, mildly dilated loops in small bowel) on May 25, 2012. I was started on a low dose of **Amatiza** at this time to help with the constipation. In addition I had a **HIDA Scan** of my gallbladder, which showed that my gallbladder was only functioning at 29%. I was then referred to a surgeon to discuss possibly having my gallbladder removed. However, after meeting with the surgeon, he and my gastroenterologist both agreed that the HIDA Scan is not an accurate test and based on my symptoms and the location of my abdominal pain, I was not a good candidate to have my gallbladder removed. I then returned to my OB/GYN to see if I could possibly have anything female related problems that could be causing my issues. After a **pelvic exam**, she determined that everything female related felt normal to her. She did begin me on a birth control, **LoEstrin**.

May 5, 2012: Period

May 10, 2012: Visited PCP with sore throat, cough, congestion, headache, stomach ache, and diarrhea; symptoms started about two weeks ago (~April 26, 2012) and has become worse; nausea, diarrhea; nasal congestion; sore throat; dry cough; post nasal drip (worse at night); facial pain maxillary and frontal sinuses, bilateral; daily headache; loss of appetite; fatigue; dizziness; taking Allegra, veramyst, and Nyquil with slight relief; treated for sinusitis; Omnicef capsule, 300 mg, 2 caps orally, 10 days; start Qnasl, 80mcg/spray, 2 sprays each nostril, daily, given sample; start zofran 8 mg; continue multi-vitamin.

~May 19, 2012: Gatlinburg trip – I was so nauseas and dizzy that I could barely ride in the car. It took us about 8 hours to drive home, typically a 4-hour trip.

May 22, 2012: Appt. with OB/GYN for pelvic pain; nausea every day for the past 3 months; all day long. Sweet foods trigger the nausea and make it worse; greasy good make it worse; no vomiting; no fever; no rash; sharp stabbing pains in lower abdomen, pelvis; pain is present every day; occasional burning pains. Drinks Alka-Seltzer every day with temporary relief. Pelvic pain has been present since September 2011; pain is worse with menses but does not feel good even when not on menses. Tried ibuprofen for the pelvic pain with temporary relief.

May 24, 2012: Went to PCP for nausea and pain in lower abdomen – started 6-8 months ago [Sept-Nov 2011 when first and second injections were given] and worse in the past month [April 17, 2012 third injection given]; nausea, constipation; abdominal distension; fatigue; loss of appetite; bloating/belching; finished Omnicef 5/24/12; zofran finished; stopped Qnasl nasal spray 5/24/12; continue Allegra d, multi-vitamin, acidophilus, zofran; phenergan.

May 25, 2012: PCP referred me to Middle Tennessee Imagining for an abdominal ultrasound. Results: Liver is normal in size and echotexture; no hepatic masses; gallbladder demonstrates no stones or sludge; gallbladder wall is normal in thickness; spleen is normal in size; no splenic masses; no adrenal masses identified; kidneys are normal in their size and position within the retroperitoneum. Negative abdominal ultrasound.

May 31, 2012: PCP referred me to Middle Tennessee Imagining for a Hydascan (at my request). Results: (1) No evidence of acute cholecystitis or biliary obstruction. (2) Abnormal response of the gallbladder to Kinevac challenge with EF of 29%, suggesting biliary dyskinesis.

June 12, 2012: Gastroenterologist – returned for chronic nausea and constipation. Also have problems with severe nausea. I have taken Phenergan and Zofran for it. I only have a bowel movement every 3 or 4 days. I occasionally have some crampy abdominal pain. I have tried MiraLax for it. I also reported being bloated. Gastroenterologist indicates that there is a history of anemia (low iron slightly when pregnant). I denied any focal weakness, headaches, vision changes. Abdomen soft. Normal active bowel sounds. No distention; no tenderness; no masses or hsm.

Impression: Chronic nausea is suspected to be functional; it is unlikely that her nausea is a sole symptom of gallbladder dyskinesia since she has no epigastric or right upper quadrant pain or any relationship with meals. Chronic constipation with symptoms suggestive or IBS.

