

No. 24-7251

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THE SUPREME COURT OF THE UNITED STATES

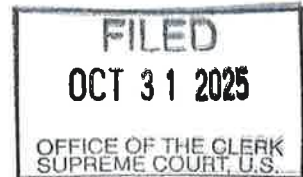
Michael Deuschel,

Petitioner,

vs.

Bayer Healthcare Pharmaceuticals, Inc., et al,

Respondents.



On Petition for a Writ of Certiorari to
the United States Court of Appeals
for the Ninth Circuit

PETITION FOR REHEARING
OF THE DENIED
PETITION FOR A WRIT OF CERTIORARI

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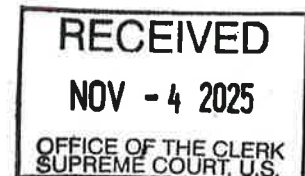


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I. Petition for Rehearing and Request for GVR Order:

Because his Petition is based upon intervening circumstance of a substantial and controlling effect and other substantial grounds not previously presented, Petitioner requests the Supreme Court to rehear his Petition for a Writ of Certiorari that they denied on October 6, 2025. (U.S. Sup Ct. Rule 44, 28 U.S.C.A.)

While preparing this Petition, Petitioner learned of the Grant, Vacate and Remand (GVR) judicial option, and respectfully requests the Court order a GVR so he may present the new study and his medical evidence in California state court.

a. Three Independent but Interrelated Grounds Warrant GVR:

1. Intervening Scientific Evidence: A study published after this Court's denial contradicts the FDA "no evidence of harm" claim, validating plaintiffs' arguments.
2. Erie Violations: The lower courts failed to apply California's delayed discovery rule—violations of fundamental federalism principles.
3. Administrative Law Development: The FDA guidance upon which the lower courts relied is premised on erroneous factual findings unsupported by substantial evidence and contradicts authoritative scientific research including the new study.

b. These Three Grounds Are Mutually Reinforcing:

The legal error is clear, procedural unfairness is evident and the intervening study validates Petitioner's argument. The lower courts committed legal errors (Erie violations) while relying on a factual premise (FDA guidance) that has been proven scientifically unsound (new study), rendering the administrative law foundation of their decisions arbitrary and capricious. Reconsideration and remand is warranted.

The FDA imbued Bayer's flawed Drug Warning for Magnevist, its linear Gadolinium-based Contrast Agent (GBCA), with controlling medical-legal authority. Bayer has subsequently used it to thwart legal actions against Magnevist's defects but its defense is founded on false science because the Drug Warning is flawed. Yet, it has excluded Petitioner from medical and legal remedies since June 2009. Ironically, when authoritative sources—the FDA—claimed, “No evidence of harm,” Petitioner cannot reasonably be expected to discover harm.

II. Intervening Circumstance of a Substantial and Controlling Effect:

An unprecedented study with the largest patient-led data set of its kind, was published on October 28, 2025, by the Lighthouse Project and co-authors, titled, *Signs & Symptoms After Gadolinium Administration: A Patient Survey, Report 1: Symptoms Paralleling Early-Phase NSF*. They present more than 300 patient reports of suspected symptoms of Gadolinium Toxicity (Gd Tox) from GBCAs. It has the power to topple Bayer and the FDA's false assertions as well as their Drug Warning's false definition of the range of risk of harm and can reverse the underlying dismissal of Petitioner's case. It is therefore legally controlling. Given the FDA existing guidance, “Harm,” from GBCAs was ‘undiscoverable,’ until this study. (*Appendix-1*)

The study is factually sound and strives to right scientific and medical misinformation that was wrongfully promoted by Bayer and imbued with legal authority by the FDA. Any scientific challenge to Bayer's flawed Drug Warning represents a legal challenge, too. It disproves the still-prevailing restrictive legal definition of the range of risk of harm that excluded Petitioner since June 12, 2009.

It thereby provides information that meets the deliberately high threshold of Rule 44. The study changes the legal landscape for GBCA litigation in time for this rehearing.

When Bayer marketed Magnevist, the FDA failed to hold them accountable at each step of review in 1988, 2007 and 2017, and falsely denied GBCAs' inherent risk of harm for *all* patients. In December 2017, the FDA finally admitted, contrary to their past denials, that Gadolinium is released from GBCAs; it is not fully discharged as first claimed; it indeed crosses the blood-brain barrier; patients indeed retain Gadolinium in their brain, spine, and other organs.

Yet, Bayer and the FDA insisted there was, "No evidence of harm," to patients from the retained *highly toxic heavy metal* Gadolinium that is released by the GBCAs. U.S. Food & Drug Administration. (2017). *FDA Drug Safety Communication, December 19, 2017.* <https://www.fda.gov/drugs/drug-safety-and-availability/fda-safety-communications-fda-warns-gadolinium-based-contrast-agents-gbcas-are-retained-body>. (*Signs & Symptoms report, page #2.*)

Bayer's and the FDA thereby built a legal barrier that had to be toppled. This study does not simply present new medical evidence but topples that barrier.

III. Another Substantial Ground Not Previously Presented:

The *Signs and Symptoms* study also reveals a key deception: The FDA's concealment of its previous admission that retained Gadolinium is toxic to patients which constitutes other substantial grounds not previously presented.

In December 2017, they claimed they saw, "No evidence of harm," from the GBCA-Released and Patient-Retained Gadolinium. (*Signs & Symptoms, page #2, 28.*)

Yet, ten years earlier, in 2007, the FDA admitted Gadolinium *is* toxic to patients' livers and calcium channels. (Calcium is a secondary signaler that influences body systems.) U.S. Food & Drug Administration, & Blank, M. (2007). *Division of Medical Imaging and Hematology Products, Memorandum to the File, Gadolinium-Based Contrast Agents (GBCAs) and Nephrogenic Systemic Fibrosis (NSF)*. <http://s3.amazonaws.com/propublica/assets/Omniscan/blank-melanie-review-omniscan2.pdf>. (*Signs & Symptoms, Abstract, cover page, page #38.*)

When the FDA capitulated to drug-makers, injured and under-resourced individuals and advocacy groups accepted the call to action to challenge the misinformation and to prevent further injury. Their grass-root efforts took close to two decades of unrelenting work by many people to incrementally dismantle the massive misinformation as the well-endowed corporations and governmental agencies capitulated and extended the unscalable walls of massive misinformation to deflect their culpability and to protect the pharmaceutical corporations that yield an incomprehensible influence over the contemporary medical service industry.

The GBCA drug-makers and FDA corrupted the legal landscape and allowed drug-makers to peddle their injections of injury and to profit from poisoning. Bayer and the FDA knew of Gadolinium's toxicity since at least 2007 but continue to conceal their awareness. Bayer and the FDA's false denial catapulted justice in a trajectory of tragedy. Herein, the U.S. Supreme Court can reverse that devastating trajectory.

IV. Credibility of Patient-Reported Adverse Effects:

Patient self-reporting is valued by FDA & European Medicines Agency.

Clinicians and patients can report serious adverse events after MRIs with a GBCA to the FDA or other governing authority. *Signs & Symptoms after Gadolinium Administration* survey questionnaire was comprised of checklists, multiple-choice, and open-ended questions. Both the FDA and European Medicines Agency (EMA) consider patient self-reports of adverse drug events (ADEs) an important additional source of information on the safety of drugs (FDA, 2020; EMA, 2022), and checklist-based questionnaires are more sensitive in identifying potential ADEs (de Vries et al., 2013). de Vries, S. T., Mol, P. G. M., de Zeeuw, D., Haaijer-Ruskamp, F. M., & Denig, P. (2013). U.S. Food & Drug Administration. (2020). *Patient-Focused Drug Development: Collecting Comprehensive and Representative Input. Guidance for Industry, Food and Drug Administration Staff, and Other Stakeholders. June 2020.* <https://www.fda.gov/media/139088/download>. Development and Initial Validation of a Patient-Reported Adverse Drug Event Questionnaire. *Drug Safety*, 36(9), 765–777. <https://doi.org/10.1007/s40264-013-0036-8>. (*Signs & Symptoms*, page #4.)

V. Credibility of the Lighthouse Project:

The authors, Sharon Williams and Hubbs Grimms, have published previous studies. Williams, S., & Grimm, H. (2014). Gadolinium Toxicity: A Survey of the Chronic Effects of Retained Gadolinium from Contrast MRIs.

<https://gdtoxicity.files.wordpress.com/2014/09/gd-symptom-survey.pdf>

Grimm H., Williams S., (2017) Gadolinium Retention for Contrast MRIs in 70 Cases with Normal Renal Function—24-hour Urine Test Results.

www.gadoliniumtoxicity.com.

Grimm, H., & Williams, S. (2018). Gadolinium Clearance Times for 135 Contrast MRI Cases Including Urine Test Results by Agent Administered for 63 Unconfounded Cases. <https://gadoliniumtoxicity.com/gadolinium-clearance-times-for-135-contrast-mri-cases-final-v1-1/> (*Signs & Symptoms*, page #31.)

The FDA confirmed The Lighthouse Project's credibility on page 38, section 2.4.4.6, U.S. Food & Drug Administration. (2017). *FDA Briefing Document, Sept 8, 2017, Medical Imaging Advisory Cmte. Meeting, Gadolinium Retention after Gadolinium-Based Contrast MRI in Patients with Normal Renal Function.* <https://www.fda.gov/media/107133/download>

VI. Judicial Error in Petitioner's Underlying Case:

a. Petitioner's Medical Negligence Complaint Against Kaiser:

On June 12, 2009, Kaiser Permanente poisoned Petitioner with Magnevist, Bayer's GBCA used to enhance an MRI image of his brain. Prior to the injection, (1) Kaiser misled him that they would use a "new" contrast dye; (2) they denied him a creatinine blood test to evaluate his impaired renal performance; (3) they thereby failed to detect his kidney stone. Post-injection, (4) the contrast dye was thereby trapped in him for more than 72 hours, exceeding the maximum 6 to 8 hour discharge window to prevent dechelation. (5) He suffered renal failure and transient degradation to CDK4 while the GBCA released its toxic Gadolinium in his body. (6) In August 2010, he learned that Kaiser did not use an iodine-based contrast dye for the MRI as claimed but the GBCA, Magnevist. (7) Petitioner found a 2008 Kaiser medical entry that stated GBCAs are "contraindicated" due to his renal insufficiency.

In 2011, he sued Kaiser Permanente for *medical negligence*.

In 2013, Petitioner's legal expert, Pharmacologist James Adams, MD, evaluated Petitioner and rendered the rogue diagnosis of Nephrogenic Systemic Fibrosis (NSF). Yet, the Judge, Defendants' experts, Yale University (the authority for NSF patient registration), the FDA and every physician treating Petitioner refuted the allegation that he was poisoned by Magnevist and contracted NSF—as per Bayer's prevailing, restrictive legal-medical definition of range of risk of harm.

Therefore, in 2014, the Judge ruled the drug did not poison Petitioner and therefore Kaiser did not commit medical negligence. Again, the ruling was based upon Bayer's 2007 prevailing legal-medical Drug Warning that excluded Petitioner from its range of risk of harm. That judicial refutation as well as plethora of physician refutations legally assuaged Petitioner of his suspicion of medical negligence despite his allegation. It is imperative to confirm that due to Bayer's massive misinformation, Petitioner did not suspect product liability until 2018, but even if he did, the extensive professional refutation would have assuaged him of any such suspicion.

b. The 2018 Transformative Event:

In February 2018, Petitioner learned of product liability because the celebrity Mr. Chuck Norris and his wife, Geena, created a Anti-GBCA social media campaign. Also, in 2018, Petitioner's treating physicians acknowledged he was poisoned but erroneously categorized it as an allergic reaction. When Petitioner viewed the Norris' articles and videos, he found incriminating information and learned of his high risk of harm, what caused his harm and the wrongful acts by Bayer and the FDA.

c. Petitioner's December 2019 Drug Defect Complaint Against Bayer:

December 19, 2019, Petitioner filed his complaint against Bayer, et al, in California state court, well within two years of his delayed discoveries.

In 2021, Defendant Bayer Pharmaceutical remanded it to Federal Court.

By 2023, he had received a hundred procedures to address injuries to ten of his eleven body systems but all providers refused to test for Gadolinium. Then a kind Mammoth Lakes physician, Timothy Crall, MD, performed and tested a bone biopsy: Petitioner continues to retain Gadolinium from a single GBCA injection in June 2009.

Yet, he was denied the right to present this medical evidence in court, because, in 2023, the Federal Court dismissed Petitioner's argument that he did not suspect product liability until 2018. Instead, the Justices held him to an unviable standard that he "should have known earlier." To do so, the Court ignored his presented facts that the FDA-established legal-medical definition of range of risk of harm from GBCAs excluded him and his patient-class and thereby prohibited the construction of suspicion and legal causation and causes of action until 2018.

The Federal Court failed to apply California's Delayed Discovery Law to the substantive issue of discovery and thereby violated the Erie Doctrine and Petitioner's constitutional right to put the delayed discovery issue of facts before a jury.

VII. Adverse Impact of Bayer's Massive Misinformation:

a. On the FDA: Entanglement:

1. FDA's Guidance Was Misguided:

From 1988, based upon the research Bayer submitted with its application, the FDA claimed Magnevist presented no risk of harm to any patient and licensed Magnevist. Bayer rushed the development of the drug to be the first-to-market.

From 2007 to 2018, based upon drug manufacturers' new disclosures and patient-presented adverse event reports, they repeatedly revised the Black Box Warnings. Bayer and FDA wrongfully divided patients according to their renal performance. They originally claimed *only* patients on dialysis, and subsequently, only those with CKD class 4 and 5 were at risk of injury from GBCAs and could contract NSF—with the “N” for Nephrogenic in the title suggesting patients' kidneys were responsible for the sustained harm. Since 2018, they see, “No evidence of harm.”

The FDA must base approval decisions on "substantial evidence" that the drug is safe for its intended use. (Federal Food, Drug, and Cosmetic Act (FDCA), 21 U.S.C. § 355(d)). The FDA's safety determinations must be based on scientific evidence, not speculation or outdated information. (FDCA § 321(p)(1), 21 U.S.C. § 321(p)(1)). Agency action must be set aside if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law *ab initio* (from the beginning)." Administrative Procedure Act (APA), 5 U.S.C. § 706(2)(A).

2. The FDA Guidance Violates the "Best Available Science" Requirement:

The FDA's guidance must base its determinations on the best available science. A guidance document (Drug Warning) that fails to account for significant new scientific evidence loses or forfeits its validity as a basis for judicial decision-making. (*Marsh v. Oregon Natural Res. Council*, 490 U.S. 360, 378 (1989))

3. Judicial Deference Was Misplaced:

Deference to FDA expertise cannot extend to determinations that contradict scientific evidence. *Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244 (2024). Since *Loper Bright*, courts must exercise independent judgment and cannot defer to agency interpretations unsupported by sound science. The lower courts erred by treating the FDA's unfounded 'no evidence of harm' position as dispositive.

In 2017, Bayer and the FDA deceived the public and concealed the 2007 admission of toxicity that presents a risk of harm to all patients. The FDA's 'no evidence of harm' position is unsupported by substantial evidence. Indeed, the *Signs and Symptoms* study demonstrates that substantial evidence exists to the contrary. The FDA's determination that directly contradicts substantial scientific evidence cannot satisfy statutory requirements and cannot be entitled to judicial deference.

b. On Professionals:

Physicians, lawyers, and judges lazily applied Bayer's misinformation in their flawed reasoning. They did not want to parse through the seven patient-centered medical negligence facts that explained the negligent mechanistic path of poisoning.

Built on confirmation bias, denial, conflation, and equivocation, first, they obsessed on the “N” in the semantically flawed “NSF” title and *assumed* he lacked the prerequisite CKD4/5 classification to be at risk of harm, despite the documented CKD4 renal failure injury; second, they *assumed* the ordinary cause for poisoning—drug defectiveness; third, they *assumed* because Petitioner claimed he was poisoned in 2013, he must have suspected a drug defect at that same time.

Bias trumped conscientious consideration. Initial objective analysis revealed his facts ran contrary to the misinformation. The discrepancy created cognitive dissonance which they quickly resolved by excluding him from fact-based differential diagnosis, causation, and justice. He was more easily dismissed than accommodated. Despite the injustice of it, he was denied a diagnosis, repeatedly—until 2018; almost.

c. On Petitioner:

Since 2010, Petitioner conducted extensive medical and legal research due to his litigation. Available information stated GBCAs were not harmful to him because he was CDK3 at the time of the injection. He still sued because fundamental medical facts established he was CKD4 while the released Gadolinium invaded his body.

In 2013, Petitioner's expert explained that he was poisoned because the drug was contraindicated due to his impaired kidneys, and, it remained in his body for over three days—far longer than the advised maximum residency of 6 to 8 hours—because, post-injection, his already compromised kidneys crashed into renal failure: CKD4. The GBCA's chelation broke-down to expose him to released Gadolinium.

Because the semantical nature of the term, “NSF,” effectively and erroneously ‘blames’ the patient's deficient kidneys, Petitioner adopted “Gadolinium Toxicity” to name the disease ravishing his body as he suffered the signs of poisoning. Also, contrary to the prevailing massive misinformation, protocol calls for the toxin to be identified within the title of the resulting disease so that it warns potential victims.

Plaintiff could not penetrate the massive wall of misinformation that excluded him from medical and legal remedy—until now, thanks to *Signs and Symptoms*.

VIII. Judicial Error Regarding California's Delayed Discovery Law:

The California Delayed Discovery Law represents a type of *equitable tolling*. The rule postpones the start of the statute of limitations until Petitioner could reasonably have discovered not only his injuries but their wrongful cause.

The rule applies when *either*: (1) Petitioner did not know of facts that would have caused a reasonable person to suspect that s/he had suffered harm that was caused by someone's wrongful conduct, *or*, (2) the exercise of reasonable diligence and a good-faith investigation would not have disclosed that a harmful product or situation contributed to his harm. *Norgart v. Upjohn Co.* (1999) 23 Cal.4th 383. See also: *NBC Universal Media, LLC v. Superior Court* (2014) 225 Cal.App.4th 1222; *Fox v. Ethicon Endo-Surgery* (2005) 35 Cal.4th 797; *Glue-Fold, Inc. v. Slautterback Corp.* (2000) 82 Cal.App.4th 1018; *Jolly v. Eli Lilly & Co.* (1988) 44 Cal.3d 1103; *Kernan v. Regents of University of California* (2022) 83 Cal. App. 5th 675; *Carillo v. County of Santa Clara* (2023) 89 Cal. App. 5th 227.

In accordance with the California Civil Jury Instructions CACI rule 455, Statute of Limitations - Delayed Discovery: If Bayer proves that Petitioner's claimed harm occurred before 2 years prior to his filing, his lawsuit is still timely if he proves that more than 2 years before filing, he did not/could not have discovered, and did not know of facts that would have caused a reasonable person to suspect that he had suffered harm caused by Bayer's wrongful conduct, *or*, Petitioner did not discover from diligent investigation that because Bayer's GBCA Magnevist was *defective*, it released toxic Gadolinium into him and contributed to his sustained harm.

The dominant FDA-approved defined range of risk of harm excluded Petitioner. Combined with the professionals' flawed reasoning and bias, the power of Bayer's propaganda prevented him from discovering the cause of his injury.

Delayed Discovery is an issue of fact for the jury. When the Federal Ninth District Court denied Peititoner a jury-trial, they violated his constitutional rights.

IX. Judicial Error Regarding the Erie Doctrine:

The Erie Doctrine mandates federal courts exercising diversity jurisdiction apply the substantive law of the forum state, including its conflict-of-laws rules, while procedural matters remain governed by federal law. It rejected the notion of general federal common law and emphasized applying state law to avoid forum-shopping and inequitable administration of laws. (*Erie R. Co. v. Tompkins*, 304 U.S. 64 (1938).

