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III. ADDENDUM
I. DIABETIC LETTER

II. CONDITIONS

Diabetes insipidus (253.5) .................................................. ENDO-1

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Thyroiditis (245)
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III. ADDENDUM
### 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 complications.
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 weight.
6. Demonstrated ability to care for self & monitor disease.
   
   **Rationale:**

   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 ophthalmologist 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.
DIABETES INSIPIDUS (253.5)

CRITERIA: N/A

ACTION: CLEAR

RESTRICTIONS/DEFER: CLEAR WITH RESTRICTIONS

RATIONALE:
1) Nephrogenic diabetes insipidus.
2) Vasopressin-sensitive diabetes insipidus.

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
**GOUT (274)**

**CRITERIA**
- Period > 6 mos. with no acute episodes, uric acid < 6 mg/dl, on or off meds.

**ACTION**
- CLEAR

**RESTRICTIONS/DEFER**
- N/A
- 1) Uric acid > 6 mg/dl, episodes within last 6 mos.
- 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 antiinflammatories (NSAID's) (Require LFT's every year if taking every day).

**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.

**ENDO-3**

7/17/95
HYPOGLYCEMIA (251.2), INSULINOMAS (211.7)

CRITERIA

1) "Reactive Hypoglycemia," asymptomatic or mild symptoms, controlled with diet.
2) Medication (except Quinine, Insulin) caused hypoglycemia, now on different medication.
3) Insulinoma, post surgery 6 mos. asymptomatic.

ACTION

CLEAR

CLEAR WITH RESTRICTIONS

Restrict to non-malarial country

DEFER

UNTIL:
1) Controlled with diet.
2) Resolved post surgery, > 6 mos.

RESTRICTIONS/DEFER

Quinine caused

1) "Reactive Hypoglycemia," symptoms not controlled with diet.
2) Insulinoma or other benign neoplasm

RATIONALE

True hypoglycemia is rarely documented, freq. misdiagnosed. Most patients while symptomatic have plasma glucose > 45 mg/dl.
Can be assoc. with GI surgery, renal or liver disease, many medications, hormone deficiencies, insulinomas or other neoplasms.

MEDICAL INFORMATION NEEDED:

Endocrinolc

Generic information
Addison's disease 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.
PITUITARY ADENOMAS (227.3), ACROMEGALY (253.0)

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>ACTION</th>
<th>RESTRICTIONS/DEFER</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>→ 1) &gt; 2 yrs post surgery for pituitary adenoma. No recurrence on CT or MRI and normal hormone levels. No further need for CT or MRI.</td>
<td>CLEAR</td>
<td>→ 1) Microadenomas, or macroadenomas on bromocriptine with CT or MRI showing no enlargement for at least 2 yrs. Prolactin normal for 2 yrs. Endocrinologist states unlikely to progress. No need for CT or MRI for next 3 yrs.</td>
<td>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.</td>
</tr>
<tr>
<td>→ Period &lt; 2 yrs. post treatment.</td>
<td>DEFER</td>
<td>→ Post treatment at least 2 yrs. and meets criteria for clear.</td>
<td>Requires frequent F/U at least first 2 years post treatment.</td>
</tr>
</tbody>
</table>
| → Residual Macroadenomas or Acromegaly | MNQ | Treatment not available in PCMUs. | Endocrinology

MEDICAL INFORMATION NEEDED: Generic information; endocrinologist evaluation; F/U needed next 3 years; MRI results; and prolactin levels.
CARCINOMA OF THE THYROID (194), SOLITARY THYROID NODULE (Newly Discovered) (241.0)

CRITERIA
1) Solitary nodule biopsy results benign.
2) Papillary, Follicular, Mixed, post surgery and all treatments for 3 yrs. Two thyroid scans 1 and 2 yrs. post treatment, show no recurrence of disease. Stable on thyroid meds. TSH WNL X 2 yrs.

ACTION
CLEAR

RESTRICTIONS/DEFER
F/U for exam yearly with TSH, T4, CXR q year.

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 radiiodine 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.

MEDICAL INFORMATION NEEDED:
Generic information; Endocrinologist evaluation;
F/U needed next 3 years; Labwork / tests / meds:
Thyroid stimulating hormone (TSH); T4.

8/15/93

Endocrinology