Eur. J. Oncol. - Library Vol. 5

NON-THERMAL EFFECTS AND MECHANISMS OF INTERACTION BETWEEN ELECTROMAGNETIC FIELDS AND LIVING MATTER

An ICEMS Monograph

RAMAZZINI INSTITUTE

Edited by
Livio Giuliani and Morando Soffritti

European Journal of Oncology

Eur. J. Oncol. - Library Vol. 5

National Institute for the Study and Control of Cancer and
Environmental Diseases "Bernardino Ramazzini"
Bologna, Italy
2010

RAMAZZINI INSTITUTE

SPONSORS

International Commission for Electromagnetic Safety

National Institute for the Study and Control of Cancer and Environmental Diseases "Bernardino Ramazzini"

isbn
978-88-6261-166-4

pubblicazione
FIDENZA 2010

CONTENTS

Section C. In vivo effects

Section D. Epidemiology

Provocation study using heart rate variability shows microwave radiation from 2.4 GHz cordless phone affects autonomic nervous system

Magda Havas*, Jeffrey Marrongelle**, Bernard Pollner***,
Elizabeth Kelley****, Camilla R.G. Rees*****, Lisa Tully******
* Environmental and Resource Studies, Trent University, Peterborough, Canada
** 1629 Long Run Road, PO Box 606, Schuylkill Haven, PA, USA
*** Haspingerstrasse 7/2, 6020 Innsbruck, Austria
**** International Commission for Electromagnetic Safety, Venice, Italy
***** 350 Bay Street, #100-214, San Francisco, California, 94133, USA
****** 27 Arrow Leaf Court, Boulder, Colorado 80304, USA

Abstract

Aim: **The effect of pulsed (100 Hz) microwave (MW) radiation on heart rate variability (HRV) was tested in a double blind study.** ***Materials and Methods:*** **Twenty-five subjects in Colorado between the ages of 37 to 79 completed an electrohypersensitivity (EHS) questionnaire. After recording their orthostatic HRV, we did continuous real-time monitoring of HRV in a provocation study, where supine subjects were exposed for 3-minute intervals to radiation generated by a cordless phone at 2.4 GHz or to sham exposure.** ***Results:*** **Questionnaire: Based on self-assessments, participants classified themselves as extremely electrically sensitive (24%), moderately (16%), slightly (16%), not sensitive (8%) or with no opinion (36%) about their sensitivity. The top 10 symptoms experienced by those claiming to be sensitive include memory problems, difficulty concentrating, eye problems, sleep disorder, feeling unwell, headache, dizziness, tinnitus, chronic fatigue, and heart palpitations. The five most common objects allegedly causing sensitivity were fluorescent lights, antennas, cell phones, Wi-Fi, and cordless phones. Provocation Experiment: Forty percent of the subjects experienced some changes in their HRV attributable to digitally pulsed (100 Hz) MW radiation. For some the response was extreme (tachycardia), for others moderate to mild (changes in sympathetic nervous system and/or parasympathetic nervous system). and for some there was no observable reaction either because of high adaptive capacity or because of systemic neurovegetative exhaustion.** ***Conclusions:*** **Orthostatic HRV combined with provocation testing may provide a diagnostic test for some EHS sufferers when they are exposed to electromagnetic emitting devices. This is the first study that documents immediate and dramatic changes in both Hearth Rate (HR) and HR variability (HRV) associated with MW exposure at levels**

Address: Magda Havas BSc, PhD, Environmental and Resource Studies, Trent University, Peterborough, ON, K9J 7B8, Canada - Tel. 705 748-1011 x7882 - Fax 705-748-1569
E-mail: mhavas@trentu.ca

well below (0.5%) federal guidelines in Canada and the United States (1000 microW/cm²).

***Key Words*: heart rate variability, microwave radiation, DECT phone, autonomic nervous system, provocation study, sympathetic, parasympathetic, cordless phone, 2.4 GHz, electrohypersensitivity**

Introduction

A growing population claims to be sensitive to devices emitting electromagnetic energy. Hallberg and Oberfeld[1] report a prevalence of electrohypersensitivity (EHS) that has increased from less than 2% prior to 1997 to approximately 10% by 2004 and is expected to affect 50% of the population by 2017. Whether this is due to a real increase in EHS or to greater media attention, is not known. However, to label EHS as a psychological disorder or to attribute the symptoms to aging and/or stress does not resolve the issue that a growing population, especially those under the age of 60, are suffering from some combination of fatigue, sleep disturbance, chronic pain, skin, eye, hearing, cardiovascular and balance problems, mood disorders as well as cognitive dysfunction and that these symptoms appear to worsen when people are exposed to electromagnetic emitting devices[2-7].

The World Health Organization (WHO) organized an international seminar and working group meeting in Prague on EMF Hypersensitivity in 2004, and at that meeting they defined EHS as follows[8]:

". . . a phenomenon where individuals experience adverse health effects while using or being in the vicinity of devices emanating electric, magnetic, or electromagnetic fields (EMFs) . . . Whatever its cause, EHS is a real and sometimes a debilitating problem for the affected persons . . . Their exposures are generally several orders of magnitude under the limits in internationally accepted standards."

The WHO goes on to state that:

"EHS is characterized by a variety of non-specific symptoms, which afflicted individuals attribute to exposure to EMF. The symptoms most commonly experienced include dermatological symptoms (redness, tingling, and burning sensations) as well as neurasthenic and vegetative symptoms (fatigue, tiredness, concentration difficulties, dizziness, nausea, heart palpitation and digestive disturbances). The collection of symptoms is not part of any recognized syndrome."

Both provocation studies (where individuals are exposed to some form of electromagnetic energy and their symptoms are documented) and amelioration studies (where exposure is reduced) can shed light on the offending energy source and the type and rate of reaction.

Several amelioration studies have documented improvements in the behavior of students and the health and wellbeing of teachers[9], among asthmatics[10], and in both diabetics and those with multiple sclerosis[11,12] when their exposure to dirty electricity is reduced. Dirty electricity refers to microsurges flowing along electrical wires in the kHz range that can damage sensitive electronic equipment and, it appears, affect the health of those exposed.

In contrast to amelioration studies, provocation studies, examining the response of people with self-diagnosed EHS, have generated mixed results.

Rea *et al.*[13] were one of the first to show that sensitive individuals responded repeatedly to several frequencies between 0.1 Hz and 5 MHz but not to blank challenges. Reactions were mostly neurological and included tingling, sleepiness, headache, dizziness, and - in severe cases - unconsciousness, although other symptoms were also observed including pain of various sorts, muscle tightness particularly in the chest, spasm, palpitation, flushing, tachycardia, etc. In addition to the clinical symptoms, instrument recordings of pupil dilation, respiration, and heart activity were also included in the study using a double-blind approach. Results showed a 20% decrease in pulmonary function and a 40% increase in heart rate. These objective instrumental recordings, in combination with the clinical symptoms, demonstrate that EMF sensitive individuals respond physiologically to certain EMF frequencies although responses were robust for only 16 of the 100 potentially sensitive individuals tested.

In a more recent review, Rubin *et al.*[14] concluded that there was no robust evidence to support the existence of a biophysical hypersensitivity to EMF. This was based on 31 double-blind experiments that tested 725 EHS subjects. Twenty-four studies found no difference between exposure and sham conditions and of the seven studies that did find some evidence that exposure affected EHS participants, the research group failed to replicate the results (two studies) or the results appeared to be statistical artifacts (three studies).

Those who live near antennas and those who suffer from EHS often complain of cardiovascular problems such as rapid heart rate, arrhythmia, chest pain, and/or changes in blood pressure[3,7,15,16].

Indeed, the doctors who signed the Freiburger Appeal[17] stated the following:

> *"We have observed, in recent years, a dramatic rise in severe and chronic disease among our patients especially . . . extreme fluctuations in blood pressure, ever harder to influence with medications; heart rhythm disorders; heart attacks and strokes among an increasingly younger population . . .*"

Based on these findings we decided to study the affect of microwave (MW) radiation generated by a digital cordless phone on the cardiovascular system by monitoring heart rate variability (HRV). Unlike cell phones that radiate microwaves only when they are either transmitting or receiving information, the cordless phone we used radiates constantly as long as the base of the phone is plugged into an electrical outlet. The phone we used was an AT&T digitalally pulsed (100 Hz) cordless telephone that operates at 2.4 GHz or frequencies commonly used for microwave ovens and Wi-Fi. It resembles its European version know as a Digital Enhanced Cordless Telecommunications (DECT) phone that operates at 1.9 GHz[18].

HRV is increasingly used for screening cardiovascular and neurological disorders[19-24]. We wanted to determine whether HRV could be used as a tool to diagnose EHS and whether it could be used to predict probability and/or intensity of the reaction to a MW provocation. The HRV analysis, using NervExpress software[25, 26], provides information about the functioning of the sympathetic and parasympathetic nervous system with real time monitoring and provides additional information including a pre-exposure fitness score based on the orthostatic test.

Materials and methods

Background electromagnetic environment

Testing was done in two locations, one in Golden and the other in Boulder, Colorado, on three separate weekdays during a 6-day period (Table 1). Background levels of low frequency magnetic fields, intermediate frequency radiation on electrical wires, and radio frequency radiation were monitored at each location and the values are provided in Table 1. All testing of the electromagnetic environment was done in the area where volunteers were tested for their heart rate variability during the provocation study.

The extremely low frequency **magnetic field** was measured with an omni-directional Trifield meter. This meter is calibrated at 60 Hz with a frequency-weighted response from 30 to 500 Hz and a flat response from 500 to 1000 Hz. Accuracy is ± 20%.

Power quality was measured with a Microsurge Meter that measures high frequency transients and harmonics between 4 and 150 kHz (intermediate frequency range). This meter provides a digital reading from 1 to 1999 of dv/dt expressed as GS units with a +/- 5% accuracy[27]. Since we were trying to ensure low background exposure, we installed GS filters to improve power quality. The results recorded are with GS filters installed.

Within at least 100 m of the testing area, all wireless devices (cell phones, cordless phones, wireless routers) were turned off. **Radio frequency radiation** from outside the testing area was measured with an Electrosmog Meter, which has an accuracy of ±2.4 dB within the frequency range of 50 MHz to 3.5 GHz. Measurements were conducted using the omni-directional mode and were repeated during the testing. This meter was also used to determine the exposure of test subjects during provocation with a digital cordless phone. This **cordless phone** emits radio frequency radiation when the base station is plugged into an electrical outlet. This happens even when the phone is not in use. We used the base station of an AT&T 2.4 GHz phone (digitally pulsed at 100 Hz) to expose subjects to MW radiation[18]. The emission of MWs at different distances from the front of the base station is provided in fig. 1.

Testing of subjects

Subjects were **recruited** by word-of–mouth based on their availability during a short period of testing. Of the 27 people who volunteered to be tested, two were excluded, one based on age (less than 16 years old) and another based on a serious heart condition.

Subjects were asked to complete a wellness and EHS **questionnaire**. They were then asked questions about their age, height, weight, blood type, time of last meal, and occupation (in the event of occupational exposure to electromagnetic fields/radiation).