It was subsequently affirmed and enhanced. (*Gasperini v. Center for Humanities, Inc.*, 518 U.S. 415 (1996); (*Cuprite Mine Partners LLC v. Anderson*, 809 F.3d 548 (2015). Then, *Guaranty Trust Co. v. York*, *Byrd v. Blue Ridge*, and *Hanna v. Plumer* refined the doctrine, shifting from a strict outcome-determinative test to a more nuanced analysis that balances federal interests and state law application, especially under the Federal Rules of Civil Procedure.

The outcome determinative test must be applied with reference to Erie's twin aims: discouragement of forum shopping and avoidance of inequitable administration of laws. Federal courts may apply "specialized" federal common law in narrowly defined areas but must otherwise adhere to state substantive law. (141 Am. Jur. Trials 377 (Originally published in 2015), (Rutter Group Prac. Guide Fed. Civ. Pro.

Before Trial Ch. 1-B, (19 Fed. Prac. & Proc. Juris. § 4504 (3d ed.) (19 Fed. Prac. & Proc. Juris. § 4507 (3d ed.), (19 Fed. Prac. & Proc. Juris. § 4514 (3d ed.)).

The most recent significant Supreme Court decision addressing the relationship between federal rules and state law was in 2010 in *Shady Grove Orthopedic Associates P.A. v. Allstate Insurance Co.* , 559 U.S. 393 (2010).

It provided guidance on the relationship between federal rules and state law through a Rules Enabling Act framework. It held that when determining whether a Federal Rule of Civil Procedure preempts state law, what matters is the nature of the federal rule, not the affected state law. The Court emphasized that under the Rules Enabling Act test, federal rules that would preempt state laws are evaluated based on whether the federal rule abridges, enlarges, or modifies substantive rights.

Circuit courts are divided on certain Erie applications, including whether enforcement of forum-selection clauses is governed by state substantive law or federal procedural law, and the interplay between federal rules and state law in procedural contexts such as discovery. These divisions highlight ongoing challenges in clearly delineating substance from procedure and how federal courts should accommodate conflicting interests, particularly in states like California where substantive and procedural rules may diverge (19 Fed. Prac. & Proc. Juris. § 4508 (3d ed.) , (19 Fed. Prac. & Proc. Juris. § 4511 (3d ed.)).

In 2015, the Ninth Circuit addressed the Erie Doctrine in a mandamus petition context. It found that while the law governing jury trial waivers is generally procedural under Erie, federal courts must import state law as the federal rule when

state law provides greater protection for the constitutional right to jury trial, a clear application of Erie principles. It consistently applies the Erie framework's analysis: the outcome determinative test guided by the twin aims of discouraging forum shopping and avoiding inequitable administration of laws. (In re County of Orange, 784 F.3d 520 (2015).

Yet, in Petitioner's case, the Ninth Circuit Court violated the Erie Doctrine.

X. Petitioner's Conclusion:

The *Signs & Symptoms* study can be accessed on the internet (online) at <https://gadoliniumtoxicity.com/research/ourresearch/contrast-mri-2025-patient-survey-report-1/> . The study includes more than 300 patients with suspected Gadolinium Toxicity symptoms and the disclosure of the indefensible contradiction between the Bayer/FDA's 2007 admission of toxicity and their December 2017 denial of any evidence of harm.

The study reshapes the legal landscape of Gadolinium Toxicity litigation in a controlling way in time to warrant a rehearing of the Supreme Court's denial of Petitioner's Petition for Writ of Certiorari and consideration of his new request for a GVR order to remand his case back to California state court.

The Ninth District's judicial errors, the FDA administrative errors, and the legal importance of the unprecedented *Sings & Symptoms* study justify remand to state court for correction.

Respectfully Submitted October 30, 2025, by ,
Adaptive Petitioner, Pro Se.

CERTIFICATE OF COMPLIANCE

No. 24-7251

Michael Deuschel,

Petitioner(s)

v.

Bayer Healthcare Pharmaceuticals Inc., et al.

Respondent(s)

As required by Supreme Court Rule 44.4, I certify that my Petition for Rehearing the denied Petition for a Writ of Certiorari and Request for a GVR Order is restricted to the grounds specified in the rule of intervening circumstances of a substantial or controlling effect and other substantial grounds not previously presented, and, it is made in good faith and not for the purpose of delay.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on the 30th day of October, 2025,

A handwritten signature in cursive script, appearing to read "Michael Deuschel", is written over a horizontal line.

Michael Deuschel, Adaptive Petitioner, Pro Se

APPENDIX:
(As per Clerk Discussion)

A-1: Signs & Symptoms After Gadolinium Administration: A Patient Survey
Report 1: Symptoms Paralleling Early-Phase NSF

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Online: <https://gadoliniumtoxicity.com/research/ourresearch/contrast-mri-2025-patient-survey-report-1/>

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Signs & Symptoms after Gadolinium Administration: A Patient Survey

Report 1: Symptoms Paralleling Early-Phase NSF

Sharon Williams¹, Hubbs Grimm¹, Sarah Ratnam², Catriona Walsh (MB, BCh, BAO, MA)³

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ABSTRACT

Background: The U.S. Food & Drug Administration (FDA) has acknowledged that after MRIs with a gadolinium-based contrast agent (GBCA), patients retain an unknown amount of gadolinium (Gd) in the brain, bone, skin, and other tissues, where it can remain for months to years. Although Gd is a toxic metal recognized as the primary cause of nephrogenic systemic fibrosis (NSF), harm attributed to long-term Gd retention in patients with normal renal function has not been recognized. This Patient Survey aims to address that issue.

Method: Members of Gd-related groups were invited to participate in this Patient Survey. 316 patients with normal or near-normal renal function who had experienced symptoms after an MRI with a GBCA completed a survey online, without any knowledge of the responses of the other participants. 185 of these patients had a laboratory test that confirmed Gd retention 30 days or longer after their last MRI (WITH) and 131 patients did not have Gd testing performed (WITHOUT). A third group was formed, comprised of 8 patients with biopsy-confirmed nephrogenic systemic fibrosis (NSF). In each patient group, reported symptoms were ranked in order of frequency. In the NSF Group, due to multiple symptoms having the same reporting frequency, the top 28 symptoms were used for comparison purposes.

Results: From a list of 60 symptoms, 19 of the 28 most frequently reported symptoms of the NSF Group were also ranked among the top symptoms reported by the two groups of Gd-exposed patients without renal impairment, indicating a substantial overlap in clinical presentation between what has been published about early-phase NSF and the post-GBCA symptom complex. Eleven of the 19 most frequently reported symptoms of the WITH, WITHOUT & NSF patient groups involve the nervous system. This pattern is also observed within a subgroup of 75 unconfounded cases (19 linear & 56 macrocyclic) comprised of patients who received a single GBCA and have confirmation of Gd retention (Tables 16 & 17). The symptoms reporting frequencies of the unconfounded subgroup strengthen the evidence presented within this Patient Survey that the symptom overlaps are genuine and not due to measurement error, exposure ambiguity, or bias. As with the clinical presentation of NSF (Table 10) and its variability in severity (Table 11), neuropathic symptoms predominate the early phase of the symptom complex reported by patients with normal renal function, and the severity of symptoms varies and can be life-altering in some patients.

Conclusion: These observations are consistent with the hypothesis that gadolinium exposure is associated with a spectrum of manifestations and underscore the need for standardized recognition, systematic clinical assessment, and further objective study of Gd-associated multisystem symptoms in all patient populations. Rather than a new or separate disease entity for patients with normal renal function, it seems that what we may be dealing with is one Gd-induced disease with varying degrees of severity, which is how NSF was described by Marckmann (2009). Symptom reporting frequencies indicate the nervous system may be most affected by Gd, possibly due to Gd having a particularly toxic effect on calcium channels, which was acknowledged by the FDA in a 2007 Memorandum (Appendix 4). The results of this Patient Survey warrant acknowledgement that retained gadolinium can cause harm in patients with normal renal function due to its recognized toxic effect on calcium channels.

Key Words: Gadolinium, gadolinium toxicity, GBCAs, NSF, normal renal function, symptoms, nervous system, calcium channels, unconfounded cases

Citation: Williams, S., Grimm, H., Ratnam, S., Walsh, C. (2025). Signs & Symptoms after Gadolinium Administration: A Patient Survey. Report 1: Symptoms Paralleling Early-Phase NSF.

[Online] <https://gadoliniumtoxicity.com/research/ourresearch/contrast-mri-2025-patient-survey-report-1/>

INTRODUCTION

Gadolinium-based contrast agents (GBCAs) have been used for contrast-enhanced magnetic resonance imaging (MRI) since the FDA approved the first GBCA, Magnevist® (Bayer HealthCare Pharmaceuticals), in 1988. However, gadolinium (Gd) is a toxic metal, which must be chelated or bound to a ligand before it can be administered as a contrast agent (Weinman et al., 1984; Mann, 1993). Once injected, the Gd ion can separate from the ligand and be deposited in patients' bones and other tissues. However, to the best of our knowledge, the long-term consequences of that deposition are still unknown due to a lack of research.

One of the mechanisms behind the toxic effects of the Gd^{3+} ion is that its ionic radius is very similar to that of calcium (Ca^{2+}), and it can compete with calcium in all biological systems and in some enzyme activity that requires Ca^{2+} for proper function, but with a much higher binding affinity (Sherry et al., 2009). Calcium plays an important role in regulating a great variety of neuronal processes (Berridge, 1998), and Gd is known to be a potent blocker of calcium channels (Bourne & Trifaró, 1982).

Differences between GBCAs are determined by the chemical structure of the chelator, with linear agents considered less stable and more likely to leave Gd in patients' bodies than macrocyclic agents (Morcos, 2008; Hao et al., 2012). However, both linear and macrocyclic GBCAs have been found to leave residual Gd in the body, including in the brain, bones, and skin of patients with normal renal function (Gibby et al., 2004; Xia et al., 2010; Murata et al., 2016). Higher levels of Gd have been found in bone than in the brain and skin (Murata et al., 2016; Kobayashi et al., 2021). Gadolinium deposited in bone could be released back into circulation during bone remodeling (Thakral et al., 2007; Darrach et al., 2009). Due to the lack of research, the effects of that release are unknown.

Initially, GBCAs were thought to be safe to use in all patient populations. However, by 1997, the first evidence of a problem appeared in patients with end-stage renal disease (ESRD) who were on dialysis and developed what was first described as a scleromyxoedema-like cutaneous disease (Cowper et al., 2000). In 2001, the new skin disorder was named Nephrogenic Fibrosing Dermopathy (NFD) (Cowper et al., 2001). By 2003, researchers had determined that the disease was not limited to dialysis patients, and it went well beyond the skin and caused a systemic disease process that affected multiple organs and tissues (Ting et al., 2003; Jimenez et al., 2004). It was then renamed Nephrogenic Systemic Fibrosis or NSF (Daram et al., 2005).

In 2006, nine years after evidence of a problem first appeared, the connection was made between NSF and the GBCA that had been administered for the patients' MRIs or MRAs (magnetic resonance angiography) (Grobner, 2006; Marckmann et al., 2006). Although NSF is still not fully understood, retention of Gd is recognized as the primary contributor to the development of NSF, which was found to affect all body systems to varying degrees (Mendoza et al., 2006). Even though impaired renal function was not necessarily the sole cause of NSF, for a long time, the focus of research remained on the "N" or nephrogenic part of NSF. Patients with normal renal function have felt their post-contrast MRI symptoms have not been taken seriously.

From 2006, when the NSF/GBCA connection was first made, until 2015, patients with 'normal' renal function, meaning an eGFR >60 , were told they were not at risk of retaining Gd and their complaints of experiencing unusual symptoms after their MRIs were generally dismissed. However, after evidence of retained Gd was identified on brain images (Kanda et al., 2014) and in tissue specimens from patients with normal or near normal renal function (Kanda et al., 2015; McDonald et al., 2015), the FDA acknowledged on July 27, 2015, that patients with normal renal function were retaining Gd as well. Additional research was conducted and a public meeting on Gd retention was held on September 8, 2017, by the FDA Medical Imaging Drugs Advisory Committee (MIDAC). Faced with evidence that Gd was remaining in the body, including the brain, for months to years after contrast administration, the FDA required new class warnings for GBCAs on December 19, 2017. However, even though retained Gd is known to have caused NSF, the FDA has continued to state that it has not seen any evidence that the long-term retention of Gd causes 'harm' in patients with normal renal function. We address that issue in this report.

After reviewing NSF literature related to the clinical presentation of NSF, we realized symptoms reported by survey participants are like those described for early-phase NSF (Mendoza et al., 2006; Marckmann & Skov, 2009; Marckmann, 2011). In 2009, Marckmann wrote, "*skin changes and neuropathic symptoms predominate the early phase of NSF*", and "*there is a large variation in the type and intensity of symptoms between NSF patients, and symptoms also vary between early and late stages of the disease.*"

The involvement of the nervous system and variability of symptoms, even among NSF patients, supports our belief that patients with normal renal function can be harmed by retained Gd in the same way as those with impaired renal function. We believe the symptoms results of this Patient Survey indicate we may be dealing with ONE disease with varying degrees of severity, not multiple Gd-induced diseases.

PATIENT SURVEY

Goals

As patient advocates, the study authors have had interactions with a significant number of patients who developed a consistent pattern of new symptoms soon after their MRIs with a GBCA. From those interactions, we know that many patients with normal renal function continue to be told that they are not at risk of retaining Gd, and urine test results, which proved otherwise, are still frequently being dismissed (Grimm & Williams, 2018; Alwasayah et al., 2018; McDonald et al., 2025).

Patients describe experiencing many symptoms after exposure to a GBCA, but because their reporting is *subjective*, their concerns are often dismissed by healthcare providers rather than systematically evaluated for potential temporal association with GBCA administration. The scope of the problem has therefore not been fully recognized or investigated.

In conducting this survey, we had three goals:

- To provide sufficient new data to the FDA, other governing authorities, and researchers on Signs & Symptoms after GBCA administration so that a professional study would be conducted.
- To provide detailed symptoms and frequency data from more patients with suspected gadolinium-related adverse effects than has been previously reported in the peer-reviewed literature.
- To provide sufficient evidence of commonality between the symptoms reported by patients with normal renal function and those associated with Gd-induced NSF, so that the FDA recognizes that retained gadolinium may also cause harm in patients with normal renal function.

The results in this report provide important new data about symptoms reported by patients with normal and near normal renal function following MRIs with GBCAs, including temporal patterns and reporting frequencies across different agent types. For the first time, symptoms are reported by the type of agent administered for patients' last MRIs, and for patients who received only one GBCA (unconfounded cases) and have confirmation of Gd retention longer than 30 days.

While analyzing the survey results it became clear that there are many similarities between the clinical picture of NSF in its early phase and the symptoms reported by the participants in this Patient Survey. Because of these similarities, we decided to add a group of patients diagnosed with NFD/NSF; however, due to difficulty in finding NSF patients, the group is comprised of only 8 biopsy-confirmed cases including one from 2024. Seven of the NSF patients are from the U.S., and one is from Cyprus.

We believe the symptoms data presented in this report provide compelling evidence of commonality between the symptoms reported by survey participants and the clinical presentation of NSF as described by Marckmann & Skov (2009), particularly the neuropathic symptoms that predominate its early phase.

Methodology

Survey Questionnaire

The online Patient Survey was created using SurveyMonkey. The questions were developed based on what the authors have learned from their interactions with patients over the course of more than 14 years. The checkbox question about Symptoms included a list of 60 symptoms compiled from information patients have shared; from the symptom report by Williams & Grimm in 2014; from symptoms published by other authors on Gadolinium Deposition Disease (GDD) (Burke et al., 2016; Semelka et al., 2016) and from Symptoms Associated with Gadolinium Exposure (SAGE) (McDonald et al., 2021). Because GBCAs are administered intravenously and circulate systemically, gadolinium released from those agents can interact with multiple organ systems, making a broad and inclusive list of symptoms both appropriate and necessary. Input on the development of the questions was provided by two medical professionals.

The questionnaire included 8 Qualifying Questions & 9 Survey Sections:

Section 1 – Demographic Information

Section 2 – MRI History & Acute Symptoms

Section 3 – Symptoms Experienced after Last MRI

Section 4 – Signs of Systemic Abnormalities after Contrast MRIs

Section 5 – Other Abnormal Lab Results within 12 months of Patient's Last MRI

Section 6 – New Diagnoses / Autoimmune Diseases

Section 7 – Functional Disabilities & Other Limitations

Section 8 – Current Status of Symptoms & What treatments helped
Section 9 – Additional Comments (Responding was optional)

Survey results pertaining to Signs of Systemic Abnormalities (Section 4) will be presented in a separate report.

Symptom Reporting Frequencies

Symptom reporting frequencies were calculated as the percentage of participants reporting each of 60 symptoms within their respective patient groups (WITH, WITHOUT & NSF). The data was provided by SurveyMonkey in an Excel file containing the responses to each survey question. Rank order of symptom prominence was then determined and analyzed based on the reporting frequency within each group. Participants' individual responses were analyzed to determine symptom frequency by gender and by type of agent administered for the 75 patients in the Unconfounded Cases subgroup (Tables 16 & 17).

Patient Self-Reporting is valued by FDA & EMA

The online *Signs & Symptoms after Gadolinium Administration* survey questionnaire was comprised of checklists, multiple-choice, and open-ended questions. Both the FDA and European Medicines Agency (EMA) consider patient self-reports of adverse drug events (ADEs) an important additional source of information on the safety of drugs (FDA, 2020; EMA, 2022), and checklist-based questionnaires are more sensitive in identifying potential ADEs (de Vries et al., 2013).

Recruitment of Survey Participants

Members of online gadolinium-related groups, as well as patients referred by doctors providing chelation therapy, were invited to participate in this Patient Survey that was conducted in the summer/fall of 2024. Patients completed the survey without any knowledge of the responses of the other participants.

Two online surveys were conducted, one for patients with at least one test result that confirmed Gd retention and one for those who have not had testing performed. The two surveys were identical except for questions 6 and 8 about test results.

Participation criteria were established that required participants to answer 8 qualifying questions before they could access the survey questionnaire.

The same online survey was later used for the NSF group, but with changes made to three questions to ask how their diagnosis was made, renal status at the time of their diagnosis, and when they were diagnosed.

Participants were told that completion and electronic submission of the online survey questionnaire served as their voluntary agreement to allow their anonymous data to be used in this survey report and in future gadolinium-related research.

Participants were assured that no identifying information would be shared with anyone without their prior written consent.

Survey Limitations

The limitations of this Patient Survey are the recruitment of participants from online gadolinium-related patient groups, the inability to independently confirm an individual's responses, and the small size of the NSF patient group (reflecting the inherent challenge of identifying affected patients in real-world settings and the privacy restrictions that prevent physician-based verification).

Survey Participants

A total of 324 participants took part in this Patient Survey: 316 patients with normal or near normal renal function and 8 with an NSF diagnosis.

WITH, WITHOUT & NSF are used throughout this report to identify the following patient groups:

WITH is for patients with a laboratory test confirming Gd retention.

WITHOUT is for those patients without a test confirming Gd retention.

NSF is for those who have been diagnosed.

All people in the NSF Group were diagnosed based on biopsy findings: 1 in 2003; 2 in 2006; 2 in 2008; 1 in 2015; 1 in 2020; 1 in 2024. The person diagnosed in 2020 had 1 MRI in 2005 while on dialysis.

Some participants answered through Section 3 about Symptoms but did not complete the remainder of the questionnaire. Survey participation for each patient group is reported in Table 1 below.

Table 1. Survey Participation by Group			
Patient Group	Answered through Section 3	Answered through Section 4	Answered through Section 8
WITH Gd Test	185	177	172
WITHOUT Gd Test	131	113	109
NSF Diagnosis	8	7	7
Total	324	297	288

Reasons for Separate Survey Questionnaires

Conducting separate surveys for patients ‘with’ and ‘without’ a Gd test result serves two purposes:

- Similarities in symptoms rankings between the two groups could be used to support the belief of patients in the WITHOUT Group that their new, unexplained symptoms after MRIs are Gd-induced.
- Keeping survey results for patients WITH confirmation of Gd retention separate allows us to provide data and comparisons that are more likely to be recognized, particularly as it relates to Unconfounded Cases and NSF.

