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13. ABSTRACT *(Maximum 200 Words)*

The Artificial Intelligence in Management (AIM) Laboratory of the Katz Graduate School of Business, University of Pittsburgh designed, developed and tested a prototype of the Expert Consult Broker of GGTS for the US Army Medical Research and Materiel Command (USAMRMC), Telemedicine and Advanced Technology Research Center (TATRC) Knowledge Engineering Group (KEG) using a combination of artificial intelligence, and management science methodologies. The Global Grid Telemedicine System (GGTS) is a proposed global telemedicine command and control system that will enable telemedical consultations to occur anywhere in the world, regardless of location or transportation medium. The ultimate objective is to determine how best to leverage extensive Department of Defense communications infrastructure to provide global telemedicine support to US and allied forces worldwide.

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Artificial Intelligence, Case-based Reasoning, Classification, Consult Broker, Telemedicine

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INTRODUCTION

The Artificial Intelligence in Management (AIM) Laboratory of the Katz School of Business designed and developed a prototype of the Expert Consult Broker of GGTS employing a combination of artificial intelligence, and management science methodologies. Figure 1 depicts the conceptual architecture of GGTS. The system components are given in Figure 2.

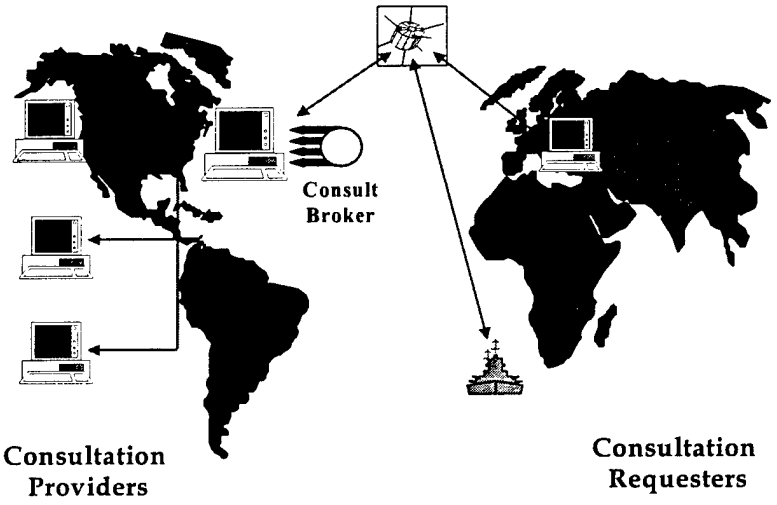


Figure 1. GGTS Conceptual Architecture

The Global Grid Telemedicine System (GGTS) is a proposed global telemedicine command and control system (Zajtchuk and Zajtchuk, 1996) that will enable telemedical consultations to occur anywhere in the world, regardless of location or transportation medium. The ultimate objective is to determine how best to leverage extensive Department of Defense communications infrastructure to provide global telemedicine support to US and allied forces worldwide.

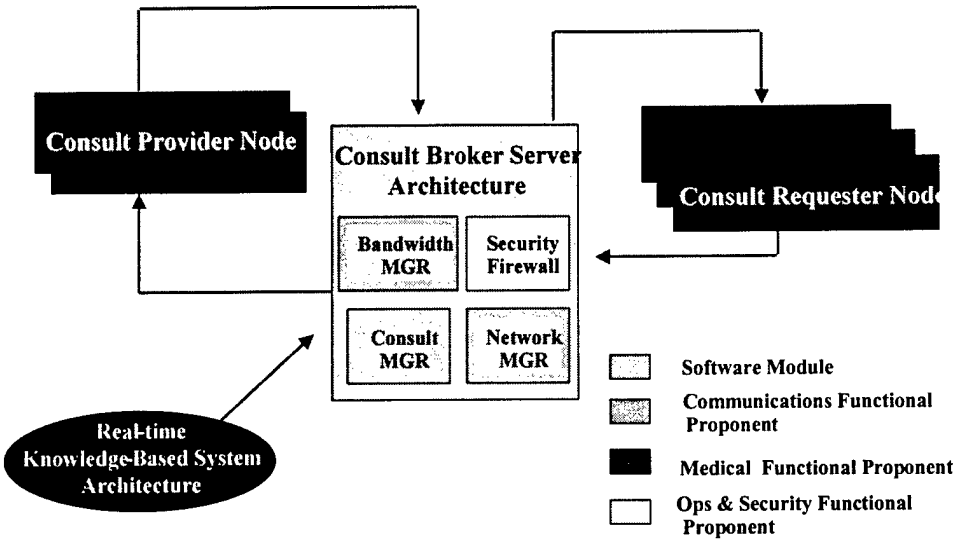


Figure 2. Proposed GGTS System Components

PROJECT STAGES

During the first part of the project we defined the scope of the problem, determined four alternative configurations, and identified probable methodologies. At the end of the first year, we set goals to extend the breadth of the prototype—that is, to determine how representative TDent is of the general medical teleconsultation problem—and to refine the types of teleconsultations to best match the KB&MS tools and interfaces to the management problem, user requirements, and organizational rules.

During the second part of the project, we worked on a teledental (TDent) prototype using real data. TDent data comes primarily from Europe. There were approximately 500 consults, and the location and specialty information is present on all consultants. Additionally, dental procedure

(CDT) codes are available for almost all of the consults, and there is a partly structured user input interface.

We identified four distinct approaches to the way in which the Consultation Broker might work with its users to determine the most desirable match of consultant to requestor (see Figure 3).

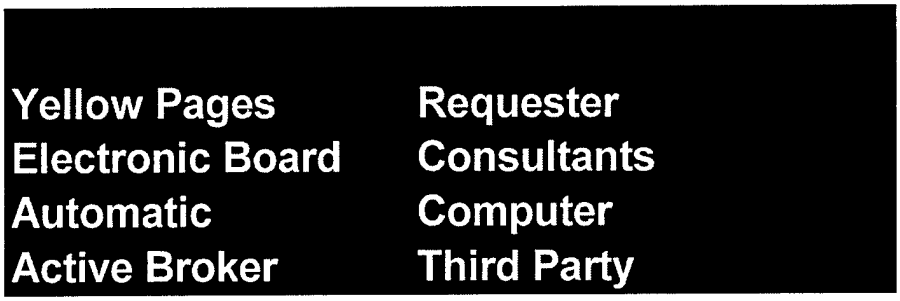


Figure 3. GGTS Alternative Configurations

Regardless of the alternative chosen, the Consultation Broker needs the following components to make it operational:

- a list of all potential consultants by name and by specialty,
- a list of sites providing consultation,
- a link to a network manager that indicates what modes of teleconsultation are feasible between a requestor and all consultation sites at the current time, and which will enable the teleconsultation once its participants have been determined,
- an interface to collect relevant information from the requestor, designed to make that information as complete and as internally consistent as possible,

- an interface to present the requestor's information to the consultant in an effective fashion, and

- a time-keeping capability and a time-based event trigger, to monitor the progress of the teleconsultation and to initiate actions necessary to guarantee that any mutually desired and feasible consultation will actually take place.

The approaches differ primarily in the degree to which the computer system controls the brokering process: (a) the "active broker" alternative, (b) the automatic alternative, (c) the e-board alternative, and (d) the "yellow pages" alternative.

a. The Active Broker Alternative (AB)

This alternative (see Figure 4) uses the CB solely to relay information from the requestor and about potential consultants to a human, who is neither the requestor nor a potential consultant. That third party makes the assignments, using the data provided by the CB. The "intelligence" in the CB under this alternative is in the selection of information to be presented to the human assigner, and in the way in which that information is presented to the human so as to make the assigner's behavior as efficient and effective as possible. Under the Active Broker alternative, the human in charge of assignments functions somewhat like an air-traffic controller, monitoring and managing the requests for teleconsultation as they are matched up with consultants.

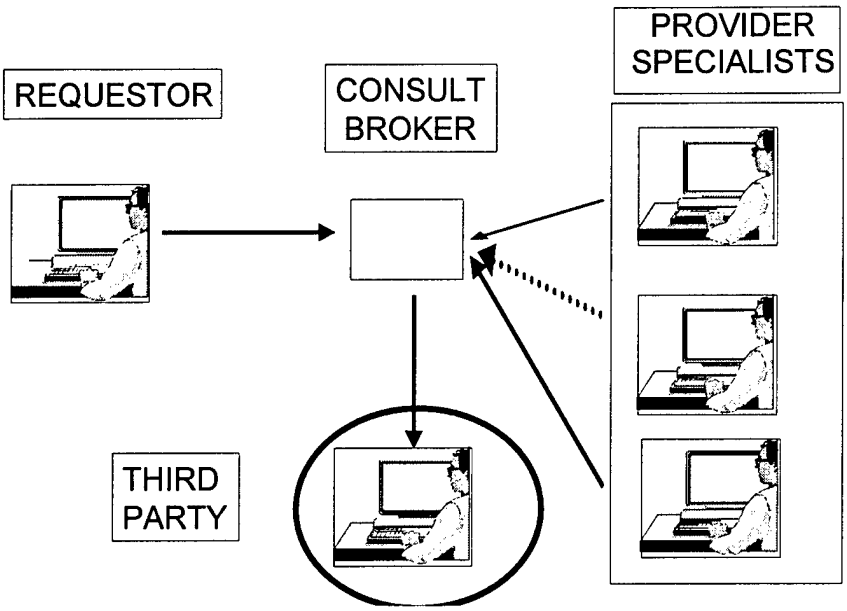


Figure 4. The Active Broker

b. The Automatic Alternative (AU)

In the Automatic Alternative (see Figure 5), the Consultation Broker behaves in an autocratic fashion, deciding on a match without user intervention. The CB may use one or more methodologies, such as those that use past experience (e.g., case-based reasoning), statistical analysis of a database (e.g., classification), or an electronic procedures manual (e.g., rule-based reasoning) as appropriate.

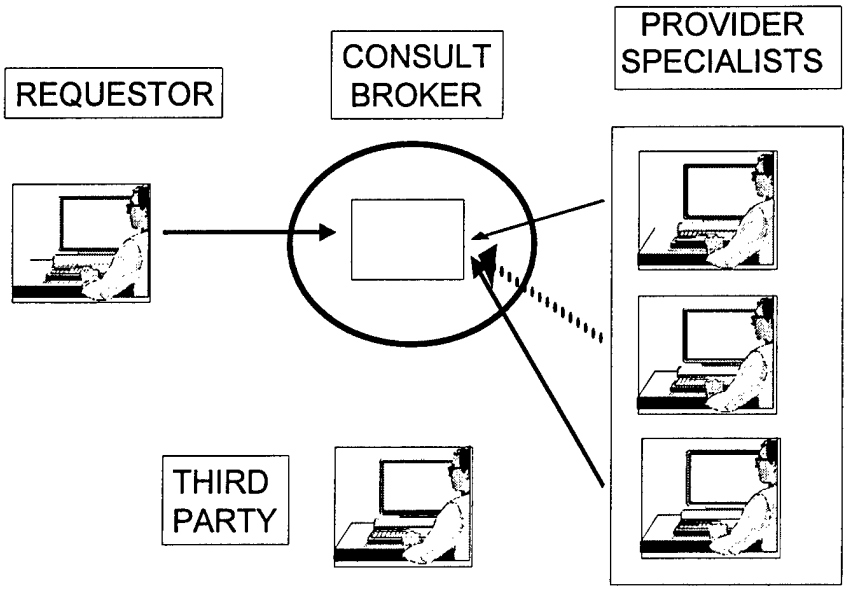


Figure 5. Automatic Alternative

Independently of the methodology used, the Automatic Alternative requires as inputs knowledge of:

- detailed profiles of consultants, and a list of consultants available at the time of the consultation,
- detailed profiles of all sites providing service,
- the list of cases requesting consultations,
- a uniform coding of cases, past and present, and
- at least one assignment methodology.

c. The Electronic Board Alternative (EB)

Requests for consults are posted on an electronic bulletin board (see Figure 6), and the consultants select the cases in which they want to participate on a first-come-first-served basis.

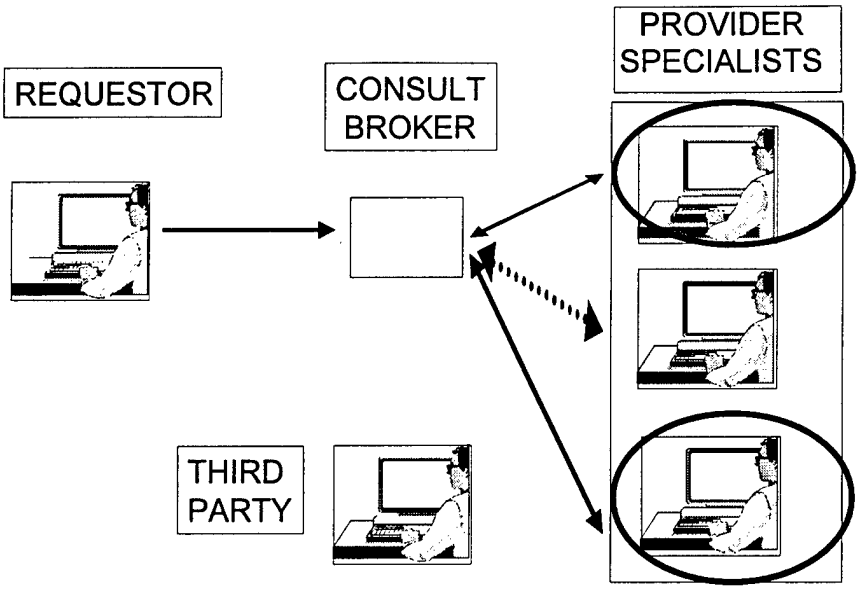


Figure 6. Electronic Board

As the requests are posted, the CB alerts all consultants in the requested specialty of the availability of a new case. If a consultant does not select the case within a time period that is determined as a function of the urgency of the case, the CB assigns it in an autocratic fashion, as it would in the automatic alternative. Note that the consultants decide on the case assignment in this alternative. The requestor may ask for a particular institution or a particular physician, but it is the respondent who determines if that particular match-up occurs. The CB's role in supporting the matching process is limited to notification of all potential respondents, and provision to them of the information from the requestor. In addition to the functionalities of the automatic alternative, which are needed if no consultant

chooses to respond to the request for a consult, to implement the e-board alternative the CB requires that:

- the requests must be disseminated to all provider nodes along with all the data available for the consultation, and
- the blackboard must be kept in real time.

d. The Yellow Pages Alternative (YP)

In contrast to the e-board alternative, in which the consultant is the decision-maker, the "yellow pages" alternative (see Figure 7) puts the requestor in charge of selecting the consultant.

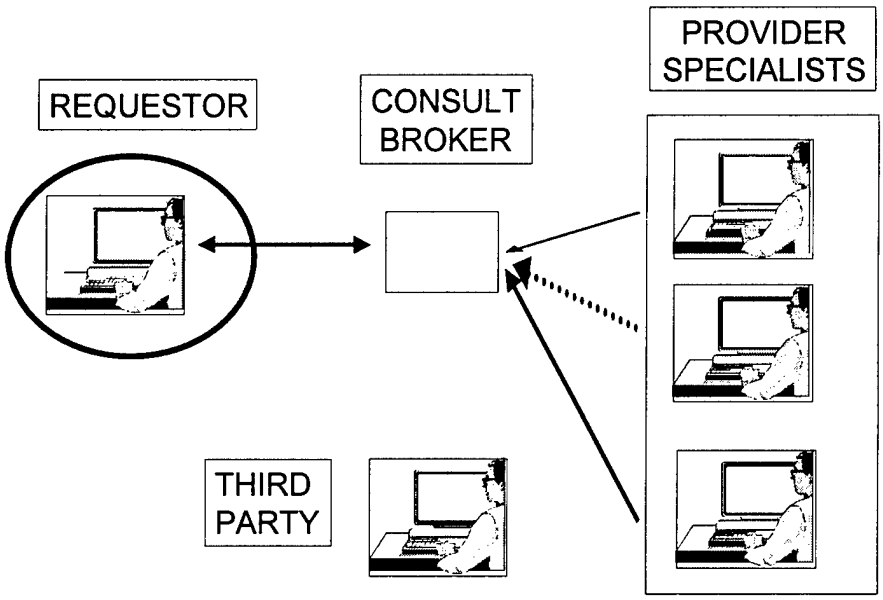


Figure 7. Yellow Pages

The CB assists the requestor by supplying a list of available consultants (the "yellow pages" listing) together with background information that might be useful in making a selection (the "yellow pages ads"). As in the e-board alternative, the CB would have to take charge and make a

selection of a consultant if the requestor did not do so within an appropriate length of time. The CB must also be capable of making the assignment if the requestor asks the CB to do so. In addition to the functionality of the automatic alternative, and a time-keeping functionality as in the e-board alternative, to implement the "yellow pages" alternative the CB would need:

- detailed profiles of all consultants along with their history of clinical work,
- detailed profiles of all sites providing service, and
- the ability to present the correct subset of the above information to a requestor in real-time in a useful format.

CONSULT BROKER PROTOTYPE

To develop the prototype we used limited data from the Ask-a-Doc system in use at WRAMC and LRMC. This system is a system of free form e-mail text input. The responses are also free-form e-mail by (possibly) multiple self-selected consultants. We have partial information on the locations and specialties of the participants in one month's worth of data (~100 consults).

The system consists of three case-based reasoners (CBR): Specialty Locator, Site Locator, and Consultant Locator. Each CBR system relies on a case base that includes a relevant set of past experiences, each stored as a description of a problem paired with the solution to it. To solve a new problem, a case-based reasoner first will typically retrieve from the case base

a set of cases whose descriptions are sufficiently similar to that of the new problem. It then extracts the solutions to the cases retrieved from the case base, adapts them if necessary, and then it adds the new case plus its solution to the case base. While most CBR systems reason based only on the single most similar case, Smyth and Keane (1998) argue that the retrieval of the most similar past case may not necessarily yield the one that is best suited to solving a new problem. Furthermore, they propose that deeper knowledge is required to determine what previous experience is most relevant.

The flow-chart of a tele-consultation with the system developed is given in Figure 8.

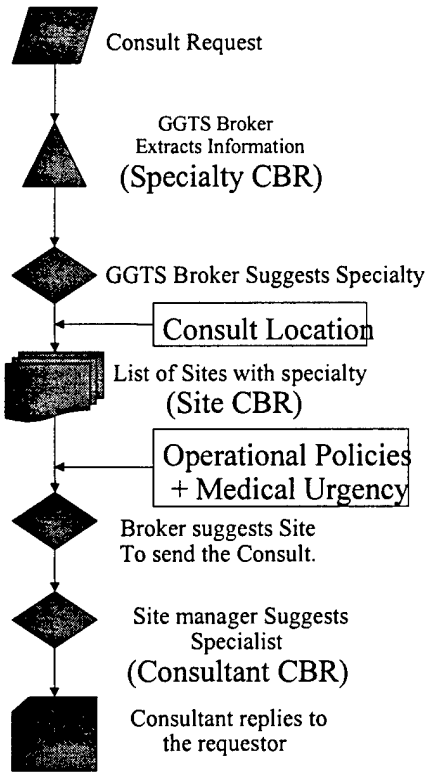


Figure 8. GGTS Consult Flowchart

At the beginning of a consult, the consult submission is made by the Requester. The entry user-interface is given in Image 1.

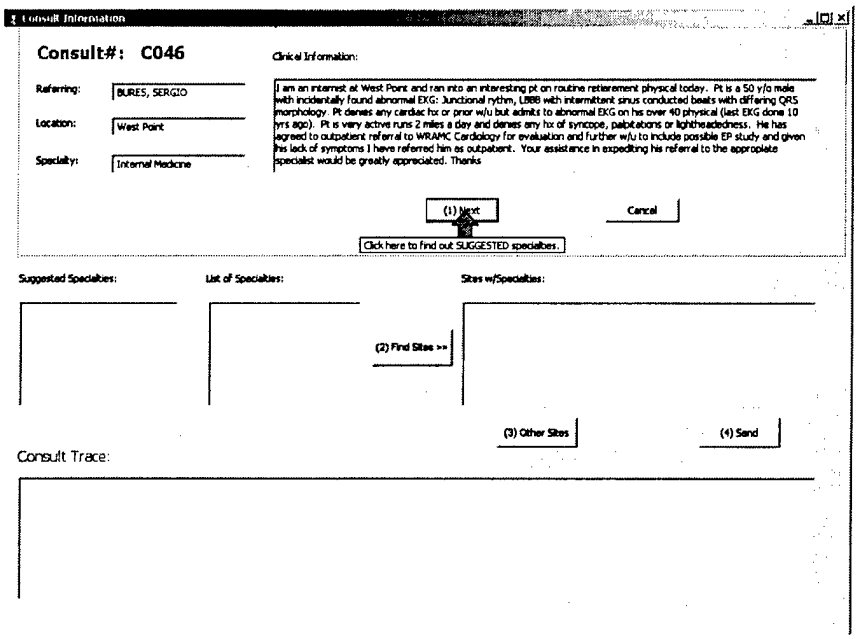


Image 1. Screen View of Consultation Request

Next, the Specialty CBR extracts information from the text, and uses the database of prior cases in order to suggest a specialty to the Requester (see Image 2). The Requester then proceeds to the next step, in which the Site CBR lists possible locations for the suggested specialties.

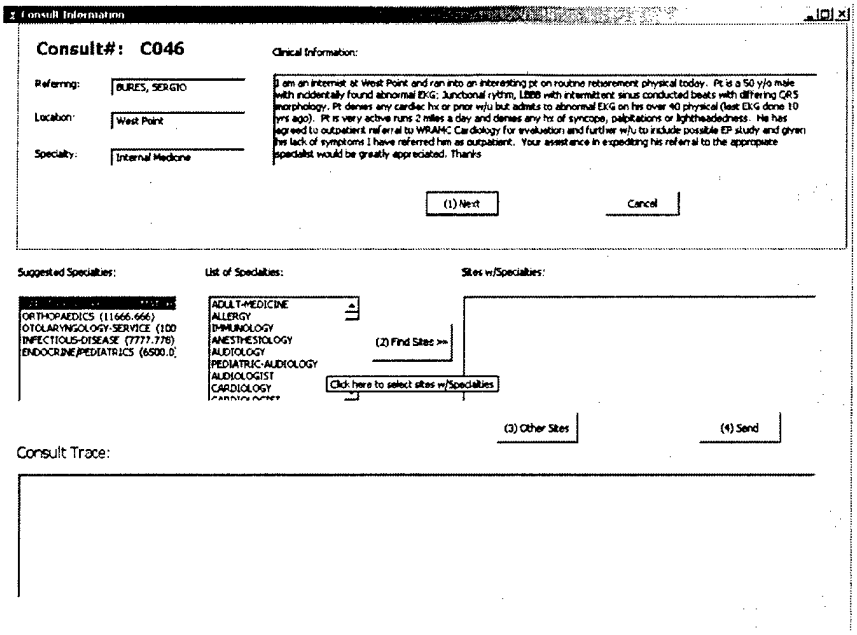


Image 2 Screen View of Specialty Site Locations

Next, the consult is sent to the Specialty Site (see Image 3).

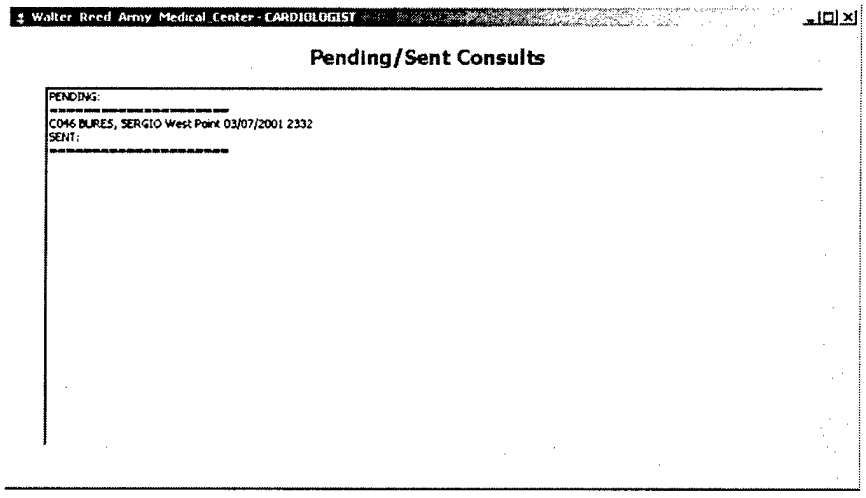


Image 3 Screen View of Pending/Sent Consults

The Consultant CBR then suggests a list of potential specialists at the site (see Image 4).

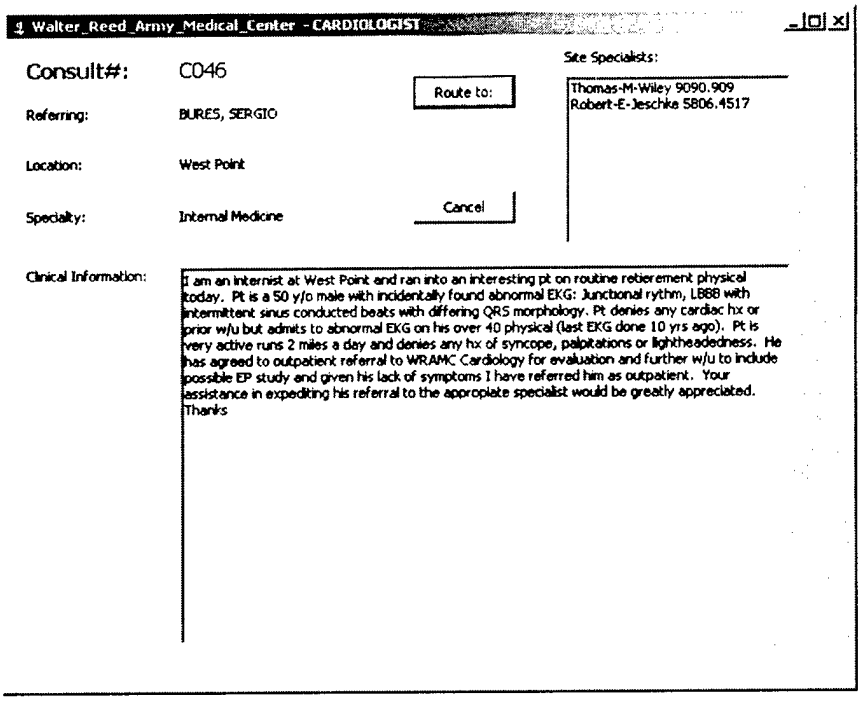


Image 4 Screen View of Site Specialists

The last step involves a reply from the specialist to the consult requester, which completes the loop. The reply is given a time stamped delivery confirmation.

RESEARCH ISSUES

There are research issues involved in the Specialty CBR. The current version looks at UMLS words in the text as individual terms. Would having it try to "understand" the text improve its functioning?

The site-locator CBR needs to combine rules and cases. We need to know the rules, have explanations for which rules should take precedence, and then discover how the two types of knowledge should interact.

There are two issues with the case-based reasoners research:

1. Obtain declarative knowledge of the specialists' experience and expertise, and combine it with case-based data.

2. Automatic knowledge acquisition of physicians' experiences, and classification of those experiences.

Example of a Consult in Which Partial Information Changes the Specialty Suggested

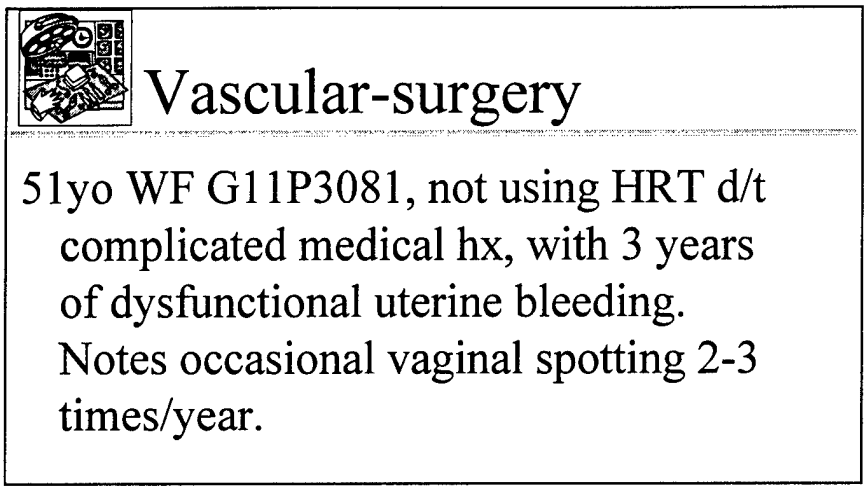


Figure 9. Suggested Specialty, Vascular-surgery

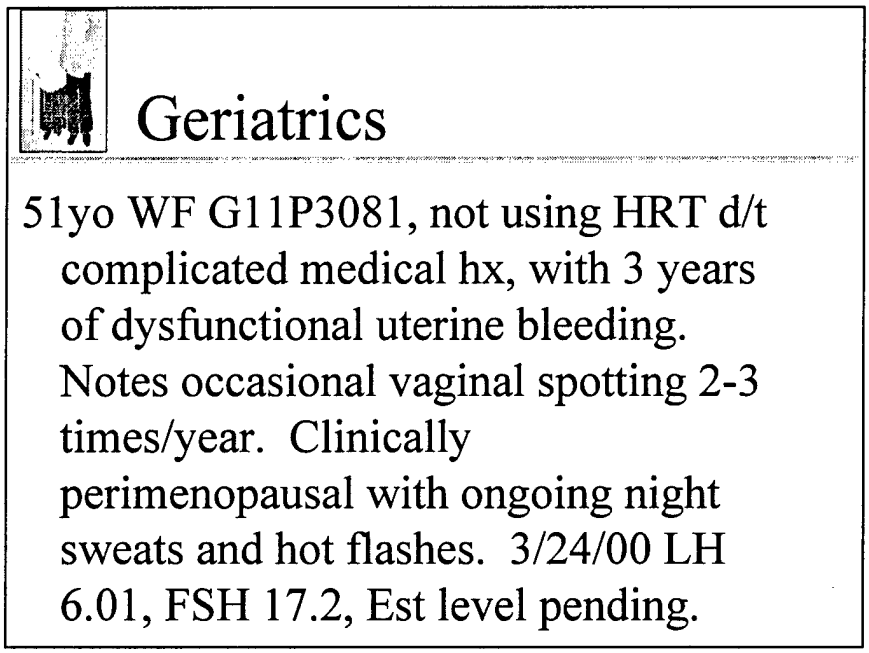


Figure 10. Suggested Specialty, Geriatrics

Cardiology

51yo WF G11P3081, not using HRT d/t complicated medical hx, with 3 years of dysfunctional uterine bleeding. Notes occasional vaginal spotting 2-3 times/year. Clinically perimenopausal with ongoing night sweats and hot flashes. 3/24/00 LH 6.01, FSH 17.2, Est level pending. S/P multiple evaluations of endometrium including D&C by civilian provider all benign. Most recent EMBX 4/99 disordered prolif EM, ECC benign.3/00 Pelvic US showed normal sized uterus with 8.8mm EM stripe, nl adnexa.

Figure 11. Suggested Specialty, Cardiology

Potential benefits of GGTS include:

- Enhanced efficiency
- Centralized transparent consult routing
- Sensitive to all potential users
- Adaptive to current and future policy decisions
- Criticality recognition and time management ability
- Provide users with list of prioritized options
- Learning capabilities

Once initiated, the system will evaluate consults on:

- Patient information (including diagnosis and criticality)
- Attending Primary Care Giver requirements
- Knowledge of physician based protocol operational policies

KEY RESEARCH ACCOMPLISHMENTS

Developed and employed a working web-based GGTS CBR System that integrates a server written in JAVA and a CBR written in LISP. This included:

- Developing a JAVA-based server that handles multiple clients and sites. It creates new consults and directs existing consults to the appropriate designated sites.
- Developing a LISP-based CBR that gives suggestions as to where to send the consults, into what specialty the consult should be grouped, and to which doctor to send the consult.
- Developing an interface that integrates the LISP CBR with the web-based JAVA main frame. This interface allows the client to utilize the LISP CBR.
- Developing, designing, and configuring the actual web site that is used for the GGTS/CBR clients. A server was set up and configured, and a collection of web pages was written in JSP, which allowed for the integration of HTML documents and the JAVA platform.
- Developing and designing multiple JAVA applications, such as the Bulletin Board, which is used at each site, and connects to the server in order to extract the consults that were sent into it. Other applications, such as the Doctor Reply window and Consult View Window, were also created.

- Researching various ways to integrate all individual parts of the Consult Broker.

REPORTABLE OUTCOMES

Gilbert, May, Vargas, Johnson, "Model for an Intelligent Global Grid Telemedicine System (GGTS) Consult Broker," AIM paper submission to Journal of Telemedicine.

Gilbert, May, Vargas, Rocca, Brienza, and Illi, "The Global Grid Telemedicine System Consult Broker," AIM paper submission to Journal of Telemedicine.

Gilbert, "Integration of Military and Civilian Global Information Grids," United States Army Medical Research and Materiel Command (USAMRMC), Telemedicine & Advanced Technology Research Center (TATRC), Ft. Detrick, MD; University of Pittsburgh Katz Graduate School of Business, Pittsburgh, PA, American Telemedicine Association, June 2001.

CONCLUSIONS

What we have learned:

- How to formulate a consult request
- Which knowledge structures are most appropriate for the key parts of the consultation process
- The shortcomings of a free-form user input interface (SEE figures 9-11).

For the future of this project, the challenge is to build a partnership with a group that has an existing teleconsultation system, or that wants to have one, so that we have automatically collected, clean and complete data on which the CBRs would be based. Also, the proposed system needs human expert knowledge in teleconsultation management, so that the system supports users without interfering with them.

REFERENCES

Zajtchuk JT, Zajtchuk R. Strategy for Medical Readiness: Transition to the Digital Age. *Telemed J* **1996**;2, 3:179-186.

Appendix 1:

List of all personnel receiving pay from the research effort

Jerrold May

Luis Vargas

Lisa Bednar

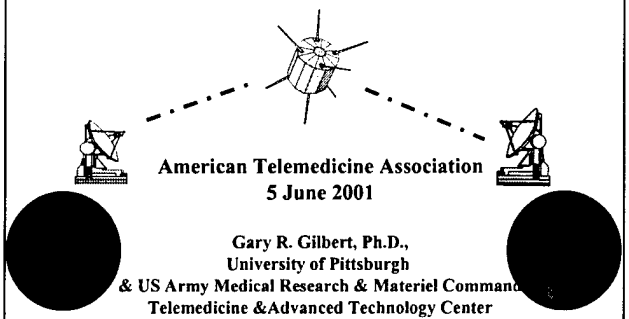
William Jacobs

Mitra Rocca (Year 1)

Appendix 2:

Gilbert, "Integration of Military and Civilian Global Information Grids," presented at the American Telemedicine Association annual meeting, June 2001

Integration of Military and Civilian Global Information Grids



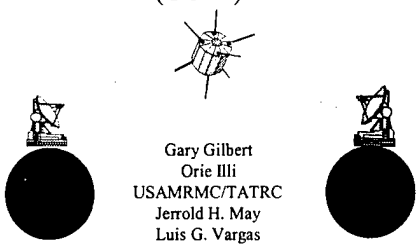
American Telemedicine Association
5 June 2001

Gary R. Gilbert, Ph.D.,
University of Pittsburgh
& US Army Medical Research & Materiel Command
Telemedicine &Advanced Technology Center

1.

Global Grid Telemedicine System

(GGTS)



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AIM Lab/KGSB
University of Pittsburgh
Nick Brienza
Booz-Allen Hamilton

2.

What Is GGTS?

The Global Grid Telemedicine System (GGTS) is a proposed Global Telemedicine Command and Control System (Zajtchuk and Zajtchuk, 1996) that will enable telemedical consultations to occur anywhere in the world, regardless of location or transportation medium.

3.

Why Is GGTS Needed?

Historically, the military medical community has had limited access to tactical and strategic communication systems. Increased use of telemedicine has previously resulted in the employment of expensive, stove-piped communications. As global telemedicine operations are incorporated into doctrine, the need for a reliable, scalable, rapidly adaptable virtual network is becoming apparent.

4.

BOSNIA EXPERIENCE

- "...providing a reliable back-bone communications infrastructure is not enough. ***More flexible and responsive network management and prioritization policies*** and procedures as well as end-to-end systems integration services and support are also essential."
  - Telemedicine Report: Case Study of Operation Joint Endeavor in Bosnia

5.

US Pacific Command Medical Bandwidth Study

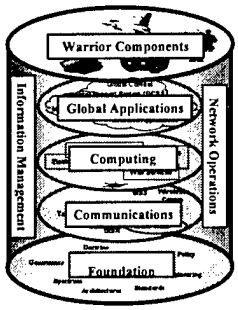
- **"DOD rapidly moving to Digital patient record, but....communications plans don't match medical data movement needs"**
- ***"not enough bandwidth identified for medical."***
- **"could be bundled with Logistics, Command & Control, Intelligence for a total picture"**
- **can support peacetime needs; wartime support questionable"**
- **"many medical systems outside firewall"**
- **"digital patient record could approach Giga-Bytes" (File Size)**
- **"ability to move data will be more difficult farther forward"**
- ***"Bandwidth needs will increase well beyond current plans"***

** USAPACOM Health care and Bandwidth Requirements Project Briefing by GTE/Birch & Davis CINC Surgeons' Conference, 3 Jun 98*

6.

The Global Information Grid: Vision

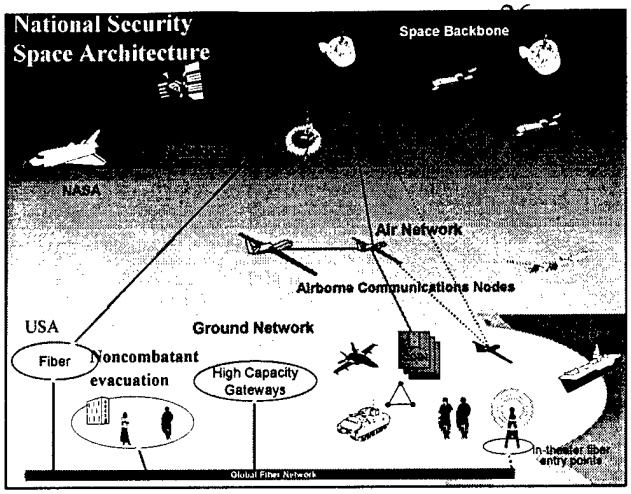
- A single secure Grid providing Information Superiority for the DoD and Intelligence Community
- Seamless end-to-end capabilities
- Joint, high capacity netted operations
- Fused with weapons systems
- "Plug and Play" interoperability
  - Guaranteed for US and Allied
  - Connectivity for Coalition users
- Information/Bandwidth on demand
- Defense in Depth against all threats



Protected, Assured, Interoperable Information

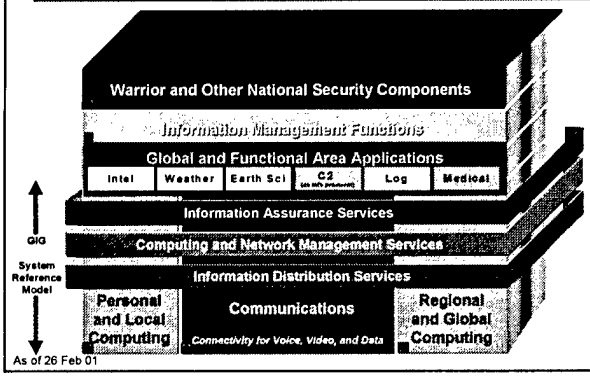
9

7.



8.

GIG Systems Reference Model



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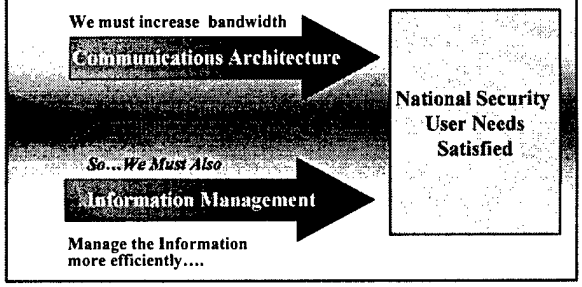
9.

National Security Space Architect

Mission Information Management (MIM) Two Pronged Approach



As of 26 Feb 01

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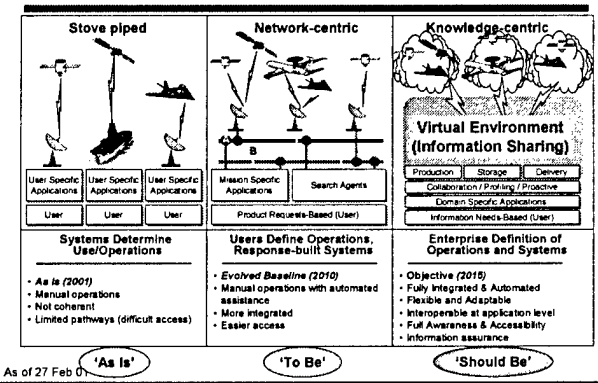
10.

Architecture Migration

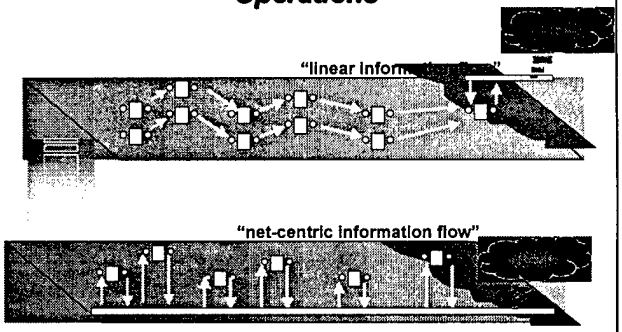


Systems Determine Use/Operations	Users Define Operations, Response-built Systems	Enterprise Definition of Operations and Systems
• *As is (2001)* • Manual operations • Not coherent • Limited pathways (difficult access)	• *Evolved Baseline (2010)* • Manual operations with automated assistance • More integrated • Easier access	• Objective *(2015)* • Fully Integrated & Automated • Flexible and Adaptable • Interoperable at application level • Full Awareness & Accessibility • Information assurance
'As Is'	'To Be'	'Should Be'

As of 27 Feb 01

11.