Table 1 - Measurements of the electromagnetic environment at each testing location

Location Colorado	Date	Magnetic Field 30 - 1000 Hz mG	Power Quality 4 - 150 kHz GS units	Radio Frequency Radiation 50 MHz – 3.5 GHz microW/cm^2
Golden	10/16/08	3 – 15	140	0.8
Boulder	10/20/08	0.4	37	<0.01
Boulder	10/21/08	0.4	80	<0.01

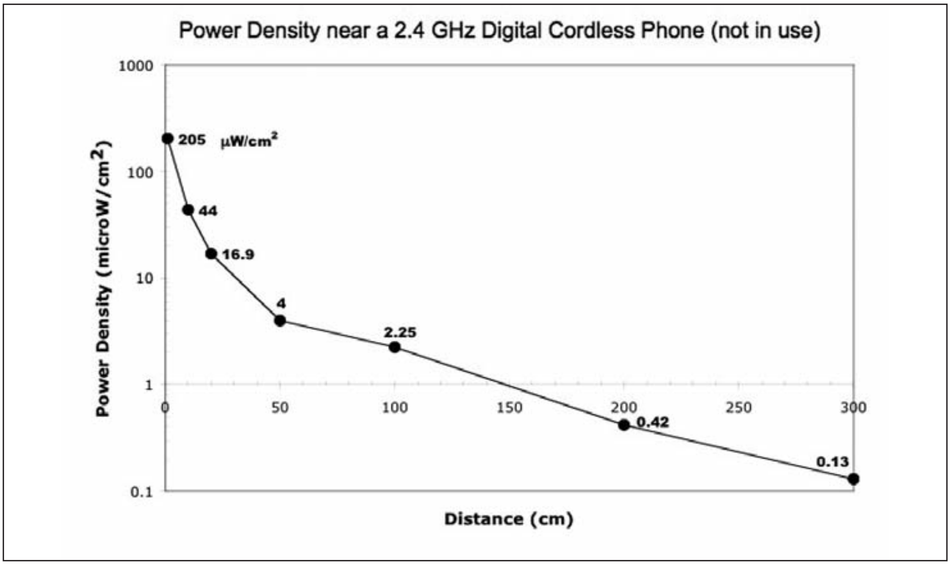

Fig. 1. Radiation near a 2.4 GHz AT&T digital cordless phone when the base station of the phone is plugged into an electrical outlet and the phone is not in use

We measured resting heart rate and blood pressure using a Life Source UA-767 Plus digital blood pressure monitor; saliva pH with pH ion test strips designed for urine and saliva (pH range 4.5-9.0), and blood sugar with ACCU-CHEK Compact Plus.

In an attempt to address the question: "Is there a simple test that relates EHS with the electrical environment of the human body?", we measured galvanic skin response (GSR), body voltage, and the high and low frequency electric and magnetic field of each subject.

Wrist-to-wrist galvanic skin response was measured as an indicator of stress using a Nexxtech voltmeter (Cat. No. 2200810) set at 20 volts DC and attached to the inner wrist with a Medi Trace 535 ECG Conducive Adhesive Electrodes Foam used for ECG monitoring. Capacitively coupled "body voltage" was measured with a MSI Multimeter connected to a BV-1 body voltage adaptor. The subject's thumb was placed on one connector and the other connector was plugged into the electrical ground, which served as the reference electrode. High frequency (HF) and low frequency (LF) electric and magnetic fields were measured with a Multidetektor II Profi Meter held at approximately 30 cm from the subject's body, while the subject was seated.

HRV testing

Two types of HRV testing were conducted. The first was an *orthostatic* test and the second was *continuous monitoring* of heart rate variability with and without provocation (exposure to MW frequencies from a digital cordless phone). NervExpress software was used for HRV testing[25]. NervExpress has both CE and EU approval and is a Class Two Medical Device in Canada and in the European Union. An electrode belt with transmitter was placed on the person's chest near the heart, against the skin. A wired HRV cable with receiver was clipped to the clothing near the transmitter and connected to the COM port of the computer for acoustical-wired transmission (not wireless). This provided continuous monitoring of the interval between heartbeats (R-R interval).

For the *orthostatic* testing subject laid down on his/her back and remained in this position for 192 R-R intervals or heartbeats (approximately 3 minutes), at which time a beep from the computer indicated that the person stand up and remain standing until the end of the testing period, which was 448 intervals (approximately 7 minutes depending on heart rate).

For the *provocation* testing, subject remained in a lying down position for the duration of the testing. A digital cordless phone base station, placed approximately 30 to 50 cm from subject's head, was then connected randomly to either a live (real exposure) or dead (sham exposure) extension cord. It was not possible for the subject to know if the cordless phone was on or off at any one time. Continuous real-time monitoring recorded the interval between each heartbeat. Data were analyzed by timed stages consisting of 192 R-R intervals (heartbeats).

The sham exposures are referred to as either pre-MW exposure or post-MW exposure to differentiate the order of testing. Since type of exposure was done randomly in some instances either the pre-MW or the post-MW is missing. Subjects who reacted immediately to the cordless phone were retested with more real/sham exposures. When subject was exposed multiple times, only the first exposure was used for comparison. Provocation testing took between 9 to 30 minutes per subject.

After the initial testing, treatments (deep breathing, laser acupuncture, Clean Sweep) that might alleviate symptoms were tried on a few subjects but these results will be reported elsewhere.

Interpretation of HRV results

The results for the orthostatic testing and provocation testing were sent to one of the authors (JM) for interpretation. An example of the type of information send is provided in fig. 2 (orthostatic) and fig. 3 (provocation). No information was provided about the subject's self-proclaimed EHS and the information about exposure was blinded. JM did not examine the provocation results until he reviewed the orthostatic results. No attempt was made to relate the two during this initial stage of interpretation.

Predicting response and health based on orthostatic test

For the orthostatic testing JM provided a ranking for cardiovascular tone (CVT), which is based on the blood pressure and heart rate (sum of systolic and diastolic blood pressure times heart rate) and provides information on whether the cardiovascular system is hypotonic (<12,500) or hypertonic (>16,500). We used a 5-point ranking scale as follows: Rank 1: < 12,500, hypotonic; Rank 2: 12,500 to 14,000; Rank 3: 14,000 to 15,500; Rank 4: 15,500 to 16,500; Rank 5: > 16,500, hypertonic.

Non-Adaptive Capacity (NAC)[a] was ranked on a 5-point scale with 1 indicating highly adaptive and 5 indicating highly non-adaptive. This was based on a balanced sympathetic (SNS) and parasympathetic (PSNS) nervous system (average orthostatic response within ±1 standard deviation from center on graph) and on the overall fitness

[a] Later Adaptive Capacity (AC) was used, which is the inverse of NAC.

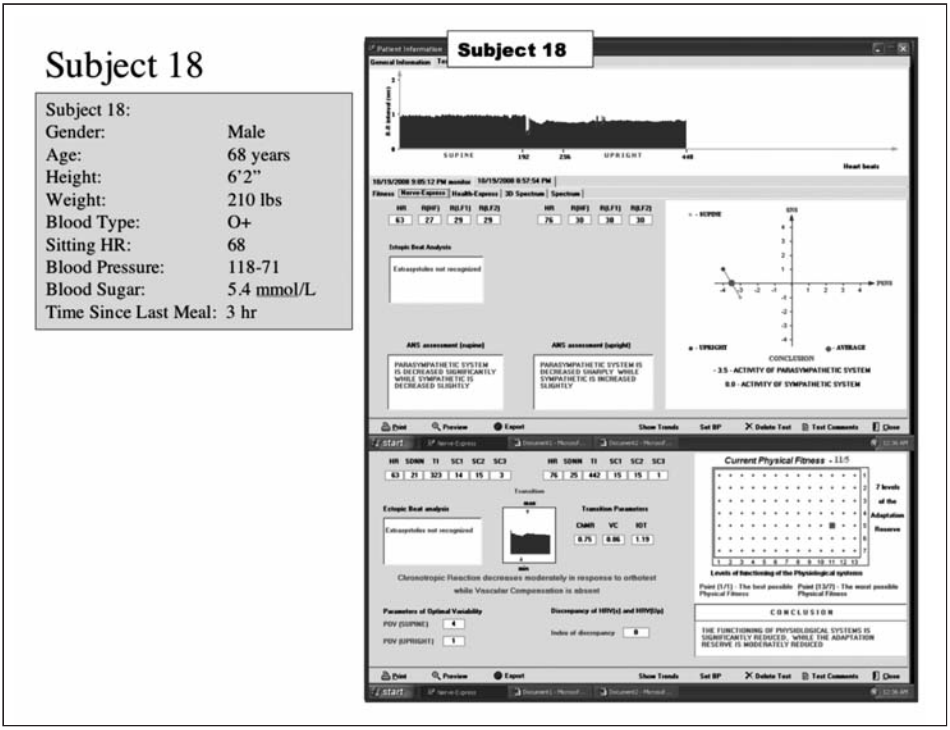

Fig. 2. Orthostatic HRV information provided for blinded analysis of Subject 18

score. The closer to normal value of the autonomic nervous system (ANS) in a given subject, the less likely they are to react, since their adaptive capacity is high. "Normal" refers to the balanced SNS/PSNS and the appropriate direction of movement under stress, in this case when person stood up. Direction of movement is shown in the NervExpress graph (fig. 2). Appropriate direction of movement would be either up 1 standard deviation (small increase in SNS and no change in PSNS); up and to the left 1 standard deviation each (small increase in SNS and small decrease in PSNS); or to left (no change in SNS and slight decrease in PSNS). For those who move further to the left (greater down regulation of PSNS) or further up and to the left (greater up regulation of SNS combined with a greater down regulation of PSNS), the less likely they are to adapt and the more likely they are to react. Likewise, if the fitness score is high or adequate, the individual would be capable of resisting the stressor. An adequate physical fitness score is between 1:1 and 10:6. The first number refers to the functioning of the physiological system and the second is the adaptation reserve. The lower the numbers the greater the level of fitness in each category. Note, if a subject with good or adequate fitness was to be a reactor to MW stress, his/her reaction would be both rapid and strong.

Probability of Reaction (POR) was ranked on a 5-point scale with "1" indicating low probability of a reaction and "5" indicating high probability of a reaction to stress of any kind. Criteria were similar to the NAC. However, greater consideration was given to the Chronotropic Myocardial Reaction Index (ChMR) value and the dysautonomic

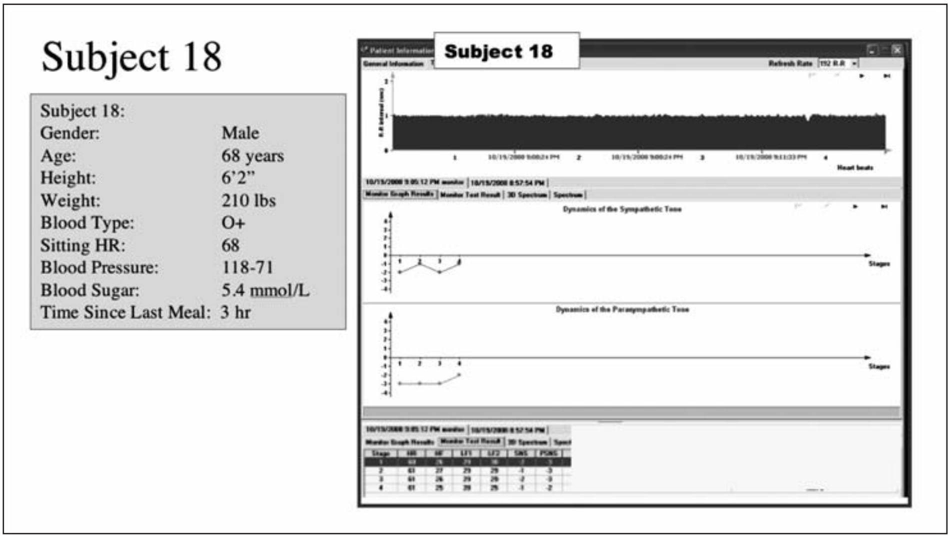

Fig. 3. Continuous monitoring of HRV with real and sham exposure to MW radiation from a digital cordless phone. Information provided for blinded analysis of Subject 18

status (average of orthostatic test is more than two standard deviations from center or up to the right) of the subject, whereby individuals with compromised ANS and a poor ChMR ranking (outside the range of 0.53 to 0.69) would be most likely to react and *vice versa*.

