ENDOCRINOLOGY

ENDOCRINE DISORDERS

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DIABETES MEILLITUS (DM); INSULIN DEPENDENT (IDDM) (250.01) AND NON-INSULIN DEPENDENT (NIDDM) (250.00); DM WITH COMPLICATIONS (250.9)

CRITERIA	→ N/A	→ 1) NIDDM: Well controlled on oral hypoglycemics for 6 mos → 2) NIDDM: diet, contr. 6 mos. → 3) IDDM controlled for 2 yrs. Required to bring to bring 2 medical information bracelets.	→ 1) NIDDM not well controlled → 2) IDDM "Brittle": frequent insulin dose changes, freq. visits MD. → 3) Glycohemoglobin > 9%. → 4) Weight >120% IBW.	→ DM: with any complications, cardiac, periph vascular, Renal, retinal involvement, skin ulcers, Neuropathy.
ACTION	**CLEAR**	**CLEAR WITH RESTRICTIONS**	**DEFER** UNTIL	**MNQ**
RESTRICT-IONS/DEFER		1-2) BMF / FYI cable to PCMO 3) PCMO concurrence approved B.C. Endocrinologist for care. Placement site within 30 mins. of 24 hr. ER facilities. Glycohemoglobin q 3 mos., fingersticks for FBS as ordered. (Bring 6 mos. supply.)	1-3) Meets criteria for "well-controlled" (see below left). 4) Weight <120% IBW	High risk for serious complications cannot support in PCMU's.
RATIONALE	CRITERIA FOR WELL-CONTROLLED IDDM OR NIDDM 1) No ER visits or paramedic calls for life threatening hypoglycemic reactions in last 2 years. 2) No renal, vascular, retinal, foot lesions, or neuro comp. 3) No diabetes-related hospitalizations in prev. 2 yrs. 4) FBS WNL, Glycohemoglobin < 9 on 2 measurements at least 2 mos. apart. 5) Weight < 120% of ideal wt. 6) Demonstrated ability to care for self & monitor disease. (Appl.to describe monitoring plan)	At risk for life threatening diabetic ketoacidosis if becomes ill, or hypoglycemic reaction, or severe infections due to slow healing of skin lesions.	Glycohemoglobin is a good indicator of control over time. Normals = 5 - 6%. * See Weight guideline	

MEDICAL INFORMATION NEEDED:

Generic information.
Detailed opthalmologist evaluation MD documented ability to care for self. Self-care plan from applicant.
FBS, Bun, Creatinine
Glycohemoglobin X 2 at least 2 mos. apart. 24 hr urinary protein and creatinine clearance if proteinuria on dipstick.

Endocrinology

7/17/95

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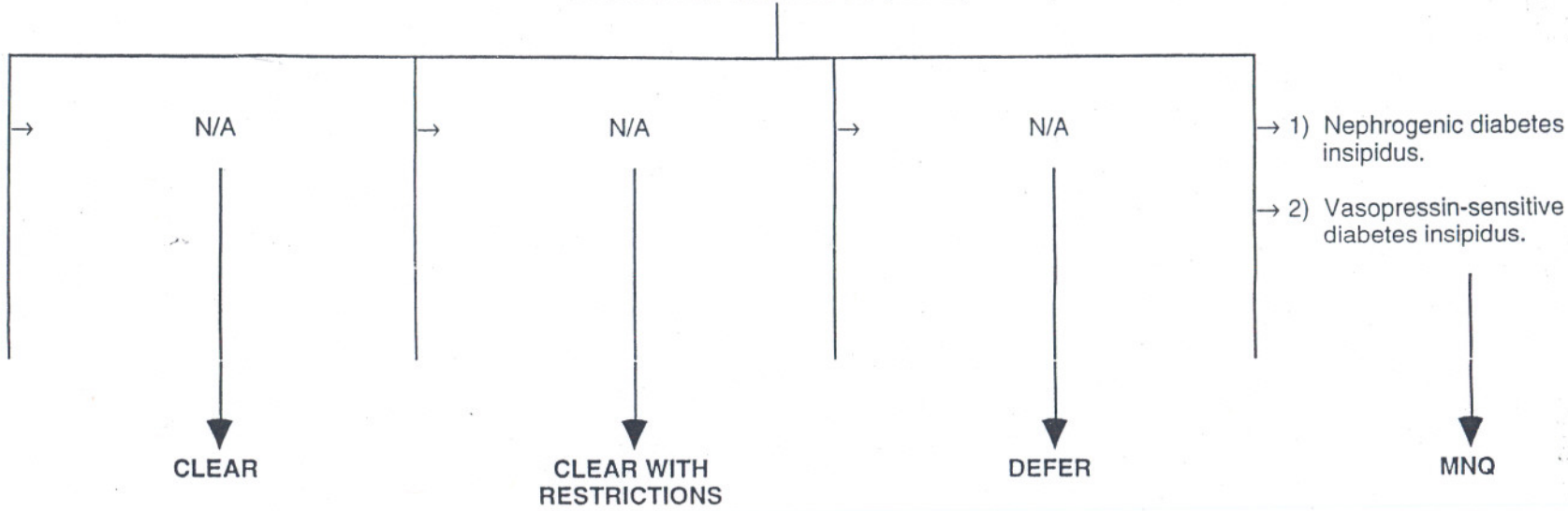
DIABETES INSIPIDUS (253.5)



