RESPIRATORY

PULMONARY

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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



Reply to: PPD or INH for old TB? (FYI all)

- 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 alop 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 Asthma, no recurrence after age 15. 2) One episode Asthmatic bronchitis. or secondary to URI exclusively. 3) Questionable-History-SOB/wheezing resolved w/antihistamines TC Bronchodilator (Primatene) in past, asymptomatic at least 1-vr:--5) Questionable history: PEFR monitoring X-2 wks and methacholine test all negative for airway disease. all reactions to cats, pets & seasonal ACTION CLEAR

→ 1) Meets all 4 criteria for mild or well controlled moderate asthma (below), stable for 3 months.

or Methacholine challenge w/ PC ₂₀>20 mg/ml

- Non seasonal bronchospasm (pet allergies) or specific chemical irritant
- Urgent Dr, visits in last 5 · yrs, .
- 3) Exercise induced as hma
- 4) > 1 episode of asthmatic bronchitis

MRB/MED

ADVISOR

- 1) > 2 episodes/wk of symptoms 1) Asthma or
- 2) > 2 episodes/m of nocturnal asthma
- 3) 30 day PEFR < 80% of predicted
- Incomplete response to MDI bronchodilators
- Cough or wheezing present btwn MDI use
- 6) Theodur use only, last serum level < 10 mcg/ml
- 7) theophylline use only, level 10-20
- 8) OTC bronchodilator use w/in 1 yr.
- Exercise tolerance reduced despite adequate inhaled steroids.

DEFER until:

 Need for systemic steroids in last 5 yrs. Asthma or bronchodila irreversible disease (emphysem COPD, lobe

MNO

CLEAR WITH RESTRICTIONS

1) Mild or well controlled asthma criteria:

a) < 3 episodes/wk requiring MDI V

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

.

- 30 day PEFR > 80% of predicted, < 20% variation
- d) All of above w/ complete response to MDI bronchodilators
- e) Does not smoke

RATIONALE

RESTRICT-

IONS/DEFER

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

2) Needs Drs' diagnosis of

asthmatic bronchitis

- Distinguish Isolated
 allergies (which can be
 cleared) from an underlying
 asthmatic condition.
- 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.

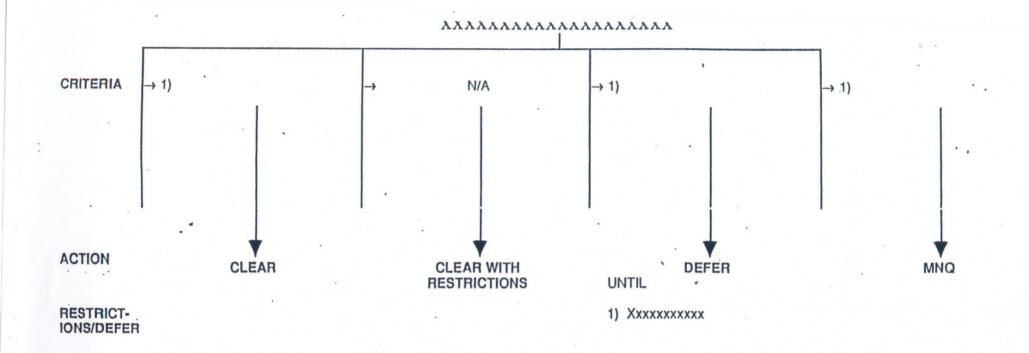
MDI= metered dose inhaler

- 1-5) Meets criteria for mild asthma 6) d/c meds and monitor response
- X 1 month.
 7) Controlled w/ MDIs, stable X 3
- 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

