

RESPIRATORY

PULMONARY

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From: Mark Miani (10/7/92)

To: Linda & Polly Zenick/Lung

CC: Molly Diamond, Toni Dumas, Judy Reidinger, Karen Roberts, Maureen Ross, Carol Stewart, Dorothy

BCC:

Priority: 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 \geq 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 develop if exposed to a large dose of infectious TB micro-droplets. This last point is interesting, 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 [REDACTED] 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 4) OTC Bronchodilator (Primatene) in past, asymptomatic at least 1-yr. 5) Questionable history-PEFR monitoring X 2 wks and methacholine test all negative for airway disease. 6) EIA 7) all reactions to cats, pets & seasonal pollens	→ 1) Meets all 4 criteria for mild or well controlled moderate asthma (below), <u>stable for 3 months.</u> or Methacholine challenge w/ PC 20>20 mg/ml	1) Non seasonal bronchospasm (pet allergies) or specific chemical irritant 2) Urgent Dr. visits in last 5 yrs. 3) Exercise induced asthma 4) > 1 episode of asthmatic bronchitis	1) > 2 episodes/wk of symptoms 2) > 2 episodes/m of nocturnal asthma 3) 30 day PEFR < 80% of predicted 4) Incomplete response to MDI bronchodilators 5) Cough or wheezing present btwn MDI use 6) Theodor use only, last serum level < 10 mcg/ml 7) theophylline use only, level 10-20 8) OTC bronchodilator use w/in 1 yr. 9) Exercise tolerance reduced despite adequate inhaled steroids. 10) Need for systemic steroids in last 5 yrs.	1) Asthma or bronchodila irreversible disease (emphysem COPD, lobe	
ACTION	CLEAR	CLEAR WITH RESTRICTIONS	MRB/MED ADVISOR	DEFER until:	MNO
RESTRICT- IONS/DEFER	2) Needs Drs' diagnosis of asthmatic bronchitis	1) Mild or well controlled asthma criteria: a) < 3 episodes/wk requiring MDI ✓ b) < 3 episodes/mo of nocturnal asthma ✓ (c) Baseline spirometry WNL except for evidence of obstructive airway Dx. or 30 day PEFR > 80% of predicted, < 20% variation d) All of above w/ complete response to MDI bronchodilators ✓ e) Does not smoke ✓	1) Distinguish isolated allergies (which can be cleared) from an underlying asthmatic condition. 3) Drs/ Hx supporting diagnosis. Needs 6-8 min of sustained exercise with return of FEV ₁ w/in 20 min; can be cleared. 4) Distinguish underlying airway 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 mths meets criteria for mild asthma 8) 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	
RATIONALE	Methacholine challenge can be used in the differential diagnosis of asthma severity or for excluding it.				

NOTE: EIA (controlled) being cleared by

8/22/94

XXXXXXXXXXXXXXXXXXXX

CRITERIA

→ 1)

→

N/A

→ 1)

→ 1)

ACTION

CLEAR

CLEAR WITH
RESTRICTIONS

UNTIL

DEFER

MNQ

RESTRICT-
IONS/DEFER

1) XXXXXXXXXXXX

RATIONALE

MEDICAL
INFORMATION
NEEDED:

Generic Information

Pulmonary Disease

PULMO-2

NIH Classification of Asthma Severity

*no free anti
in Africa. Only
North + South
America*

Characteristics	MILD*	MODERATE*	SEVERE*
A) Pretreatment			
Frequency of exacerbations	no more than 1-2 times/week	more than 2 times/wk Infrequent severe exacerbations (urgent care <3 times/yr)	virtually daily wheezing, often with sudden, severe exacerbations urgent care >3 times/yr often hospitalized with or without complications
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 exercise	reduced	very poor, marked limitation of activity
Nocturnal asthma	rare (up to 2 times/mo)	frequent (2-3 times/wk)	almost nightly, sleep interrupted, chest tightness in the morning
School/work attendance	good	may be affected	poor
<i>Optional for med clearance</i>			
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	PC ₂₀ [†] > 20 mg/ml (higher dose)	PC ₂₀ 2-20 mg/ml	PC ₂₀ <2 mg/ml (low dose)
B) After optimal treatment			
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 long periods of time	Requires continuous, round the clock therapy including steroids (often high dose MDI or systemic).

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

[†] dose of methacholine required to cause a 20% decrease in FEV₁.

