

## COLONIC POLYPS (211.3), POLYPECTOMY

CRITERIA	→ 1) Removed via endoscopy or surgery. F/U ≥ 3 yrs or longer	→ N/A	→ 1) Current polyp(s)	→ N/A
ACTION	↓ <b>CLEAR</b>	↓ <b>CLEAR WITH RESTRICTIONS</b>	↓ <b>DEFER</b>	↓ <b>MNQ</b>
RESTRIC-TIONS/ DEFER			UNTIL:  Resolved, routine f/u every 3 yrs or longer.	
RATIONALE	Incidence of polyposis high (up to 50%). Risk of developing colon CA increases with type and size of the polyps.  Tubular adenoma and villoglandu-lar polyps: approx. 2% risk of CA.  Villous adenoma =35% risk of CA.	Sometimes small polyps are left intact and only biopsied. May be "cleared" if biopsy is neg.	1) Depending on size, type and number of polyps, may be precursor to CA.  Recommended F/U for polyps: repeat colonoscopy 1 - 2 yrs. depending on type and number of polyps, then every 3 years.	

### MEDICAL INFORMATION NEEDED:

Generic information

F/U next 3 yrs.; including need for repeat colonoscopy / sigmoidoscopy;

Gastroenterologist's evaluation

**SURGICAL PROCEDURES: APPENDICITIS (541), APPENDECTOMY (47.0), BOWEL ANASTOMOSIS (45.90), COLON RESECTION (45.79), COLOSTOMY (46.10), ILEOSTOMY (46.20), PROCTOCOLECTOMY (45.79)**

CRITERIA	→ 1) Appendicitis and Appendectomy > 6 wks. → 2) Post abdominal / bowel surgery > 6 wks.	→ N/A	→ Continent colostomy (no external appliance).	→ 1) Appendectomy < 6 wks. → 2) Post any abdominal / bowel surgery < 6 wks.	→ Any ostomy, not tolerated well (see below). → 1) Ileostomy, any type → 2) Colostomy, except continent colostomy (no external appliance).
ACTION	↓ <b>CLEAR</b>	↓ <b>CLEAR WITH RESTRICTIONS</b>	↓ <b>MRB/ MED ADVISOR</b>	↓ <b>DEFER</b>	↓ <b>MNQ</b>
RESTRICTIONS/ DEFER				UNTIL: 1) Post surgery > 6 wks. 2) Post surgery, returned to normal function > 6 wks.	
RATIONALE		F/U depends on reason for surgery (see diagnosis).  After bowel surgery, less water is absorbed from the gut PCV is at additional risk for dehydration.			Requires frequent stoma revisions. Frequent skin breakdown under stoma appliance, or poor emotional adjustment.

*(See addendum for further information)*

**MEDICAL INFORMATION NEEDED:**

Generic information

# ANAL FISSURES (565.0) AND FISTULAS (565.1), ANORECTAL ABSCESS (566)

CRITERIA	→ 1) Fissure resolved. → 2) Fistula or abscess resolved > 3 mos. medical or surgical treatment.	→ N/A	→ 1) Fissure, current. → 2) Fistula or abscess, resolved < 3 mos., medical or surgical treatment.	→ Associated with Crohn's Disease.
ACTION	CLEAR	CLEAR WITH RESTRICTIONS	DEFER	MNQ
RESTRIC-TIONS/ DEFER			UNTIL: 1) Resolved, surgically or medically, period > 3 mos. 2) Post surgical repair, resolved, period > 3 mos.	
RATIONALE	Fissures often respond to conservative measures, i.e. stool softeners. Abscesses and Fistula must be repaired surgically.			See diagnosis.

