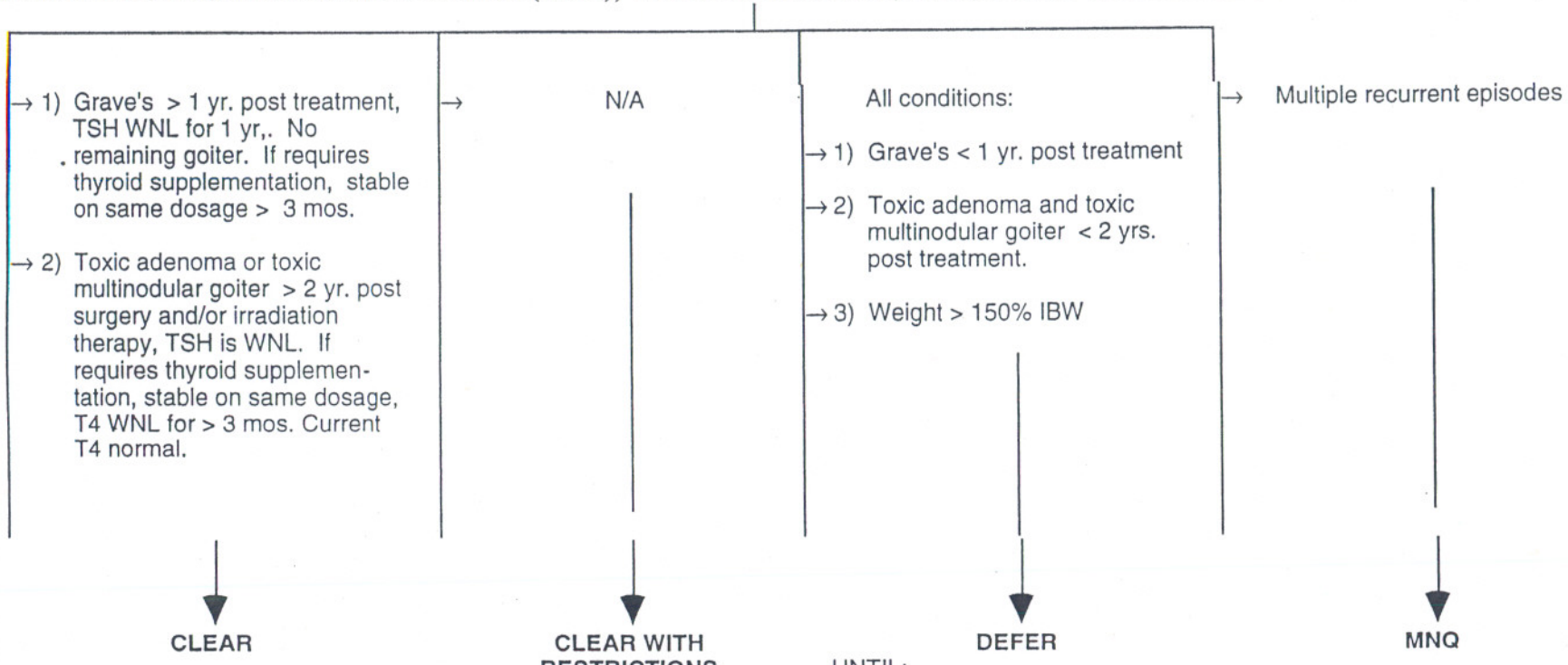
HYPERTHYROIDISM: GRAVE'S DISEASE (242.0), TOXIC ADENOMA (242.3), TOXIC MULTINODULAR GOITER (242.2)



RESTRICT-IONS/DEFER

UNTIL:

1) One yr. post treatment and stable.
2) Two yrs. post treatment and stable.

RATIONALE

Treatment of choice is surgery, radioiodine therapy or thyroid depleting medications.

1&2) Occasionally too much of the thyroid has been destroyed as a result of treatment. Then thyroid supplementation is needed. These meds safe and easily monitored in PCMU's.

3) Weight < 150% IBW
Anti-thyroid meds some-times have serious side effects. Not appropriate for P.C.

* See Weight guideline

MEDICAL INFORMATION NEEDED:

Generic information;
Endocrinologist evaluation;
Biopsy results of nodules;
TSH, and T4.