Where needed for comparison purposes, the results for the WITH and WITHOUT Groups are reported separately. Otherwise, the groups’ responses are added together.

Qualifying Questions & Demographics

Participants were asked to provide a name or alias and an email address; none of that information will be disclosed. They were asked to confirm who was completing the questionnaire, confirm their renal status, enter their test results, and indicate if they are willing to share a copy of their test results, if needed for research purposes. Participants without a test result were asked to explain why they have never been tested for evidence of Gd.

Person Completing Questionnaire

305 patients from the WITH and WITHOUT Groups completed the survey themselves; in addition, it was completed by the parents of 7 children, 2 spouses, and a family member of 2 patients, one of whom was deceased. The total number of responses was therefore 316.

Renal Status at Time of MRI(s)

261 patients in the WITH & WITHOUT Groups confirmed they had normal renal function at the time of their MRIs.

6 patients did not have normal renal function (meaning they had an eGFR <60) at the time of their MRIs.

49 did not know their renal status at the time of the MRIs.

In the NSF Group (8 total):

2 patients were on dialysis	1 had a ‘normal’ eGFR	1 had an eGFR >50 but was acidotic and had DVT
1 had an acute kidney injury	1 had an eGFR >99	
1 needed a kidney transplant	1 did not remember	

Gender of Patients in the WITH & WITHOUT Groups

In general, we feel that women are more likely to join online support groups and respond to surveys, which may explain why more women than men participated in the patient survey. (The NSF Group was equally divided with 4 females & 4 males).

246 Females
68 Males
1 Preferred not to say
1 Self-described
316 Participants

Age at Time of Last MRI

Figure 1 shows the breakdown by age range for the 316 patients in the WITH & WITHOUT Groups at the time of their last contrast MRIs.

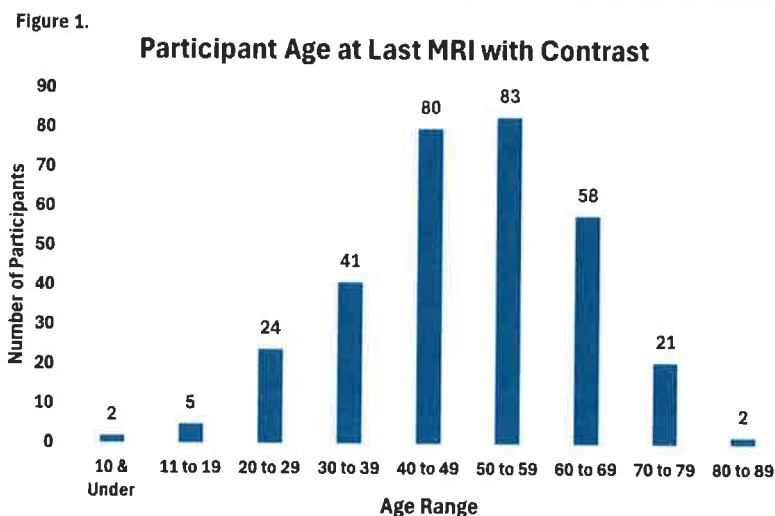


Table 2. Race or Ethnicity of Participants			
	WITH	WITHOUT	NSF
East Asian	2	0	0
South Asian	4	1	0
Black or African American	3	1	0
Hispanic	5	5	0
Latino	2	2	0
Middle Eastern or North African	4	0	0
Multiracial or Multiethnic	0	2	0
Native American or Alaska Native	0	0	0
Native Hawaiian or other Pacific Islander	0	0	0
White	156	107	7
Prefer not to answer	3	6	0
Another race or ethnicity, please describe*	6	7	1
Total	185	131	8

* WITH Group, Another race or ethnicity: European American, Caucasian European descent, Ashkenazi Jewish white, Hebrew Ashkenazi, American, American Indian/American European.

WITHOUT Group, Another race or ethnicity: Mixed Caucasian & Hispanic, Chinese, Arabic, Native Métis & Fr. Canadian, American, Maltese, Italian.

NSF Group, Another race or ethnicity: Greek Cypriot.

Geographic Location of Participants

Patients from around the world participated in the survey with 220 from the United States, including 7 from the NSF Group.

Below are the other countries and the number of respondents represented in the survey:

Algeria (1), Australia (12), Austria (3), Bulgaria (1), Canada (12), Chile (1), Cyprus (1), Finland (1), France (3), Germany (30), India (2), Israel (1), Latvia (1), Libya (1), Malta (1), Mexico (1), Netherlands (2), New Zealand (1), Norway (1), Poland (1), Slovenia (3), Switzerland (5), and UK (19).

Grouping of Participants

WITH Group – Gadolinium Test Results

Participants with test results were asked to enter the results from at least one test that confirmed they retained Gd 30 days or longer after their last MRI with a GBCA. The result could be from the testing of urine, blood, stool, skin, hair, nails, bone, or other tissue. Many patients entered results from multiple tests. The unit of measurement reported was not uniform from all countries and labs, but the results confirmed Gd retention. Due to medical privacy concerns, participants were not asked to provide copies of their test results.

Table 3a provides the breakdown for the types of testing the 185 participants in the WITH Group had performed. There were 282 test results entered. Although patients are excreting Gd in their urine for much longer than expected (Grimm & Williams, 2018; Alwasiyah et al., 2018), the results in Table 3b indicate that not all Gd is being eliminated in every patient.

<u>Specimen Tested</u>	<u># of Results Reported</u>
Urine (unprovoked)	146
Urine (provoked)	62
Blood	19
Stool	12
Hair	10
Nails	2
Skin	4
Bone	4
Teeth	9
Sweat	2
Other tissues	12

Table 3b provides insight into the long-term retention of Gd in patients with normal renal function. Based on the results provided by survey participants, connective tissues and glandular tissues appear to show the greatest retention (this includes bone and teeth as well as cartilage and skin).

Patient ID #	Tissue Specimen Tested	Amount of Gd Detected	Time since Last Contrast MRI	LAST Agent Received & Number of MRIs
1*	Sigmoid colon	7.0 ng/g	13.6 years	Magnevist/ 5 MRIs/ unconfounded
	Bone – Lumbar Spine	5,373 ng/g	11 years	
	Tissue & Muscle/lumbar spine	2,742 ng/g	11 years	
	Right Ovary	80 ng/g	9.8 years	
	Left Ovary	122 ng/g	9.8 years	
	Thyroid gland	211 ng/g	4 years	
2	Bone – Left Femoral Neck	21 ng/g	4 years	Dotarem/ 1 MRI
	Cartilage from Femoral Bone	34 ng/g	4 years	
	Skin	6 ng/g	17 months	
3	Jawbone	1,310 µg/kg	Not provided	Unknown Agents/ 2 MRIs
	Skin	106 µg/kg		
	Skin	37 µg/kg		
	Tooth	533 µg/kg		
	Tooth	978 µg/kg		
	Tooth	810 µg/kg		
4	Tooth	1,470 µg/kg	8 Years	Omniscan/ 5 MRIs/ confounded
	Tooth	2,180 mcg/kg		
	Tooth Root	940 mcg/kg		

5	Uterus	8.0 µg/kg	1 year	Dotarem/ 16-20 MRIs/ confounded
	Tooth	1,710 µg/kg	1 year	
	Sweat	0.3 µg/l	2 years	
6	Bone - Pelvic	791 ng/g	14 years	Magnevist/ 1 MRI
7	Prostate	534 ng/g	22 years	Unknown Agents/ 4 MRIs
8	Skin	0.1 ng/g	5 years	Unknown Agents/ 5 MRIs
9	Nails	0.005 mg/kg	4.7 years	MultiHance/ 1 MRI
10	Nails	16 mg/kg	15.8 years	Magnevist/ 1 MRI
11	Tooth	40 µg/kg	Not provided	ProHance/ 2 MRIs/ confounded
12	Tooth (molar)	257 ng/g	Not provided	Gadovist/ 11 MRIs/ confounded
13	Sweat	0.6 µg/l	Not provided	Gadovist/ 6 MRIs/ confounded
14	Fat	5.0 ng/g	2.5 years	Dotarem/ 13 MRIs/ confounded
15	Abortion Material	0.06 mcg/g	3 years	Clariscan/ 1MRI
16	Eluate after 10th Dialysis	307 nmol/l	6 years	Unknown Agents/ 18 MRIs
17	Granuloma in Finger	4.0 ng/g	Not provided	Eovist/ 1 MRI

* **Disclosure:** Patient #1 is author SW.

Note: Test Results are Available to Researchers

167 of the 185 patients in the WITH Group indicated they are willing to share a copy of their test results with researchers. Patients are interested in participating in research that might shed light on how retained Gd is affecting the human body.

Tissue Repository

Developing a multiorgan tissue biorepository was suggested in McDonald et al.'s, 2018, "*Gadolinium Retention: A Research Roadmap*." However, to the best of our knowledge, it has not been created. That is unfortunate, since some of the specimens included in Table 3b were collected after 2018 from both linear and macrocyclic unconfounded cases.

WITHOUT Group – No Gadolinium Testing Performed

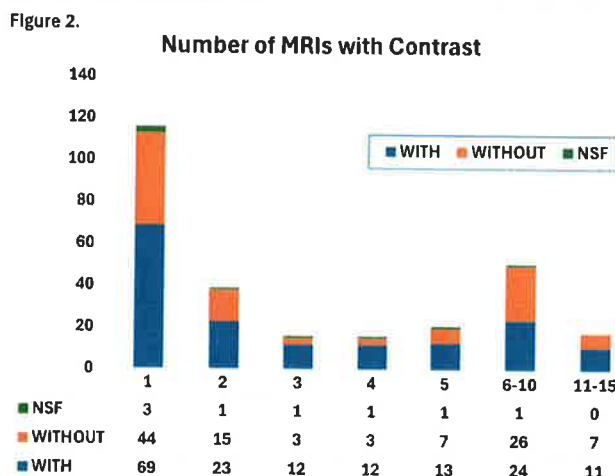
Participants without a test result were asked to explain why they have never been tested for evidence of Gd. More than one reason could be selected. Responses were as shown in Table 4.

Table 4.	Reason for Not Having Gd Testing Performed	Responses
	My doctor refused to order a test.	26
	I didn't know I could order a test online myself. *	52
	I could not afford to order my own testing online. *	17
	My test was performed long after my MRI & Gd was below detection limits.	5
	Other – Had done testing but did not have the results	9
	Other – Patients just learning about Gd retention problems	10
	Other – Testing not available / easily accessible	7
	Other – Thought exposure was too long ago for unprovoked testing	4
	Other – Doctor didn't believe patient and/or know about Gd retention	5
	Other – Patients waiting to do testing and get results	2
	Other – Patient too ill and stressed to do another test	1

* In the U.S., patients can order testing of urine, stool & hair at DirectLabs.com; the testing is performed by Doctor's Data.

Participant History with GBCAs

As shown below, more than one-third of respondents reported only a single MRI with a GBCA yet subsequently developed symptoms that led them to seek information and support from gadolinium-related patient groups. Many did so after receiving insufficient guidance in clinical settings, reflecting the limited awareness of potential adverse effects following GBCA administration. As can be seen in the NSF Group, even one dose of a GBCA can cause NSF.



Informed Consent Document Prior to Contrast MRI

Based on patient feedback, we know that several patients feel that the Informed Consent documents that patients are asked to sign prior to their MRIs are inadequate when it comes to informing patients about potential risks associated with gadolinium retention and the document is not always provided to patients.

To gather data related to those issues, participants were asked if they signed an Informed Consent document that mentioned gadolinium. They were reminded that Medication Guides about gadolinium retention were not required by the FDA until 2018.

The responses of the 316 patients in the WITH & WITHOUT Groups are as follows:

- 56 Signed an Informed Consent document that did mention gadolinium.
- 59 Signed a document that did not mention gadolinium.
- 19 Signed an Informed Consent but their MRIs were before 2018 & Gd was not mentioned.
- 55 Were not given an Informed Consent document to sign prior to their MRIs.
- 82 Were not sure if they had been given an Informed Consent document to sign.
- 45 Provided other comments

In the NSF Group, only 2 signed an Informed Consent document.

Date of Last MRI

Patients were asked for the date of their last MRI. In the 1988 to 2000 Date Range, their MRIs were in 1998, 1999, and 2000. Those MRIs were 25+ years ago, yet the patients are symptomatic enough to still be active in an online Gd patient group.

Table 5.	Total by Date Range for Last MRI		
Date Range	WITH	WITHOUT	NSF
1988-2000	1	2	0
2001-2010	9	4	6
2011-2020	91	44	1
2021-2024	83	77	1
Yr not given	1	4	0
Total	185	131	8

In the NSF Group, 6 patients had their last MRIs between 2003 and 2006, 1 in 2015, and 1 in 2023.

The patients in 2015 and 2023 both had 'normal' renal function with one having an eGFR of 99. NSF is still being diagnosed and in patients with normal renal function.

Agent Administered for Last MRI

Table 6a presents information about the GBCA administered for participants' most recent MRI. The data show a predominance of macrocyclic agents, reflecting their broader adoption by radiology departments in recent years as part of a global shift away from linear GBCAs. While this trend is consistent with current clinical practice, the distribution in this survey may also be influenced by demographic factors, as individuals who underwent MRI examinations decades ago with linear agents are less likely to be represented due to age, health status, or reduced online engagement. Nevertheless, the symptom data presented in Tables 16 and 17 for patients who received only one GBCA may help clarify potential similarities or differences in adverse effects between linear and macrocyclic agents.

Table 6a. AGENT ADMINISTERED FOR LAST MRI			
Answer Choices*	WITH	WITHOUT	NSF
Don't know the name of the agent I received	33	80	1
Ablavar®/Vasovist® (gadofosveset trisodium)	0	0	0
Clariscan™ (gadoterate meglumine)	8	9	0
Dotarem® (gadoterate meglumine)	44	14	0
Elucirem™ (gadopiclenol)	0	0	0
Eovist® (gadoxetate disodium)	2	0	0
Gadovist® (gadobutrol)	49	11	2
Gadobutrol® (generic, 2023)	1	0	0
Gadoterate Meglumine (generic, 2022)	0	0	0
Magnevist® (gadopentetate dimeglumine)	9	6	1
MultiHance® (gadobenate dimeglumine)	17	5	0
Omniscan® (gadodiamide)	5	1	4
OptiMark™ (gadoversetamide)	2	0	0
Primovist® (gadoxetic acid disodium)	1	0	0
ProHance® (gadoteridol)	13	4	0
Vueway® (gadopiclenol)	1	0	0
Other - Dotagraf	0	1	0
Total	185	131	8

* Appendix 1 contains GBCA trademark information

Table 6b. TYPE of GBCA ADMINISTERED for LAST MRI			
Agent Type	WITH	WITHOUT	NSF
Name of Agent Unknown	33	80	1
Linear for Last MRI	36	12	5
Macrocyclic for Last MRI	116	39	2
Total	185	131	8

Symptoms after earlier MRIs

Participants who had multiple MRIs with contrast were asked if, in retrospect, they believed they experienced Gd-induced symptoms after their earlier MRIs. They were then asked if those symptoms caused them to have additional MRIs to investigate the new unexplained symptoms.

86 (47%) in the WITH Group & 54 (41%) in WITHOUT Group said that they experienced symptoms after their earlier MRIs.

42 (23%) in the WITH Group & 23 (18%) in WITHOUT Group said those symptoms caused them to have additional MRIs to investigate their new symptoms.

In the NSF Group, 4 of the 8 reported experiencing symptoms after earlier contrast MRIs that caused them to undergo additional MRIs, which resulted in their subsequent NSF diagnosis. These patients, suffering from initial symptoms of toxicity, were unfortunately exposed to more GBCAs, which are now recognized as the primary contributors to this life-altering iatrogenic disease.

Anaphylaxis & Severe/Acute Symptoms

Radiologists and MRI personnel are aware of and expected to document cases of anaphylaxis that manifest during or immediately after contrast administration. Nevertheless, there remains a critical information gap regarding patient outcomes and adverse events that occur after their discharge from the imaging facility. Here we provide data that, to the best of our knowledge, has never been reported based on information provided by the patient.

Anaphylaxis

19 patients in the WITH Group & 17 in the WITHOUT Group experienced a life-threatening allergic reaction (anaphylaxis) after contrast administration that required emergency medical intervention.

Severe/Acute Symptoms

Participants were asked if they experienced severe or acute symptoms immediately after or within a day or two after their MRIs that caused them to seek medical attention.

Table 7. Answer Choices	WITH		WITHOUT	
No	82	44%	75	57%
Yes, I saw my doctor	48	26%	25	19%
Yes, I went to ER or Urgent Care	55	30%	31	24%
Total	185		131	

In the NSF Group, 2 patients were hospitalized at the time of their MRIs, and 3 other patients sought medical care within a day or two of their MRI.

Additional ER Visits within 6 months of Last MRI

Participants were asked if they visited an ER at any other time within the first 6 months after their last MRI.

Table 8. Answer Choices	WITH		WITHOUT	
No	114	62%	92	70%
Yes (Briefly describe reason) *	71	38%	39	30%
Total	185		131	

* The reasons for ER visits include pain/ especially burning pain, deep bone pain, rib pain, muscle spasms, severe headaches/migraines, vertigo, liver pain, tachycardia, low blood pressure, high blood pressure, chest pain, palpitations, shortness of breath, nausea, and kidney pain.

In the NSF Group, 2 patients were hospitalized at the time of their last MRI, and 1 remained there for 3 months; two others visited the ER within the first 6 months. The reasons for their ER visits were chest pain, low blood pressure, heart issues, bone pain, rash, difficulty breathing, autonomic dysfunction, and adrenal issues.

Time between Last MRI & seeing a doctor.

129 or 70% of the WITH Group and 69 or 53% of the WITHOUT Group sought medical attention within the first month after their last contrast MRI.

Table 9. When Patient saw Doctor	WITH		WITHOUT		NSF	
The same day or the next day	31	17%	18	14%	3	37%
Within 1 week	56	30%	30	23%	2	25%
Within 1 month	42	23%	21	16%	0	0%
Within 3 months	21	11%	13	10%	2	25%
Within 6 months	8	4%	6	5%	0	0%
Within 1 year	4	2%	8	6%	1	13%
I did not seek medical attention within 1 year*	23	12%	35	27%	0	0%
Total	185		131		8	

* Patients in the WITH & WITHOUT Groups said they did not know Gd, or the contrast agent could cause the symptoms they were experiencing. Some said the symptoms were like those they had after previous MRIs, and they thought they were just side effects. Some people were dealing with serious health problems, such as cancer, and did not associate their symptoms with the MRI until later.

Early-phase NSF Symptoms

To appreciate the significance of the survey results, one must know about the clinical presentation of NSF beyond skin changes and joint contractures, which are the ‘visible’ evidence of Gd-induced disease. We present relevant facts here.

According to observations made by Marckmann & Skov (2009), “*skin changes and neuropathic symptoms predominate the early phase of NSF.*” As can be seen later in this report, symptoms involving the nervous system rank high in the NSF, WITH and WITHOUT groups. Other symptoms are also like those described in the NSF literature.

For reference, the early phase of NSF ranged from 14 to 60 days after GBCA exposure, with an intermediate phase of 60 to 180 days. The late phase of NSF was more than 180 days [6 months] after the patient’s MRI (Marckmann & Skov, 2009).