A potential non-responding reactor is someone with low energy, average orthostatic response in lower left quadrate, and a physical fitness score between 10:6 and 13:7. Subject 18 in fig. 2 is a borderline non-responding reactor. Note, this does not necessarily imply that this person is hypersensitive, only that he probably does not have enough energy to mount a reaction even if he was EHS.

JM also provided his comments on the health status of the subject based on the rhythmogram, autonomic nervous system assessment (changes in the SNS and PSNS), Fitness Score, Vascular Compensation Reaction (VC), ChMR, Compensation Response (CR), Ortho Test Ratio (OTR), Parameters of Optimal Variability (POV), Index of Discrepancy (ID); and Tension Index (TI). The interpretation of the HRV parameters is dependant to a certain degree on the integration of all the data provided as a whole with value being given to the total ANS picture presented. Those skilled in the art and science of HRV analysis should reach similar interpretive assessment of the data presented here[26].

Blinded analysis of provocation results

The blinded data for the continuous monitoring of heart rate variability with real and sham exposure were sent to JM for analysis (fig. 3). JM attempted to identify the stage during which exposure took place, stage during which the subject reacted, and then ranked symptom probability (5-point scale) and intensity (non-reactive, mild, moderate, intense). The assessment is provided in Appendix A.

Wellness and EHS Questionnaire

Prior to any testing, each subject was asked to complete a wellness and EHS questionnaire. This was designed on surveymonkey (www.surveymonkey.com) and was administered in paper format. This questionnaire was analyzed separately from the HRV data.

Results

Background electromagnetic environment

The two environments, where we conducted the testing, differed in their background levels of EMF and electromagnetic radiation (EMR). The Golden site had high magnetic fields (3-15 mG), high levels of dirty electricity (140 GS units) despite the GS filters being installed, and elevated levels of radio frequency (RF) radiation (0.8 microW/cm^2) coming from 27 TV transmitters on Lookout Mountain within 4 km of our testing environment. Despite RF reflecting film on windows the RF levels inside the home were elevated. The Boulder environment was relatively pristine and differed only with respect to power quality on the two days of testing (Table 1).

The cordless phone, used for provocation, produced radiation that was maximal at the subject's head (3 to 5 microW/cm^2) and minimal at the subject's feet (0.2 to 0.8 microW/cm^2) depending on height of subject and the environment. The cordless phone did not alter magnetic field or power quality.

Participants

A total of 25 subjects were included in this pilot study, ranging in age from 37 to 79 with most (40%) of the subjects in their 50s (Table 2). Eighty percent were females. Approximately half of the participants had normal body mass index and the other half were either overweight (28%) or obese (16%)[28]. Mean resting heart rate for this group was 70 (beats per minute) and ranged from 53 to 81. Blood pressure fell within a normal range for 40% of participants and fell within stage 1 of high blood pressure for 16% of the subjects[29]. None of the subjects had pacemakers, a prerequisite for the study. Forty percent had mercury amalgam fillings and 28% had metal (artificial joints, braces, etc.) in their body. This is relevant as metal implants and mercury fillings may relate to EHS[30].

Questionnaire

Self-perceived Electrosensitivity

One third of participants did not know if they were or were not electrically sensitive, 40% believed they were moderately to extremely sensitive, 16% stated that they had a little sensitivity, and 8% claimed they were not at all sensitive. Their sensitivity was slightly debilitating for 24% and moderately debilitating for 20% of participants (fig. 4).

Reaction time for symptoms to appear after exposure ranged from immediately (12%) to within 2 hours (4%) and was within 10 minutes for the majority of those who believe they react (28%) (fig. 5). Recovery time ranged from immediately to within 1 day with

Table 2 - Information about participants

		#	%
Gender	Male	5	20%
	Female	20	80%
Age	Mean and Range	60 years	37-79 years
Age Class	20s	1	4%
	30s	1	4%
	40s	2	8%
	50s	10	40%
	60s	5	20%
	70s	7	28%
BMI[a]	obese	4	16%
	overweight	7	28%
	normal	13	52%
	underweight	1	4%
Resting Heart Rate	Mean and Range	70 bpm	53-81 bpm
Blood Pressure[b]	Normal	10	40%
	Pre-hypertension	11	44%
	High Blood Pressure	4	16%
Metal in Body	Pace maker	0	0%
	Mercury fillings	10	40%
	Other metal	7	28%

[a] BMI = Body Mass Index based on height and weight[28]
[b] Blood Pressure (BP) according to National Heart Lung and Blood Institute (nd)[29]

only 4% claiming to recover immediately. Several participants noted that the rate of reaction and recovery is a function of the severity of their exposure and their state of health. The more intense the exposure the more rapid their response and the slower their rate of recovery. These results may have a bearing on the provocation study as we are testing an immediate reaction/recovery response (~3 minutes) to a moderate intensity exposure (3 to 5 $\mu W/cm^2$) and the percent that claims to respond quickly is low among this group.

Symptoms

The most common symptoms of exposure to electrosmog, as identified by this group of participants, included poor short-term memory, difficulty concentrating, eye problems, sleep disorder, feeling unwell, headache, dizziness, tinnitus, chronic fatigue and heart palpitations (fig. 6, upper graph). Of the symptoms commonly associated with EHS, heart palpitations (10th), rapid heartbeat (18th), arrhythmia (21st), and slower heartbeat (23rd) are the only ones we would be able to identify with HRV testing. For most participants who claim to react, reactions are mild to moderate.

All of the symptoms, except high blood pressure, arrhythmia, and slower heartbeat, were experienced several times per day (daily) or several times per week (weekly) by at least one or more participants. The patterns for symptom severity and frequency are similar (fig. 6, upper *vs* lower graph). Some of the symptoms (feeling unwell, pain, chronic fatigue, gas/bloat, skin problems) were experienced several times each month (monthly) may relate to menses in pre-menopausal or peri-menopausal women (16 women).

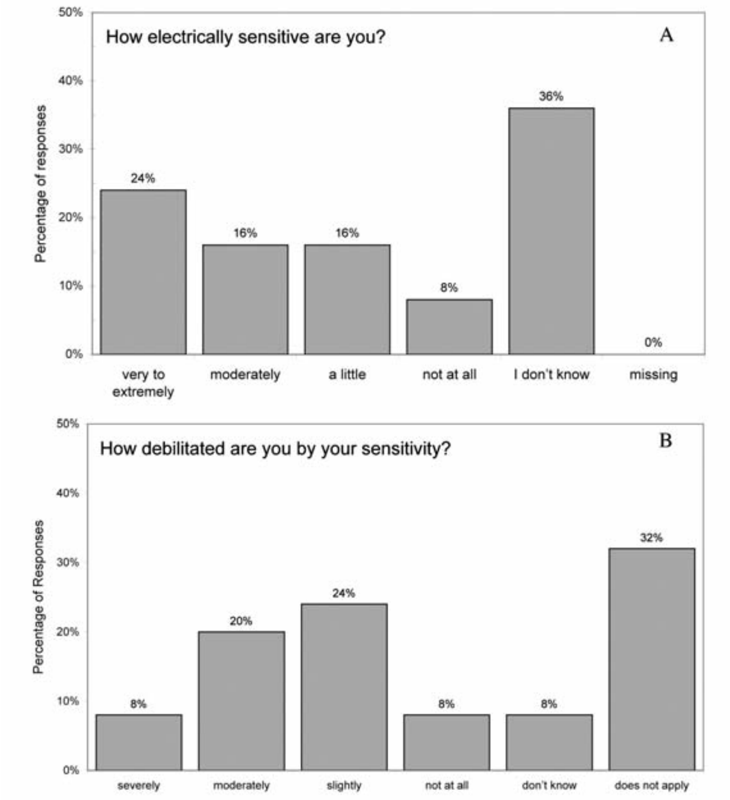

Fig. 4. Self-proclaimed electrosensitivity of participants (n=25)

A large percentage of participants had food allergies (64%), mold/pollen/dust allergies (48%), pet allergies (20%), and were chemically sensitive (36%) (fig. 7).

Some also had pre-existing health/medical conditions (fig. 8). The top five were anxiety (28%); hypo-thyroidism (24%); autoimmune disorder (20%), depression (16%) and high blood pressure (16%). Note these may be self-diagnosed rather than medically diagnosed conditions.

Objects contributing or associated with adverse health symptoms

Among the objects identified as contributing to adverse health symptoms, tube fluorescent lights were at the top of the list with more than 40% of participants reacting *often* or *always* (fig. 9). The next 4 items on the list (antennas, cell phones, Wi-Fi, cordless phones) all emit microwave radiation. According to this figure 16% of subjects respond to cordless phones *often* or *always* and their responses may include headaches, dizziness, depression, which we are unable to monitor with HRV.

Fifty-two percent stated they are debilitated by their sensitivity, 24% slightly, 20% moderately, and 8% severely. Some have difficult shopping, which may relate to

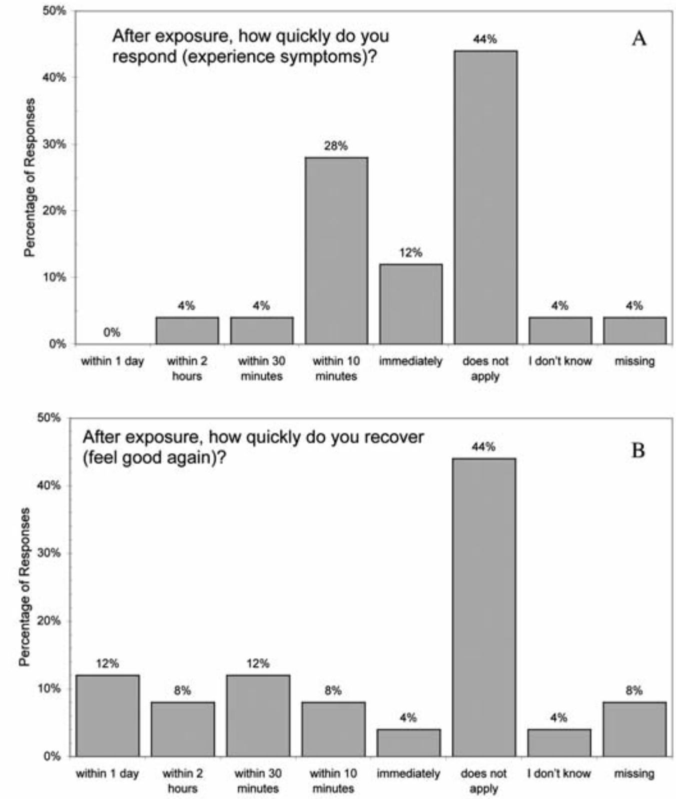

Fig. 5. Self-proclaimed response time of participants to electro-stress and recovery (n=25)

lighting in stores. Others have difficulty flying or traveling by car, perhaps due to microwave exposure on highways and in airplanes. A few subjects are unable to use mobile phones and computers and are unable to watch television. Some are unable to wear jewelry because it irritates the skin and/or watches because they often malfunction (fig. 7).

EHS and person's EMF

The body voltage, as measured by the potential difference between the subject and the electrical ground, differed at the two sites. Subjects at Golden had much higher values than those at Boulder. This was also the case for the high and low frequency electric field and for the HF and LF magnetic field (Table 3). Galvanic skin response was highly variable among subjects prior to testing and did not relate to either sensitivity or the environment. There was no association between any of the EMF measurements (body voltage, GSR, electric field or magnetic field) that we conducted prior to testing and EHS of the subjects tested. In a follow-up study it would be useful to monitor each person's EMF before, during, and after exposure.

