

Concerned about early dementia, esp. considering brain MRI findings. This may or may not be impeding her ability to accept that there is no strong evidence for a mold-related allergic condition causing her chronic health symptoms.

Tee Guidotti, October 6, 2005

Documents in their entirety may be available with express consent.

The following is in regard to a teacher made ill from mold within her school. In the Spring of 2005, she was seen at Johns Hopkins. The probable diagnosis made was sickbuilding syndrome.

Starting in the fall of 2005, she began to be seen by Dr. Tee Guidotti, Chair of the Association of Occupational and Environmental Clinics, Chair of the Pediatric Environmental Health Specialty Units, and Co-Chair of the Mid Atlantic Center for Childrens Health and Environment, and recent past President of the American College of Occupational and Environmental Medicine.

Although the teacher had numerous symptoms known to be consistent with symptoms indicative of neurotoxicity and could demonstrate exposure within her school, Dr. Guidotti - one of the key people we are giving much control and funding to further the national understanding of environmental illnesses - found this teacher of 20 years to be, "manipulative" and that her "physician shopping behavior was due to progressive mental deficient".

Final diagnosis of Dr. Guidotti: "underlying neuropsychological disorder and early onset dementia.

Needless to say, the teacher had to fight the School District tooth and nail to receive her rightfully due workers compensation from her illness brought on by mold exposure within the school. She appears to have finally won.

And with proper medical treatment, no longer has "dementia". It appears her "physician shopping" may have paid off. Unfortunately, numerous others in the United States today, are not as lucky.



# JOHNS HOPKINS M E D I C I N E

## Johns Hopkins Medicine

### Reason for Visit:

The patient is a 59-year-old woman referred to me by Dr. Jaitly for "MRI abnormalities."

### History of Present Illness:

The patient is a 59-year-old woman. She is a school teacher. She works in a building, which has been associated with unusually high levels of fungus and various air-borne pathogens, consistent with a sick building syndrome. She was recently diagnosed with a pulmonary disease, with pulmonary fibrosis. She also had a headache and reported that she was having ear changes or hearing changes related potentially to her exposure to fungus. She went and had MRI of her brain, which was normal and was referred to Dr. Jaitly in Bethesda, Maryland. \*

Basically, her history goes like this. On 12/06/04 she had a pulmonary function test, which showed that she had some basilar fibrosis. While with the CAT scan they verified that, she had allergy test, which suggested that she had bronchial asthma, which was new for her at the age 59. No specific allergens detected. On 02/05/05, she had an audiogram, which suggested that she had excessive hearing loss. She was seen by a cardiologist on 02/16/05, reported that she had a normal myocardial perfusion scan. She had various blood tests including some lupus anticoagulant reflex test, which were mildly elevated. The normal range of the test is 52, hers was at 60.6. These are, I believe, bleeding time tests, suggesting that she may have some anticoagulation. She had her Dilute Russell's Viper Venom, which corrected to 34.5. She has had a 2-week history of headache, posterior with throbbing. No phonophobia or photophobia associated with beginning of a new medication called Advair. She had headaches in the past, but is not a headache person. She had an MRI at some point, which revealed that she had diffuse T2 hyperintensities in her white matter, primarily in the front as well as the back that seem to be at proportion for her age.

Review of Systems: She has no fevers, sweats. Reports no fatigue, some headaches, and her sleep pattern is being disrupted. Her appetite is stable. She has no vision loss, change, diplopia, history of glaucoma. She has had hearing loss and had a hearing test to verify this. Has some tinnitus. No vertigo or dental problems. Cardiovascular: No chest pain, palpitations or heart murmurs. Respiratory: Shortness of breath. She does have asthma and has been treated for that with Advair. GI: She has no nausea, vomiting, diarrhea or constipation. GU: No bladder dysfunction, no incontinence. Skin: No rash. Musculoskeletal: No muscle or joint pain or swollen joints. Psychiatric: No depression, anxiety or psychiatric history. She has had counseling in the past. Did have some depression related to some job related issues in the past. Heme/Lymphatic: No bruising, bleeding, swollen lymph nodes. She has a history of transfusion and again, she is not heat or cold intolerant. Has no weight loss, weight gain or history of hormone therapy. Allergy/Immunology: No known allergies.

Past medical history is significant for carpal tunnel, right and left, in 2002, appendectomy 1985, and tonsillectomy in 1971. She has no stroke, seizure, epilepsy, chronic or severe headaches. She has had number of headaches since fall of 2004. Recently, was diagnosed with high blood pressure. She has had no heart attack, no diabetes, no cancer, no high cholesterol.