Netcentric Medical Operations



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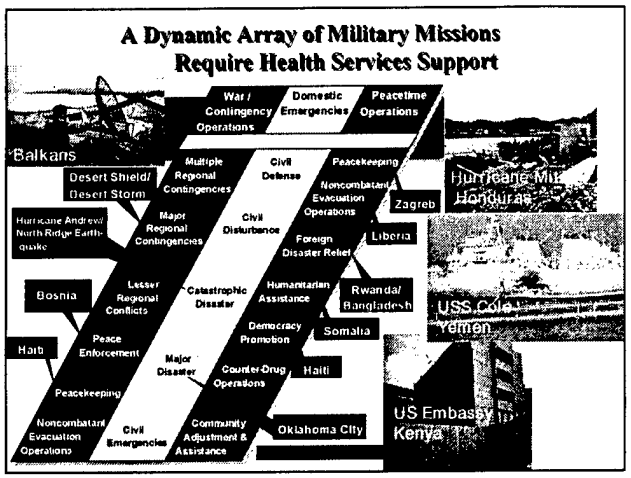

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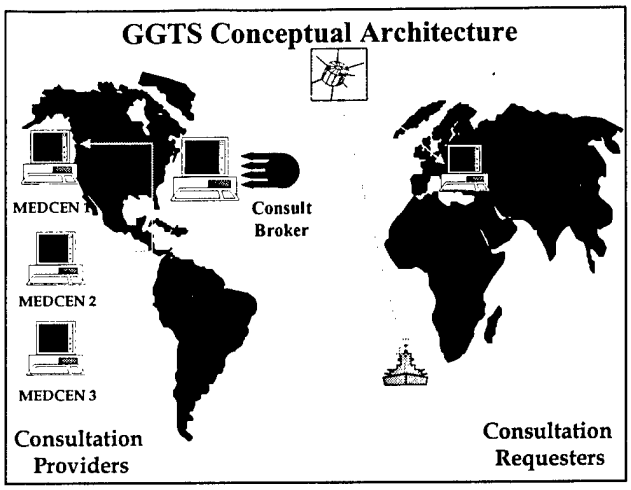

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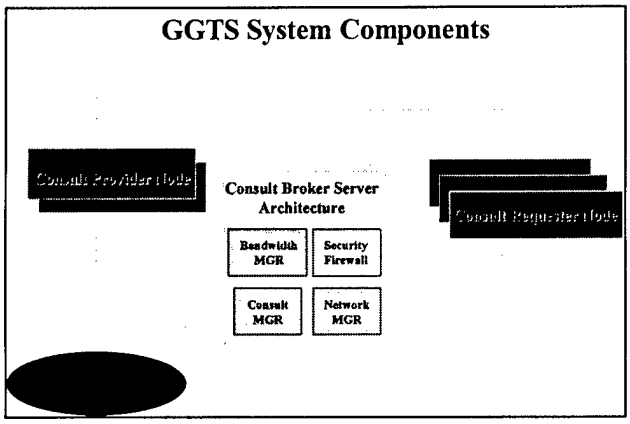

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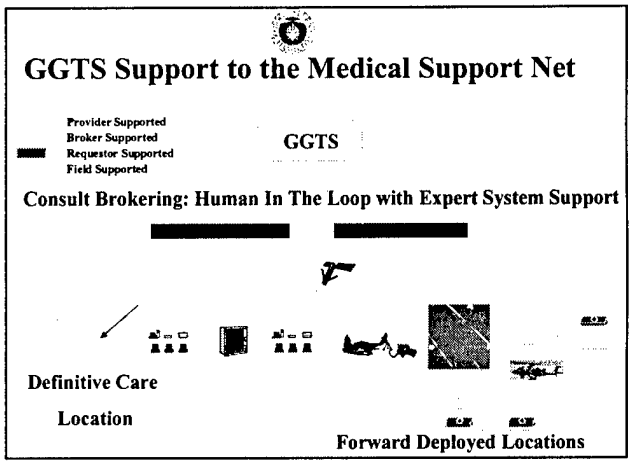

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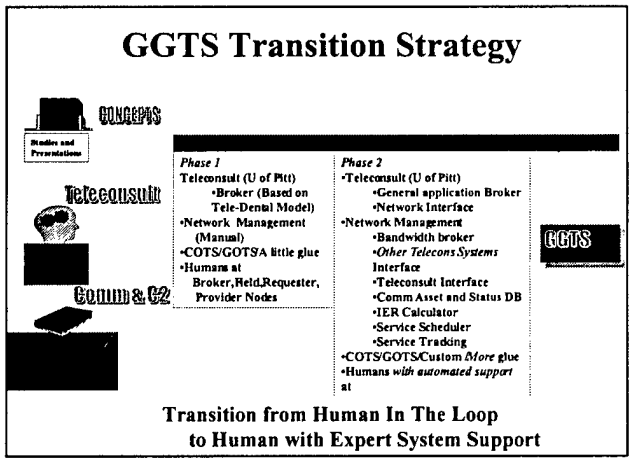

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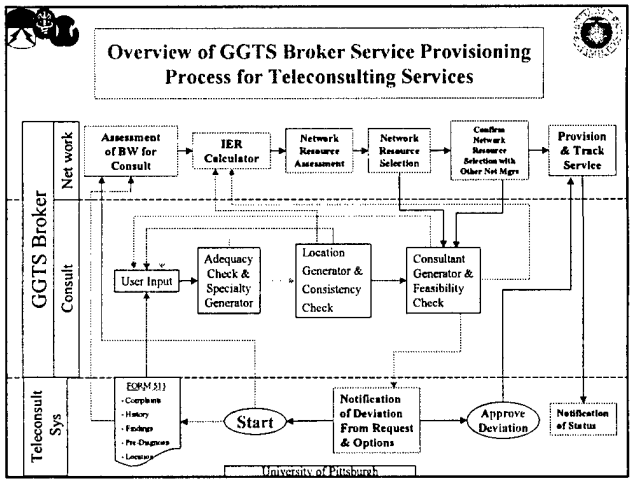

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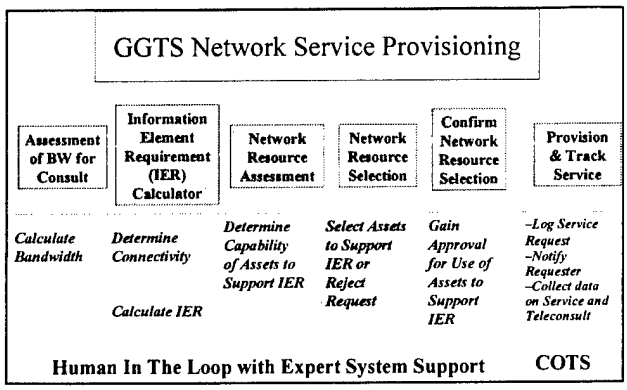
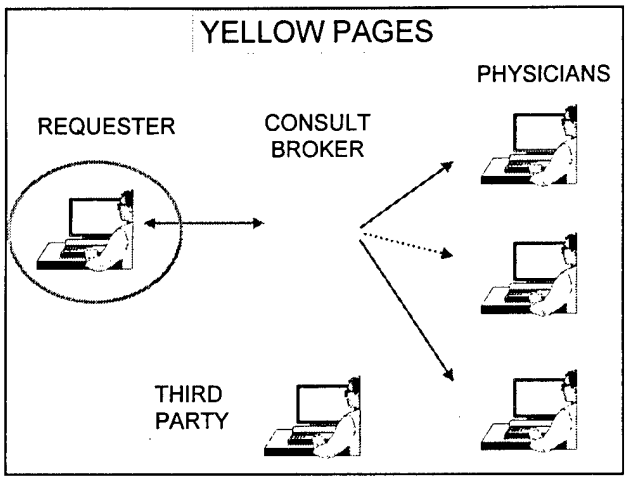


19.

GGTS Consultant Broker Alternative Configurations

- Automatic (AU)
- Active Broker (AB)
- Electronic Board (EB)
- Yellow Pages (YP)

20.



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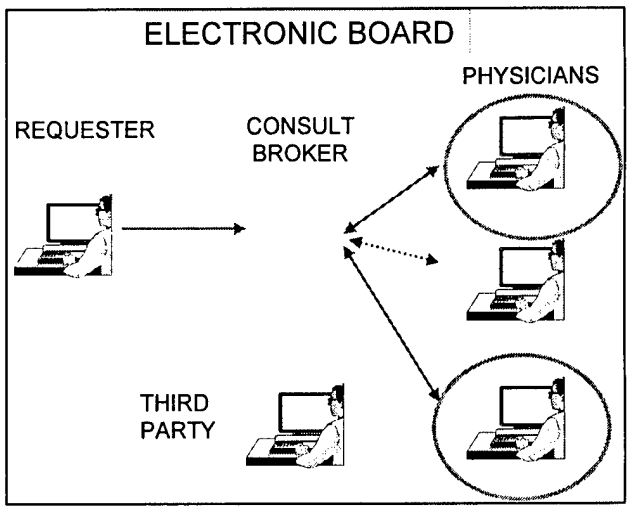

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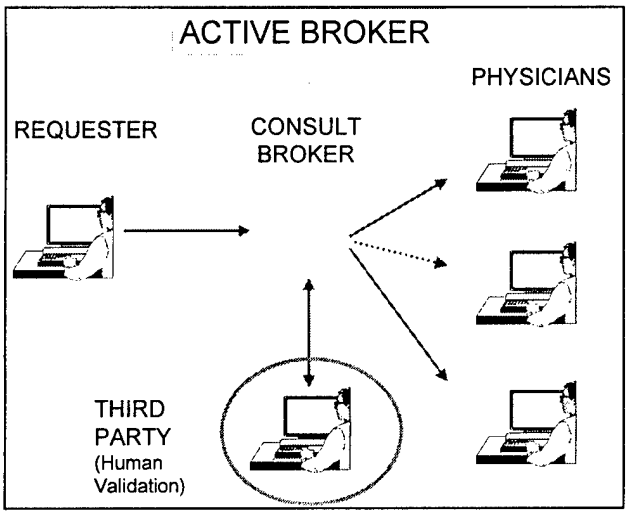

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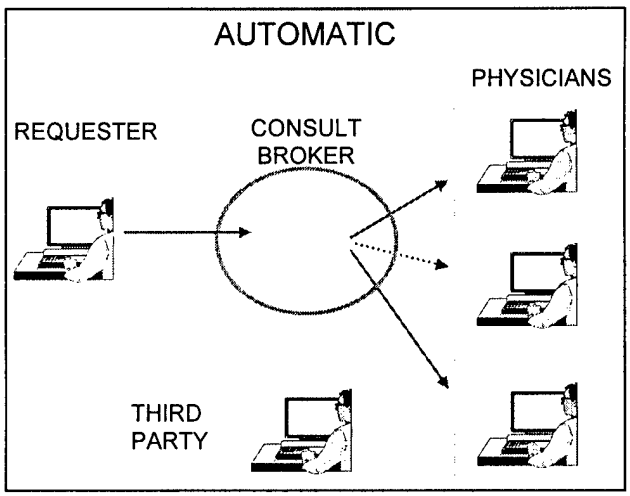


24.

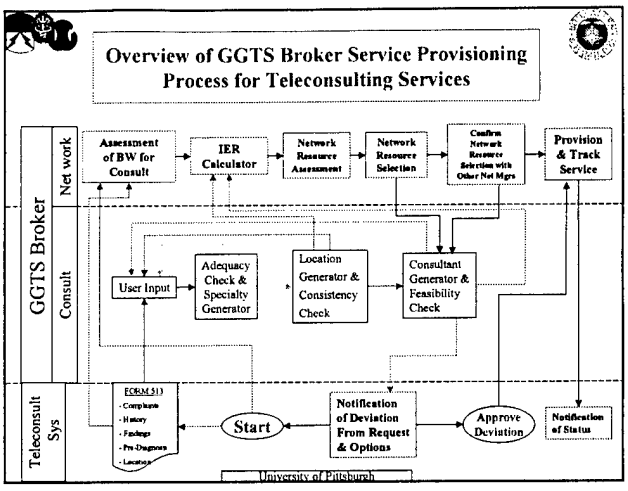
Reasoning Methodologies

- Case-based Reasoning

"A case-based reasoner solves new problems ***by adapting solutions that were used to solve old problems...Case-based reasoning means reasoning from prior examples.***" (Riesbeck and Schank, 1989, page 25).

- Rule Systems
- Classification theory
  - Statistical classifiers
  - Neural Nets
  - Machine Learning

25.



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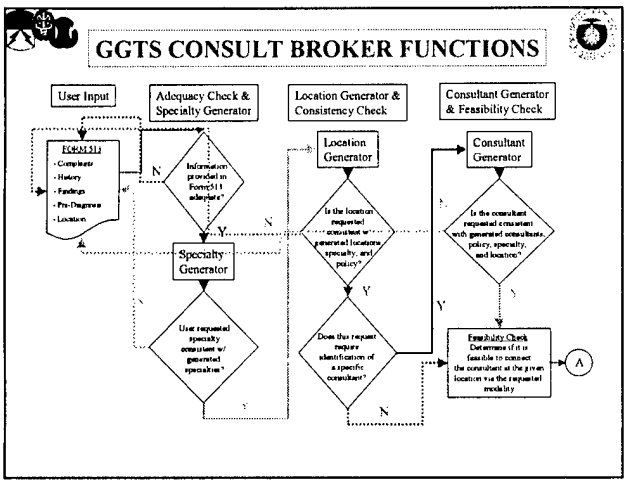

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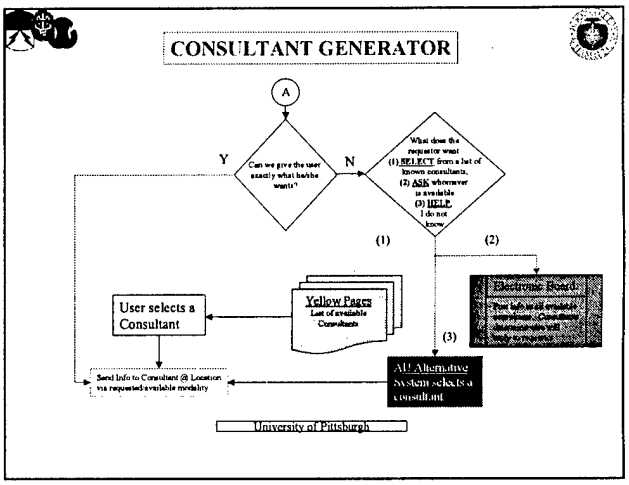

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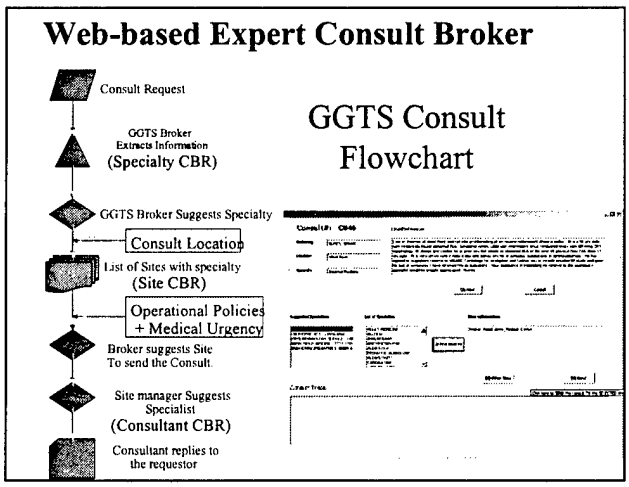

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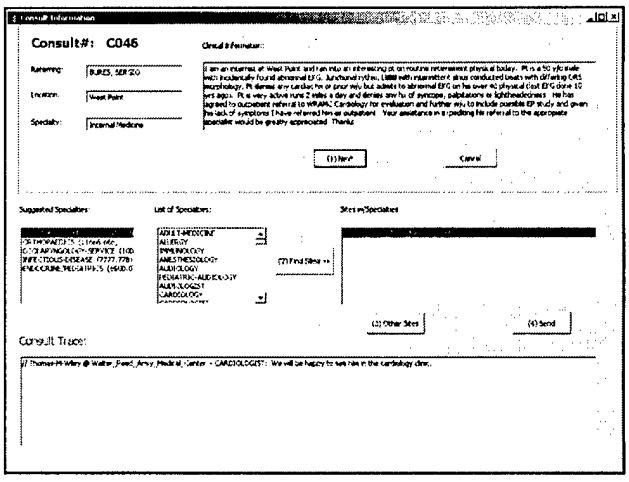

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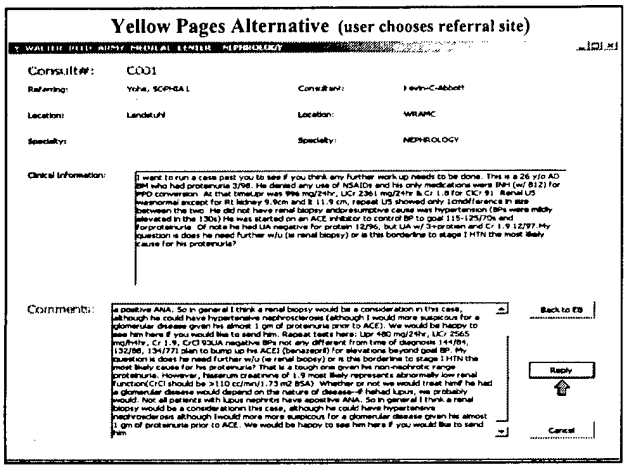

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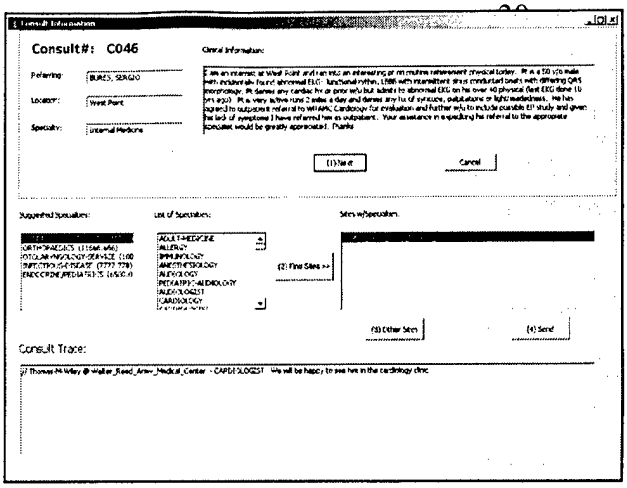


32.

Summary & Conclusions

- Global Information Grid provides infrastructure for network integration & bandwidth sharing among all functional users & between military and civilian applications.
- Consult routing requires integration of network management and medical consult brokering functions.
- Web-based intelligent Telemedicine consult broker provides flexible method for routing consults to appropriate referral centers.
- Universal Telemedicine Reference Architecture would enhance consult brokering among and between both military and civilian health care institutions and providers.

33.

Appendix 3:

Model for an Intelligent Global Grid Telemedicine System (GGTS) Consult Broker [Product Line Review]

Global Grid Telemedicine System (GGTS), The Expert Consult Broker

15 March 2001

1.

Project Information

Lab/Company/Group: Artificial Intelligence in Management Laboratory, University of Pittsburgh

Primary Investigator: Dr. Jerrold May

Government COR: Cathy Beck

Government Project Officer: Gary Gilbert

Date Initiated: October 1, 1999

2.

Project Funding - Execution

Description	Amount Awarded	Amount Expended	% Expended
Wages & Comp.	$ 192,833.00	$ 123,252.90	63.9%
Supplies & Office	$ 700.00	$ 305.00	43.6%
Fixed Assets	$ 3,500.00	$ 0.00	00.0%
Printing & Pub.	$ 250.00	$ 0.00	00.0%
Distributed Exp.	$ 92,078.00	$ 61,832.96	67.2%
TOTAL EXPENSE	$ 298,111.00	$ 188,894.79	63.4%

(Financial figures as of January 31, 2001)

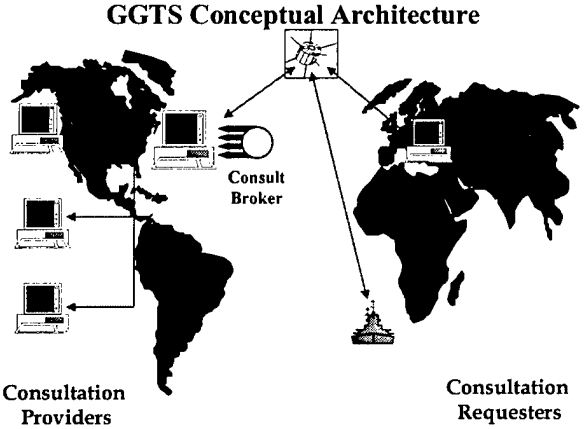
3.

Project Description

The Artificial Intelligence in Management (AIM) Laboratory of the Katz School of Business, will employ AIM Lab personnel and consultants to Design, Develop, and Prototype the Expert Consult Broker of GGTS. The AIM Lab will employ a combination of cognitive science, computer science, artificial intelligence, and management science methodologies to perform the task.

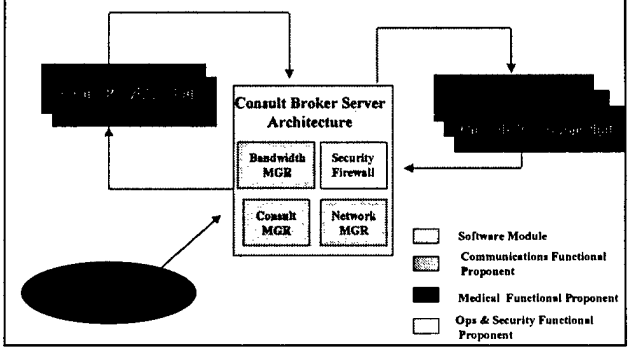
4.

GGTS Conceptual Architecture



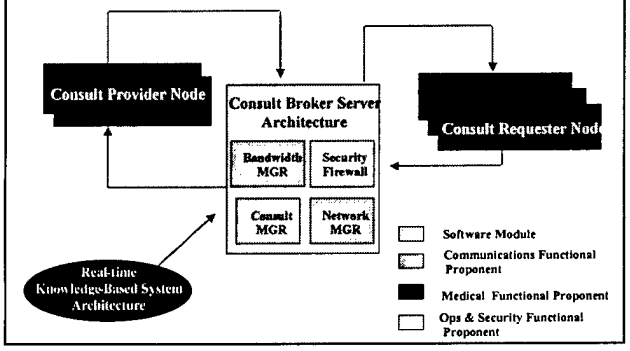
5.

Proposed GGTS System Components



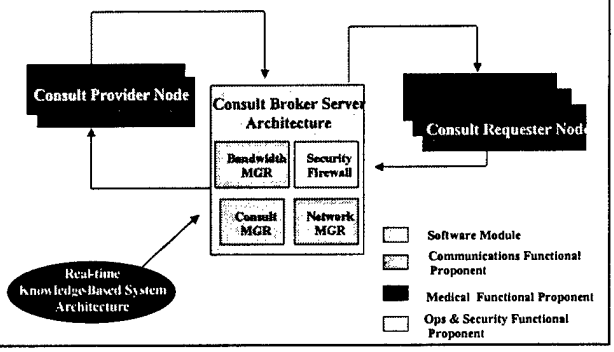
6.

Proposed GGTS System Components



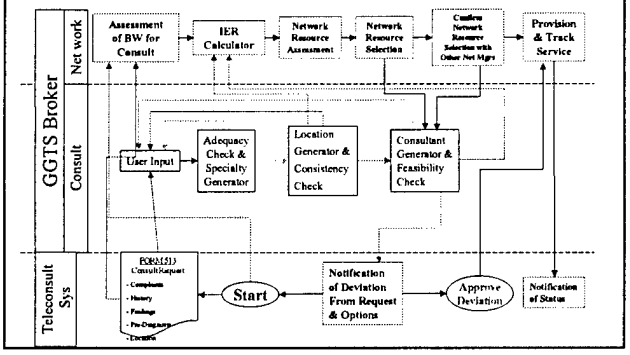
7.

Proposed GGTS System Components



8.

Overview of GGTS Broker Service Provisioning Process for Teleconsulting Services



9.

What Knowledge Does GGTS Need?

- A list of potential consultants
- A list of sites providing consultation
- A link to a network manager with feasible modes of consultation
- An interface to collect relevant information from the requestor
- A ***time keeping capability*** and
- A time-based event trigger

10.

What Information is Needed for a GGTS Tele-medical Consultation?

- **Modality** (e.g., audio, real-time full motion, store-and-forward)
- **Patient demographic data** (e.g., name, date, location, age)
- **Consultation specific data** (e.g., requesting physician's specialty, ***consultation urgency***, subspecialties requested, type of equipment used or available, history of present illness, and ***current differential diagnosis***).

Walters (1996)

11.

Methodologies

- **Case-Based Reasoning**

"A case-based reasoner solves new problems ***by adapting solutions that were used to solve old problems...Case-based reasoning means reasoning from prior examples.***" (Riesbeck and Schank, 1989, page 25).

- **Rule Systems**
- **Classification Theory**
  - Statistical classifiers
  - Neural Nets
  - Machine Learning

12.

GGTS Alternative Configurations

Yellow Pages	Requester
Electronic Board	Consultants
Automatic	Computer
Active Broker	Third Party

13.

Second Part of Effort

We worked on a teledental (TDent) prototype using real data to see what actually works

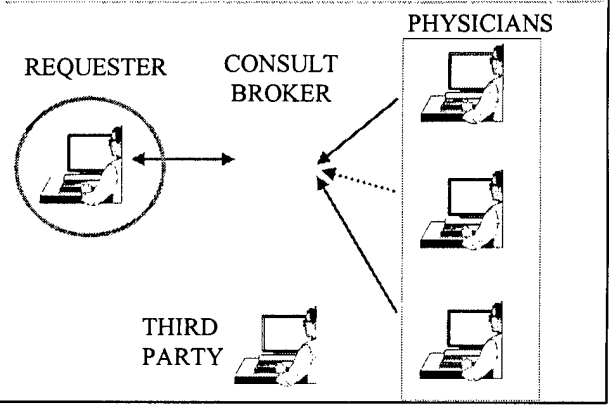
14.

TDent Data

- Primarily in use in Europe
- ~500 consults
- Location and specialty information on all consultants
- Dental procedure (CDT) codes for almost all consults
- Partly structured user input interface

15.

TDent Yellow Pages (TDent-YP)



16.

Types of Teleconsultations

- **Type 1**: Requester will <u>almost certainly refer</u> patient; purpose is administrative; precise medical problem not critical
- **Type 2**: Requester will <u>almost certainly retain</u> patient; purpose is medical; specified problem very likely to be accurate
- **Type 3**: Requester will <u>retain patient if routine</u>; specified problem may be only approximate

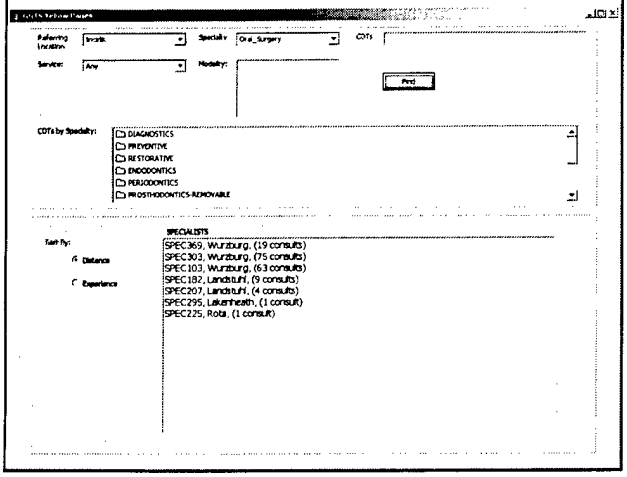
17.

TDent-YP, Six Scenarios

- Type 1, peacetime
- Type 1, wartime – different specialist locations
- Type 1, wartime – special organizational rules
- Type 2, exact match in case base
- Type 2, no exact match in case base
- Type 3, uncertainty about the problem

18.

TDent-YP



19.

Goals Set at the End of the First Year of Effort

- Extend the breadth of the prototype - how representative is TDENT of the general medical teleconsultation problem?
- Refine the types of teleconsultations to best match the KB&MS tools and the interfaces to the management problem, user requirements, and organizational rules

20.

Third (Current) Part of the Effort

Work to achieve those goals

21.

Use of Ask-A-Doc Data

- System in use at WRAMC and LRMC
- Free form e-mail text input
- Free form e-mail response by possibly multiple self-selected consultants
- Partial information on the locations and specialties of the participants in one month's worth of data (~100 consults)

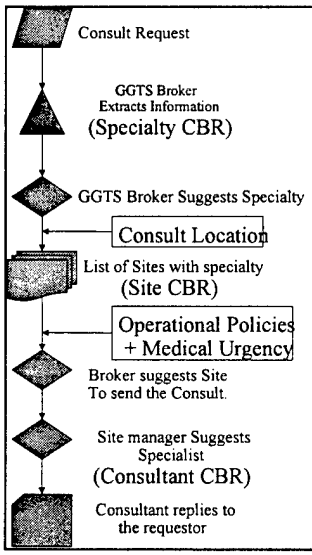
22.

Three CBRs

- Site Locator
- Specialty Locator
- Consultant Locator

23.

GGTS Consult Flowchart



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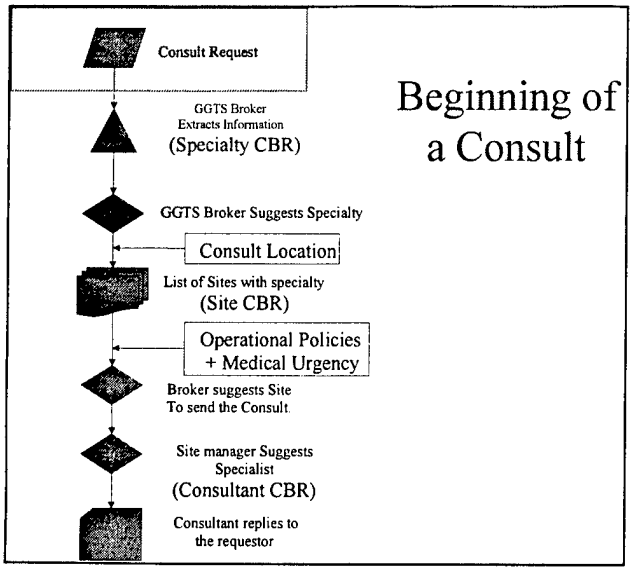

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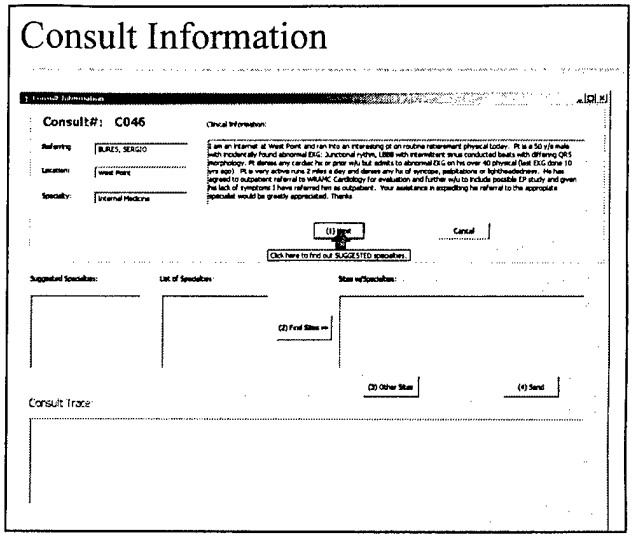

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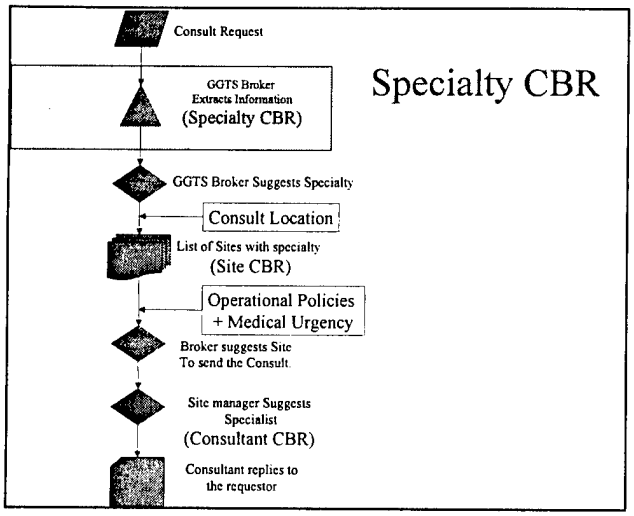

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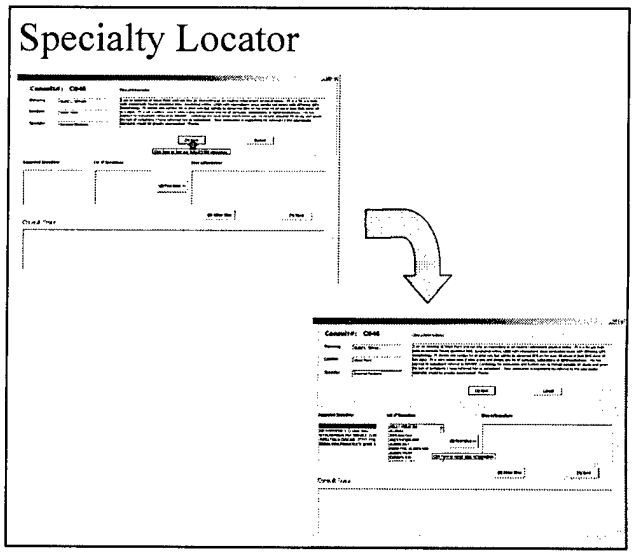

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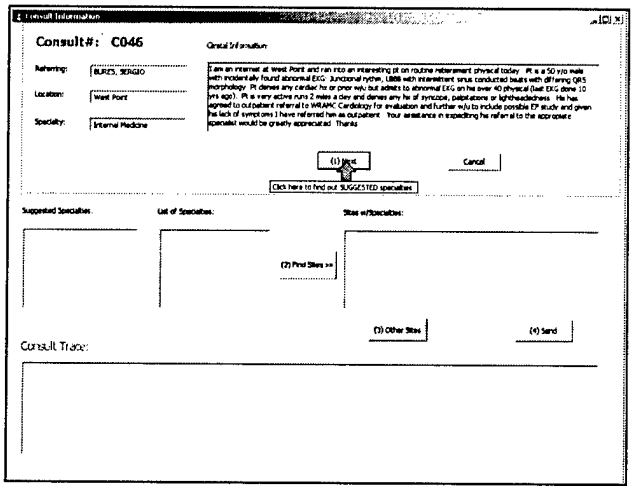

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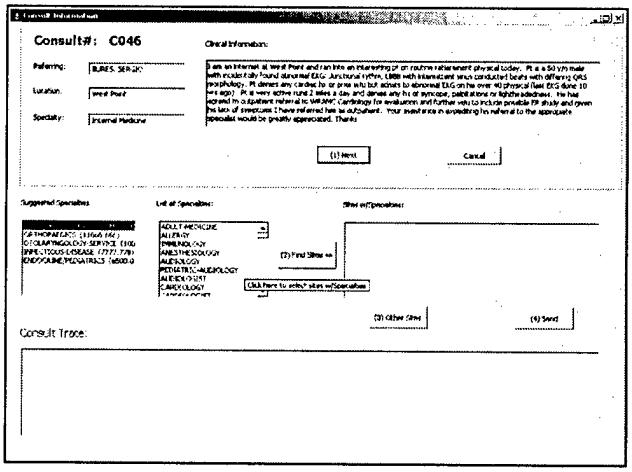
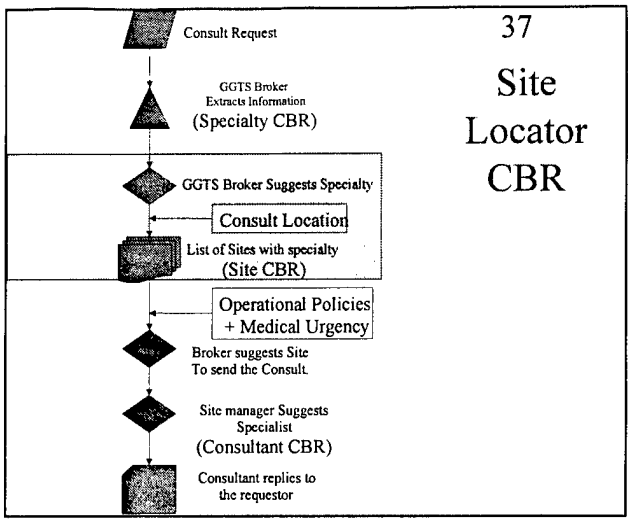


30.

Case-Based Reasoners Research Issues – Specialty CBR

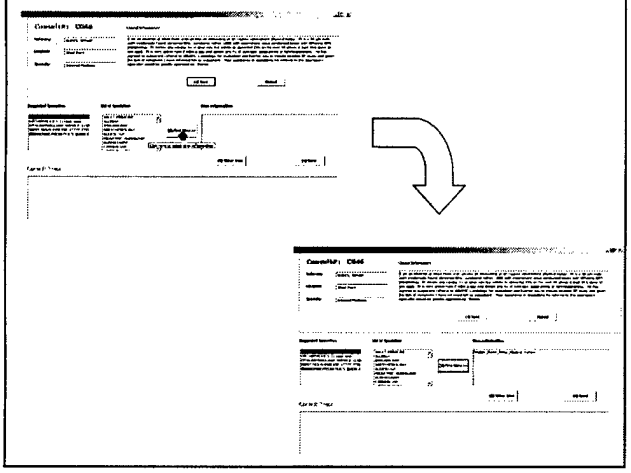
- Current version looks at the UMLS words in the text as individual terms. Would having it try to "understand" the text improve its functioning?

31.



32.

Site Locator



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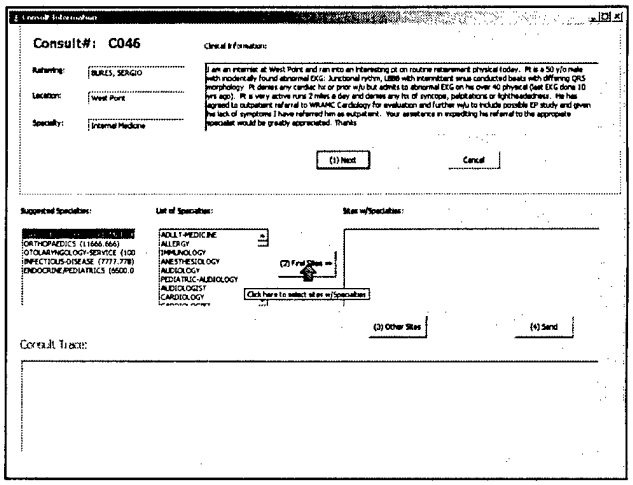

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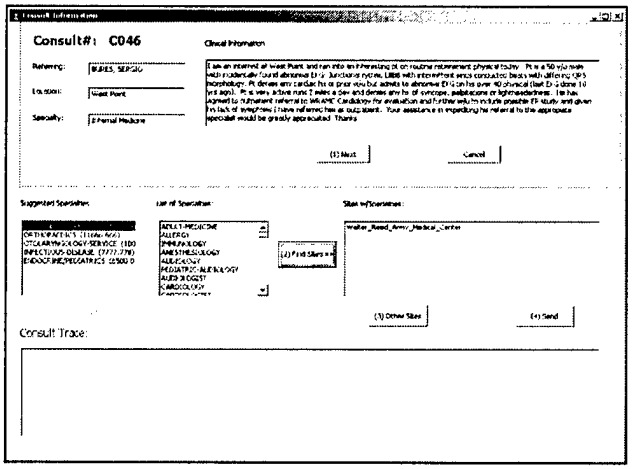
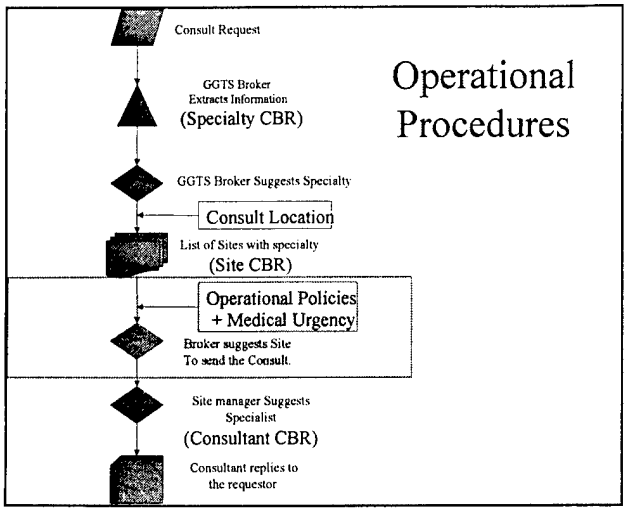


35.

Case-Based Reasoners Research Issues – Site Locator CBR

- This CBR needs to combine rules and cases. We need to know the rules, have explanations for when the rules should be overruled, and then discover how the two types of knowledge should interact.

36.