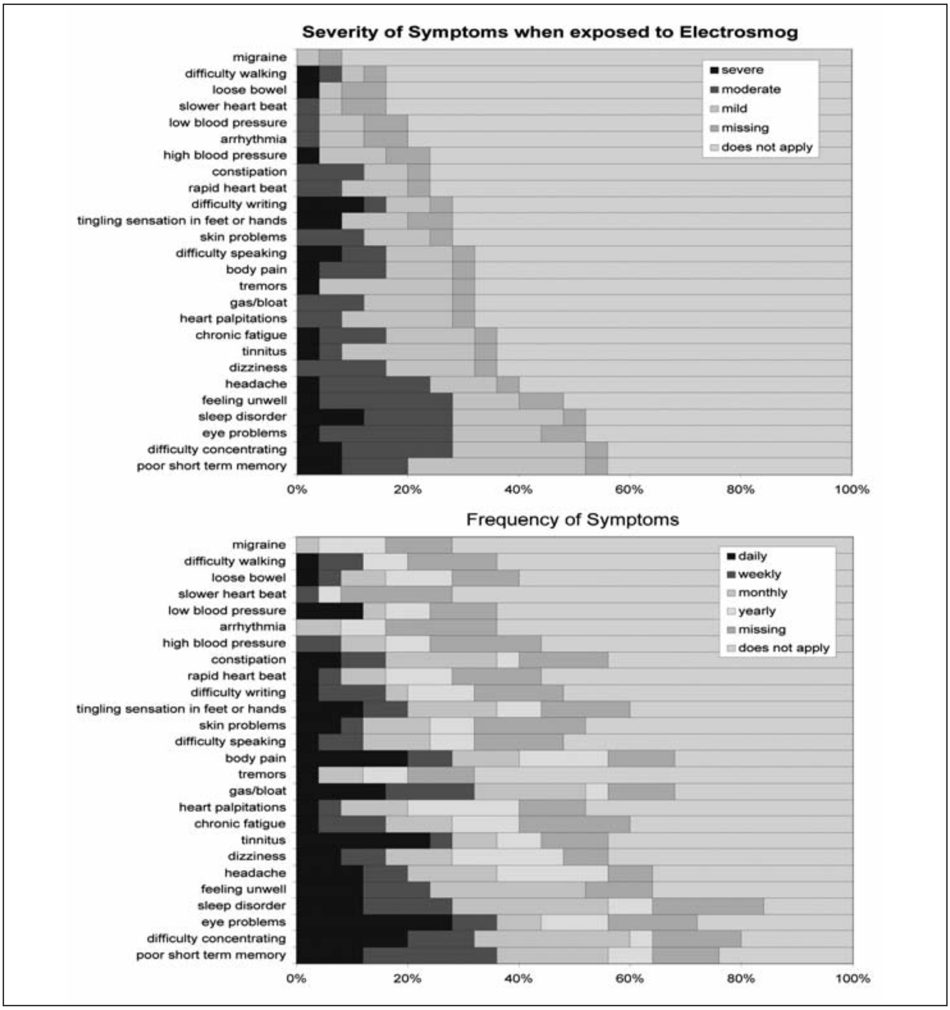

Fig. 6. Severity and frequency of symptoms associated with electrosmog exposure (n=25)

Blind assessment of responses: orthostatic HRV provocation HRV

The Orthostatic HRV provided us with the state of the ANS and the relative fitness score of the individual prior to exposure, which is important for predicting the intensity outcome of exposure.

A summary of the orthostatic HRV (blinded analysis) along with the self-assessment and the provocation HRV (blinded and unblinded) are provide in Appendix A for each subject. For those individuals who had either a moderate or intense response, the blinded predictions show good agreement for stage of exposure and for intensity of exposure.

Based on the orthostatic test, those with high adaptive capacity had a lower probability of reacting to stress, but if they did react, their reaction would be moderate to

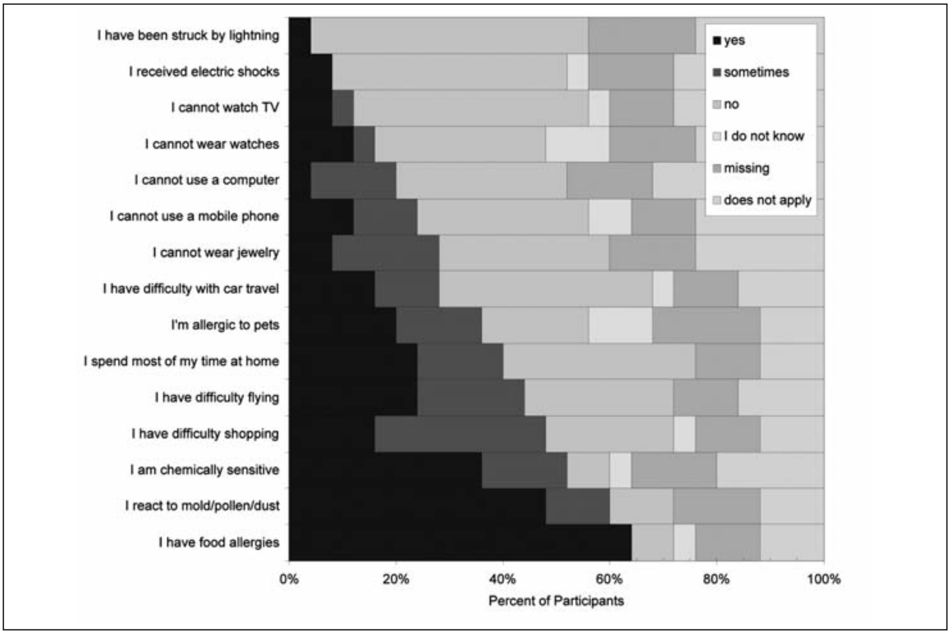

Fig. 7. Response to specific questions that may contribute to or be associated with electrical sensitivity (n=25)

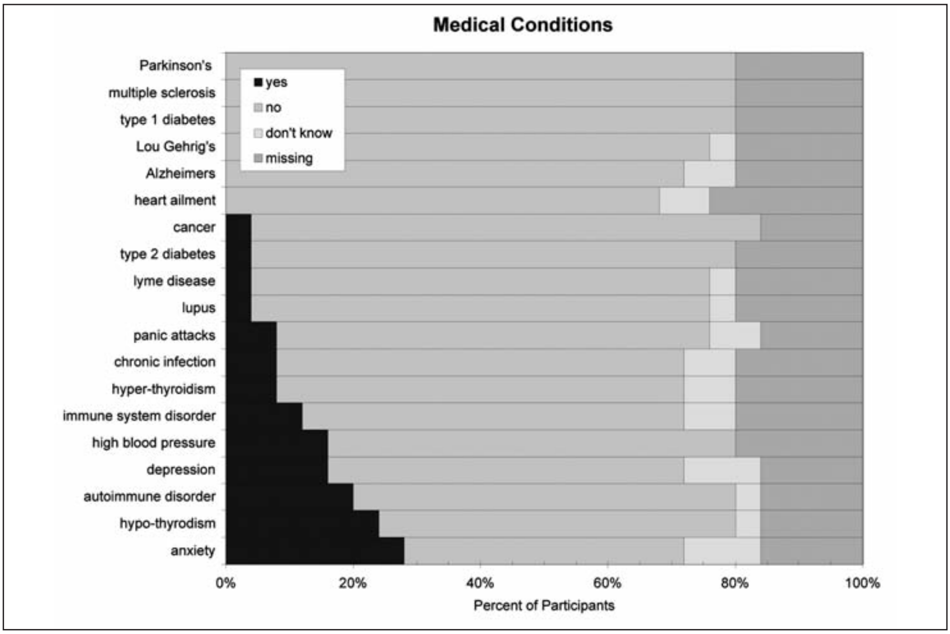

Fig. 8. Existing medical conditions of participants (n=25)

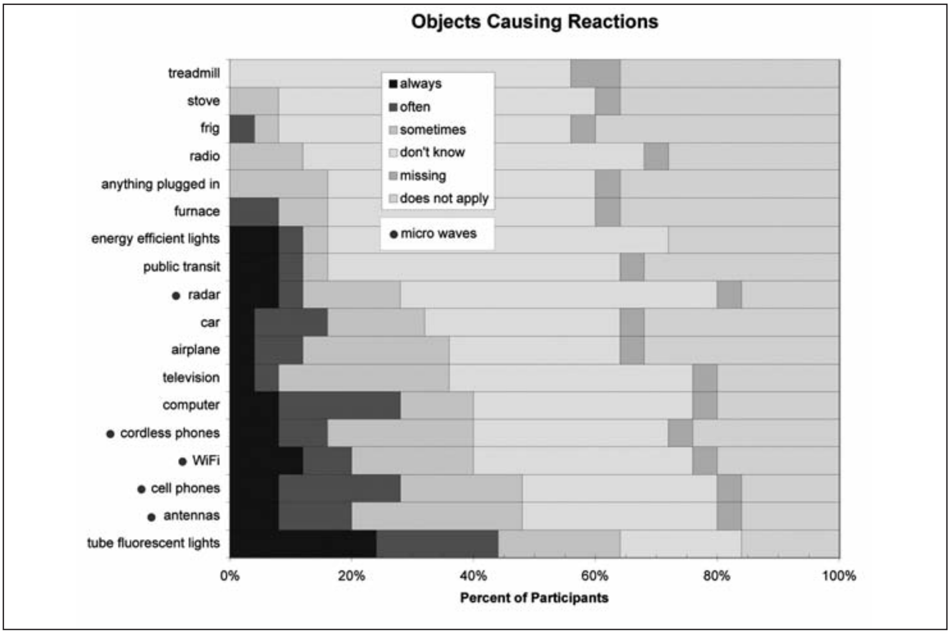

Fig. 9. Objects contributing to adverse health symptoms. Those marked with a dot generate microwave frequencies (n=25)

Table 3 - Personal electromagnetic environment (mean ± standard deviation) of subjects tested including galvanic skin response (GSR), body voltage, electric (E-field) and magnetic fields (M-field) at both high and low frequency (HF and LF) [* P ≤0.05].

Location	Date	GSR mV	Body Voltage mV	E-field HF mV	E-field LF mV	M-field HF mG	M-field LF mG
Golden	10/16/08	3.5 ± 1.8	3.4 ± 0.5*	88 ± 85*	333 ± 71*	4.6 ± 5.7*	17 ± 14*
Boulder	10/20/08	3.2 ± 2.5	0.5 ± 0.5	13 ± 33	63 ± 94	0.2 ± 0.6	2.7 ± 0.7*
Boulder	10/21/08	4.1 ± 1.3	0.2 ± 0.1	2 ± 0.8	57 ± 50	0.1 ± 0.4	1.7 ± 0.6*

intense. Conversely, those with low adaptive capacity had a higher probability of reacting but they didn't always have the energy to react and hence their reactions would be mild.

Provocation HRV

Most of the subjects (15/25, 60%) did not respond appreciable to the MW radiation generated by the cordless phone when it was plugged into a live outlet. The rhythmogram was unchanged and the heart rate, parasympathetic and sympathetic tone remained constant (figs. 3, 10, 12).