Table 10. Early-phase Symptoms of NSF as described by Marckmann & Skov (2009) & Marckmann (2011):

- **Skin changes** - Rash, erythema, skin discoloration, itching, burning sensations, swelling that is often warm & painful. Localized to lower legs, forearms, hands, thighs, seldom trunk, and almost never face involvement. [Note that Cowper et al., 2008, reported face involvement in 3% of NSF cases].
- **Neuropathic symptoms** - 80% of patients complained of pain, dysesthesia [burning, itching, electric-shock sensations, and pins & needles] or hyperalgesia [increased sensitivity to pain]. Some presented with restless leg syndrome. Neuropathic symptoms may be so intense that the patient becomes physically disabled. Walking may become very painful.
- **Muscles** - Complaints of muscle weakness are common.
- **Bone** - Deep bone pain in the hips and ribs has been described.
- **Kidneys** - Reviews have concluded that nephrotoxicity may be seen with some GBCAs at a rate similar to that seen with iodine-based contrast agents.
- **Hair** - Diffuse hair loss in up to 50% of the patients
- **Intestines** - Acute gastroenteritis discomfort with pain, vomiting, and diarrhea soon after GBCA exposure.
- **Eyes** - 20% or more may present with red eyes as signs of noninfectious conjunctivitis
- **Lungs** - 15% developed acute pneumonia symptoms, including shortness of breath, hypoxia, and bilateral infiltrates on chest X-ray within a few days after GBCA exposure
- **Systemic Inflammation** - The initial phase of NSF frequently includes signs of systemic inflammation with fever, elevated C-reactive protein, elevated ferritin, anemia, and thrombocytosis or thrombocytopenia.

Other relevant points made by Marckmann and his colleagues are as follows:

- There is a large variation in the type and intensity of symptoms between NSF patients, and symptoms also vary between early and late stages of the disease.
- A minority of patients may have no or very mild symptoms, whereas others may present with very dramatic symptoms from one or more organs.

- In severe early-phase symptoms, patients may suffer from associated problems such as sleeplessness, depression, anorexia, and weight loss.
- Some GBCA-exposed patients develop some of the early-phase symptoms of NSF without progressing into the late and chronic phase of NSF [which they termed ‘abortive or subclinical’ NSF].
- Some NSF case reports indicate that symptoms may appear and progress even later.

Because the intensity and pattern of late-NSF symptoms varied ‘enormously’ among NSF cases, a severity scoring scale of 0 (no symptoms) to 4 (severely disabling symptoms) was proposed (Marckmann et al., 2008; Marckmann & Skov, 2009). The severity grading of NSF in Table 11 indicates that patients without joint contractures and severe disabilities, but with symptoms of gadolinium toxicity after their MRIs, may not have been properly diagnosed.

Grade	Clinical Presentation	Comments [Marckmann’s]
0	No symptoms	NSF cases with full symptom remission
1	Mild physical, cosmetic, or neuropathic symptoms not causing any kind of disability	These cases are easily overlooked
2	Moderate physical or neuropathic symptoms limiting physical performance to some extent	May remain mis- or undiagnosed
3	Severe symptoms limiting daily physical activities (walking, bathing, shopping, and so forth)	May remain mis- or undiagnosed
4	Severely disabling symptoms causing dependence on aid devices for common, daily activities	These cases are likely to be diagnosed and included in registry studies of NSF.

As a result of the unusual clinical presentation and nonspecific histology, Marckmann wrote that it may be “very hard to come to the NSF diagnosis in some patients.” *“In practice, the diagnosis of NSF therefore sometimes has to be based primarily on patient history of GBCA-exposures, subsequent appearance of otherwise unexplained symptoms from the skin, the limbs, or other organs, and the exclusion of relevant differential diagnoses.”*

We believe those facts and others support our thinking about the significance of the symptoms data presented in this report.

Symptoms Results

To the best of our knowledge, we provide more Gd-related symptoms data than has been published previously. In addition to having data from more respondents, we report symptoms results for 19 linear and 56 macrocyclic unconfounded cases.

Unlike with NSF patients, skin changes are not the primary symptoms reported by the WITH and WITHOUT Groups. Because many ESRD patients received a double or triple dose of a linear GBCA prior to the onset of NSF (Grobner & Prischl, 2007), they may have retained more Gd than someone with normal renal function. However, that does not mean that the amount of Gd retained by patients with normal renal function is benign; the survey results indicate the opposite is true.

In the Symptoms Tables, a two-letter code identifies the body system associated with each symptom:

CS/Cardiovascular & Circulatory System	NS/Nervous System
DS/Digestive System	RS/Respiratory System
ES/Endocrine System	SS/Skeletal System
IS/Integumentary System	US/Urinary System

Results for the survey question about Symptoms after Contrast Administration are presented here in several tables. To draw attention to symptoms involving the nervous system ‘NS’ is bold.

Table 12 – WITH Group presents symptoms data from 185 respondents WITH a Gd test result. Symptoms results are presented based on the type of GBCA administered for patients' LAST MRIs. (Unconfounded Cases are in Tables 16 & 17)

Answer Choices (in order listed in survey)		Total Responses		Percentage calculated on Total MRIs by Agent Type							
		#	%	#	%	#	%	#	%	#	%
1 NS	Ache (dull continuous pain)	105	57%	22	61%	61	53%	22	67%		
2 NS	Burning pain	128	69%	28	78%	77	66%	23	70%		
3 NS	Numbness	89	48%	18	50%	54	47%	17	52%		
4 NS	Tingling / Prickling sensations	146	79%	27	75%	93	80%	26	79%		
5 NS	Low-level internal buzzing / electric-like sensations	98	53%	26	72%	53	46%	19	58%		
6 NS	Head Pain (stabbing/ sharp/ localized head pain)	88	48%	19	53%	54	47%	15	45%		
7 NS	Headache (atypical/new onset)	82	44%	19	53%	48	41%	15	45%		
8 NS	Brain Fog / Cognitive Issues	134	72%	32	89%	75	65%	27	82%		
9 NS	Migraine Auras	28	15%	8	22%	12	10%	8	24%		
10 NS	Lightheadedness/ Dizziness	89	48%	21	58%	49	42%	19	58%		
11 NS	Seizures	15	8%	4	11%	9	8%	2	6%		
12 NS	Considered suicide/ suicidal ideation	45	24%	9	25%	28	24%	8	24%		
13 NS	Muscle Spasms/ Cramps	106	57%	24	67%	56	48%	26	79%		
14 NS	Muscle Twitching / Fasciculations	127	69%	28	78%	75	65%	24	73%		
15 NS	Balance Issues	85	46%	20	56%	43	37%	22	67%		
16 NS	Difficulty Walking	77	42%	18	50%	44	38%	15	45%		
17 SS	Deep Bone Pain	105	57%	26	72%	62	53%	17	52%		
18 SS	Pain in Joints	112	61%	27	75%	64	55%	21	64%		
19 SS	Joint instability (clicking, popping, unstable joints)	60	32%	15	42%	33	28%	12	36%		
20 SS	Pain in Ribs	67	36%	17	47%	38	33%	12	36%		
21 IS	Skin Changes (hyperpigmented, mottled, or blotchy)	74	40%	21	58%	42	36%	11	33%		
22 IS	Skin Rash	60	32%	18	50%	32	28%	10	30%		
23 IS	Skin Lesions (such as ulcers, papules, macules, or nodules)	44	24%	14	39%	23	20%	7	21%		
24 IS	Wrinkled skin (accelerated aging of skin)	73	39%	17	47%	44	38%	12	36%		
25 IS	Itchy Skin	70	38%	15	42%	45	39%	10	30%		
26 IS	Tight Skin	47	25%	12	33%	27	23%	8	24%		
27 IS	Stretchy Skin	13	7%	4	11%	7	6%	2	6%		
28 IS	Sagging Skin	31	17%	7	19%	19	16%	5	15%		
29 CS	Hypotension (low blood pressure) (new onset)	27	15%	4	11%	19	16%	4	12%		
30 CS	Hypertension (high blood pressure) (new onset)	34	18%	10	28%	16	14%	8	24%		
31 CS	Labile Hypertension	11	6%	3	8%	5	4%	3	9%		
32 CS	Tachycardia (fast heart rate)	71	38%	15	42%	45	39%	11	33%		
33 CS	Arrhythmias (irregular heartbeat)	54	29%	13	36%	32	28%	9	27%		
34 CS	Other Palpitations	47	25%	11	31%	28	24%	8	24%		
35 CS	Chest Pain	56	30%	12	33%	33	28%	11	33%		
36 RS	Shortness of Breath	65	35%	13	36%	43	37%	9	27%		
37 CS	Edema (swelling of extremities)	33	18%	8	22%	16	14%	9	27%		
38 DS	Digestive Symptoms (nausea, vomiting, diarrhea, etc)	90	49%	25	69%	51	44%	14	42%		
39 DS	Abdominal Pain	61	33%	14	39%	36	31%	11	33%		
40 US	Pain in Kidneys or Bladder	56	30%	13	36%	34	29%	9	27%		
41 DS	Pain in Liver/Gallbladder Area	40	22%	10	28%	24	21%	6	18%		
42 NS	Dysphagia (swallowing problems)	45	24%	15	42%	22	19%	8	24%		
43 NS	Speech Difficulty/ Voice Changes	47	25%	16	44%	25	22%	6	18%		
44 NS	Eye Redness	40	22%	9	25%	27	23%	4	12%		
45 NS	Dry Eyes	72	39%	14	39%	49	42%	9	27%		
46 NS	Floaters (eyes)	60	32%	15	42%	35	30%	10	30%		
47 NS	Vision Changes / Blurry Vision	90	49%	23	64%	50	43%	17	52%		
48 NS	Tinnitus (ringing in ears)	85	46%	18	50%	52	45%	15	45%		
49 ES	Hair Loss	64	35%	16	44%	38	33%	10	30%		
50 ES	Low Body Temperature	52	28%	9	25%	36	31%	7	21%		
51 ES	Low-grade Fevers	16	9%	5	14%	9	8%	2	6%		
52 ES	Fatigue	121	65%	24	67%	73	63%	24	73%		
53 ES	Insomnia	96	52%	18	50%	60	52%	18	55%		
54 ES	Loss of Appetite/ Anorexia	48	26%	9	25%	30	26%	9	27%		
55 NS	Loss of Taste	14	8%	4	11%	8	7%	2	6%		
56 RS	Flu-like Symptoms	42	23%	12	33%	21	18%	9	27%		
57 NS	Metal Taste in Mouth	47	25%	10	28%	28	24%	9	27%		
58 ES	Unexplained Weight Loss	47	25%	9	25%	31	27%	7	21%		
59 ES	Unexplained Weight Gain	17	9%	6	17%	9	8%	2	6%		
60 DS	Food intolerances (new)	40	22%	10	28%	23	20%	7	21%		

* CS/Cardiovascular & Circulatory System; DS/Digestive System; ES/Endocrine System; IS/Integumentary System; NS/Nervous System (bold); RS/Respiratory System; SS/Skeletal System; US/Urinary System

Total Respondents WITH Test Results 185 36 Linear 116 Macro 33 Unknown

Table 13. SYMPTOMS / Within 3 months of Last MRI			Compare Results of WITH & WITHOUT Groups		
(WITH Group Responses sorted from high to low percentages)			(WITHOUT Group Responses sorted from high to low percentages)		
	WITH Gd Results			WITHOUT Gd Results	
	#	%		#	%
1 *NS Tingling / Prickling sensations	146	79%	NS Tingling / Prickling sensations	81	62%
2 NS Brain Fog / Cognitive Issues	134	72%	NS Brain Fog / Cognitive Issues	77	59%
3 NS Burning pain	128	69%	NS Burning pain	75	57%
4 NS Muscle Twitching / Fasciculations	127	69%	ES Fatigue	69	53%
5 ES Fatigue	121	65%	NS Muscle Twitching / Fasciculations	68	52%
6 SS Pain in Joints	112	61%	NS Numbness	66	50%
7 NS Muscle Spasms/ Cramps	106	57%	NS Muscle Spasms/ Cramps	66	50%
8 NS Ache (dull continuous pain)	105	57%	NS Ache (dull continuous pain)	62	47%
9 SS Deep Bone Pain	105	57%	NS Low-level internal buzzing / electric-like sensations	61	47%
10 NS Low-level internal buzzing / electric-like sensations	98	53%	NS Lightheadedness/ Dizziness	61	47%
11 ES Insomnia	96	52%	SS Pain in Joints	61	47%
12 DS Digestive Symptoms (nausea, vomiting, diarrhea, etc.)	90	49%	NS Balance Issues	59	45%
13 NS Vision Changes / Blurry Vision	90	49%	NS Head Pain (stabbing/ sharp/ localized head pain)	54	41%
14 NS Numbness	89	48%	IS Itchy Skin	54	41%
15 NS Lightheadedness/ Dizziness	89	48%	NS Tinnitus (ringing in ears)	53	40%
16 NS Head Pain (stabbing/ sharp/ localized head pain)	88	48%	ES Insomnia	52	40%
17 NS Balance Issues	85	46%	SS Deep Bone Pain	50	38%
18 NS Tinnitus (ringing in ears)	85	46%	DS Digestive Symptoms (nausea, vomiting, diarrhea, etc.)	49	37%
19 NS Headache (atypical/new onset)	82	44%	IS Hair Loss	49	37%
20 NS Difficulty Walking	77	42%	NS Headache (atypical/new onset)	47	36%
21 IS Skin Changes (hyperpigmented, mottled, or blotchy)	74	40%	RS Shortness of Breath	45	34%
22 IS Wrinkled skin (accelerated aging of skin)	73	39%	IS Skin Changes (hyperpigmented, mottled, or blotchy)	44	34%
23 NS Dry Eyes	72	39%	NS Vision Changes / Blurry Vision	43	33%
24 CS Tachycardia (fast heart rate)	71	38%	NS Dry Eyes	40	31%
25 IS Itchy Skin	70	38%	IS Skin Rash	39	30%
26 SS Pain in Ribs	67	36%	SS Pain in Ribs	36	27%
27 RS Shortness of Breath	65	35%	CS Chest Pain	36	27%
28 IS Hair Loss	64	35%	NS Difficulty Walking	34	26%
29 DS Abdominal Pain	61	33%	NS Floaters (eyes)	34	26%
30 SS Joint instability (clicking, popping, unstable joints)	60	32%	NS Metal Taste in Mouth	34	26%
31 IS Skin Rash	60	32%	IS Wrinkled skin (accelerated aging of skin)	32	24%
32 NS Floaters (eyes)	60	32%	SS Joint instability (clicking, popping, unstable joints)	30	23%
33 CS Chest Pain	56	30%	NS Dysphagia (swallowing problems)	30	23%
34 US Pain in Kidneys or Bladder	56	30%	DS Abdominal Pain	29	22%
35 CS Arrhythmias (irregular heartbeat)	54	29%	CS Tachycardia (fast heart rate)	27	21%
36 ES Low Body Temperature	52	28%	CS Edema (swelling of extremities)	27	21%
37 ES Loss of Appetite/ Anorexia	48	26%	DS Food intolerances (new)	27	21%
38 IS Tight Skin	47	25%	NS Migraine Auras	26	20%
39 CS Other Palpitations	47	25%	RS Flu-like Symptoms	26	20%
40 NS Speech Difficulty/ Voice Changes	47	25%	CS Other Palpitations	25	19%
41 NS Metal Taste in Mouth	47	25%	CS Arrhythmias (irregular heartbeat)	24	18%
42 ES Unexplained Weight Loss	47	25%	US Pain in Kidneys or Bladder	24	18%
43 NS Considered suicide/ suicidal ideation	45	24%	ES Low Body Temperature	24	18%
44 NS Dysphagia (swallowing problems)	45	24%	ES Unexplained Weight Loss	24	18%
45 IS Skin Lesions (such as ulcers, papules, macules, or nodules)	44	24%	IS Tight Skin	23	18%
46 RS Flu-like Symptoms	42	23%	ES Loss of Appetite/ Anorexia	21	16%
47 DS Pain in Liver/Gallbladder Area	40	22%	NS Speech Difficulty/ Voice Changes	19	15%
48 NS Eye Redness	40	22%	NS Eye Redness	19	15%
49 DS Food intolerances (new)	40	22%	ES Unexplained Weight Gain	18	14%
50 CS Hypertension (high blood pressure) (new onset)	34	18%	NS Considered suicide/ suicidal ideation	17	13%
51 CS Edema (swelling of extremities)	33	18%	CS Hypertension (high blood pressure) (new onset)	17	13%
52 IS Sagging Skin	31	17%	IS Sagging Skin	16	12%
53 NS Migraine Auras	28	15%	DS Pain in Liver/Gallbladder Area	16	12%
54 CS Hypotension (low blood pressure) (new onset)	27	15%	IS Skin Lesions (such as ulcers, papules, macules, or nodules)	15	11%
55 ES Unexplained Weight Gain	17	9%	ES Low-grade Fevers	12	9%
56 ES Low-grade Fevers	16	9%	CS Hypotension (low blood pressure) (new onset)	10	8%
57 NS Seizures	15	8%	NS Loss of Taste	9	7%
58 NS Loss of Taste	14	8%	IS Stretchy Skin	8	6%
59 IS Stretchy Skin	13	7%	NS Seizures	6	5%
60 CS Labile Hypertension	11	6%	CS Labile Hypertension	6	5%

* CS/Cardiovascular & Circulatory System; DS/Digestive System; ES/Endocrine System; IS/Integumentary System; NS/Nervous System (bold); RS/Respiratory System; SS/Skeletal System; US/Urinary System

Total Respondents WITH Test Results 185

Total Respondents WITHOUT Test Results 131

Table 13 – WITH and WITHOUT Groups shows symptom responses sorted from high to low based on percentages. Symptoms linked to NS, or the Nervous System, make up 64% of the top 25 symptoms listed for the WITH Group and 60% of the top 25 for the WITHOUT Group. **Our Assessment:** The similarity in the pattern and prevalence of their top-reported symptoms supports the hypothesis that the two groups represent a similar patient population experiencing the same underlying condition after their MRIs with a GBCA.

Figure 3 provides a different perspective of the symptoms data presented in Table 14. Due to multiple symptoms in the NSF Group having the same reporting frequency, we compared the top 28 symptoms of the NSF, WITH and WITHOUT Groups. The 3 groups had 19 of the same symptoms in their top 28, 11 of which involve the nervous system

Figure 3.