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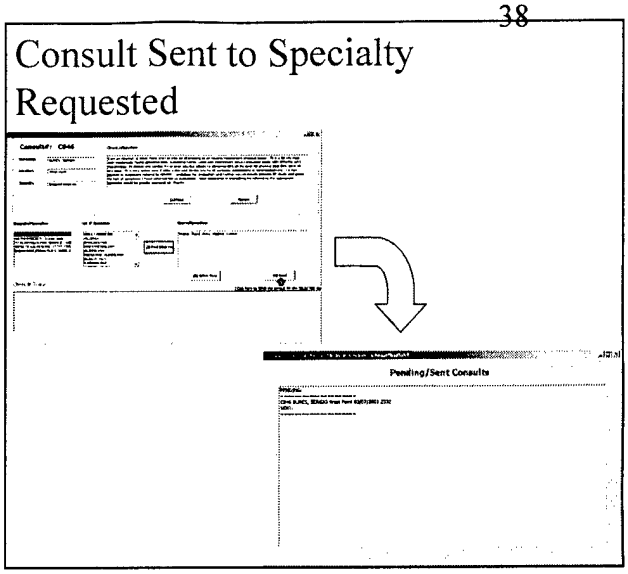

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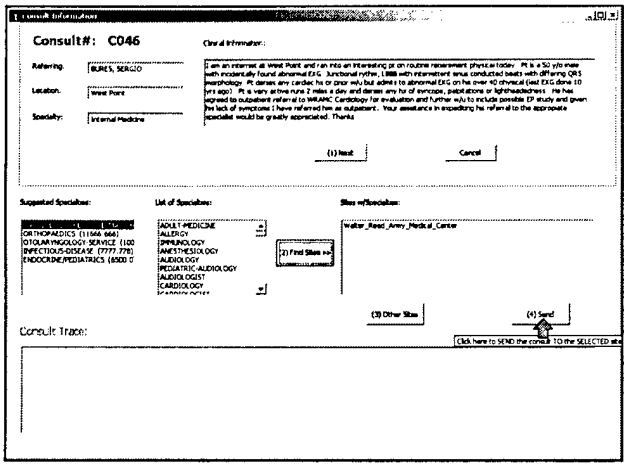

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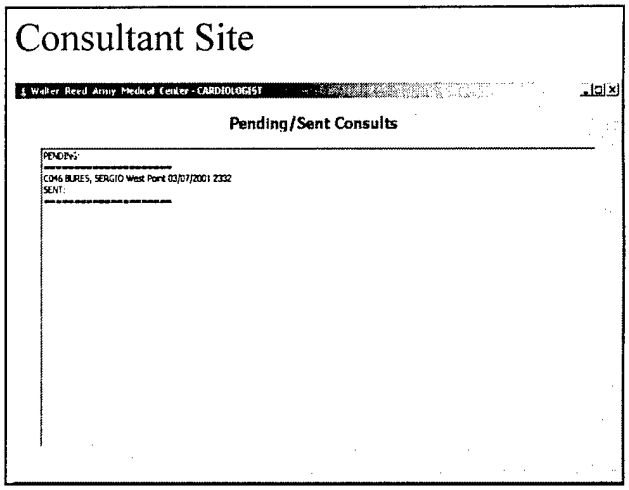

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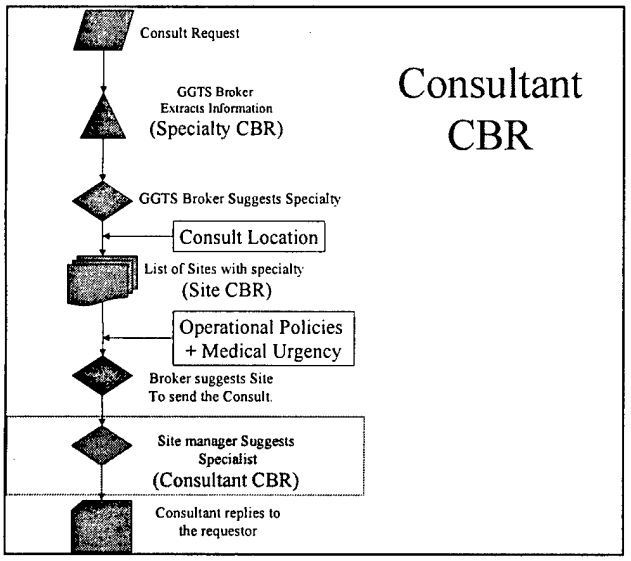

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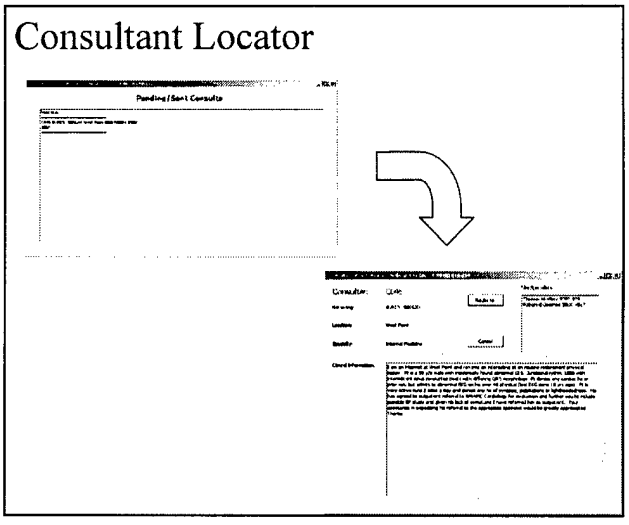

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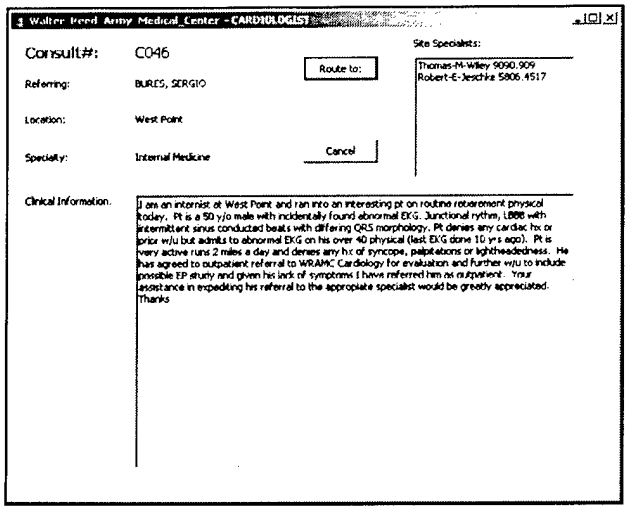
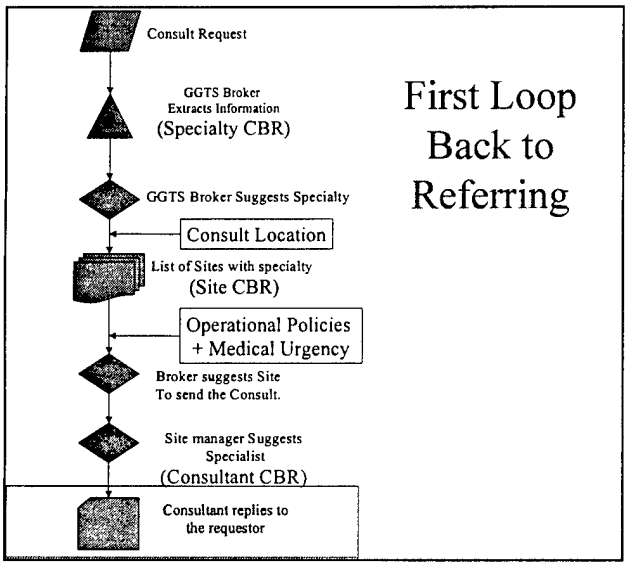


43.

Case-Based Reasoners Research Issues – Consultant CBR

- Issue 1: Obtain declarative knowledge of the specialists' experience and expertise, and combine it with case-based data.
- Issue 2: Automatic knowledge acquisition of physicians' experiences, and classification of those experiences

44.



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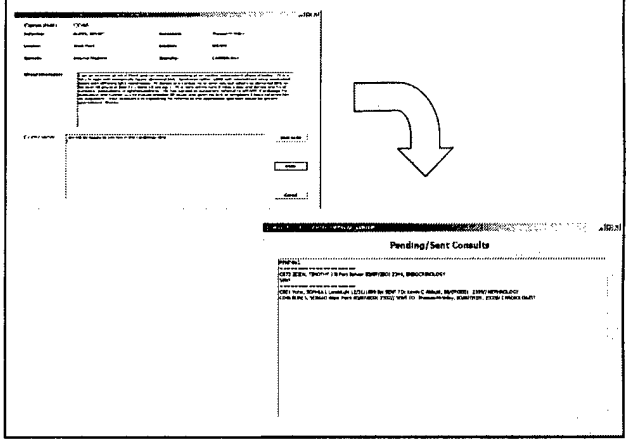
Time Stamped Delivery Confirmation



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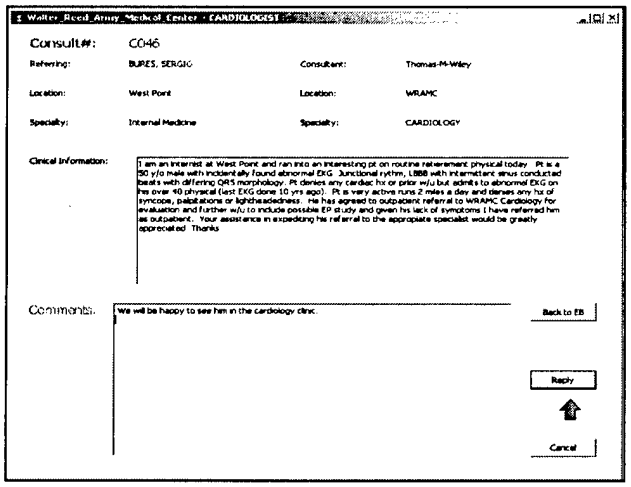

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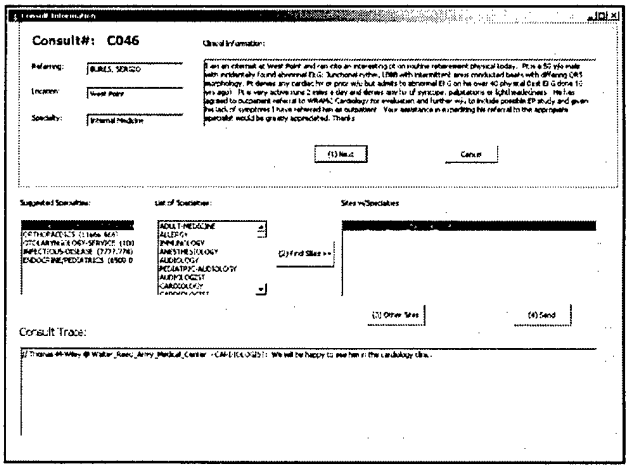

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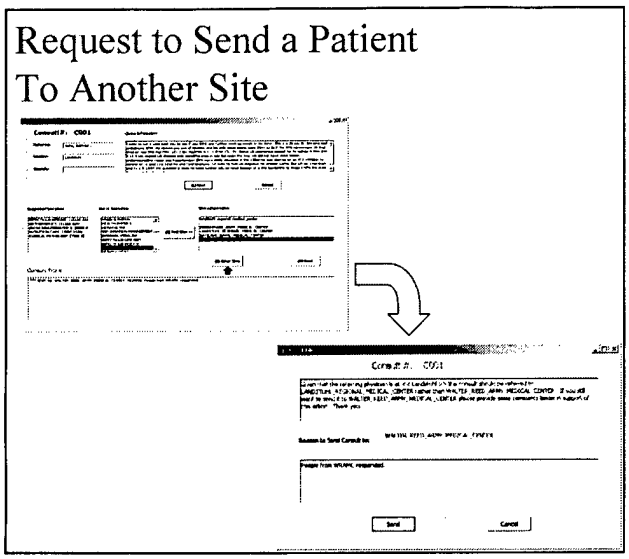
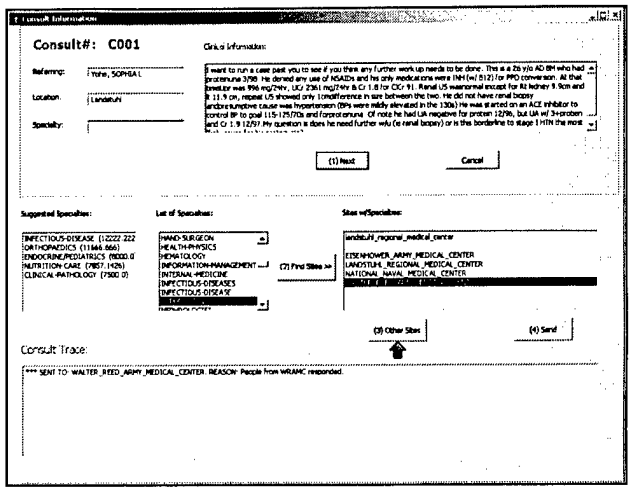


49.



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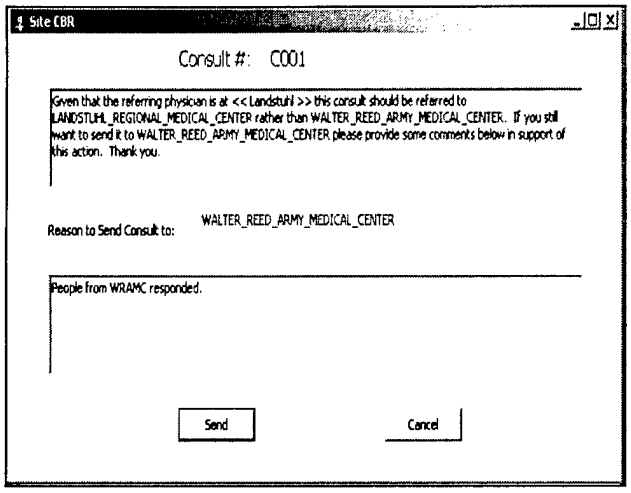

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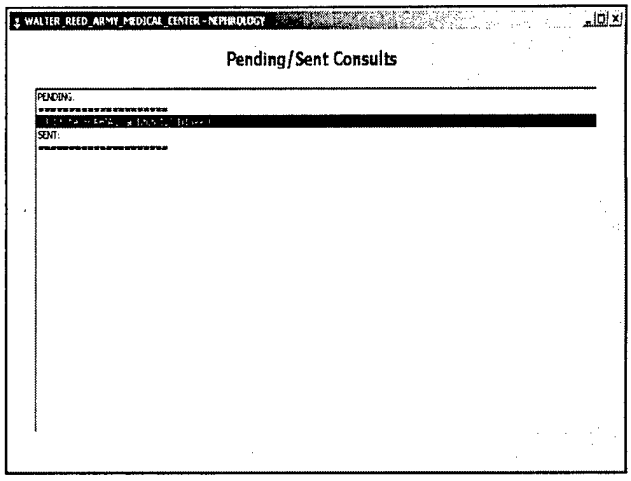

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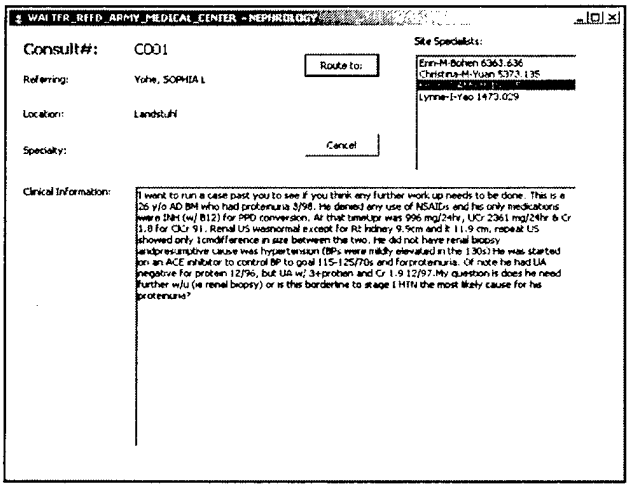

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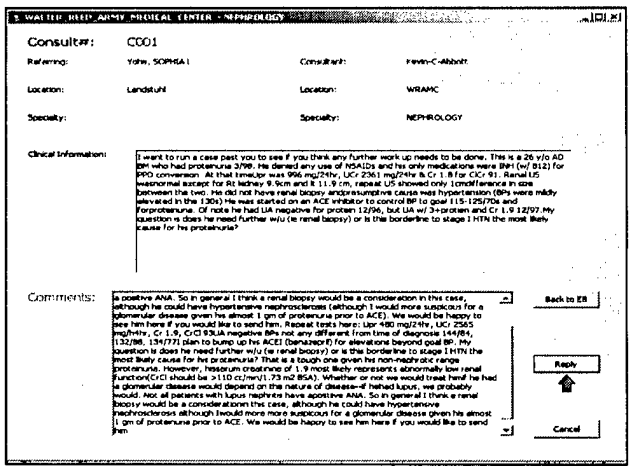

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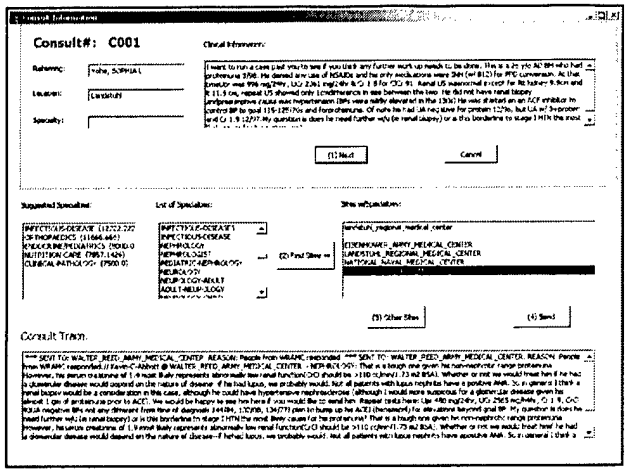


55.

Deliverables

- Conceptual model of a telemedicine consult management system operating within a dynamic military environment
  - 100% complete
- Expert system model specification
  - 75% complete – administrative and logistic information incomplete
- Prototype test plan
  - 0% complete – delivery environment and scenarios not defined

56.

Deliverables (cont.)

- Computer-based expert system prototype that implements the model
  - 50% complete – network support environment not funded or developed; insufficient data to develop and test case and knowledge bases
- System Maintenance Manual, User Documentation, and Training Manuals
  - cancelled by mutual agreement
- Test Report from both verification and validation tests
  - Delayed until the system prototype is completed enough to define a testing plan

57.

Project Schedule

- Annual Report completed for Year 1 of Research
- Medical classifier, based on a medical dictionary, in process of development
- Ask-A-Doc data analyzed for use in classifier
- A paper for the Telemedicine Journal and two abstracts for ATA 2001 prepared

58.

Potential Benefits

The GGTS system will:

- work with humans to enhance their efficiency
- provide centralized transparent consult routing with knowledge-based system technology
- be sensitive to requirements of all potential customers
- be responsive to and incorporate current and future policy decisions
- be able to recognize the criticality of the request and have time management capability
- provide a medical decision maker with a list of prioritized options
- augment its knowledge base with the results of completed consult case information

59.

Potential Benefits (cont.)

Once initiated, the system will evaluate consults on:

- Patient information (including diagnosis and criticality)
- Attending Primary Care Giver requirements
- Knowledge of physician based protocols
- Operational policies

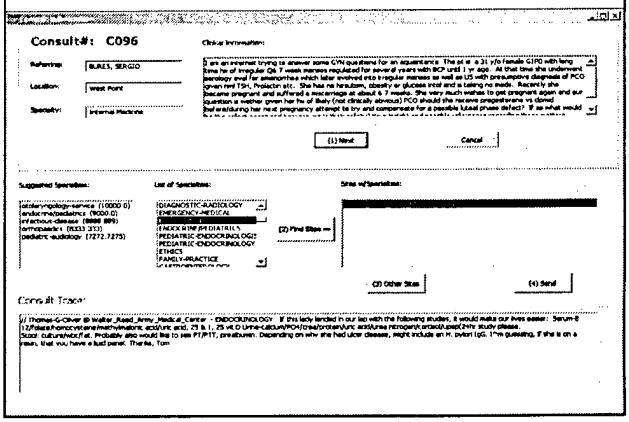
60.

What We Have Learned

- How to formulate a consult request
- Which knowledge structures are most appropriate for the key parts of the consultation process
- The shortcomings of a free-form user input interface

61.

An Example of an Ask-a-doc consult that requires more information to be answered



62.

FDA / RCQ / Intellectual Property Status

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63.

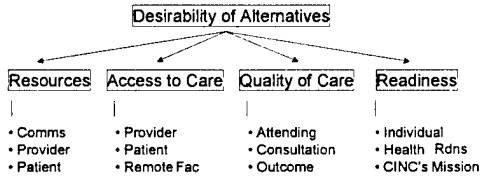
Challenges

- To build a partnership with a group that has an existing teleconsultation system, or that wants to have one, so that we have automatically collected, clean and complete data on which the CBRs would be based
- To collect human expert knowledge in teleconsultation management, so that the system's behavior will support users without interfering with them

64.

Military Relevance

Evaluation of Alternative Configurations



65.

Appendix 4

THE GLOBAL GRID TELEMEDICINE SYSTEM CONSULT BROKER*

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ABSTRACT

The Global Grid Telemedicine System (GGTS) is a proposed global telemedicine command and control system (Zajtchuk and Zajtchuk, 1996) that will enable telemedical consultations to occur anywhere in the world, regardless of location or transportation medium. Gilbert (1998, 2000) defined a model for a GGTS composed of three functional nodes: Requestor, Provider, and Consultation Broker. This paper concentrates on the Consultation Broker (CB), which is designed using Artificial Intelligence methodologies. We identify four distinct approaches to the way in which the CB might work with its users to determine the most desirable match of consultant to requestor, called automatic, active broker, yellow pages and electronic board. To illustrate how the GGTS may function when it is eventually fielded, we developed a functional prototype using data from a teledentistry system (TDENT) currently used by the US Army, Navy and Air Force. Although this system is purely, a web-based, store and forward teleconsultation system, the data generated from it contains useful information to model and explore some of the behavior and features of GGTS. Based on work to date,

we outline common requirements that the four configurations must satisfy.

1. INTRODUCTION

The Global Grid Telemedicine System (GGTS) is a proposed global telemedicine command and control system (Zajtchuk and Zajtchuk, 1996) that will enable telemedical consultations to occur anywhere in the world, regardless of location or transportation medium. The ultimate objective is to determine how best to leverage extensive Department of Defense communications infrastructure to provide global telemedicine support to US and allied forces worldwide.

Gilbert (1998, 2000) defined a model for a GGTS composed of three functional nodes: Requestor, Provider, and Consultation Broker. This paper concentrates on the Consultation Broker (CB), which is designed using Artificial Intelligence methodologies. The CB is an object-oriented global teleconsultation system designed to route incoming requests for consultation to the appropriate "on duty" medical personnel. The CB must have sufficient ingrained "intelligence" to enable, in real time, the appropriate selection of a consultant from (possibly) a minimum of requestor provided information, and to determine protocol conversions needed, priority of need, and optimal network routing to facilitate connectivity.

Previous research within the Army indicates that telemedical practice requires "standards of utilization"

(Walters, 1996). Significant controversy exists over the value various telemedical modalities offer to the consultation process, the minimum information needed for consultations, and how the information should be presented to the consultant. There are also debates over which medical sub-specialties require what information media or telemedical modalities: store-and-forward versus real-time video consultations, high resolution still images versus full motion video clips, radiology and pathology images versus radiology and pathology reports, and telephone consultations versus e-mail. Calcagni et al. (1996) and Clyburn et al. (1998) provide some experiences with the use of telemedicine. However, insufficient empirical data or hard analysis yet exists to make definitive recommendations by sub-specialty. Therefore, an important function of the CB system should be to collect and analyze information on the telemedicine consultation process.

Walters (1996) identified a number of objective and subjective questions that should be asked about each telemedicine consultation in order to determine how best to execute it. In addition to the consideration of which telemedical modalities are appropriate for each case, Walters' list of questions includes basic patient demographic data (e.g., name, date, location, age, and

nationality), and consultation specific data (e.g., the requesting physician's specialty, what he/she is asking the consultant, consultation urgency, specialties or sub-specialties requested, type of equipment used or available, history of present illness, and current differential diagnosis). Walters also extracted and retained information from the consultant's reply, such as the adjusted diagnosis and treatment recommendations. In her research, Walters employed a physician reviewer, who addressed questions such as:

- How sick was the patient?
- Did the consultation change the diagnosis, treatment, or duty status of the patient or affect the outcome?
- What type of communication modality was needed by the consultant to reply to the consultation?

Walters found that two basic types of consultation referral were developed. The first type involved physicians consulting on conditions outside their own specialty. The second type involved specialty physicians consulting with subspecialists or with specialists who had greater expertise in the requestor's own specialties.

Navein et al. (1996) reported on the Army telemedicine experience in the republics of the former Yugoslavia. They

observed that the quality of service (response time, quality of consultation, expertise of consultants, etc.) was the most significant factor in the choice of consultant when consultation routing was left to the prerogatives of requesting physicians alone. Even though the Army considered that best practice would dictate that consultations be directed to the referral center hospital to which it wanted patients to be evacuated, deployed physicians generally directed consults to the medical center providing the best telemedicine service.

An emerging information architecture doctrine for the Department of Defense, called Global Information Grid (GIG), is based on a military concept called "Network Centric Warfare" (NCW). NCW is defined as an information superiority-enabled concept of operations that generates increased combat power by networking sensors, decision makers, and combatants to achieve shared awareness. Information superiority is the capability to collect, process, and disseminate an uninterrupted flow of information while exploiting or denying an adversary's ability to do the same. The objective of NCW is to translate information superiority into combat power by effectively linking knowledgeable entities in the battle space. The GIG was born from concerns regarding

interoperability and end-to-end integration of automated information systems within the Department of Defense. As a unified "system-of-systems," the GIG is the key enabler of information superiority. The GIG is the globally interconnected, end-to-end set of information capabilities, associated processes and personnel for collecting, processing, storing, disseminating and managing information on demand to war fighters, policy makers, and support personnel (Department of Defense 2000).

The NCW concept is also the basis of the emerging "net-centric" architecture for military medical operations (Mease et al. 2000). Net-centric operations, military operations are built around *command, control, communications, computers, and intelligence* (C^4I) *systems* with the specific goal of supplementing or replacing directed linear point-to-point information flows with network centered information flows similar to a message board. A distributed network centered information architecture serves as both a collection center for information from those generating it, as well as a source of information for those needing it, without a pre-planned or required communications link between information generators and information users. Communications systems are traditionally described in terms of send and receive

architectures. While any information flow from the *communications technical architecture* perspective involves a "send and receive" concept, net-centric information flows from the *operational architecture* perspective involve information contributions (new inputs and updates) and information queries (requests with accompanying outputs). Within net-centric operations, many of the information deposits will be of the "transmit and forget" nature (those inputting the information are not concerned with who will use it), while many of the information queries will be "blind" (those requesting and using the information will not be aware of its source). In order for the GGTS medical information and communication support network discussed above to be efficiently and *securely* implemented within the Military Global Information Grid, and also to be flexible enough to accommodate spontaneous, random, 24-hour consultation requests, and all four Consultation Broker implementation alternatives discussed in Section 4 below, a net-centric architecture approach that supports "transmit and forget" input and "blind query" output, is essential.

2. THE NETWORK ENVIRONMENT

Booze-Allen Hamilton (1999) observed that the GGTS, at its highest level, is a system that manages a medical

information exchange network in the support of key military health service support processes. The GGTS accomplishes this through the use of four distinct elements operating through a managed interface to the network. In addition, an underlying communications network is employed to facilitate the interaction between each of the elements. Figure 1 shows the relationship among the five health-service support "pillars," the medical support net, and the GGTS network elements.

The GGTS is composed of four distinct functional nodes: Field, Requestor, Broker and Provider. Each one of the nodes provides a specific interface to the communications network that supports medical operations across the operational continuum. In addition to providing interfaces, each node also contains a specific set of functionalties that helps enable the GGTS to manage the communications network.

[Insert Figure 1.]

The Field Node is most commonly associated with the end-user of GGTS. The end-user can be anyone from a first responder and forward-deployed medics to medical command and control and medical space awareness personnel. It is the Field Node that provides the initial gateway through

which medical information and services may be requested. This node accomplishes three tasks:

- gathers medically relevant information from the patients and facilities,
- makes available relevant information about patients and facilities, and
- initiates telemedicine consultation sessions by establishing a connection with the GGTS Requestor Node.

The Requestor Node's primary duty is to act as the central gathering point for Field Node requests and to maintain communications links with the Broker and each Field Node for which it is responsible. Thus the Requestor Node acts as a mediator between the Broker and each Field Node for which it is responsible. It serves as the central point of contact for all Field Nodes. It serves as the central point of contact for all Field Nodes in the assigned area of responsibility by

- processing user requests to start applications,
- retrieving information and beginning teleconsultations,

- maintaining communication with the Broker Node and Field Node/Units,
- reallocating bandwidth among numerous Field Nodes,
- maintaining the status of the communications equipment,
- formatting and transmitting request messages to the consult manager in the broker node, and
- if possible, assigning a medical specialty and establishing the required and requested bandwidth the duration of the consultation.

The Broker Node is the "brains" of the GGTS. As shown in Figure 2, the Broker Node is sub-divided into four separate managers. Each one is responsible for a different separate managers. Each one is responsible for a different management aspect of the GGTS.

Insert Figure 2.]

At a high level, the Broker Node:

- receives consultation requests from Requestor Nodes,
- matches requests with appropriate Provider nodes,
- uses medical artificial intelligence (AI) to satisfy Field Node requests,
- manages the network,

- determines physical communications links and topology,
- establishes and maintains a permanent path between Broker and Requestor nodes,
- dynamically reallocates bandwidth as required,
- maintains numerous ongoing sessions, and
- establishes a connection.

The Network Manager Module is responsible for monitoring the communications networks allocated to the GGTS. It provides continuous topology information to the Network/Bandwidth/Content Manager Module, and to the Decision Aids Module.

The Network/Bandwidth/Content Manager Module manages the bandwidth assigned to the GGTS and the content of the information flowing across its allocated networks. Its duties are:

- to generate and execute bandwidth reallocation commands based on input from the Network Manager and Consult Manager Modules,
- to monitor and display the status of the Consultation Provider Nodes, the system performance (e.g. error rate, quality of service) of on-going consultations and the available bandwidth in the entire system, and

- to monitor and manage prioritized content sent across the network.

The Decisions Aids Modules provide the Broker with a set of tools designed to help facilitate its decision making process. The tools can be anything from additional rule sets to automated software applications that keep track of specific data and information. Among its functionalities are:

- to support the interpretation of relationships between system dynamics and user priorities,
- to help determine optimal utilization of available resources such as communication and medical assets, specific paths/links, available equipment, and satellite footprints,
- to provide direction to the Network Bandwidth Manager Module (through the Consult Manager) in allocating communication assets, and
- to evaluate consultation requests against Provider and Field Node profiles, communications availability, request priorities, and other mission specific rules.

The Consult Manager is the part of the Broker that determines which medical providers best meet the stated request from a Field Node. Its primary tasks are:

- to receive and to prioritize consultation requests,
- to query the Decision Aids Module for requested system performance (e.g. error rate, quality of service, availability),
- to notify consultation providers of incoming consultation requests,
- to prepare and to transmit network configuration messages and responses,
- to coordinate consultation request information among other Consultation Broker Server Modules, and
- to determine which providers to assign to which consultation request.

The Provider Node is the part of the GGTS that interfaces with those locations that contain the requested medical support applications or medical personnel as stated in a Field Node Requests. It is the job of the Provider Node to enable these medical personnel and applications to interact effectively with the requesting Field Node. It is in charge of:

- processing requests to start applications,
- receiving and processing incoming consult warning messages and configuration messages,
- configuring co-located communications equipment,

- hosting, when appropriate, telemedicine "applications" or interfacing with them as external systems,
- launching applicable and appropriate telemedicine applications or interfacing with them,
- facilitating medical personal interaction with the consultation,
- logging all consultation-related information into a database,
- maintaining the interface and communications with the Broker Node,
- allocating bandwidth among Provider Node workstations, and
- maintaining provider user machine interface.

In order for the GGTS to perform its functions effectively, each functional node of the GGTS needs to be able to communicate with all the other nodes. Figure 3 shows the structure of the communications network that makes that possible.

[Insert Figure 3.]

3. REPRESENTAION AND REASONING

The Consultation Broker must have a way to represent requestor, patient, consultant, and consultation site information, and a way to represent actual and elapsed time. Much of the patient information can be described numerically. The International Classification of Diseases, Revision 9 (ICD9) diagnostic codes could be used by the requestor to convey possible patient problems and for the consultant to refine differential diagnoses, confirm diagnoses, or modify diagnoses. ASA codes could be used to describe the severity of the patient's condition and the rate of deterioration. Patient demographics (such as age, sex, etc.) could also be communicated either numerically or by menu choice that would be coded numerically by the CB. Critical consultant and site information could also be represented using ranges of ICD9 codes for specialties, subspecialties, and consultation histories. The data also must be represented in a way that is compatible with its reasoning methodology.

Booze-Allen Hamilton (1999) proposed to analyze each functional requirement and to generate a specific set of rules for it. Those rules would then form the basis upon which consultation and communications asset allocation decisions would be made. Rule generation would be an

iterative process, with the rules being modified as the complexity of the GGTS system development increases. The GGTS would have a rule manager module, a rule-based knowledge-based system that interprets relationships between system dynamics and user priorities. The rule manager module would apply its rules to determine the optimal utilization of available resources (both communications assets and medical personnel) and to provide direction to the Network Bandwidth Manager Module to dynamically allocate communications assets.

In their approach to the CB, the rule manager module would have the following functions:

- evaluate requests against user and facility profiles, communications availability, request priorities, and other mission-based rules,
- provide responses to requests from the Consult Manager Module,
- provide recommendations to the Consult Manager Module if quality of service or level of service parameters cannot be met,
- track network resources through interface with the Network Bandwidth Manager and the Network Manager Modules,

- collect status/topology information from the Network Manager Module,
- determine potential connectivity for paths, links, available equipment, and satellite footprints, and
- determine connection set-up options such as virtual path / virtual circuit (VP/VC), bandwidth, ATM Adaptation Layer (AAL), and Forward Error Correction (FEC).

[Insert Figure 4.]

The Consultation Broker must work in close conjunction with a network system manager (see Figure 4). The network system manager tells the CB what types of teleconsultations are feasible at a particular point in time, and handles all administrative functions necessary to initiate and sustain the chosen connection for its duration. France Telecom and INTELSAT's successful development of telecommunication hardware management systems using Gensym's G2 software product (http://www.gensym.com/products/G2.HTM) and a rule-based approach support the contention that a similar methodology would likely be appropriate for the GGTS network system manager. The type of knowledge necessary to have an effective Consultation Broker, though, is sufficiently different from that involved in a network

system manager. We expect that other reasoning approaches would be more effective for the CB than would be a rule-based methodology.

Rules are an effective way of representing and acting on knowledge when the action (the right-hand-side) parts of the rules are static and deterministic results of the condition (the left-hand-side) parts. The primary hardware components of a telecommunication network do not change frequently, the hardware's behavior is highly predictable, and the physical processes by which the network functions are well understood. As a result, a written procedure manual could be constructed to define the behaviors a person should follow if the network were to be managed manually. The written procedures manual should be adequate to cover almost all decisions that would have to be made as long as the network is functioning normally. A rule-based system is the computer-based equivalent of such a written procedure manual. Reasoning with and about time is a complication in telecommunications management, but G2 has a proven track record for such problem domains, as mentioned earlier, so that a rule-based artifact using that product is a good strategy for the GGTS network system manager.

The Consultation Broker's task of matching requestors to consultants requires reasoning in rapidly changing

situations in which procedures are subject to preferences as well as firm guidelines. The decision environment changes because the pool of available consultants changes frequently. The experience and expertise of consultants who remain in the system evolve over time, and consultants' availability may change on a daily or hourly basis. There are advantages to routing all patients with similar problems to the same consultant, because the consultant might then be able to detect patterns of occurrences that are problematic. There are also advantages to utilizing multiple consultants for a set of patients with similar problems, so that more than one individual has the expertise and experience to deal with each type of problem. Rules are good for representing knowledge of the IF (conditions) THEN (actions) type, where the same thing is always done when the same situation is encountered. Rules are not as good for knowledge of the type IF (conditions) THEN USUALLY (actions) UNLESS (more conditions) IN WHICH CASE (actions). Telecommunication network management should be primarily of the former variety. We expect that those aspects of the CB's problem that are based on medical considerations are primarily of the latter; portions of the CB's reasoning that are based on absolute institutional directives might better be represented by rules.

When the Consultation Broker must select a consultant, it is supposed to choose the most appropriate one of a fixed set of alternatives, a classification task. In a stable environment, in which the set of potential consultants, their locations and their skills remained the same, a statistical approach might be attractive, particularly if the system did not have to deal with too many different kinds of patients. The dynamic military environment and the diversity of patient types make an approach such as case-based reasoning (CBR) more promising than a statistical methodology. CBR reasons analogically from prior examples. It retains all experiences as opposed to only regularities found in those experiences, so it has the ability to "learn" from what it does—that is, if we consider remembering to be the most fundamental aspect of learning (Riesbeck and Schank, 1989). A CBR system relies on a case base that includes a relevant set of past experiences, each stored as a description of a problem paired with the solution to it. To solve a new problem, a case-based reasoner first will typically retrieve from the case base a set of cases whose descriptions are sufficiently similar to that of the new problem. It then extracts the solutions to the cases retrieved from the case base, adapts them if necessary, and then it adds the new

case plus its solution to the case base. While most CBR systems reason based only on the single most similar case, Smyth and Keane (1998) argue that the retrieval of the most similar past case may not necessarily yield the one that is best suited to solving a new problem. Furthermore, they propose that deeper knowledge is required to determine what previous experience is most relevant.

As a conceptual representation of human problem solving, the CBR approach is very attractive. It "remembers" all of its experiences. Unlike rule-based systems, it works well on problem domains that are poorly understood, for which there is only weak domain theory, and that are dynamic over time. A rule-based system provides answers and explains its reasoning by documenting the rules it used. A CBR system provides precedents, and explains it reasoning by citing a precedent. A CBR approach is thus attractive for problem domains, such a legal reasoning, in which human arguments traditionally proceed by citing precedents. A set of cases might be used by a discovery learning system to extract regularities and rules; see Corruble and Ganascia (1997) for an example of machine learning in a medical context. Kohno et al. (1997) combined rule-based and case-based systems, with the user and the CBR system detecting and correcting mistakes made

by the rule-based system. Their architecture combines problem solving and knowledge acquisition, with the case base serving to improve the rules.

CBR has traditionally been applied to static reasoning problems. Ram and Santamaria (1997) proposed an extension of the approach to continuous domains, such as ones in which sensor data is the basis for reasoning. Managing the teleconsultation process over time might utilize aspects of their formalization. Spyropoulos and Papagounos (1995) evaluate various AI models used in medicine, and discuss their ethical and methodological limitation. McKenzie and Forsyth (1995) surveyed similarity-based methods for classification. Evans and Winter (1995) and Petersen (1997) discuss medical applications of CBR.

To be effective, a CBR system must be able to retrieve the proper set of past cases from its knowledge base and must be able to adapt the retrieved solutions to the new problem. The adaptation difficulty can be avoided by selecting classification, as opposed to synthetic tasks, because it is logical to identify a new case with those cases to which it is most similar, so that no adaptation may be necessary. Classification requires recognition of features; synthesis requires the ability to construct an artifact from a specification. Most CBR work focuses on

classification tasks, an area in which there are statistical techniques available, such as discriminant analysis, as well as Artificial Neural Network (ANN) models and tree-induction approaches. In a study comparing CBR, linear discriminant analysis, and neural network models for a medical classification task (Musgrove and Davies, 1995, quoted in Watson, 1998), a CBR model performed better than a neural network, and the neural network performed better than linear discriminant analysis.

While adaptation might be avoidable, retrieval is not. Retrieval of a case from a case base is similar to conventional database retrieval. In both instances, a set of critical features must be defined for each record (case) to be included, and an effective and efficient algorithm for searching the data (case) base when desired must be present. However, CBR retrieval seeks to find the nearest match, while database retrieval returns exact matches. Case representation--that is, the selection of the characteristics for indexing cases--is particularly difficult for CBR applications, such as legal opinions or medical records, in which natural language is used. Representation should be less problematic for applications such as the Consultation Broker, for which the information

in a case could be solicited using a menu with no open-ended entries. Note that certain case descriptors may be measured on at least an interval scale, such as age, some on an ordered categorical scale (ASA classification of the patient), and others on an unordered categorical scale (ICD9 diagnostic code(s), physician requested for consult, medical center requested for consult).

The minimum requirement for the retrieval of the most appropriate set of cases from the case base is a metric that can, for any new case and two past cases, determine which of the two past cases is more similar to the new case. The metric might be a weighted combination of distance measures for each of the descriptors individually, or it might be a multivariate function of the descriptors. For the Consultation Broker, the more difficult descriptors to use in a metric are those measured on an unordered categorical scale. Of the patient descriptors, the ICD9 diagnostic codes are the most important categorical information. The tree structure that underlies the ICD9 taxonomy may provide a natural metric for determining how similar two ICD9 codes are.

4. CONSULTATION BROKER APPROACHES

We identified four distinct approaches to the way in which the Consultation Broker might work with its users to determine the most desirable match of consultant to requestor. Regardless of the alternative chosen, the Consultation Broker needs the following components to make it operational:

- a list of all potential consultants by name and by specialty,
- a list of sites providing consultation,
- a link to a network manager that indicates what modes of teleconsultation are feasible between a requestor and all consultation sites at the current time, and which will enable the teleconsultation once its participants have been determined,
- an interface to collect relevant information from the requestor, designed to make that information as complete and as internally consistent as possible,
- an interface to present the requestor's information to the consultant in an effective fashion, and
- a time-keeping capability and a time-based event trigger, to monitor the progress of the teleconsultation and to initiate actions necessary

to guarantee that any mutually desired and feasible consultation will actually take place.

The approaches differ primarily in the degree to which the computer system controls the brokering process: (a) the "active broker" alternative, (b) the automatic alternative, (c) the e-board alternative, and (d) the "yellow pages" alternative.

a. The Active Broker Alternative (AB)

This alternative uses the CB solely to relay information from the requestor and about potential consultants to a human, who is neither the requestor nor a potential consultant. That third party makes the assignments, using the data provided by the CB. The "intelligence" in the CB under this alternative is in the selection of information to be presented to the human assigner, and in the way in which that information is presented to the human so as to make the assigner's behavior as efficient and effective as possible. Under the Active Broker alternative, the human in charge of assignments functions somewhat like an air-traffic controller, monitoring and managing the requests for teleconsultation as they are matched up with consultants.

[Insert Figure 5.]

b. The Automatic Alternative (AU)

In the Automatic Alternative, the Consultation Broker behaves in an autocratic fashion, deciding on a match without user intervention. The CB may use one or more methodologies, such as those that use past experience (e.g., case-based reasoning), statistical analysis of a database (e.g., classification), or an electronic procedures manual (e.g., rule-based reasoning) as appropriate. Independently of the methodology used, the Automatic Alternative requires as inputs knowledge of:

- detailed profiles of consultants, and a list of consultants available at the time of the consultation,
- detailed profiles of all sites providing service,
- the list of cases requesting consultations,
- a uniform coding of cases, past and present, and
- at least one assignment methodology.