However, 10 subjects (40%) did respond to the MW challenge. Fig. 13 shows the response for six of those 10. Response and the recovery were immediate. MW provoca-

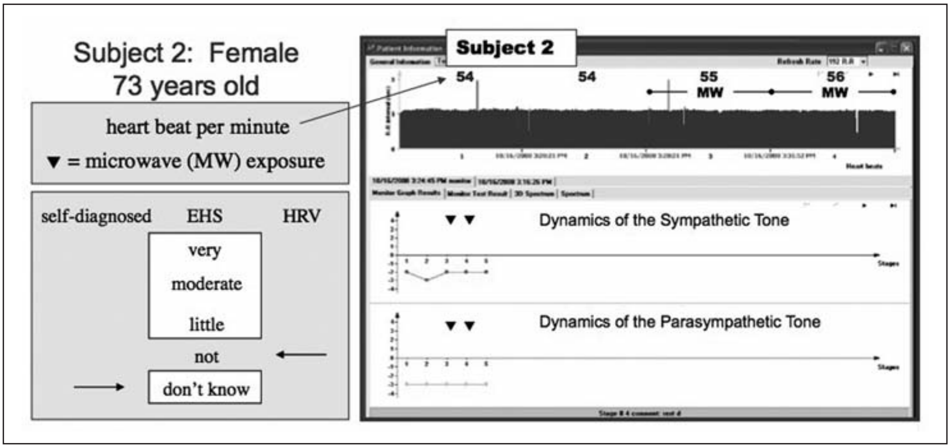

Fig. 10. Continuous monitoring of HRV during provocation part of this study for one subject who was non-reactive

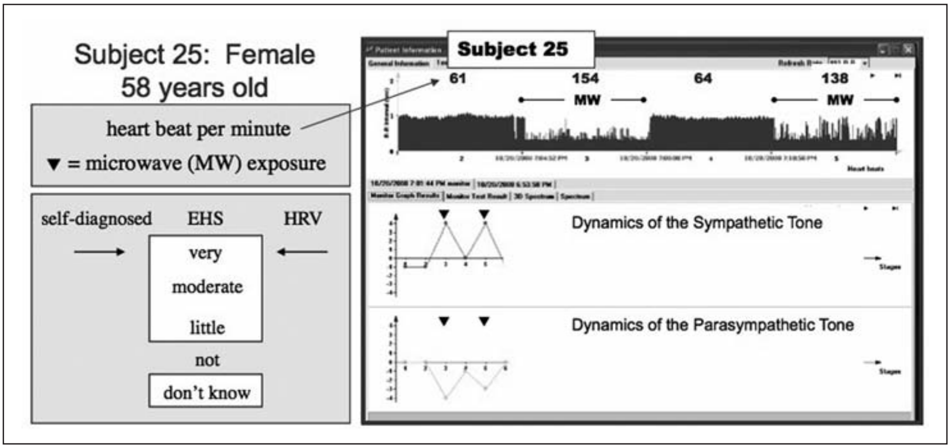

Fig. 11. Continuous monitoring of HRV during provocation part of this study for one subject who reacted to the MW radiation from a digital cordless 2.4 GHz phone

tion differed noticeably compared with sham exposure. Heart rate increased significantly for four of the subjects, resulting in tachycardia for three. The heart rate for subject 25 jumped from 61 bpm to 154 bpm (with real provocation) and returned to 64 bpm (with sham provocation) (fig. 11). The increase in heart rate was accompanied by up regulation of the SNS and down regulation of the PSNS during cordless phone exposure for four subjects in Table 4 (fig. 13). Response of the one subject (Subject 27) was paradoxical in that the heart rate increased from 72 to 82 bpm during which time the parasympathetic tone increased and the sympathetic tone remained constant.

Fig. 14 shows the range of responses of some non- or slightly reactive subjects to provocation.

Table 4 - Real-time monitoring of heart rate, sympathetic and parasympathetic tone before, during, and after exposure to a 2.4 GHz digital cordless phone radiating 3-5 microW/cm²

EHS	Subject	EHS	Heart Rate (bpm)				Sympathetic Response				Parasympathetic Response			
	Code	Ranked	bgrnd	pre	MW	post	bgrnd	pre	MW	post	bgrnd	pre	MW	post
Intense	25	1	61	61	154	64	-1	-1	4	0	0	0	-4	-1
	17	2	66	68	122	66	0	0	4	0	0	-2	-3	0
	26	3	59	61	106	61	-1	-1	3	0	1	2	-3	1
	27	4	72	nd	82	69	0	nd	0	0	-3	nd	2	-2
Moderate	5	5	66	66	66	65	1	1	3	0	-1	-1	-3	-1
	9	6	77	75	75	73	1	1	0	1	-2	0	-3	-1
	3	7	48	50	53	nd	2	-2	0	nd	2	0	0	nd
	16	8	61	nd	62	63	0	nd	-2	0	-2	nd	-2	-2
	8	9	81	nd	81	80	1	nd	1	1	0	nd	-2	-1
	10	10	69	68	70	70	0	0	0	0	-2	-2	-3	-1
Mild	2	11	54	54	55	56	-2	-3	-2	-2	-3	-3	-3	-3
	23	12	59	nd	58	60	-1	nd	0	-2	-2	nd	-2	-3
	12	13	71	nd	69	74	0	nd	1	0	-1	nd	-1	-1
	18	14	60	61	61	61	-2	-1	-2	-1	-3	-3	-3	-2
	19	15	63	62	62	61	-1	0	-1	-1	-3	-3	-3	-2
	6	16	65	66	66	65	0	0	0	0	-3	-3	-4	-3
	4	17	61	62	61	61	-2	-1	-1	-2	-3	-2	-3	-2
	24	18	71	72	71	69	0	0	0	0	-3	-2	-1	-2
None	1	19	71	70	71	71	0	0	0	1	-3	-1	-1	-1
	11	20	57	nd	57	58	0	nd	0	0	3	nd	3	2
	21	21	78	78	78	nd	1	1	1	nd	-2	-3	-3	nd
	7	22	70	71	70	69	0	0	0	0	-3	-3	-3	-3
	14	23	69	68	67	66	0	0	0	0	-1	-2	-2	-1
	20	24	67	nd	66	66	0	nd	0	0	-1	nd	-1	-1
	13	25	80	78	76	nd	1	1	1	nd	-3	-2	-2	nd

Response	Mean Heart Rate (bmp)				Mean Sympathetic Response				Mean Parasympathetic Response			
Intense	65	63	116	65	-0.5	-0.7	2.8	0.0	-0.5	0.0	-2.0	-0.5
Moderate	67	65	68	70	0.8	0.0	0.3	0.4	-0.8	-0.8	-2.2	-1.2
Mild	63	63	63	63	-1.0	-0.8	-0.6	-1.0	-2.6	-2.7	-2.5	-2.3
None	70	73	69	66	0.3	0.4	0.3	0.2	-1.4	-2.2	-1.3	-0.8
All	66	66	74	66	-0.1	-0.3	0.4	-0.2	-1.5	-1.7	-2.0	-1.4

Note:
EHS categories described in text: bgrnd = background; pre=sham exposure before real exposure; MW=microwave exposure; post=sham exposure after real exposure; nd=no data

The pre- and post-MW cordless phone response (SNS & PSNS) differed significantly for this group (fig. 15) with up regulation of the SNS and down regulation of the PSNS with MW exposure and the reverse for post-MW exposure suggesting a recovery phase.

The severe and moderate responders had a much higher LF/HF ratio than those who either did not respond or had a mild reaction to the MW exposure from the cordless phone (fig. 16B). This indicates, yet again, a stimulation of the SNS (LF) and a down-

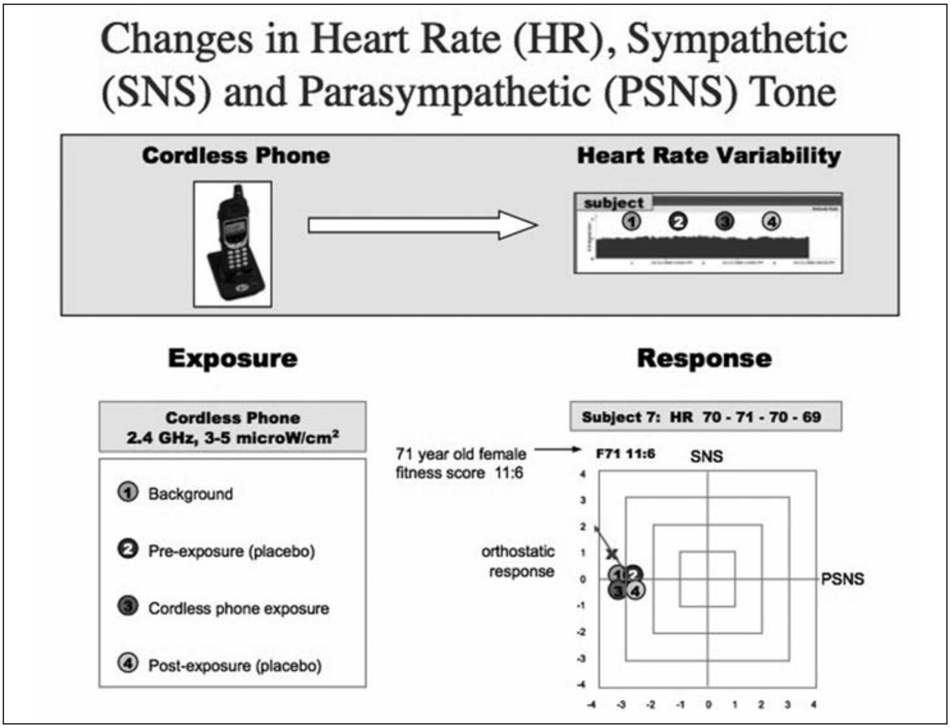

Fig. 12. Subject 7: no changes in heart rate, sympathetic, and parasympathetic tone before, during, and after blind provocation with a 2.4 GHz cordless phone generating exposure of 3 to 5 microW/cm^2

regulation of the PSNS (HF). The up regulation was greater for LF2 than for LF1 (fig. 16A).

Based on self-assessment and the results from the provocation study, 2 subjects (8%) underestimated their sensitivity and 5 subjects (20%) overestimated their sensitivity to the cordless phone provocation. However, only two of the 5 claim to experience mild heart palpitations and only one of those responds “sometimes” to cordless phones.