Treatment: High fiber diet plus plenty of fresh fruits and vegetables and drink plenty of fluids, especially water. Continue miralax as needed which may be titrated; probiotic such as Align or Activia yogurt daily; take antispasmodic trial of Levsin.

July 2, 2012: Appt. with surgeon for possible gallbladder disease; my pain seems to be mostly located in lower abdomen and is more or less constant; seems to be getting better in the last couple of weeks. It sounds more gynecologic in origin to surgeon. Surgeon recommended I get back with OB/GYN and discuss the possibility of a laparoscopy. My HIDA scan did not reproduce my pain. My ultrasound of gallbladder is normal. 29% ejection fraction but surgeon did not get a good medical history on her whatsoever about postprandial right upper quadrant or right subcostal pain. There is absolutely no abdominal tenderness, no masses. Recommended that gallbladder not be removed.

Symptoms indicated by me: feeling tired (fatigue); weight loss; headache; mouth sores; abdominal pain; nausea; constipation.

July 12, 2012: Appt. with OB/GYN regarding continued pelvic pain; stated symptoms have not changed since they began in September 2011. Pain is moderate and sharp in bilateral lower quadrants. Pain is worse around the time of my menstrual period although I feel bad most of the time. Continued nausea. Complaints: Fatigue and nausea.

July 20, 2012: Began loestrin 1.5/3.0 (21) oral tablet 1.5-30 mg-mcg.

August 3, 2012: Went to PCP for sore throat – had white patch on back of throat. Started August 2, 2012. Not taking multivitamin; Finished acidophilus; taking Allegra D, finished phenergan, amitiza 8 mcg 2 times a day; Zofran, lo loestrin FE 20 mcf; start magic mouthwash; continue Allegra d; continue Loestrin; continue Zofran; strep test negative.

August 6, 2012: Called gastroenterologist– still having issues with constipation. Is there a stool test that I could have done to see what could be causing this? No – no stool test. He suggested that I increase Miralax if needed plus take Dulcolax. I had been taking benefiber only but will try miralax.

August 14, 2012: ENT – patient reports chronic nausea and upset stomach; has been diagnosed with IBS (no testing performed to confirm this); using nausea meds which have not been helpful; does not have vertigo; she does have a sense of motion or spinning. She does not have any ear-related symptoms; no fullness or pressure in ears; did have an ear infection recently and was treated with antibiotics but feels her ear is doing better. Diagnosed with Acute Swimmers Ear; does have right-sided external otitis, which is mild. Placed on Ciprodex for right ear and told her to practice dry ear precautions. ENT did not feel that the mild otitis external on the right ear is the complete explanation for nausea. But will treat the infection. Current meds: Loestrin, Zofran, Promethazine, Benefiber.

August 16, 2012: I was referred by PCP to have a **Gastric Emptying Study** performed. This test revealed that my stomach was in fact emptying too slowly, and in turn probably causing some of my stomach discomfort. This may indicate gastro paresis or partial gastric outlet obstruction. I was then started on the liquid form of **Reglan**.

August 17, 2012: I called gastroenterologist to schedule colonoscopy; insurance will not pay for a colonoscopy, gastroenterologist suggested that I be scheduled for a BE; did not schedule BE.

August 21, 2012: PCP referred me for thyroid test, which was normal. Also checked for H-pylori infections, which was negative. Medications: Magic Mouthwash, Allegra D, Amitiza, Zofran, Lo Loestrin, Omnicef, Transderm-Scop patch, Reglan 5mg/5ml syrup.

September 7-14, 2012: While at Disney World in Orlando, I had an "attack" one night. My entire body began shaking, I was hot and cold at the same time, my heart was racing, and although I was conscious I had a difficult time speaking. An ambulance came and took my vitals and determined I was having a panic attack, which I have never had before.

September 2012 – February 2013: I have since had 3 other attacks similar to this one; however they were not as severe.

Late September or Early Oct. 2012 – nausea subsided; not every day

October 1, 2012: I met with a second Gastroenterologist at Vanderbilt, after asking my PCP to refer me to Vanderbilt GI. VB Gastroenterologist immediately **discontinued Reglan** stating it was not a safe prescription for me to be on due to its possible side effects. Abdominal bloating and burning sensation; nausea; constipation; epigastric pain; diarrhea; fatigue. About a year ago [Sept.-Oct. 2011 when first injection was given], I began to experience vague abdominal and flank pain that was thought to be a UTI. About a month later, I developed severe abdominal pain in my lower left quadrant. Currently, I continue to experience intermittent abdominal pain. My main complaint is **constant nausea** without vomiting.