MEDICAL INFORMATION NEEDED:

Generic information



# HEMORRHOIDS (INTERNAL OR EXTER. ....) (455.6), HEMORRHOIDECTOMY (49.46)

CRITERIA	→ 1) Post Hemorrhoidectomy 6 wks.  → 2) Asymptomatic or mild, episodic symptoms, self managed	→ N/A	→ 1) Surgery required in next 3 yrs.  → 2) Grade IV, significant painful, bleeding, on freq. meds.  → 3) Post hemorrhoidectomy < 6 wks.	→ N/A
ACTION	<b>CLEAR</b>	<b>CLEAR WITH RESTRICTIONS</b>	<b>DEFER</b>	<b>MNQ</b>
RESTRIC- TIONS/ DEFER		No countries with high incidence of diarrhea.	UNTIL:  1-3) Hemorrhoids resolved and/or post surgery 6 wks.	
RATIONALE	Hemorrhoids post hemorrhoidectomy unlikely to recur for 5 - 10 yrs.	Hemorrhoids likely to worsen in P.C. conditions.		

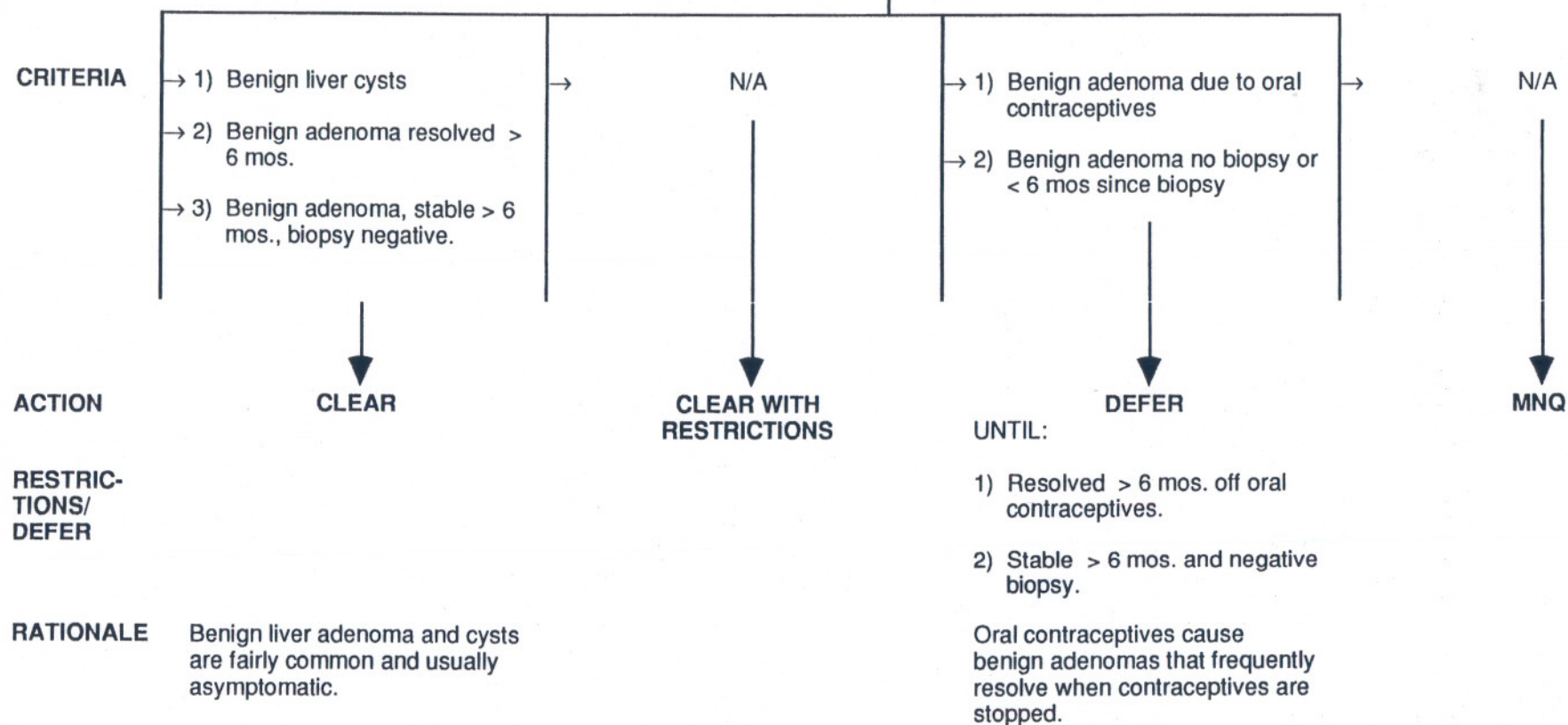
## MEDICAL INFORMATION NEEDED:

Generic information

*Re-write*

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## BENIGN LIVER CYSTS (573.8) AND ADENOMAS (211.5)

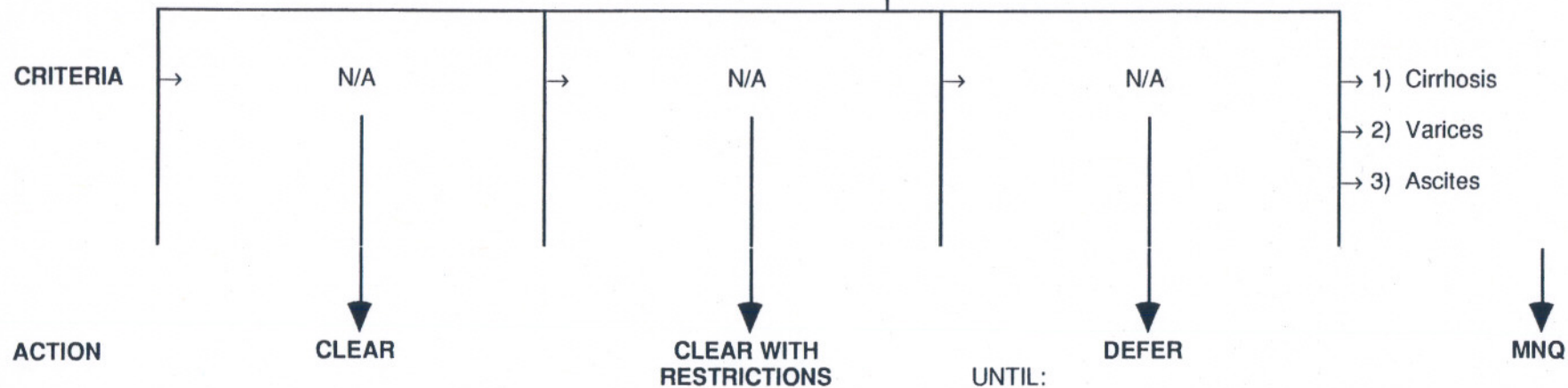


**MEDICAL INFORMATION NEEDED:**

Generic information

Biopsy results for adenoma not due to oral contraceptives.

# **CIRRHOSIS (571.5), ESOPHAGEAL VARICES (456.1), ASCITES (789.5)**



**RESTRIC-  
TIONS/  
DEFER**

## **RATIONALE**

Extent of Cirrhosis is difficult to ascertain. Tends to plateau for long period and then deteriorate rapidly.

The major cause of Cirrhosis is ETOH Abuse. However, Cirrhosis caused by Chronic Hepatitis (usually C, but sometimes B), is rising.

Treatment cannot be supported in PCMU's.

## **MEDICAL INFORMATION NEEDED:**

Generic information



**HEPATITIS VIRAL (070.9), "A" (070.1), "B" (070.3), "C" (070.51), CHRONIC, UNSPECIFIED (571.4)  
HEPATITIS, GILBERT'S DISEASE (277.4), OR ROTOR'S SYNDROME (277.4), OTHER (573.3)**