Similarities and Differences of Top 28 Symptoms Reported by Each Group

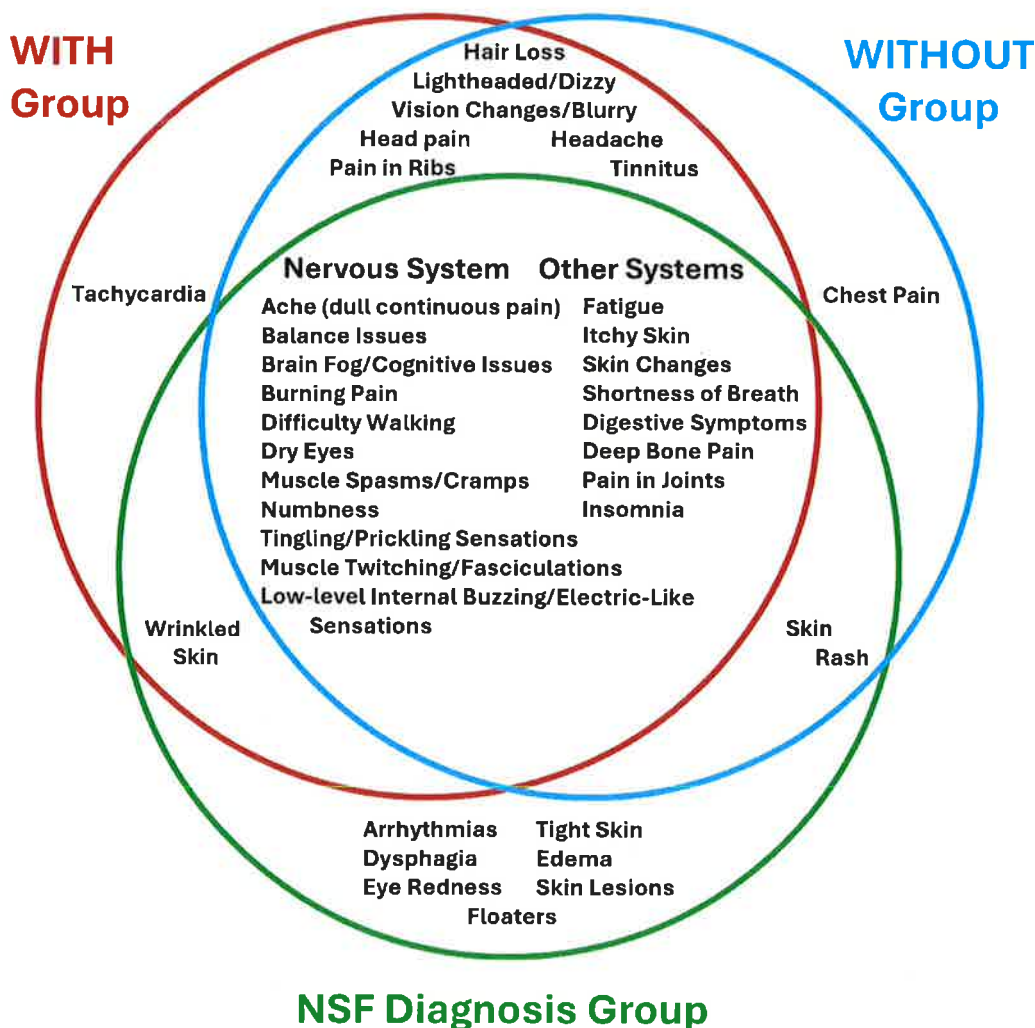


Table 14. COMPARISON of SYMPTOM RANKINGS TO NSF GROUP		NSF GROUP		WITH GROUP		WITHOUT GROUP	
Highlighted Symptoms in WITH & WITHOUT Groups are in NSF Group's Top 28		Ranking	%	Ranking	%	Ranking	%
IS* Skin Changes (hyperpigmented, mottled, or blotchy)		1	100%	21	40%	22	34%
NS Difficulty Walking		2	88%	20	42%	28	26%
IS Tight Skin		3	88%	38	25%	45	18%
ES Fatigue		4	75%	5	65%	4	53%
NS Brain Fog / Cognitive Issues		5	63%	2	72%	2	59%
NS Muscle Spasms/ Cramps		6	63%	7	57%	7	50%
SS Deep Bone Pain		7	63%	9	57%	9	47%
IS Skin Rash		8	63%	31	32%	25	30%
IS Skin Lesions (such as ulcers, papules, macules, or nodules)		9	63%	45	24%	54	12%
IS Wrinkled skin (accelerated aging of skin)		10	63%	22	40%	31	24%
IS Itchy Skin		11	63%	25	38%	14	41%
CS Edema (swelling of extremities)		12	63%	51	18%	36	21%
NS Ache (dull continuous pain)		13	50%	8	57%	8	47%
NS Burning pain		14	50%	3	69%	3	57%
NS Tingling / Prickling sensations		15	50%	1	79%	1	62%
SS Pain in Joints		16	50%	6	61%	11	47%
NS Eye Redness		17	50%	48	22%	48	15%
NS Dry Eyes		18	50%	23	39%	24	31%
NS Numbness		19	38%	14	48%	6	50%
NS Low-level internal buzzing / electric-like sensations		20	38%	10	53%	9	47%
NS Muscle Twitching / Fasciculations		21	38%	4	69%	5	52%
NS Balance Issues		22	38%	17	46%	12	45%
DS Digestive Symptoms (nausea, vomiting, diarrhea, constipation, bloating, ret		23	38%	12	49%	18	37%
ES Insomnia		24	38%	11	52%	16	40%
RS Shortness of Breath		25	38%	27	35%	21	34%
NS Dysphagia (swallowing problems)		26	38%	44	24%	33	23%
NS Floaters (eyes)		27	38%	32	32%	29	26%
CS Arrhythmias (irregular heartbeat)		28	38%	35	29%	41	18%
NS Lightheadedness/ Dizziness		29	25%	15	48%	10	47%
SS Joint instability (clicking, popping, unstable joints)		30	25%	30	32%	32	23%
IS Stretchy Skin		31	25%	59	7%	58	6%
IS Sagging Skin		32	25%	52	17%	52	12%
CS Tachycardia (fast heart rate)		33	25%	24	38%	35	21%
CS Other Palpitations		34	25%	39	25%	40	19%
CS Chest Pain		35	25%	33	30%	27	28%
DS Abdominal Pain		36	25%	29	33%	34	22%
NS Vision Changes / Blurry Vision		37	25%	13	49%	23	33%
NS Tinnitus (ringing in ears)		38	25%	18	46%	15	41%
ES Hair Loss		39	25%	28	35%	19	37%
NS Loss of Taste		40	25%	58	8%	57	7%
RS Flu-like Symptoms		41	25%	46	23%	39	20%
ES Unexplained Weight Loss		42	25%	42	25%	44	18%
NS Head Pain (stabbing/ sharp/ localized head pain)		43	13%	16	48%	13	41%
NS Migraine Auras		44	13%	53	15%	38	20%
NS Seizures		45	13%	57	8%	59	5%
SS Pain in Ribs		46	13%	26	36%	26	28%
CS Hypotension (low blood pressure) (new onset)		47	13%	54	15%	56	8%
CS Labile Hypertension		48	13%	60	6%	60	5%
US Pain in Kidneys or Bladder		49	13%	34	30%	42	18%
NS Speech Difficulty/ Voice Changes		50	13%	40	25%	47	15%
ES Low Body Temperature		51	13%	36	28%	43	18%
ES Low-grade Fevers		52	13%	56	9%	55	9%
ES Loss of Appetite/ Anorexia		53	13%	37	26%	46	16%
NS Metal Taste in Mouth		54	13%	41	25%	30	26%
ES Unexplained Weight Gain		55	13%	55	9%	49	14%
DS Food intolerances (new)		56	13%	49	22%	37	21%
NS Headache (atypical/new onset)		57	0%	19	44%	20	36%
NS Considered suicide/ suicidal ideation		58	0%	43	24%	50	13%
CS Hypertension (high blood pressure) (new onset)		59	0%	50	18%	51	13%
DS Pain in Liver/Gallbladder Area		60	0%	47	22%	53	12%

* CS/Cardiovascular & Circulatory System; DS/Digestive System; ES/Endocrine System; IS/Integumentary System; NS/Nervous System (bold); RS/Respiratory System; SS/Skeletal System; US/Urinary System

Total Respondents for each group 8 185 131

Table 14 – Comparison of Symptom Rankings to NSF Group shows the responses of the NSF Group listed from high to low percentages next to the ranking and response percentage for that symptom in the WITH and WITHOUT Groups.

In the NSF Group, multiple symptoms had the same reporting frequency. For comparison purposes, we included the 28 symptoms with a reporting frequency of 38% or higher. Symptoms that are ranked in the top 28 of the NSF Group and the WITH and/or WITHOUT Groups are highlighted in yellow in Table 14.

Note: The NSF Group consists of only 8 cases, and 6 of the 8 patients had their last MRI with contrast between 2003 and 2006 and may not have recalled all symptoms they experienced at that time.

Brain Fog & Cognitive Issues

In the literature, brain fog and cognitive issues are not usually identified as being symptoms of NSF. We believe we have found a possible explanation for it.

In a 2013 editorial in the “American Journal of Kidney Diseases”, Seliger & Weiner opened with this first line - “*Cognitive impairment is common in individuals with chronic kidney disease (CKD), particularly among those treated with dialysis.*”

Because cognitive impairment is common in patients on dialysis, any cognitive change in those patients may not have been recognized in case reports as also being a symptom of NSF. However, we know that gadolinium is neurotoxic (Mallio et al., 2020; Hui & Mullins, 2009; Ray et al., 1996).

Our Assessment: Skin changes and neuropathic symptoms not only predominate the early phase of NSF but also the symptoms experienced by survey participants. Of the top 28 symptoms in the NSF Group, 6 involve the skin and 14 the nervous system (NS); in addition, 2 involve the skeletal system, 2 the endocrine system, 2 the cardiovascular & circulatory system, 1 the digestive system, and 1 the respiratory system.

The WITH and WITHOUT Groups both had 19 of the same NSF symptoms in their top 28, and each group had 1 additional symptom for a total of 20 of the top 28 symptoms of the NSF Group.

The following 11 NS symptoms ranked in the top 28 of the NSF, WITH & WITHOUT Groups:

Ache (dull continuous pain)	Low-level internal buzzing/electric-like sensations
Balance issues	Muscle spasms/cramps
Brain fog/cognitive issues	Muscle twitching/fasciculations
Burning pain	Numbness
Difficulty walking	Tingling/prickling sensations
Dry eyes	

The other NS symptoms in the NSF Group’s top 28 are dysphagia (swallowing problems), eye redness, and floaters (eyes).

The following 8 other symptoms are also in the top 28 of all three groups:

Deep bone pain	Itchy skin
Digestive symptoms	Pain in joints
Fatigue	Shortness of breath
Insomnia	Skin changes (hyperpigmented, mottled, or blotchy)

The results from the NSF Group may not carry much weight statistically due to the small size of the group. However, there are obvious similarities between the symptom rankings of the NSF Group and those of the WITH and WITHOUT Groups. The top 28 symptoms in the NSF Group are in line with the results of the WITH and WITHOUT Groups and the early-phase symptoms of NSF as described by Marckmann (Table 10). This similarity suggests that they are symptoms of Gd-induced NSF, or as Marckmann suggested calling it, Gd-induced systemic fibrosis.

Unconfounded Cases

Received the Same GBCA for all contrast MRIs

In the NSF-related literature, there was a focus on what were referred to as “unconfounded” cases. For consistency, we use the term here. Unconfounded NSF cases are those cases in which the patient received one dose of contrast or had multiple MRIs

with the same GBCA. Knowing which agent or type of agent was administered before the onset of symptoms can provide important information for researchers, and we are able to provide such information in Table 15.

Table 15. UNCONFOUNDED CASES 1 or More MRIs with Same Agent				
Agent Received for All MRIs	WITH		WITHOUT	
	1 MRI	Multiple	1 MRI	Multiple
Ablavar®/Vasovist® (gadofosveset trisodium)	0	0	0	0
Clariscan™ (gadoterate meglumine)	4	1	5	0
Dotarem® (gadoterate meglumine)	20	2	8	2
Elucirem™ (gadopiclenol)	0	0	0	0
Eovist® (gadoxetate disodium)	0	0	0	0
Gadovist® (gadobutrol)	16	8	3	3
Gadobutrol (generic, 2023)	0	0	0	0
Gadoterate Meglumine (generic, 2022)	0	0	0	0
Magnevist® (gadopentetate dimeglumine)	6	1	5	0
MultiHance® (gadobenate dimeglumine)	5	3	2	1
Omniscan™ (gadodiamide)	2	0	0	0
OptiMark™ (gadoversetamide)	2	0	0	0
Primovist® (gadoxetic acid disodium)	0	0	0	0
ProHance® (gadoteridol)	4	0	2	0
Vueway® (gadopiclenol)	1	0	0	0
Agent UNKNOWN – Had only 1 MRI	9	0	19	0
Unconfounded Cases – LINEAR	15	4	7	1
Unconfounded Cases – MACROCYCLIC	45	11	18	5
TOTAL UNCONFOUNDED CASES	69	15	44	6
	1 MRI	Multiple	1 MRI	Multiple

Symptoms Associated with Linear versus Macrocytic Agents

Researchers have been looking for details that might link symptoms to linear versus macrocytic agents (Tweedle, 2021).

We provide that information for **75 Unconfounded Cases (19 linear & 56 macrocytic) in the WITH Group**. All patients have at least one test result that confirms they retained gadolinium longer than 30 days after their MRI, including as long as 14 years in pelvic bone and 13 years in sigmoid colon tissue (Table 3b). Symptom reporting frequencies and rankings within this group closely parallel those observed in the NSF Group and in the broader WITH cohort, reinforcing the consistency of the NSF-like symptom signature when agent identity is clearly defined and retention is documented.

In Table 17, the same 14 symptoms involving the nervous system ranked in the top 25 for linear & macrocytic GBCAs:

Ache (dull continuous pain)	Headache (atypical/new onset)	Low-level internal buzzing/electric-like sensations
Balance issues	Lightheadedness/dizziness	Tingling/prickling sensations
Brain fog/cognitive issues	Muscle spasms/cramps	Tinnitus
Burning pain	Muscle twitching/fasciculations	Vision changes/blurry vision
Difficulty walking	Numbness	

7 other symptoms were in the top 25 for both types of GBCAs:

Deep bone pain	Fatigue	Pain in Joints	Skin changes (hyperpigmented, mottled or blotchy)
Digestive symptoms	Insomnia	Wrinkled skin	

For easier comparison, symptom responses from 75 Unconfounded Cases are presented here in two tables:

Table 16 – Symptom Reporting Frequency by Gender & Agent Type with symptoms in the order listed in the Survey. Response percentages for Females and Males are reported side-by-side for both linear and macrocytic unconfounded cases.

Table 17 – Symptom Reporting Frequency Ranked from High to Low Percentages by Agent Type for 19 linear and 56 macrocytic unconfounded cases in the WITH Group. All symptoms involving the nervous system are bold.

Table 16. SYMPTOMS / UNCONFOUNDED Cases / WITH Results			19 Linear Cases				56 Macrocytic Cases			
Symptom Reporting Frequency by Gender & Agent Type for 75 Unconfounded Cases			14 Females		5 Males		37 Females		19 Males	
			#	%	#	%	#	%	#	%
1 NS	Ache (dull continuous pain)		9	64%	2	40%	20	54%	11	58%
2 NS	Burning pain		11	79%	4	80%	28	76%	11	58%
3 NS	Numbness		6	43%	3	60%	19	51%	7	37%
4 NS	Tingling / Prickling sensations		11	79%	2	40%	30	81%	14	74%
5 NS	Low-level internal buzzing / electric-like sensations		11	79%	1	20%	22	59%	8	42%
6 NS	Head Pain (stabbing/ sharp/ localized head pain)		6	43%	1	20%	21	57%	4	21%
7 NS	Headache (atypical/new onset)		7	50%	2	40%	17	46%	9	47%
8 NS	Brain Fog / Cognitive Issues		14	100%	4	80%	27	73%	6	32%
9 NS	Migraine Auras		2	14%	1	20%	7	19%	1	5%
10 NS	Lightheadedness/ Dizziness		8	57%	2	40%	21	57%	4	21%
11 NS	Seizures		1	7%	0	0%	3	8%	1	5%
12 NS	Considered suicide/ suicidal ideation		5	36%	1	20%	15	41%	2	11%
13 NS	Muscle Spasms/ Cramps		9	64%	3	60%	15	41%	7	37%
14 NS	Muscle Twitching / Fasciculations		9	64%	4	80%	25	68%	10	53%
15 NS	Balance Issues		8	57%	2	40%	15	41%	4	21%
16 NS	Difficulty Walking		6	43%	2	40%	14	38%	5	26%
17 SS	Deep Bone Pain		12	86%	2	40%	19	51%	7	37%
18 SS	Pain in Joints		11	79%	3	60%	20	54%	8	42%
19 SS	Joint instability (clicking, popping, unstable joints)		5	36%	2	40%	12	32%	5	26%
20 SS	Pain in Ribs		9	64%	1	20%	10	27%	6	32%
21 IS	Skin Changes (hyperpigmented, mottled, or blotchy)		8	57%	4	80%	16	43%	3	16%
22 IS	Skin Rash		7	50%	3	60%	10	27%	5	26%
23 IS	Skin Lesions (such as ulcers, papules, macules, or nodules)		5	36%	2	40%	8	22%	2	11%
24 IS	Wrinkled skin (accelerated aging of skin)		6	43%	2	40%	18	49%	7	37%
25 IS	Itchy Skin		6	43%	2	40%	11	30%	6	32%
26 IS	Tight Skin		7	50%	1	20%	9	24%	3	16%
27 IS	Stretchy Skin		1	7%	1	20%	0	0%	0	0%
28 IS	Sagging Skin		1	7%	1	20%	8	22%	1	5%
29 CS	Hypotension (low blood pressure) (new onset)		1	7%	0	0%	9	24%	1	5%
30 CS	Hypertension (high blood pressure) (new onset)		1	7%	1	20%	4	11%	1	5%
31 CS	Labile Hypertension		1	7%	0	0%	1	3%	0	0%
32 CS	Tachycardia (fast heart rate)		3	21%	1	20%	19	51%	5	26%
33 CS	Arrhythmias (irregular heartbeat)		5	36%	1	20%	11	30%	5	26%
34 CS	Other Palpitations		3	21%	1	20%	9	24%	4	21%
35 CS	Chest Pain		5	36%	1	20%	12	32%	5	26%
36 RS	Shortness of Breath		3	21%	1	20%	14	38%	3	16%
37 CS	Edema (swelling of extremities)		2	14%	1	20%	2	5%	1	5%
38 DS	Digestive Symptoms (nausea, vomiting, diarrhea, constipation, etc)		10	71%	3	60%	19	51%	6	32%
39 DS	Abdominal Pain		6	43%	1	20%	12	32%	6	32%
40 US	Pain in Kidneys or Bladder		3	21%	1	20%	13	35%	7	37%
41 DS	Pain in Liver/Gallbladder Area		3	21%	0	0%	6	16%	5	26%
42 NS	Dysphagia (swallowing problems)		4	29%	1	20%	6	16%	3	16%
43 NS	Speech Difficulty/ Voice Changes		4	29%	3	60%	9	24%	3	16%
44 NS	Eye Redness		3	21%	1	20%	10	27%	4	21%
45 NS	Dry Eyes		6	43%	1	20%	18	49%	9	47%
46 NS	Floaters (eyes)		5	36%	2	40%	10	27%	6	32%
47 NS	Vision Changes / Blurry Vision		8	57%	3	60%	16	43%	9	47%
48 NS	Tinnitus (ringing in ears)		7	50%	1	20%	19	51%	6	32%
49 ES	Hair Loss		7	50%	2	40%	12	32%	6	32%
50 ES	Low Body Temperature		1	7%	0	0%	13	35%	4	21%
51 ES	Low-grade Fevers		1	7%	0	0%	3	8%	1	5%
52 ES	Fatigue		10	71%	2	40%	27	73%	8	42%
53 ES	Insomnia		7	50%	3	60%	23	62%	7	37%
54 ES	Loss of Appetite/ Anorexia		2	14%	2	40%	11	30%	2	11%
55 NS	Loss of Taste		2	14%	0	0%	4	11%	1	5%
56 RS	Flu-like Symptoms		4	29%	0	0%	11	30%	1	5%
57 NS	Metal Taste in Mouth		5	36%	1	20%	7	19%	4	21%
58 ES	Unexplained Weight Loss		3	21%	1	20%	12	32%	5	26%
59 ES	Unexplained Weight Gain		2	14%	0	0%	4	11%	1	5%
60 DS	Food intolerances (new)		3	21%	0	0%	9	24%	3	16%
Total by Gender & Agent Type: Female (F) & Male (M)			14 F/Linear		5 M/Linear		37 F/Macro		19 M/Macro	

* CS/Cardiovascular & Circulatory System; DS/Digestive System; ES/Endocrine System; IS/Integumentary System; NS/Nervous System (bold); RS/Respiratory System; SS/Skeletal System; US/Urinary System