[Insert Figure 6.]

c. The Electronic Board Alternative (EB)

Requests for consults are posted on an electronic bulletin board, and the consultants select the cases in which they want to participate on a first-come-first-served basis. As the requests are posted, the

CB alerts all consultants in the requested specialty of the availability of a new case. If a consultant does not select the case within a time period that is determined as a function of the urgency of the case, the CB assigns it in an autocratic fashion, as it would in the automatic alternative. Note that the consultants decide on the case assignment in this alternative. The requestor may ask for a particular institution or a particular physician, but it is the respondent who determines if that particular match-up occurs. The CB's role in supporting the matching process is limited to notification of all potential respondents, and provision to them of the information from the requestor. In addition to the functionalities of the automatic alternative, which are needed if no consultant chooses to respond to the request for a consult, to implement the e-board alternative the CB requires that:

- the requests must be disseminated to all provider nodes along with all the data available for the consultation, and
- the blackboard must be kept in real time.

[Insert Figure 7.]

d. The Yellow Pages Alternative (YP)

As opposed to the e-board alternative, in which the consultant is the decision-maker, the "yellow pages" alternative puts the requestor in charge of selecting the consultant. The CB assists the requestor by supplying a list of available consultants (the "yellow pages" listing) together with background information that might be useful in making a selection (the "yellow pages ads"). As in the e-board alternative, the CB would have to take charge and make a selection of a consultant if the requestor did not do so within an appropriate length of time. The CB must also be capable of making the assignment if the requestor asks the CB to do so. In addition to the functionality of the automatic alternative, and a time-keeping functionality as in the e-board alternative, to implement the "yellow pages" alternative the CB would need:

- detailed profiles of all consultants along with their history of clinical work,
- detailed profiles of all sites providing service, and

- the ability to present the correct subset of the above information to a requestor in real-time in a useful format.

[Insert Figure 8.]

5. EVALUATION OF ALTERNATIVES

Deciding about the configuration of the Consultation Broker involves the consideration of tangible benefits and/or costs and intangibles. The measurement of intangibles was not possible until a few years ago when Saaty (1977, 1986) developed the Analytic Hierarchy Process (AHP). This theory is based on the use of relative measurement to construct ratio scales, which can be combined in hierarchic structures to yield nonlinear approximations. The theory is based on three principles: decomposition (construction of a hierarchy or network of interactions), measurement (development of ratio scales) and synthesis (hierarchic or network composition). This theory requires expert knowledge to develop the decision-making structure (i.e., the hierarchy) and to assess the relative importance/contribution of the criteria and the alternatives (i.e., ratio scales from pairwise comparisons). As an illustration of how the alternatives could be evaluated, Figure 9 shows a simple hierarchy of

objectives, criteria and alternatives that could be used by a group of experts to evaluate the four alternatives. It is important to note that this theory does not have the same shortcomings as some other theories such as utility theory or outranking methods. The AHP allows for intransitivities of the decision-makers and hence, the logic behind it must be non-monotonic which allows for new facts not necessarily consistent with all other existing facts at the time of a decision.

The selection of an alternative could consider the following four objectives:

- optimal utilization of resources,
- maximum accessibility of service,
- quality of care, and
- readiness.

These objectives could in turn be decomposed as in Figure 9. Below the level of objectives we should insert a set of criteria that will help to measure the contribution of the alternatives to the attainment of the objectives.

To evaluate the four alternative configurations, first the importance of the objectives must be assessed; then the importance of the criteria with respect to each objective; and finally, the relative importance of the alternative configurations with respect to each criterion. The results

of these comparisons can then be combined into a unidimensional scale that will indicate, in relative terms, the importance of the alternative according to all the objectives and criteria. This evaluation requires knowledge and experience on the alternative configurations, which is not yet readily available. It is the subject of future research. We propose to select four cases to illustrate the four configurations and show their weaknesses and strengths. A good example of a case similar to this one was summarized in Vlhakis and Partridge (1989). This publication is a summary of a larger study conducted by the US Department of Energy and the Office of the Inspector General to determine the adequacy of security at selected US Department of Energy facilities that produce nuclear weapons. The AHP provided a flexible tool for assessment, planning, and allocation of resources for enhanced security.

[Insert Figure 9.]

Note that to obtain a synthesized scale for the configurations we would need to: (a) prioritize the criteria with respect to their contribution to the overall goal, Resources(u_1,u_2,u_3), Access to Care (a_1,a_2,a_3), Quality of

Care (c_1, c_2, c_3) and Readiness (r_1, r_2), where $\sum_{j=1}^{3}(u_j + a_j + c_j) + \sum_{k=1}^{2} r_k = 1$;

(b) prioritize the alternative configurations with respect to each criterion, i.e., find the priorities (u_{ij}), (a_{ij}), (c_{ij}) and (r_{ik}), of the alternative configurations with respect to Resources, Access to Care, Quality of Care, and Readiness, respectively, with $\sum_{i=1}^{4} u_{ij} = 1$, $\sum_{i=1}^{4} a_{ij} = 1$, $\sum_{i=1}^{4} c_{ij} = 1$ $\sum_{i=1}^{4} r_{ik} = 1$; and (c) combine the individual scales obtained under each criterion using the principle of hierarchic composition. The relative standing of the configurations would be given by the configuration priority (CP):

$$CP(i) = \underbrace{\sum_{j=1}^{3} u_{ij} u_j}_{\text{Resources}} + \underbrace{\sum_{j=1}^{3} a_{ij} a_j}_{\text{Accessibility}} + \underbrace{\sum_{j=1}^{3} c_{ij} c_j}_{\text{Quality}} + \underbrace{\sum_{k=1}^{2} r_{ik} r_k}_{\text{Readiness}}$$

6. AN EXAMPLE USING A TELEDENTAL PROTOTYPE

To illustrate how the GGTS may function when it is eventually fielded, we developed a functional prototype using data from a teledentistry system. (TDENT) currently used by the US Army, Navy and Air Force. Although this system is purely, a web-based, store and forward teleconsultation system is purely, a web-based, store and forward teleconsultation system, the data generated from it contains useful information to model and explore some of the behavior and features of GGTS.

We used objects and classes to represent the information contained in the TDENT records. In the US Army TDENT system, those data are usually electronically introduced using a standard form (Form 513). The fields of the dentistry system contain patient demographic data, patient location, referring physician data and location, medical data (complaint, history, exam findings, preliminary diagnosis and treatment), specialist/consultant data and location, dental procedure codes (CDTs) and diagnostic codes (ICD9s). For example, the patient in Figure 10 with fictitious first name (fn59) middle initial (E) and last name (ln59) was involved in two prior consultations. Thus, the patient object for FN59 E. LN59 contains links to the previous consultations, c1637 and c1642. Each consultation is an instance of the consultation class.

[Insert Figure 10.]

Figure 11 shows the information contained in the structure of consultation c1637. The information in a consultation is divided into three categories:

1. Patient demographic and medical information displayed in the upper half of the consultation information dialog in Figure 11.

2. Specialty, diagnostic and procedural codes displayed in the lower left.
3. Specialist/consultant information such as diagnosis, suggested treatment, and specialist demographic data and location, displayed in the bottom right panel.

Every consultation (known as an "encounter" in the medical arena) creates an object with the information displayed in Figure 11. Dental images and radiographs can be included with a consult.

[Insert Figure 11.]

Each specialist, meaning a potential consultant, belongs to the class "doctor" which contains information about the specialist's demographic information (e.g., location, unit to which assigned) and involvement with prior consults in the database (past consults, procedures (CDT3s) and problems (ICD9s) addressed in those consultations). Figure 12 is an example of a doctor with ID# 101.

[Insert Figure 12.]

Doctor 101 is an endodontist who is assigned to the hypothetical unit combat hospital Csh-5. Note, from Figure 12, that Doctor 101 is the person who handled consultation c1637. "Unit" is also the name of a class, and each actual unit is an instance of it. The information represented in

the instance for Csh-5 is shown in Figure 13. Csh-5 is a deployable unit, so that it and/or Doctor 101 might not always be associated with the same brick-and-mortar facility. As shown in Figure 13, Csh-5 is currently located at the US Army hospital in Würzburg, Germany.

[Insert Figure 13.]

Facilities are also represented as objects because we need to know things about them in order for the Consult Broker to be able to support decision-making. Each actual facility is an instance of the "facility" class, and includes information such as its geographical location (longitude and latitude), its type (clinic, hospital, and so on), and the type of teleconsultation modalities it can support. Figure 14 shows the data for a hypothetical hospital at Würzburg. The modality information shown in Figure 14 is for illustrative purposes only, and we do not claim that it describes the capability of the actual US Army hospital in Würzburg. Other than latitude and longitude, the information about the specific facility is not accurate and it is only used for purposes of illustration. A similar object exists for the facility to which the consultant is assigned in case of combat.

[Insert Figure 14.]

The simplest type of support provided by the Consultation Broker is for it to function as a database lookup system, similar to a yellow pages directory. In such a case, the requestor chooses the heading under which to look up doctors, and uses the system to identify potential consultants, ordered either by their proximity or by their experience. The Broker does not try to comprehend the nature of the medical problem, but does collect the Form 513 information provided by the requestor so as to help facilitate the consultation process. Figure 15 shows an anonymous example from the TDENT system in which the reqeustor asked for Oral Surgeon without specifying any likely procedural codes. The Broker, in Figure 16, offers a list of available consultants, where "consultant" in this case means anyone listed as being an oral surgeon. The list of oral surgeons in Figure 16 is sorted in order of increasing (great circle) current distance from the requestor's location. Because the Broker's knowledge base includes information about where consultant's units are currently located, it adjusts the proximity list if consultants are deployed away from their default locations. Instead of listing the consultants by location, the user could have asked for the consultants to be sorted by the number of prior consults in the database. If the requestor

had specified procedural codes, the lists returned by the Broker would be limited to specialists with experience in exactly those codes, if there were such data in the knowledge base. If no matching data existed, the list would then be compiled from those with experience in the most similar codes.

[Insert Figure 15.]

[Insert Figure 16.]

Recall that in Yellow Pages mode, the requestor is the decision-maker. The Broker presents its relevant knowledge to the requestor, and waits for the requestor to choose a consultant. Once the requestor does so, the Broker hands off the request to the system components that manage the requestor-consultant interaction. If the Broker is to make the decision, as it would in the Automatic Mode, it works its way down the list of specialists in conformity with organizational rules and preferences. If a human third party, neither the requestor nor the consultants, is to make the decision, in Active Broker mode, the Consultation Broker presents its lists to that human, and waits for that human's decision. Finally, in Electronic Board mode, the consultants are the decision-makers, so the Consultation Broker would post the Form 513 information to all relevant potential consultants and await a response from them.

7. CONCLUSIONS

In this paper, we have described a global telemedicine command and control system (GGTS), still under development, which will enable telemedical consultations to occur anywhere in the world, regardless of location or transportation medium. The GGTS consists of four distinct functional nodes: Field, Requestor, Broker and Provider. Each node provides a specific interface to the communications network that supports medical operations across the operational continuum. This paper concentrates on the Consultation Broker (CB) component, which is operationalized using artificial intelligence methodologies. The CB routes incoming requests for consultation to the appropriate "on duty" medical personnel. It may adopt one of four alternative architectures, called automatic, active broker, yellow pages and electronic board. We illustrated how the architectures would handle a teleconsultation, using data from an operational teledentistry system.

Based on work to date, it appears that the following are common requirements that the four configurations must satisfy. Specifics of the items below will be refined once working prototypes of the configurations are available. In general, the Consultation Broker architecture must:

(1) be a virtual link between healthcare providers and medical centers for 24/7 telemedicine consultations;

(2) leverage existing and available military telecommunication infrastructure backed up by civilian networks to provide remote military health care providers with telemedicine access to consulting physicians at medical centers;

(3) function with humans to enhance their efficiency;

(4) provide centralized transparent network management and consult routing using knowledge-based system technology;

(5) be dynamic and flexible;

(6) deal with uncertainty;

(7) adjust to change;

(8) be similar to a telecommunications routing system for phone calls;

(9) have a mirrored capability to ensure that if the initial consultation broker drops off-line, the consult in progress is maintained and new consultations are rerouted to the alternative site;

(10) be sensitive to requirements of all potential customers, who include, at a minimum, the patient, the primary care giver, humans at the GGTS control center and the consulting physician at the medical center;

(11) be able to be responsive to and incorporate current and future policy decisions;

(12) be continuously aware, along with network and bandwidth managers, of the state of its physical resources and be able to respond to unexpected changes in the availability of those resources;

(13) be able to recognize the urgency of the consultation request and have a time management capability to clear requests and/or upgrade previous requests over time;

(14) remain in standby mode until initiated, making it the triggering mechanism of the GGTS architecture;

(15) once initiated, evaluate consults predicated upon patient information, attending primary care giver requirements, knowledge of physician based protocols, network and bandwidth resource availability, and operational policies;

(16) provide a medical decision maker with a list of prioritized options with whom to initiate the consult; and

(17) augment its knowledge base with the results of completed consult case information.

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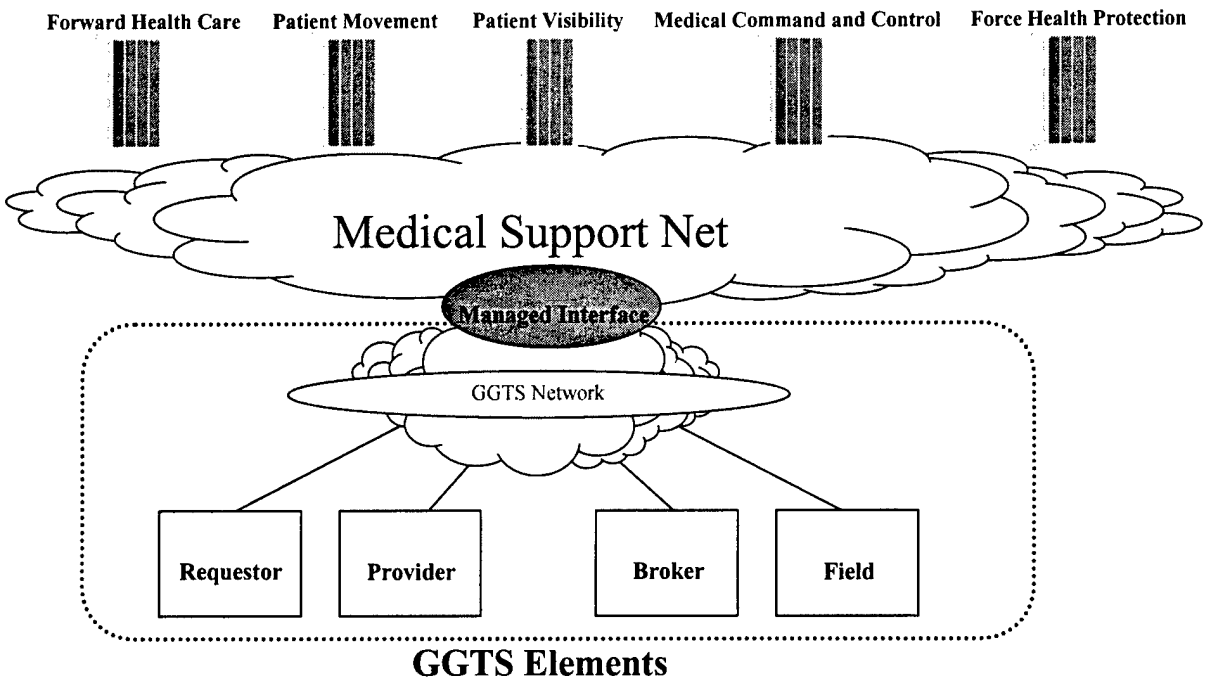

Figure 1. GGTS Support to Five Medical Business Processes and interfaces.