According to VG gastroenterologist, her nausea and pain may be related to her constipation; if so, she is under dosed on the Amitiza; other less likely possibility is atypical celiac sprue.

October 8, 2012: It was time for my annual exam with OB/GYN [the doctor that gave me all Gardasil injections]– I reported daily nausea, daily lower pelvic pain, worse with menses; have not had intercourse in months secondary to pain associated with intercourse.

November 1, 2012: I met with VB gastroenterologist again. She increased my dose of Amitiza to help with the constipation. She also started me on **Omeprozole** 40 mg once daily. I noticed almost immediate relief with my stomach issues after beginning the Omeprozole (I did notice I started having daily minor headaches, but they were tolerable). She ordered a **CT scan of the head** (to make sure there was nothing related to my nausea) and another **abdominal ultrasound**, both came back normal. She then referred me to a GYN doctor at Vanderbilt.

Dr. Notes: The nausea has improved some but not completely resolved. Her BMs have been more regular of late. She does continue to have generalized abdominal discomfort. Will schedule CT scan of her head and abdominal ultrasound to ensure that there is no obvious worrisome pathology at play.

November 5, 2012: CT Scan of head without contrast; no acute or abnormal intracranial findings. Abdominal ultrasound Normal.

November 5, 2012: I met with the OB/GYN at Vanderbilt, who determined my pelvic muscles were extremely week and she referred me to a **physical therapist** to begin physical therapy for **Pelvic Floor Dysfunction** (network of muscles known as the pelvic floor, which supports the abdominal cavity, the reproductive and digestive systems; muscles should relax during intercourse, voiding, and/or defecating but instead act in an uncoordinated way creating pain and voiding/defecation difficulties). I went to physical therapy for 4-6 weeks before being released.

Chief Complaints (Dr. Notes): abnormally heavy menses and severe dysmenorrheal (painful periods). Although she has had her periods for 13 years, she never thought to complain about them until the pain has become unbearable. She has fallen to her knees while walking through bedroom because the abdominal pain is unbearable. Her periods are heavy with clots. Abdominal bloating and burning sensation; nausea; constipation; epigastric pain (upper middle region of abdomen); diarrhea; fatigue; menorrhagia (abnormally heavy and prolonged menstrual period); dyspareunia (painful intercourse).

November 8, 2012: VB OB/GYN had my hormone levels (Testosterone, Sex Hormone Binding Globulin, DHEA Sulfate, Estradiol, FSH) checked, however I was on birth control at this time, LoEstrin, so my levels may not have been accurate. With the exception of the Estradiol and FSH, the levels came back normal. The ranges are not indicated in the records from Estradiol and FSH – so we do not know if they are normal or not.

November 20, 2012: "I could not see of out my left eye and I had arm numbness and weakness." Began at 11:00AM (while making a hair bow for my daughter).

I was admitted to MTMC for what was originally thought was a TIA. After a **CT scan**, **MRI**, **blood work**, **EKG**, **Bubble Test**, **Carotid Doppler,** and Diagnostic ultrasound of the heart it was then determined by a neurologist that I had a **Complex Migraine with Aura**. My symptoms were vision distortion in my left eye, almost like a puzzle piece was missing, for approximately 20 minutes, then my left hand, arm, and left side of my face went completely numb for approximately 10 minutes, followed by a severe headache over my right eye. Neurologist took me off of LoEstrin birth control, stating that my risk of stroke is increased with complex migraines with aura AND being on an estrogen based birth control. Neurologist also suggestion that I avoid vasoactive migraine drugs, such as Triptans, which at least in theory could be dangerous in patients who have very prolonged or dramatic neurologic aura.

