

### PULMONARY

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I.V.	ADDENDUM

Printed By: Joy & Jan Brown/Slevin

From: Mark Miani (10/7/92)

To: Linda & Polly Zenick/Lung

CC: Molly Diamond, Toni Dumas, Judy Reidinger, Karen Roberts, Maureen Ross, Carol Stewart, Dorothi

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BCC:

iority: Normal Date sent: 10/7/92



# #eply to: רצו אלויטו לולו אלויטו לולו "אליניו לולו "אליניו לולו" (רצו אוו)

- 1) Unless BCG vaccination is recent, it should be disregarded in deciding if INH is indicated.
- 2) CXR looks like old TB- PPD testing is used to confirm that the granuloma are most. likely TB- go ahead with PPD testing.
- 3) He falls in a category where INH therapy is beneficial as defined by 'abn. cxr likely to represent old TB' and 'PPD>=5 mm'. Note the use of the lower cut-off in those with a high risk of TB infection.
- 4) After INH there is no value in continued PPD screening. We still do CXRs pre and post service but the medical value is questionable.

The greatest risk is that of reactivation of infection; however a new infection can slop if exposed to a large dose of infectious TB micro-droplets. This last point is eresting, as even well developed immunity does not fully prevent re-infection in settings such as long term care institutions where close contact to infected persons occurs.

THIS SUBJECT IS ONE OF THE BEST PLACES WHERE PROTOCOLS AND ALGORITHMS CAN ASSIST IN THE IDENTIFICATION AND MANAGEMENT OF CLINICAL PROBLEMS. I WILL RECOMMEND THAT WE USE OUR CONSULTANTS TO GET THESE TYPES OF GUIDES PRODUCED.

Date: 10/7/92 3:50 PM

To: Mark Miani

From: Linda & Polly Zenick/Lung

HE IS A 24 YR. OLD MALE WHO IMMIGRATED FROM IN 1978. HE RECEIVED BCG AS A CHILD. CURRENT CXR SHOWS OLD GRANULOMATOUS DISEASE. DOES HE NEED TO HAVE A PPD?

### ASTHMA (493.9): Childhood (493), Exercise Induced, Others

CRITERIA 1). Childhood Asthman, no recurrence เ⇒่า ! "เกษอเร"ะก จะปกเษาะ roi "" ไ"พบการษสรบาไลเ 1) ก 3 อาษัทรชนประพัพธ์ บารจุทโทยการ 1.1 ประเทศเลางา mild or well controlled 2) > 2 episodes/m of nocturnal bronchodila bronchospasm (pet after age 15. moderate asthma allergies) or specific asthma irreversible 2) One episode Asthmatic bronchitis. 3) 30 day PEFR < 80% of or secondary to URI exclusively (below), stable for 3 chemical Irritant disease predicted 3) Questionable-Historymonths. (emphysem 2) Urgent Dr. visits in last 5 -4) Incomplete response to MDI COPD, lobe SQB/wheezing resolved bronchodilators w/antihistamines yrs. 5) Cough or wheezing present TC Bronchodilator (Primatene) in Methacholine challenge w/ past, asymptomatic at least 1-yr. btwn MDI use 3) Exercise induced as hma PC 20>20 mg/ml 6) Theodur use only, last serum 5) Questionable history: PEFR level < 10 mcg/ml monitoring-X-2 wks and 4) > 1 episode of 7) theophylline use only, level metracholine lest an negative for asthmatic bronchitis airway disease. 8) OTC bronchodilator use w/in 1 yr. 9) Exercise tolerance reduced all reactions to cats. pets & reasonal despite adequate inhaled steroids. 10) Need for systemic steroids in last 5 yrs. ACTION MNO MRB/MED **DEFER until: CLEAR WITH** CLEAR RESTRICTIONS **ADVISOR** 1) Distinguish isolated 1-5) Meets criteria for mild asthma 1) Mild or well controlled asthma criteria: 21, Needs Drs' dlagnosis of RESTRICT, allergies (which can be 6) d/c meds and monitor response asthmatic bronchitis a) < 3 episodes/wk requiring MDI V IONS/DEFER cleared) from an underlying X 1 month. bronchodilator 7) Controlled w/ MDIs, stable X 3 asthmatic condition. b) < 3 episodes/mo of nocturnal asthma V

b) < 3 episodes/mo of nocturnal asthma (c) Baseline spirometry WNL.except for evidence of obstructive alrway Dx.

or or

- 30 day PEFR > 80% of predicted, < 20% variation
- d) All of above w/ complete response to MDI bronchodilators 🗸

e) Does not smoke

RATIONALE

Methacholine challenge can be used in the differential diagnosis of asthma severity or for excluding it.