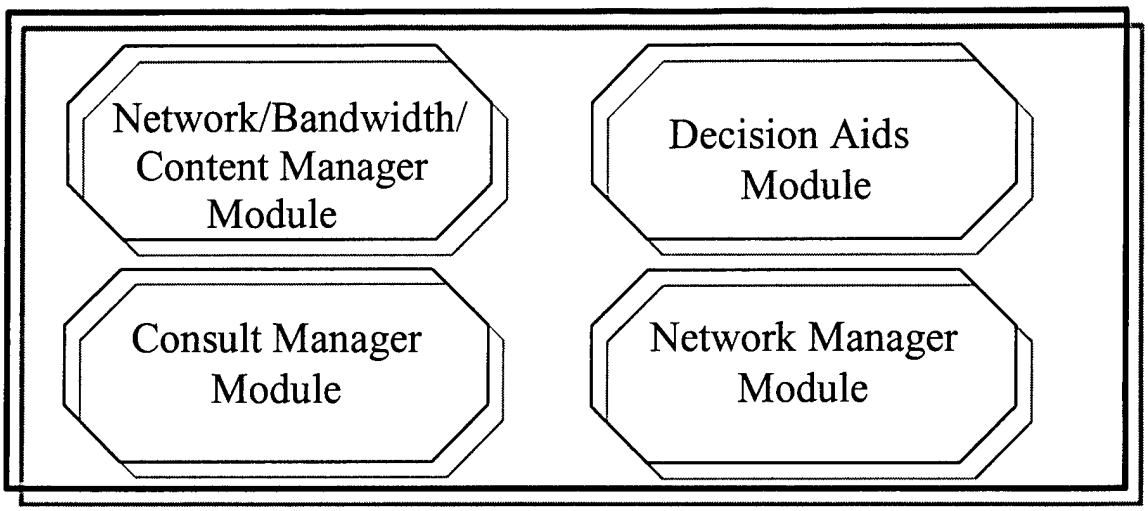

Figure 2. GGTS Broker Node Managers

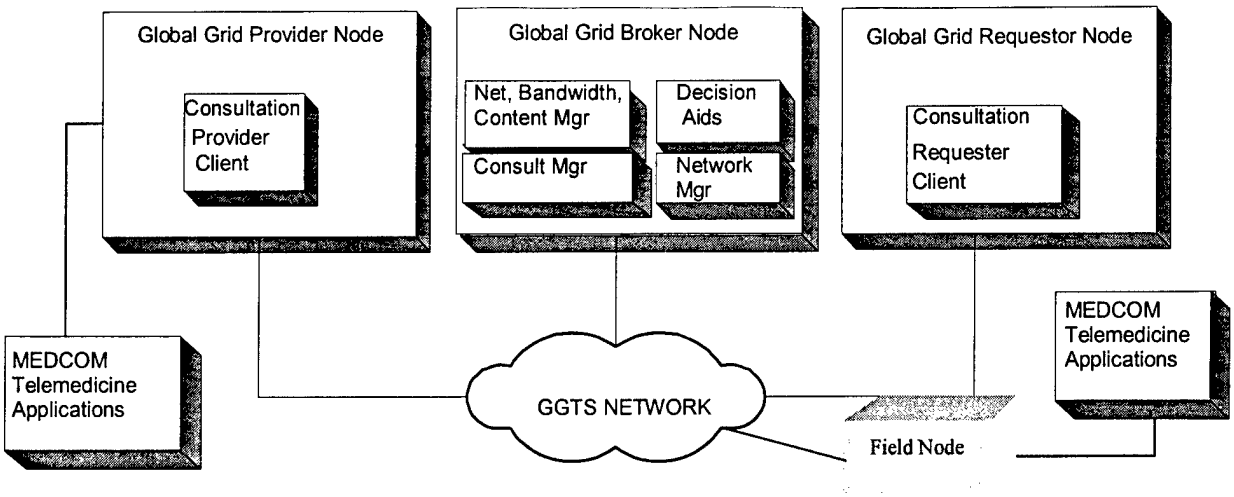

Figure 3. GGTS Element Relationship

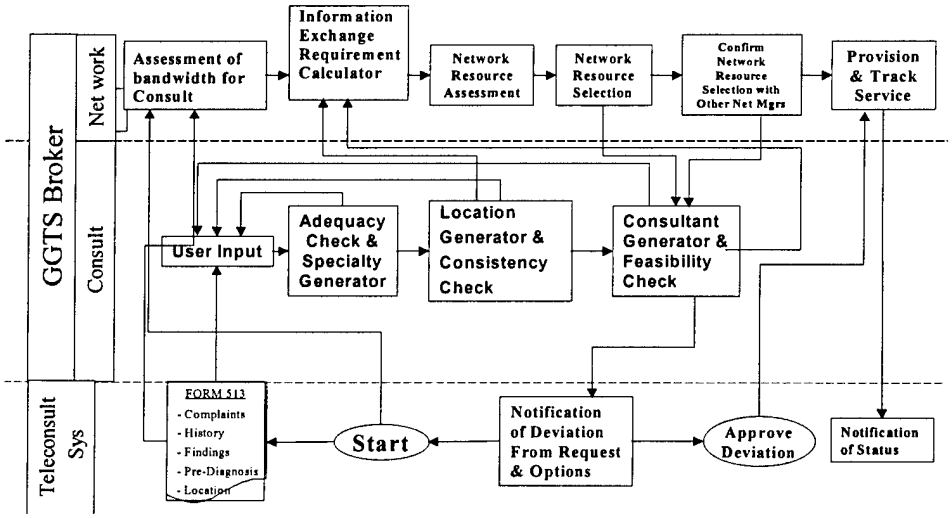

Figure 4. Overview of GGTS Broker Process for Telecommuting Services

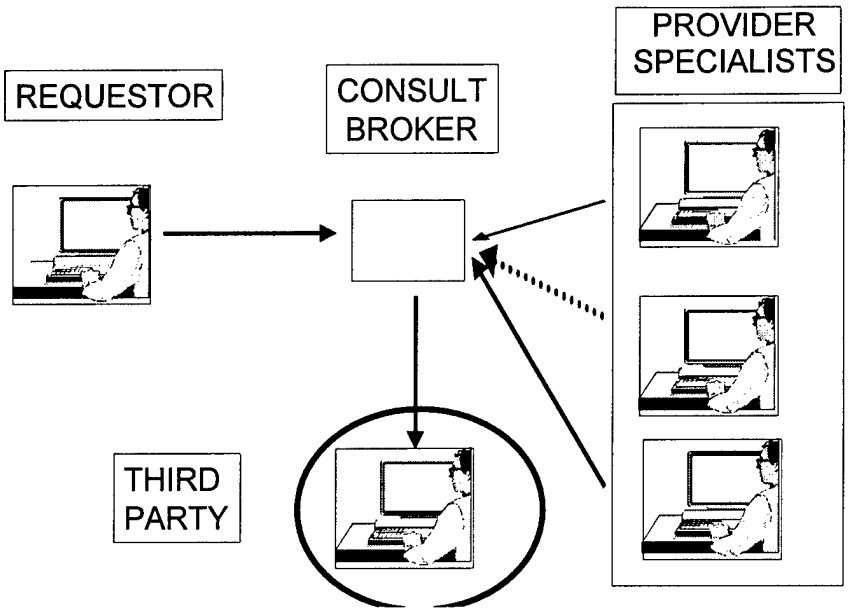

Figure 5. Active Broker

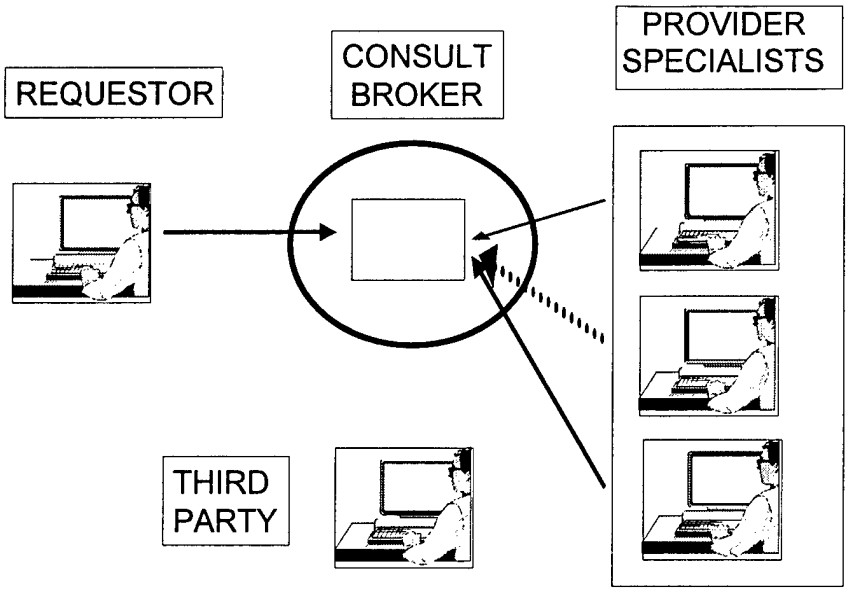

Figure 6. Automatic Alternative

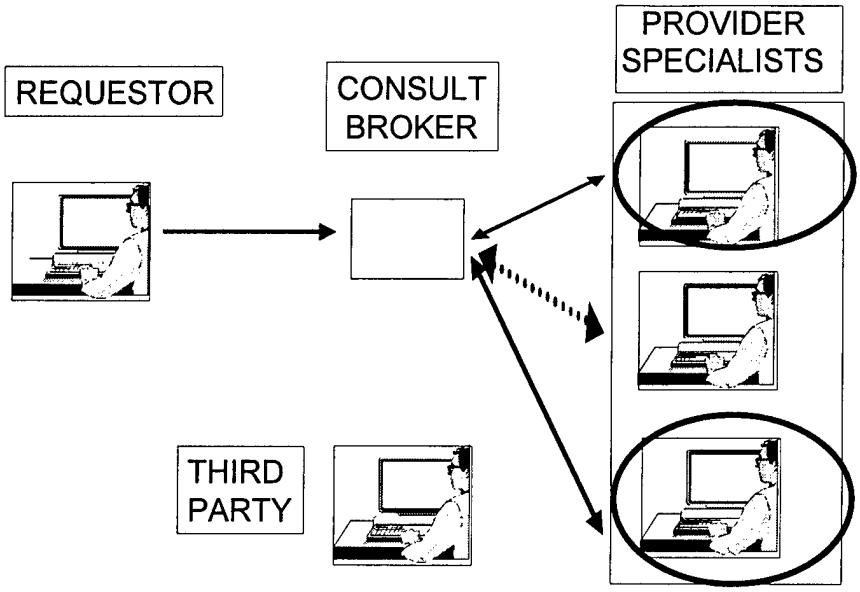

Figure 7. Electronic Board

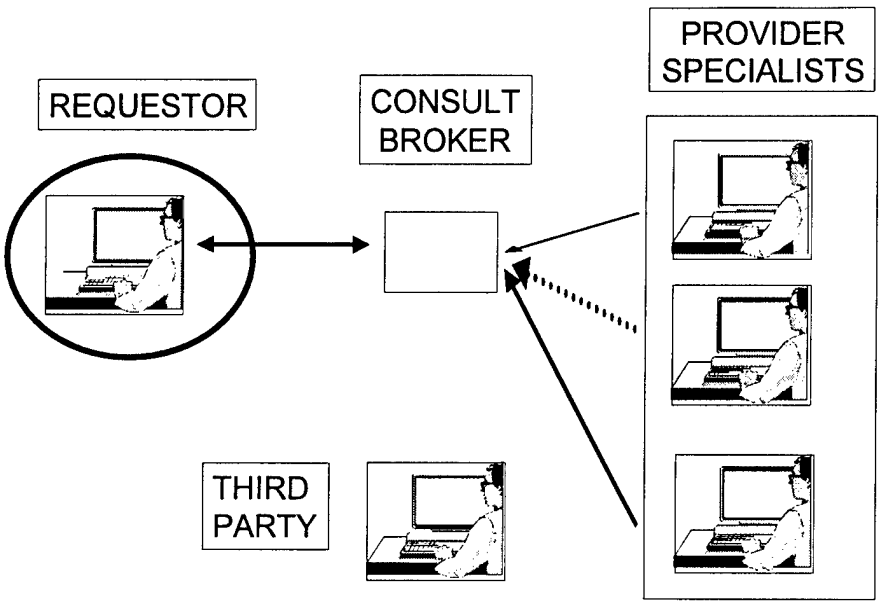

Figure 8. Yellow Pages

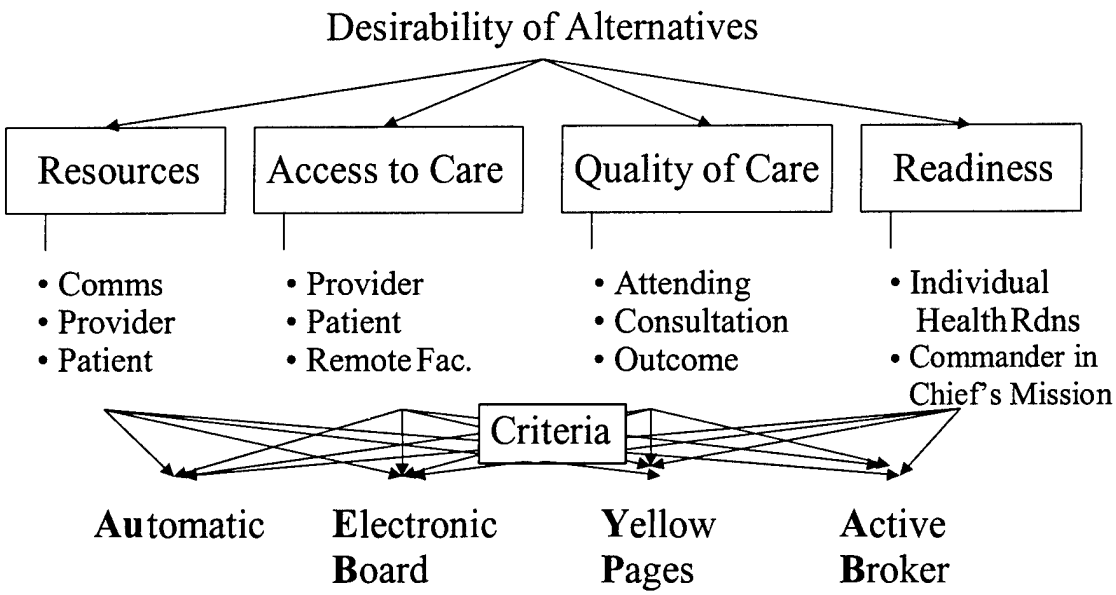

Figure 9. Consultation Broker Alternatives Hierarchy

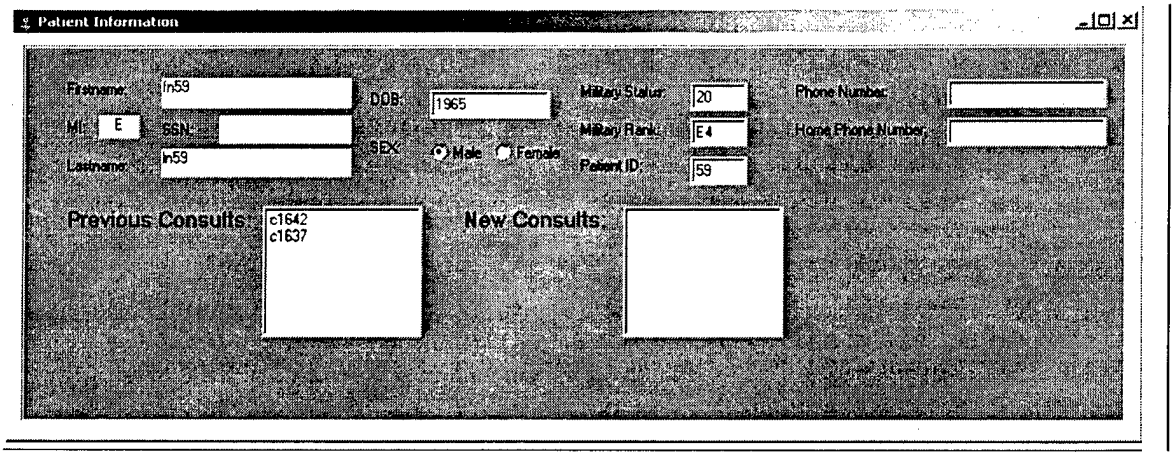

Figure 10. A patient instance

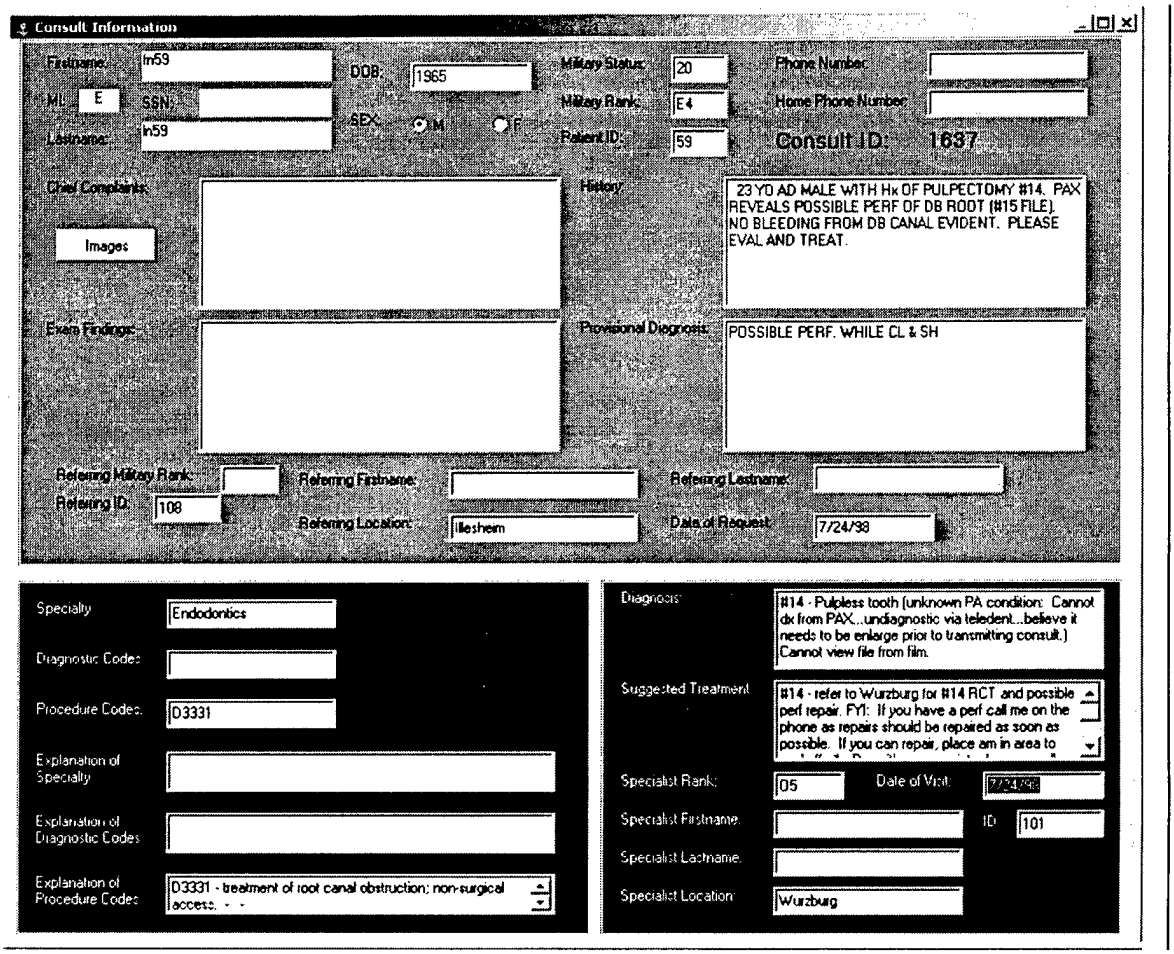

Figure 11. Details of a consultation instance

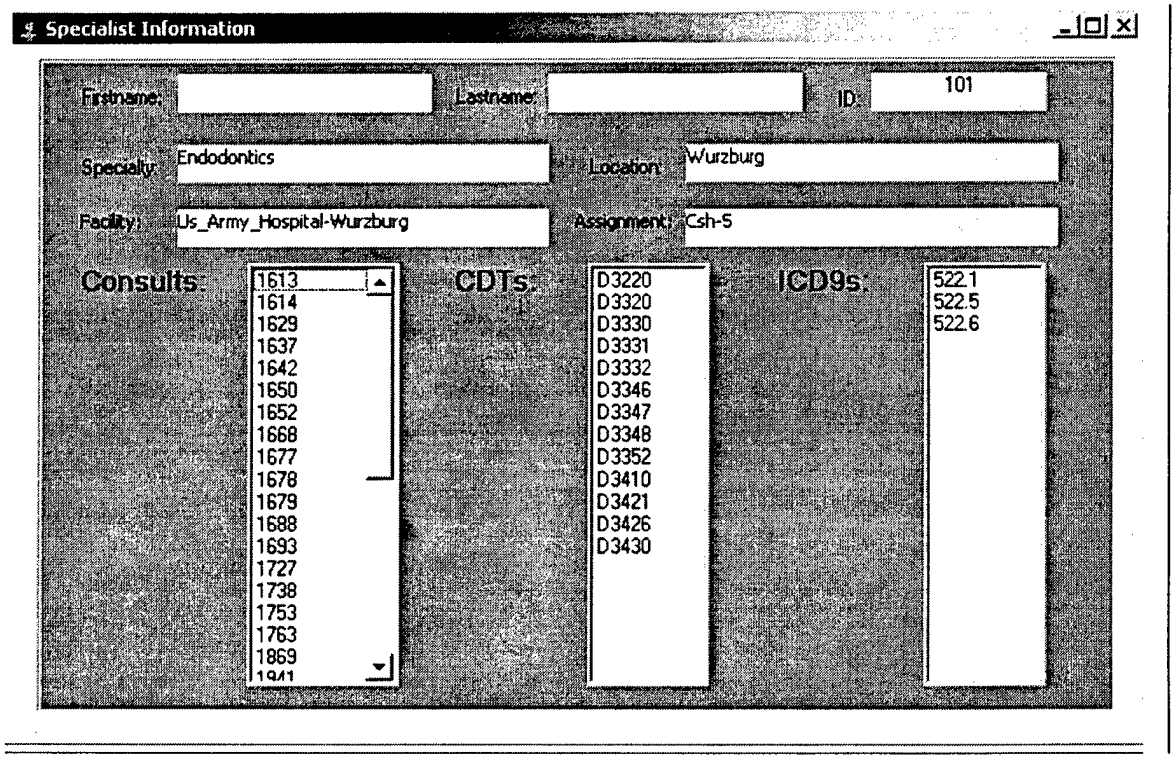

Figure 12. An example of a consultant

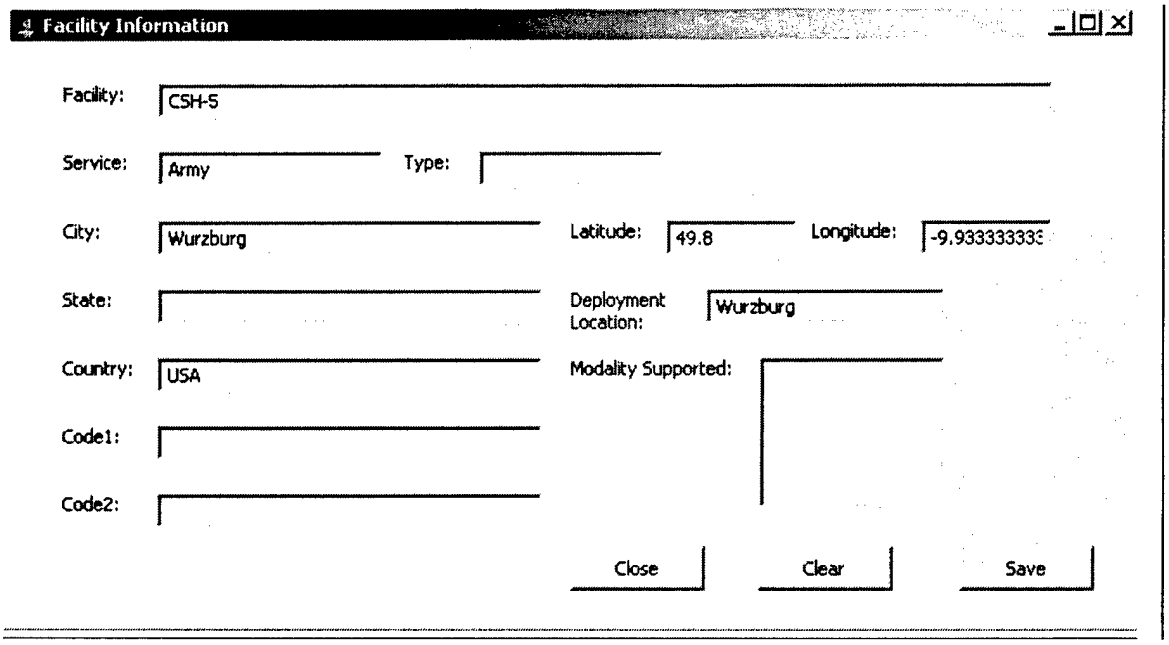

Figure 13. An example of a unit

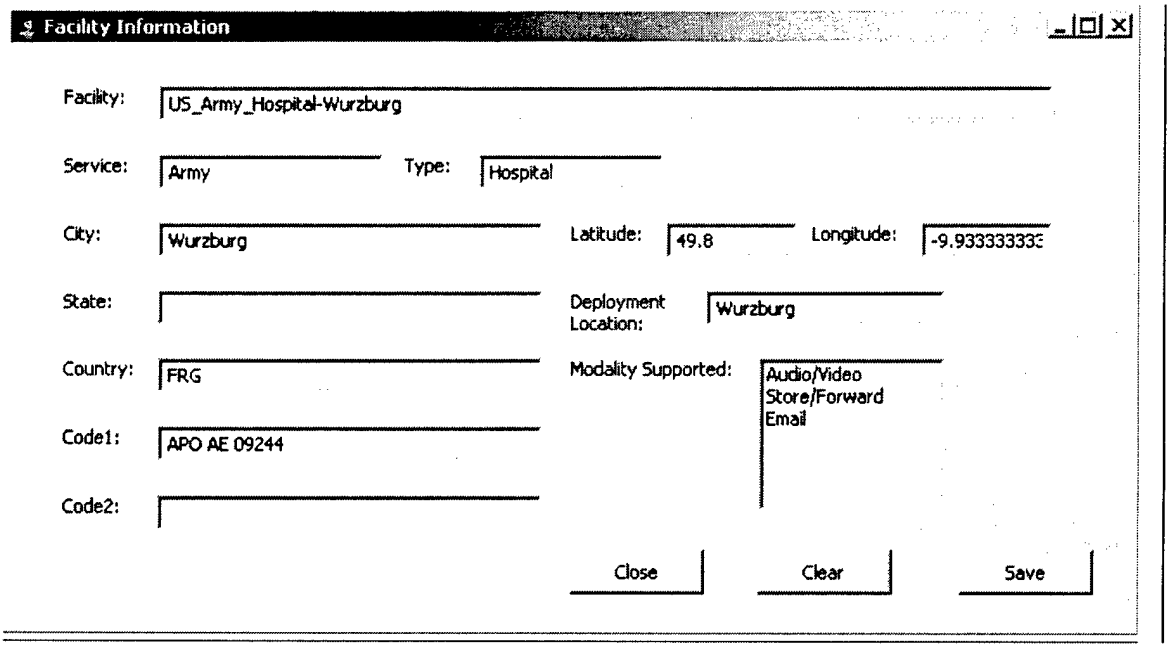

Figure 14. An example of a medical facility

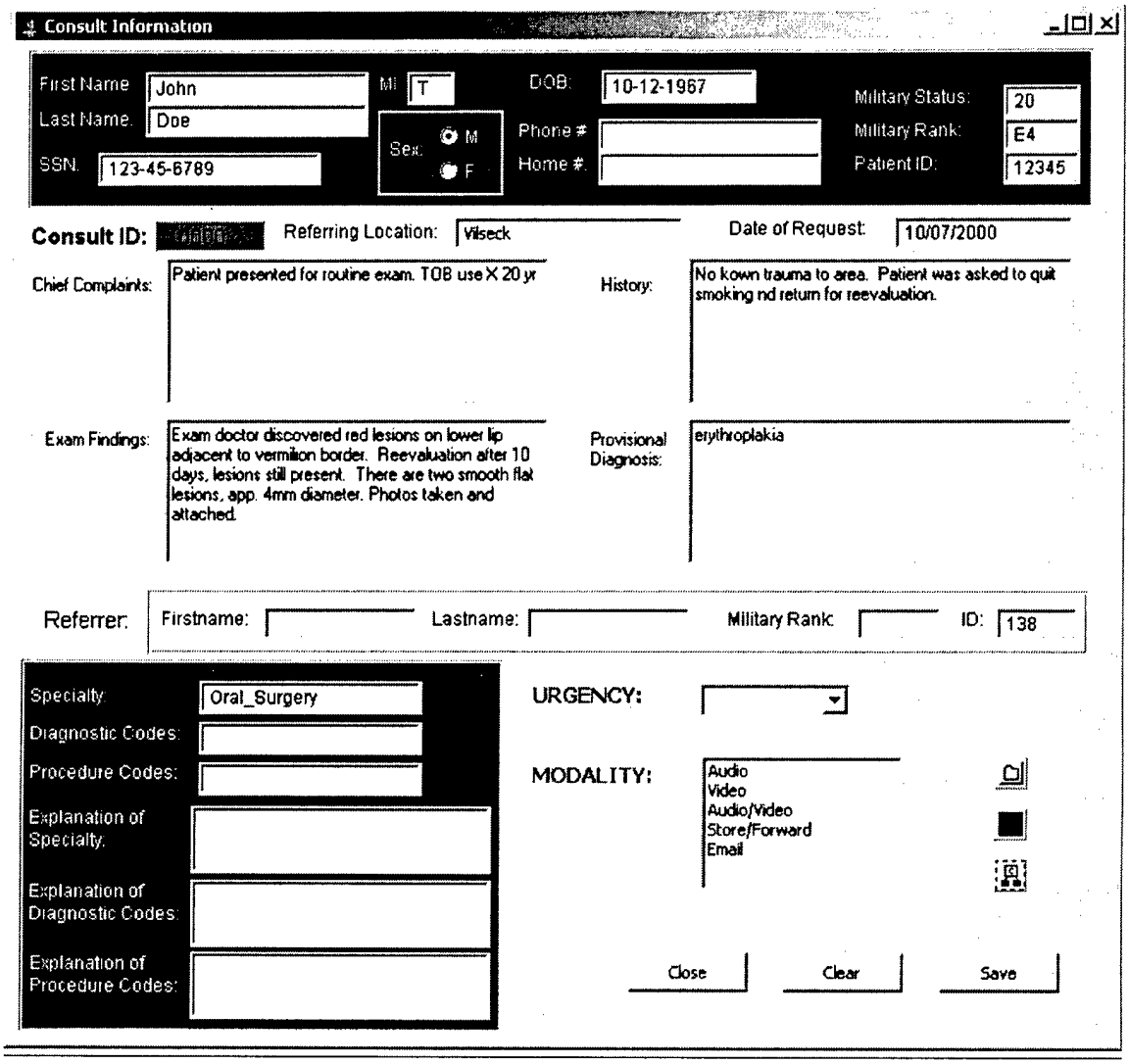

Figure 15. A user request for an Oral Surgeon

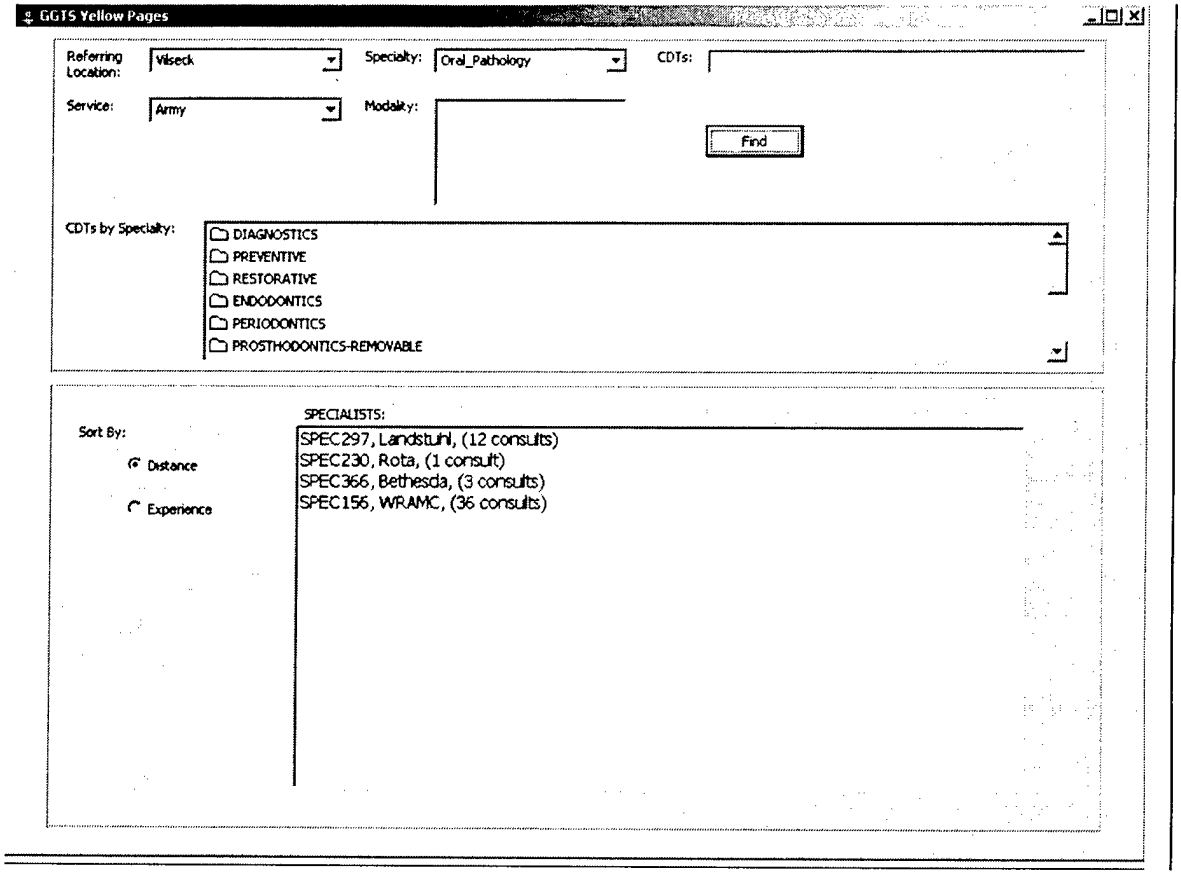

Figure 16. Broker response to a request for an Oral Surgeon, Yellow Pages alternative

Appendix 5:

Code listing for Global Grid Telemedicine System Consult Broker

```
<%
  // submit.jsp
  //
  // This file is called when a user submits a new consult or
  // a reply to a consult. It parses all information, including
  // consult form data and images, and saves it to the new or
  // existing consult. It uses the various Java classes in order
  // to save the consult information onto the server.
  //
  ////////////////////////////////////////////////////////


  // put all arguments into "myreq"
  java.util.Hashtable myreq = new java.util.Hashtable();
  java.util.Vector fileNames = new java.util.Vector();

  consult.Consult theConsult = new consult.Consult();


  boolean keepGoing = true;
  com.oreilly.servlet.multipart.MultipartParser parser = new com.oreilly.servlet.multipart.MultipartParser(request, 1000000);

  while(keepGoing)
  {
          try {
            com.oreilly.servlet.multipart.Part part = parser.readNextPart();
            if(part.isFile())
            {
                    com.oreilly.servlet.multipart.FilePart filepart = (com.oreilly.servlet.multipart.FilePart)part;
                    if(filepart.getFileName() != null)
                    {
                      String fileName = new String((new Long((new java.util.Date()).getTime())).toString() +
filepart.getFileName());
                      String fullPath = new String("c:\\Tomcat\\webapps\\ROOT\\GGTS\\picFiles\\" + fileName);
                      filepart.writeTo(new java.io.File(fullPath));
                      fileNames.addElement(fileName);
                    }
            }
            else if(part.isParam())
            {
                    com.oreilly.servlet.multipart.ParamPart parampart = (com.oreilly.servlet.multipart.ParamPart)part;
                    myreq.put(parampart.getName(), parampart.getStringValue());
            }
          }
          catch(java.lang.NullPointerException e) {
                    keepGoing = false;
          }
  }
//////////////////////////////////////////////////////////////////
%>


<% boolean thisIsANewConsult = false;     // if the Consult needs to be saved new
  boolean thisWasAReply = false;                  // if the Consult needs to have a reply added
                                                                  // NOTE: if both are false, then submit is processing
                                                                  // the Consult to return to consultview.jsp for the CBR
  if(myreq.get("cid").equals("-1"))
          thisIsANewConsult = true;

  String buttonValue;
  buttonValue = (String)myreq.get("theButton");
  if(buttonValue.equals("Submit Reply"))
          thisWasAReply = true;

  // must pass username to every file in every instance
  String usr = (String)(myreq.get("username"));
  misc.ReferrerDatabase refs = new misc.ReferrerDatabase();
  consult.Doctor ref = refs.getReferrer(usr);

  if(!thisWasAReply)
```

```
{
        consult.Person thePt = new consult.Person();
        thePt.setFirstName((String)(myreq.get("fname")));
        thePt.setMiddleName((String)(myreq.get("mname")));
        thePt.setLastName((String)(myreq.get("lname")));
        thePt.setSex(Integer.parseInt((String)(myreq.get("sex"))));
        if(!((String)(myreq.get("age"))).equals(""))
          thePt.setAge(Integer.parseInt((String)(myreq.get("age"))));
        if(!((String)(myreq.get("patid"))).equals(""))
          thePt.setId(Integer.parseInt((String)(myreq.get("patid"))));

        theConsult = new consult.Consult();
        theConsult.setPatient(thePt);
        theConsult.setDialog((String)(myreq.get("descrip")));
        theConsult.setSuggestedSpecialty((String)(myreq.get("chosenSpec")));
        theConsult.setSuggestedSite((String)(myreq.get("chosenSite")));

        // set referrer
        theConsult.setReferring(ref);

        int category = Integer.parseInt((String)myreq.get("category"));
        theConsult.setTypeCategory(category);

        theConsult.setReferringLocation((String)myreq.get("location"));

        for(int i = 0; i < fileNames.size(); i++)
        {
          theConsult.addPicFileName((String)fileNames.elementAt(i));
        }
}

////////////////////////////////////////////////////////////////////////////

        consult.util.FileManager fm = new consult.util.FileManager();
        int theCid;
        if(thisIsANewConsult)
        {
          theCid = fm.saveConsult(theConsult);
          out.println("<H4>Consult (C" + theCid + ") has been submitted</H4><BR>");          // doesn't show up
        }
        else if(thisWasAReply)
        {
          String chosenSite = (String)myreq.get("chosenSite");
          String chosenSpec = (String)myreq.get("chosenSpec");

          String reply = (String)(myreq.get("reply"));
          theCid = Integer.parseInt((String)myreq.get("cid"));

          consult.Consult tempConsult = new consult.Consult();
          tempConsult = fm.getConsult(theCid);
          fm.addToDialog(theCid, ((new java.util.Date()) + " [" + ref.toPlainString() +
                                  " (" + ref.getSpecialty() + ") @ " +  tempConsult.getReferringLocation() + "] Responds: " + reply));
          fm.changeSite(theCid, chosenSite);
          fm.changeSpecialty(theCid, chosenSpec);
          out.println("<H4>Consult (C" + theCid + ") reply has been submitted</H4><BR>"); // doesn't show up
        }
        else
        {
          theCid = Integer.parseInt((String)myreq.get("cid"));
          theConsult.setConsultId(theCid);
          fm.changeConsult(theConsult);
          out.println("<H4>Consult (C" + theCid + ") changes have been submitted</H4><BR>"); // doesn't show up
        }
////////////////////////////////////////////////////////////////////////////


        String newUrl = new String();
        String sortType = new String();
        sortType = (String)myreq.get("theButton");
        if(sortType.equals("Sort Specialties"))        // line 174
```

```
            newUrl = new String("consultView.jsp?cid=" + theCid + "&sorttype=specialty&username=" + usr);
          else if(sortType.equals("     Find Sites     "))
            newUrl = new String("consultView.jsp?cid=" + theCid + "&sorttype=site&username=" + usr);
          else
            newUrl = new String("submitMessage.jsp?cid=" + theCid + "&username=" + usr);


%>

<jsp:forward page='<%= newUrl %>' />
// This is an applet that runs on the "consultView.jsp" web-page.  It checks every 10
// seconds for updates to the Consult that is being viewed, and alerts the viewer
// when replies are made.  It also displays the current date and time.



import java.applet.*;
import java.awt.*;
import java.io.*;
import java.net.*;
import java.util.*;
import javax.swing.*;

public class UpdateApplet extends Applet
{
 private final int PORT = 7483;
 private final String serverAddress = "136.142.59.46";
 String numReplies;
 Date currTime;
 int previousNumReplies;
 boolean previousNumRepliesInitialized;
 boolean updateHasBeenCalled;
 int cid = 0;

 public void start() {}

 public void stop()
 {
  this.destroy();
 }

 public void paint(Graphics g) {
  if(updateHasBeenCalled)
  {
   int numRepliesInt = Integer.parseInt(numReplies);
   String replyText = new String(" replies - ");
   if(numRepliesInt == 1)
    replyText = new String(" reply - ");

   g.drawString((numReplies + replyText + currTime), 50, 15);
  }
 }

 public void init()
 {
  this.setBackground(Color.white);
  this.setFont(new Font("Monospaced", Font.BOLD, 12));

  previousNumReplies = 0;
  previousNumRepliesInitialized = false;
  updateHasBeenCalled = false;

  cid = Integer.parseInt(getParameter("cid"));
  (new Thread(new Updater())).start();
 }

 public synchronized void update()
 {
  Socket socket;
  ObjectOutputStream oStream;
```

```
    ObjectInputStream iStream;

    try
    {
     socket = new Socket(serverAddress, PORT);
     oStream = new ObjectOutputStream(socket.getOutputStream());
     iStream = new ObjectInputStream(socket.getInputStream());

     oStream.writeObject("Single Request");
     oStream.writeObject((new Integer(cid)).toString());

     numReplies = (String)iStream.readObject();
     currTime = (Date)iStream.readObject();

     oStream.close();
     iStream.close();
     socket.close();
    }
    catch(Exception e) {
     e.printStackTrace();
    }

    int numRepliesInt = Integer.parseInt(numReplies);
    if(numRepliesInt > previousNumReplies  && previousNumRepliesInitialized)
     this.setForeground(Color.red);
    else
     this.setForeground(Color.blue);

    previousNumReplies = numRepliesInt;
    previousNumRepliesInitialized = true;

    updateHasBeenCalled = true;
    repaint();
   }

   private class Updater implements Runnable
   {
    int secondsBetweenUpdates = 10;

    public Updater(){}

    public void run()
    {
     while(true)
     {
      update();
      try {
       Thread.sleep(secondsBetweenUpdates * 1000);
      }
      catch(Exception e) {
       e.printStackTrace();
      }
     }
    }
   }

}
```

```
// The "Consult" class is used to store and manipulate all information that makes up a
// medical consultation including the referring party, patient, description, as well as
// all locations and specialties that the Consult was sent to.


package consult;

import java.awt.*;
import java.util.*;
import java.io.*;

/*

These particular times are used for testing purposes only

ROUTINE = no urgency
URGENT (Answer within 6 minutes) = 1 star (2 minutes), 2 stars (4 minutes), 3 stars (6 minutes)
EMERGENT (Answer within 3 minutes) = 1 star (1 minute), 2 stars (2 minutes), 3 stars (3 minutes), 4 stars (4 minutes)
FOLLOWUP = no urgency
*/


public class Consult implements Serializable, Comparable
{
 private int consultId;

 private Person patient;
 private Doctor referring;
 private Vector dialog;  // holds Strings (conversations)

 private String referringLocation;

 private String suggestedSpecialty;
 private String suggestedSite;

 private Vector picFileNames;  // holds Strings of filenames (attached pictures)
 private Vector icd9Codes;

 public static final int ROUTINE = 0, URGENT = 1, EMERGENT = 2, FOLLOWUP = 3;
 private int typeCategory;

 private Date timeCreated;
 private Date timeClockWasStopped;
 private boolean clockHasBeenStopped = false;

 private boolean isPending;

 public Consult()
 {
  consultId = -1;

  patient = new Person();
  referring = new Doctor();
  dialog = new Vector();

  referringLocation = new String();

  suggestedSpecialty = new String();
  suggestedSite = new String();

  picFileNames = new Vector();
  icd9Codes = new Vector();

  typeCategory = ROUTINE;

  timeCreated = new Date();
  timeClockWasStopped = null;

  isPending = true;
 }
```

```
//////////////// set methods ////////////////

public void setConsultId(int id) {
  consultId = id;
}

public void setPatient(Person thePatient) {
  patient = thePatient;
}

public void setReferring(Doctor theReferring) {
  referring = theReferring;
}

public void setReferringLocation(String theLocation) {
  referringLocation = theLocation;
}

public void setDialog(String theInitialString) {
  dialog.insertElementAt(theInitialString, 0);
}

public void addToDialog(String theString) {
  dialog.addElement(theString);
}

public void setSuggestedSpecialty(String theSpec) {
  suggestedSpecialty = theSpec;
}

public void setSuggestedSite(String theSite) {
  suggestedSite = theSite;
}

public void setTypeCategory(int theCategory) {
  typeCategory = theCategory;
}

public void addPicFileName(String filename) {
  picFileNames.addElement(filename);
}

public void setTimeStamp() {
  timeCreated = new Date();
}

public void stopClock() {
  clockHasBeenStopped = true;
  timeClockWasStopped = new Date();
}

public void setPending(boolean isIt)
{
  isPending = isIt;
}


// XXX method to add icd9Code


//////////////// get methods ////////////////

public int getConsultId() {
  return consultId;
}

public Person getPatient() {
  return patient;
```

```
}

public Doctor getReferring() {
 return referring;
}

public String getReferringLocation() {
 return referringLocation;
}

public Vector getDialog() {
 return dialog;
}

public String getDescription() {
 if(!dialog.isEmpty())
  return (String)dialog.elementAt(0);
 else return (new String());
}

public String getResponses() {
 String returnString = new String();
 for(int i = 1; i < dialog.size(); i++)
 {
  returnString = returnString.concat(new String((String)dialog.elementAt(i) + "\n\n"));
 }

 return returnString;
}

public String getSuggestedSpecialty() {
 return suggestedSpecialty;
}

public String getSuggestedSite() {
 return suggestedSite;
}

public Vector getPicFileNames() {
 return picFileNames;
}

public Vector getIcd9Codes() {
 return icd9Codes;
}

public int getNumberOfReplies() {
 return (dialog.size() - 1);
}

public boolean isPending() {
 return isPending;
}

public int getTypeCategory() {
 return typeCategory;
}

public Date getTimeCreated() {
 return timeCreated;
}

public int getElapsedSeconds() {
 Date rightNow = new Date();
 long now = rightNow.getTime();
 long then = timeCreated.getTime();
 float msElapsed = (float)(now - then);
 int secondsElapsed = Math.round(msElapsed/1000);
 return secondsElapsed;
}
```

```
// figures out how many 'stars' are needed to represent the urgency (depending on elapsed time)
public int getUrgency() {
  int urgency = 0;
  int elapsedSeconds = getElapsedSeconds();
  if(typeCategory == ROUTINE || typeCategory == FOLLOWUP) urgency = 0;
  else if(typeCategory == URGENT) {
    if(elapsedSeconds > 360) urgency = 3;
    else if(elapsedSeconds > 240) urgency = 2;
    else if(elapsedSeconds > 120) urgency = 1;
  }
  else if(typeCategory == EMERGENT) {
    if(elapsedSeconds > 240) urgency = 4;
    else if(elapsedSeconds > 180) urgency = 3;
    else if(elapsedSeconds > 120) urgency = 2;
    else if(elapsedSeconds > 60) urgency = 1;
  }
  return urgency;
}

//////////////// misc methods ////////////////

public int compareTo(Object o)
{
  if(this.getUrgency() > ((Consult)o).getUrgency())
    return -1;
  else if(this.getUrgency() == ((Consult)o).getUrgency())
  {
    if(this.getTimeCreated().before(((Consult)o).getTimeCreated()))
      return -1;
    else
      return 1;
  }
  else
    return 1;
}

public String formatElapsedSeconds(int numSeconds) {
  if(isPending)
  {
    int hours, minutes, seconds;
    int timeRemaining = numSeconds;
    hours = timeRemaining/3600;
    timeRemaining -= hours * 3600;
    minutes = timeRemaining/60;
    timeRemaining -= minutes * 60;
    seconds = timeRemaining;

    String zeroM = new String();
    String zeroS = new String();
    if(minutes < 10) zeroM = "0";
    if(seconds < 10) zeroS = "0";

    return new String(hours + ":" + zeroM + minutes + ":" + zeroS + seconds);
  }
  else return new String("");
}

public String toString() {

/* this will be deleted probably
String stars = new String();
int urgency = getUrgency();
for(int i = 0; i < urgency; i++) {
  stars = stars.concat("*");
}
////////////////////////////*/

  return new String(consultId + "   " + patient + "   " + suggestedSpecialty +
      "   " + formatElapsedSeconds(getElapsedSeconds()));// + stars);
```

```
    }

} // end Consult
```

```
// This class holds information for a doctor.
// "Doctor" is a subclass of "Person".

package consult;

import java.io.*;


public class Doctor extends Person implements Serializable
{
 private String specialty;
 private String location;

 public Doctor()
 {
  super();
  specialty = new String();
  location = new String();
 }

 public Doctor(String name, String specialty)
 {
  super();
  this.firstName = name;
  this.specialty = specialty;
 }

 public Doctor(String fname, String mname, String lname, int id, String specialty, String location)
 {
  super();
  this.firstName = fname;
  this.middleName = mname;
  this.lastName = lname;
  this.idNumber = id;
  this.specialty = specialty;
  this.location = location;
 }

 ////////////// set methods //////////////

 public void setSpecialty(String spec) {
  specialty = spec;
 }

 public void setLocation(String loc) {
  location = loc;
 }


 ////////////// get methods //////////////

 public String getSpecialty() {
  return specialty;
 }

 public String getLocation() {
  return location;
 }


 ////////////// toString() overwrite //////////

 public String toString() {
  return this.firstName;
 }

 // XXX fix this
 public String toFullString() {
  return new String(lastName + ", " + firstName + " " + middleName);
 }
```

```
 public String toPlainString() {
   return new String(firstName + " " + middleName + " " + lastName);
 }

} // end Doctor
```

```
// "Person" holds all the basic information for any Person.
// It is used to represent patients, etc.

package consult;

import java.io.*;


public class Person implements Serializable
{
 protected int idNumber;

 protected String firstName;
 protected String middleName;
 protected String lastName;

 protected int age;
 protected int sex;

 public static int MALE = 0, FEMALE = 1;

 public Person()
 {
  idNumber = -1;

  firstName = new String();
  middleName = new String();
  lastName = new String();

  age = -1;
  sex = -1;
 }


 ////////////// set methods //////////////

 public void setId(int id) {
  idNumber = id;
 }

 public void setFirstName(String fname) {
  firstName = fname;
 }

 public void setMiddleName(String mname) {
  middleName = mname;
 }

 public void setLastName(String lname) {
  lastName = lname;
 }

 public void setAge(int age) {
  this.age = age;
 }

 public void setSex(int sex) {
  this.sex = sex;
 }


 ////////////// get methods //////////////

 public int getId() {
  return idNumber;
 }

 public String getFirstName() {
  return firstName;
 }
```

```
 public String getMiddleName() {
  return middleName;
 }

 public String getLastName() {
  return lastName;
 }

 public int getAge() {
  return age;
 }

 public int getSex() {
  return sex;
 }


 ////////////// misc methods //////////////

 public String toString() {
  return new String(lastName + ", " + firstName + " " + middleName);
 }

} // end Person
```

```
2001.12.03 13:35 B E:\Army source code\classes\consult\Consult.java --> unixs.cis.pitt.edu /afs/pitt.edu/usr71/wgjst/Army source code/classes/consult Consult.java
2001.12.03 13:35 B E:\Army source code\classes\consult\Doctor.java --> unixs.cis.pitt.edu /afs/pitt.edu/usr71/wgjst/Army source code/classes/consult Doctor.java
2001.12.03 13:35 B E:\Army source code\classes\consult\Person.java --> unixs.cis.pitt.edu /afs/pitt.edu/usr71/wgjst/Army source code/classes/consult Person.java
// This class is the engine behind the site software.  It runs the site
// using the "SiteFrame" class.

package site;

import javax.swing.UIManager;
import java.awt.*;

public class Site {
  boolean packFrame = false;

  /**Construct the application*/
  public Site() {
    SiteFrame frame = new SiteFrame();
    //Validate frames that have preset sizes
    //Pack frames that have useful preferred size info, e.g. from their layout
    if (packFrame) {
      frame.pack();
    }
    else {
      frame.validate();
    }
    //Center the window
    Dimension screenSize = Toolkit.getDefaultToolkit().getScreenSize();
    Dimension frameSize = frame.getSize();
    if (frameSize.height > screenSize.height) {
      frameSize.height = screenSize.height;
    }
    if (frameSize.width > screenSize.width) {
      frameSize.width = screenSize.width;
    }
    frame.setLocation((screenSize.width - frameSize.width) / 2, (screenSize.height - frameSize.height) / 2);
    frame.setVisible(true);
  }
  /**Main method*/
  public static void main(String[] args) {
    try {
      UIManager.setLookAndFeel(UIManager.getSystemLookAndFeelClassName());
    }
    catch(Exception e) {
      e.printStackTrace();
    }
    new Site();
  }
}
// "SiteFrame" is the actual window that is seen when the site software is first
// run.  It displays all pending and sent consults in the database, and allows
// the person at site to choose each one.  Once a consult is chosen, the DocChooser
// window is displayed.

package site;

import consult.*;
import java.awt.*;
import java.awt.event.*;
import javax.swing.*;
import javax.swing.border.*;
import java.util.*;
import java.net.*;
import java.io.*;

public class SiteFrame extends JFrame {
  JPanel contentPane;
  JLabel jLabel1 = new JLabel();
```

```
JLabel jLabel2 = new JLabel();
JLabel jLabel3 = new JLabel();
TitledBorder titledBorder1;
JPanel jPanel1 = new JPanel();

private final int PORT = 7483;
private final String serverAddress = "136.142.59.46";
private String siteName = "";
JScrollPane jScrollPane1 = new JScrollPane();
JList pendingList = new JList();
JScrollPane jScrollPane2 = new JScrollPane();
JList sentList = new JList();

/**Construct the frame*/
public SiteFrame() {

 String [] siteArray = new String[4];
 siteArray[0] = new String("Walter Reed Army Medical Center");
 siteArray[1] = new String("Landstuhl Regional Medical Center");
 siteArray[2] = new String("Eisenhower Army Medical Center");
 siteArray[3] = new String("National Naval Medical Center");

 JOptionPane pane = new JOptionPane("Select a location", JOptionPane.QUESTION_MESSAGE);
 String theSite = (String)pane.showInputDialog(this, "Select a Location",
          "GGTS Site", JOptionPane.QUESTION_MESSAGE, null, siteArray,
          siteArray[0]);

 siteName = theSite;

 if(siteName == null)
 {
  System.out.println("OOPS!");
  siteName = new String("Walter Reed Army Medical Center");
 }

 enableEvents(AWTEvent.WINDOW_EVENT_MASK);
 try {
  jbInit();
 }
 catch(Exception e) {
  e.printStackTrace();
 }
 (new Thread(new SiteUpdater())).start();
}
/**Component initialization*/
private void jbInit() throws Exception  {
 //setIconImage(Toolkit.getDefaultToolkit().createImage(SiteFrame.class.getResource("[Your Icon]")));
 contentPane = (JPanel) this.getContentPane();
 titledBorder1 = new TitledBorder("");
 contentPane.setLayout(null);
 this.setSize(new Dimension(672, 516));
 this.setTitle(siteName);
 jLabel1.setFont(new java.awt.Font("Dialog", 1, 14));
 jLabel1.setText("SENT:");
 jLabel1.setBounds(new Rectangle(13, 263, 62, 17));
 jLabel2.setBounds(new Rectangle(12, 57, 78, 17));
 jLabel2.setText("PENDING:");
 jLabel2.setFont(new java.awt.Font("Dialog", 1, 14));
 jLabel3.setFont(new java.awt.Font("Dialog", 1, 21));
 jLabel3.setForeground(Color.red);
 jLabel3.setText("Pending/Sent Consults");
 jLabel3.setBounds(new Rectangle(192, 6, 237, 36));
 jPanel1.setBorder(BorderFactory.createEtchedBorder());
 jPanel1.setBounds(new Rectangle(6, 50, 648, 431));
 jScrollPane1.setBorder(null);
 jScrollPane1.setBounds(new Rectangle(14, 77, 612, 176));
 pendingList.addMouseListener(new java.awt.event.MouseAdapter() {
  public void mouseClicked(MouseEvent e) {
   pendingList_mouseClicked(e);
  }
```

```
  });

  // added for colors
  pendingList.setCellRenderer(new ColoredCellRenderer());

  jScrollPane2.setBorder(null);
  jScrollPane2.setBounds(new Rectangle(15, 283, 610, 175));
  sentList.addMouseListener(new java.awt.event.MouseAdapter() {
    public void mouseClicked(MouseEvent e) {
      sentList_mouseClicked(e);
    }
  });
  contentPane.add(jLabel1, null);
  contentPane.add(jLabel2, null);
  contentPane.add(jLabel3, null);
  contentPane.add(jScrollPane1, null);
  contentPane.add(jScrollPane2, null);
  contentPane.add(jPanel1, null);
  jScrollPane2.getViewport().add(sentList, null);
  jScrollPane1.getViewport().add(pendingList, null);
 }
 /**Overridden so we can exit when window is closed*/
 protected void processWindowEvent(WindowEvent e) {
  super.processWindowEvent(e);
  if (e.getID() == WindowEvent.WINDOW_CLOSING) {
    System.exit(0);
  }
 }

 void pendingList_mouseClicked(MouseEvent e) {
  DocChooser dc = new DocChooser((Consult)((ColoredItem)pendingList.getSelectedValue()).getObject());
  dc.show();
 }

 void sentList_mouseClicked(MouseEvent e) {
  DocChooser dc = new DocChooser((Consult)((ColoredItem)sentList.getSelectedValue()).getObject());
  dc.show();
 }

 private synchronized void updateSite()
 {
  Socket socket;
  ObjectOutputStream oStream;
  ObjectInputStream iStream;

  Vector updatedList = new Vector();
  Vector pendingTemp = new Vector();
  Vector sentTemp = new Vector();


  try
  {
   socket = new Socket(serverAddress, PORT);
   oStream = new ObjectOutputStream(socket.getOutputStream());
   iStream = new ObjectInputStream(socket.getInputStream());

   oStream.writeObject(siteName);
   updatedList = (Vector)iStream.readObject();
   Collections.sort(updatedList);

   // seperate pending from sent
   for(int i = 0; i < updatedList.size(); i++)
   {
    Consult temp = new Consult();
    temp = (Consult)updatedList.elementAt(i);

    // change to colorable
    ColoredItem tempC = new ColoredItem(temp);

    if(temp.getUrgency() == 0)
```

```
        tempC = new ColoredItem(temp, Color.black);
      else if(temp.getUrgency() == 1)
        tempC = new ColoredItem(temp, Color.orange);
      else if(temp.getUrgency() == 2)
        tempC = new ColoredItem(temp, Color.red);
      else if(temp.getUrgency() >= 3)
        tempC = new ColoredItem(temp, Color.red);

      if(temp.isPending())
        pendingTemp.addElement(tempC);
      else
        sentTemp.addElement(tempC);
     }

     oStream.close();
     iStream.close();
     socket.close();
    }
    catch(Exception e) {
     e.printStackTrace();
    }

    pendingList.setSelectionBackground(Color.cyan);

    pendingList.setListData(pendingTemp);
    sentList.setListData(sentTemp);
   } // end updateSite()

   private class SiteUpdater implements Runnable
   {
    private int secondsBetweenUpdates = 10;
    public SiteUpdater()
    {}
    public void run()
    {
     while(true)
     {
      updateSite();
      try {
       Thread.sleep(secondsBetweenUpdates * 1000);
      }
      catch(Exception e) {
       e.printStackTrace();
      }
     }
    }
   }

////////////// NEW STUFF FOR COLORED CELLS //////////////

class ColoredCellRenderer extends DefaultListCellRenderer implements ListCellRenderer
{
 public Component getListCellRendererComponent(JList list, Object value,
                int index, boolean isSelected, boolean cellHasFocus)
 {
  setText((value == null) ? "" : value.toString());
  Color c = ((Colorable) value).getColor();
  if (isSelected) {
   setBackground(list.getSelectionBackground());
   setForeground(c);
  }
  else
  {
   setBackground(list.getBackground());
   setForeground(c);
  }

  setEnabled(list.isEnabled());
  if(c.equals(Color.red) || c.equals(Color.orange))
   setFont(new Font((list.getFont().getName()), Font.BOLD, list.getFont().getSize()));
```

```
    else
      setFont(list.getFont());

    return this;
  }
}

class ColoredItem implements Colorable
{
 Object object;
 Color color;

 public ColoredItem(Object object, Color color)
 {
  this.object = object;
  this.color = color;
 }

 ColoredItem(Object object)
 {
  this(object, Color.black);
 }

 public Object getObject()
 {
  return object;
 }

 public Color getColor()
 {
  return color;
 }

 public void setColor(Color color)
 {
  this.color = color;
 }

 public String toString()
 {
  return object.toString();
 }
}

interface Colorable
{
 public Color getColor();
 public void setColor(Color c);
}

//////////////////////////////////////////////////////////////


}
```

```
// The "SiteServer" runs on port 7483 and allows the web pages to communicate with the
// Java classes located on the server machine.  It allows the web pages to perform
// operations such as locating or saving a consult, image, or PIC file.

package site;

import java.util.*;
import java.io.*;
import java.net.*;
import consult.*;
import consult.util.*;


public class SiteServer
{
 private final int PORT = 7483;

 public SiteServer()
 {
  try {
   runServer();
  }
  catch(Exception e) {
   System.out.println("Problem starting server");
  }
 }

 public void runServer() throws IOException
 {
  ServerSocket s = new ServerSocket(PORT);
  System.out.println("Started: " + s);
  try
  {
   while(true)
   {
    try
    {

     // wait for a socket connection (request for consults), then
     // wait to receive site name, then create vector of consults addressed
     // to that particular site name, then send them
     Socket newSocket = s.accept();
     synchronized(this)
     {
      ObjectInputStream tempReader = new ObjectInputStream(newSocket.getInputStream());
      ObjectOutputStream tempWriter = new ObjectOutputStream(newSocket.getOutputStream());
      System.out.println("Request");

      String siteName = (String)tempReader.readObject();

      if(siteName.equals(new String("Single Request")))
      {
       System.out.println("SINGLE");
       String consultNumber = (String)tempReader.readObject();
       int cid = Integer.parseInt(consultNumber);
       Consult consultToSend = new Consult();
       consultToSend = getConsultFromServer(cid);
       // send number of replies
       String numReplies = (new Integer(consultToSend.getNumberOfReplies())).toString();
       tempWriter.writeObject(numReplies);

       // send the current time and date
       Date currTime = new Date();
       tempWriter.writeObject(currTime);
      }
      else if(siteName.equals(new String("Change Consult")))
      {
       Consult theConsult = (Consult)tempReader.readObject();
       this.changeConsult(theConsult);
      }
```

```
        else
        {
         Vector vectorToSend = new Vector();
         vectorToSend = getConsultsAddressedToSite(siteName);
         tempWriter.writeObject(vectorToSend);
        }

        tempReader.close();
        tempWriter.close();
        newSocket.close();
       }
      }
      catch(Exception e) {
       e.printStackTrace();
      }
     }
    } // try
    catch(Exception e)
    {
     e.printStackTrace();
    }
    finally
    {
     System.out.println("Server shutting down");
     // XXX close all sockets HERE
    }
}


// for now, this just returns ALL consults in the database
public Vector getConsultsAddressedToSite(String siteName)
{
 Vector theVector = new Vector();
 FileManager fm = new FileManager();
 Hashtable consultHash = new Hashtable();
 consultHash = fm.getAllConsults();
 Enumeration e = consultHash.elements();
 while(e.hasMoreElements())
 {
  Consult tempConsult = (Consult)e.nextElement();
  siteName = (siteName.replace('_', ' ')).trim();
  String consultSiteName = ((tempConsult.getSuggestedSite()).replace('_', ' ')).trim();
  if(consultSiteName.equalsIgnoreCase(siteName))
   theVector.addElement(tempConsult);
 }

 return theVector;
}

public Consult getConsultFromServer(int cid)
{
 Consult theConsult = new Consult();
 FileManager fm = new FileManager();
 theConsult = fm.getConsult(cid);

 return theConsult;
}


public void changeConsult(Consult changedConsult)
{
        FileManager fm = new FileManager();
        fm.changeConsult(changedConsult);
}


public static void main(String[] args)
{
 SiteServer s = new SiteServer();
}
```

```
} // end SiteServer class
```

```
// This window appears once a consult is chosen.  It allows someone to choose an
// appropriate specialist according to the description and suggested specialty
// of the consult.  After a specialist is chosen, the DocReplyWindow appears.


package site;

import consult.*;
import misc.*;
import java.awt.*;
import java.awt.event.*;
import javax.swing.*;
import java.util.*;

public class DocChooser extends JFrame {

 Consult theConsult;

 JPanel contentPane;
 JButton routeToButton = new JButton();

 boolean enteringDocManually = false;


 JButton cancelButton = new JButton();
 JTextField specialtyValue = new JTextField();
 JLabel jLabel6 = new JLabel();
 JLabel jLabel5 = new JLabel();
 JLabel jLabel4 = new JLabel();
 JLabel jLabel3 = new JLabel();
 JTextField referringValue = new JTextField();
 JLabel jLabel2 = new JLabel();
 JLabel jLabel1 = new JLabel();
 JTextField locationValue = new JTextField();
 JLabel consultNumberL = new JLabel();
 JScrollPane jScrollPane1 = new JScrollPane();
 JTextArea informationValue = new JTextArea();
 JScrollPane jScrollPane2 = new JScrollPane();
 JList docList = new JList();
 JButton picButton = new JButton();
 JTextField manualDocField = new JTextField();
 JLabel manualEnterLabel = new JLabel();

 /**Construct the frame*/
 public DocChooser(Consult c) {
  enableEvents(AWTEvent.WINDOW_EVENT_MASK);
  this.theConsult = c;
  try {
   jbInit();
  }
  catch(Exception e) {
   e.printStackTrace();
  }
 }
 /**Component initialization*/
 private void jbInit() throws Exception  {
  consultNumberL.setBounds(new Rectangle(103, 23, 58, 26));
  consultNumberL.setForeground(Color.blue);
  consultNumberL.setText((new Integer(theConsult.getConsultId())).toString());
  consultNumberL.setFont(new java.awt.Font("Dialog", 0, 16));
  locationValue.setBounds(new Rectangle(94, 94, 167, 21));
  locationValue.setText(theConsult.getReferringLocation());
  jLabel1.setBounds(new Rectangle(16, 20, 82, 33));
  jLabel1.setText("Consult#:");
  jLabel1.setForeground(Color.red);
  jLabel1.setFont(new java.awt.Font("Dialog", 1, 16));
  jLabel2.setBounds(new Rectangle(17, 59, 63, 19));
  jLabel2.setText("Referring:");
  referringValue.setBounds(new Rectangle(93, 57, 168, 21));
```

```
// temporary solution below
try {
 referringValue.setText(theConsult.getReferring().toFullString());
}
catch(NullPointerException exc) {
 referringValue.setText("");
}
//////////////////////////

jLabel3.setText("Location:");
jLabel3.setBounds(new Rectangle(18, 96, 63, 19));
jLabel4.setText("Specialty:");
jLabel4.setBounds(new Rectangle(17, 134, 63, 19));
jLabel5.setBounds(new Rectangle(421, 17, 115, 18));
jLabel5.setText("Site Specialists:");
jLabel6.setBounds(new Rectangle(16, 191, 116, 17));
jLabel6.setText("Clinical Information:");
specialtyValue.setBounds(new Rectangle(93, 132, 169, 21));
specialtyValue.setText(theConsult.getReferring().getSpecialty());
cancelButton.addActionListener(new java.awt.event.ActionListener() {
 public void actionPerformed(ActionEvent e) {
  cancelButton_actionPerformed(e);
 }
});
cancelButton.setBounds(new Rectangle(308, 127, 92, 25));
cancelButton.setText("Cancel");
cancelButton.setPreferredSize(new Dimension(87, 27));
cancelButton.setMinimumSize(new Dimension(87, 27));
cancelButton.setMaximumSize(new Dimension(87, 27));
routeToButton.addActionListener(new java.awt.event.ActionListener() {
 public void actionPerformed(ActionEvent e) {
  routeToButton_actionPerformed(e);
 }
});
routeToButton.setBounds(new Rectangle(308, 53, 91, 27));
routeToButton.setText("Route To:");
//setIconImage(Toolkit.getDefaultToolkit().createImage(Frame3.class.getResource("[Your Icon]")));
contentPane = (JPanel) this.getContentPane();
contentPane.setLayout(null);
this.setSize(new Dimension(600, 496));
this.setTitle("Select Consultant");


jScrollPane1.setHorizontalScrollBarPolicy(JScrollPane.HORIZONTAL_SCROLLBAR_NEVER);
jScrollPane1.setAutoscrolls(true);
jScrollPane1.setBorder(BorderFactory.createLoweredBevelBorder());
jScrollPane1.setBounds(new Rectangle(131, 214, 438, 228));
informationValue.setBorder(BorderFactory.createRaisedBevelBorder());
informationValue.setText(theConsult.getDescription() + "\n----------\n" + theConsult.getResponses());
informationValue.setLineWrap(true);
informationValue.setWrapStyleWord(true);
jScrollPane2.setBounds(new Rectangle(413, 37, 156, 131));
picButton.setText("View Image");
picButton.setBounds(new Rectangle(17, 243, 100, 31));
picButton.addActionListener(new java.awt.event.ActionListener() {
 public void actionPerformed(ActionEvent e) {
  picButton_actionPerformed(e);
 }
});
manualDocField.setEnabled(false);
manualDocField.setEditable(false);
manualDocField.setBounds(new Rectangle(414, 176, 154, 26));
manualEnterLabel.setEnabled(false);
manualEnterLabel.setText("Enter specialtist name:");
manualEnterLabel.setBounds(new Rectangle(279, 176, 132, 25));
contentPane.add(jLabel1, null);
contentPane.add(routeToButton, null);
contentPane.add(jLabel2, null);
contentPane.add(referringValue, null);
contentPane.add(jLabel3, null);
```

```
    contentPane.add(locationValue, null);
    contentPane.add(jLabel4, null);
    contentPane.add(specialtyValue, null);
    contentPane.add(jLabel6, null);
    contentPane.add(cancelButton, null);
    contentPane.add(jLabel5, null);
    contentPane.add(consultNumberL, null);
    contentPane.add(jScrollPane1, null);
    jScrollPane1.getViewport().add(informationValue, null);
    contentPane.add(jScrollPane2, null);
    contentPane.add(picButton, null);
    contentPane.add(manualDocField, null);
    contentPane.add(manualEnterLabel, null);
    jScrollPane2.getViewport().add(docList, null);

    //docList.setListData(HardcodedInfo.getAllConsultants());
    docList.setListData(HardcodedInfo.getFilteredConsultants(theConsult.getSuggestedSpecialty(),
                                        theConsult.getSuggestedSite()));

    if(docList.getFirstVisibleIndex() == -1) // then the consultant list is empty
    {
      enteringDocManually = true;
      manualEnterLabel.setEnabled(true);
      manualDocField.setEnabled(true);
      manualDocField.setEditable(true);
      manualDocField.requestDefaultFocus();
    }
  }
  /**Overridden so we can exit when window is closed*/
  protected void processWindowEvent(WindowEvent e) {
    super.processWindowEvent(e);
    if (e.getID() == WindowEvent.WINDOW_CLOSING) {
      this.dispose();
    }
  }

  void routeToButton_actionPerformed(ActionEvent e) {
    Doctor theDoc;
    if(!enteringDocManually)
      theDoc = (Doctor)docList.getSelectedValue();
    // change info for doc here to comply with location, specialty stuff
    else
      theDoc = new Doctor(manualDocField.getText(), "");

    DocReplyWindow drw = new DocReplyWindow(theConsult, theDoc);
    drw.show();
    this.dispose();
  }

  void cancelButton_actionPerformed(ActionEvent e) {
    this.dispose();
  }

  void picButton_actionPerformed(ActionEvent e) {
    Vector picVec = new Vector();
    picVec = theConsult.getPicFileNames();
    String theFileName = new String("c:/Tomcat/webapps/ROOT/GGTS/picFiles/" + ((String)picVec.elementAt(0)));

    ImageDrawer id = new ImageDrawer(theFileName, theConsult.getPatient().toString());
  }

}
```

```
// The DocReplyWindow allows the specialist (chosen by someone using the DocChooser window)
// to reply to the referrer, or to add dialog to the consult.  Once a specialist replies,
// the consult is no longer considered "pending".


package site;

import consult.*;
import consult.util.*;
import java.awt.*;
import java.awt.event.*;
import javax.swing.*;
import java.util.*;
import java.net.*;
import java.io.*;


public class DocReplyWindow extends JFrame {

 Consult theConsult;
 Doctor theDoctor;

 JPanel contentPane;
 JTextField specialtyValue = new JTextField();
 JTextField consultantValue = new JTextField();
 JTextField rSpecialtyValue = new JTextField();
 JLabel jLabel7 = new JLabel();
 JLabel jLabel6 = new JLabel();
 JLabel jLabel5 = new JLabel();
 JLabel jLabel4 = new JLabel();
 JLabel jLabel3 = new JLabel();
 JTextField locationValue = new JTextField();
 JLabel jLabel2 = new JLabel();
 JTextField referringValue = new JTextField();
 JLabel jLabel1 = new JLabel();
 JTextField rlocationValue = new JTextField();
 JLabel consultId = new JLabel();
 JButton cancelButton = new JButton();
 JLabel jLabel9 = new JLabel();
 JButton ebButton = new JButton();
 JLabel jLabel8 = new JLabel();
 JButton replyButton = new JButton();
 JScrollPane jScrollPane1 = new JScrollPane();
 JTextArea commentsArea = new JTextArea();
 JScrollPane jScrollPane2 = new JScrollPane();
 JTextArea clinicalInfoArea = new JTextArea();
 JButton picButton = new JButton();

 private final int PORT = 7483;  // port to connect to SiteServer
 private final String serverAddress = "136.142.59.46";  // ip " "


 /**Construct the frame*/
 public DocReplyWindow(Consult c, Doctor d) {
  enableEvents(AWTEvent.WINDOW_EVENT_MASK);
  this.theConsult = c;
  this.theDoctor = d;
  try {
   jbInit();
  }
  catch(Exception e) {
   e.printStackTrace();
  }
 }
 /**Component initialization*/
 private void jbInit() throws Exception  {
  rlocationValue.setBounds(new Rectangle(90, 88, 176, 25));
  rlocationValue.setText(theConsult.getReferringLocation());
  rlocationValue.setFont(new java.awt.Font("SansSerif", 0, 11));
  jLabel1.setBounds(new Rectangle(21, 21, 86, 27));
```

```
jLabel1.setText("Consult #:");
jLabel1.setForeground(Color.red);
jLabel1.setFont(new java.awt.Font("Dialog", 1, 16));
referringValue.setBounds(new Rectangle(90, 53, 176, 25));
referringValue.setText(theConsult.getReferring().toString());
jLabel2.setBounds(new Rectangle(25, 56, 63, 17));
jLabel2.setText("Referring:");
locationValue.setBounds(new Rectangle(382, 86, 185, 25));
locationValue.setFont(new java.awt.Font("SansSerif", 0, 11));
//locationValue.setText(theDoctor.getLocation()); // XXX maybe do this later
locationValue.setText(theConsult.getSuggestedSite());
jLabel3.setText("Location:");
jLabel3.setBounds(new Rectangle(24, 91, 63, 17));
jLabel4.setBounds(new Rectangle(312, 90, 63, 17));
jLabel4.setText("Location:");
jLabel5.setBounds(new Rectangle(24, 124, 63, 17));
jLabel5.setText("Specialty:");
jLabel6.setText("Specialty:");
jLabel6.setBounds(new Rectangle(312, 123, 63, 17));
jLabel7.setText("Consultant:");
jLabel7.setBounds(new Rectangle(313, 55, 69, 17));
rSpecialtyValue.setBounds(new Rectangle(90, 121, 177, 25));
rSpecialtyValue.setText(theConsult.getReferring().getSpecialty());
rSpecialtyValue.setFont(new java.awt.Font("SansSerif", 0, 11));
consultantValue.setBounds(new Rectangle(382, 52, 185, 25));
consultantValue.setText(theDoctor.toString());
specialtyValue.setBounds(new Rectangle(383, 120, 185, 25));
specialtyValue.setText(theDoctor.getSpecialty());
specialtyValue.setFont(new java.awt.Font("SansSerif", 0, 11));
//setIconImage(Toolkit.getDefaultToolkit().createImage(Frame2.class.getResource("[Your Icon]")));
contentPane = (JPanel) this.getContentPane();
contentPane.setLayout(null);
this.setSize(new Dimension(625, 599));
this.setTitle("Consultant Reply");
consultId.setFont(new java.awt.Font("Dialog", 0, 16));
consultId.setForeground(Color.blue);
consultId.setText((new Integer(theConsult.getConsultId())).toString());
consultId.setBounds(new Rectangle(109, 19, 66, 32));
cancelButton.setText("Cancel");
cancelButton.setBounds(new Rectangle(512, 480, 93, 27));
cancelButton.addActionListener(new java.awt.event.ActionListener() {
 public void actionPerformed(ActionEvent e) {
  cancelButton_actionPerformed(e);
 }
});
jLabel9.setFont(new java.awt.Font("Dialog", 0, 16));
jLabel9.setForeground(Color.red);
jLabel9.setText("Comments:");
jLabel9.setBounds(new Rectangle(19, 373, 98, 28));
ebButton.setBounds(new Rectangle(513, 381, 93, 27));
ebButton.addActionListener(new java.awt.event.ActionListener() {
 public void actionPerformed(ActionEvent e) {
  ebButton_actionPerformed(e);
 }
});
ebButton.setText("Back to EB");
jLabel8.setFont(new java.awt.Font("Dialog", 0, 13));
jLabel8.setText("Clinical Information:");
jLabel8.setBounds(new Rectangle(18, 184, 114, 20));
replyButton.setText("Reply");
replyButton.setBounds(new Rectangle(513, 432, 93, 27));
replyButton.addActionListener(new java.awt.event.ActionListener() {
 public void actionPerformed(ActionEvent e) {
  replyButton_actionPerformed(e);
 }
});
jScrollPane1.setBounds(new Rectangle(137, 368, 365, 176));
commentsArea.setLineWrap(true);
jScrollPane2.setBounds(new Rectangle(138, 181, 428, 171));
clinicalInfoArea.setLineWrap(true);
```

```
    clinicalInfoArea.setBorder(BorderFactory.createEtchedBorder());
    clinicalInfoArea.setText(theConsult.getDescription() + "\n----------\n" + theConsult.getResponses());
    clinicalInfoArea.setLineWrap(true);
    clinicalInfoArea.setWrapStyleWord(true);
    commentsArea.setLineWrap(true);
    commentsArea.setWrapStyleWord(true);
    picButton.setText("View Image");
    picButton.setBounds(new Rectangle(23, 230, 99, 29));
    picButton.addActionListener(new java.awt.event.ActionListener() {
     public void actionPerformed(ActionEvent e) {
      picButton_actionPerformed(e);
     }
    });
    contentPane.add(jLabel1, null);
    contentPane.add(consultId, null);
    contentPane.add(jLabel2, null);
    contentPane.add(jLabel3, null);
    contentPane.add(jLabel5, null);
    contentPane.add(rSpecialtyValue, null);
    contentPane.add(rlocationValue, null);
    contentPane.add(referringValue, null);
    contentPane.add(jLabel7, null);
    contentPane.add(consultantValue, null);
    contentPane.add(jLabel4, null);
    contentPane.add(locationValue, null);
    contentPane.add(specialtyValue, null);
    contentPane.add(jLabel6, null);
    contentPane.add(jLabel8, null);
    contentPane.add(jLabel9, null);
    contentPane.add(ebButton, null);
    contentPane.add(replyButton, null);
    contentPane.add(cancelButton, null);
    contentPane.add(jScrollPane1, null);
    contentPane.add(jScrollPane2, null);
    contentPane.add(picButton, null);
    jScrollPane2.getViewport().add(clinicalInfoArea, null);
    jScrollPane1.getViewport().add(commentsArea, null);
   }
   /**Overridden so we can exit when window is closed*/
   protected void processWindowEvent(WindowEvent e) {
    super.processWindowEvent(e);
    if (e.getID() == WindowEvent.WINDOW_CLOSING) {
     this.dispose();
    }
   }

   void cancelButton_actionPerformed(ActionEvent e) {
    this.dispose();
   }

   void ebButton_actionPerformed(ActionEvent e) {
    //for(int i = 0; i < theConsult.getDialog().size(); i++)
    //{
    // System.out.println(theConsult.getDialog().elementAt(i).toString());
    //}
    System.out.println(theConsult.getResponses());

   }

/* old version that only worked when used on server
   void replyButton_actionPerformed(ActionEvent e) {
    theConsult.addToDialog((new Date()) + " " + theDoctor + " (" + theDoctor.getSpecialty() + ") Responds: " +
commentsArea.getText());
    FileManager fm = new FileManager();
    fm.changeConsult(theConsult);

    this.hide();
    JOptionPane.showMessageDialog(this, "Reply has been sent.");

    this.dispose();
```

```
  }
*/

  void replyButton_actionPerformed(ActionEvent e) {
   theDoctor.setSpecialty(specialtyValue.getText());
   theConsult.addToDialog((new Date()) + " [" + theDoctor + " (" + theDoctor.getSpecialty() +
          ") @ " + theConsult.getSuggestedSite() + "]  Responds: " + commentsArea.getText());

   Socket socket;
   ObjectOutputStream oStream;
   ObjectInputStream iStream;

   try
   {
    socket = new Socket(serverAddress, PORT);
    oStream = new ObjectOutputStream(socket.getOutputStream());
    iStream = new ObjectInputStream(socket.getInputStream());

//    if(theConsult.getDialog().size() == 2)
//     theConsult.stopClock();

    theConsult.stopClock();
    theConsult.setPending(false);

    oStream.writeObject(new String("Change Consult"));
          oStream.writeObject(theConsult);

    oStream.close();
    iStream.close();
    socket.close();
   }
   catch(Exception ex) {
    ex.printStackTrace();
   }

   this.hide();
   JOptionPane.showMessageDialog(this, "Reply has been sent.");

   this.dispose();
  }          // end replyButton


  void picButton_actionPerformed(ActionEvent e) {
   Vector picVec = new Vector();
   picVec = theConsult.getPicFileNames();
   String theFileName = new String("c:/Tomcat/webapps/ROOT/GGTS/picFiles/" + ((String)picVec.elementAt(0)));

   ImageDrawer id = new ImageDrawer(theFileName, theConsult.getPatient().toString());
  }

}
```

```
// ImageDrawer is a class written to display images inside of the Site software.
// It is used to display the images located on the server in the "picFiles"
// subdirectory.


package site;

import javax.swing.*;
import java.awt.*;
import java.awt.geom.*;
import java.awt.event.*;
import java.util.*;


public class ImageDrawer extends JFrame
{
	Image currImage;
	ImageIcon currImageIcon;
	PicturePanel drawPanel;

	public ImageDrawer(String filename) {
		super("GGTS");

		currImageIcon = new ImageIcon(filename);
		currImage = currImageIcon.getImage();

		drawPanel = new PicturePanel(500, 500);
	//drawPanel = new PicturePanel(currImage.getHeight(this), currImage.getWidth(this));

		Container c = getContentPane();
		//drawPanel.setBackground(Color.white);
		c.add(drawPanel, BorderLayout.NORTH);

	drawPanel.setSize(currImage.getWidth(this), currImage.getHeight(this));

		//setSize(500, 375);
	setSize((int)(currImage.getWidth(this) + 10), (int)(currImage.getHeight(this) + 25));

		show();
	}

	public ImageDrawer(String filename, String description) {
		super(description);

		currImageIcon = new ImageIcon(filename);
		currImage = currImageIcon.getImage();

		drawPanel = new PicturePanel(500, 500);
	//drawPanel = new PicturePanel(currImage.getHeight(this), currImage.getWidth(this));

		Container c = getContentPane();
		//drawPanel.setBackground(Color.white);
		c.add(drawPanel, BorderLayout.NORTH);

	drawPanel.setSize(currImage.getWidth(this), currImage.getHeight(this));

		//setSize(500, 375);
	setSize((int)(currImage.getWidth(this) + 10), (int)(currImage.getHeight(this) + 25));

		show();
	}


	private class PicturePanel extends JPanel
	{
		private int prefwid, prefht;

		public PicturePanel(int pwid, int pht)
		{
			prefwid = pwid;
```

```
                    prefht = pht;
                    setOpaque(false);
                }

                public Dimension getPreferredSize()
        {
          return new Dimension(prefwid, prefht);
        }

        public void paintComponent(Graphics g)
        {
          super.paintComponent(g);
          Graphics2D g2d = (Graphics2D)g;

          g2d.drawImage(currImage, 0, 0, this);

        }

         }

         public static void main(String [] args)
         {
                ImageDrawer a = new ImageDrawer("c:/pic.gif", "A Cat");
                a.addWindowListener(
                        new WindowAdapter()
                        {
                 public void windowClosing(WindowEvent e)
            {
             System.exit(0);
            }
                        }
        );
         }

}
```

```
// This is the hardcoded information, such as the list of specialties, sites, etc.,
// that is used by various other classes.

package misc;

import java.util.Vector;
import consult.*;

public class HardcodedInfo
{
 public static Vector getAllSpecialties()
 {
  Vector returnVector = new Vector();

returnVector.addElement("ADULT-MEDICINE");
returnVector.addElement("ADULT-NEUROLOGY");
returnVector.addElement("ADULT-UROLOGY");
returnVector.addElement("ALLERGY");
returnVector.addElement("ANESTHESIOLOGY");
returnVector.addElement("AUDIOLOGIST");
returnVector.addElement("AUDIOLOGY");
returnVector.addElement("CARDIOLOGIST");
returnVector.addElement("CARDIOLOGY");
returnVector.addElement("CARDIOTHORACIC");
returnVector.addElement("CHILD-NEUROLOGY");
returnVector.addElement("CLINICAL-PATHOLOGY");
returnVector.addElement("COLORECTAL-SURGEON");
returnVector.addElement("COMMUNITY-HEALTH-NURSE");
returnVector.addElement("CRITICAL-CARE");
returnVector.addElement("DENTISTRY");
returnVector.addElement("DERMATOLOGY");
returnVector.addElement("DIAGNOSTIC-RADIOLOGY");
returnVector.addElement("EMERGENCY-MEDICAL");
returnVector.addElement("ENDOCRINE/PEDIATRICS");
returnVector.addElement("ENDOCRINOLOGY");
returnVector.addElement("ETHICS");
returnVector.addElement("FAMILY-PRACTICE");
returnVector.addElement("GASTROENTEROLOGY");
returnVector.addElement("GASTROENTEROLOGY/PEDIATRICS");
returnVector.addElement("GENERAL-INTERNIST");
returnVector.addElement("GENERAL-SURGEON");
returnVector.addElement("GENETICIST");
returnVector.addElement("GERIATRICS");
returnVector.addElement("GULF-WAR");
returnVector.addElement("GYN-ONCOLOGY");
returnVector.addElement("HAND-SURGEON");
returnVector.addElement("HEALTH-PHYSICS");
returnVector.addElement("HEMATOLOGY");
returnVector.addElement("HEMATOLOGY/ONCOLOGY");
returnVector.addElement("IMMUNOLOGY");
returnVector.addElement("INFECTIOUS-DISEASE");
returnVector.addElement("INFECTIOUS-DISEASES");
returnVector.addElement("INFORMATION-MANAGEMENT");
returnVector.addElement("INTERNAL-MEDICINE");
returnVector.addElement("NEPHROLOGIST");
returnVector.addElement("NEPHROLOGY");
returnVector.addElement("NEUROLOGY");
returnVector.addElement("NEUROLOGY-ADULT");
returnVector.addElement("NEUROLOGY-CHILD");
returnVector.addElement("NEUROPSYCHOLOGY");
returnVector.addElement("NEUROSURGEON");
returnVector.addElement("NEUROSURGERY");
returnVector.addElement("NUCLEAR-MEDICINE");
returnVector.addElement("NURSING");
returnVector.addElement("NUTRITION");
returnVector.addElement("NUTRITION-CARE");
returnVector.addElement("OB/GYN");
returnVector.addElement("OCCUPATIONAL-HEALTH");
returnVector.addElement("OCCUPATIONAL-THERAPY");
returnVector.addElement("ONCOLOGIST");
```

```
returnVector.addElement("ONCOLOGY");
returnVector.addElement("OPHTHALMOLOGY");
returnVector.addElement("OPTOMETRY");
returnVector.addElement("ORGAN-TRANSPLANT");
returnVector.addElement("ORTHOPAEDICS");
returnVector.addElement("ORTHOPAEDIC-SURGEON");
returnVector.addElement("OTOLARYNGOLOGY/ENT");
returnVector.addElement("PAIN-MANAGEMENT");
returnVector.addElement("PATHOLOGY");
returnVector.addElement("PATHOLOGY/ANATOMIC");
returnVector.addElement("PATHOLOGY-ANATOMIC");
returnVector.addElement("PEDIATRIC-AUDIOLOGY");
returnVector.addElement("PEDIATRIC-ENDOCRINOLOGIST");
returnVector.addElement("PEDIATRIC-ENDOCRINOLOGY");
returnVector.addElement("PEDIATRIC-GASTROENTEROLOGIST");
returnVector.addElement("PEDIATRIC-GASTROENTEROLOGY");
returnVector.addElement("PEDIATRICIAN");
returnVector.addElement("PEDIATRIC-NEPHROLOGY");
returnVector.addElement("PEDIATRIC-NEUROLOGY");
returnVector.addElement("PEDIATRICS");
returnVector.addElement("PERINATOLOGY");
returnVector.addElement("PHARMACY");
returnVector.addElement("PHYSICAL-MED-REHABS");
returnVector.addElement("PHYSICAL-THERAPY");
returnVector.addElement("PM&R");
returnVector.addElement("PODIATRY");
returnVector.addElement("PREVENTIVE-MEDICINE");
returnVector.addElement("PRIMARY-CARE");
returnVector.addElement("PSYCHIATRY");
returnVector.addElement("PSYCHIATRY-ADULT");
returnVector.addElement("PSYCHIATRY-CHILD");
returnVector.addElement("PSYCHOLOGY");
returnVector.addElement("PSYCHOLOGY-CHILD");
returnVector.addElement("PULMONARY");
returnVector.addElement("PULMONARY-MEDICINE");
returnVector.addElement("RADIATION-ONCOLOGY");
returnVector.addElement("RADIOLOGIST");
returnVector.addElement("RADIOLOGY");
returnVector.addElement("RECONSTRUCTIVE-SURGEON");
returnVector.addElement("RECONSTRUCTIVE-SURGERY");
returnVector.addElement("REFERRAL-SERVICE");
returnVector.addElement("RENAL-TRANSPLANT-LICSW");
returnVector.addElement("RHEUMATOLOGY");
returnVector.addElement("SPEECH-PATHOLOGY");
returnVector.addElement("TELEMEDICINE");
returnVector.addElement("UROLOGY");
returnVector.addElement("UROLOGY-ADULT");
returnVector.addElement("VASCULAR-SURGERY");

  return returnVector;
 } // end getAllSpecialties()


 public static Vector getAllSites()
 {
  Vector returnVector = new Vector();
  returnVector.addElement("Eisenhower_Army_Medical_Center");
  returnVector.addElement("Landstuhl_Regional_Medical_Center");
  returnVector.addElement("National_Naval_Medical_Center");
  returnVector.addElement("Walter_Reed_Army_Medical_Center");

  return returnVector;
 }


 public static Vector getAllConsultants()
 {
  Vector returnVector = new Vector();
returnVector.addElement(new Doctor("kevin m o'neil","PULMONARY"));
returnVector.addElement(new Doctor("andrew j reynolds","PULMONARY"));
```

```
returnVector.addElement(new Doctor("kevin d deweber","FAMILY PRACTICE"));
returnVector.addElement(new Doctor("salvatore a manno","NEPHROLOGY"));
returnVector.addElement(new Doctor("sophia l yohe","NEPHROLOGY"));
returnVector.addElement(new Doctor("alicia y armstrong","OB/GYN"));
returnVector.addElement(new Doctor("andrew d montemarano","DERMATOLOGY"));
returnVector.addElement(new Doctor("ann n kim","PM&R"));
returnVector.addElement(new Doctor("arn h eliasson","PULMONARY MEDICINE"));
returnVector.addElement(new Doctor("arthur w loesevitz","ALLERGY"));
returnVector.addElement(new Doctor("burkhardt h zorn","UROLOGY"));
returnVector.addElement(new Doctor("christina m yuan","NEPHROLOGY"));
returnVector.addElement(new Doctor("clifton a hawkes","INFECTIOUS DISEASE"));
returnVector.addElement(new Doctor("cydney l fenton","PEDIATRIC ENDOCRINOLOGY"));
returnVector.addElement(new Doctor("dale k block","GASTROENTEROLOGY"));
returnVector.addElement(new Doctor("erin m bohen","NEPHROLOGY"));
returnVector.addElement(new Doctor("george w turiansky","DERMATOLOGY"));
returnVector.addElement(new Doctor("glenn w wortmann","INFECTIOUS DISEASES"));
returnVector.addElement(new Doctor("henry b burch","ENDOCRINOLOGY"));
returnVector.addElement(new Doctor("james m ecklund","NEUROSURGERY"));
returnVector.addElement(new Doctor("jeffrey l jackson","INTERNAL MEDICINE"));
returnVector.addElement(new Doctor("kevin a ceckowski","RENAL TRANSPLANT LICSW"));
returnVector.addElement(new Doctor("kevin c abbott","NEPHROLOGY"));
returnVector.addElement(new Doctor("kurt l maggio","DERMATOLOGY"));
returnVector.addElement(new Doctor("laurie j smith","ALLERGY"));
returnVector.addElement(new Doctor("marc p difazio","PEDIATRIC NEUROLOGY"));
returnVector.addElement(new Doctor("margretta m diemer","INTERNAL MEDICINE"));
returnVector.addElement(new Doctor("maria h sjogren","GASTROENTEROLOGY"));
returnVector.addElement(new Doctor("mark d menich","ALLERGY"));
returnVector.addElement(new Doctor("mary k mather","DERMATOLOGY"));
returnVector.addElement(new Doctor("merrily y poth","ENDOCRINE/PEDIATRICS"));
returnVector.addElement(new Doctor("michael h mitchell","NEUROLOGY"));
returnVector.addElement(new Doctor("milton t smith","GASTROENTEROLOGY"));
returnVector.addElement(new Doctor("nagla a wahab","PHARMACY"));
returnVector.addElement(new Doctor("nancy l grass","INTERNAL MEDICINE"));
returnVector.addElement(new Doctor("oleh w hnatiuk","PULMONARY"));
returnVector.addElement(new Doctor("pankaj j malik","CARDIOLOGY"));
returnVector.addElement(new Doctor("rita l svec","PEDIATRIC ENDOCRINOLOGY"));
returnVector.addElement(new Doctor("robert a vigersky","ENDOCRINOLOGY"));
returnVector.addElement(new Doctor("robert e jeschke","CARDIOLOGY"));
returnVector.addElement(new Doctor("robert j christie","HEMATOLOGY/ONCOLOGY"));
returnVector.addElement(new Doctor("robert j labutta","NEUROLOGY"));
returnVector.addElement(new Doctor("robert l ramsey","INTERNAL MEDICINE"));
returnVector.addElement(new Doctor("ruben j alvero","OB/GYN"));
returnVector.addElement(new Doctor("sandra e smith","NUTRITION CARE"));
returnVector.addElement(new Doctor("sean d o'donnell","VASCULAR SURGERY"));
returnVector.addElement(new Doctor("stephen j krivda","DERMATOLOGY"));
returnVector.addElement(new Doctor("steven e braverman","PM&R"));
returnVector.addElement(new Doctor("steven r shannon","PM&R"));
returnVector.addElement(new Doctor("stuart a roop","PULMONARY"));
returnVector.addElement(new Doctor("thomas m wiley","CARDIOLOGY"));
returnVector.addElement(new Doctor("thomas r furlow","NEUROSURGERY"));
returnVector.addElement(new Doctor("victor j bernet","ENDOCRINOLOGY"));
returnVector.addElement(new Doctor("william e duncan","ENDOCRINOLOGY"));
returnVector.addElement(new Doctor("william f kelly","PULMONARY MEDICINE"));
returnVector.addElement(new Doctor("w s frank","ALLERGY"));
returnVector.addElement(new Doctor("donna m macneil","PEDIATRIC AUDIOLOGY"));
returnVector.addElement(new Doctor("lynne i yao","PEDIATRIC NEPHROLOGY"));
returnVector.addElement(new Doctor("karin a cox","PULMONARY"));
returnVector.addElement(new Doctor("david g mcleod","UROLOGY"));
returnVector.addElement(new Doctor("thomas g oliver","ENDOCRINOLOGY"));
// additions
returnVector.addElement(new Doctor("robert j oglesby","RHEUMATOLOGY"));
returnVector.addElement(new Doctor("charles engel","PSYCHIATRY"));
returnVector.addElement(new Doctor("sandra yerkes","PSYCHIATRY"));

  return returnVector;
 } // end getAllConsultants()


 public static Vector getFilteredConsultants(String specialty, String site)
 {
```

```
    // XXX shortcut for now, only returns consultants to WRAMC
    site = (site.replace('_', ' ')).trim();
    if(!site.equalsIgnoreCase("Walter Reed Army Medical Center"))
      return new Vector();
    ////////////////////////////////////////////////////////

        Vector tempVector = getAllConsultants();
        if(specialty != null)
        {
                Vector returnVector = new Vector();
                for(int i = 0; i < tempVector.size(); i++)
                {
                        Doctor currDoc = (Doctor)tempVector.elementAt(i);
                        //if((currDoc.getSpecialty()).equalsIgnoreCase(specialty))
            if(stringsMatch(currDoc.getSpecialty(), specialty))
             returnVector.add(currDoc);
                }
                return returnVector;
        }
        else return tempVector;
}


public static boolean stringsMatch(String leftString, String rightString)
{
 int [] leftIndexes = new int[10];
 int [] rightIndexes = new int[10];

 String [] leftWords = new String[10];
 String [] rightWords = new String[10];

 leftIndexes[0] = -1;
 rightIndexes[0] = -1;

 boolean done = false;
 int numHyphensLeft = 0;
 int i = 0;
 int j = -1;
 while(!done)
 {
  j = leftString.indexOf("-", i+1);
  if(j != -1)
  {
   numHyphensLeft++;
   leftIndexes[numHyphensLeft] = j;
   i = j;
  }
  else done = true;
 }
 leftIndexes[numHyphensLeft+1] = leftString.length();

 done = false;
 int numHyphensRight = 0;
 i = 0;
 j = -1;
 while(!done)
 {
  j = rightString.indexOf("-", i+1);
  if(j != -1)
  {
   numHyphensRight++;
   rightIndexes[numHyphensRight] = j;
   i = j;
  }
  else done = true;
 }
 rightIndexes[numHyphensRight+1] = rightString.length();

 for(int x = 0; x <= numHyphensLeft; x++)
  leftWords[x] = leftString.substring(leftIndexes[x] + 1, leftIndexes[x+1]);
```

```
  for(int x = 0; x <= numHyphensRight; x++)
   rightWords[x] = rightString.substring(rightIndexes[x] + 1, rightIndexes[x+1]);

  for(int x = 0; x <= numHyphensLeft; x++)
   for(int y = 0; y <= numHyphensRight; y++)
   {
    if(leftWords[x].equalsIgnoreCase(rightWords[y]))
     return true;
   }


  if(leftString.equalsIgnoreCase(rightString))
   return true;
  if(((leftString.replace('-', ' ')).trim()).equalsIgnoreCase((rightString.replace('-', ' ')).trim()))
   return true;
  return false;
 }

 // for testing purposes only
 public static void main(String[] args)
 {
  HardcodedInfo h = new HardcodedInfo();
  System.out.println(h.stringsMatch("HeLlo", "yo-Me-HELLO"));
  System.out.println(h.stringsMatch("yo-you", "yoo"));

 }


} // end HardcodedInfo class
```

```
// This is the database of "referrers," or users of the systems
// This class stores each referrer as a doctor in the database.
// It holds each referrer's username, but not password.

package misc;

import consult.*;
import java.util.*;

public class ReferrerDatabase
{
 private Hashtable referrers;

 public ReferrerDatabase()
 {
  referrers = new Hashtable();
  initDatabase();
 }

 public void addReferrer(String username, Doctor ref)
 {
  referrers.put(username, ref);
 }

 public Doctor getReferrer(String username)
 {
  if(username != null)
   return (Doctor)referrers.get(username);
  else return null;
 }

 private void initDatabase()
 {
  Doctor bill = new Doctor("William", "G.", "Jacobs", 303, "Family Medicine", "WRAMC");
  Doctor jerry = new Doctor("Jerrold", "H.", "May", 214, "Cardiovascular", "Pittsburgh");
  Doctor luis = new Doctor("Luis", "G.", "Vargas", 314, "Primary Care", "Landstuhl");
  Doctor gary = new Doctor("Gary", "", "Gilbert", 100, "Pediatric Audiology", "Maryland");
  addReferrer("Bill", bill);
  addReferrer("Jerry", jerry);
  addReferrer("Luis", luis);
  addReferrer("Gary", gary);
 }
}
```

```
// This class is used to verify the username, password information when
// a referrer attempts to login into the system.

package misc;

import java.util.*;

public class Verifier
{
 Hashtable users;

 public Verifier()
 {
  users = new Hashtable();
  addUser("Bill", "Jacobs");
  addUser("Jerry", "May");
  addUser("Luis", "Vargas");
  addUser("Gary", "Gilbert");
 }

 public void addUser(String username, String password)
 {
  users.put(username, password);
 }

 public boolean isLoginValid(String username, String password)
 {
  String realPass = (String)users.get(username);
  if(password.equals(realPass))
   return true;
  else return false;
 }
}
```

```
// This class uses the jlinker interface in order to allow the interaction
// between Java and Lisp.  The callLisp method allows any Java program to
// utilize any LISP method contained in the "Lisp Cbr" directory.  Lisp must
// be running on a specified port (3360) in order for the interaction to take place.

package lisp;

import com.franz.jlinker.JavaLinkDist;
import com.franz.jlinker.LispConnector;
import com.franz.jlinker.TranStruct;

// This class communicates (on localhost) between Java and LISP
// allows the user to call LISP functions

public class LispBridge
{
        private int port;
        String[] cerr;
        private final int TYPE = 2;        // jlinker - type of call

        public LispBridge(int portnum)
        {
                port = portnum;
                cerr = new String[1];

                LispConnector.lispPort = port;
                LispConnector.debug = false;

        }

    public String callLisp(String functionName, String[] arguments)
        {
                if(LispConnector.go(false, cerr))
                {
                        TranStruct opToLisp;
                        TranStruct[] argsToLisp = new TranStruct[arguments.length];
                        opToLisp = JavaLinkDist.newDistOb(functionName);
                        for(int i = 0; i < arguments.length; i++)
                        {
                                argsToLisp[i] = JavaLinkDist.newDistOb(arguments[i]);
                        }
            TranStruct[] returnValues;
            try {
             returnValues = new TranStruct[2];  // possibly fixes the nullPointerException
                         returnValues = JavaLinkDist.invokeInLisp(TYPE, opToLisp, argsToLisp);
            }
            catch(NullPointerException e)
            {
             System.out.println("LispComm Null pointer exception");
             return new String(":Error");
            }
                        // Lisp passes back an array of return values
                        // The first item is usually an int indicating the number of return values
                        // Here the function is expected to return only one value so index 1 is chosen
            String returnString = new String();
            try {
             returnString = JavaLinkDist.stringValue(returnValues[1]);
            }
            catch(Exception e) {
             System.out.println("WHOA! " + returnValues[0]);
            }

                        return returnString;
                }
                else // if connection fails
                {
                        //report in cerr
                        System.out.println( "Connect failed: " + cerr[0] );
                        return new String("");
                }
```

```
        }

        public void disconnect()
        {
                //System.out.println( "Disconnecting..." );
                JavaLinkDist.disconnect();
        }
}
```

```
// This class emulates the LISP case-based reasoner by providing the same methods
// as the actual CBR.  It passes arguments to LISP through the jlinker interface
// and passes the return values back to the Java application


package lisp;

import java.util.Vector;
import com.franz.jlinker.JavaLinkDist;
import com.franz.jlinker.LispConnector;
import com.franz.jlinker.TranStruct;


public class LispCbr
{
 private final int javaLispPort = 3360;

 public LispCbr()
 {}

 // this returns a vector of the strings returned from LISP
 private Vector parseString(String theString)
 {
  theString = theString.replace('_', ' ');
  Vector stringVector = new Vector();

  // seperate words by ':' and place each one into a vector
  int stringBreak = 1;
  for(int i = 1; i < theString.length(); i++)
  {
   if(theString.charAt(i) == ':')
   {
    stringVector.addElement(theString.substring(stringBreak, i));
    stringBreak = i + 1;
   }
   if(i == (theString.length() - 1)) // add the last item into the vector
   {
    stringVector.addElement(theString.substring(stringBreak, i+1));
   }
  }
  return stringVector;
 }

 /*
 public Vector getAllSpecialties()
 {}

 public Vector getAllSites()
 {}

 public Vector getAllDocs()
 {}
 */

 public Vector sortSpecialties(String descrip)
 {
  LispBridge lb = new LispBridge(javaLispPort);
  String[] argsToPass = new String[1];
  argsToPass[0] = descrip;
  String returnString = lb.callLisp("find-specialties", argsToPass);
  lb.disconnect();

  Vector returnVector = new Vector();
  returnVector = parseString(returnString);

  // take the scores out of the Vector (optional)
  for(int i = 0; i < returnVector.size(); i++)
  {
   String tempSpec = (String)returnVector.elementAt(i);
   tempSpec = tempSpec.toUpperCase();
```

```
    tempSpec = tempSpec.substring(0,tempSpec.indexOf(' '));
    returnVector.setElementAt(tempSpec, i);
   }

   return returnVector;
  }

  public Vector sortSites(String location)
  {
   LispBridge lb = new LispBridge(javaLispPort);
   String[] argsToPass = new String[1];
   argsToPass[0] = location;
   String returnString = lb.callLisp("quick-find", argsToPass);
   lb.disconnect();

   Vector returnVector = new Vector();
   returnVector = parseString(returnString);

   return returnVector;
  }

  public Vector sortDocs(String descrip, String site, String specialty)
  {
   String bigString = new String(":" + site + ":" + specialty + ":" + descrip);
   bigString.replace(' ', '_');

   LispBridge lb = new LispBridge(javaLispPort);
   String[] argsToPass = new String[1];
   argsToPass[0] = bigString;
   String returnString = lb.callLisp("find-docs", argsToPass);
   lb.disconnect();

   Vector returnVector = new Vector();
   returnVector = parseString(returnString);

   return returnVector;
  }

 } // end LispCbr
 (defun find-specialties (description)
  (declare (ignore-if-unused dialog widget))
  (let* ((all-specialties (mapcar #'(lambda (x) (string (car x))) *specialties*))
       (text-string description)
       (text-list (string-to-word-list text-string))
       (temp-scores (simple-classify text-list *specialty-words*))
       (spec-score-list (rearrange-according-to-keywords temp-scores text-list))
       (suggested-specialties (format-scores spec-score-list 10)) ; take top 10
       (specialties-only (format-just-specialties spec-score-list 10))
       )
   (setq scores spec-score-list)
   ;;(eval `(setf (range suggested-specialties-value) (quote ,suggested-specialties)))
   ;;(eval `(setf (range specialties-list-value) (quote ,all-specialties))

   ;suggested-specialties
   ;convert into a simple string for Java

   (setq return-string "")
   (dolist (item suggested-specialties)
           (setf return-string (concatenate 'string return-string ":" (string-capitalize item)))
   )
   return-string
  )
 )
```

```
(defun find-sites (consult-location)

 (setf suggested-specialties-list 'SUGG-SPECS-WIDGET)  ;;;(find-widget :suggested-specialties-value dialog))
 (setf available-specialties 'AVAILABLE-SPECS-WIDGET)  ;;;(find-widget :specialties-list-value dialog))
 (setf referring-location 'REFERRING-LOCATION-WIDGET)  ;;;(find-widget :referring-location-value dialog))
 (let* ((consult-number "33")          ;;;(value (find-widget :consult-number-value dialog)))
      (suggested-specialty 'SELECTED-SUGG-SPEC)  ;;;(value suggested-specialties-list))
      (selected-specialty 'SELECTED-ALL-SPEC)    ;;;(value available-specialties))
      (specialty "FINAL-SPECIALTY-ANSWER")       ;;;(cond ((and (null selected-specialty)
      (consult-location consult-location)    ;;;(value referring-location))
      )


  ;;;(setf (referring-location (eval (string-to-symbol consult-number))) consult-location) ;;;?????


(format t "AAA")

  (if (equal (string-trim '(#\Space) consult-location) "")
    nil
   (if (null specialty)
     nil
    (let* ((sites-w-specialties     ;;; IF INITIAL LOCATION AND CHOSEN SPECIALTY ARE SPECIFIED
          (list-to-string
           (delete-duplicates
            (remove nil
                 (mapcar #'(lambda (x)
                         (let ((site-specialties
                              (string-to-symbol
                               (subseq (list-to-string (specialties (eval (car x))))
                                     (find-the-first-blank (list-to-string (specialties (eval (car x))))))))))
                           (if (mapcar #'(lambda (y) (same-specialty (string-to-symbol specialty) y)) site-specialties)
                             (list-to-string x))))
                  *consultant-sites*)
                 :test #'equal)
           :test #'equal)))
         (default-site
           (cond ((member consult-location (mapcar #'(lambda (x) (city (eval (car x)))) *NARMC*) :test #'equal)
                 (list "Walter_Reed_Army_Medical_Center"))
                ((member consult-location (mapcar #'(lambda (x) (city (eval (car x)))) *SEMHS*) :test #'equal)
                 (list "Eisenhower_Army_Medical_Center"))
                ((member consult-location (mapcar #'(lambda (x) (city (eval (car x)))) *LRMC*) :test #'equal)
                 (list "Landstuhl_Regional_Medical_Center"))
                (t
                 nil)))
         )

(format t "BBB")

      ;;(setf sites-w-specialties-value (find-widget :sites-w-specialties-value dialog))
      ;;(eval `(setf (range sites-w-specialties-value) (quote ,default-site)))

          ;sites-w-specialties
          ;default-site

          ;;; convert list into a simple string for Java
          (setq return-string "")
          (dolist (item default-site)
                  (setf return-string (concatenate 'string return-string ":" item))
          )



          return-string


          ))))

)
```

```
(defun quick-find(consult-location)
        (setq default-site
          (cond ((member consult-location (mapcar #'(lambda (x) (city (eval (car x)))) *NARMC*) :test #'equal)
           (list "Walter_Reed_Army_Medical_Center"))
         ((member consult-location (mapcar #'(lambda (x) (city (eval (car x)))) *SEMHS*) :test #'equal)
          (list "Eisenhower_Army_Medical_Center"))
         ((member consult-location (mapcar #'(lambda (x) (city (eval (car x)))) *LRMC*) :test #'equal)
          (list "Landstuhl_Regional_Medical_Center"))
              (t
               nil)
    )
        )

        (setq return-string "")
        (dolist (item default-site)
                (setf return-string (concatenate 'string return-string ":" item))
        )

        return-string
)
```

```
(defun find-docs (big-string)
  (let* ((arg-list (put-colon-string-into-list big-string))
             (site-name (nth 0 arg-list))
             (chosen-specialty (nth 1 arg-list))
             (description (nth 2 arg-list))
             (text (string-to-word-list description))
             (doc-list (list-of-consultants (eval (string-to-symbol site-name))))
       (scores (classify-from-list-of-docs text doc-list))
       (site-doc-list (format-list-to-range-2 scores))
            )

           (setf available-specialist-list
             (remove nil
                       (mapcar #'(lambda (x)
                    (let* ((doctor-specialty (specialty (eval (string-to-symbol (subseq x 0 (find-the-first-blank x))))))
                             (specialty-from-list (is-a-specialty doctor-specialty))
             (doctor-specialty-from-list-of-specialties
                       (if (null specialty-from-list) "" (string doctor-specialty))))
                            (if (same-specialty  (string-to-symbol doctor-specialty-from-list-of-specialties)
                          (string-to-symbol chosen-specialty)) x))
           )
                       site-doc-list)
           :test #'equal)
           )

    available-specialist-list

    (setf return-string "")
    (dolist (doc available-specialist-list)
           (setf return-string (concatenate 'string return-string ":" doc))
    )

    (format t "~A" return-string)

    return-string
  )
)
```