Symptoms: Transient visual loss left eye, could not see out of peripheral field of the left eye (entirely monocular) and lack of proper depth perception and items abnormally shaped (30 minutes and resolved), disturbance of skin sensation (numbness and tingling and weakness on the upper left extremity lasted 30 minutes), followed by a pulsating right-headed headache with increased nausea and sensitivity to light and sound; other malaise and fatigue, chronic nausea, other chronic pain, chronic abdominal pain, IBS, constipation, episodic headaches, neuropathy.

When admitted a neurological strengths test was performed. The Right Upper Extremity, Right Lower Extremity, and Left Lower Extremity indicated strong strength, normal tone, and intact sensation, while the **Left Upper Extremity** [Gardasil injections were all given in my left arm] indicated strong strength, normal tone, and **DECREASED sensation**.

Cardiac monitoring indicated Sinus Tachycardia (heart rhythm with elevated rate of impulses originating from sinoatrial node in excess of 100 beats per minute) at 11:30AM. (denied headache at this time – came later).

White blood cell count within normal limits; H and H was 14 and 41.3; serum electrolytes were within normal limits. BUN and creatinine were normal at 7 and 0.8.

Treatment: CT scan of head (negative - no acute intracranial abnormalities); MRI of brain without contrast (no acute intracranial changes or abnormalities); Bilateral arterial carotid Doppler showed no hemodynamically significant stenosis; echocardiogram normal.

Diagnosis: ***Probably*** migraine with aura, probable episodic migraine.

November 26, 2012: I called neurologist with a question. Is it normal for my left side to feel numb and heavy almost a week after episode?

November 27, 2012: Neurology; follow-up for headaches after hospitalization in November. Reflux (GERD); Migraine headache; fatigue; Abdominal pain; nausea; diarrhea; constipation; menstrual problems; weakness; numbness/tingling; headaches; seasonal allergies; sleepiness; vision loss (during migraine); no more visual field abnormalities [7 days since 11/20/12]; she does get intermittent tingling and heaviness at night in her left arm and leg; mild during the day; has ongoing feelings of lightheadedness that comes in spells and lasts about 30 minutes. I stated that it does feel like I am going to pass out, although she has not had any loss of consciousness. The patient does continue to have an episodic migraine. She has about one a week that lasts 1 to 2 hours; takes advil almost daily; does not have a headache today. She has stopped her BC pills.

Treatment: Increase hydration.

November 29, 2012: OB/BYN - discussed alternative birth control.

November 30, 2012: Period

December 5, 2012: neurologist; urgent visit for headaches; pressure on top and sides of head and behind eyes; headaches; dizziness; numb hands and feet; poor balance; weakness; vision lost; neck pain; fatigue; has been hydrating aggressively; still gets an occasional lightheaded feeling, but not nothing nearly as strong and frequent as she was having on 11/27; complains of a constant painful band like sensation on the top of my head, the sides of her head and behind her eyes; constant squeezing and as it escalates in severity she does get sensitivity to light. I wake up some mornings with a headache, although other times I will wake up without a headache and this band like headache will start in the course of the day and escalate in severity as the day goes on. Some nights I go to bed with a headache and wake up with a headache. When this head sensation got severe yesterday, I took an Advil C&S and then later an Excedrin Migraine both of which helped, but it was only mild and temporary, and the headache escalated when the medication wore off. I have daily headaches with migrainous features unremitting since November 20, 2012; not as severe as when she was in the hospital, but still persistent and uncomfortable. I am not currently on prevention. Presyncopal feelings improved with aggressive

hydration. They are only mild and intermittent now. Unable to rule out a feature related to the headache sensation. Intermittent paresthesia and heaviness of the limbs resolved.

Treatment: continue aggressive hydration; trial topiramate 25 mg; start with one pill at bed; increase 1 pill a week to a maximum of 5 pills at bed as tolerated for headache prevention.

December 6, 2012: Called neurologist; I want to hold off on starting the Topamax to see if headache might be weather/seasonal related and I just came off birth control; Janet said that I may hold off two weeks to see if symptoms resolve, if not I should begin the Topamax.

December 7, 2012: Ophthalmology; nausea, diarrhea, pressure behind eyes, migraine with aura; went to ophthalmologist for extensive exam to check for tumors behind eyes; pressure was good; no indication of tumor.

