ENDOCRINOLOGY
# ENDOCRINE DISORDERS

## TABLE OF CONTENTS

### I. DIABETIC LETTER

### II. CONDITIONS
- Diabetes insipidus (253.5) .......................................................... ENDO-1
- Diabetes Mellitus
  - Insulin dependent (250.1) .................................................. ENDO-2
  - Non-insulin dependent (250.00) ............................................. ENDO-2
  - With complications (250.9) ................................................. ENDO-2
- Gout (274) ................................................................................. ENDO-3
- Hyperglycemia (790.6) ............................................................... ENDO-2
- Hypoglycemia (251.2) ................................................................. ENDO-2
- Insulinomas (211.7) ................................................................. ENDO-4

### PITUITARY:
- Addison's Disease (255.4) .......................................................... ENDO-5
- Pituitary Adenoma (227.3)
  - Acromegaly (253.0) ............................................................... ENDO-6
  - Macroadenomas (227.3) ....................................................... ENDO-6
  - Microadenomas (227.3) ........................................................ ENDO-6

### THYROID
- Carcinoma of Thyroid (193) ......................................................... ENDO-7
- Solitary Thyroid Nodule (241.0) ................................................. ENDO-7
- Hyperthyroidism
  - Grave's Disease (242.0) ....................................................... ENDO-8
  - Toxic Adenoma (242.3) ......................................................... ENDO-8
  - Toxic Multinodular Goiter (242.2) ........................................ ENDO-8
- Hypothyroidism
  - Diffuse Nodular Goiter (240.9) ............................................ ENDO-9
  - Non-Specific (244.9) ............................................................. ENDO-9
  - Non-Toxic Nodular Goiter (241) ........................................... ENDO-9
- Thyroiditis (245)
  - Hashimoto's (245.2) ............................................................ ENDO-10
  - Sub-Acute Thyroiditis (245.1) ............................................. ENDO-10
- Thyroidectomy (06) ............................................................... ENDO-9

### III. ADDENDUM
I. DIABETIC LETTER

II. CONDITIONS

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

Diabetes Melitus
- Insulin dependent (250.1) .................................................. ENDO-2
- Non-insulin dependent (250.00) ......................................... ENDO-2
- With complications (250.9) ................................................ ENDO-2

Gout (274) ................................................................. ENDO-3

Hyperglycemia (790.6) ......................................................... ENDO-2

Hypoglycemia (251.2) ......................................................... ENDO-4

Insulinomas (211.7) ........................................................... ENDO-4

PITUITARY:
Addison's Disease (255.4) .................................................... ENDO-5

Pituitary Adenoma (227.3)
- Acromegaly (253.0) .......................................................... ENDO-6
- Macroadenomas (227.3) ..................................................... ENDO-6
- Microadenomas (227.3) ..................................................... ENDO-6

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Carcinoma of Thyroid (193) ................................................ ENDO-7

Solitary Thyroid Nodule (241.0) ........................................... ENDO-7

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- Grave's Disease (242.0) .................................................... ENDO-8
- Toxic Adenoma (242.3) ....................................................... ENDO-8
- Toxic Multinodular Goiter (242.2) .................................... ENDO-8

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- Diffuse Nodular Goiter (240.9) ......................................... ENDO-9
- Non-Specific (244.9) ........................................................ ENDO-9
- Non-Toxic Nodular Goiter (241) ....................................... ENDO-9

Thyroiditis (245)
- Hashimoto's (245.2) ......................................................... ENDO-10
- Sub-Acute Thyroiditis (245.1) ...................................... ENDO-10

Thyroidectomy (06) ........................................................... ENDO-9