CRITERIA				
→ 1) Acute Hepatitis current HbsAg neg • A, Symptoms resolved • B, Symptoms resolved, liver enzymes normal post-infection. • C, resolved 1 yr., liver enzymes normal post-infection	→	N/A	→	Acute
→ 2) Other causes Sx resolved, liver enz, nl post episode, HbsAg neg				
→ 3) Gilbert's or Rotor's Syndrome, latest bilirubin submitted				
→ 4) Hepatitis B carrier, current liver enzymes normal X2 over 6 mos.				
	↓	↓	↓	↓
<b>ACTION</b>	<b>CLEAR</b>	<b>CLEAR WITH RESTRICTIONS</b>	<b>DEFER</b>	<b>MNQ</b>
<b>RESTRIC- TIONS/ DEFER RATIONALE</b>	<p>1) Resolved Hepatitis = Hepatitis serology neg. ad LFTS-WNL chronic = hepatitis serology positive &gt; 6 mos. <b>Hepatitis A</b> always resolves without sequelae.</p> <p><b>Hepatitis B</b></p> <ul style="list-style-type: none"> <li>• 50% of cases are subclinical.</li> <li>• 2 - 3% become carriers.</li> <li>• 10% develop chronic hepatitis</li> <li>• Also passed sexually.</li> </ul> <p><b>Hepatitis C</b></p> <p>50% develop chronic hepatitis.</p> <p>2) Inflamed liver is also assoc. with Q fever, CMV, mononucleosis, medications, ETOH IV drug abuse, amoebae, fungi, INH, Nitrofurantoin.</p> <p>3) Gilbert's and Rotor's Syndromes are an abnormality of bilirubin metabolism. Bilirubin is usually slightly elevated and may rise due to fever or other illness.</p>			
			UNTIL: Asymptomatic, meets clearance criteria.	Chronic Hepatitis: at risk for long-term complications of cirrhosis and liver CA.

**MEDICAL  
INFORMATION  
NEEDED:**

Generic information; Type of Hepatitis, if documented  
HbsAg if any history of hepatitis of any cause

12/2/93

## CHOLELITHIASIS (574.2) / CHOLECYSTITIS / CHOLANGITIS (575.1), CHOLECYSTECTOMY (51.2)

<b>CRITERIA</b>	<ul style="list-style-type: none"> <li>→ 1) Post Cholecystectomy &gt; 3 mos., Asymptomatic</li> <li>→ 2) Never symptomatic</li> <li>→ 3) Laparoscopic cholecystectomy, &gt; 6 wks., asymptomatic.</li> <li>→ 4) Cholelithiasis resolved on medical therapy</li> </ul>	<p>→ N/A</p> <p>↓</p>	<ul style="list-style-type: none"> <li>→ 1) Cholecystectomy &lt; 3 mos. post.</li> <li>→ 2) Cholelithiasis symptomatic, past or present.</li> </ul> <p>↓</p>	<p>→ N/A</p> <p>↓</p>
<b>ACTION</b>	<b>CLEAR</b>	<b>CLEAR WITH RESTRICTIONS</b>	<b>DEFER</b> UNTIL: <ul style="list-style-type: none"> <li>1) Post surgery for 3 mos.</li> <li>2) Resolved medically or post surgery 3 mos.</li> </ul>	<b>MNQ</b>
<b>RESTRICTIONS/ DEFER</b>				
<b>RATIONALE</b>	<ul style="list-style-type: none"> <li>2) Asymptomatic cholelithiasis has only a 1 - 2% chance/ year of becoming symptomatic. Is not treated unless becomes symptomatic.</li> <li>3) Three mos. post surgery is needed to assess surgery. Occasionally a stone is missed and it will lodge in the bile duct post surgery.</li> </ul>			

**MEDICAL INFORMATION NEEDED:**

Generic information  
F/U plan if on medical therapy.



