RHEUMATOLOGY

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IV. ADDENDUM

POLYMYOSITIS (710.4) / DERMATOMYSITIS (710.3)

CRITERIA	Childhood Hx of, now resolved, no residual weakness	N/A	Asymptomatic and off all meds for 2 yrs.	On steroid therapy	Severe and/or with renal, pulmonary, cardiac involvement.
ACTION	CLEAR	CLEAR WITH RESTRICTIONS	MRB/ MED ADVISOR	DEFER	MNQ
RESTRIC-TIONS/ DEFER				UNTIL: 1) Off steroids and meds, asymptomatic 2 yrs.	
RATIONALE	Remissions and total recoveries have occurred in polymyositis, particularly childhood polymyositis. Symptoms of disease include: severe muscle pain and weakness, cutaneous eruptions, fever, weight loss. Usually appears after 40 yrs. of age.			Polymyositis is an inflammatory degenerative disease of the muscles, and frequently the skin (Dermatomyositis).	PCV cannot function and medical support cannot be provided in PCMU's.

MEDICAL INFORMATION NEEDED: Generic information

5/4/93

REITER'S SYNDROME (RS) (099.3)

CRITERIA	→ Single episode 2 yrs. since end of acute syndrome; no sequelae or slight joint impairment	→ N/A	→ 1) Active syndrome. → 2) Single episode currently active or active within 2 yrs.	→ Recurrent or chronic Reiter's Syndrome.
ACTION	CLEAR	CLEAR WITH RESTRICTIONS	DEFER UNTIL:	MNQ
RESTRICTIONS/ DEFER	Initial illness typically resolves in 3-4 mos. Patient experience of 50% transient occurrences after initial episode.		Treated and asymptomatic 2 yrs.	
RATIONALE	Reiter's Syndrome is a reactive arthritis assoc. with non-bacterial urethritis or cervicitis, conjunctivitis, and mucocutaneous lesions. RS has two forms: sexually transmitted (usually Chlamydia) and Dysenteric (usually shigella, salmonella, yersinia, campylobacter). Occasionally limitations in joint mobility persist, particularly of knees, lower back and hip.			Disease interferes with PCV's ability to function. Risk of relapse.

MEDICAL INFORMATION NEEDED: Generic information; F/U needed next 3 yrs.; Activity limitations.

Rheumatologist evaluation; risk of recurrence following bacterial infections.

5/4/93

ANKYLOSIS SPONDYLITIS (720.0), SPONDYLITIS (720.9)

:RITERIA	→ N/A	→ N/A	→ 1) Asymptomatic, 2 yrs. → 2) Mild stable back discomfort self-treated PRN NSAID.	→ Exacerbation or moderate to severe symptoms return 2 yrs.	→ N/A
.CTION	CLEAR	CLEAR WITH RESTRICTIONS	MRB/ MED ADVISOR	DEFER UNTIL: Two yrs. stable or resolved.	MNQ
IESTRIC- 'IONS/)EFER					
IATIONALE					

MEDICAL NFORMATION NEEDED: Generic information

5/4/93

Write Like Psoriatic Arthritis / Include Psoriatic Arthritis

RHEUMATOID ARTHRITIS (RA) (714.0), JUVENILE RHEUMATOID ARTHRITIS (714.3)

:RITERIA	JRA asymptomatic for 10 yrs.	N/A	Asymptomatic and off meds for 2 yrs., none or mild functional limitations	1) On meds 2) Symptomatic 3) On steroids	N/A
,CTION	CLEAR	CLEAR WITH RESTRICTIONS	MRB/ MED ADVISOR	DEFER UNTIL:	MNQ
IESTRIC-IONS/ IEFER				1-3) Asymptomatic and off meds for 2 yrs.	
:ATIONALE	Flags - multiple joint Replacements. - No Sx's for 2 years. - No Treatment, does not include steroids. (NSAIDS, cox2, Aspirin.) - No Sx: Sx's do not significantly interfere with ADLs		Permanent spontaneous remission occurs occasionally	1-3) Treatment for RA includes physiotherapy and extensive medication regimen, neither of which can be provided in PCMU's. 3) Steroids place PCV at risk for severe infections.	5% - 10% eventually become disabled.

IEDICAL NFORMATION IEEDED:

Generic information;
F/U needed next 3 yrs.; activity limitations.

Rheumatologist evaluation (except for JRA)
- severity of symptoms
- Likelihood of exacerbation

- Date of Dx
- Sx to include to severity
- Tx
- Current status
- Limitations
- Recommendations

5/4/93

SYSTEMIC LUPUS ERYTHEMATOSUS (710.0)

CRITERIA	→ N/A	→ N/A	→ N/A	→ Any Hx of systemic involvement.
ACTION	CLEAR	CLEAR WITH RESTRICTIONS	DEFER	MNQ
RESTRICTIONS/ DEFER			UNTIL: 1&2) Two yrs. asymptomatic on aspirin, NSAIR's or antimalarials only.	
RATIONALE	SLE is commonly chronic and relapsing but remissions sometimes last for years. Flares rarely occur after menopause. Mild disease: fever, arthritis, pleurisy, headaches, rash. Often can be easily controlled with aspirin and antimalarials. Severe: can be life threatening, ie. hemolytic anemia, pericardial complications, renal damage, CNS complications.			Treatment cannot be provided in PCMU's.