Pulmonary Disease

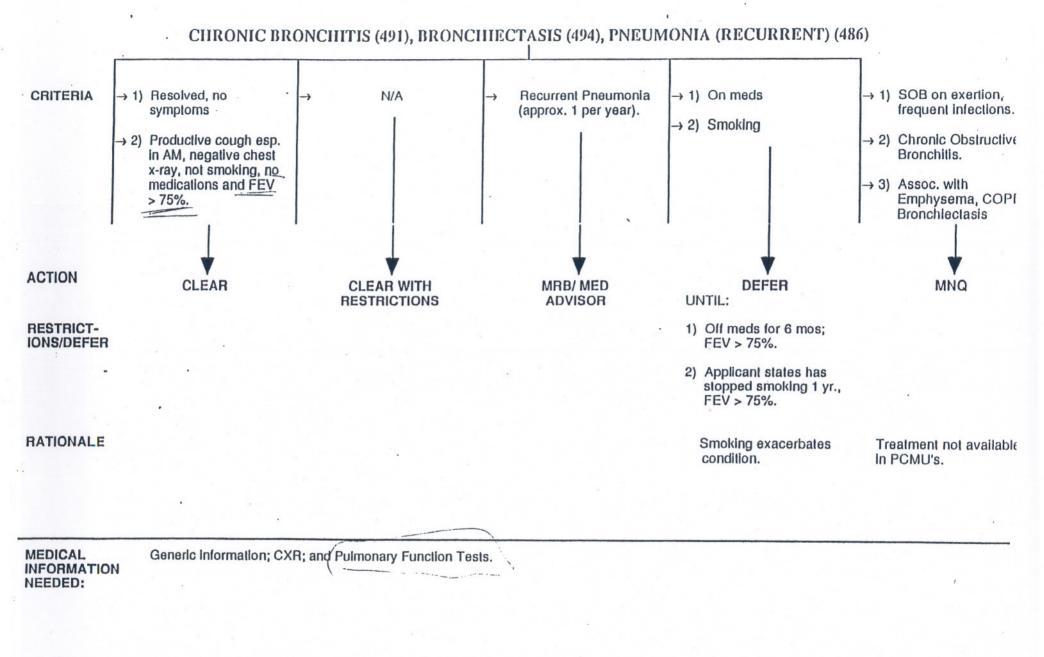
PULMO-2

NIH Classification of Asthma Severity in Consider

Characteristics A) Pretreatment	WILD.	MODERATE*	SEVERE*
Frequency of exacerbations	no more than 1-2 times/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 compilications
Frequency of symptoms	few or no signs/symptoms between exacerbations	cough and mild wheezing often present between exacerbations	continuous cough and wheezing almost always present
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 tlmes/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 ₂₀ [†] > 20 mg/ml (hlgher dose)	PC ₂₀ 2-20 mg/ml	PC ₂₀ <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 integrations of time	Requires continuous, round the clock therapy including steroids (often high dose MDI or systemic).

the state of the state of the sauce a 200' decrease in FFV.