## PANCREATITIS: ACUTE (577.0), CHRONIC (577.1)

CRITERIA	<ul style="list-style-type: none"> <li>→ 1) Single episode, asymptomatic 2 yrs., no malabsorption or diabetes due to pancreatitis.</li> <li>→ 2) Pancreatic pseudocyst resolved medically or surgically &gt; 1 yr.</li> </ul>	→	N/A	→	<ul style="list-style-type: none"> <li>→ 1) Acute, any cause, asymptomatic &lt; 2 yrs.</li> <li>→ 2) Symptomatic</li> <li>→ 3) Pseudocyst present or resolved &lt; 1 yr.</li> </ul>	→	<ul style="list-style-type: none"> <li>→ 1) Chronic pancreatitis evidenced by chronic abdominal pain, diabetes, chronic diarrhea and/or malabsorption.</li> <li>→ 2) Idiopathic &gt; 1 episode.</li> </ul>
	↓		↓		↓		↓
ACTION	<b>CLEAR</b>		<b>CLEAR WITH RESTRICTIONS</b>		<b>DEFER</b>		<b>MNQ</b>
RESTRICTIONS/DEFER				UNTIL:	<ul style="list-style-type: none"> <li>1&amp;2) Asymptomatic for 2 yrs.</li> <li>3) Resolved &gt; 1 yr.</li> </ul>		
RATIONALE			<p>Acute pancreatitis is 80% ETOH induced. Chronic pancreatitis is 98% ETOH induced. Other causes include blockage of the biliary track by calculi, trauma, hyperlipidemia.</p> <p>Familial idiopathic 3 yrs. without relapse is less likely to recur.</p>				<ul style="list-style-type: none"> <li>1) Treatment cannot be supported in PCMU's.</li> <li>2) Very likely to continue to recur.</li> </ul>

**MEDICAL INFORMATION NEEDED:**

Generic information

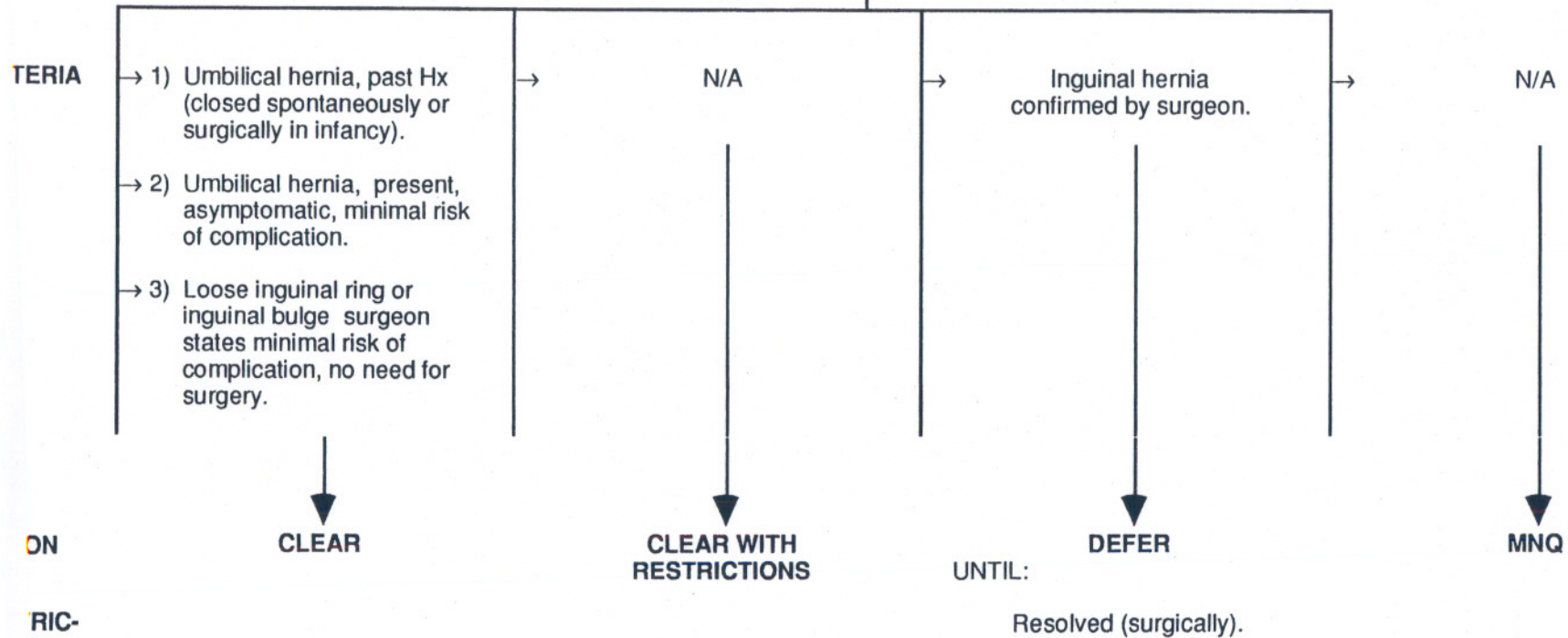
# HIATAL HERNIA (SLIDING AND PARAESOPHAGEAL) (553.3), HIATAL HERNIA REPAIR (53.7; 53.8)