Discussion

The most intriguing result in this study is that a small group of subjects responded immediately and dramatically to MW exposure generated by a digital cordless DECT phone with blinded exposure. Heart rate (HR) increased significantly for 4 subjects (16%) (10 to 93 beats per minute) and the sympathetic/parasympathetic balance changed for an additional 6 subjects (24%) while they remained in a supine position. This is the first study documenting such a dramatic change brought about immediately and lasting as long as the subject was exposed and is in sharp contrast to the provocation studies reviewed by Levallois[5], Rubin *et al.*[14], and Bergqvist *et al.*[31]. Authors of these reviews generally conclude that they were unable to establish a relationship between low or high frequency fields and electromagnetic hypersensitivity (EHS) or with symptoms typically occurring

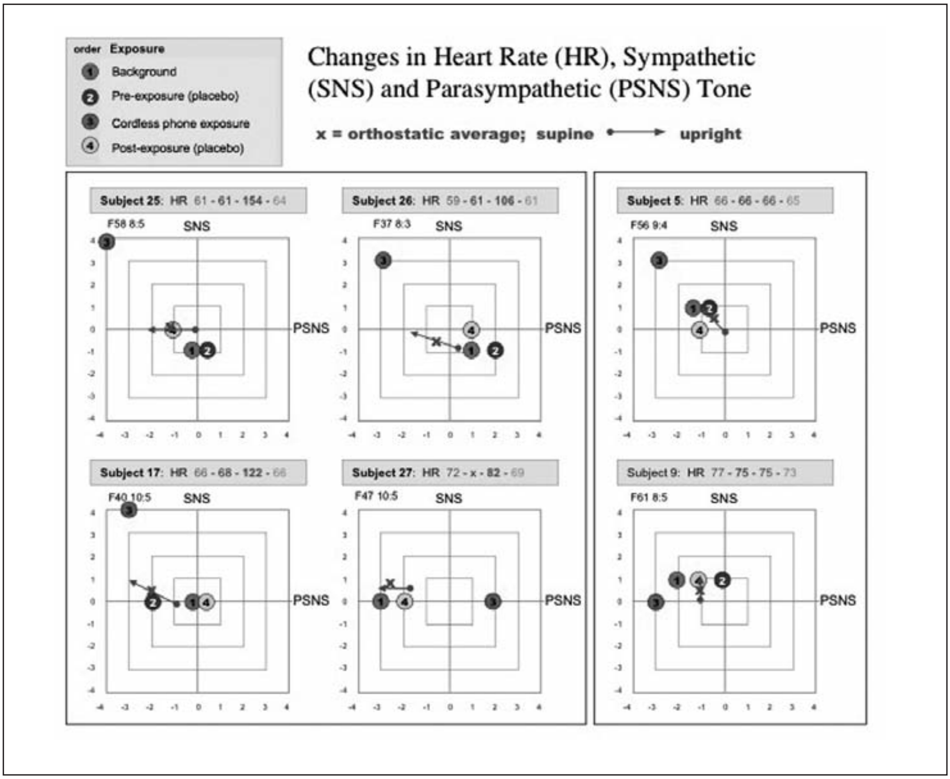

Fig. 13. Reactive Subjects: changes in heart rate, sympathetic, and parasympathetic tone before, during, and after blind provocation with a 2.4 GHz cordless phone that generates exposure of 3 to 5 microW/cm^2

among such afflicted individuals. Furthermore, several studies report no effect of mobile phones (various exposure conditions) on human HRV-parameters[32-39].

Our results clearly show a causal relationship between pulsed 100 Hz MW exposure and changes in the ANS that is physiological rather than psychological and that may explain at least some of the symptoms experienced by those sensitive to electromagnetic frequencies. Dysfunction of the ANS can lead to heart irregularities (arrhythmia, palpitations, flutter), altered blood pressure, dizziness, nausea, fatigue, sleep disturbances, profuse sweating and fainting spells, which are some of the symptoms of EHS.

When the SNS (fight or flight response) is stimulated and the PSNS (rest and digest) is suppressed the body is in a state of arousal and uses more energy. If this is a constant state of affairs, the subject may become tired and may have difficulty sleeping (unable to relax because of a down regulated PSNS and/or up regulated SNS). Interestingly, Sandstrom[40] found a disturbed pattern of circadian rhythms of HRV and the absence of the expected HF (parasympathetic) power-spectrum component during sleep in persons who perceived themselves as being electrically hypersensitive.

If the dysfunction of the ANS is intermittent it may be experienced as anxiety and/or panic attacks, and if the vagus nerve is affected it may lead to dizziness and/or nausea.

Our results show that the SNS is up regulated (increase in LF) and the PSNS is down regulated (decrease in HF) for some of the subjects during provocation. The greatest

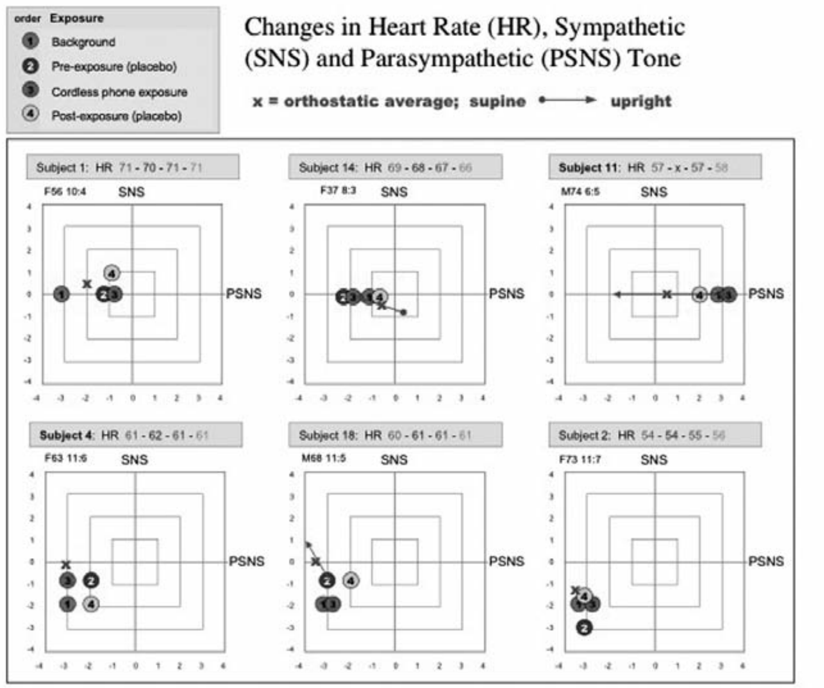

Fig. 14. Non or slightly reactive subjects: patterns of response for before, during, and after blind provocation with a 2.4 GHz cordless phone that generates exposure of 3 to 5 microW/cm[2]

increase is in LF2, which is the adrenal stress response, although LF1 also increases. We not know the degree to which this is due to the 100 Hz pulse, the MW carrier, or their combination.

Several studies lend support to our results.

Lyskov *et al.*[41] monitored baseline neurophysiological characteristics of 20 patients with EHS and compared them to a group of controls. They found that the observed group of patients had a trend to hypersympathotone, hyper-responsiveness to sensor stimulation and heightened arousal. The EHS group at rest had on average lower HR and HRV and higher LF/HF ratio than controls. We found that subjects with intense and moderate reactions to the MW provocation also had higher LF/HF ratios than those who did not respond.

Kolesnyk *et al.*[42] describes an "adverse influence of mobile phone on HRV" and Rezk *et al.* [43] reports an increase of fetal and neonatal HR and a decrease in cardiac output after exposure of pregnant women to mobile phones.

Andrzejak *et al.*[44] reports an increased parasympathetic tone and a decreased sympathetic tone after a 20-minute telephone-call. While these results are contrary to our findings, the effect of speaking cannot be ruled out in Andrzejak's study. In our study the subject remained in a supine position, silent and still during the testing.

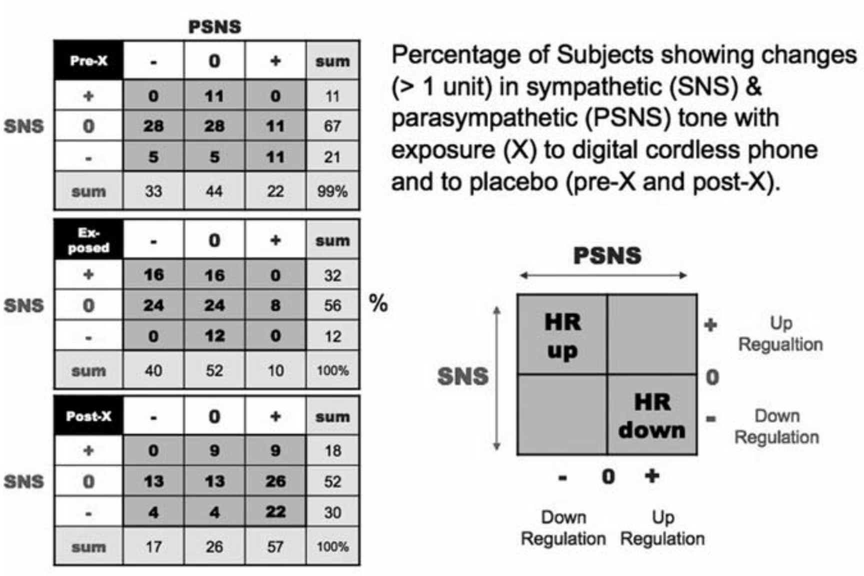

Fig. 15. Response of 25 subjects to blind provocation by a 2.4 GHz digital cordless phone that generates exposure of 3 to 5 microW/cm^2

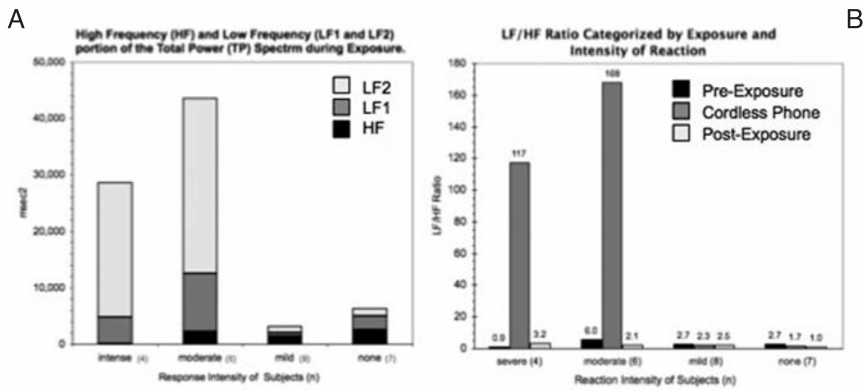

Fig. 16. A. Mean high frequency (parasympathetic) and low frequency (sympathetic) spectral distribution as a function of response intensity of 25 subjects exposed to a 2.4 GHz cordless phone. B. Low frequency (LF1 + LF2) to high frequency (HF) ratio for different exposures

Workers of radio broadcasting stations have an increased risk of disturbances in blood pressure and heart rhythm. They have a lower daily heart rate, a decreased HR variability, higher incidences of increased blood pressure and disturbances in parameters of diurnal rhythms of blood pressure and HR-all of no clinical significance, but showing a certain dysregulation of autonomic cardiac control[45-48].

Bortkiewicz *et al.*[49] reported that exposure to AM radio frequency EMF within hygienic standards affects the functions of the ANS of workers. Workers had higher frequency of abnormalities in resting and 24-h ECG than controls and an increased number of heart rhythm disturbances (ventricular premature beats). As in our study, RF exposure was associated with a reduced HF power spectrum suggesting that the EMF field reduce the influence of the PSNS on circulatory function.

Several studies report changes in blood pressure with electromagnetic exposure[50, 51]. Others show an increase of oxidative stress and a decrease of antioxidative defense-systems in heart-tissue irradiated with 2.45 GHz and 900 MHz respectively[52, 53]. Still others show a stress-response reaction following exposure to radio frequency radiation either in the form of heat shock proteins (hsp) or changes in enzymatic activity. Irradiation of rats with a low-intensity-field (0.2-20 MHz) resulted in an increase of myocardial hsp70[54]. Similarly 1.71 GHz MW exposure increased hsp70 in p53-deficient embryonic stem cells[55]. Abramov and Merkulova[56] report pulsed EMFs increase the enzymatic activity of acetylcholinesterase in the animal heart, which suppresses the parasympathetic and allows the sympathetic to dominate.

Most of the studies on humans, that did not show any effects of MW radiation in some of the studies mentioned above, were conducted with young, healthy subjects, giving rise to the question whether the experiments would have yielded different results with subjects with a "higher level of pathologic pre-load" and thus fewer possibilities to acutely compensate the possible stressor of radiation.

The studies on work-exposure to MW radiation were able to show different levels of effects on the cardiovascular system, and this could be interpreted as the necessity to remain regularly, repeatedly, and for a longer time under the influence of a certain EMF exposure, hence pointing out the great importance of the electromagnetic exposures in the work and home environment. Perhaps only chronic exposure to MW-EMF can influence various rhythms (e.g. cardiovascular biorhythms) sufficiently to cause detectable effects. Perhaps it is these individuals who become EHS and then respond to stressors if they have sufficient energy to mount a reaction.