- Drs/ Hx supporting diagnosis. Needs 6-8 min of sustained exercise with return of FEV, w/in 20 min; can be cleared.
- Distinguish underlying alrway inflammation from isolated bronchitis.

MDI= metered dose inhaler

 Controlled w/ MDIs, stable X 3 mnths meets criteria for mild asthma

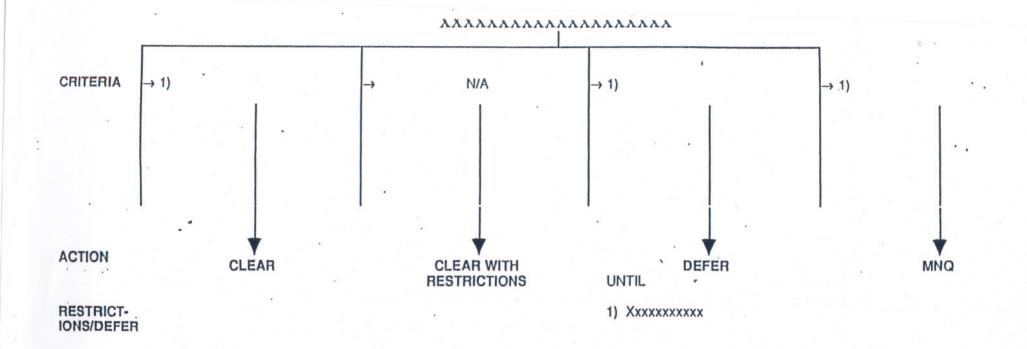
 Physician addresses problem, must meet criteria for mild asthma or d/c therapy

9-10) Period of 5 yrs during which applicant not more severe than restrict column

NOTE: EIA (controlled)
being cleared by

8/22/94

PULMO-1



RATIONALE

MEDICAL INFORMATION NEEDED: Generic Information

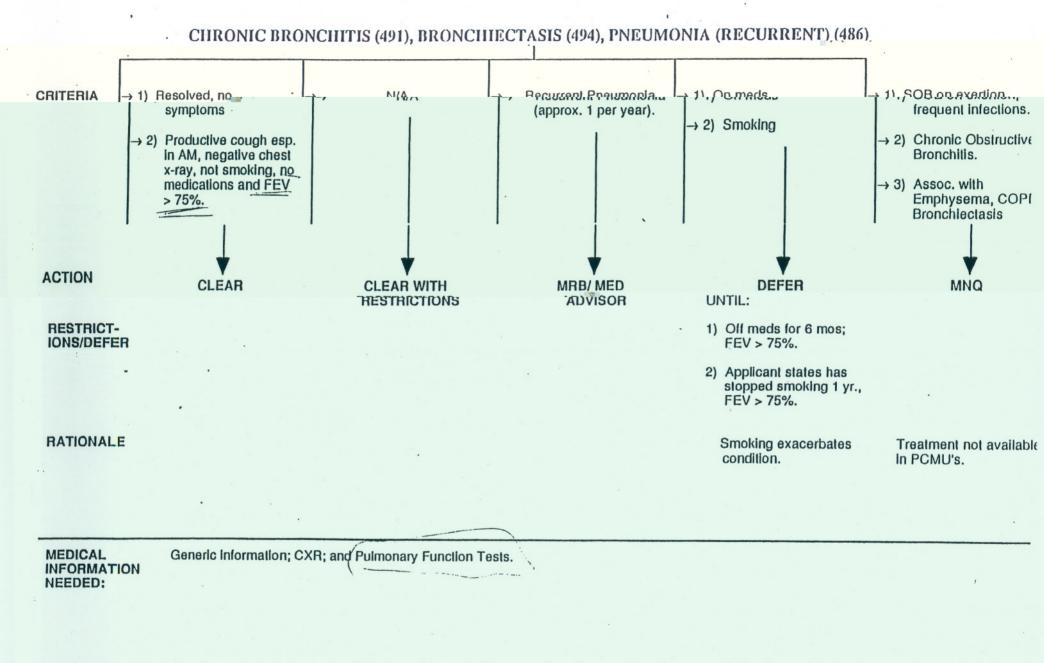
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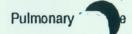
PILLMQ-2