RESTRICT-IONS/DEFER

RATIONALE

1) Adequate availability of potable water to maintain hydration cannot be guaranteed.

2) Adequate treatment is not available in PCMU's.

MEDICAL INFORMATION NEEDED: Generic information

5/4/93

GOUT (274)

CRITERIA	Period ≥ 6 mos. with no acute episodes, uric acid < 6 mg/dl, on or off meds.	N/A	1) Uric acid ≥ 6 mg/dl, episodes within last 6 mos. 2) Weight > 150% IBW	N/A
ACTION	**CLEAR**	**CLEAR WITH RESTRICTIONS**	**DEFER**	**MNQ**
RESTRICT-IONS/DEFER			UNTIL: 1) No flare-ups in 6 mos., uric acid < 6 mg/ld. 2) Weight < 150% IBW	

RATIONALE

Medications:

1) Allopurinol for suppression. Requires no F/U, serious side effects are very rare.

2) Acute attacks: Colchicine, non-steroidal antiinflama-tories (NSAID's) (Require LFT's every year if taking every day).

* See weight guideline

MEDICAL INFORMATION NEEDED:

Generic information;

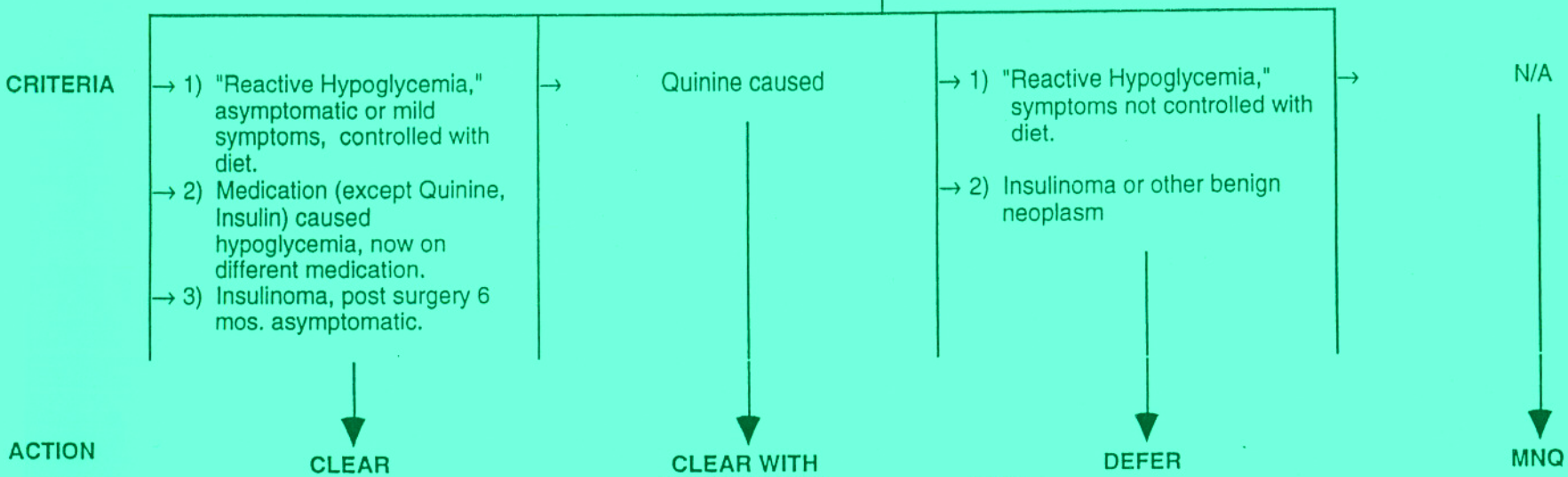
Uric acid level: should be less than 6 mg/dl

Specific medications for gout currently taking and in the past; and

MD and app provide management plan for acute attacks.