December 13, 2012: Chiropractor for pain.

December 17, 2012: Appt. with ENT - Middle ear testing and hearing test – both normal; reports that original symptoms of nausea during the summer have gotten dramatically better. On 11/20/12 she had an episode where she had a tingling on left side of her body, as well as vision loss in her left eye. She was admitted to hospital. An MRI was performed and she was diagnosed by neurology with a migraine. Since that time, she has had lightheadedness, but not passed out. She has not had a sense of motion or vertigo. No ear-related symptoms; no fullness or pressure; no fluctuating hearing loss and no tinnitus. She has not had vertigo. She would like to rule out in her ear cause for symptoms. Current medications: Benefiber.

December 20, 2012: Visited allergist to be tested for food allergies; negative to all allergens, including wheat. The doctor does not think GI symptoms are due to food allergy; try to limit wheat and gluten for symptom control.

History: One-year history of headaches, worsening abdominal complaints, bloating, abdominal pain, constipation, nausea, and occasional vomiting. Symptoms are intermittent but have progressively worsened over the past year.

December 20, 2012: Chiropractor for pain.

December 21, 2012: Massage for pain.

December 27, 2012: Chiropractor for pain.

December 29, 2012: Period

January 19, 2013: Birthday dinner at Miller's; shaky hands; seizure type episode; hot and cold; ruined my birthday dinner.

January 20, 2013: I again had the same symptoms as I did on November 20, 2012. Went to ER.

Complaints of left eye visual disturbance and left arm numbness that lasted approximately 10 minutes and was spontaneously resolved. Began at 5pm; visual distortion in left eye, peripheral vision out and left face and arm numb. Nausea; pain worse with light

Diagnosis: Migraine, tension headache

Treatment: given fioricet 2 tablets; gave ketorolac injection 60mg/2mL; ondansetron ODT 4 mg tab, ondansetron 8mg, omeprazole 40 mg capsule.

January 21, 2013: Period

January 21, 2013: neurologist; headaches; dizziness; numb hands; poor balance; weakness; vision loss; neck pain; fatigue; follow up after visit to ER on 1/20/13 for severe headache and for lightheadedness; feels lightheaded daily with a pressure sensation in her head; I declined Topamax. Suggested that I try Migrerelief (OTC-natural). Referred to Cardiologist.

January 26, 2013: Circus (miserable; sound and light sensitivity; struggled through for my daughter).

January 31, 2013: I was referred to Cardiologist by my neurologist office to see if there was anything related to my blood pressure or heart rate that is causing my constant light headedness. Cardiologist did not believe any of these were contributing factors and suggested referring me to the Autonomic Dysfunction Center at Vanderbilt since I am not getting answers elsewhere.

I have not been feeling well for approximately one year. For many months I have had chronic nausea and then in November 2012 began to develop migraine headaches. I have had at least 2 fairly pronounced episodes of headache and have been evaluated by neurologist. I had a normal CT and MRI of the head. A cardiac echo and carotid duplex study are normal. In spite of this, I continue to feel lightheaded most of the day. My symptoms are improved if I lay flat but remain present on some level even then. I've had no presyncope and no problems with palpitations. I cannot do much physical activity because I feel poorly. **Her past medical history is generally benign**. Positive for visual changes and chest pain. Diagnosed with dizziness, uncertain etiology. Orthostatic blood pressure check. Exam was negative for drop of blood pressure with assumption of erect posture. We will refer to Vanderbilt Autonomic Disorder clinic. Skeptical that the symptoms are related to an autonomic dysfunction or orthostatic hypotension

February 4, 2013: Lightheadedness improving from attack on January 20.

February 15, 2013: Period

February 20, 2013: Autonomic Dysfunction Clinic at Vanderbilt; Approximately 8 months ago (May 2012) I began with DAILY nausea and abdominal pain. In September 2012, I had an attack of non-positional violent full-body shaking/shivering associated with sensations of feeling hot and cold and having tachycardia (heart rate that exceeds normal range, > 100 beats/minute). Patient denies having any vertigo, presyncope, syncope, or impaired consciousness; however, she had trouble speaking, which

attributes to the violent shivering and clenched jaw. EMS told her she was having a panic attack. Subsequently, she has had three similar events but none was as severe as the first.