Table 17. SYMPTOMS / 75 UNCONFOUNDED Cases / WITH Results Group

Percentages Calculated on Total Unconfounded Cases by Agent Type											
(Responses sorted from high to low percentages)				19 LINEAR		(Responses sorted from high to low percentages)				56 MACRO	
				#	%					#	%
1	NS	Brain Fog / Cognitive Issues	18	95%	NS	Tingling / Prickling sensations	44	79%			
2	NS	Burning pain	15	79%	NS	Burning pain	39	70%			
3	SS	Deep Bone Pain	14	74%	NS	Muscle Twitching / Fasciculations	35	63%			
4	SS	Pain in Joints	14	74%	ES	Fatigue	35	63%			
5	NS	Tingling / Prickling sensations	13	68%	NS	Brain Fog / Cognitive Issues	33	59%			
6	NS	Muscle Twitching / Fasciculations	13	68%	NS	Ache (dull continuous pain)	31	55%			
7	DS	Digestive Symptoms (nausea, vomiting, diarrhea, etc.)	13	68%	NS	Low-level internal buzzing / electric-like sensations	30	54%			
8	NS	Low-level internal buzzing / electric-like sensations	12	63%	ES	Insomnia	30	54%			
9	NS	Muscle Spasms/ Cramps	12	63%	SS	Pain in Joints	28	50%			
10	IS	Skin Changes (hyperpigmented, mottled, or blotchy)	12	63%	NS	Dry Eyes	27	48%			
11	ES	Fatigue	12	63%	NS	Numbness	26	46%			
12	NS	Ache (dull continuous pain)	11	58%	NS	Headache (atypical/new onset)	26	46%			
13	NS	Vision Changes / Blurry Vision	11	58%	SS	Deep Bone Pain	26	46%			
14	NS	Lightheadedness/ Dizziness	10	53%	NS	Head Pain (stabbing/ sharp/ localized head pain)	25	45%			
15	NS	Balance Issues	10	53%	NS	Lightheadedness/ Dizziness	25	45%			
16	SS	Pain in Ribs	10	53%	IS	Wrinkled skin (accelerated aging of skin)	25	45%			
17	IS	Skin Rash	10	53%	DS	Digestive Symptoms (nausea, vomiting, diarrhea, etc.)	25	45%			
18	ES	Insomnia	10	53%	NS	Vision Changes / Blurry Vision	25	45%			
19	NS	Numbness	9	47%	NS	Tinnitus (ringing in ears)	25	45%			
20	NS	Headache (atypical/new onset)	9	47%	CS	Tachycardia (fast heart rate)	24	43%			
21	ES	Hair Loss	9	47%	NS	Muscle Spasms/ Cramps	22	39%			
22	NS	Difficulty Walking	8	42%	US	Pain in Kidneys or Bladder	20	36%			
23	IS	Wrinkled skin (accelerated aging of skin)	8	42%	NS	Balance Issues	19	34%			
24	IS	Itchy Skin	8	42%	NS	Difficulty Walking	19	34%			
25	NS	Tinnitus (ringing in ears)	8	42%	IS	Skin Changes (hyperpigmented, mottled, or blotchy)	19	34%			
26	IS	Tight Skin	8	42%	DS	Abdominal Pain	18	32%			
27	NS	Head Pain (stabbing/ sharp/ localized head pain)	7	37%	ES	Hair Loss	18	32%			
28	SS	Joint instability (clicking, popping, unstable joints)	7	37%	NS	Considered suicide/ suicidal ideation	17	30%			
29	IS	Skin Lesions (such as ulcers, papules, macules, or nodules)	7	37%	SS	Joint instability (clicking, popping, unstable joints)	17	30%			
30	DS	Abdominal Pain	7	37%	IS	Itchy Skin	17	30%			
31	NS	Speech Difficulty/ Voice Changes	7	37%	CS	Chest Pain	17	30%			
32	NS	Dry Eyes	7	37%	RS	Shortness of Breath	17	30%			
33	NS	Floaters (eyes)	7	37%	ES	Low Body Temperature	17	30%			
34	NS	Considered suicide/ suicidal ideation	6	32%	ES	Unexplained Weight Loss	17	30%			
35	CS	Arrhythmias (irregular heartbeat)	6	32%	SS	Pain in Ribs	16	29%			
36	CS	Chest Pain	6	32%	CS	Arrhythmias (irregular heartbeat)	16	29%			
37	NS	Metal Taste in Mouth	6	32%	NS	Floaters (eyes)	16	29%			
38	NS	Dysphagia (swallowing problems)	5	26%	IS	Skin Rash	15	27%			
39	CS	Tachycardia (fast heart rate)	4	21%	NS	Eye Redness	14	25%			
40	CS	Other Palpitations	4	21%	ES	Loss of Appetite/ Anorexia	14	25%			
41	RS	Shortness of Breath	4	21%	CS	Other Palpitations	13	23%			
42	US	Pain in Kidneys or Bladder	4	21%	IS	Tight Skin	12	21%			
43	NS	Eye Redness	4	21%	NS	Speech Difficulty/ Voice Changes	12	21%			
44	ES	Loss of Appetite/ Anorexia	4	21%	RS	Flu-like Symptoms	12	21%			
45	RS	Flu-like Symptoms	4	21%	DS	Food intolerances (new)	12	21%			
46	ES	Unexplained Weight Loss	4	21%	DS	Pain in Liver/Gallbladder Area	11	20%			
47	NS	Migraine Auras	3	16%	NS	Metal Taste in Mouth	11	20%			
48	CS	Edema (swelling of extremities)	3	16%	IS	Skin Lesions (such as ulcers, papules, macules, or nodules)	10	18%			
49	DS	Pain in Liver/Gallbladder Area	3	16%	CS	Hypotension (low blood pressure) (new onset)	10	18%			
50	DS	Food intolerances (new)	3	16%	IS	Sagging Skin	9	16%			
51	IS	Stretchy Skin	2	11%	NS	Dysphagia (swallowing problems)	9	16%			
52	IS	Sagging Skin	2	11%	NS	Migraine Auras	8	14%			
53	CS	Hypertension (high blood pressure) (new onset)	2	11%	CS	Hypertension (high blood pressure) (new onset)	5	9%			
54	NS	Loss of Taste	2	11%	NS	Loss of Taste	5	9%			
55	ES	Unexplained Weight Gain	2	11%	ES	Unexplained Weight Gain	5	9%			
56	CS	Hypotension (low blood pressure) (new onset)	1	5%	NS	Seizures	4	7%			
57	CS	Labile Hypertension	1	5%	ES	Low-grade Fevers	4	7%			
58	ES	Low Body Temperature	1	5%	CS	Edema (swelling of extremities)	3	5%			
59	ES	Low-grade Fevers	1	5%	CS	Labile Hypertension	1	2%			
60	NS	Seizures	1	5%	IS	Stretchy Skin	0	0%			

* CS/Cardiovascular & Circulatory System; DS/Digestive System; ES/Endocrine System; IS/Integumentary System; **NS/Nervous System (bold)**; RS/Respiratory System; SS/Skeletal System; US/Urinary System

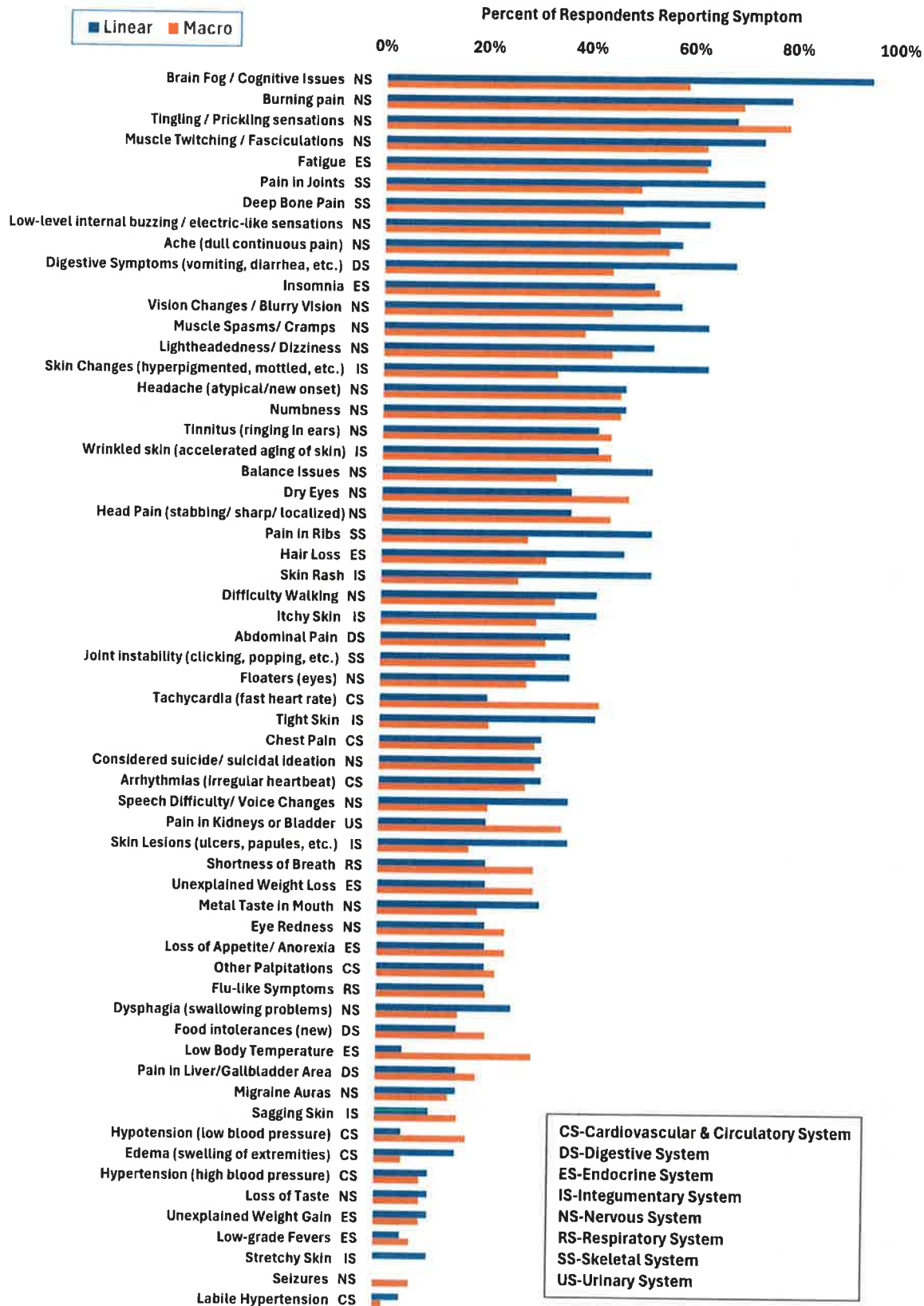
Unconfounded Cases with LINEAR Agent 19

Unconfounded Cases with MACROCYCLIC Agent 56

Figure 4 below provides a different perspective of the symptoms data presented in Table 17.

Figure 4.

SYMPTOMS / 75 UNCONFOUNDED Cases / WITH Results Group



Chronic Adverse Effects

The symptoms data presented in the previous tables appears to indicate that the nervous system may be the body system most affected by gadolinium, which could potentially result in a cascade of adverse effects.

Although the cause has not been confirmed, many survey respondents indicated that their initial symptoms became chronic or progressive, resulting in new diagnoses, functional disabilities or limitations, and reduced quality of life.

New Diagnoses / Autoimmune Diseases or Other Health Conditions

Patients were asked if they had been diagnosed with an autoimmune disease or other health condition that they believe relates to the signs or symptoms they identified elsewhere in the questionnaire.

71 (38%) of the patients in the WITH Group and 42 (32%) in the WITHOUT Group indicated they had received a new diagnosis since their last contrast MRI. The complete list of new diagnoses can be found in Appendix 2.

Patients in the WITH and WITHOUT Groups reported the following new diagnoses multiple times:

Fibromyalgia (13 cases)	Small Fiber Neuropathy (SFN) (6 cases)
Hashimoto's & Hypothyroidism (10 cases)	Cognitive deficits/Functional cognitive disorder/Dementia (5 cases)
Mast Cell Activation Syndrome (MCAS) (7 cases)	

While causality cannot yet be established, biological plausibility is present: gadolinium has been shown to excite pro-inflammatory cytokines (Maecker et al., 2020), activate mast cells (Liu et al., 2022; Garcia-Bara et al., 2022), disrupt mitochondrial function (Goetzl et al., 2022, and trigger oxidative stress and inflammatory pathways (Coimbra., 2024). These are all mechanisms implicated in autoimmune and inflammatory disease pathogenesis.

In addition, prior studies suggest plausible associations between GBCA exposure and the conditions listed above. Fibromyalgia-like symptoms have been reported after repeated GBCA exposure (Lattanzio & Imbesi, 2020; Lattanzio, 2019), and preclinical studies indicate that gadolinium deposition in tissues may affect small nerve fibers, potentially contributing to SFN (Krämer et al., 2023; Radbruch et al., 2020). Gadolinium has also been implicated in mast cell activation, suggesting a possible mechanistic link to MCAS-like symptoms in susceptible individuals (Ruiz de Azcárate, et al., 2023; Garcia-Bara et al., 2022; Liu et al., 2022). Experimental studies further indicate that GBCA exposure may disrupt thyroid hormone receptor function, which could be relevant for new-onset Hashimoto's disease or hypothyroidism (Ariyani et al., 2016; Kartamihardja et al., 2021). In the context of cognitive function, animal and imaging studies demonstrate gadolinium accumulation in the central nervous system, though clinical evidence for long-term cognitive deficits remains limited (Yao et al., 2024; Iyad et al., 2023; Khairinisa et al., 2021). Collectively, these findings underscore the need for further systematic investigation into potential immune, neuroimmune, and endocrine sequelae following GBCA exposure. These observations highlight that gadolinium-based contrast agents, administered intravenously, circulate throughout the body and can interact with multiple organ systems. This systemic exposure may be linked to multi-organ and immune-related effects, emphasizing the need for further research to better understand the spectrum and mechanisms of GBCA-related outcomes.

Functional Disabilities & Other Limitations

Patients were asked about post-contrast MRI events that caused them to become disabled or to suffer functional disabilities that adversely affected their quality of life. There was no time limit as to when these events occurred. Patients were instructed to select only those events that occurred since their last dose of a GBCA.

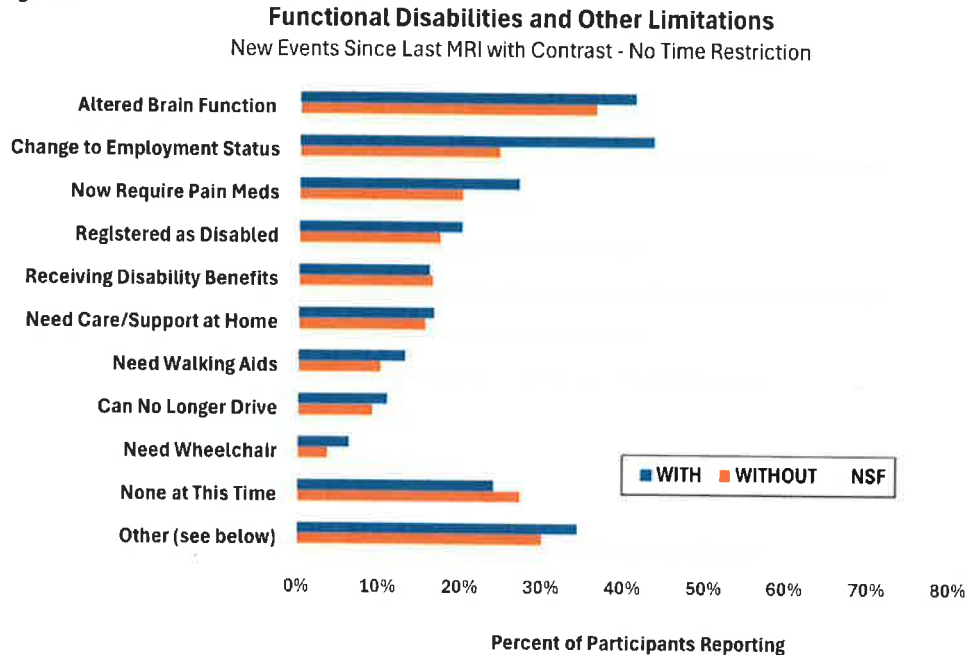
Altered Brain Function and Change to Employment Status affected more patients in our survey:

43% (76/175) in the WITH Group and 25% (27/110) in the WITHOUT Group indicated they had a change in their employment status due to their health issues, reduced working hours, and loss of income.

41% (72/175) in the WITH Group and 36% (40/110) in the WITHOUT Group said their altered brain function and memory affects their ability to work as they did prior to the MRIs with a GBCA.

The complete results are presented in Figure 5 below.

Figure 5.



Other Issues affecting Patients' Quality of Life

The other comments made by patients shed light on the scope of the life-altering effects of retained gadolinium. Some health issues were mentioned multiple times, particularly those involving muscles, bone pain, spine, fatigue, neurological issues, and pain in general. Some people reported losing their job or business. One person had to drop out of high school; another had to reduce their course load in college and needed text-to-speech reading aids. Several people mentioned being bedridden or homebound. The comments of these patients (and others) suggest that retained gadolinium can have long-term adverse effects.

Current Status of Symptoms & What Helped

Respondents were provided with a list and asked to select which answer choice best described the current status of their symptoms that they believe were caused by retained gadolinium.

As Table 17 shows, 32 patients in the WITH Group and 15 in the WITHOUT Group reported at least 75% improvement in their symptoms. However, 39 patients in the WITH Group and 32 in the WITHOUT Group said they had no improvement at all.

There were 88 patients in the WITH and WITHOUT Groups who reported that some of their symptoms have improved but others have gotten worse. The list of symptoms patients said have worsened or continued can be found in Appendix 3.

On a positive note, 1 person in the NSF Group reported a 75% improvement in their symptoms, which was unexpected.

Table 17. Current Status of Symptoms

Answer Choices	WITH		WITHOUT		NSF	
I have had no improvement in my symptoms.	39	23%	32	29%	2	29%
I have had 25% or mild improvement in my symptoms.	20	12%	15	14%	0	0%
I have had 50% or modest improvement in my symptoms.	23	13%	17	16%	0	0%
I have had 75% or good to very good improvement.	26	15%	10	9%	1	14%
I am now completely or nearly completely symptom free.	6	4%	5	5%	0	0%
I am now totally disabled	-	-	-	-	2	29%
Some symptoms improved but others have gotten worse.	58	34%	30	28%	2	29%
Total Answered	172		109		7	

Table 18. What Contributed to Symptom Improvement

Answer Choices / Select all that apply	WITH		WITHOUT		NSF	
My symptoms have not improved.	39	23%	32	29%	4	57%
Time (natural progression of improvement)	80	47%	52	48%	1	14%
IV chelation therapy with DTPA	35	20%	2	2%	0	0%
IV chelation therapy with EDTA	10	6%	0	0%	0	0%
Oral EDTA	4	2%	3	3%	0	0%
Sauna therapy	37	22%	12	11%	0	0%
Dietary changes	55	32%	33	30%	1	14%
Physical exercise	50	29%	23	21%	2	29%
Alternative therapies (e.g., acupuncture, homeopathy)	45	26%	27	25%	0	0%
Other treatments, medications, or supplements	78	45%	43	39%	4	57%
Total Answered	172		109		7	

Patients with Significant Improvement

In response to anticipated questions, we are providing details of the GBCA history of the patients with 75% to 100% improvement. The type and frequency of GBCA exposure does not appear to explain improvement of their symptoms.

100% Improvement WITH Group:

5 had 1 MRI - 2 with Gadovist; 1 MultiHance; 1 Omniscan; 1 with unknown agent.

1 had 5 MRIs with Gadovist

100% Improvement WITHOUT Group:

4 had 1 MRI – 1 with Clariscan; 1 MultiHance; 2 with unknown agent.

1 had between 6 & 10 MRIs with unknown agents.

75% Improvement WITH Group:

13 had 1 MRI – 4 with Dotarem; 1 Eovist; 2 Gadovist; 3 Magnevist; 2 MultiHance; 1 OptiMark.

6 had 2 MRIs – 1 Dotarem confounded case; 2 Gadovist unconfounded; 1 Gadovist confounded; 2 ProHance confounded.

1 had 5 MRIs & last was with Dotarem.

2 had between 6 & 10 MRIs – last with Magnevist (1); unknown agent (1).

1 had 9 MRIs – last with Magnevist.

1 had between 11 & 15 MRIs – last with Gadovist.

2 Do not know how many MRIs they had, but last agent received was Dotarem (1) & Clariscan (1).

75% Improvement WITHOUT Group:

2 had 1 MRI with Dotarem.

2 had 2 MRs – 1 with MultiHance; 1 with unknown agent(s).

2 had 4 MRIs with unknown agent(s).

2 had 5 MRIs with unknown agent(s).

1 had between 6 & 10 MRIs with unknown agent(s).

1 had more than 20 MRIs & last agent received was Gadovist.

