nocebo effect could be in action, this is unlikely since dizziness was not presented as a potential side effect on initiation of the medication. In addition, methylcobalamin can cause hyperviscosity syndrome, but due to an absence of visual disturbances and altered mental status, it is also improbable. The relatively rapid onset with initiation and resolution upon discontinuation of this medication strongly suggests that it is not a coincidence, rather an origin for the dizziness. Those who are treated with CFLN-NAC should be queried as to new onset dizziness. For those already dizzy, one should consider other treatment options.

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## Menstrual Synchrony of Burning Mouth Syndrome

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**ABSTRACT:** Study Objective: Burning mouth syndrome (BMS) is characterized by oral mucosal burning sensations, with normal clinical and laboratory results. Menstrual synchrony of migraines and epilepsy have been discussed; however, menstrual synchrony of BMS has not heretofore been described.

**METHODS:** Case Study: A 29 year old right-handed female exhibited intermittent BMS symptoms, one month after suffering a left parietal infarction. She describes the pain as a burningsensation, localized to the bilateral and anterior aspects of her tongue. It lasts for four days, starts three days prior to her menses, and occurs twice a month. She is unable to correlate any patterns or triggers that may cause to exacerbate her BMS. She denies any taste disturbances, hot-flashes, night sweats, and perspiration.

**RESULTS:** Abnormalities during neurological examination were noted. Cranial nerves (CN) III, IV, and VI showed bilateral lateral first degree end-gaze unsustained nystagmus. CN IX and X showed decreased bilateral gag reflex. A right pronator drift with a right abductor digiti minimi sign was seen in the motor examination. The cerebellar examination was positive for bilateral dysmetria during the Finger-To-Nose examination, and exhibited Holmes rebound phenomena, right more than left. Sensory examination showed decreased light touch in the lower extremities, right more than left. Hoffman reflex was bilaterally positive. Mental status examinations demonstrated poor similarity interpretation and calculation ability. Her neuropsychiatric testing was normal, and included the Go-No-Go and Animal Fluency Testing. MRI of the brain exhibited gliosis/laminar necrosis in the left inferior parietal lobe, and an 8mm descent of cerebellar tonsils below the foramen magnum.

**CONCLUSION:** The potential mechanism for catamenial BMS is manyfold. Estrogen and progesterone both have nociceptive properties. Premenstrual drop or reduction of estrogen and progesterone may act to disinhibit pain [Vincent 2008], with pain modulation being more effective during the ovulatory phase (high estrogen and low progesterone) [Rezaii 2012]. Depression in the presence of Late Luteal Phase Dysphoric Disorder may function to exacerbate the perception of underlying pain throughout the body, including the mouth and tongue. Decrease in estrogen and progesterone levels may also alter salivary output and composition. This may allow baseline reduction of proprioceptive input on the tongue, thus acting through Melzack and Wall's Gate Control Theory of Pain to disinhibit small C fibers, which is perceived as burning pain [Melzack 1978]. Along with menses, olfactory ability drops, and food preferences are often reported to change [Keller 2013]. A decrease in estrogen and progesterone can also enhance trigeminal nerve sensitivity [Martin 2007], which exacerbates pain. This may indirectly influence or be associated with her BMS. Such observations justifies a trial of hormonal agents for therapy of BMS.

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## Gait Ignition Failure Syndrome Secondary to Spinal Stenosis

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**ABSTRACT:** Case Objective: Gait ignition failure syndrome, where immobility occurs only upon initiation of ambulation and normal gait ensues once entrained, has been reported with frontal lobe and midbrain locomotor region pathology. However, gait ignition failure

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