;;; (Consult_no referring location specialty clinical_information Consultant_name location specialty reply (these fields repeat for each consultant)

(setf *consults*
'(
("001" "Yohe, SOPHIA L" "Landstuhl" "" "I want to run a case past you to see if you think any further work up needs to be done. This is a 26 y/o AD BM who had proteinuria 3/98. He denied any use of NSAIDs and his only medications were INH (w/ B12) for PPD conversion. At that timeUpr was 996 mg/24hr, UCr 2361 mg/24hr & Cr 1.8 for ClCr 91. Renal US wasnormal except for Rt kidney 9.9cm and lt 11.9 cm, repeat US showed only 1cmdifference in size between the two. He did not have renal biopsy andpresumptive cause was hypertension (BPs were mildly elevated in the 130s) He was started on an ACE inhibitor to control BP to goal 115-125/70s and forproteinuria. Of note he had UA negative for protein 12/96, but UA w/ 3+protien and Cr 1.9 12/97.My question is does he need further w/u (ie renal biopsy) or is this borderline to stage I HTN the most likely cause for his proteinuria?"
"ABBOTT, KEVIN C" "WRAMC" "Nephrology" "That is a tough one given his non-nephrotic range proteinuria. However, his serum creatinine of 1.9 most likely represents abnormally low renal function(CrCl should be >110 cc/min/1.73 m2 BSA). Whether or not we would treat him if he had a glomerular disease would depend on the nature of disease--if he had lupus, we probably would. Not all patients with lupus nephritis have a positive ANA. So in general I think a renal biopsy would be a consideration in this case, although he could have hypertensive nephrosclerosis (although I would more suspicous for a glomerular disease given his almost 1 gm of proteinuria prior to ACE). We would be happy to see him here if you would like to send him. Repeat tests here: Upr 480 mg/24hr, UCr 2565 mg/h4hr, Cr 1.9, CrCl 93UA negative BPs not any different from time of diagnosis 144/84, 132/88, 134/77I plan to bump up his ACEI (benazepril) for elevations beyond goal BP. My question is does he need further w/u (ie renal biopsy) or is this borderline to stage I HTN the most likely cause for his proteinuria? That is a tough one given his non-nephrotic range proteinuria. However, hisserum creatinine of 1.9 most likely represents abnormally low renal function(CrCl should be >110 cc/min/1.73 m2 BSA). Whether or not we would treat himif he had a glomerular disease would depend on the nature of disease--if hehad lupus, we probably would. Not all patients with lupus nephritis have apostiive ANA. So in general I think a renal biopsy would be a considerationin this case, although he could have hypertensive nephrosclerosis although Iwould more more suspicous for a glomerular disease given his almost 1 gm of proteinuria prior to ACE. We would be happy to see him here if you would like to send him.")
("002" "GOWDA, PADMA" "" "Geriatrics" "58 yr old female with s/p masrectomy for breast ca on tomoxifen for 5 yrs. also has severe asthma, on sx steroids from time to time . d/c tomoxifen recently. bone density studied showed osteopenia and increased risk of frcture has o.8 in comparion of t score 2.0 age matched. pt has dub for which takes depo q 3 months. on calcium 1nd exercises. question is what other modality for osteoporosis rx. thanks." "BERNET, VICTOR J" "WRAMC" "Endocrinology" " Run the BMD results by us again T score (young nls) Z score (age matched)" "DUNCAN, WILLIAM E" "WRAMC" "Endocrinology" "we cannot recommend specific therapy without evaluating the patient - we would be glad to answer questions about specific therapies. Would recommend referring her to us for evaluation." "CHRISTIE, ROBERT J" "WRAMC" "Hematology/Oncology" "The role of raloxifene in this setting is being explored. There are no data on the relative benefits/risks of raloxifene in women who have completed 5 years of Tam. I would defer to Endo as far as alternative therapies--certainly she may be a candidate for alendronate.")
("003" "RAMSEY, ROBERT L" "WRAMC" "Internal Medicine" "A 59 yo female smoker has persistent back pain, especially in LCVA area, and persistent microhematuria. Should I get an imaging study of her kidneys before sending her to you, and, if so, what study?" "ZORN, BURKHARDT H" "WRAMC" "Urology" "Would get a IVP and have her scheduled for a cystoscopy. We will obtain a cytology at that time.")
("004" "FRIAR, DAVID A" "Landstuhl" "" "65y male evaluated at WRAMC 2 weeks ago, has severe CHF (ef <15%), has ascities, has CRI (worsening) presumably due to renal artery stenosis (had renal artery PTCA x2). Control of CHF leads to Uremic syndrome. Control of uremic syndrome leads to CHF. Told needs dialysis.... returned to Germany to discuss with family. Can't afford dialysis on economy here - wants to know if can come to WRAMC and be started on peritoneal dialysis then return here for f/u with local nephrologist while obtaining dialysis solution from our MEDDAC??? Is this medically reasonable? Can a general surgeon place the peritoneal catheter here? How much does the dialysate cost? Will this bankrupt our already bankrupt MEDDAC to supply this fluid to him? (He is aware that he cannot be follow by us internist for dialysis issues or complications)."
"BOHEN, ERIN M" "WRAMC" "Nephrology" "" "ABBOTT, KEVIN C" "WRAMC" "Nephrology" "When we saw Mr. S here his CrCl was 23 cc/min. Developing ESRD is something patients retiring in Germany do not plan for. His wife still works in the German community and was unwilling to move. He would not even call her about his health problems while he was here! He said he wanted to discuss it with her in person. Mr. S would need to move to the U.S. permanently for his dialysis care--I am sure it would not be paid for from the LRMC or WRAMC budget, since Medicare is the payer in the U.S. As a diabetic he would need initiation at 15 cc/min. We estimate this will be in 2-3 months, but could happen sooner. PD catheters should generally be placed no more than 2 weeks ahead of their anticipated need. Therefore, Mr. S needs to decide if he will move to the U.S. permanently if he wishes to receive ESRD care--that is all we can do. He saw our renal social worker, Mr. Ci, before he left for Germany and was counseled on these issues. I will also foward this message through Mr. Ci and Dr. T, who was the fellow on service when Mr. S was admitted here. Thanks and let us know if there is anything else we can do."
"CECKOWSKI, KEVIN A" "WRAMC" "Renal Transplant LICSW" "This patient was counseled about signing up for Medicare while the season is open, through 31 March 2000. We were able to get Medicare on the phone and he will be fined a penalty because he has not paid into the system for 11 years. His premiums will be higher, probably pay 63.00 per month instead of the usual $43.00 per month for Medicare B premium, which pays for his dialysis in the civilian sector. He is having Medicare office mail his home in Germany the forms. He is really in a tight spot for his wife is a German national and has a very good job in Germany. She also speaks very little English. They were married while he was retired and in Germany, so she really does not wish to be relocated back in the States. This could change. Medicare will NOT pay in Germany. He does not have any other insurance. He uses the German Health Care system. PD is approx. $2, 000.00 per month here in the states. HemoDialysis is approx. $4, 000.00 per month. Of that, Medicare covers 80% of the cost, 20% is covered by the Patient or his/her Supplemental Insurance. Pt was advised about all the above. He stated that he would think about what he is going to do. He has very little support here in the States, and I do not see him living by himself without his wife, but that may be what he has to do." "CECKOWSKI, KEVIN A" "WRAMC" "Renal Transplant LICSW" "I thought he was older than 65, must be confusing him with someone else. Sorry for the confusion on his age/Medicare penalty. If he is 65 than he needs to begin paying for his Medicare Premium NOW. I believe I have the wife info correct. Private pay in Germany or moving back to CONUS are his two options.")

("005" "YAVOREK, TRUDY A" "West Point" "Cadet Health Clinic" "DR McLeod, Can the female cadet who I e-mailed you about that is growing Bets Strep Gp B in her urine come see you this Monday 6 March???? She has a h/o recurrent UTI but noe C/o back pain. Also she has a h/o urological surgery as a child for recurrent Utis. If she can come monday, where and when should she report." "MCLEOD, DAVID G" "WRAMC" "" "Yes, please send her.")

("006" "OWENS, NICOLE M" "" "" "Have a 65 yo man with copd, ascad, hx of colon cancer with hemicolectomy one year ago--has had a persistent leucoyctosis since an admission for copd exacerbation in January WBC count on admission was actually normal, rose to 34K after steroids and had gradually decreased over six weeks to 12 but is now back up to 18 --normal diff, no abnormal forms on peripheral smear the pt feels well, has no fevers, lymphadenopathy, skin rash, cxr repeatedly negative blood cultures X2 and urine culture negative did a ct scan of his belly because of an episode of abdominal pain which revealed either a new pancreatic tail lesion or recurrence of his colon cancer--no diverticulitis, abscess or liver lesions seen he is going for an ex-lap in two weeks would you recommend any further evaluation prior to surgery?(either ID or bone marrow) Is this likely a leukemoid reaction to whatever is in his belly? Thanks." "HAWKES, CLIFTON A" "WRAMC" "INFECTIOUS DISEASE" "From the ID perspective, I cannot think of any other diagnostic test. My first thought was, as you considered, steroid-induced. My second consideration was a perforated viscous that was walled-off, but CT Scan of the abdomen should have identified that. Indium scan is sometimes useful, but I do not think the cost is justified if he is going to have a definitive procedure (and you are not pressured to start antibiotics in the setting of fever). I assume he is off all steroids now." "MURPHY, TIMOTHY J" "" "" "would like to know the actual breakdown of his differential. Are there basophils in his peripheral blood?" "WILLIS, CARL R" "WRAMC" "Hematology/Oncology" "Greetings Dr. Owens. Agree that the diff would help. A Leukemoid reaction by definition is inclusive of a luekocytosis of > 50k. Steroid induced was also my first thought, but would expect early band forms which can also be seen with leukemoid reactions (may be resolving). A LAP score may help you to differ between an infectious/inflammatory etiology and CML (unlikely given.).")

("007" "WILDER, JAY S" "WRAMC" "Internal Medicine" "78yo WF htn controlled, phx TIA 1y ago while on ECASA 325 bid. Inpt eval by neuro and switched to plavix 75mg qd. Had her stereotypic TIA sxs again last wk (transitory fortification scintillation followed by hatband- like tighten ss and then L lower facial numbness for afew hrs. ?migraine?. No sxs since. What is next? add asa?, switch to ticlid? switch to persantine+asa?" "MARINI, ANN M" "" "" "I would like to know whether she has a history of migraine (complicated), how long sx last, neurological examination, stroke risk factors and more detailed history. I would suggest that she needs to be seen in Neurology. Please let me know if you would like us to see her." "WILDER, JAY S" "WRAMC" "Internal Medicine" "Would appreciate your seeing her, since atypical features for TIA." "MARINI, ANN M" "" "" "I will see her on Monday." "WILDER, JAY S" "WRAMC" "Internal Medicine" "Thanks, would you like me to call her?" "MARINI, ANN M" "" "" "I already called her and scheduled an appointment. She was admitted to Neurology in Jan 1999. Also, she said that she has had these episodes since 1982. No stroke on her CT scan. Unclear what these episodes are due to but having them for so long without evidence of stroke is gratifying."

"WILDER, JAY S" "WRAMC" "Internal Medicine" "I got out her inpt record. Interestingly, she described the scintillations then too. I am also concern re poss cognitive decline but I did not have time to do a MMSE. She has always had anxious/hesitant affect." "MARINI, ANN M" "" "" "My point about the scintillations is that she was around 57 when they started and easily could be aura without migraine. I agree with your assessment that she is anxious. She told me that in 1982 she had a retinal hemorrhage and is frightened that the scintillations may be a harbinger of another hemorrhage. I did not get the sense that her cognition has declined but this too can be evaluated." "WILDER, JAY S" "WRAMC" "Internal Medicine" "We were on the same wavelength. This why I emphasized the scintillations too. I will boast that I mentioned migraine in my original message. I am looking foward to your assessment. Thanks. " "MARINI, ANN M" "" "" "ok. We may be splitting hairs here but she could not correlate headache with aura so that is why I believe these events may be aura without migraine. Hopefully, I will know more when I see her on Monday. Thanks." "MARINI, ANN M" "" "" "Dr. Wilder, Ms. W did not show up this morning. I scheduled her appointment for 10:30am." "WILDER, JAY S" "WRAMC" "Internal Medicine" "I talked to her in person on fri and handed her the referral form with date & time. I will call her to find out what happened." "MARINI, ANN M" "" "" "ok" "WILDER, JAY S" "WRAMC" "Internal Medicine" "I just spoke to her. Over the wkend she realized she ahd a conflicting appt at NNMC for a f/u for MGUS and she went there this am. She said she called the neuro cl and was told they did not have her done for an appt. I told her one of us would contact her again with a new neuro appt.")

("008" "ADAWADKAR, PRAKASH D" "" "" "THIS IS A 6 YR OLD MALE, WHO PRESENTED FIRST TIME WITH STREP THROAT.IN 5-6 DAYS HE PRESENTED WITH PURPURA ON LOWER EXT.(DX.HSP) he was treated with steroids 2ndary to blood in the stools. his ua was always nl. after 2 weeks he was completely recovered. last week he developed URI sx. today he started with purpric rash again. this time it is milder than before. mother wants to give him varicella immunization.since it is alive attenueted viral vacc. I would like to know, how to responce to this.(pt never had varicella as per m0m) 1. to obtain varicella titer. 2. to give him varicella vacc. 3. if ok to give vaccine, when it is safe. 4. other Thanks." "WOODS, JON B" "" "Pediatric Infectious Diseases" "Children on high-dose corticosteroids (greater than 2mg/kg/day of prednisone equivalent for a child <10kg, or greater than 20mg/day for a hild>10kg). Once off steroids for 2 weeks it is probably safe (and effective) to give the vaccine (see the 1997 Redbook...Report of the Committee of Infectious Diseases of the AAP).")

("009" "GAUER, ROBERT L" "" "" "i have a pt with severe shooting leg pain from his diabetes. he has tried gabapentin and tcas. any other thoughts?" "KELLY, CHARLES A" "" "Neurophysiology" "If the pains are indeed paroxysmal as you have described, a trial of other anti-epilepic meds is warrented. would consider tegretol 200 mg, increasing every two weeks to 200-400 TID or dilantin 100 BID r TID. If this fails you can refer the patient to me- Chuck Kelly Neurophysiology Staff")

("010" "GEORGE, ARLENE E" "" "Adult Medicine" "WHT SHOULD I LOOK FOR IN A PATIENT WITH LUPUS WITHINCREASING FREQUENCY OF MIGRAINE HA, WITH sob, NECK AND CHEST PAIN. CXR, CBC AND P1 WERE NORMAL." "DUNCAN, WILLIAM E" "WRAMC" "Endocrinology" "did you want this to go to endocrinology ask a doc?" "GEORGE, ARLENE E" "" "Adult Medicine" "NO THIS WAS MEANT FOR RHEUM." "BERNET, VICTOR J" "WRAMC" "Endocrinology" "I forwarded it" "PARKER, CHRISTOPHER T" "" "" "A rheumatologist. The DDX for migraine/head pain is large as is SOB with chest pain and includes all of the common etiologies and those with autoimmunity. Rheumatology support is designed to answer the latter and is a subspecialty of medicine due to the frequency of the former especially given the complexity of this type of patient. Any time you are faced with this challenge we are easily reached by calling ... and saying you are Dr. X and would like to speak to the ROC -- rheumatologist on call.")

("011" "GIBSON, CAROL C" "" "Nursing" "i have a 73 yo f who had an endometerial bx done last year for an endometerial stripe that measured 1.5cm--emb was wnl--pt had another sono done this year to eval and measure the endometerial stripe and it measurred

1.3cm--would like to send this pt for another emb but would like to know whether or not it is indicated--(ovaries were not visualized on sono but both adnexa were unremarkable as per sono report)--please give your opinion. also, how long should a post-menopausal pt stay on estratest? there are some pts who have been on it for atleast 6 months to a year--would like to know the answer to this because i thought it was for short-term use--any other suggestiions for help in pts complaints of decreased sexual libido? i heard that wellbutrin (sp) was a medication that could help with increasing sexual libido (the drug that is used for depression) but would like to know of any general interventions. any help that you could give me would be greatly appreciated. Thanks" "FISK, DANIEL R" "" "" "This size endometrial stripe is not normal in this age range and will require further investigation beyond EMB even. Please do send her to us at her earliest convenience, and thanks for the referral. Do you need phone numbers?" "GIBSON, CAROL C" "" "Nursing" "thanks for responding--i will tell the pt that she will have to be seen-I have the phone numbers--pt contacted today and she will make an appt -her name is rosella crane 30-0724." "GIBSON, CAROL C" "" "Nursing" "dr. fisk, what about my other question? Thanks")

("012" "GEORGE, ARLENE E" "" "Adult Medicine" "30 y female with 12yr history of dry mouth with stenosis of salivary ducts.What do you recommend I try as conservative management? Is this anaddressed by ent?" "CASLER, JOHN D" "" "Otolaryngology" "An ENT consult would certainly be reasonable. She could be seen at KACC.How do you know she has stenosis of her salivary ducts? Did she have asialogram? This is often associated with rheumatologic conditions. Has thatbeen addressed? Thanks" "GEORGE, ARLENE E" "" "Adult Medicine" "she was evaluated by a dentist. I am working her up for sjogrens, sle." "CASLER, JOHN D" "" "Otolaryngology Service" "An ENT referral would be helpful. Thanks.")

("013" "AARONSON, JACOB W" "" "Family Practice" "Pt is a 4 y/o male with following exam: Right testicle normally descended, left testicle just barely palpable at opening of inguinal canal (but definately palpable and normal in size and texture). Cremasteric reflex was very strong and testicle would easily disappear into canal with palpation. Mother states this has been addressed in the past, but no further w/o has occurred. Is there any concern? Thank You, Jacob Aaronson" "PEPPAS, DENNIS S" "" "Urology" "I would like to see this child for a possible orchiopexy. Thanks. D P" "AARONSON, JACOB W" "" "Family Practice" "thank you so much for your response. I will put in an official consult, but you can call the patient^s mother if that is better for you. Thanks again, let me know the outcome please ... so I can get a feel for what is an appropriate consult. Jacob A" "MCLEOD, DAVID G" "WRAMC" "" "Thank you for the referral. Please refer us any patients this way and don^t bother with any of that trycare crap-please." "PEPPAS, DENNIS S" "" "Urology" "Tasha, please call the parent and schedule an appointment with me. Thanks." "AARONSON, JACOB W" "" "Family Practice" "I agree - I will email you from now on as I have in the past.")

("014" "COSTELLO, KATHRYN" "" "Nursing" "in process of initial infertility eval in 26 yr old presumed anovulatoy(oligomenorrheic)mildly overwt (# 170 5 ft 7 in); cholesterol noted to be 321; HDL 41LDL 250; triglycerides 148; smokes 1 PPDto keep the rest of hx brief all other labs and exam wnlshe obviously needs to stop smoking, reduce wt, but how would you address the cholesterol in one who is anxious to conceive; statins are contraindicated inpregnancy so is a trial of clomid out? could she take clomid and delay rx ofcholesterol? focus on cholesterol and address infertility at a later date?(but the cholesterol will probably require long term RX)she probably fits picture of PCO syndrome to a Thank you in advance for your input Kathy Costello nurse practitioner" "OLIVER, THOMAS G" "" "" "Please supply a phone number or pager which does not double as a fax #. I would be happy to chat about this patient. Thanks, Tom" "DUNLOW, SUSAN G" "" "OB/GYN" "Col Armstrong is here with me (RE&I subspecialist) recommends she goes tomed-endocrine to have her chol issues addressed prior to any referral toRE&I." "COSTELLO, KATHRYN" "" "Nursing" "OK, i agree needs med F/U prior to pursue infertility, but what do you folks do with ladies with such high LDLs who require RX which is contraindicated with pregnancy? k costello" "OLIVER, THOMAS G" "" "" "I have replied to the current question. No further replies are necessary. She will call again with additional questions. Thanks, ")

("015" "MCCROARY, KATHIE D" "" "Family Practice" "I saw a pt who c/o bilateral pain, cold, white fingers and toes. Episodes are triggered by cold, but also occur when not cold or not under emotional sress. I did the labs suggested for Raynaud^s by Griffiths-CBC, esr, rf, ana. All were wnl except a pos ANA. This is a 31 yr old AD female. The primary reason for her visit was non-specific GI complaints. (she had been on 6 consecutive courses of abx for various complaints- strep x 2, uti, bacterial vaginosis) Her bowel complaints were improving after a week of Bentyl. Otherwise, this pt is healthy with no other medical problems. I know that the ANA is a non-specific test, but now that I got it I just wanted to make sure that there is nothing else that I need to do. I consulted with our clinic Internal med doctor. She advised that no further work-up is needed other than counseling the pt to protect her extremities from the cold. I just wanted to see if you concur. Thanks. MAJ My, FNP" "ROEBUCK, JON D" "" "Rheumatology" "Measures to avoid cold induced vasospasm are certainly a good start. If this soldier has any other features to suggest a systemic inflammatory condition ie rash, mucosal sores, arthritis, sicca symptoms etc., specific antibody testing to include ANA titer, double stranded DNA and extractable nuclear antigens would be indicated. Urinalysis should be done if not already to screen for proteinuria or active sediment. In any event we would be happy to evaluate her here at Walter Reed. There are active duty slots available now if you would like to enter a consult." "DENNIS, GREGORY J" "" "Arthritis, Pain, and Immune Response Specialist" "The rationale behind screening tests is that if any of them are positive, further evaluation should be performed in order to attempt to confirm a specific diagnosis. Raynauds phenomenon is a clinical sign that serves as a harbinger of a immunologic dysfunction most often associated with the connective tissue diseases. The presence of a positive ANA in this individual warrants additional serological evaluation primarily for prognostication and patient education. We will be happy to assist with both."

"MCCROARY, KATHIE D" "" "Family Practice" "Thank you for your prompt and informative responses. I really appreciate the guidance. I will give the patient a consult. MAJ McCroary"

"DENNIS, GREGORY J" "" "Arthritis, Pain, and Immune Response Specialist" "Thank you for the referral.")

("016" "BIGBEE, JOHN A" "" "" "I saw a 47y/o female in clinic yesterday for the first time. She had been seen by another HCP here on 2/18/00cough, paresthesias in fingers, and pain in hands. A chest x-ray was ordered on 2/18/00 and read as showing deviation of the trachea to the left in the upper thorax. Dr. Pontius recommended CT of chest. Yesterday the patient was concerned about an acute onset fullness in the right side of her neck, anteriorly, which hurts when she coughs. She has an enlarged right lobe of the thyroid, in my opinion, of sudden onset. The mass is sensitive but not very tender. Blood work ordered on 2/18/00 shows a TSH of 1.75 and free T4 of 0.84; CBC shows a WBC=3.9;HGB=12.2;HCT=36.4; P1, P2, and P3 are normal. I ordered an US and the CT recommended. Could your clinic arrange an appointment for this patient?" "HARARI, AMIR E" "" "" "I will contact the pt and see her on Monday or Tuesday. -Amir Harari" "BIGBEE, JOHN A" "" "" "Thanks for the quick response :)" "BERNET, VICTOR J" "WRAMC" "Endocrinology" "No contrast with that CT please. Dr Harari comment further after his Assessmnet")

("017" "RAMSEY, ROBERT L" "WRAMC" "Internal Medicine" "2 of our retirees are moving to Abu Dhabi, United Arab Emirates. They are on diabetes meds. Do we have a mechanism to send them meds? Thanks!" "SPAIN, JOHN" "" "Pharmacy" "Sir, will they have an APO address? Will they be located at the embassy compound? Are they > 65 years old? Several possibilities based

on answers Sir." "RAMSEY, ROBERT L" "WRAMC" "Internal Medicine" "No APO address (they are working on a contract at the military hospital). Living on the economy. Both under 65." "SPAIN, JOHN" "" "Pharmacy" "Sir: The National Mail Order Pharmacy only mails to stateside addresses or APO so that option is out. If they do get an APO that option will be avialable since they are under 65. One option is to have another person back in the states drop off and pick up their Rxs and mail to them. This representative would have to have a copy of each ID card and a statement signed by them saying there authorized to pick up the Rxs. This is the option I think they will have to go with. I don^t know if they can work out something with the local embassy. The Pentagon pharmacy does assist members working at the embassy. However they are not employees so I don^t know how much luck they will have." "RAMSEY, ROBERT L" "WRAMC" "Internal Medicine" "That is very helpful. Thanks a lot.")

("018" "AARONSON, JACOB W" "" "Family Practice" "Pt is a 3 y/o male with Dandy-Walker syndrome Dx^d at birth, with no apparentsignificant findings otherwise. He has a mild speech delay that is beingaddressed. On routine exam, partially at mother^s concern for a funnylooking back there is a right sidebent sacrum, with a gentle right lateralcurve up to the lower-mid thoracic where there is a rather sharp curve to the right with compensation in the upper throracic and c-spine. No other obvious remarkable findings. Mother states that he is normally active and does notc/o pain usually, though when he occasionally does, mother can^t determine where. He is normally cooperative for a 3 y/o, but exam was pretty much limited to a structural exam. Any suggestions for necessary work-up/imaging, is there a correlation with Dandy-Walker syndrome - should he be seen by Pedsortho? Would appreciate any input. Jacob A Family Medicine" "MCHALE, KATHLEEN A" "" "Orthopaedics" "SURE, WOULD LOVE TO SEE HIM." "POLLY, DAVID W JR" "" "" "Agree that he should be seen." "AARONSON, JACOB W" "" "Family Practice" "Thank you for your response. I will contact mother and put a referral into the system. In case you would like to contact his mother, here is the necessary info: I appreciate you seeing him. Let me know what you decide to do.")

("019" "DEUEL, JOHN P" "" "" "Dear Sirs I have a 53 yo male pt who has recently returned from East Timor and was found to have an asymptomatic infection with E.hstolitica on 2 successive routine stool cultures. I am inquiring re: treatment option with Iodoquinol 650 tid for 20 days, this drugs potential side effects, or option for nontreatment. John D." "HAWKES, CLIFTON A" "" "INFECTIOUS DISEASE" "Options for treatment are Iodoquinol as you mentioned and Paromamycin. I don^t think nontreatment is an option. I^m assuming he is an asymptomatic cyst passer, but if he is coming back to live in the U.S., a nonendemic area for E. histo., he should be treated. If he was going to remain in an endemic region treatment would not be indicated, since he would become reinfected." "TOEDT, DOMINIQUE M" "" "" "I^d like to know a few things: 1. Are there any changes to the NARMC GERD CPG? 2.Is propulcid still second line, given the company has stopped promoting it due to providers not paying attention to EKG and drug interactions? 3. Have you considered Aciphex as an alternative to prilosec 40mg?" "KIKENDALL, JAMES W" "" "Gastroenterology" "I don^t think the guidelines have been revised. That is a problem with guidelines. They go out of date faster than they can be written, and it may take years for everyone in the NARMC to agree they need to be revised, then more years to agree on the revisions. I would relegate Propulcid to the garbage heap as far as treating GERD goes. Aciphex is being touted as an improvement, but it is probably not very significant as far as real clinical results go. It would depend on cost and whatever the pharmacy decided to make available. I don^t have a lot of information on Aciphex." "CHENEY, CHRISTOPHER P" "" "Gastroenterology" "No changes have been made. But I was the one who generated the guideline. ALthought Cisapride is on it, I rarely used it an now do not use it at all. I doubt Aciphex will get on the formula in the near future. Addition of that medication are decided centrally in San Antonio.")

("020" "FRANK, JENNIFER E" "" "Family Practice" "I saw a 10 year old boy with a suspected allergic reaction to a topical anesthetic used by his dentist. It contained benzocaine in a polyethylene glycol base. Does he need further testing to ascertain particularly what component of the med he is allergic to? Thanks, "

"OAKS, HOWARD G" "" "Allergy Immunology" "We would be pleased to evaluate the patient and review the history. In general, local anaesthetic reactions are toxic reactions resulting from rapid drug absorption, rather than an anaphylactic event from IgE-mediated allergy. Large local reactions and contact dermatitis from delayed-type hypersensitivity are the principal immunologically mediated reactions from local anesthetic agents. The performance of skin testing to local anesthetics can help determine whether the patient is at higher risk than the general population of experiencing an IgE-mediated adverse event on reexposure to the drug. You could have the parents to arrange an appointment with me, Dr H.. Please have them plan to bring in whatever documentation of the event they have. Optimally, the patient should be off antihistamines for at least three days prior to evaluation, in case skin testing is performed. Thanks, HGO" "FRANK, JENNIFER E" "" "Family Practice" "Dr. Oaks, Thank you for your response. I called the mom and asked her to make an appt with you. Jennifer Frank" "OLIVER, THOMAS G" "" "" "" "BERNET, VICTOR J" "WRAMC" "Endocrinology" "Okay, we repeated his labs: This time the norepi came back at 146 (15-80) and dopamine was 447 (65-400) and normetanephrine 732 (82-500) and toatl metanephrines 915 (nrl 120-700). His urine vol was 1500 cc and he has a creatinine clearance of 204 ml/min based on his urine and serum creatinines. DId he over collect? As far as his spells, he gets brief periods of shaking, sweating and flushing which last less thatn 15 min and these occur without any relationship to activity/meals/sleep etc and occur appprox qweek. I have not gotten the plamsa cathcols--would you still recommend or is this enough info to go to the OR?"

"BERNET, VICTOR J" "WRAMC" "Endocrinology" "Can^t remember the whole case Jeannie. Urines are suspicious. I would use Cr index to decide if he over collected. Use Cr/kg body wt; 20-25 mg/kg/day is normal in a male. Serum measurements would still be helpful; And sometime the levels help decide if a confrimatory stim or suppression test is needed. By the way, did you imagine the adrenals yet? If so was there a substabtial lesion. Actually, we would probably still wait on imaging until we are convinced of a pheo chemically. Vic")

("021" "MCKINNON, HARRY D" "" "" "Dear Sir/Madam: I have a 60 year old male that I originally saw for complaint of erectile dysfunction. He has past medical history significant for tobacco abuse (50 pack years), anxiety disorder. Physical exam normal. Meds include Aspirin 325mg QD, Multivitamin and Sertraline PRN for anxiety (has not taken in several weeks). I did recommended labs for ED screening and his prolactin was elevated to 19.4. I did repeat which is pending. Do you have any recommendations for this gentleman? Would you like to see him? Thanks.....Harry McK" "DUNCAN, WILLIAM E" "WRAMC" "Endocrinology" "Not sure if there is a cause and effect - need to assess the medications he is taking, his thyroid status, renal status etc. could you refer him to us. Please ask him to repeat his prolactin level, testosterone, fsh/lh, nucl profile, p1, p2, p3. Thanks")

("022" "WASHINGTON, LARRY H" "" "" "In general, do patients with high LDL levels offset by high HDL levels still require cholesterol lowering medication? Please provide references, as I have not been able to find the answer to this question through my sources. Thanks. Larry H." "HUDAK, CRAIG M" "" "" "Try the NCEP guidelines! If these are not clear to you, please respond back.")

("023" "MAGUIRE, MICHAEL D" "Fort Meade" "CARDIOLOGY" "I^m following a patient who has a history of myopathy with multiple statins. Before trying him on yet another (his preference) or niacin, I repeated CK isoenzymes with the following results

TOTAL CK 271, CK BB 0, CK MB 4, CK MM 96. Are there other unmeasured subfractions accounting for the missing 171?" "DAVIS, BRAD J" "" "Clinical Pathology" "What^s the patient^s name/SSN? I^d like to review the instrument results." "MAGUIRE, MICHAEL D" "Fort MEADE" "CARDIOLOGY" "William R. W" "MAGUIRE, MICHAEL D" "Fort MEADE" "CARDIOLOGIST" "Got cut off. He had very similar numbers on 24 Nov 99, with a total of 233, BB of 0, MB of 4, and MM of 96. He^s also had an inconclusive muscle biopsy that^s also in CHCS." "MAGUIRE, MICHAEL D" "Fort MEADE" "CARDIOLOGY" "Forget it, guys. I musta been smoking something funny when I sent this message, but it finally hit me as strange that the MB and MM^s were identical on both, and I looked more carefully and see that they^re expressed as %^s not IU^s, so they do add up. Glad I caught that before you told me or I^d feel even dumber! He^s still interesting both because of very prolonged times to normalize after CK^s go up, and because his brother has the same problem. Rheum has been involved and nobody can come up with anything exotic. It^s just too bad he has CAD, can^t take stains or resins, and also is allergic to ASA and clopidegrel." "INGRAM, KENNETH" "" "" "Dr M. not a problem!..let us know if we can be of further assistance.")

("024" "OTT, WILLIAM A" "West Point" "" "In late 10/99 I e mailed you about a 71 y.o. male with Hep B sAG+, eAG+, cAB+, e AB-, s AB-, and you recommended following him twice yearly with AFPs and once yearly with US liver. Here^s an update. His US was normal (1999), his LFT^s have remained unchanged with AST being slightly elevated (unchanged) last done 1999, and his AFP has risen from 7.8 to 8.3, and now to 13.4 (2/00). His HBV DNA was >2000 pg/ml (2/00). What would be the next step? CT liver? Consultation?" "HOLTZMULLER, KENT C" "" "Gastroenterology" "what is your normal for AFP?. I would get a CT of the liver if it is over the normal." "OTT, WILLIAM A" "West Point" "" "less than 8.1. I^ll get the CT done and contact you then with the results." "HOLTZMULLER, KENT C" "" "Gastroenterology" "Thanks." "OTT, WILLIAM A" "West Point" "" "CT of abdomen without contrast was completely normal except for a small left pleural effusion. FYI, pt is s/p CABG approx 3-4 months ago. What^s the next step in this case? Continue to follow the AFP given that the CT is essentially normal and the LFTs are normal?" "CHENEY, CHRISTOPHER P" "" "Gastroenterology" "I would have a high index of suspicion that he has an underlying hepatocellular carcinoma that has yet to be detected by CT scan. My next step would be to repeat AFP in 3 months and if it continues to rise consider an MRI scan with gadillium vs repeat CT scan." "OTT, WILLIAM A" "West Point" "" "Thanks for your response. I^ll let you know the results of the MR in 3 months." "CHENEY, CHRISTOPHER P" "" "Gastroenterology" "I need to get in touch with LTC V.. Do you have is email address or phone #. Thanks." "OTT, WILLIAM A" "West Point" "" "" "CHENEY, CHRISTOPHER P" "" "Gastroenterology" "thanks for the information.")

("027" "BAVARI, DEBRA L" "Fort Detrick" "" "For the general pediatric clinic do you have an SOP for scrrening weights on children one year and under - i.e always in onsie and dry diaper, in onsie only, always unclothed etc, Thank you." "HORN, CHARLES S" "Fort Belvoir" "Pediatrics" "Because of the inconsistency, and subsequent inaccuracies of practices of doing measurements and vital signs among the Family Health Centers of the Dewitt Health Care system for our 25, 000 children, we developed and distributed guidelines for these based on ages, reason for visit, etc. In fact, they were a compilation and comparable practice if you will of what was being done at WRAMC and NNMC. If you give me your fax number we will gladly send you a copy (one sheet) that can be displayed in your vital signs rooms. Thank you for your interest. COL H. Ped." "BAVARI, DEBRA L" "Fort Detrick" "" "That would be fantastic, exactly what I would like for here at Detrick, to my attention please. I have a guideline from previous civilian practice, but it would be much easier to initiate an already established military item. THANK YOU - Debra B." "HORN, CHARLES S" "Fort Belvoir" "Pediatrics" "will send one your way today." "HARPER, BRENDA S" "" "Pediatrics" "Will fax our SOP.")

("028" "BIGBEE, JOHN A" "" "" "I have been seeing a patient for several months and need your assistance in management. My concerns are about a rapid weight gain with a habitus very suggestive of Cushings syndrome. He is diabetic in poor control and hypertensive, also with poor control. I have ordered 24 hour cortisol and creatinine and random serum cortisol.Is there possibility you could see this patient? " "DUNCAN, WILLIAM E" "WRAMC" "Endocrinology" "we would be very happy to see this patient" "BURCH, HENRY B" "WRAMC" "Endocrinology" "The fastest way to make an appt is to enter the consult in CHCS and have him call our front desk to book (). If the timing isn^t satisfactory, call this number and ask to speak to our on-call physician." "BIGBEE, JOHN A" "" "" "thanks for the swift response.")

("029" "MYERS, MADELEINE" "" "Nursing" "I am covering for another practictoner, without prior knowledge of this pt. LABS: TSH: 17.25, ANTI-THRROGLOBU <2.0, ANTI-THYROID PE 1870.0. At present pt. c/c is fatigue past hx: after giving birth to a severely mis-shapened infant and the infant^s death (6mo old). pt began to have panic anxeity, irritablity, nervouness, and insommia. Would should my next step be? Should I redo labs, treat for hypothyroidism, order a thyroid scan, refer to endocrinologist ASAP. Thank you for your time and energy." "DUNCAN, WILLIAM E" "WRAMC" "Endocrinology" "how long post partum is she? any family history of thyroid or autoimmune disease? would repeat TSH and if elevated - begin treatment with thyroid hormone. No reason to do a thyroid scan." "BURCH, HENRY B" "WRAMC" "Endocrinology" "Agree. The early symptoms may have been due to thyrotoxicosis from postpartum thyroiditis, in which case she may have recovery of normal thyroid function.
Were tfts done during her period of anxiety, etc? I would still treat her with thyroid hormone if this were PPT, but would probably withdrawal and retest after 1 year. A common starting dose would be between 0.05 and 0.1 mg once daily, depending on the patient age, size, etc. The TFTs are adjusted from there. We would be happy to see her to assist in her management.")

("029B" "AARONSON, JACOB W" "" "Family Practice" "I recently performed a flex sig on a 55 y/o male, non smoker, otherwise healthy, finding 4 wide-based mucosal colored polyps at 15 cm. The patient was unable to tolerate scope passage beyond 35+cm. The largest polyp was biopsied after attempts were made at the (much) smaller others. Biopsy was returned as hyperplastic. What would recommend at this point? Should a BE be performed, or a colonoscopy? Would appreciate any input. Jacob" "HOLTZMULLER, KENT C" "" "Gastroenterology" "I recommend that he just proceed with a colonoscopy. Not all the polyps were biopsied and there is a chance one is an adenoma. Given his age and the flex sig findings, I would be on the aggressive side." "CHENEY, CHRISTOPHER P" "" "Gastroenterology" "I agree, a barium enema would be of no use to you at this point. However, don^t be surprised that all the polyps you saw in that location turn out to be hyperplastic." "MOSES, FRANK M" "" "GASTROENTEROLOGY" "I don^t disagree. However, if the polyps were all small (that is <7-10mm) and the largest was hyperplastic, he really is at only an average risk for important proximal lesions and not at higher risk because of your findings." "AARONSON, JACOB W" "" "Family Practice" "Thank you for your responses, I favored colonoscopy in the first place, but I wanted to make sure it was an appropriate referral." "CHENEY, CHRISTOPHER P" "" "GASTROENTEROLOGY" "Col Moses brings up a good point in that cheapest alternative is to have a repeat flex sigm with bx of all polyps. However he is over 55 and a flex sigm is equivalent to a unilateral mammogram." "AARONSON, JACOB W" "" "Family Practice" "Thanks for the responses.")