October 2012 I felt like I had a headband on that was too tight-all of the time.

I also complain of an increased frequency of low-grade tension type headaches. In November, I also had some episodes of sudden onset of blindness in her left eye such that "I looked at my daughter and her face was missing". This lasted approximately 20 minute then left side of her face and **left upper extremity** "went completely numb". I then developed a severe headache localized to my forehead above my right eye. Admitted to ER, worked up, discontinued LoEstrin (due to concern for stroke) and Omeprazole (due to concern for side effects causing the neurological problems). A similar event occurred at the end of January 2013.

From this point forward, I began having constant lightheadedness, which is currently my primary complaint. She describes the lightheadedness as feeling like she is "spacy" or "floating" and denies vertigo, syncope, presyncope, palpitations, and postural effects. She cannot think of any precipitating factors and states that the lightheadedness is slightly better when she lies down but it does not abate entirely. The quality and severity of the lightheadedness has not changed. She is nauseated but describes is as the same nausea she has experienced since May 2012. Her only other associated symptom is easy fatigability.

I cried because of frustration for lack of diagnosis when I was told she did not have an autonomic dysfunction. Suspects a central vestibular dysfunction or perhaps symptoms are secondary to her complex migraines. Her symptoms are not consistent with an autonomic dysfunction.

March 4, 2013: ENT - had an episode of spinning vertigo one month ago (Feb. 2013); caused nausea but no vomiting; reports a fluctuating hearing loss in right ear, as well as right-sided tinnitus. She has had symptoms of lightheadedness associated with migraine headache. She has been evaluated by neurology but has declined anti-migraine medicines. Saccade test, gaze test, position test, tracking test, and optokinetic test; Peak velocities, accuracies, and latencies of horizontal saccades were normal. There was no significant gaze evoked, spontaneous or positional nystagmus. The Dix Hallpike test was negative HHL and negative HHR. Horizontal tracking was normal in both directions (pursuit tracking appeared to have small saccades, but not clinically significant). Horizontal optokinetic nystagmus was normal in both directions. VNG test showed no significant abnormalities but caloric testing was not completed at the patient's request. ECOG test performed; waveforms present bilaterally with good morphology and repeatability; the SP/AP ratio in the right ear was .54; left ear was .45. Based on a .50 criteria the results in the right ear are abnormal.

Diagnosed with **Meniere 's disease** in the right ear by ENT. Started a **diuretic**, Dyazide, hydrochlorothiazide-triamterene capsule, 25 mg-37.5mg, 1 cap daily; low salt diet; must get electrolytes checked.

March 14, 2013: Gluten-free

March 14, 2013: Period

March 17, 2013: Started Diuretic

March 22, 2013: Thyroid testing normal; hormone testing normal; other misc. labs.

March 29, 2013: Gracyn horseback riding lesson (miserable; so sick but struggled through because of my daughter)

March or April 2013: I began having internal tremors, not visible to the naked eye. Although they happen during the day and night, they are most bothersome at night and more noticeable since she is trying to sleep. My entire body is vibrating, although it is most prevalent on my left side. It is not painful but keeps me awake; can't get comfortable. My left side of my body feels like it does when neurologists perform sensory testing with a vibrating tuning fork. This was prevalent from March or April 2013 until approximately August 2013.

April 7, 2013: Period

April 7, 2013: Had third complex migraine with aura; lost vision in both eyes; the visual loss lasted about 15 minutes and then the paresthesia came about 45 minutes and lasted for 20 minutes and then after that the headache began. The headache was on the right side of my head and was associated with nausea but no vomiting with sensitivity to light and noise. The pain was 9 out of 10. Two of my headaches were associated with menstrual cycle.

April 8, 2013: ENT – follow-up; has a history of Meniere's Disease in right ear. Started diuretic 3 weeks ago; has not had any vertigo; over the last 3 weeks she does report an **upper respiratory infection** prior to that time, which resolved spontaneously. She has also been diagnosed with migraines and is getting a second opinion from Vanderbilt Neurology on Wednesday. ENT felt her vertigo may be related to her migraines. She maybe a candidate for Decadron injection in her right ear. Current medications: hydrochlorothiazide-tramterene, valium 2 mg tablet (NEVER TOOK), loestrin (NOT TAKING) Benefiber.