NIH Classification of Asthma Severity in Consider

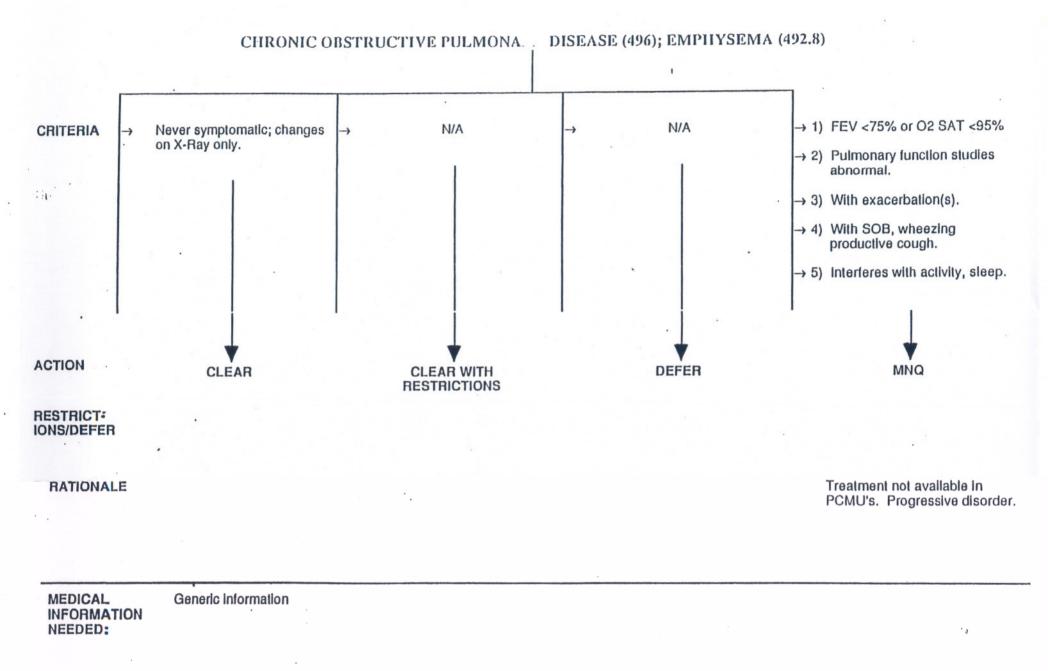
Characteristics	MILD*	MODERATE* .	SEVERE*
A) Pretreatment			
Frequency of exacerbations	no more than 1-2 tlmes/week	more than 2 times/wk infrequent severe exacerbations (urgent care <3 times/yr)	virtually dally wheezing, often with sudden, severe exacerbations urgent care >3 times/yr often hospitalized with or without complications
Frequency of symptoms	few or no signs/symptoms	cough and mild wheezing often.	บางเกาะละสมาวาน เรียกจากสามาวาน
	between exacerbations	เรากให้สำหารหลาย	<sup>อไ</sup> ซเกฝระไหเลเตร มาลเลง)
Exercise tolerance	good, may have problems with vigorous excercise	reduced	very poor, marked limitation of activity
Nocturnal asthma	rare (up to 2 tlmes/mo)	frequent (2-3 times/wk)	almost nightly, sleep interrupted chest tighness in the morning
School/work attendance  Optional for med clearance	good	may be affected	poor
PEFR (peak expiratory flow rate)	PEFR >80% predicted variability <20%	PEFR 60-80% predicted variability 20-30%	PEFR <60% predicted variability >30%
Spirometry (PFTs)	minimal or no evidence of airway obstruction; usually >15% response to bronchodilator even if normal pre-dilator	evidence of airway obstruction, often with increased lung volumes; >15% response to bronchodilator	significant/severe airway obstruction which may not normalize even with bronchodilators or steroids
Methacholine sensitivity  B) After optimal treatment	PC <sub>20</sub> <sup>f</sup> > 20 mg/ml (hlgher dose)	PC <sub>20</sub> 2-20 mg/ml	PC <sub>20</sub> <2 mg/ml (low dose)
Response to and duration of therapy	Response to bronchodilators within 12-24 hrs Rare exacerbations require steroids or regular medication for short periods of time)	Exacerbations usually require regular bronchodilators and often steroids for 1 week or more Regular steroid or cromolyn therapy may be required for long periods of time	Requires continuous, round the clock therapy including steroids (often high dose MDI or systemic).