7/17/95

HYPOGLYCEMIA (251.2), INSULINOMAS (211.7)



RESTRICT-IONS/DEFER

Restrict to non-malarial country

UNTIL:

1) Controlled with diet.

2) Resolved post surgery, > 6 mos.

RATIONALE

True hypoglycemia is rarely documented, freq. misdiag-nosed. Most patients while symptomatic have plasma glucose > 45 mg/dl.

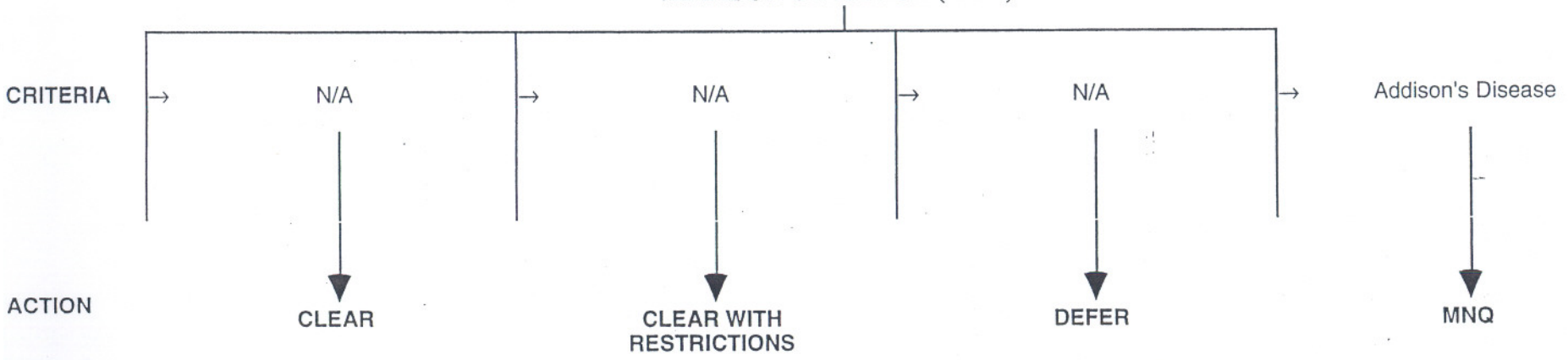
Can bé assoc. with GI surgery, renal or liver disease, many medications, hormone deficiencies, insulinomas or other neoplasms.

May require Quinine treatment for malaria.

MEDICAL INFORMATION NEEDED:

Generic information

ADDISON'S DISEASE (255.4)