April 9, 2013: Appointment with PCP to become established patient.

April 10, 2013: neurologist at Vanderbilt; gave history; neurologist determined that I have menstrual migraine, complicated migraine with aura, and possible anxiety. I suffer from insomnia and have a daughter who is 5 years old and has not slept well at night. History of Meniere's Disease with fogginess; visual lost and paresthesia and parestesia in the left upper extremity can last for weeks after the headaches. Patient was encouraged and **counseled** at length regarding the **importance of stress-relieving activity**, exercise, yoga, good sleep hygiene, and was encouraged to take melatonin 12 mg 4 hours before bed. Placed on Bupap without caffeine (NEVER TAKEN); patient will begin Topamax.

April 12, 2013: Began taking Topamax 25mg daily. Saw PCP

April 12-19, 2013: Discovered Vitamin D deficiency

April 19 or 26, 2013: Began Vitamin D (50,000 IU)

April 20, 2013: My sister's Bridal Shower; left early; not feeling well at all (lights and sounds were more than I could cope with).

April 24, 2013: EEG at Vanderbilt Neurologist; because of confusion and fogginess; normal, greater than 1 hour EEG recorded during awake, drowsy, and sleep. No epileptiform discharges were noted.

May 2, 2013: Period

May 3, 2013: Vanderbilt Neurologist – results of EEG; headaches are well-controlled (for 3 weeks with no period). The patient had a feeling that she was going to have a headache but did not have one and that was around her menstrual cycle. CTA normal. Patient states she may have some tingling and memory loss but not enough to interfere with her daily activity or life.

May 6, 2013: My mom bought a juicer for me.

May 10, 2013: Gynecologist at Vanderbilt; heavy flow; having menstrual migraines and migraines with aura; her migraines are getting increasingly worse to the point she isn't functional as she is in so much pain; she started Topamax but complains of memory loss and doesn't want to stay on it. Not currently using contraception. Complains of pain with intercourse and menses; abdominal pain has been getting progressively worse over the past 6 months; abdominal cramping daily, but worse with periods; pain is sharp and intermittently crampy. On the heaviest day of her period she passes clots and changes her tampon every hour and has to change her pad 4-5 pads. Has discontinued pelvic floor physical therapy while she learns to cope with migraines.

May 20, 2013: ENT ; 6 week follow up for Meniere's Disease; continues on Dyazide for Meniere's disease; patient is doing better; Topamax has been helpful; mild sense of off balance; would benefit from vestibular rehabilitation physical therapy; gave samples of Zetonna nasal spray; start flonase nasal spray

May 29, 2013: Star Physical Therapy for pelvic floor physical therapy

May 30, 2013: Potassium checked

May 30, 2013: Period

May-June 2013: Began juicing

June 10, 2013: Second neurologist at Vanderbilt; 3 severe debilitating headaches with visual aura in past 7 months; chronic daily headache with chronic nausea and lightheadedness; severe; menstrual-associated headache; left sided numbness with hemiparesis; history of insomnia; dizziness, possible Meniere's disease; IBS; assessed with **variants of migraine, not elsewhere classified.** VB Neurologist would not have any reservations for me to try a triptan since he says I do NOT have hemiplegic migraines.

June 14-15, 2013: Sister rehearsal dinner and wedding (barely made it through dinner – headlights driving home make driving very frightening); wedding sound, lights, heat…I am not sure how I made it through my sister's wedding. Sheer exhaustion!

June 17, 2013: ENT

June 25, 2013: Period

July 10, 2013: First seen Integrated Medicine Physician; no episodes over past 3 months; has been gluten free. Physician notes Gluten "appears to be long, possibly precipitating, event of 5 months of GI nausea syndrome that may be part of the complex migraine." He notes that two weeks preceding the long period of nausea that I took antibiotics for sinus infection (5/10/12 – PCP).

July 11, 2013: Began pre- and pro-biotics, L-Glutamine, and dairy-free.