III. ADDENDUM
<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>N/A</th>
<th>1) NIDDM: Well controlled on oral hypoglycemics for 6 mos.</th>
<th>1) NIDDM not well controlled</th>
<th>1-3) Meets criteria for &quot;well-controlled&quot; (see below left).</th>
<th>DM: with any complications, cardiac, periph vascular, Renal, retinal involvement, skin ulcers, Neuropathy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTION</td>
<td>CLEAR</td>
<td>CLEAR WITH RESTRICTIONS</td>
<td>UNTIL</td>
<td>DEFER</td>
<td>MNQ</td>
</tr>
<tr>
<td>RESTRICTIONS/DEFER</td>
<td>1-2) BMF / FYI cable to PCMO PCMO concurrence approved B.C. Endocrinologist for care. Placement site within 30 mins. of 24 hr. ER facilities. Glycohemoglobin q 3 mos., finger sticks for FBS as ordered. (Bring 6 mos. supply.)</td>
<td>3)</td>
<td>1-3) Meets criteria for &quot;well-controlled&quot; (see below left).</td>
<td>4) Weight &lt;120% IBW</td>
<td>High risk for serious complications cannot support in PMU's.</td>
</tr>
<tr>
<td>RATIONALE</td>
<td>CRITERIA FOR WELL-CONTROLLED IDDM OR NIDDM At risk for life threatening diabetic ketoacidosis if becomes ill, or hypoglycemic reaction, or severe infections due to slow healing of skin lesions.</td>
<td>Glycohemoglobin is a good indicator of control over time. Normals = 5 - 6%.</td>
<td>* See Weight guideline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEDICAL INFORMATION NEEDED:</td>
<td>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.</td>
<td></td>
<td></td>
<td>7/17/95</td>
<td></td>
</tr>
</tbody>
</table>
DIABETES INSIPIDUS (253.5)

CRITERIA

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

ACTION

CLEAR
CLEAR WITH RESTRICTIONS
DEFER
MNQ

RESTRICTIONS/DEFER

1) Adequate availability of potable water to maintain hydration cannot be guaranteed.
2) Adequate treatment is not available in PCMU's.

RATIONALE

MEDICAL INFORMATION NEEDED:

Generic information
## GOUT (274)

<table>
<thead>
<tr>
<th>CRITERIA</th>
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<th>RESTRICTIONS/DEFER</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period &gt; 6 mos. with no acute episodes, uric acid &lt; 6 mg/dl, on or off meds.</td>
<td>CLEAR</td>
<td>CLEAR WITH RESTRICTIONS</td>
<td>Medications:</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>1) Uric acid &gt; 6 mg/dl, episodes within last 6 mos.</td>
<td>1) Allopurinol for suppression. Requires no F/U, serious side effects are very rare.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2) Weight &gt; 150% IBW</td>
<td>2) Acute attacks: Colchicine, non-steroidal antiinflammatories (NSAID's) (Require LFT's every year if taking every day).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>* See weight guideline</td>
</tr>
</tbody>
</table>

### 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.

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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
- DEFER
- N/A

**RESTRICTIONS/DEFER**
Restrict to non-malarial country

**RATIONALE**
True hypoglycemia is rarely documented, freq. misdiagnosed. Most patients while symptomatic have plasma glucose > 45 mg/dl. Can be associated 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

---
Endocrinol
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 PCMUs. At risk for additional Addisonian crisis, which is life threatening.
CRITERIA

→ 1) > 2 yrs post surgery for pituitary adenoma. No recurrence on CT or MRI and normal hormone levels. No further need for CT or MRI.

→ 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.

→ Period < 2 yrs. post treatment.

PATIENTS

Residual Macroadenomas or Acromegaly

ACTION

CLEAR

CLEAR WITH RESTRICTIONS

2) Approved Endocrinologist for F/U T4, TSH, Prolactin levels, electrolytes q yr.

UNTIL:

DEFER

Post treatment at least 2 yrs. and meets criteria for clear.

Requirements frequent F/U at least first 2 years post treatment.

MEDICAL INFORMATION NEEDED:

Endocrinology evaluation;

F/U needed next 3 years;

MRI results; and prolactin levels.

9/12/94
### CARCINOMA OF THE THYROID (193), SOLITARY THYROID NODULE (Newly Discovered) (241.0)

<table>
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<th>RESTRICTIONS/DEFER</th>
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<tbody>
<tr>
<td>→ 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.</td>
<td>CLEAR</td>
<td>F/U for exam yearly with TSH, T4, CXR q year.</td>
<td>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</td>
</tr>
<tr>
<td>→ 1) All thyroid cancers, post all treatment &lt; 3 yrs.; stable on thyroid medication.</td>
<td>CLEAR WITH RESTRICTIONS</td>
<td>UNTIL: 1) Three yrs. post treatment, current evaluation, with 2 scans showing no recurrence, stable on replacement medications. 2) Biopsy, treated appropriately (see goiter).</td>
<td>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.</td>
</tr>
<tr>
<td>→ 2) Newly discovered nodule</td>
<td>DEFER</td>
<td></td>
<td>Poor prognosis, Anaplastic usually fatal within one year</td>
</tr>
<tr>
<td>→ 3) MRI or CAT scans show recurrence.</td>
<td>MNQ</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Endocrinology

ENDO-7

8/15/93