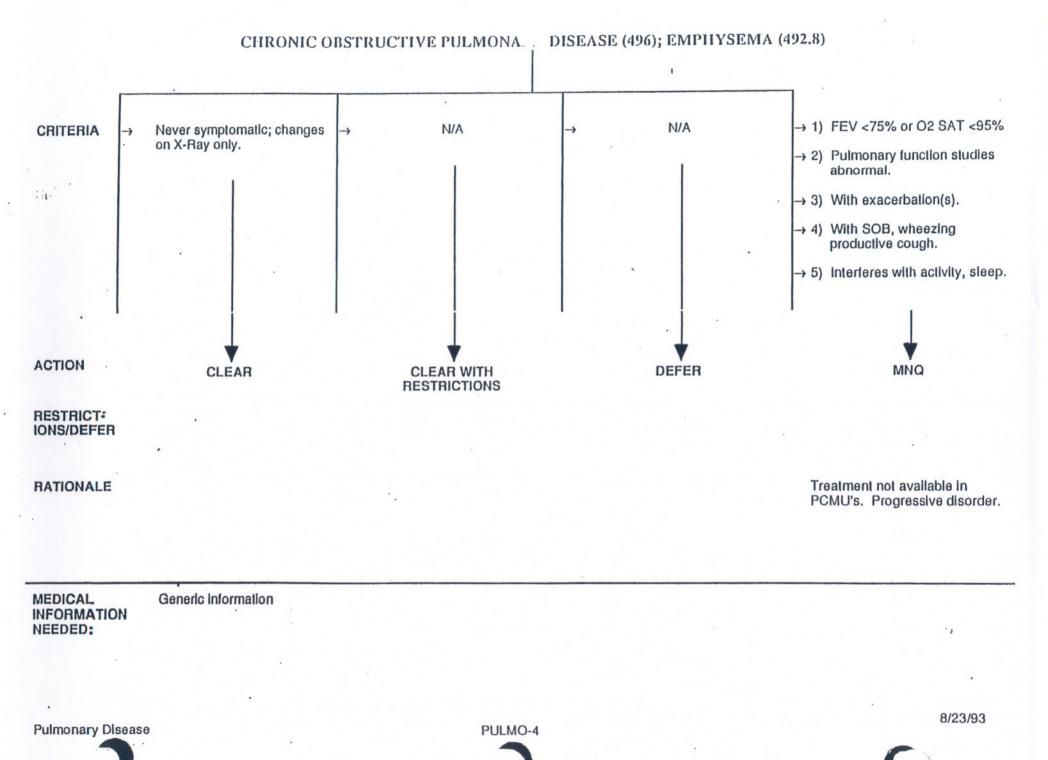
variability in PEFR between morning and evening or between morning PEFRs over one week



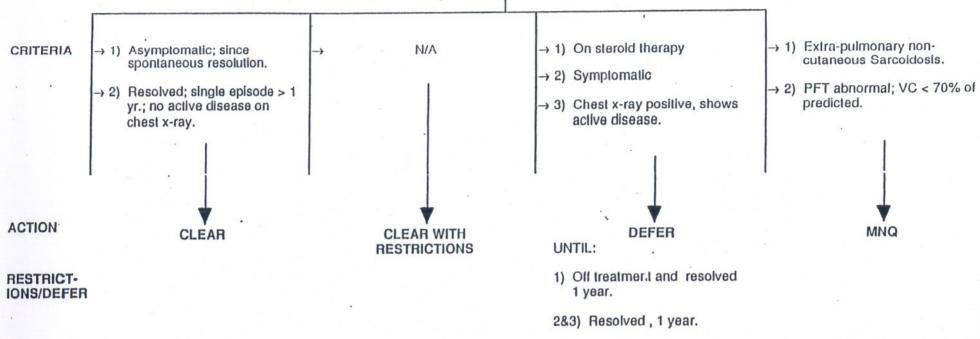
Pulmonary 7

PU'

8/23/93



SARCOIDOSIS-PULMONARY (517.8), RCOIDOSIS-NON-PULMONARY (135)



10% develop serious disabilities (ocular, respiratory, liver, CNS).

MEDICAL INFORMATION NEEDED:

RATIONALE

Generic information;

Sarcoldosis can clear

spontaneously within months or years, without consequences.

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) Traumatic pneumothorax CRITERIA more) spontaneous, not surgically with pleurodesis or treated with pleurodesis or pleurectomy < 6 mos. post. surgically treated. 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 sarcoldosis, or other resp. pleurectomy < 6 mos. post. needed. disease. → 3) Spontaneous, treated with pleurodesis or pleurectomy > 6 mos. post. 4) Sincle, apontanoont, resolved 1> 6 miss 5) ACTION MNQ DEFER **CLEAR WITH CLEAR** UNTIL: RESTRICTIONS 1&2) Post surgery 6 mos. RESTRICT-IONS/DEFER Surgery is sometimes done with pneumothorax. The bullae are At risk for recurrence: most PCV at no added medical RATIONALE 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 is done.

MEDICAL INFORMATION NEEDED:

Generic Information