July 20-25, 2013: Period

July 30, 2013: Follow up with ENT

August 2013: Stopped diuretic

August 21, 2013: Integrated Medicine Physician; complex migraines, on minimal dose of Topamax, no major headaches in 4 months; further history today confirms increased risk factors in childhood for substantial gut dysbiosis. Should evaluate hormones including progesterone at some point; blood drawn for labs; began Super Thisilyn.

September 8, 2013: Thomas the Train; felt bad, lightheaded, dizzy, and nausea and diarrhea.

Late September 2013: I began having noticeable left shoulder muscle twitches; not painful but annoying and disrupted and prevented sleep. This lasted for several days, possibly 5-7 days. This twitching was visibly noticeable to Dustin, my husband.

October 4, 2013: I had been driving 15-20 minutes with my daughter when I felt a very sharp electric shock in my brain (zapped). The sensation, although short in duration, was very intense; I felt as though my eyes were rolling back into my head and that I was going to faint. I felt an out-of-body experience, like I wasn't there. For a very brief moment, I felt like I disappeared. It happened very quickly; like someone flipped a switch and I was out of my body. I could feel myself driving but mentally I was not there. There was little to no pain associated with this, it was just very frightening. I called my mother and pulled over; mother came and picked me and my daughter, Gracyn, up. No headache associated with this episode (may be due to Topamax).

October 4, 2013: Primary Care Physician; after the episode above, we went to PCP's office. He had a cancellation and we were able to immediately see PCP. We discussed in as much detail as possible (without notes) about what I have been through since September 2011. We asked PCP to draw blood and test for heavy metal toxicity.

October 14, 2013: Received blood test results for heavy metal toxicity.

Name	Value	Reference Range
Aluminum, Serum	<5	0-15 ug/L
Boron	None Determined	
Copper	91	80-155 ug/dL
Iron	118	28-170 ug/dL
Lead Whole Blood (Venous)	<2.0	0.0-4.9 ug/dL
Magnesium	1.9	1.8-2.5 mg/dl
Vitamin D 25-Hydorxy	45.4	30.0-100.0 ng/mL
Glomerular Filtration Rate GFR/Black	>60	60->60 mL/min/1.73m2
Glomerular Filtration Rate GFR/White	>60	60->60 mL/min/1.73m2

Comprehensive Metabolic Panel

Name	Value	Reference Range
Sodium	141	134-145 mEq/L
Potassium	3.8	3.4-5.4 mEq/L
Chloride	106	97-109 mEq/L
CO2	25	22-32 mEq/L
Glucose	85	65-105 mg/dL
BUN	8	5-26 mg/dL
Creatinine	0.8	0.5-1.5 mg/dL
Calcium	9.3	8.5-10.3 mg/dL
Protein	7.1	6.3-8.3 g/dL
Albumin	4.6	3.7-5.2 g/dL
Alkaline Phosphatase	45	38-126 IU/L
ALT (SGPT)	11	7-52 IU/L
AST (SGOT)	16	13-39 IU/L
Bilirubin, Total	0.6	0.2-1.5 mg/dL
A/G Ratio	1.8	1.1-2.5 mg/dL

October 21, 2013: Appt. with Integrated Medicine Physician. Shared our knowledge that the Gardasil injection injured me. Tested me for thiamine deficiency (blood test) – showed that I have an excess of B-1 in my system; requested that I cease taking all B-vitamins and re-check in two months. Tested for MTHFR mutation, which was positive for two copies of the A1298C Mutation Interpretation. The doctor explains I am positive for the typically benign form for which there is so far no real evidence for concern. He suggested that I start with an OTC form of methylfolate at about 800-1000 mcg per day. I am getting a kit to send off a hair sample to be checked for heavy metal toxicity. Results forthcoming.

October 31, 2013: Since having the episode of 10/4/13, I feel very "spacey". I drove home on 10/5/13 but do not recollect the drive home. I feel spacey and in a brain fog. I am extremely fatigued; drained mentally and physically from episode; Left side extremely week (arm and leg); kept me awake for 2-3 nights. My left leg and arm feel like dead weight; Gait is off; I feel off balance when I walk.