75% Improvement NSF Group: 1 person had 6 MRIs with Omniscan within 3 weeks.

Treatment Information

Details of various other treatments, supplements, or detoxification methods mentioned by survey respondents are not being provided in this report. However, we provide the following treatment information for those with 75% to 100% improvement.

Based on the percentage of responses in Table 18, which includes the results below, it appears that time, dietary changes and physical exercise may provide some level of relief for some patients who have been affected by gadolinium.

Treatments & number of responses for the 11 patients in the 100% Improvement WITH & WITHOUT Groups:

Time (natural progression of improvement) (9)	Sauna therapy (0)
IV chelation with DTPA (1)	Dietary changes (4)
IV chelation with EDTA (1)	Physical exercise (2)
Oral EDTA (0)	Alternative therapies (e.g., acupuncture, homeopathy) (1)

Treatments & number of responses for the 36 patients in the 75% Improvement WITH & WITHOUT Groups

Time (natural progression of improvement) (24)	Sauna therapy (10)
IV chelation with DTPA (5)	Dietary changes (20)
IV chelation with EDTA (1)	Physical exercise (13)
Oral EDTA (2)	Alternative therapies (e.g., acupuncture, homeopathy) (10)

75% Improvement NSF Group:

The NSF patient attributed their improvement to “extreme self-therapy, exercise, swimming, walking, and lifting very light weights.” Although having 75% improvement, that individual still has issues with range of motion, flexibility, stiff joints, weak joints on fingers, restricted flexibility in their wrist, and their ligaments and tendons have never recovered.

Troubling Survey Responses

Told symptoms psychosomatic – Many patients shared that their doctors dismissed their concerns that the symptoms they were experiencing were caused by the GBCA or gadolinium. Patients’ concerns were not only dismissed, but many doctors told the patient their symptoms were psychosomatic or caused by mental or emotional disturbances. This troublesome occurrence was reported by 60% of the WITH Group, 47% of the WITHOUT Group, and 38 % of the NSF group.

Clinicians should be better informed about the issue of Gd retention and made aware that *everyone* can retain some gadolinium from each contrast MRI, and it could cause symptoms in some people. The lack of recognition of their symptoms can have a negative impact on patients’ mental health.

Considered suicide – Another concerning statistic is that 45 patients (24%) in the WITH Group, and 17 patients (13%) in the WITHOUT Group indicated they had considered suicide. Those are troubling numbers that should not be ignored or accepted as just being another potential side effect of having an MRI with contrast. Study authors are aware of cases in which affected individuals have taken their own lives.

Respondents described a devastating loss of independence, function, career, and social connections, often compounded by limited clinical recognition of their symptoms. Such experiences can lead to isolation, hopelessness, and self-blame. Suicidal ideation in this context may arise from the combined effects of persistent, debilitating symptoms, possible neurotoxic mechanisms, and the psychological burden of medical dismissal. This issue merits further regulatory attention and greater clinical awareness to ensure that patients receive appropriate support and follow-up care.

DISCUSSION

When we began this project, our goal was not to prove how or why gadolinium exposure might cause the symptoms reported by patients, but to carefully document the results. As the data was reviewed, consistent and biologically plausible patterns became apparent, prompting consideration of how these findings relate to established clinical observations. We believe it is important to point out how the results of this Patient Survey relate to the clinical picture of NSF and how gadolinium’s toxic effects, particularly on calcium channels and the nervous system, may explain many of the symptoms experienced by both NSF patients and those with normal renal function.

It is widely recognized that retained gadolinium is the primary cause of NSF in renally impaired patients. The question now is whether retained gadolinium can cause harm to patients with normal renal function when it is retained in varying quantities, in different body systems, and for potentially long periods of time, regardless of the patient’s level of renal function.

Symptoms of NSF & Gd Toxicity

For this Patient Survey, we wanted to know how the clinical picture of NSF might compare to participants’ responses to our questions about Signs & Symptoms after gadolinium administration. Marckmann & Skov’s 2009 paper, “*Nephrogenic Systemic Fibrosis: Clinical Picture and Treatment*”, and Marckmann, 2011, provide important clinical details about NSF that may not be widely known, such as the observation that “*skin changes and neuropathic symptoms predominate the early phase of NSF*.”

Table 10 provides details about the clinical picture of NSF, and the symptoms data in Tables 12 and 13 indicates that neuropathic symptoms predominate the early phase of the symptoms reported by patients with normal renal function as well.

According to other details provided by Marckmann (2009 & 2011), there were significant individual differences in the clinical course of NSF, even in ESRD patients, which seems to indicate that retained gadolinium could trigger a range of symptoms, with a varied clinical outcome in all patient populations.

The variability of the symptoms was likely due to many factors, but it shows that even in severely renally impaired patients Gd-induced NSF did not cause the exact same set of symptoms or level of severity; in other words, it was a disease of degrees.

The hallmark signs of the late stages of NSF are skin changes and contractures, but Marckmann wrote there were “other GBCA-associated symptoms that have not received the same attention but still may be considered part of the NSF syndrome.” He added, “The other late manifestations of NSF can have a marked impact on the life quality of the patient.” The results in Figure 5 about functional disabilities and limitations indicate this is the case for patients with normal renal function as well.

We believe the variability in the severity of symptoms seen with NSF (Table 11) explains what is currently happening to patients with normal renal function. These patients are experiencing many of the same symptoms as those with NSF, but for the most part, few of them develop NSF-like skin changes, and those who do have difficulty obtaining skin biopsies.

Without *visible* evidence of a problem, patients with normal renal function are less likely to have their cases investigated for a connection to gadolinium, so there is no gadolinium-related diagnosis or reporting to the FDA. As a result, the full scope of the adverse health effects caused by retained gadolinium may remain unrecognized, at least until non-visible manifestations are formally acknowledged and patients gain access to appropriate diagnostic evaluation.

Gd, Calcium Channels & the Nervous System

Symptom results for both the NSF and normal renal function groups confirm that the nervous system is significantly affected by gadolinium with 14 to 16 of each group’s top 25 symptoms involving the nervous system (Tables 13 & 14). For the unconfounded cases, 14 of the same nervous system symptoms ranked in the top 25 for cases involving both linear and macrocyclic agents (Table 17).

Some symptoms could be caused by the gadolinium ion (Gd^{3+}) competing with calcium (Ca^{2+}) in all biological systems that require calcium for proper function (Sherry et al., 2009). Calcium ions control all cellular processes not only by generating electrical signals but also by functioning as signaling molecules (Kloc et al., 2025).

Besides competing with calcium, gadolinium could cause symptoms via its direct access to the sensory neurons in the dorsal root ganglion (DRG) (Godel et al., 2016). A 2014 study found that “gadolinium can directly activate a large population of human nociceptive DRG neurons” (Zhang et al., 2014). The DRG contains the greatest proportion of the body’s sensory neurons, cells that transmit information to the central nervous system (CNS) (Krames, 2014). We know that almost immediately after GBCA administration, it gains access to the patient’s cerebrospinal fluid (CSF) and CNS, including in patients with an intact blood-brain barrier (Nehra et al., 2018; Berger et al., 2018).

In 2017, McDonald et al., wrote that the discovery of neuronal tissue deposition of Gd, including *within* the nucleus of a neuronal cell, “raises the possibility of biologic activity of these deposits, possibly from modulation of calcium channel activity or direct interaction with cellular biomolecules.”

A 2024 review article provides data gathered from 93 studies on the toxicity mechanisms of gadolinium and GBCAs. Some of the identified toxicity mechanisms involve signaling pathways; upregulation of inflammation, oxidative stress and apoptosis; and promoting production of reactive oxygen species (ROS). Gadolinium was found to interfere with calcium homeostasis. The authors found that competition of Gd^{3+} with calcium, needed for cellular processes, was highlighted as a potential mechanism of cytotoxicity in several studies (Coimbra et al., 2024).

Evidence of Harm

Evidence suggesting potential mechanisms of harm extends beyond what is visible to the naked eye or seen under a microscope: body systems may *dysfunction* when gadolinium interferes with various processes, particularly those that require calcium for proper function. Gadolinium’s interference with calcium channels has been shown to affect mitochondrial function in the nervous system (Goetzl et al., 2022), which plays a critical role in the functioning of human body systems. Gadolinium has also been shown to excite pro-inflammatory cytokines (Maecker et al., 2020), representing another possible pathway to symptom development.

The discovery of gadolinium-rich nanoparticles was first reported in 2016 (Wagner et al., 2016; Wagner, 2017). Research since then has revealed the *in vivo* toxicity of insoluble gadolinium-rich nanoparticles evidenced by mitochondrial swelling, cristae disruption, renal proximal tubular epithelial lysis, and pathological endosomal structures (Henderson et al., 2025; Cunningham et al., 2024; Do et al., 2020; Do et al., 2019). Accumulation of gadolinium-rich nanoparticles *inside* cells could potentially cause chronic metallosis, even in patients with normal kidney function (DeAgüero et al., 2023).

The works cited in this paper are part of a growing body of research that identifies the toxic effects of gadolinium and GBCAs. Moreover, there is also confirmation of these effects in the 2007 FDA, Division of Medical Imaging and Hematology Products, “Memorandum to the File”, from Medical Reviewer, Melanie Blank, MD. The topic was: Gadolinium-Based Contrast Agents (GBCAs) and Nephrogenic Systemic Fibrosis (NSF), Date Completed: 5/15/07 (Appendix 4). Item ‘b’ in the Summary states the following: “*Unchelated gadolinium is a very toxic compound, particularly to the liver and to calcium channels.*”

The FDA’s recognition that gadolinium is toxic to calcium channels is important. However, the FDA should have recognized that its toxic effect on calcium channels is also how gadolinium can cause harm. We believe gadolinium’s documented adverse effects on the *function* of cells, particularly nerve cells that require calcium for proper function, provides evidence of how some and perhaps all patients can be harmed. It could well explain many of the ‘unexplained’ symptoms experienced by survey participants and other patients after their MRIs with a GBCA.

Retained Gd is Not Benign

Since the initial clinical experience with Gd-DTPA in 1984 (Carr et al.), extensive research has documented gadolinium retention in patients with normal renal function. Framing this retention as biologically inert is increasingly difficult to reconcile with mechanistic studies indicating that gadolinium-based contrast agents can disrupt mitochondrial and cellular processes. This dissonance between evidence and interpretation highlights the need for renewed scientific scrutiny. In light of emerging patient-reported and mechanistic findings, the data presented here invite a re-examination of prevailing assumptions about retained gadolinium.

We have the results of this Patient Survey with 316 patients with normal and near normal renal function reporting symptoms involving multiple body systems soon after their MRIs with a GBCA. Of these, 185 have one or more test results that confirm gadolinium retention for as long as 22 years after contrast administration, including in bone for more than 14 years from one dose of a linear GBCA and 4 years from one dose of a macrocyclic GBCA.

While many of the reported symptoms (e.g., fatigue, paresthesia) are nonspecific, the consistent clustering of neuropathic and calcium-related manifestations across the patient groups strengthens the plausibility of a shared mechanism, which in this case is gadolinium.

The survey results, combined with two-biopsy confirmed NSF diagnoses in patients with normal renal function, including one diagnosed in 2024 after exposure to macrocyclic agents, provide compelling evidence that challenges the assumption that retained gadolinium is clinically benign in patients with normal renal function. These findings warrant urgent investigation into the biological activity of retained gadolinium across all patient populations.

A Disease of Degrees

During the FDA’s 2017 MIDAC public meeting on gadolinium retention, Williams and Grimm (The Lighthouse Project) described gadolinium toxicity as a “disease of degrees,” with NSF representing its most severe manifestation. Highlighting this statement, the findings of this Patient Survey, together with existing clinical and mechanistic evidence, challenge the current binary view of gadolinium-induced disease as either “nephrogenic systemic fibrosis (NSF)” or “no effect.” Current medical guidance and regulatory frameworks largely recognize harm only in the context of NSF, often dismissing gadolinium retention in patients with normal renal function as clinically insignificant. The findings in this survey, however, point to a spectrum of toxicity in which severity and organ involvement can vary among individuals. Across all patient groups, the most frequently reported manifestations involved the nervous, musculoskeletal, and integumentary systems. This pattern mirrors the early neuropathic and inflammatory phases of NSF as described by Marckmann and Skov (2009) and by Mendoza and colleagues (2006).

Marckmann (2009) observed that some GBCA-exposed patients developed early-phase symptoms of NSF without progressing to the late fibrosing form, which he termed “abortive or subclinical NSF.” The symptom clusters identified in this survey extend that observation to patients without renal impairment. This suggests that the difference between “NSF” and “non-NSF” may be one of severity rather than kind, supporting the interpretation that gadolinium toxicity represents a spectrum of biological injury rather than an all-or-nothing phenomenon, where organ involvement and reversibility vary among individuals. While we cannot establish causation yet, the consistency and coherence of the reported symptom patterns represent an

emerging safety signal that warrants careful attention. Recognizing gadolinium-related disease as a possible spectrum of manifestations, rather than a rare, binary condition, may help the medical community strengthen patient safety, refine risk assessment, and prioritize further investigation into the mechanisms and true scope of gadolinium-associated effects.

One may ask: Is NSF itself the “disease of degrees”? Do all patients affected by gadolinium manifest NSF to varying extents, but without the “N” or nephrogenic component? The many similarities between the early clinical picture of NSF and the symptoms reported by participants in this Patient Survey suggest that they do.

ONE Disease with Varying Severity

Gadolinium Deposition Disease (GDD) is a term introduced by Semelka and colleagues (2016, refined in 2023) to describe a range of symptoms reported by patients with normal renal function following exposure to gadolinium-based contrast agents (GBCAs). These individuals often experience symptoms (as listed below) that resemble, and are generally less severe than, those observed in NSF. The concept of GDD was introduced to describe cases of gadolinium toxicity occurring in patients without significant kidney disease, thereby expanding the diagnostic framework beyond its traditional association with NSF.

However, our findings suggest that GDD and NSF may not represent separate disease entities. Instead, they are likely to reflect different points along a continuum of gadolinium-induced toxicity. In other words, what we are observing may be ONE gadolinium-induced disease process manifesting with varying degrees of severity, as Marckmann originally described NSF in his Severity Grading (See Table 11, NSF Severity Grading).

The severity of Gd-induced symptoms may depend on multiple factors, including the amount of gadolinium retained (which may be cumulative; McDonald et al., 2015), tissue distribution, an individual’s underlying health issues, detoxification capacity, and the risk factors associated with NSF (Schlaudecker & Bernheisel, 2009), such as renal impairment or acute kidney injury following GBCA exposure.

The symptoms associated with GDD are listed below and closely mirror those of NSF. An asterisk is next to symptoms ranked in the top 28 of this survey’s NSF Group (Table 14). Although head pain and hearing problems did not rank in the top 28 of the NSF group, both appeared in the top 20 of the WITH and WITHOUT Groups (Table 13).

“Subcutaneous tissue loss” was the only GDD symptom not listed in our survey, but involvement of subcutaneous tissue is reported in NSF literature (Zou et al., 2011; Shabana et al., 2012), indicating that it is not unique to GDD.

Some terminological differences exist between the GDD literature and our dataset, though they describe equivalent clinical features (for example, Imbalance = Balance Issues; Pins and Needles sensation = Tingling/Prickling sensations; Hearing problems = Tinnitus) (See Tables 12 and 13).

For reference, we include the symptoms of GDD as listed in, *Gadolinium Deposition Disease – Current State of Knowledge and Expert Opinion (2023)*. (Symptoms with an asterisk are ranked in the top 28 of this survey’s NSF Group).

Gadolinium Deposition Disease (GDD) Symptoms:

*Fatigue	*Bone pain (rib pain classical)
*Imbalance	*Joint pain (commonly large joints like knee & hip)
*Pins and needles sensation (often hands)	*Muscle fasciculation
*Cognitive impairment, including brain fog & memory loss	*Vision problems including blurred vision & dry eyes
*Skin crawling	*Burning sensation skin and/or deep tissue
*Skin morphology changes, including progressive thickening and discoloration	Hearing problems
Subcutaneous tissue loss (classic face and hands)	*Gastrointestinal issues (vomiting, diarrhea, hypotonia)
Head pain	*Cardiac arrhythmias

Overall, the overlap in symptom profiles points to a single gadolinium-induced disease process expressed with varying intensity. Depending on exposure, tissue burden, and individual susceptibility, this process may manifest as subtle neurological or musculoskeletal symptoms or progress to the systemic fibrosis seen in NSF. Viewing these conditions as a continuum unifies disparate observations and provides a clearer basis for understanding and managing gadolinium-related disease

Undiagnosed NSF

Identifying patients with NSF remains challenging, as we were only able to find 8 cases for the NSF Group, and 7 are from the United States. Reports from European participants and clinicians indicated that there are currently no recognized physicians or

hospitals specializing in the diagnosis or management of 'NSF' in many European countries. However, that problem is not unique to Europe and has also been reported in the U.S. and elsewhere.

Patients frequently report difficulty obtaining an accurate diagnosis, as well as follow-up care. Such diagnostic gaps are concerning, as they likely contribute to missed or delayed recognition of NSF, which may obscure the true frequency of Gd-related adverse outcomes following GBCA administration.

The absence of standardized diagnostic criteria for NSF and the recognition that a similar disease process may occur in patients with normal renal function likely contributes to persistent underdiagnosis worldwide. These observations highlight the important need for increased clinician awareness and the development of clear diagnostic and management frameworks.

Gd-induced Systemic Fibrosis

In 2009, Marckmann wrote, "It may be time to consider renaming NSF to what it really seems to be, which is Gd-induced systemic fibrosis." Likewise, Wagner (2016) and Kay (2008) argued that the term "nephrogenic systemic fibrosis" should be changed to reflect that gadolinium can induce systemic fibrosis even in the absence of severe renal impairment. While our survey cannot determine whether retained gadolinium causes fibrosis in all patients, the accumulating evidence suggests that the current terminology may not adequately reflect the broader range of gadolinium-associated findings now being reported. Whatever the nomenclature, it should allow for inclusion of patients with normal renal function and recognize that symptom severity may vary, as was also observed among patients with NSF.

Before the FDA's 2015 communication recognizing gadolinium retention in patients with normal renal function, susceptibility to gadolinium-related injury was believed to be limited to those with renal impairment. However, based on what we know now, perhaps the risk exists with varying degrees of severity for all patients exposed to GBCAs.

Long-Term Patient-Centered Outcomes: A Critical Gap in GBCA Research

A significant concern in the evaluation of GBCA safety is the historical inadequacy of research in assessing long-term, patient-centered outcomes. The initial clinical trials supporting the approval of first-generation GBCAs in the 1980's and early 1990's, such as gadopentetate dimeglumine (Magnevist®), primarily focused on acute safety and short-term events.

This narrow evidentiary pattern continues into recent decades, as shown in a 2024 paper on gadobutrol (Gadovist®) reviewing 45 clinical studies in the last 25 years (Endrikat et al., 2024). It also focuses on the short-term, immediate effects of the contrast agent, acknowledging that long-term data on tissue Gd presence and clinical effects are still absent, with no availability of prospective and controlled long-term data. Despite this data gap, the authors of that paper arrived at the same conclusion frequently drawn in the GBCA literature, stating that no causal relationship has been confirmed between GBCA exposure and the chronic symptom clusters reported by patients with normal renal function.

To date, there are no randomized clinical trials that have robustly excluded long-term clinical effects of gadolinium retention. Given the objective evidence of tissue retention (e.g., bone and brain) in humans and animals (Darrah et al., 2009; Murata et al., 2016; Kobayashi et al., 2021), translational animal and neuropathic findings (Radbruch et al., 2020; Krämer et al., 2023), and consistent patient-reported multisystem symptom clusters (Burke et al., 2016; current survey), the accumulating body of evidence constitutes a notable safety signal that justifies prospective, controlled clinical research.

The findings from this Patient Survey provide novel data on the potential long-term adverse effects of gadolinium retention in all patient populations, underscoring the need for systematic investigation by unbiased, independent researchers. Adverse events related to GBCAs go undetected due to the underreporting to the FDA and other regulatory bodies.