CRITERIA	→ 1) Sliding Hiatal, asymptomatic → 2) Surgically repaired, post op. care completed.	→	N/A	→	1) Surgical repair 2) Paraesophageal hernia or Hx strangulated hernia. 3) Asymptomatic on meds for reflux	→	N/A
ACTION	CLEAR		CLEAR WITH RESTRICTIONS		DEFER		MNQ
RESTRICTIONS/ DEFER			See esophageal reflux.		UNTIL: 1&2) Surgical repair, post op care completed 3) See esophageal reflux.		
RATIONALE	Sliding hiatal hernia present in > 40% of the population. Most are asymptomatic and require no treatment.			Paraesophageal hernia must be surgically repaired due to risk of strangulation.			

## **MEDICAL INFORMATION NEEDED:**

Generic information  
 M.D. evaluation, only if symptomatic (see reflux).  
 Surgery report if paraesophageal hernia.

## UMBILICAL HERNIA (553.1), INGUINAL HERNIA (550)



ONALE Most umbilical hernias close spontaneously without complications.

AL MATION ED: M.D. evaluation  
Surgical evaluation for current hernias or "loose inguinal ring" or inguinal bulging.



## GASTROENTEROLOGY

### Achalasia of the

**Esophagus** Can now be fairly successfully treated with pneumostatic dilatation. The cure rates are 60-80%. With no recurrence of the condition in 2 yrs., it is unlikely to recur.

### Esophageal

**Obstruction** Has differing causes. The obstruction could be caused by a benign neoplasm or a swallowed object, both of which could be successfully removed. If the obstruction was removed without any damage to the Esophagus, the individual is considered totally recovered, requires no f/u and no likelihood of the obstruction recurring exists.

### Barrett's

**Esophagus :** Some controversy surrounds the f/u required in Barrett's. It is considered a mildly precancerous condition. Only 10% develop a malignancy. The usual f/u is endoscopy at 1-2 year intervals. There is no treatment. Barrett's is basically an adaptive condition. Due to prolonged exposure to gastric contents refluxing into the esophagus, the walls become thickened and cellular changes occur. Usually with the development of Barrett's, the patient's symptoms from reflux have ceased. Barrett's with Dysplasia is more serious and requires very close f/u.

### Esophagitis/Esophageal

**Reflux:** Are both treated basically in the same manner. 98% of Esophagitis is caused by reflux. Esophagitis can also be pill or trauma induced. The irritation can be so severe that bleeding occurs. When the offending medication is d/c'd, the Esophagitis resolves. The current practice for treating Esophagitis is H2 antagonists (Zantac, Tagamet) or Prilosec. The medications are given in the acute phase for treatment and for an extended time after resolution of the condition to prevent relapse. These drugs are safe and non-toxic and available many places in the world. They require no special lab work or tests as f/u. While on medications for prophylaxis, the chance of relapse is minuscule. The patient needs an endoscopy within the preceding 6 months before departure to r/o Barrett's. The patient should not use alcohol or tobacco as they aggravate the condition. Yearly exam by a physician (Board certified not necessary) is recommended but not required.

**Gastritis:** Is treated with the same medications as Esophagitis. An endoscopy within 6 months before departure is recommended to r/o PUD. Patients on prophylactic meds do very well.