variability in PEFR between morning and evening or between morning PEFRs over one week



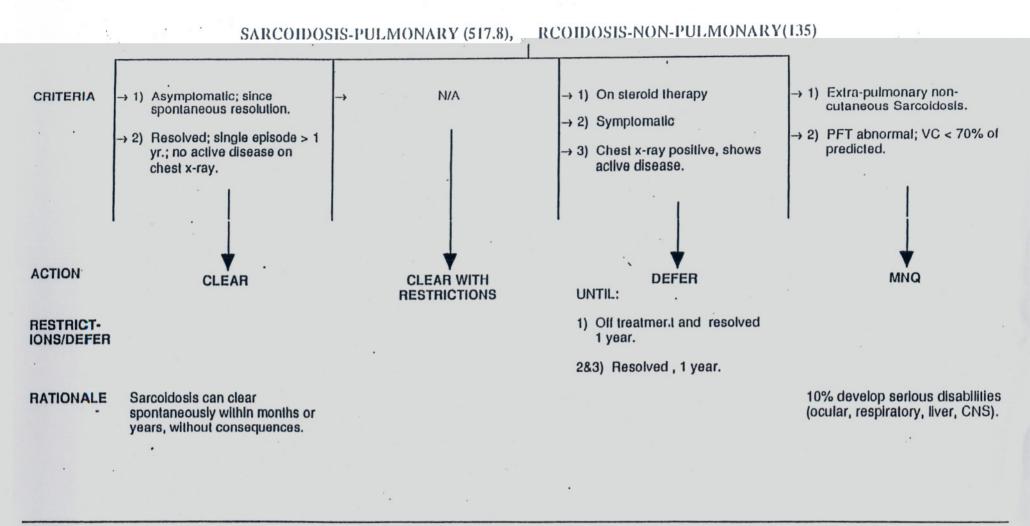






Pulmonary Disease

8/23/93



MEDICAL INFORMATION NEEDED:

Generic information;

Pulmonologist, if symptomatic in post 5 years.

8/23/93





## PNEUMOTHORAX: SPONTANEOUS (512), TRAUMATIC (860)

→ 1)\_Single or recurrent,/2\_or. → 1) Spontaneous, treated N/A. (->-1), Traumalia Jaaumalharax. **CRITERIA** more) spontaneous, not surgically with pleurodesis or treated with pleurodesis or surgically treated. pleurectomy < 6 mos. post. pleurectomy > 6 mos. post. → 2) Assoc. with CVD, → 2) Traumatic pneumothorax, → 2) Traumatic resolved without emphysema, asthma, treated with pleurodesis or surgery for 6 weeks, no F/U sarcoidosis, or other resp. pleurectomy < 6 mos. post. needed. disease. → 3) Spontaneous, treated with pleurodesis or pleurectomy > 6 mos. post. 4) Sincle, apontanoone, resolved 1> 6 nos 5) ACTION MNQ DEFER **CLEAR WITH** CLEAR RESTRICTIONS UNTIL: 1&2) Post surgery 6 mos. RESTRICT-IONS/DEFER Surgery is sometimes done with At risk for recurrence: most PCV at no added medical RATIONALE pneumothorax. The bullae are spontaneous pneumothorax risk for recurrence if treated excised or oversewn and the occur in males 20 - 40 yrs. due surgically. pleura roughened mechanically to rupture of an (plication of emphysematous emphysematous bulla. bleb). When bullous disease is extensive, parietal pleurectomy

MEDICAL INFORMATION NEEDED: Generic Information

is done.