MEDICAL INFORMATION NEEDED: Generic Information

5/4/93

ADDENDUM

IMMUNOLOGY

Any applicant with a history of allergies should be closely screened. The history of allergies is not as important as determining the present status. The present status is determined by ascertaining:

1). The causative agents by history
2). The bodies present reaction to the allergen by skin testing, challenge, and blood tests (RAST, leukocyte histamine release)
3). Length of time since reaction.

With time, the immune system "forgets" allergies. If the length of time since last exposure is long enough, the body may no longer react to that particular allergen. For example, a person reacting to Penicillin 15-20 years ago, may not be allergic to Penicillin any longer.

Allergic Rhinitis: Steroid nasal sprays are considered standard treatment. They do not have any side effects. The steroids are not absorbed into the system and are not associated with a higher risk of infection.

Anaphylaxis: The present status must be determined. A person with a history of anaphylaxis, anaphylactoid, or severe reaction must be evaluated by an allergist. Most agents producing anaphylaxis can be tested for. Some people will no longer react on skin test or challenge. Their risk for a severe anaphylactic reaction has returned to normal (2%). If the individual is still reactive to a common substance that is not easily avoided, they are at risk for severe life threatening reaction. If, however, they are still reactive to an uncommon substance that is easily avoided, they are relatively safe. It still may be prudent to instruct the PCV to have an adrenalin kit with him/her, and be placed in a less isolated area. Anaphylactoid Reaction: Anaphylactoid reaction differs in the mechanism from anaphylaxis. No skin tests are available. Most common agents producing anaphylactoid reactions are IV dyes, and narcotics (codeine and morphine). Exercise can also trigger this reaction. If the agent can be easily avoided, the person is relatively safe. If not they are at risk for a severe life threatening reaction. Each case needs to be decided on an individual basis.

Desensitization Therapy: Desensitization injections are given for a year. If successful (by skin test), the injections are continued but less frequently for up to 3-5 years. If not successful after 1 year, the injections are stopped. As with any allergy, the current status must be ascertained by skin test. If the skin test is non-reactive, the risk for reaction has returned to normal (2%). Desensitization therapy only works for environmental allergens and insect venom.

Controversy surrounds desensitization therapy. Some allergist believe lifetime treatment is needed. Other allergists believe the treatment is effective after about 5 years of injections. With Bee venom, some people have good protection after five years, according to a skin test. National Institute for Health stated that desensitization injections are effective.

Environmental

Allergens: Nasal steroids and antihistamines are the considered standard treatment.

Food

Allergens: Food allergies are controversial. As with any allergy, the current status must be ascertained (as above). If the allergen is easily avoidable, then the individual is relatively safe to travel. The worst offenders are shrimp, nuts and sometimes eggs.

Immunization

Allergies: Skin tests can be done for MMR and DPT. Antibody levels can be checked for most of the diseases and some vaccines will not be needed.

Medication

Allergies: Again, current status is what is important. All applicants reporting allergies to penicillin should be skin tested, especially if the reaction occurred years ago. There is no skin test for sulfa drugs. Penicillin can be easily avoided overseas.

Urticaria and Angioedema: Similar to anaphylaxis, so the current status needs to be identified. Chronic Urticaria is a benign condition and should pose no hindrance to functioning; it rarely develops serious sequelae. It is easily controlled with antihistamines. However, acute or chronic urticaria caused by cold water can be life-threatening. Cases have occurred where a susceptible individual dove into very cold water and suffered cardiac arrest.

Wasp/Bee Venom: As above, controversy surrounds desensitization therapy for insect venom. Some allergists feel that adequate protection develops after five years of treatment with desensitization injections. Other allergists believe lifelong treatment is needed. National Institutes of Health state protection is good after five years of treatment. Again, current skin test must be done.

Autoimmune Disorders:

Reiter's Syndrome: Patients on NSAID's[1] require twice yearly blood count, liver function tests, chemistry panel to assess kidney function, and a urinalysis. Also some people with Reiter's syndrome develop joint deformities that are mild that would not greatly interfere with functioning, ie. a limp from knee damage. Six months, after the disease is asymptomatic and inactive, and the joint inflammation is gone, is an appropriate time to assess joint function. Reiter's syndrome does not predispose someone to infections nor would frequent infections, have any effect on the course of the Reiter's syndrome.

Systemic Lupus Erythematosus: If on NSAID's, twice yearly f/u with blood count, chemistry panel, UA and LFT's are required to assess liver and kidney function. The patients on chloroquine for treatment of Lupus require yearly or twice yearly examination by an Ophthalmologist. The sun has an adverse effect on the course of this disease. Sun exposure aggravates the skin complications and also causes exacerbations of the systemic disease. Patients must wear sun screen, hats and spend a great deal of time indoors. Heat or humidity is not a factor.

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[1] NSAID's=Nonsteroidal Anti-inflammatories