CHRONIC BRONCHITIS (491), BRONCHIECTASIS (494), PNEUMONIA (RECURRENT) (486)

CRITERIA	→ 1) Resolved, no symptoms → 2) Productive cough esp. in AM, negative chest x-ray, not smoking, <u>no medications and FEV</u> <u>> 75%.</u>	→ N/A	→ Recurrent Pneumonia (approx. 1 per year).	→ 1) On meds → 2) Smoking	→ 1) SOB on exertion, frequent infections. → 2) Chronic Obstructive Bronchitis. → 3) Assoc. with Emphysema, COPD, Bronchiectasis
ACTION	CLEAR	CLEAR WITH RESTRICTIONS	MRB/ MED ADVISOR	DEFER	MNQ
RESTRICTIONS/DEFER				UNTIL: 1) Off meds for 6 mos; FEV > 75%. 2) Applicant states has stopped smoking 1 yr., FEV > 75%.	
RATIONALE				Smoking exacerbates condition.	Treatment not available in PCMU's.

MEDICAL INFORMATION NEEDED:

Generic Information; CXR; and Pulmonary Function Tests.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (496); EMPHYSEMA (492.8)

CRITERIA	→ Never symptomatic; changes on X-Ray only.	→ N/A	→ N/A	→ 1) FEV <75% or O2 SAT <95% → 2) Pulmonary function studies abnormal. → 3) With exacerbation(s). → 4) With SOB, wheezing productive cough. → 5) Interferes with activity, sleep.
ACTION	↓ CLEAR	↓ CLEAR WITH RESTRICTIONS	↓ DEFER	↓ MNQ

RESTRICTIONS/DEFER

RATIONALE

Treatment not available in PCMU's. Progressive disorder.

MEDICAL INFORMATION NEEDED:

Generic Information

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

CRITERIA	<ul style="list-style-type: none"> → 1) Asymptomatic; since spontaneous resolution. → 2) Resolved; single episode > 1 yr.; no active disease on chest x-ray. 	→	N/A	→	<ul style="list-style-type: none"> → 1) On steroid therapy → 2) Symptomatic → 3) Chest x-ray positive, shows active disease. 	→	<ul style="list-style-type: none"> → 1) Extra-pulmonary non-cutaneous Sarcoidosis. → 2) PFT abnormal; VC < 70% of predicted.
ACTION	CLEAR		CLEAR WITH RESTRICTIONS		DEFER		MNQ
RESTRICTIONS/DEFER					UNTIL: 1) Off treatment and resolved 1 year. 2&3) Resolved, 1 year.		
RATIONALE	Sarcoidosis can clear spontaneously within months or years, without consequences.					10% develop serious disabilities (ocular, respiratory, liver, CNS).	

MEDICAL INFORMATION NEEDED:

Generic information;
Pulmonologist, if symptomatic in past 5 years.

8/23/93

PNEUMOTHORAX: SPONTANEOUS (512), TRAUMATIC (860)

CRITERIA	<ul style="list-style-type: none"> → 1) Traumatic pneumothorax treated with pleurodesis or pleurectomy > 6 mos. post. → 2) Traumatic resolved without surgery for 6 weeks, no F/U needed. → 3) Spontaneous, treated with pleurodesis or pleurectomy > 6 mos. post. 4) <i>Single, spontaneous, resolved > 6 mos</i> 	N/A	<ul style="list-style-type: none"> → 1) Spontaneous, treated surgically with pleurodesis or pleurectomy < 6 mos. post. → 2) Traumatic pneumothorax, treated with pleurodesis or pleurectomy < 6 mos. post. 	<ul style="list-style-type: none"> → 1) Single or recurrent (2 or more) spontaneous, not surgically treated. → 2) Assoc. with CVD, emphysema, asthma, sarcoidosis, or other resp. disease.
ACTION	5) CLEAR	CLEAR WITH RESTRICTIONS	DEFER	MNQ
RESTRICTIONS/DEFER			UNTIL: 1&2) Post surgery 6 mos.	
RATIONALE	PCV at no added medical risk for recurrence if treated surgically.		Surgery is sometimes done with pneumothorax. The bullae are excised or oversewn and the pleura roughened mechanically (plication of emphysematous bleb). When bullous disease is extensive, parietal pleurectomy is done.	At risk for recurrence: most spontaneous pneumothorax occur in males 20 - 40 yrs. due to rupture of an emphysematous bulla.

MEDICAL INFORMATION NEEDED:

Generic Information