In our study, half of those tested claimed to be moderately to extremely sensitive to electromagnetic energy and they ranged in age from 37 to 79 years old. The symptoms they identified are similar to those reported elsewhere and include poor short-term memory, difficulty concentrating, eye problems, sleep disorder, feeling unwell, headache, dizziness, tinnitus, chronic fatigue, and heart palpitations[2, 7, 57].

The common devices attributed to stress generation included fluorescent lights, antennas, cell phones, Wi-Fi, and cordless phones. The last 4 items all emit MW radiation.

Many of those claiming to have EHS also had food allergies, mold/pollen/dust allergies and were chemically sensitive. With so many other sensitivities it is difficult to determine whether the sensitivity to electromagnetic energy is a primary disorder attributable to high and/or prolonged EM exposures or a secondary disorder brought about by an impaired immune system attributable to other stressors.

Interestingly, the younger participants (37 to 58) displayed the most intense responses presumably because they were healthy enough to mount a response to a stressor. Those who did not respond to the MW exposure were either not sensitive, or they had a low adaptive capacity coupled with a poor fitness score and did not have enough energy to mount a reaction. Orthostatic HRV combined with provocation monitoring may help distinguish these three types of responses (sensitive, not sensitive, non-responsive reactors).

The term EHS was deemed to imply that a causal relationship has been established between the reported symptoms and EMF exposure and for that reason the WHO[8] has labeled EHS as *Idiopathic Environmental Intolerance* (IEI) to indicate that it is an acquired disorder with multiple recurrent symptoms, associated with diverse environmental factors tolerated by the majority of people, and not explained by any known medical, psychiatric or psychological disorder. We think this labeling needs to be changed especially in light of this study.

Conclusions

The orthostatic HRV provides information about the adaptive capacity of an individual based on fitness score and on the state of the SNS and PSNS. A person with high adaptive capacity is unlikely to respond to a stressor (because they are highly adaptive) but if they do respond the response is likely to be intense. Orthostatic HRV was able to predict the intensity of the response much better than the probability of a response to a stressor, which in this case was a 2.4 GHz digital cordless phone that generated a power density of 3 to 5 microW/cm^2.

Forty percent of those tested responded to the HRV provocation. Some experienced tachycardia, which corresponded to an up regulation of their SNS and a down regulation of their PSNS (increase in LF/HF ratio). This was deemed a severe response when the HR in supine subjects increased by 10 to 93 beats per minute during blinded exposure. HR returned to normal during sham exposure for all subjects tested. In total, 16% had a severe response, 24% had a moderate response (changes in SNS and/or PSNS but no change in HR); 32% had a slight response; and 28% were non-responders. Some of the non-responders were either highly adaptive (not sensitive) or non-responding reactors (not enough energy to mount a reaction). A few reactors had a potentiated reaction, such that their reaction increased with repeated exposure, while others showed re-regulation with repeated exposure.

These data show that HRV can be used to demonstrate a physiological response to a pulsed 100 Hz MW stressor. For some the response is extreme (tachycardia), for others moderate to mild (changes in SNS and/or PSNS), and for some there is no observable reaction because of high adaptive capacity or because of systemic neurovegetative exhaustion. Our results show that MW radiation affects the ANS and may put some individuals with pre-existing heart conditions at risk when exposed to electromagnetic radiation to which they are sensitive.

This study provides scientific evidence that some individuals may experience arrhythmia, heart palpitations, heart flutter, or rapid heartbeat and/or vasovagal symptoms such as dizziness, nausea, profuse sweating and syncope when exposed to electromagnetic devices. It is the first study to demonstrate such a dramatic response to pulsed MW radiation at 0.5% of existing federal guidelines (1000 microW/cm^2) in both Canada and the US.

Acknowledgements

We thank those who offered their homes for testing and those who volunteered to be tested. Special thanks goes to Evelyn Savarin for helping with this research.

References

1. Hallberg O, Oberfeld G. Letter to the Editor: Will we all become electrosensitive? Electromagn Biol Med 2006; 25: 189-91.
2. Firstenberg A. Radio wave packet. President, cellular phone taskforce. 2001; http://www.goodhealthinfo.net/radiation/radio_wave_packet.pdf
3. Eltiti S, Wallace D, Zougkou K, *et al*. Development and evaluation of the electromagnetic hypersensitivity questionnaire. Bioelectromagnetics 2007; 28: 137-51.
4. Hillert L, Berglind N, Arnetz BB, *et al.* Prevalence of self-reported hypersensitivity to electric or magnetic fields in a population-based questionnaire survey. Scand J Work Environ Health 2002; 28(1): 33-41.
5. Levallois P. Hypersensitivity of human subjects to environmental electric and magnetic field exposure: a review of the literature. Environ Health Perspect 2002; 110 (suppl 4): 613-8.
6. Johansson O. Electrohypersensitivity: State-of-the-art of a functional impairment. Electromagn Biol Med 2006; 25: 245-58.
7. Schooneveld H, Kuiper J. Electrohypersensitivity (EHS) in the Netherlands. A questionnaire survey. 2nd graphical edition. Stichting EHS (Dutch EHS Foundation), 2008, 23.
8. Mild KH, Repacholi M, van Deventer E (eds). Electromagnetic Hypersensitivity. Proceedings International Workshop on EMF Hypersensitivity Prague, Czech Republic October 25-27, 2004, 196.
9. Havas M, Olstad A. Power quality affects teacher wellbeing and student behavior in three Minnesota Schools. Sci Total Environ 2008; 402(2-3): 157-62.
10. Havas M. Dirty electricity: an invisible pollutant in schools. Feature Article for Forum Magazine, Ontario Secondary School Teachers' Federation (OSSTF), 2006; Fall.
11. Havas M. Electromagnetic hypersensitivity: biological effects of dirty electricity with emphasis on diabetes and multiple sclerosis. Electromagn Biol Med 2006; 25: 259-68.
12. Havas M. Dirty electricity elevates blood sugar among electrically sensitive diabetics and may explain brittle diabetes. Electromagn Biol Med 2008; 27(2): 135-46.
13. Rea WJ, Pan Y, Fenyves EJ, *et al*. Electromagnetic field sensitivity. J Bioelectr 1991; 10: 241-56.
14. Rubin GJ, Das Munshi J, Wessely S. Electromagnetic hypersensitivity: a systematic review of provocation studies. Psychosom Med 2005; 67: 224-32.
15. Santini R, Santini P, Danze JM. Study of the health of people living in the vicinity of mobile phone base stations: 1st influence of distance and sex. Pathol Biol 2002; 50: S369-73.
16. Granlund R, Lind J. Black on White: voices and witnesses about electro-hypersensitivity, the Swedish Experience. 2nd Internet Edition Oct 3, 2004. Translation: J. Ganellen; Diagrams: J. Rennerfelt © Mimers Brunn Kunskapsförlaget, Sweden. mimersbrunn@spray.se
17. IGUMED. Freiburger Appeal. nterdisziplina re Gesellschaft fur Umweltmedizin e. Bergseestr. Bad Sackingen, October 9 2002, 57, 79713. igumed@gmx.de
18. Haumann T, Sierck P. Nonstop pulsed 2.4 GHz radiation inside US homes. 2nd International Workshop on Biological Effects of Electromagnetic Fields, 7-11 Oct. 2002.
19. Singer DH, Martin GJ, Magid N, *et a*l. Low heart rate variability and sudden cardiac death. J Electrocardiol 1988; 21: S46-55.
20. Cerutti S. Power spectrum analysis of heart rate variability signal in the diagnosis of diabetic neuropathy, IEEE Engineering in Medicine and Biology Society 11th Annual International Conference, 1989, 12-13.
21. Hayano J. Decreased magnitude of heart rate spectral components in coronary artery disease. Circulation 1990; 81: 1217-24.
22. Muhlnickel B. The value of heart rate frequency variability in the prognostic evaluation of patients with severe cerebral injuries. Anaesthesiol Reanim 1990; 15: 342-50.

23. Van Ravenrwaaij-Arts CM, Kollee LA, Hopman JC, *et al*. Heart rate variability. Ann Int Med 1993; 118: 436-47.
24. Camm AJ, Malik M. Guidelines, heart rate variability, standards of measurement, physiological interpretation, and clinical use. Task Force of the European Society of Cardiology and the North American Society of Pacing and Electrophysiology. Eur Heart J 1996; 17: 354-81.
25. Riftine A. Nervexpress. System Guide and User's Manual. Heart Rhythm Instruments Inc., 2002, 72. Metuchen NJ. www.nervexpress.com.
26. Riftine A. Quantitative assessment of the autonomic nervous system based on heart rate variability analysis theoretical review of the nerve-express system with sample cases. Theoretical Review and Clinical Use 2005; 43 pp. www.intelwave.net
27. Graham MH. A microsurge meter for electrical pollution research. Memorandum No. UCB/ERL M03/3, 19 February 2003, Electronics Research Laboratory, College of Engineering, University of California, Berkeley.
28. NHLBI. High Blood Pressure. National Heart Lung and Blood Institute, Diseases and Conditions Index. November 2008. http://www.nhlbi.nih.gov/health/dci/Diseases/Hbp/HBP_WhatIs.html.
29. NHLBI. National Heart Lung and Blood Institute, Obesity Education Initiative, Calculate our Body Mass Index. No date; http://www.nhlbisupport.com/bmi/
30. Mortazavi SM, Daiee E, Yazdi A, *et al*. Mercury release from dental amalgam restorations after magnetic resonance imaging and following mobile phone use. Pak J Biol Sci 2008; 11(8): 1142-6.
31. Bergqvist U, Vogel E (eds). Possible health implications of subjective symptoms and electromagnetic fields. A report prepared by a European group of experts for the European Commission, DG V, Swedish: National Institute for Working Life, 1997; 135 pp.
32. Mann K, Röschke J, Connemann B, *et al*. No effects of pulsed high-frequency electromagnetic fields on heart rate variability during human sleep. Neuropsychobiology 1998; 38: 251-6.
33. Röschke J, Mann K, Connemann B. Cardiac autonomic activity during sleep under the influence of radiofrequency electromagnetic fields. Somnologie 2005; 9: 180-4.
34. Wilén J, Johansson A, Kalezic N, *et al*. Psychophysiological tests and provocation of subjects with mobile phone related symptoms. Bioelectromagnetics 2006; 27: 204-14.
35. Atlasz T, Kellényi L, Kovács P, *et al*. The application of surface plethysmography for heart rate variability analysis after GSM radiofrequency exposure. J Biochem Biophys Methods 2006; 69: 233-6.
36. Parazzini M, Ravazzani P, Tognola G, *et al*. Electromagnetic fields produced by GSM cellular phones and heart rate variability. Bioelectromagnetics 2007; 28: 122-9.
37. Barker AT, Jackson PR, Parry H, *et al*. The effect of GSM and TETRA mobile handset signals on blood pressure, catechol levels and heart rate variability. Bioelectromagnetics 2007; 28: 433-8.
38. Johansson A, Forsgren S, Stenberg B, *et al*. No effect of mobile phone-like RF exposure on patients with atopic dermatitis. Bioelectromagnetics 2008; 29: 353-62.
39. Ahamed VI, Karthick NG, Joseph PK. Effect of mobile phone radiation on heart rate variability. Comput Biol Med 2008; 38: 709-12.
40. Sandstrom M, Lyskov E, Hornsten R, *et al*. Holter ECG monitoring in patients with perceived electrical hypersensitivity. Int J Psychophysiol 2003; 49: 227-35.
41. Lyskov E, Sandström M, Hansson Mild K. Neurophysiological study of patients with perceived 'electrical hypersensitivity'. Int J Psychophysiol 2001; 42: 233-41.
42. Kolesnyk I, Zhulinsky M, Abramov VO, *et al*. Effect of mobile phone electromagnetic emission on characteristics of cerebral blood circulation and neurohumoral regulations in humans. Fiziol Zh 2008; 54: 90-3.
43. Rezk AY, Abdulqawi K, Mustafa RM, *et al*. Fetal and neonatal responses following maternal exposure to mobile phones. Saudi Med J 2008; 29: 218-23
44. Andrzejak R, Poreba R, Poreba M, *et al*. The influence of the call with a mobile phone on heart rate variability parameters in healthy volunteers. Ind Health 2008; 46: 409-17.
45. Bortkiewicz A, Zmylony M, Gadzicka E, *et al*. Evaluation of selected parameters of circulatory system function in various occupational groups exposed to high frequency electromagnetic fields. II. Electrocardiographic changes. Med Pr 1996; 47: 241-52.
46. Bortkiewicz A, Zmylony M, Gadzicka E, *et al*. Ambulatory ECG monitoring in workers exposed to electromagnetic fields. J Med Eng Technol 1997; 21: 41-6.
47. Gadzicka E, Bortkiewicz A, Zmylony M, *et al*. Evaluation of selected functional circulation param-