### Peptic Ulcer

**Disease:** Treated with H2 antagonists and Prilosec. After the initial episode, patients remain on meds for at least a year. This practice has cut the relapse rate greatly. Currently, <10% of patients relapse while on meds the first year. Approximately 20% relapse during the second or third years after the medication is discontinued. Previously without H2 antagonists, the overall relapse rate was 60-80%. A repeat endoscopy should be done to confirm the healing of the ulcer. Some individuals present with hemorrhage from a perforated Peptic Ulcer. With proper treatment the ulcer disease resolves very well. Hemorrhage while on proper treatment is an indication of treatment failure and severe disease. Gastrectomy is now rarely done for PUD because it is easily controlled with proper medications. However, some people may have a partial gastrectomy done several years ago. Some of these people have complications such as dumping syndrome, bile reflux, or strictures. It is recommended that individuals with PUD should remain on medications during their entire Peace Corps tour to prevent relapse.

### Surgical

**Procedures:** One million people in the US have some type of ostomy. Patients with a Colostomy, Ileostomy or any type of Bowel Resection are at greater risk for dehydration due to their shortened intestines. Less fluid is absorbed from the shortened gut. They should have access to adequate amounts of potable water and be within at least 12 hours of decent medical care for treatment during diarrheal episodes.

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- 1). **Bowel Anastomosis and Ileoanal Anastomosis** both leave individuals with shortened guts, but intact rectums and continent of stool. They do not require any exterior appliance or equipment to evacuate the bowel.
- 2). **Ileostomy with Interior Pouch** does not require an exterior appliance (ostomy bag).  
The procedure does require equipment to evacuate the bowels.
- 3). **Ileostomy, Colostomy, Proctocolectomy with Ostomy:** Require an exterior ostomy bag. Depending on the placement of the ostomy and the length of intestine removed, they may also require equipment to evacuate the bowels. The skin under the stoma appliance is at risk for developing skin irritation in humid, tropical settings. Permanent Colostomies are done in only 15% of patients with colorectal Cancer.
- 4). **Temporary Colostomy:** Frequently a temporary Colostomy is done to let the lower colon and rectum heal. When the area has healed, the second operation to close the stoma is done. Normal bowel function is regained.

patients are usually on 5-ASA medication prophylactically for the rest of their lives. If they are asymptomatic on meds for 2 years, they are considered well controlled. The meds prevent relapses in the majority of cases. If a patient has had colitis for more than ten years, they need a colonoscopy every year to r/o Cancer. After ten years of disease, the risk for Ca rises 10% per year. For patients with colitis <10 years, an annual physical exam is recommended. Pan-Colitis with a history of steroid medication indicates severe disease that is at high risk for relapse.

Asymptomatic Diverticulosis is common. If Diverticulitis has been asymptomatic for 2 years, the diverticulitis has resolved and the patient is again considered to have Diverticulosis. The likelihood that severe symptoms of Diverticulitis will return after two years without relapse is small. Dietary restrictions: diet high in fiber excluding nuts, seeds, or popcorn. (The small hard pieces of food may lodge in a diverticuli and cause irritation.)

Crohn's is a variable condition, with symptoms and severity of symptoms manifesting with greatly varying intensity in different individuals. The applicant with Crohn's needs a thorough GI evaluation. Only patients with minor disease and asymptomatic for 5 years (no meds) are candidates for living overseas away from medical care. Post surgery the risk of developing a major exacerbation still exists. Most patients require additional surgery within 7-10 years. However, if after 5 years post surgery they continue symptomatic free, the likelihood of relapse greatly diminishes.

well

**IBS):** is a benign chronic condition requiring an individual evaluation by a physician. Some individual's symptoms do not interfere with their job, social life, or functioning while in others the syndrome can be debilitating. In some individuals, stress exacerbates the condition. Patients with IBS are not at any additional risk for dehydration. A GI infection will affect them the same as a person without IBS. They require a high fiber diet and sometimes a stool expander such as metamucil.

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**Polyps:** The minimum time to accept an applicant with a history of polyps is post colonoscopy and/or polypectomy is immediately post surgery. Then they are polypectomized and do not require a repeat colonoscopy for another 1-2 years, depending on the individual. The size and type of polyp must be determined. The likelihood they are cancerous increases with size, number and type. A small polyp can be biopsied and if neg. it is sometimes left intact. Colonoscopy is not considered the optimal screening exam for Colon Ca. The recommended screening exams for Colon CA are annual Stools for occult blood x 3 and annual flexible Sigmoidoscopy, starting at age 50.