HYPOTHYROID: DIFFUSE NODULAR GOITER (240.9), HYPOTHYROID, NON-SPECIFIC (244.9), NON-TOXIC NODULAR GOITER (241), THYROIDECTOMY: NON-MALIGNANT CAUSE (06)

CRITERIA	→ 1) Idiopathic or post surgical hypothyroidism, asymptomatic: TSH normal. → 2) Idiopathic or post surgical hypothroidism; asymptomatic: TSH low, dose being adjusted to achieve normal TSH (monitor at least every 3 months until normal TSH). [Do not need to defer if asymptomatic]. → 3) Non-Toxic or diffuse nodular goiter: biopsy neg., maintained on medication. Stable on meds > 6 mos. → 4) Diffuse nodular goiter, stable on meds > 3 mos. TSH WNL.	→ N/A	→ 1) Idiopathic or post-surgical hypothyroidism: symptomatic → 2) Idiopathic or post-surgical hypothyroidism: high TSH → 3) Period < 3 mos. post procedure removal of thyroid gland for non-malignant cause → 4) Non-Toxic nodular goiter → 5) Diffuse nodular goiter → 6) Weight > 150% IBW	→ N/A
ACTION	**CLEAR**	**CLEAR WITH RESTRICTIONS**	**DEFER**	**MNQ**
RESTRICT-IONS/DEFER			UNTIL: 1) Asymptomatic for > 3 months and meets clearance criteria 2) TSH normal-see clearance criteria 3) Three mos. post procedure on meds if needed, and TSH WNL. (see note) 4) Biopsy neg., post surgical , meets clearance criteria. 5) Stable, on meds for 3 mos., TSH WNL. (see note) 6) Weight < 150% IBW * See Weight guideline	
RATIONALE	Note: optimal treatment of hypothroidism includes adjustment of thyroid replacement to achieve normal TSH.			

MEDICAL INFORMATION NEEDED: Generic information; Endocrinologist evaluation; Dosage and type of thyroid supplement Current length of time on present dosage TSH, T4, Biopsy results of nodules.

7/17/95

THYROIDITIS (245), HASHIMOTO'S (245.2), SUB-ACUTE THYROIDITIS (245.1)

CRITERIA	→ 1) Subacute thyroiditis: period > 6 mos. post-episode, asymptomatic, TSH WNL; if on T4, stable dosage for 3 mos. → 2) Hashimoto's: asymptomatic on thyroid supplementation for > 3 mos. TSH, T4 WNL.	→ N/A	→ 1) Hashimoto's newly diagnosed or TSH abnormal → 2) Subacute Thyroiditis, < 6 mos. since onset or symptomatic. → 3) Weight > 150% IBW	→ N/A
ACTION	**CLEAR**	**CLEAR WITH RESTRICTIONS**	**DEFER**	**MNQ**
RESTRICT-IONS/DEFER			UNTIL: 1) Well maintained on thyroid replacement therapy for 3 mos. TSH WNL. 2) Period > 6 mos. post-episode, or recurrence, asymptomatic, TSH WNL. Symptoms include fever, neck pain, prostration. 3) Weight < 150% IBW Need to be monitored until stable on replacement meds. * See Weight guideline	
RATIONALE	Usually viral cause, self-limited, without sequelae.			

MEDICAL INFORMATION NEEDED:

Generic information;

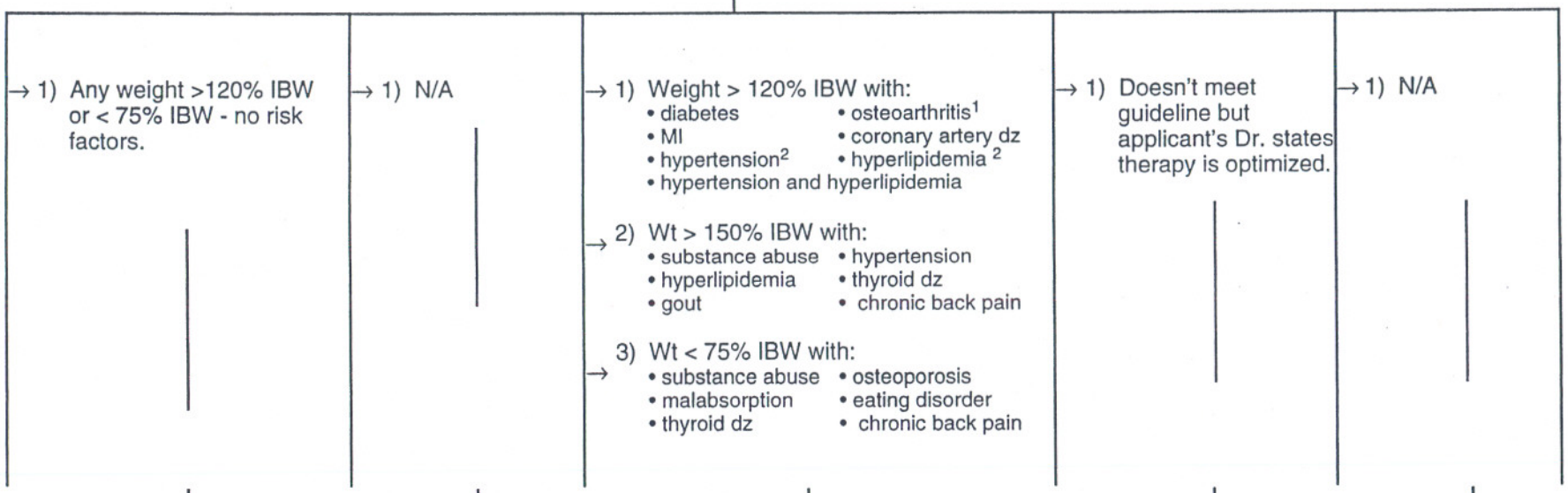
Endocrinologist evaluation;