eters of workers from various occupational groups exposed to electromagnetic fields of high frequency. III. 24-h monitoring of arterial blood pressure (ABP). Med Pr 1997; 48: 15-24.
48. Szmigielski S, Bortkiewicz A, Gadzicka E, *et al*. Alteration of diurnal rhythms of blood pressure and heart rate to workers exposed to radiofrequency electromagnetic fields. Blood Press Monit 1998; 3: 323-30.
49. Bortkiewicz A, Gadzicka E, Zmylony M. Heart rate variability in workers exposed to medium-frequency electromagnetic fields. J Auton Nerv Syst 1996; 59: 91-7.
50. Lu ST, Mathur SP, Akyel Y, *et al*. Ultrawide-band electromagnetic pulses induced hypotension in rats. Physiol Behav 1999; 65: 753-61.
51. Li BF, Guo GZ, Ren DQ, *et al*. Electromagnetic pulses induce fluctuations in blood pressure in rats. Int J Radiat Biol 2007; 83: 421-9.
52. Kim MJ, Rhee SJ. Green tea catechins protect rats from microwave-induced oxidative damage to heart tissue. J Med Food 2004; 7: 299-304.
53. Ozguner F, Altinbas A, Ozaydin M, *et al*. Mobile phone-induced myocardial oxidative stress: protection by a novel antioxidant agent caffeic acid phenethyl ester. Toxicol Ind Health 2005; 21: 223-30.
54. Ronchi R, Marano L, Braidotti P, *et al*. Effects of broad band electromagnetic fields on HSP70 expression and ischemia-reperfusion in rat hearts. Life Sci 2004; 75: 1925-36.
55. Czyz, J, Guan K, Zeng Q, *et al*. High frequency electromagnetic fields (GSM signals) affect gene expression levels in tumor suppressor p53-deficient embryonic stem cells. Bioelectromagnetics 2004; 25: 296-307.
56. Abramov LN, Merkulova LM. Histochemical study of the cholinesterase activity in the structures of the rat heart normally and during exposure to a pulsed electromagnetic field. Arkh Anat Gistol Embriol 1980; 79: 66-71.
57. Bergqvist U, Wahlberg J. Skin symptoms and disease during work with visual display terminals. Cont Derm 1994; 30: 197-204.

APPENDIX A: Summary of data based on blind assessment.

1		2	3	4		5		6					7			Notes:
					Orthostatic HRV			Actual	Changes in			Blind Assessment				
EHS	Subject Code	EHS Ranked	EHS Self Assessment	CV Tone	IOR Code	AC Code	POR Code	Stages Exposed	HR	SNS	PSNS	Stages Exposed	Stages showing reaction	POR Code	IOR	
intense	25	1	very	3	3.5	4.5	1.5	3, 5 (6,7,9)	93	5	-4	**3, 5**	3, 5	5	high to extreme	8
	17	2	very	3	3.5	3.5	3.0	3, 5 (6)	54	4	-1	**3, 5, 6**	3, 5, 6	4.5	moderate	9
	26	3	moderate	1	5.0	5.0	1.5	3, 5, 6 (7, 8)	45	4	-5	**3, 5, 6, 7**	3, 5, 6, 7	5	moderate to intense	10
	27	4	little	3	3.0	3.0	3.5	2, 4 (5, 6)	10	0	5	**2, 4, 5**	2, 4, 5	5	mild	11
moderate	5	5	moderate	2	4.0	3.5	3.5	3, 5	0	2	-2	**3, 5**	3, 5	5	moderate to high	12
	9	6	don't know	2	3.5	4.5	2.0	3, 5, 6, 8	0	-1	-3	**3, 5, 6**	3, 5, 6	4	high	13
	3	7	don't know	-1	5.0	4.0	1.0	3, 4	3	2	0	2, **3**	3, 4	4	moderate	14
	16	8	very	1	4.0	4.0	3.5	2, 4, 6	1	-2	0	**2**	2	1	mild	15
	8	9	not	5	2.5	1.5	4.5	2, 3	0	0	-2	**2**, 4	2, 4	1	mild	16
	10	10	don't know	2	3.5	3.0	3.0	3 (7, 8, 9)	2	0	-1	**3, 7,8,9**	3 mild, 7,8,9 intense	5	intense	17
mild	2	11	don't know	2	2.0	1.0	3.5	3, 4	1	1	0	unknown	none	1.75	mild	18
	23	12	little	-1	5.0	1.5	4.5	2, 4 (5, 6)	-1	1	0	**2, 5**	2, 5	2	mild to moderate	19
	12	13	little	3	4.0	4.0	2.5	2, 3 (5)	-2	1	0	**3**	3, 4, 5	3	mild to moderate	20
	18	14	don't know	2	2.5	2.5	4.5	3	0	-1	0	**3**	3	1.5	mild	21
	19	15	don't know	4	2.0	2.5	3.0	3	0	-1	0	2, 4	2, 4	3	mild to moderate	22
	6	16	very	2	3.5	2.0	4.5	3, 4	0	0	-1	2	2	2	mild	23
	4	17	little	1	2.0	1.0	4.0	3, 4	-1	0	-1	**3, 4**	4, 5	2.25	moderate	24
	24	18	little	2	3.0	4.0	3.0	3, 5	-1	0	1	2, 4, **5**	2, 4, 5	2.5	mild	25
none	1	19	don't know	5	3.5	3.5	3.5	3, 4	1	0	0	**3, 4**	4, 5	1	mild	26
	11	20	not	1	1.0	5.0	1.5	2, 4, 5	0	0	0	3	3	1	mild or non-symptomatic	27
	21	21	little	3	2.5	2.0	3.5	3 (4, 5)	0	0	0	2, **5**	2, 5	1.5	none to mild	28
	7	22	very	2	2.5	1.5	4.0	3, 4	-1	0	0	unknown	unknown	1.5	mild	29
	14	23	don't know	5	2.5	3.5	3.0	3, 4	-1	0	0	2	2, 3, 4	1.75	mild	30
	20	24	little	3	3.5	4.0	4.5	2	-1	0	0	possibly 5?	6	1	mild	31
	13	25	very	4	3.0	2.5	3.5	3, 4	-2	0	0	unknown	unknown	1	mild	32

code	code	code	code	code	code	code
5	hypo	intense	high	high	high	intense
4		strong				strong
3	normal	moderate	moderate	moderate	moderate	moderate
2		mild				mild
≤ 1	hyper	don't know	low	low	low	don't know

Notes:

1 Electrohypersensitivity (EHS) response categories are based on HR = heart rate; SNS = sympathetic nervous system; PSNS = parasympathetic nervous system.

2 EHS was ranked based on changes in HR and changes in the SNS and PSNS during exposure to microwave (MW) radiation.

3 Self-assessment of sensitivity based on questionnaire response.

4 Cardiovascular (CV) Tone is based on the HR times the sum of the systolic and diastolic blood pressure; values at 1 or lower are hypotonic and values at 5 are hypertonic.

5 Intensity of reaction (IOR); adaptive capacity (AC), which is 6 - non adaptive capacity (NAC); and probability of reaction (POR) are based on the orthostatic heart rate variability (HRV) results and are described in the text.

6 Subjects were exposed to MW radiation at different stages. Stages in parentheses were not used in the study as they reflect multiple exposures with interference from other agents.

7 Blind assessment was based on the HRV during continuous monitoring with real and sham exposure to MW radiation from a 2.4 GHz digital cordless phone radiating and at a power density between 3 and 5 microW/cm^2.

8 Excellent subject.

9 Symptomatic at stage 3, parasympathetic rally begins to recovery but feels anxiety, stage 3 faint or dizziness predicted. Decent Chronotropic Myocardial Reaction Index (ChMR) and vascular compensation reaction (VC). Middle of bell curve.

10 The healthier a subject the more likely the reaction. This person has the energy to become symptomatic.

11 Mildly inflamed. Mildly fatigued but highly adaptive. ChMR and VC good. Has ability to react.

12 Adaptive person. Could use Mg and/or K based on high standing HR.

13 Has plenty of energy. Moderate response due to weakening. Stage 7 body re-regulating from exposure.

14 Shows a weakening reaction (down regulation of SNS). Positive reactor. Very healthy for age. Highly adaptive geriatric.

15 Lot of adaptive capacity. If she is exposed her reaction would be a fairly strong reaction.

16 Has diminished energy capacity (11:6). This person doesn't have enough energy to have a robust response.
17 Potentiated reactor, time sensitive, couldn't tolerate re-exposure. If she reacts it will be moderately strong because of ChMR. Needs minerals for VC factor slowed her down.
18 May be on heart medication. Cardiac rate and rhythm non-adaptive. CV tone hypertonic.
19 Any neurological insult will be met with a hard reaction since she has inverted response when she stands up.
20 If reactor, it will be strong because of ChMR strong. Highly adaptive capability and reserve. Slow VC could be mineral or vitamin D deficiency.
21 Don't have a strong PSNS resistance. Reactivity is based on inability to go parasympathetic, and then they will go more sympathetic if they have the energy to do so. No energy. Either a delayed reaction or a weak reaction.
22 Afibrillation, palpitations of heart probable. Strong girl. 11:6 fitness is OK for a person this age.
23 May have dental problems based on S/P response. Neurologically compromised.
24 Neurologically compromised. May be overmedicated on CV drug.
25 Strong gal. Decent reserve capacity but temporary fatigue. Doesn't feel bad but poor health for her age.
26 Normal reaction to stress, mild non-toxic reaction. Potential for reaction: moderately high because of the 10.4 but may tolerate an amount of exposure before they react because of the reserve capabilities.
27 Ridiculously healthy. Poster boy for his age. He can take a lot based on fitness of 6:5.
28 Lower end of bell curve. Doesn't have energy to react although may be symptomatic.
29 Either highly adaptive or non-reactive. Orthostatic response indicates that person doesn't have enough energy to have a robust response.
30 Normal CV tone for age, Decent Tension Index (TI). Good geriatric pattern. If she reacts it would be moderate to mild.
31 Strong girl. Has strong adrenal capacity. If she reacts it will be strong. May have chronic fatigue.
32 Moderate inflammation. Tired and has low adaptive reserve. If stressor comes along it will produce more stress. If reacting it would be medium.