Social History: Does not smoke. Does not drink. The patient is single. Works as an English teacher.

SIGNED DOCUMENT

Printed: 04/15/2005



Indoor air quality evaluation done 15 February 2005 showed one ceiling tile with mold growth, an active leak and dampness in ceiling, and CO2 levels of >1500 ppm (suggesting poor ventilation).

**Appears to have either a hearing or attention problem. Much of encounter was**

wasted with trying to get records straight and handing them back and forth. Pt. appeared to have difficulty focusing on my interview questions.

Impression: Rule out hypersensitivity pneumonitis. Rule out asthma and mold allergy, which may have been missed on allergen panel or peculiar history of delayed response. Concerned that there is more than one pathology here and pt's behavior and MRI findings may suggest unrelated CNS lesion.

Plan: Require follow-up CXR and PFTs w/out bronchodilators.  
Speak to allergist - could eruptions have indicated delayed response to antigen? (timing unclear)  
May suggest audiometry to primary care physician.

TLG

Sep 15 2005 1:00PM

Review of medical records and supplemental note

Pt. made unannounced visit on 16 Sept to drop off medical records. Was observed to be very disorganized, as in clinic the previous day.

Neurologist, Dr. R. Jaitly, states in August 2005 normal spinal tap and serologies. Noted in June that she easily loses train of thought.

MRI of head: 12 Feb 2005 shows "numerous abnormal foci...within white matter bilaterally", apparently they are what is called UBO (unidentified bright object), a finding that is nonspecific but abnormal and suggest microvascular, infectious or demyelinating disease. Internal auditory canals normal.

Impression: Pt's level of confusion and attention deficit seems remarkable for a successful school teacher. Concerned that there is indeed a neurological basis for this. This condition, whatever it turns out to be, may be limiting factor in return to work, rather than allergies.

S: Just had "trigger shots" in neck that relieves pain. Has obtained records from her many physicians. WC claim turned down but she is appealing. Case manager indicated that many other positive tests shed doubt on diagnosis.

O: See note regarding allergist. Comes today with a lengthy chronology. She presents same photo - she states reaction occurred two days after tests planted; he states they appeared immediately after and are not indicative of an allergic reaction. Repeat CXR shows no sign of hypersensitivity pneumonitis or other interstitial disease. Continues to be vague and easily distracted.

A: Possible mold allergy to sp. not tested for, but otherwise no indication of mold-related pathology.

Dr. N also agrees with my own impression that there is an underlying neuropsychiatric disorder. Ms. [redacted] appears to have some sort of executive function deficit that makes it very hard for her to organize her affairs - quite inconsistent with history as a schoolteacher. Abnormal MRI may be indicative that she is developing a dementia, presently borderline.

Sep 29 2005 3:30PM

Spoke with Dr. Raymond O. Nwadiuko, allergist, who states that prick and skin tests were indeed negative. He says that pt has regularly shown photos of initial erythema from skin tests to physicians but exaggerates time elapsed: photo taken soon after placement. All tests were actually negative.

Dr. N concurs that CT scan is not sufficient evidence for hypersensitivity pneumonitis and states that he did serologies which were negative.

Dr. N describes her as manipulative and fixated on the red spots in photo from prick test. He thinks that physician-shopping behavior is related to progressive mental deficit.

Dr. N also agrees with my own impression that there is an underlying neuropsychiatric disorder. Ms. [REDACTED] appears to have some sort of executive function deficit that makes it very hard for her to organize her affairs - quite inconsistent with history as a schoolteacher. Abnormal MRI may be indicative that she is developing a dementia, presently borderline.

TLG

Electronically signed by: Tee Guidotti MD Sep 22 2005 3:42PM EST

Concerned about early dementia, esp. considering brain MRI findings. This may or may not be impeding her ability to accept that there is no strong evidence for a mold-related allergic condition causing her chronic health symptoms.

P: No follow-up scheduled. Experience with pt suggests that she will be back for further clarification.

TLG

Electronically signed by: Tee Guidotti MD Oct 6 2005 3:17PM EST

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Impression: Rule out hypersensitivity pneumonitis. Rule out asthma and mold allergy, which may have been missed on allergen panel or peculiar history of delayed response. Concerned that there is more than one pathology here and pt's behavior and MRI findings may suggest unrelated CNS lesion.

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TLG

Electronically signed by: Tee Guidotti MD Sep 15 2005 2:18PM EST

[REDACTED]