RESTRICT-IONS/DEFER

RATIONALE

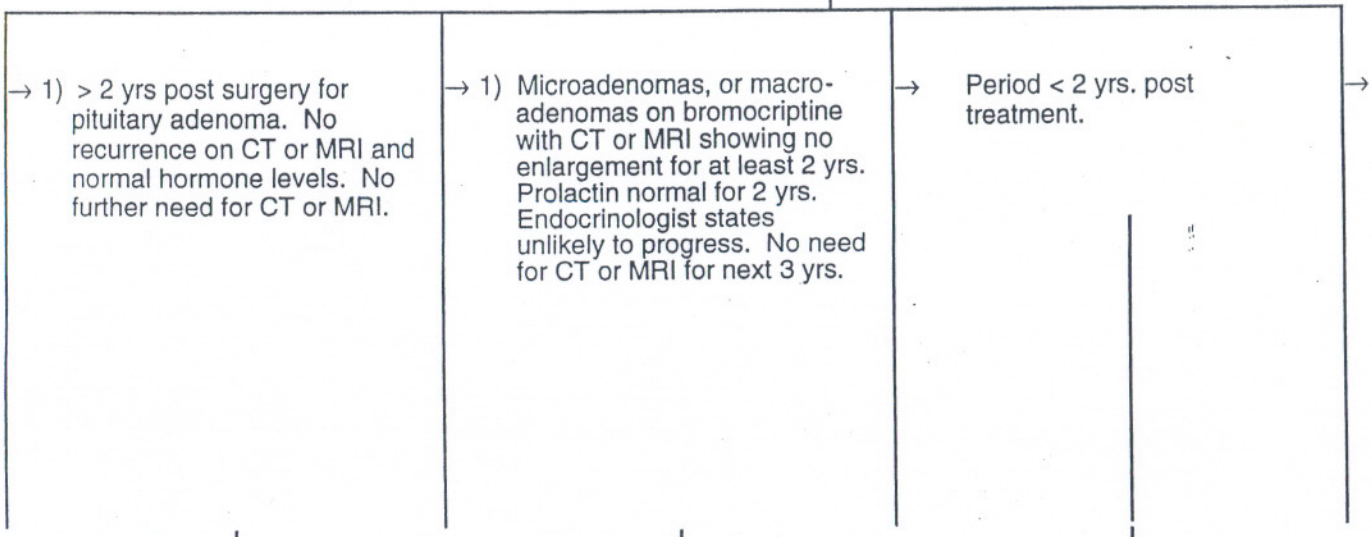
Addison's is a rare condition that is treated with cortisone replacement therapy. When ill, patients are advised to double their steroid dose. If vomiting, can inject self with dexamethasone, the effects of which last 3 days. Medical support may be life-saving.

The steroid dose is a replacement dose and does not place the PCV at any additional risk of infection.

Treatment not available in PCMU's. At risk for additional Addisonian crisis, which is life threatening.

MEDICAL INFORMATION NEEDED:

PITUITARY ADENOMAS (227.3), ACROMEGALY (253.0)



ACTION	CLEAR	CLEAR WITH RESTRICTIONS	DEFER UNTIL:	MNQ
RESTRICT-IONS/DEFER		2) Approved Endocrinologist for F/U T4 TSH, Prolactin levels, electrolytes q yr.	Post treatment at least 2 yrs. and meets criteria for clear.	
RATIONALE	F/U for adenomas consists of MRI or CAT scan at 1,2, and 4, 5 years to R/O recurrence. Hormone levels should be monitored also.		Requires frequent F/U at least first 2 years post treatment.	Treatment not available in PCMU's.

MEDICAL INFORMATION NEEDED:

Generic information;

endocrinologist evaluation;

F/U needed next 3 years;

MRI results; and prolactin levels.

CARCINOMA OF THE THYROID (193), SOLITARY THYROID NODULE (Newly Discovered) (241.0)

	CLEAR	CLEAR WITH RESTRICTIONS	DEFER	MNQ
CRITERIA	→ 1) Solitary nodule biopsy results benign. 2) Papillary, Follicular, Mixed, post surgery and all treat-ments for 3 yrs. Two thyroid scans 1 and 2 yrs. post treat-ment, show no recur-rence of disease. Stable on thyroid meds. TSH WNL X 2 yrs.		→ 1) All thyroid cancers, post all treatment < 3 yrs.; stable on thyroid medication. → 2) Newly discovered nodule	→ 1) Anaplastic → 2) Medullary CA. Thyroidectomy. → 3) MRI or CAT scans show recurrence.
ACTION	↓	↓	↓	↓
RESTRICTIONS/DEFER	F/U for exam yearly with TSH, T4, CXR q year.		UNTIL: 1) Three yrs. post treatment, current evaluation, with 2 scans showing no recurrence, stable on replacement medications. 2) Biopsy, treated appropriately (see goiter).	
RATIONALE	Thyroid cancers are not highly malignant and are compatible with normal life expectancy. Five types exist: 1) Papillary 2) Follicular 3) Anaplastic 4) Mixed 5) Medullary	The treatment of choice is thyroidectomy, lobectomy, post-operative radioidine ablation or remaining thyroid tissue, if needed. replacement doses of L-thyroxine then given, if needed. F/U is a thyroid scan or MRI at 1, 2, or 3, and 5 years, monitoring of thyroid levels and CXR.		Poor prognosis, Anaplastic usually fatal within one yea

MEDICAL INFORMATION NEEDED:

Generic information; Endocrinologist evaluation;

F/U needed next 3 years; Labwork / tests / meds:

Thyroid stimulating hormone (TSH); T4.

8/15/93