TSH, T4 F/U needed;

R/O autoimmune diseases.

7/17/95

OVERWEIGHT (278.0), UNDERWEIGHT (783.4)



ACTION

CLEAR

CLEAR WITH RESTRICTIONS

DEFER

MRB/ADVISOR

MNQ

RESTRIC-TIONS/ DEFER

* Notify VRS evaluate need to accommodate weight condition

UNTIL:

1) Weight <120% or waist to hip ratio ≤1.05 for males or ≤ 0.9 for females
2) Weight <150% or waist to hip ratio ≤ 1.05 for males or ≤ 0.9 for females
3) Weight >75%

1-3 note: also must meet specific guidelines for each risk factor

RATIONALE

[1] weight bearing joints - spine, legs, hips

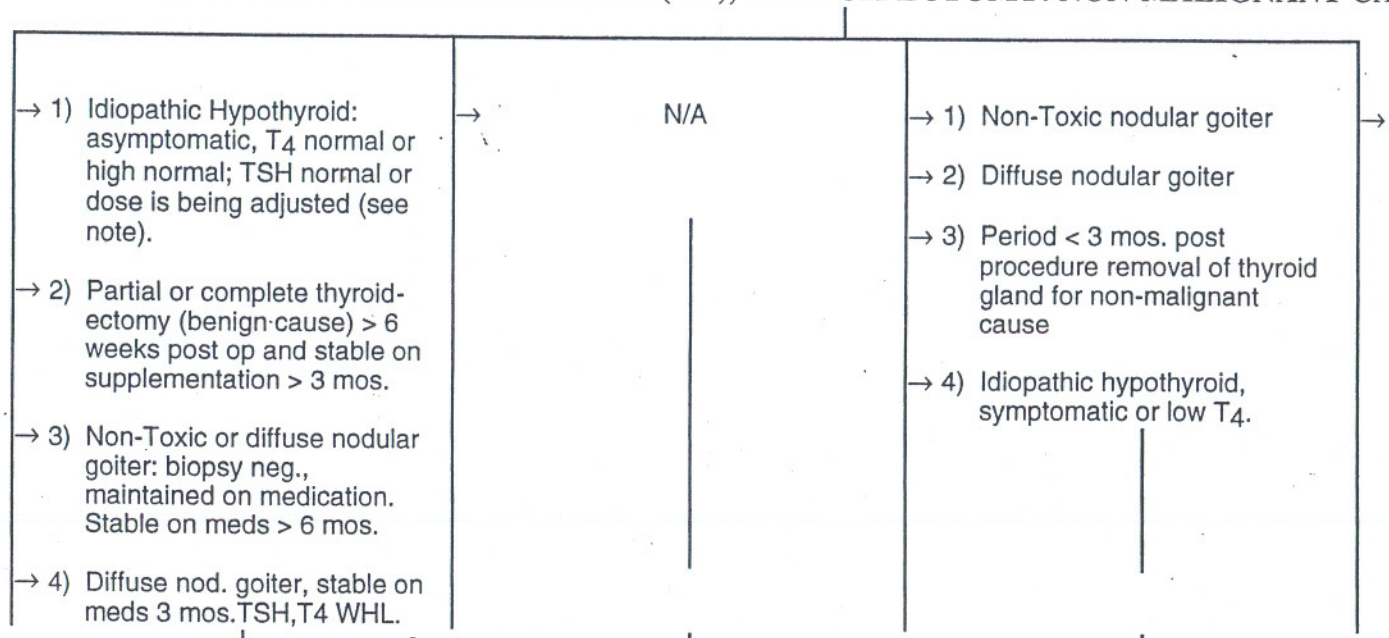
[2] combined with gout, substance abuse, or thyroid disease.