**Hemorrhoidectomy:** Surgery does not cure the condition. It is likely the hemorrhoids will return. Asymptomatic Grade II hemorrhoids are highly likely to remain asymptomatic. Grade IV hemorrhoids are highly likely to cause a great deal of discomfort. Hemorrhoidectomy is more likely to prevent relapse than banding of the hemorrhoids. Episodes of diarrhea will definitely exacerbate the condition.

**Proctitis:** Ulcerative Proctitis is similar to Ulcerative Colitis. Patients are treated with 5-ASA and/or steroid enemas or suppositories. After resolution of the symptoms, they are weaned off meds. If the condition recurs, they are usually on 5-ASA prophylactically long term, which in most cases prevents relapses. If a patient has recurrent proctitis and not been on prophylactic meds, they are not receiving adequate treatment. Recurrent Ulcerative Proctitis, on meds, is not common, and would require frequent medical care.

**Benign liver cysts:** are not problematic, on or off oral contraceptives.

**Liver Adenoma** must be investigated. Solid adenomas must be biopsied. If the individual is on oral contraceptives, the BCP's should be discontinued. The patient needs a repeat liver scan after 6 months to see if the adenomas have resolved.

**Cirrhosis:** Seventy-five percent of the cases of Cirrhosis are due to chronic alcoholism. Cirrhosis caused by chronic Hepatitis (B and C) is increasing, particularly from sexually acquired Hepatitis B. The course of cirrhosis is difficult to predict. It is frequently "silent". Lab tests are not accurate. Needle biopsy gives a much better picture of the disease. Liver-spleen scans are also helpful. These patients need individual consideration. Tests to consider are LFT's, Platelet count, Serum Bilirubin, and Stool for Occult blood. Any bleeding must be thoroughly investigated.

**Hepatitis:** Hepatitis has been identified as types A,B,C,D, and E. Hepatitis A is relatively benign, never becomes chronic. The carrier state is unknown in Hepatitis A. Many people have had subclinical cases of A. Patients are considered well 2 months after resolution of Hepatitis A. Hepatitis B resolves more slowly. 7-10% develop chronic hepatitis and 2-3 % become asymptomatic carriers, many unknowingly. 50 % of hepatitis B cases are subclinical. Hepatitis C develops a chronic course in 50% of cases. One year post Hepatitis C is recommended to rule out chronic cases. Any chronic Hepatitis requires close f/u. Six months post onset of disease, carrier states and chronic cases can be diagnosed. Chronic Hepatitis is defined as positive Hepatitis Serology 6 months post development of disease. Chronic Hepatitis is associated with Cancer of the Liver and Cirrhosis. Hepatitis B carrier status is not associated with these complications, but it can run a remitting course with some relapses. Hepatitis B is also a sexually transmitted disease and anyone with recent case of Hepatitis B, should have an HIV test 6 months post infection. All applicants should have the Hepatitis B vaccine. In the US, Hepatitis C is usually passed through blood (post transfusion). However, there is an epidemic form in Asia that follows a similar course to Hepatitis A. Hepatitis D and E are rare. D is associated with Chronic state. Screen as for other Hepatitis, if seen.

**It is highly recommended by all the consultants that Peace Corps vaccinate volunteers to prevent Hepatitis B. The reasons stated were:**

1. The high rates of infection in most Peace Corps country sites
2. The long convalescence (6 months) sometimes required
3. The expense in treating chronic Hepatitis
4. The very serious sequelae to chronic Hepatitis of Liver Cancer and Cirrhosis
5. The risk of becoming a carrier
6. The CDC is recommending Hepatitis B vaccine for all newborns.

% of cases, the cause is unknown. Other causes include (that is surgically resolved) has no likelihood of relapse. It will usually resolve and not recur. Chronic Pancreatitis

ption, and/or diarrhea. Pancreatic Pseudocyst is associated with the absence of Pancreatitis.

duct. This will happen within the first few weeks post surgery to destroy stones.

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