It is important that clinicians and patients report serious adverse events after MRIs with a GBCA to the FDA or appropriate governing authority. In the U.S., it can be done online via MedWatch: www.accessdata.fda.gov/scripts/medwatch/
In Europe (EMA EudraVigilance): <https://www.adrreports.eu/en/>

Retrospective Research

We can assist with finding study subjects for retrospective research studies to determine how Gd may be affecting patients with normal renal function, including those who received only one GBCA and have confirmation of long-term Gd retention.

CONCLUSION

The assertion that gadolinium-based contrast agents (GBCAs) have a long history of safety conflates prolonged use with evidence of patient-centered safety. The historical record demonstrates delayed recognition of severe harm, such as nephrogenic systemic fibrosis (NSF), official acknowledgment of long-term tissue retention of gadolinium including in patients with normal renal function, regulatory restrictions and warnings, and widespread under-documentation of imaging correlates.

Mechanistic data support biologic plausibility for chronic neurologic and systemic effects from retained gadolinium, yet robust data on mortality, disability, quality of life, and work capacity remain scarce. In this context, the precautionary principle and transparent consent are warranted.

From the results of this Patient Survey, we believe the following conclusions can be reached:

- The symptoms reported by those with normal renal function closely match the early phase symptoms of NSF as well as the responses of the NSF Group in this survey. While many may be milder in intensity than full-blown NSF, this pattern consistency supports the hypothesis of a gadolinium-related symptom spectrum that extends to those with normal renal function and warrants prospective investigation.
- Patients with normal renal function report symptoms ranging from mild to life-altering. Absence of systematic symptom documentation in peer-reviewed literature has contributed to clinical underrecognition and diagnostic uncertainty, which patient advocates identify as compounding patient distress and delaying appropriate evaluation.
- Evidence of harm can be found in how body systems *dysfunction* due to gadolinium's interference with various processes, particularly those that require calcium for proper function. The number of survey responses linked to the nervous system is consistent with gadolinium's documented toxic effects on calcium channels.
- Because gadolinium is released slowly from bone over an undetermined duration, individuals who are initially asymptomatic could potentially develop symptoms associated with gadolinium retention later.
- In Unconfounded Cases, in which gadolinium retention and GBCA exposure to either a linear or a macrocyclic GBCA (Table 16) were confirmed, the consistent symptoms observed across both groups indicate that the associations are not confined to a single GBCA class.
- The Patient Survey results warrant a comprehensive investigation into the long-term adverse health effects of gadolinium retained in connective tissues and glandular tissues in all patient populations.
- The symptoms data from this Patient Survey combined with the FDA's 2007 Memorandum that stated, "*unchelated gadolinium is a very toxic compound, particularly to the liver and to calcium channels,*" warrant acknowledgement that retained gadolinium can cause harm to patients with normal renal function, just as it did to some renally impaired patients diagnosed with NSF.

We do not know why some patients with normal renal function who received a GBCA report persistent symptoms after their MRIs while others do not. However, a similar situation occurred with NSF, when not all patients with end-stage renal disease who were administered a linear GBCA developed NSF-like symptoms. While the explanation remains unknown, the finding nevertheless occurred, and it was recognized by the FDA and other governing authorities worldwide.

We believe a similar recognition for patients with normal renal function is long overdue.

In summary, the symptom profile reported by gadolinium-exposed patients without renal impairment closely parallels that described in early-phase NSF. This pattern is reproduced among survey participants with clearly defined single-agent exposures and laboratory evidence of gadolinium retention. Collectively, these findings support recognition of a consistent NSF-like symptom signature associated with gadolinium exposure in all patient populations and warrant further investigation.

Note: Patient Survey results pertaining to objective medical signs of abnormalities after contrast administration will be released in a separate paper: *Report 2: Signs of Systemic Abnormalities*.

Other Reports by The Lighthouse Project

On page 38, Section 2.4.4.6, of the Briefing Document for the September 8, 2017, Medical Imaging Drugs Advisory Committee Meeting about gadolinium retention in patients with normal renal function, reports produced by The Lighthouse Project about symptoms and gadolinium urine levels were referenced (Williams & Grimm, 2014; Grimm & Williams, 2017). The FDA noted that the data collection was conducted by a support group of patients with self-reported gadolinium toxicity. It

concluded by saying, “Those reports have been generated by the Lighthouse Project and should be acknowledged even though they have not been published in peer-reviewed journals” (See Appendix 5). In collaboration with authors Sarah Ratnam and Catriona Walsh, the report of this Patient Survey was produced with the same high standards applied to those earlier reports; the important data contained herein should also be acknowledged and given appropriate attention.

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Appendix 1 – Gadolinium-Based Contrast Agent Trademark Information

Gadolinium-based Contrast Agent Product Information as of August 2025			
Brand Name & Manufacturer	Other Names	Molecular Structure	FDA Approval
Ablavar®/Vasovist® Lantheus Medical Imaging, Inc.	Gd-DTPA (gadofosveset trisodium)	Linear, ionic	2008 - Withdrawn from market 2017
Clariscan™ GE Healthcare Inc.	Gd-DOTA (gadoterate meglumine)	Macrocyclic, ionic	2019
Dotarem® Guerbet LLC	Gd-DOTA (gadoterate meglumine)	Macrocyclic, ionic	2013
Elucirem™ Guerbet LLC	(gadopiclenol)	Macrocyclic, non-ionic	2022
Eovist®/Primovist® Bayer HealthCare Pharmaceuticals	Gd-EOB-DTPA (gadoxetate disodium)	Linear, ionic	2008
Gadovist®/Gadavist® Bayer HealthCare Pharmaceuticals	Gd-BT-DO3A (gadobutrol)	Macrocyclic, non-ionic	2011
Gadobutrol Injection Fresenius Kabi USA, LLC.	(gadobutrol)	Macrocyclic, non-ionic	2023/Generic
Gadoterate Meglumine Injection Fresenius Kabi USA, LLC	(gadoterate meglumine)	Macrocyclic, ionic	2022/Generic
Magnevist® Bayer HealthCare Pharmaceuticals	Gd-DTPA (gadopentetate dimeglumine)	Linear, ionic	1988 - Withdrawn from market 2019
MultiHance® Bracco Diagnostics Inc.	Gd-BOPTA (gadobenate dimeglumine)	Linear, ionic	2004
Omniscan™ GE Healthcare Inc.	Gd-DTPA-BMA (gadodiamide)	Linear, non-ionic	1993
OptiMark™ Guerbet LLC	Gd-DTPA-BMEA (gadoversetamide)	Linear, non-ionic	1999 - Discontinued by mfr. in 2018
ProHance® Bracco Diagnostics Inc.	Gd-HP-DO3A (gadoteridol)	Macrocyclic, non-ionic	1992
Vueway® Bracco Diagnostics Inc.	(gadopiclenol)	Macrocyclic, non-ionic	2022

Appendix 2 – New Diagnoses / Autoimmune Diseases or Other Health Conditions

Patients were asked if they had been diagnosed with an autoimmune disease or other health condition that they believe relates to the signs or symptoms they identified elsewhere in the Patient Survey questionnaire. Unless noted otherwise, there was one case reported for each of the diagnoses or diseases listed.

NEW DIAGNOSES / AUTOIMMUNE DISEASES OR OTHER HEALTH CONDITIONS		
WITH Results Group	WITH Results Group	WITHOUT Results Group
Multiple Sclerosis (after MRIs – 2 cases)	Small Fiber Neuropathy (SFN) (6 cases)	Myasthenia Gravis
Dementia	Neuropathy (3 cases)	Stroke
Cognitive deficits (3 cases)	Vascular neuropathy	Functional Cognitive Disorder
Encephalomalacia	Motor neuron disease (MND)	Functional Neurological Disorder
Brain lesions	Somatic dysfunction	High cerebrospinal fluid pressure
Systemic Lupus Erythematosus (4)	Autonomic dysfunction	Systemic Lupus Erythematosus (SLE)
Antiphospholipid syndrome (APS)	Thrombotic vasculitis	Raynaud's disease (3 cases)
Anxiety & depression	Behcet's vasculitis	Anxiety
Diabetes	Myopathy	Diabetes (2 cases)
Iron deficiency anemia	Myelopathy	Autoimmune hemolytic anemia (AIHA)
Celiac disease	Benign fasciculation syndrome	Celiac disease
Crohn's disease	Chemical-induced Asthma	Scleroderma
Gut dysbiosis	Multiple Chemical Sensitivity (2 cases)	Nephrotic syndrome
Bowel blockage	Allodynia	New onset chronic kidney disease
Hashimoto's thyroiditis (4 cases)	Hearing loss	Vasovagal syncope
Hypothyroidism (3 cases)	TMJ	Hashimoto's thyroiditis (3 cases)
Addison's disease	Eosinophilic esophagitis (EoE)	Optic migraines
Sjogren's syndrome (4 cases)	Orofacial granulomatosis	Sjogren's syndrome (2 cases)
Immune deficiency disorder	Wegener's granulomatosis	Fibromyalgia (6 cases)
Fibromyalgia (7 cases)	Idiopathic pruritus	Mast Cell Activation Syndrome (2 cases)
Mast Cell Activation Syndrome (5 cases)	Psoriatic arthritis	Thoracic Outlet Syndrome (TOS)
Chronic fatigue syndrome (CFS)	Rheumatoid arthritis (RA)	Chronic fatigue syndrome (CFS)
Adrenal fatigue (2 cases)	Thoracic calcification	Vitiligo
NAFLD - Fatty liver (3 cases)	Cervical, thoracic & lumbar spine disease (onset after 1 MRI with GBCA)	Chronic Inflammatory Demyelinating Polyneuropathy (CIPD)
Autoimmune liver disease / fibrosis and atrophy of liver	Gadolinium Deposition Disease (2 cases)	Postural orthostatic tachycardia syndrome (POTS) (2 cases)
Postural orthostatic tachycardia syndrome (POTS)	MGUS - Monoclonal Gammopathy of Unknown Significance (2 cases)	Ankylosing spondylitis
Autoimmune Autonomic Ganglionopathy		Morphea
Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) (4 cases)		Sarcoidosis
Autoimmune Lymphoproliferative Syndrome Type 1 (ALP3)		Connective tissue disease
		Idiopathic autoimmune disease
		Immunoglobulin deficiency
		Psoriatic arthritis
		NSF GROUP - NEW DIAGNOSIS
		Diabetes
		Sjorgen's syndrome
		Unspecified autoimmune disease

Appendix 3 – Symptoms That Have Worsened or Continued

Unless noted otherwise, there was one case reported for each symptom listed.

SYMPTOMS THAT HAVE WORSENERD OR CONTINUED	
WITH Results Group	WITHOUT Results Group
Widespread generalize pain (5 cases)	Pain in injected arm (right arm)
Joint pain (7 cases)	Joint pain (3 cases)
Rib pain (2 cases)	Bone pain
Bone pain (4 cases)	Back pain (2 cases)
Back pain (3 cases)	Legs & knees cannot bend
Painful hands	Neuropathy (2 cases)
Severe osteoporosis	Stabbing pain
Neuromuscular pain	Muscle wasting
Neuropathy (9 cases)	Muscle weakness
Neurological symptoms	Continued weakening of facial muscles
Balance issues	Dystonia
Vertigo/dizziness (2 cases)	Dizziness
Nonstop itching & burning all over body	Arthritis worse
Fasciculations/muscle twitching (5 cases)	Connective tissue disease worse
Tremors	Autoimmune issues
Muscle cramps (2 cases)	Nephrotic syndrome
Muscle pain	Pain in bladder
Stiff muscles	Reduced kidney function
Muscle wasting	Sjogren's-like symptoms
Muscle weakness	Fatigue
Loss of movement	Tinnitus
Recurring sprains & tendon/ligament issues	Ongoing vascular issues
Can't wear closed shoes due to numbness & pain	Memory loss 48hrs after MRI has worsened to the point of needing constant daily care.
Memory issues (3 cases)	Cognitive issues (4 cases)
Brain function (3 cases)	Difficulty with speech
Vision/Eye issues (5 cases)	Confusion
Visual disturbances	Depression
Fatigue (5 cases)	Vision/Eye issues
Tinnitus (5 cases)	Mast Cell Activation Syndrome
Skin lipomas/larger & spread to more areas	Restlessness
Skin thickening	Hair loss
Changes to skin (4 cases)	Extensive vitiligo
Thickened tissue	Heart palpitations
Scalp lesion (not psoriasis)	GI issues (3 cases)
Hair loss/thinning	Numerous skin changes
Shortness of breath/lung issues (4 cases)	Receding gums
Difficulty swallowing	Difficulty sleeping due to pain
GI issues	Food sensitivity
Labile hypertension	
Palpitations (2 cases)	NSF GROUP – WORSE or CONTINUED
Irregular heartbeat	AFib is moderate & treated with meds
Can't regulate body temperature	Lungs abnormal findings on scan
Allergic reactions more frequent & severe	Lymphedema is worse
Sensory sensitivity	Organ fibrosis is worse
Food & Heat sensitivity	Contractures are better
Now depend on others with daily living	Skin better in terms of thickening appearance

Appendix 4 – May 15, 2007, FDA Memorandum to the File about GBCAs & NSF

Blue box was added by authors to highlight relevant text in the document.

DIVISION OF MEDICAL IMAGING AND HEMATOLOGY PRODUCTS

MEMORANDUM TO THE FILE

i. NDA: 20-123, 22-066	Product: Omniscan
ii. NDA: 19-596, 21-037	Product: Magnevist
iii. NDA: 20-976, 20-937, 20-975	Product: OptiMARK
iv. NDA: 21-357, 21-358	Product: MultiHance
v. NDA: 20-131, 21-489	Product: ProHance

Topic: Gadolinium-Based Contrast Agents (GBCAs) and Nephrogenic Systemic Fibrosis (NSF) Date Completed: 5/15/07
Medical Reviewer: Melanie Blank, MD

I. OBJECTIVE

The purpose of this memorandum is to summarize the evidence for the causative role of gadolinium-based contrast agents in the development of NSF and to describe the risk modification steps culminating with the proposal to request revised class labeling from the drug manufacturers that includes a warning.

II. SUMMARY

- a. GBCAs are gadolinium chelates (large organic molecules with a total of 8 bonds, 7 to Gd+++ (gadolinium) and 1 to H₂O). This structure makes the Gadolinium paramagnetic so that it can move with higher relaxivity in a strong magnetic field and therefore appear differently on an MRI (Magnetic Resonance Imaging) or MRA (Magnetic Resonance Angiography) scan than the surrounding tissue.
- b. Unchelated gadolinium is a very toxic compound, particularly to the liver and to calcium channels
- c. 5 gadolinium contrast agents are FDA approved for MRI. No GBCAs are FDA approved for MRA
- d. GBCAs are administered IV and are indicated for CNS and body/liver MRI
 - i. Omniscan: CNS and total body
 - ii. Magnevist: CNS and total body
 - iii. OptiMARK: CNS and liver
 - iv. MultiHance: CNS
 - v. ProHance: CNS and head/neck
- e. GBCAs are renally excreted and therefore severe renal insufficiency prolongs exposure
- f. GBCAs are eliminated by hemodialysis but clearly not as efficiently as the normal kidney
- g. Peritoneal dialysis is not as efficient as hemodialysis in clearing GBCAs.

Appendix 5, page 1 of 3 – FDA 2017 Briefing Document, September 8, 2017



Medical Imaging Drugs Advisory Committee Meeting
Gadolinium Retention after Gadolinium Based Contrast Magnetic
Resonance Imaging in Patients with Normal Renal Function

Briefing Document
September 8, 2017

The attached package contains background information prepared by the Food and Drug Administration (FDA) for the panel members of the advisory committee. The FDA background package often contains assessments and/or conclusions and recommendations written by individual FDA reviewers. Such conclusions and recommendations do not necessarily represent the final position of the individual reviewers, nor do they necessarily represent the final position of the Review Division or Office. We have brought this safety issue to the advisory committee in order to gain the committee's insights and opinions, and the background package may not include all issues relevant to the final regulatory recommendation and instead is intended to focus on issues identified by the Agency for discussion by the advisory committee. The FDA will not issue a final determination on the issues at hand until input from the advisory committee process has been considered and all reviews have been finalized. The final determination may be affected by issues not discussed at the advisory committee meeting.

Appendix 5, page 2 of 3 – FDA 2017 Briefing Document (page 38)

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deep grey nuclei, but also hemispheric white matter and cerebellar cortex in adults and children, the majority of which had normal renal function, corroborating imaging study findings.^{6,107-112} Post-mortem gadolinium retention in brain tissue has been reported for linear GBCAs, but also in seven patients who have exclusively received macrocyclic GBCAs.¹⁰⁹ Higher post-mortem concentrations have been generally reported in the dentate nucleus and globus pallidus compared to other brain regions. At an ultrastructural level, gadolinium retention has been localized to capillary endothelium and neural tissue (interstitium and nuclei) in three studies.^{6,111,112} While three studies did not identify any gross histopathologic changes on light microscopy using hematoxylin-eosin stain,^{6,109,112,113} one small case series in pediatric patients revealed histopathological changes using neurofilament immunohistochemistry in two out of three patients with findings consisting of mild to severe gliosis of the dentate nucleus with prominent axonal spheroids.¹¹¹

One study found a positive correlation between gadolinium retention in neural tissue and T1-weighted signal intensity on MRI without contrast.⁶ None of the cases in those post-mortem studies had any pre-mortem adverse events reported, although no studies explicitly stated whether pre-mortem adverse events were sought beyond clinical information such as immediate cause of death, imaging indication or major diagnosis, and laboratory results. A summary of those post-mortem studies is presented in Appendix K. Gadolinium retention was also observed in primary brain tumor specimens after GBCA administration, especially with less stable linear non-ionic GBCAs (gadodiamide) compared to more stable linear ionic GBCAs (gadobenic acid), with an interval between the first administration and the specimen collection ranging from 0 to 2556 days.¹¹⁴

Systemic retention in a number of tissues including skin, bone, and liver has been reported in patients with normal renal function and the retention in bone reportedly occurred at much higher level than in the brain.^{109,113,115-119} Those publications did not describe symptoms attributable to retention in those tissues although they were not designed to collect such information. Extracranial sites have been suggested as surrogates for brain tissue given the limitations inherent to MRI-based gadolinium measurement in brain tissue.¹²⁰ Zinc exposure and siderosis have been suggested as possible risk factors for systemic gadolinium retention.^{118,121} In addition, brain irradiation and progressive forms of multiple sclerosis have been associated with T1-weighted hyperintense signal abnormality of the dentate nucleus, but the contribution of prior GBCA administration was not assessed in those studies as they predated the awareness of gadolinium retention.^{122,123}

2.4.4.6 Unpublished Reports

A few data collection reports including symptoms and body fluid gadolinium measurements have been conducted by a support group of patients with self-reported gadolinium toxicity. Those reports have been generated by the Lighthouse Project and should be acknowledged even though they have not been published in peer-reviewed journals.^{124,125}

2.5 Discussion

The primary purpose of this review was to identify adverse events in conjunction with gadolinium retention after exposure to GBCAs in patients with normal renal function reported to the FAERS database and in the medical literature. We considered cases that reported detectable

Appendix 5, page 3 of 3 – FDA 2017 Briefing Document (page 50)

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No. 24-7251

**IN THE
SUPREME COURT OF THE UNITED STATES**

Michael Deuschel—Petitioner

vs.

Bayer Healthcare Pharmaceutical Inc., et al.—Respondents

PROOF OF SERVICE

I, Michael Deuschel, do swear or declare that on this date, May 15, 2025, as required by Supreme Court Rule 29 I have served the enclosed PETITION FOR REHEARING on each party to the above proceeding or that party's counsel, and on every other person required to be served, by depositing an envelope containing the above documents in the United States mail properly addressed to each of them and with first-class postage prepaid, or by delivery to a third-party commercial carrier for delivery within 3 calendar days.

The names and addresses of those served are as follows:

See attached list of parties and counsel served.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on October 30, 2025



Adaptive Petitioner, Pro Se

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