MEDICAL INFORMATION NEEDED: Needs supplemental medical Hx if wt > 120% IBW or < 75% IBW

IBW = Ideal Body Weight

7/24/95

HYPOTHYROID: DIFFUSE NODULAR GOITER (240.9), HYPOTHYROID, NON-SPECIFIC (244.9), NON-TOXIC NODULAR GOITER (241), THYROIDECTOMY: NON-MALIGNANT CAUSE (06)



CRITERIA

→ 1) Idiopathic Hypothyroid: asymptomatic, T_4 normal or high normal; TSH normal or dose is being adjusted (see note).

→ 2) Partial or complete thyroid-ectomy (benign cause) > 6 weeks post op and stable on supplementation > 3 mos.

→ 3) Non-Toxic or diffuse nodular goiter: biopsy neg., maintained on medication. Stable on meds > 6 mos.

→ 4) Diffuse nod. goiter, stable on meds 3 mos.TSH,T4 WHL.

→ N/A

→ 1) Non-Toxic nodular goiter

→ 2) Diffuse nodular goiter

→ 3) Period < 3 mos. post procedure removal of thyroid gland for non-malignant cause

→ 4) Idiopathic hypothyroid, symptomatic or low T_4.

→ N/A

ACTION

CLEAR

CLEAR WITH RESTRICTIONS

DEFER

MNQ

RESTRICT-IONS/DEFER

Note: optimal treatment of hypothroidism includes adjustment of thyroid replacement to achieve normal TSH. Can accept slightly low TSH if stable for > 1 year and no adjustment of dosage advised by endocrinologist.

UNTIL:

1) Biopsy neg., post surgical reduction if needed > 3 weeks stable on meds for 3 mos., TSH WNL. (see note)

2) Stable, on meds for 3 mos., TSH WNL. (see note)

3) Three mos. post procedure on meds if needed, and TSH WNL. (see note)

4) Until asymptomatic for 3 mo or T_4 within normal range.

RATIONALE

MEDICAL INFORMATION NEEDED:

Generic information; Endocrinologist evaluation;
Dosage and type of thyroid supplement
Current length of time on present dosage TSH, T4,
Biopsy results of nodules.

THYROIDITIS (245), HASHIMOTO'S (245.2), SUB-ACUTE THYROIDITIS (245.1)

CRITERIA	→ 1) Subacute thyroiditis: period > 6 mos. post-episode, asymptomatic, TSH WNL; if on T4, stable dosage for 3 mos. → 2) Hashimoto's: asymptomatic on thyroid supplementation for > 3 mos. TSH, T4 WNL.	N/A	→ 1) Hashimoto's newly diagnosed or TSH abnormal → 2) Subacute Thyroiditis, < 6 mos. since onset or symptomatic.	N/A
ACTION	**CLEAR**	**CLEAR WITH RESTRICTIONS**	**DEFER**	**MNQ**
RESTRICT-IONS/DEFER			UNTIL: 1) Well maintained on thyroid replacement therapy for 3 mos. TSH WNL. 2) Period > 6 mos. post-episode, or recurrence, asymptomatic, TSH WNL. Symptoms include fever, neck pain, prostration.	
RATIONALE	Usually viral cause self-limited, without sequelae.		Need to be monitored until stable on replacement meds.	

MEDICAL INFORMATION NEEDED:

Generic information;

Endocrinologist evaluation;

TSH, T4 F/U needed;

R/O autoimmune diseases.

5/4/93

ADDENDUM

ENDOCRINOLOGY

Diabetes Mellitus: All diabetics need to be within a day's travel of decent medical facilities if they become sick. Any diabetic can go into keto acidosis if they are not taking their oral hypoglycemics or insulin when ill. Both insulin dependent and diabetics taking oral hypoglycemics need to have insulin with them at all times in case of emergencies and know how to treat themselves with injectable insulin if they get ill. The optimum indicator for long term control of blood glucose levels is glycohemoglobin; it measures the amount of glucose adhering to the cell and gives a picture of blood sugars over time. Glycohemoglobin is more informative than an FBS. Normal range is 5-6%. A diabetics should be no more than 8%. A reading of >8% indicates poor control over time. Any applicant with a severe life-threatening hypoglycemic episode should be deferred for 2 years until his/her diabetes is well controlled control. For the 10-20% of diabetics with renal complications, the usual time frame from onset of renal disease in diabetics to dialysis is only 5 years.

Gout: Gout is considered well controlled if there is no episode in 6 months and a Uric Acid level < 6 mg/dl. All PCV's with a history of Gout should take medications for both an acute attack and for suppression. Colchicine and NSAID's are the treatment of choice for an acute attack. Then the PVC should start on Allopurinol for suppression. Neither medication requires special F/U and the PCV should be able to monitor his/her own medications.

Hypoglycemia: True reactive hypoglycemia is very rare. Documented blood glucose < 50 while symptomatic is diagnostic. Most symptomatic individuals have blood glucose > 50 while having symptoms. Hypoglycemia is sometimes caused by a insulinoma or other neoplasm. These and other diseases should be r/o'd. Current research is suggesting that a condition (Post Prandial Syndrome) may exist. The syndrome occurs when a large amount of carbohydrates are dumped in the gut. The body responds by producing high levels of cathecolamine. The symptoms that have been associated with hypoglycemia result.

Addison's Disease: A person with Addison's Disease, well maintained on replacement cortisone, is not in any additional risk for developing infections. The dose of steroids is a replacement dose and brings the hormone level to within normal. Many individuals with Addison's are taught to care for themselves when sick. The standard regimen is to double their steroid dose while ill to meet the increased demands of the body. Another options for the individual with Addison's when they become ill is to self inject with Dexamethasone. The dexamethasone prevents Addisonian Crisis. The effect of the injection lasts three days and provides time for the individual to travel to medical treatment, if necessary. As long as the individual is responsible and reliable, they are considered more stable than IDDM individuals. Most individuals with Addison's live normal lives and have normal life expectancy.

Pituitary Adenomas: Patients with Micro or Macro adenomas are usually released from medical treatment two years after treatment with a clear MRI or CT scan. The patients need an MRI or CT scan 1, 2 and 4 or 5 years after surgery to r/o recurrence. The patients also require yearly prolactin levels, T4 and TSH.

Carcinoma of the Thyroid and Thyroidectomy: Individuals 3 years post treatment for small (<2 cm.) thyroid cancers (papillary or follicular type) with a clear thyroid scan are considered cured after 3 years. Larger growths need longer f/u. Every year as f/u they require a chest X-ray, T4 and TSH. Anaplastic Thyroid CA is fatal. Medullary CA is a slow growing CA with no known

treatment, but patients remain well and active for many years. Thyroid CA has been known to recur up to 20 years after initial treatment. Frequently, thyroid supplementation is needed after treatment.

Hyperthyroidism:

Grave's Disease,
Toxic Adenoma, Toxic MULTINODULAR
Goiter: Toxic goiter means that the nodule is causing hyperthyroid symptoms. Treatment consists of thyroidectomy, radiation therapy or medication to destroy the overactive thyroid tissue. The medications, Tapazole or PTU, have serious side effects such as Agranulocytosis, leading to septicemia and death in 3/1000. During medication treatment, the patients require very close f/u. The criteria for well controlled disease is post treatment one year with a stable Thyroid Stimulating Hormone level (TSH), are the criteria for well controlled. Yearly f/u of TSH and T4 is required. Toxic Adenoma and Toxic Multinodular goiter have a high recurrence rate and require close f/u for 1 year post treatment.

Hypothyroidism:

Idiopathic, Non-Toxic
Nodular Goiter, Diffuse
Nodular Goiter: All nodules require a biopsy to r/o Ca. Non-toxic means no hyperthyroid symptoms are present. Individuals with Idiopathic Hypothyroid are usually considered stable after 3 months on thyroid supplementation with normal thyroid levels. All people with a history of goiters or hypothyroidism need f/u of yearly exam of their thyroid, T4 and TSH. Nodular Goiter, with a neg biopsy and TSH WNL, is considered controlled after 6 months.

Thyroiditis: Hashimoto's is occasionally congenital, but frequently the cause is unknown. It is easily treated with thyroid medication and is non-progressive and benign. It is very rare to have it associated with other autoimmune disorders.