("030" "WILLIAMS, KAREN A" "" "" "I have a patient that I^m not sure what to do with his cholesterol. He^s a 43 year old black male who came in for an overseas screening and we did a lipid profile- he^s never been tested before. He^s in excellent

physical shape- is an avid weight lifter (he^s a retiree, wife on AD) His dad in his 60^s has a large heart but no known history of CAD or HTN. No diabetes either. His total cholesterol is 309, but triglycerides are 84 and HDL is 107, with an LDL of 185 and a VLDL of 17. Based on the break down it^s only the LDL putting him at increased risk. Should this be treated medically? I didn^t want to screw up his TG and HDL. He^s on no other medications and is otherwise healthy. Thanks. Dr. W." "HUDAK, CRAIG M" "" "" "It^s hard to make an argument for pharmacologic rx in this guy! If you strictly follow the NCEP guidelines, as he has no risk factors (the HDL negates age/sex), the target LDL is 160, initiating drug rx at 190. As his HDL is supernormal (I guess he^s not abusing anabolic steroids!), I think I would just counsel him on a heart-healthy lifestyle, and send him on his way, and plan on checking a repeat lipid panel in 5 years. As these values are a little unusual, you might also consider checking a repeat lipid panel now for confirmation.")

("031" "APPLE, DARRELL J" "" "" "59YO M ADA HAS SINCE 1983 CREAT FLUCTUATING IN 1.1 TO 1.5 RANGE. 1980^S 1.3 1.4 1.0 1.4 1.1 1.4-1990^S 1.3 1.3 1.3 1.3 1.1 1.1 1.2 1.4 1.1 1.1 1.2 1.1-1/31/00=1.5, 2/3/00=1.2, 2/23/00 =1.3. BUN RUNS IN 10-19 RANGE BEING 5^4in 150 LB. HE HAS HAD RECURRENT GOUT ATTACKS PLACED ON ALLOPURINOL 1986 BUT D/C 1995 HAVING LFT ELEVATION. BENEMID STARTED 9/17/96. CREAT OF 1.5 NOTED ABOVE WAS AFTER PT USED MOTRIN FOR GOUT ATTACK. HE HAS SINCE BEEN OFF NSAID. SPOT PROTEIN CREAT RATIO SHOWS PROTEIN 43MG/GM CREAT. U.S. OF KIDNEYS 3/3/00 WAS NORMAL X FOR BPH. COCKROFT-GAULT FORMULAE SHOWS CC 56. LAST U.A. 5.2 1/31/00. 24HR U.A. LEVELS 1989 660MG/ 1996 496MG PER 24 HRS ON NO MEDS. BP IS NORMAL/PT DOES NOT HAVE DIABETES/HAS BEEN USING NSAID PERIODICALLY OVER THE YEARS. WOULD APPRECIATE YOUR SUGGESTIONS." "ABBOTT, KEVIN C" "WRAMC" "Nephrology" "We would be happy to see him. It sounds as if he has moderate CRI with non-nephrotic range proteinuria. Since he is over 40, a UPEP and SPEP would be in order, along with an US. We would be happy to do that here. Our waiting time for new AD appointments should be very short.")

("032" "ARO, JENNIFER M" "" "Primary Care" "36yo WM w/ 3 month h/o short term memory loss. Forgets things his wife just told him; forgets to load the second kid in the van before taking off down the street; having to take copious notes in class (CGSC and grad school) in order to remember the material next class.(unusual for him). Sleeping very lightly w/ frequent awakenings; however, initiates sleep easily. Feels very fatigued lately, especially after working out and experiencing longer recovery times between weight lifting sessions. Denies rash, fever, drugs, ETOH, joint/muscle pain, depressed feeling, marital problems, stress. FHx: thyroid, RA, Crohn^s, DMPE: WDWNWM NAD A&Ox4Mini Mental Status-30/30Zung Depression Screen-WNLLungs-CTA Cor-RRR w/o m/r/g Abd-b9 Ext-no c/c/e, no TTP Skin-no rash Guaiac-negLab: CBC, HIV, RPR, TSH, RF, ANA, ceruloplasm, B12, Folate all WNLALT/AST-50/70 CK-525, then 1099, then 799 (drawn over course of 2 weeks) Progress: No worsening of memory in last 6 weeks. Pt is making a concerted effort to remember which seems to be helping; however, it takes much more effort than it should (he thinks). No change in fatigue. Question: What does this CK represent, and could it be related to the memory problem or fatigue? Where else should I look? This question was sent from a fellow FP. Should I send to G. Ask a doc, or do you have any answers. Jen"

"TOEDT, DOMINIQUE M" "" "" "no answers...hi CPK could indicate a acquired muscle enzyme deficiency would refer to Rheum for biopsy for that, but I don^t think that explains memory. I would send to Psych for psychometric testing, also consider sleep apnea as etiology..."

"ARO, JENNIFER M" "" "Primary Care" "thanks. I will send on to those services on Ask a Doc and see what their recommendation is..." "OGLESBY, ROBERT J" "" "Rheumatology" "I guess a question to ask is if the ^fatigue^ he is experiencing is weakness? - and if there is documentation of weakness. As you know the ddx for the idiopathic myopathies is wide and covers infection, toxin/drug, endocrine, neurologic and connective tissue disease etiologies in addition to the classic but rare inflammatory myopathies. This is an interesting case and we will be glad to help in the evaluation. At this point, a relation to his memory problems cannot be answered. You can give us a call and we will be glad to facilitate an appointment for you - either through our on call physician or with me directly. I apologize for the delay in getting back to you." "ARO, JENNIFER M" "" "Primary Care" "thank you for your assistance."

"ENGEL, CHARLES C JR" "" "" "Suspect that his elevated CK is from lifting weights if he does that with any regularity. This sounds like someone with several symptoms typical of depression. That is also probably the most likely diagnosis given a your basically neg workup thus far and his symptomatology. He may not acknowledge a depressed mood. Best to start with a question about anhedonia (^still enjoying your hobbies or other things you normally enjoy doing?^) hen go to sig-e-caps sx of depression. He may not be receptive to the notion that his difficulty could be psychiatric, however, and I would not force it on him if he seems unreceptive, but instead destigmatize it (^depression is a medical disorder and specific treatments are available - we just need to figure out what is right for you...^) and convey a sense of optimism about effective treatment. If he is unreceptive about seeing psychiatry (assuming all this fits that I am saying) then it is possible to manage him very well in your setting. If military factors are important, you can reassure him that as long as he is working okay, their is no reason that a diagnosis of depression should hurt his career in any way. It is only if his work is suffering that this could become an issue. Ask him about hope for the future - if he has compelling future plans and is functioning okay on the job with no history of suicide attempts then I would not belabor the suicide issue until you know him a bit better. Hope that is useful..."

"ARO, JENNIFER M" "" "Primary Care" "thank you." "YERKES, SANDRA A" "" "" "Is his CPK continuing to go up? those levels sound a little high for just routine weight lifting. Agree with Dr. Engel that this gentleman has several symptoms of depression. We are always happy to evaluate and assit with treatment." "ARO, JENNIFER M" "" "Primary Care" "Latest update:
ASO-166 (elevated for his age) as was the AntiDNASE B (I^m not sure what to make of that)
Urine copper - 72 (24-64) He had a low-normal serum ceruloplasmin in his initial w/u at 25.7, and the initial visit w/ an internest was suspicious for Kayser-Fleischer rings. However, optometry wasn^t overly impressed, told him they had a data point, and to return in a yr. My concern is that this is an unusually late presentation of Wilson^s dz in its early stages. And with the memory deficits and intermittent rt hand twitching, I^m concerned that this could represent copper deposits on the brain. I^m sending him to GI for definitive eval for this. If that proves negative. What is your opinion at this point.?" "ENGEL, CHARLES C JR" "" "" "My two cents worth is that you take a ^watchful waiting^ approach, get another set of data points in 3-months, and wait for this to ^declare itself^ in some more definitive way. I can^t imagine that this is Wilson^s Dz. Virtually all of them are severely demented at this man^s age. This strikes me as a very typical sort of evaluation for chronic medically unexplained physical symptoms - lots of equivocal findings that don^t add up

but keep you interested enough to continue extending the evaluation. Experience with this sort of patient leads me to suggest that you watch him for a bit before launching new and aggressive evaluations, unless someone on this thread thinks this presentation ^adds up^ in some readily apparent way. and to return in a yr.")

("033" "MANCIL, HANNELORE B" "" "" "MRI was done at PNH for newly onset headaches following an intense weight lifting session. No masses/infarct or hemorrhage. Incidental finding of extra CSF space on right temporal lobe suggestive of a n arachnoid cyst (no size given) also a 11x10 mm cystic structure in the pineal region suggestive of cyst. Is this a common finding? F/u in 1 year ok. Patient is a 32 yo AD WM who is otherwise healthy. His headaches have resolved." "SIPOS, ERIC P" "" "" "Pineal cysts are a normal variant and arachnoid cysts may also occur in this region. The challenge is to distinguish these from neoplastic processes in the pineal region which can be cystic and can cause mass effects upon adjacent structures. In asymptomatic patients, serial imaging can be quite helpful. I recommend that this patient see one of the neurosurgeons at WRAMC to evaluate the two cystic structures further and to generate a management plan.")

("034" "DESAI, SWATI M" "" "" "Yesterday there was a news article on TV about how cardura is not only an ineffective antihypertensive but also increases incidence of congestive heart failure. Just get a tel.message from a pt on cardura asking whether he should stay on it or not. I am sure many more will call. Would like everyone^s opinion on this matter. What about its use in BPH?.....ANY COMMENTS APPRECIATED....." "WILDER, JAY S" "" "Internal Medicine" "I found the NHLBI news release on this. It^s from the ALLHAT study comparing chlorthalidone, cardura, amlodipine, & lisinopril. After 2-6y f/u of 42, 000 pts over 55yo, broad demographics, pts with at least one other coronary risk factor, the users of cardura had 25% more cardiovascular events and were 2x^s as likely to be hosp for CHF as useers of chlorthalidone. No difference in incidence of MI or death. They concluded cardura and other alpha blockers should not be the first
choice for htn, and not be used as monotx; no data for use in combined tx; no relevant data for the pt with BPH. No other data from this ongoing study was released." "HUDAK, CRAIG M" "" "" "Was this arm prematurely terminateed? Tachyphylaxis is a problem for alpha blockers fo this type, so they are not great drugs for HTN, but their hemodynamic profile is favorable such that their use was examined in an early CHF trial, w/o benefit, but w/o harm, so I^m a little surprised.
Comment on statistical significance?" "WILDER, JAY S" "" "Internal Medicine" "They did terminate the cardura arm, so it must have been a significant finding." "DESAI, SWATI M" "" "" "can you experts elaborate more on this.should we switch patients on cardura to another antihypertensive?any guidelines to go by?" "O^MALLEY, PATRICK G" "" "Internal Medicine" "The trial did not include a placebo arm, so to conclude that cardura is causing harm is not appropriate. However, its a great opportunity to get them on a BETTER drug, such as thiazides or beta-blockers." "JONES, DAVID L" "" "" "Agree. Will still use for BPH but it is still not a first or second (or third) choice for HTN. Diuretic remains 1st choice and, when not used 1st, 2nd choice. Beta blockers are great in some groups. Lisinopril price is down to $0.14/tab, and it is a great choice as well.")

("035" "PATTERSON, GEORGE E" "" "" "What is the upper limits of normal of prolactin for a breast feeding woman? In working up a possible hirsutism, I discovered a prolactin level of 1970." "BERNET, VICTOR J" "WRAMC" "Endocrinology" "How long has she been breast feeding? The last I checked prolactins actually tend toward normal w/in several months postpartum even with continued breast feeding. I will check some references but 1970 seems awful high. Did she have nl menses pre pregnancy or galactorrhea? Hx of pituitasry disorder. The is also a syndrome of macroprolactinemia where the prolactin molecule is abnormally large and cannot be readily excreted but not sure what levels are seen with that rare condition." "BERNET, VICTOR J" "WRAMC" "Endocrinology" "Prl may incraese to around 100 -300 range soon after suckling but then returns close to normal range. A minimally elevated prolactin might not worry me. I would think that level suspicious for a macroprolactinoma. I would definitely repeat x 2 plus consider TFTs, 24 hr UFC with Cr, somatomedin C, and referral to us. Thanks" "PATTERSON, GEORGE E" "" "" "Yes, thank you for your input. She is 38 with a prior history of normal menses. She had stopped breast feeding 1 week prior to work up for XS hair. I repeated her prolactin level, results pending. TFT^s were WNL. Testosterone was 141. She would prefer not to travel to WRAMC and I will refer her to endocrinology at Hershey. I have to decide if I should order an MRI before that referal. Thank you for all your thoughts and answers." "BERNET, VICTOR J" "WRAMC" "Endocrinology" "Sorry to hear we won^t see her. We have seen a lot of ptiuitary cases over the years, and would have been happy to work her in promptly, but I can understand the reluctance to drive a distance. I would lean towards getting a MRI of the sella with gadolinium esp if repeat PRL is as high again." "PATTERSON, GEORGE E" "" "" "")

("036" "BURES, SERGIO" "West Point" "Internal Medicine" "I am an Internist at West Point and would like a bit of clarification on a general clinical matter. If a patient presents with a lession that is suspicious for primry syphilis and it is early in the course (<3 weeks) wouldn^t you expect the nontreponemal screening tests to still not be positive (RPR and VDRL)? If so and you start treating empirically, how are you to follow serial VDRL titers to confirm resolution? What if the initial test is negative? Since FTA is positive earlier is this a better screening test early on? Your help with this somewhat confusing matter would be greatly appreciated." "HAWKES, CLIFTON A" "WRAMC" "Infectious Disease" "Diagnostically, I think there are two important things to do in this patient right now; one is scraping lesion for darkfield examination (if possible); second is having the laboratory perform appropriate modifications in the testing procedure to rule out prozone phenomena which could give you a false negative result. FTA does appear to be more
sensitive in primary disease than VDRL (85% vs 70%), however, both should be checked; MHA-TP is less sensitive than both of these in primary disease. If tests are negative, make sure you have carefully ruled out other diseases in the differential, including herpes simplex, chancroid, LGV, condyloma accuminata." "BURES, SERGIO" "West Point" "Internal Medicine" "Thanks")

("037" "WINFIELD, ELIZABETH J" "" "" "I have a 26 year old male who presented to me with flank pain. History of solitary kidney with maybe yearly infection. Normal cbc, U/A and negative culture, but very tender kidney. Ultrasound shows some abnormalities that I^m not familiar with. My question is: does he need further workup/ follow up? He has been doing ok since without treatment, but I want to make sure I^m not missing something." "WELCH, PAUL G" "" "Nephrology" "I^d have questions 1) why does he have a solitary kidney? 2) why is he having
frequent infections? 3) What specifically are the abnormalities described on the ultrasound? 4) What is his BUN and Creatinine? You may have access to only some of the answers to those questions, but that would be my questions. If he has any hydronephrosis, vescicoureteral reflux and pyelonephritis might explain some of these problems and his tender Kidney. If hydronephrosis or dilated collecting system present, would obtain lasix renal scan and VCUG.
The answers to my above questions and additional tests would determine if he needs urologic or nephrology referral. Thanks")

("038" "BURES, SERGIO" "West Point" "Internal Medicine" "I am an Internist at West Point and have been referred a female pt by the OB/GYN service which I have a question on. She is a 30 y/o pregnant female (first trimester) without c/o incidentally found to

have a leukocytosis. Upon h & P there are no abn findings. Several repeat cbc^s show elevated leukocytosis with normal or near normal (slight bandemia) differential WBC 15-16.9 range. ESR was 12. UA nml. Platelets have remained slightly elevated 410-450. I viewed the peripheral smear and saw some megakaryocytes and thought the automated diff could be interpreting these as WBC^s in the total count and hence the nml diff but I am not sure that makes sense. I am not aware of leukocytosis during pregnancy as a normal occurrence. In her latest cbc she has developed a mild anemia which I suspect is secondary to plasma vol expansion and normal at this stage of her pregnancy. Given the lack of physical findings or c/o I am inclined to just follow this without any more aggressive w/u at this time but want to make sure this is not a mistake and see if you have any experience with this. Any help would be greatly appreciated. Sergio" "MURPHY, TIMOTHY J" "" "" "looking at the smear and obttaining a differential is imperative. Megakaryocytes are not seen in peripheral blood, ever. Would make sure she does not have a UTI/cystitis. Would want to know the exact differential on
her blood (bands, metamyelocytes, lymphocytes, basophils,). would also want to have an earlier CBC (prior to pregnancy) if possible." "WILLIS, CARL R" "" "Hematology/Oncology" "Agree with Dr. m should be seen promptly by a hematologist/oncologist.")

("039" "BIGBEE, JOHN A" "" "" "I saw a 19y/o male today with significant gynecomastia bilaterally; has had this for years but never addressed regarding possible treatment. Does your
clinic see dependents for possible breast revision/reduction with this diagnosis? The problem is a problem to the patient." "EMORY, ROGER E JR" "" "" "We see these patients as routine consultation. He needs to have a basic enocrine evaluation prior to his visit." "KIM, JUN W" "" "Family Practice" "Would you help me clarify the correct dose of Vit-D for Osteoporosis. I noticed there are at least 3 types of Vit-D preparations; DHT, D2 (ergocalciferol), and calcitriol, and their units are quite confusing some in IU and some in mcg or mg. I have researched few articles and checked our formulary and it^s still somewhat confusing. Which would you most recommend for Osteoporosis (for both prevention and therapy) and what is the correct dose?
Thanks" "BERNET, VICTOR J" "WRAMC" "Endocrinology" "The recommended dose is 400 to 800 IU QD of Vitamin D. A MVI has 400 IU. The pharmacy did away with the 400 IU Vit D tabs that we sometimes gave to pts with their MVI. Pharmacies solution to get 800 IU is to take 2 MVI per day, they swear that no one will get toxic with taking two MVI day. Another, way is to have pts purchase calcium supllemenst with 200 IU Vit D. Then they can take MVI (Vit D 400 IU) plus two caclium tabs with (calcium 500 mg ea. and Vit D 200 IU each)for a total of 800 IU. Typically we use the other preparations you see on CHCS for more prominent Vit D deficiency states." "KIM, JUN W" "" "Family Practice" "Thanks Dr. Bernet")

("041" "BETT, BARI J" "" "" "I have a 43 y o b f with long h/o chronic anemia and h/o vogt-Koyanagi-Harada syndrome, vision fine, everyone in family anemic also, hct now 31.3, mcv
98.2, mch 34.8 mchc 35.4 wbc 5.3 Iron 13 (low) tibc 389 b12 428 folate 6.9 and ferritin 20.6, light periods, no known bleeding. Could not find out if v-k-h syndrome may cause anemia, although she is only one in family w this. What do you suggest for her anemia? Give her feso4 and see if she improves? do you want to see her? She feels fine and has no sympt. Thanks." "LEGUIZAMO, JORGE P" "" "" "I would like to see her blood smear and meet someone with V-K-H syndrome, which is not classically associated with anemia. If you give me her name, I will get in touch with her. Jorge h/o fellow")

("042" "BIGBEE, JOHN A" "" "" "I have seen a 73y/o male recently, who was given a ?punch biopsy at the VAC Dermatology Department. The patient states it was done to rule out cancer.
When I saw him for the first time, he had a large erythematous area with ulceration centrally. I gave him antibiotics and Dome Burrow soaks and adivesed him to contact the dermatologist of record. The Dermatology Department at the VAC is closed until 21March. This ?infectious process is no better but no worse in my opinion. Would there be any possibility your clinic
could see him before the 21st?" "MAGGIO, KURT L" "WRAMC" "Dermatology" "We^d be happy to see him but would really need the biopsy report to avoid another biopsy and needless waiting. wish, but again I think everything hinges on the biopsy report." "BIGBEE, JOHN A" "" "" "thanks for the swift reply; I^ll contact the patient to see if he can get the biopsy report .")

("043" "DIEMER, MARGRETTA M" "WRAMC" "Internal Medicine" "a pt of mine saw advertisements for a new DM drug called ^abandix^ does anyone know what this is - I tried to do a Pub med search on this name and got nothing" "BERNET, VICTOR J" "WRAMC" "Endocrinology" "New one on me." "BURCH, HENRY B" "WRAMC" "Endocrinology" "I bet she means avandia or rosiglitazone (insulin sensitizer)." "DIEMER, MARGRETTA M" "WRAMC" "Internal Medicine" "that sounds likely - how is roglitzone re the liver?" "BURCH, HENRY B" "WRAMC" "Endocrinology" "Much better than troglitazone, but a couple of recent reports of hepatotoxicity. Drug company recommends q 2 mo LFTs x 1 year then
periodically")

("044" "SCHAFER, MAUREEN L" "West Point" "" "43yo lady in good health, c/o loss of libido-no interest in sexual activity although is able to orgasim. Menses q 26-28 days, PE negative, no psyche/social issues surfaced. TSH normal. Testosterone below normal. Request advice on BCP and can I also use testosterone cream for patient. All other labs wnl. Thank
you." "LOCKROW, ERNEST G" "" "" "if the pt is a non-smoker and is interested in BCP^s I generally will place them on a 20mcg pill ie allesse or other brand. testosterone cream probably
does no harm and if the pt can tolerate the greasiness then you can prescribe. Probably no value in following testosterone levels." "FISK, DANIEL R" "" "" "Agree with above. Libido is more than a question of testosterone levels and supplements. I believe it has much, much more to do with the strength of the relationship and other life factors than any hormonal levels ever will. A band-aid solution to a much deeper problem in my book." "VIGERSKY, ROBERT A" "WRAMC" "Endocrinology" "I see no reason to use BCP^s if its only to treat her libido since she is normally menstruating. This also excludes any significant hypothalamic-pituitary-ovarian axis abnormality. I would check a "free" testosterone and DHEA (not DHEA-sulfate) and cortisol level to exclude an adrenal cause.")

("045" "GRASS, NANCY L" "WRAMC" "Internal Medicine" "I have a pt 73 y.o. female w/ persistent fe def anemia, gi w/u to include egd, colonoscopy and sbft all wnl and no vaginal bleeding. No hx of GI surgery. responds to oral fe if taken bid but pt doesn^t tolerate this due to
side effects, on qd therapy hct remains in 28-29 range. Any thoughts on why she would have a persistent problem w/ fe deficiency w/o source of loss and adequate intake? Thanks" "LEGUIZAMO, JORGE P" "" "" "I would make sure she is not losing blood in the urine. There are also some conditions that cause decreased absorption of Iron, including small bowel dz such as celiac disease (that can be subclinical -even at her age), IBD (doubtful with her w/u), parasites, etc. Has Gi done a small bowell bx or celiac dz serologies? For her anemia, the next step can be IV iron.")

("046" "BURES, SERGIO" "West Point" "Internal Medicine" "I am an internist at West Point and ran into an interesting pt on routine retierement physical today. Pt is a 50 y/o male with incidentally found abnormal EKG: Junctional rythm, LBBB with intermittent sinus conducted beats with differing QRS morphology. Pt denies any cardiac hx or prior w/u but admits to abnormal EKG on his over 40 physical (last EKG done 10 yrs ago). Pt is very active runs 2 miles a day and denies any hx of syncope, palpitations or lightheadedness. He has agreed to outpatient referral to WRAMC Cardiology for evaluation and further w/u to include possible EP study and given his lack of symptoms I have referred him as outpatient. Your assistance in expediting his referral to the appropiate specialist would be greatly appreciated. Thanks" "WILEY, THOMAS M" "WRAMC" "Cardiology" "We will be happy to see him in the cardiology clinic.")

("047" "DENNIS, BETH L" "" "Family Practice" "70 yo male with 1 gm proteinuria but normal renal function. Was eval for microscopic hematuria 2-3 yrs ago and found to have RLP stone. Would this also account for proteinuria. Looks like he^s had trace to 1+ protein in UA for years as well. Has DM, HTN, CAD, past hx gout." "ABBOTT, KEVIN C" "WRAMC" "Nephrology" "It^s possible, but without prior quantitation we don^t really know if this represents a progressive increase. Since he^s over 40, would recheck a renal US, check UPEP if he is anemic or has high calcium. How is is BP? Does he have persistent hematuria?" "BOHEN, ERIN M" "WRAMC" "Nephrology" "I would not assume that his proteinuria can be explained by nephrolithiasis. Early diabetic nephropathy or hypertensive nephrosclerosis can cause low-grade proteinuria. We would be happy to see him in Nephrology Clinic." "DENNIS, BETH L" "" "Family Practice" "calcium normal, HCT ok. will get US and UPEP. Thanks!")

("048" "GUERRINA, MARYLOU" "" "Nursing" "This is not a joke! I saw a 51 y/o bf today with c/o burning lips for the last month which worsens with eating. Lips are usually dry but she has tried otc products to keep moist but the burning persist and she sees little bumps on them when they really burn. Exam is normal....help. I have asked her to stop using lipstick and just apply chapstick to keep moist. Any ideas what might be causing this? Thanks for your attention and for not laughing." "MATHER, MARY K" "WRAMC" "Dermatology" "Sounds like a possible contact sensitivity---have her d/c lipstick, use plain vaseline for moisture, consider referral to Derm for eval and possible patch testing." "MONTEMARANO, ANDREW D" "WRAMC" "Dermatology" "Also to stop using all mouth products including toothpaste, gum, rinses, etc. Baking soda mixed with a small amount of water can be used as a toothpaste.")

("049" "JIMENEZ, ANTONIO S" "" "Family Practice" "Mr. 049 has a small meningioma (1.5 to 2 cm) on the posterior fossa arising from the posterior lip of the foramen magnum, no signs or symptoms of increased intracerebral pressure or flow obstruction. This patient needs to be evaluated by neurosurgery, but i would like to know how soon should he be seen thank you
antonio jimenez md" "FURLOW, THOMAS W JR" "WRAMC" "Neurosurgery" "This benign neoplasm appears most likely to be an incidental (read, subclinical) tumor that does not require immediate attention. Neurosurgical consultation should be requested on a routine basis. Very likely, the tumor could be followed with periodic imaging studies. Thomas W. Furlow, " "JIMENEZ, ANTONIO S" "" "Family Practice" "thank you very much for the reply; i will then follow your instructions" "ECKLUND, JAMES M" "WRAMC" "Neurosurgery" "Did this patient get an appointment? Thanks.")

("050" "EARWOOD, JOHN S" "" "" "38yo male who was referred to me for BRBPR flex sig 2 weeks after bleeding episode showed no hemorrhoids or fissures. Pt did have an imflamed rectal
mucosa extending 4-6cm from anal verge so biopsies were done. My thought was that this inflamation was probably secondary to prep but decided to biopsy to be complete. The biopsy showed lamina propria expansion by histocytes. AFB stains were negative however PAS and GMS stains were positive. Pathology stated that this did not appear to represent microorganisms. Pt had no diarrhea. What further work-up needs to be done? Pt with no further BRBPR." "SMITH, MILTON T" "WRAMC" "Gastroenterology" "Not sure what all that means. It sounds like the main question is whether or not he has proctitis. You should probably refer him to GI along with his biopsy slides and endophotos.")

("051" "ATANASOFF, SARAH E" "Pentagon Clinic" "Internal Medicine" "i have a 41yobm who donated a kidney to his sister a few years ago, he hasno medical problems, no meds, creatinine 1.5, last year 1.4. UA and P1 o/wwnl. As far as follow up, he is pcsing, and he reports no instruction giventto him as far as how often to get labwork, drugs to avoid etc. I realizethat humans do quite well with one kidney (even play professionalbasketball). In general, what guidance to you give these folks other than hydration and being cautious with non-renal-friendly meds? thanks Sarah" "WELCH, PAUL G" "" "Nephrology" "Get annual check up with primary provider to include blood pressure, urinalysis, and BUN/Cr." "ATANASOFF, SARAH E" "Pentagon Clinic" "Internal Medicine" "thnks")

("052" "TOBLER, STEVEN K" "Fort Meade" "Internal Medicine" "I was curious about the treatemtn for PFB. Today I saw a gentleman for long standing PFB. He had been told to use Retin A in the past for this. I looked in Habif and they recommended glycolic acid, short course abx, and possible intralesional steroids but didn^t recomend Retin A. Do you recommend retin A? When do you use topical steroids? Thanks." "TURIANSKY, GEORGE W" "WRAMC" "Dermatology" "my usual tx consists of a shaving profile with westcort cream on the days
that the pt uses a depilatory, or clippers. I discourage use of a razor blade. If pustules or crusting exist i get a skin culture to rule out secondary bacterial infection and tx appropriately. Although some people advocate the use of retin a, i find this causes an irritant dermatitis in the sensitive neck area. Hypertrophic scars and keloids may occur in some individuals for which intralesional steroids may be useful." "TOBLER, STEVEN K" "Fort Meade" "Internal Medicine" "")

("053" "MALIK, PANKAJ" "WRAMC" "Cardiology" "I have a 55yr old pt with a history of von willebrands disease. No h/o recent active acute bleeding. Has used EACA/DDAVP prior to dental procedures with generally good response. Pt is wondering if we have anything new to offer? I will appreciate advice. she has been seen at WRAMC-heme/onc in the past. Thanks" "LEGUIZAMO, JORGE P" "" "" "ddavp is the way to go j leguizamo h/o fellow" "WILLIS, CARL R" "" "Hematology/Oncology" "I agree with Dr. Leguizamo. Newer factor concentrates are available, but if he is responsive to DDAVP that is best option.")

("054" "BIGBEE, JOHN A" "" "" "I am seeing a patient who is followed in Rheumatology at WRAMC. He is on Methotrexate for RA. As part of evaluation for a low albumin with fever or
weight loss, he has been found to have a IGG Lambda Monoclonal Gammopathy. He is not anemic. Is there anything which need be done further for this finding? I think he is due a Rheumatology follow-up next month. Thanks for your assistance. John " "DENNIS, GREGORY J" "" "" "We will review our clinic file and get back to you shortly." "LEGUIZAMO, JORGE P" "" "" "We usually get a 24 hrs urine protein electrophoresis, beta2 macroglobulin, ldh, quantitative immunoglobulins and skeletal survey/metastatic survey x-rays. We then decide on a bone marrow biopsy. Let me know if you want to get the tests and then get in touch with me or I can see him now. J Leguizamo h/o fellow" "OGLESBY, ROBERT J" "" "Rheumatology" "Mr. Jacobs has seen me in the past. I do not have access to his file today but recall only a slight decrease in his albulmin in the past year with an SPEP in the fall that did not reveal any abnormal band at that time. I will be glad to follow up with him at any time. Rob Oglesby" "BIGBEE, JOHN A" "" "" "Rob, perhaps

it might be better if you could see Mr. Jacobs and get the above tests submitted down there. Having seen him already and with him due in soon to your clinic that might be best. Let me know if you need a consult submitted for the TriCare wickets :) Thanks for you both for your swift responses." "OGLESBY, ROBERT J" "" "Rheumatology" "I called and left a message for Mr. Jacobs to call me.")

("055" "KELLY, WILLIAM F" "WRAMC" "Pulmonary Medicine" "As briefly mentioned at wed am conference: INH x 9 months will be the new recommendation for latent TB infection, regardless of HIV status. Twice weekly therapy is an alternate but acceptable regimen. INH resistant TB exposure is treated with RIF+PZA x 2 months or RIF x 4 months. Guidelines to come out in April issue of the American Journal of Respiratory and Critical Care medicine (supplement). REF: Dr. David L " "ELIASSON, ARN H" "WRAMC" "Pulmonary Medicine" "Thanks for the scoop, Bill.")

("056" "HUDAK, CRAIG M" "" "" "I have a patient, a 45 yo Hawaiian woman with mitral stenosis, who would benefit from a balloon mitral valvuloplasty. The balloon involved is made of latex. Just recently she developed what sounds like a contact allergy to latex. She works as a dental hygeinist, and with prolonged use of latex-containing gloves (hypo-allergenic or not, powder-free or not)--but not with latex-free gloves--she develops a rash only on her hands. No rash elsewhere, no bronchospasm, no hypotension, no mucous membrane sx. Is putting a latex balloon in her bloodstream contraindicated?" "FRANK, W THOMAS" "WRAMC" "Allergy" "Sorry for tardy response. Somehow I missed this one. Usually contact allergy is to a component of the gloves other than the latex (powder, accelerant etc).. We usually refer such pts to derm for patch testing. My guess is that you will probably be able to proceed with the valvuloplasty but we should see her in this clinic first to screen her for true latex allergy. Tom" "HUDAK, CRAIG M" "" "" "I was wondering when you guys would chime in! I^m at Tripler, and have a limited time window for treating this patient. I^ve had input from Allergy and Derm; unfortunately, because of
the patient^s work schedule, they have not fully evaluated her. She underwent repeat TEE (with a rubber tipped probe) yesterday with no unusual problems (other than anxiety). Allergy recommended RAST latex blood testing--won^t have the results probably until after the procedure.
The general consensus here seems to be go ahead and proceed with caution--and the patient has been so informed--and premedication would probably not be useful." "HUDAK, CRAIG M" "" "" "She had her procedure today--I premedicated with Solumedrol, and PO Benadryl and Tagamet, and avoided latex as much as possible. She had an uneventful procedure. Thanks for the help!" "ENGLER, RENATA" "" "" "Sorry for delay in response. The measurement of latex specific IgE certainly would be nice to know but up to 15% of in vitro screening tests are negative in truly allergic individuals. The history however is more contact in nature and may or may not be due to latex. This is a tough benefit-risk ratio case but as your subsequent history described tolerance to inert latex containing device use, so I would suspect this to be the case for the valvuloplasty. Certainly every other exposure during the procedure should be as latex-safe (NOT latex free)as possible. Documentation that no alternative device (non-latex) could be used. Most of these types of devices do NOT release the antigen so in that regard I would also suspect a low risk for serious systemic anaphylaxis. However, the theoretical risk exists and certainly all drugs to treat this should be readily available. Informed consent is also indicated for this issue after details of device latex content has been clarified. I am unaware of any case of systemic symptoms in this history related to a cardiac procedure but certainly have not done a lit search. I would search on the catheter device to be used and anaphylaxis, immediate hypersensitivity and/or latex to make sure there is not some case report out there we have missed.")

("057" "MCCROARY, KATHIE D" "" "Family Practice" "I am an FNP. I saw a 29 yr old AD male 2 weeks ago who c/o a lump on his chest. He had been seen at a civilian ER one day prior for the same complaint. He was dc^d w/o a dx and referred to his PCM. When I saw him, he had a smooth, mobile, painless 3in x 3in solid feeling mass behind the areolar region on his r chest. He had no fever, pain, erythema, etc. He denied the use of meds- rx, otc, or supplements. I didn^t specifically ask re recreational drugs. PMH-neg other than chronic musculoskeletal complaints for which he is currently undergoing a med board for. I sent him to rad for an ultrasound. The report said dense tissue. Rad then did a bilateral mammo which showed gynecomastia- r > l. Since I have never managed an adult male with gynecomastia, I looked up the recommended w/o in Griffiths 5-min consult. It states lab eval is rarely needed, however bhcg, testosterone, lh, estradiol, prolactin, lfts, tsh, chromosomal studies may be indicated. I have reason to suspect that recreational drug use may be a factor since he is being allowed to go to a civilian school while undergoing a MEB (with only phone contact to his unit) and lives in Baltimore. He also has
been very difficult to track down. He lives with his mother. I have called the residence several times. He has not been home for >5days and his mother has no idea where he is. My question to you is: What, if any, of the endocrine related tests are appropriate? Should I send him to you before or after the results are in?, and should I have his unit do a drug screen on him? Any help is appreciated. MAJ M." "VIGERSKY, ROBERT A" "WRAMC" "Endocrinology" "I would recommend that you obtain a testosterone, estradiol, beta-hcg, TSH LH/FSH, liver function tests, and serum creatinine. I agree that screening for recreational drugs may be appropriate since gynecomastia may be caused by THC contained in marihuana. Also the use of anabolic agents, like androstenedione or oral synthetic androgens, may cause gynecomastia. I would ask him about their use. Once these studies are done, it would be appropriate to get an endocrine consult." "MCCROARY, KATHIE D" "" "Family Practice" "Thanks for the assistance. MAJ McCroary")

("058" "SHALAUTA, MARK D" "" "Family Practice" "I^m one of the FPs from DeWitt. I know some departments do elective procedures to keep up their skills, and patients pay some out of pocket expense. Does Derm do any hair removal techniques for women eg upper lip/chin? If so, what is the cost? Thanks. Mark" "MONTEMARANO, ANDREW D" "WRAMC" "Dermatology" "No. We don^t do electrolysis or laser hair removal." "MAGGIO, KURT L" "WRAMC" "Dermatology" "We actually do a limited amount of this work now. Potential candidates for
laser hair removal are patients generally with coarse, dark hair with a valid medical problem ie chin folliculitis in a woman, etc. Patients can be referred to me on a regular consult booked through Sierra and I will make arrangements for their treatment. At this time there is no expense to patients. Our intention is to provided a limited amount of laser hair removal on a space available basis for valid medical problems...ie chin folliculitis in a woman. A man who does not want hair on his chest any more is clearly inappropriate, for example as we have limited resources, time, and
manpower to provide this service." "SHALAUTA, MARK D" "" "Family Practice" "Thanks so much!")

("059" "OTT, WILLIAM A" "West Point" "" "I have a 30 y.o african american soldier who I happened to incidentally notice an anemia in his past blood tests. When inquired about it he had no
idea that it existed. His h/h was 12.6 (14-18) and 37.5 (42-52) with a white count of 4.2 (4.8-10.8), done in 1999. No sig family hx, no signs and symptoms...I initiated a brief w/u, and his repeat h/h was 13.9/40.8 with a WBC of 4.0. Looking back in the records he had an earlier 1999 h/h of 15.0 and 45.3 with a WBC of 3.7. Every CBC had normal indices. His recent ferritin/TIBC/vit b12/folate/tsh/lfts were all WNL. His sickledex was neg. Should I be pursing his anemia anymore? And what of the leukocytosis on

each CBC? HIV neg 1999. Should I be concerned about that or assume in an otherwise healthy, fit soldier that this is normal for him?" "GALU, FRANCES" "West Point" "Information Management" "Dr. Ott this was transmitted to WRAMC without any problems, You might want to call WRAMC since this person might be on leave or TDY. Fran" "LEGUIZAMO, JORGE P" "" "" "is the blood smear normal? If you want we can see him, it is always nice to see the smear." "OTT, WILLIAM A" "West Point" "" "His smear was completely normal. Should I repeat the lab in a few weeks, and if still abnormal then refer?" "LEGUIZAMO, JORGE P" "" "" "sounds good")

("060" "TOEDT, DOMINIQUE M" "" "" "I have a 43 yo wf s/p thyroidectomy 1994 for papillary/follicular thyroid ca. Has been on suppression tx. Her current dose is .4 mg Her TSH=<.005, FT4=2.78 (hi) is this target, or is she on a bit too much?" "BURCH, HENRY B" "WRAMC" "Endocrinology" "Definitely a bit too much!! The exact target depends on a number of factors such as her age at diagnosis (she was in the low risk age group < 45), size of the tumor, local invasion, etc. Even in a high risk for recurrence patient, it^s rare to have to elevate the free T4 to above the upper normal limit to obtain a maximally suppressed TSH. I would stop her LT4 for a week and then restart at 0.2 mg/d, adjusting per tfts. We should see her in follow-up to help define a target TSH and imaging schedule.")

("061" "DEWEBER, KEVIN D" "Landstuhl" "" "My wife had symptomatic nephrolithiasis for the first time last summer. Itresolved with symptomatic treatment, but before undergoing her pelvic reconstruction surgery at Madigan she underwent an IVP, which showed noresidual stones but slight hydronephrosis on the right. She felt fine untillast month when she developed ephrolithiasis. The Klebsiella was adequatlytreated with ofloxacin, with negative f/u cultures after 2 wks, but she continued to have severe renal pain. An IVP recently showed no stones butbilateral medullary nephrocalcinosis. I^ve done a metabolic w/u that has revealed nl serum Ca, Mg, PO4, Na, bicarb, Cl, Bun/Cr, slightly low K of 3.5, and nl PTH. Urine 24 hr resultsincluded high Ca at 306, low citrate at 16, low K at 16, and normal Na (145)and PO4 (762).. She continues to be very weak and to have flank pains. constant Motrinusage have now led to classic ulcer symptoms, and she^s on Zantac now for that, and tramadol for pain (which causes too much sedation to be useful). I^m assuming the next step is to treat her with K-citrate, but I have some questions:1. Should we do a NH4Cl load test to r/o type I RTA?2. Is the citrate contraindicated given her ulcer (even orange juice upsets her stomach)?3. Are there other diagnoses we should consider?4. Will the nephrocalcinosis go away after treatment with citrate? Ifso, how long will it take, and how long can she expect to be in pain? Kevin deWeber, MD FP, Schweinfurt")

("062" "MENICH, MARK D" "WRAMC" "Allergy" "The December 1998 issue of Neurology had a supplement that addressed the use of IVIG in neurologic disorders. The library^s copy is in a very thick bound volume that doesn^t lend itself to quality copying. Does anyone have a loose copy on his or her journal shelf that I could borrow briefly to make a more readable copy? Thanks. Mark Menich" "LABUTTA, ROBERT J" "WRAMC" "Neurology" "Believe it or not, I was looking at that suppl. today. I have a copy in my" "MENICH, MARK D" "WRAMC" "Allergy" "What a system, huh? On my way....." "MARINI, ANN M" "" "" "Everyone should know that although supplements have reasonable information in them, they are NOT peer-reviewed. Thus, the information should be taken with that problem in mind." "MENICH, MARK D" "WRAMC" "Allergy" "Good; thanks. It^s a decent introductory summary, and the references are numerous.")

("063" "BUSSEY-GRANT, MARGARET E" "" "" "Dear GYN, I have a 37yo hf with Feb00 pap result of endometrial cells out of cycle and following endometrial bx sig for proliferative endometrium (no evid hyperplasia or dysplasia). Can I now reaasure her and place her back on her yearly pap schedule or does she need closer f/u? Thank you for your help!" "LOCKROW, ERNEST G" "" "" "Yes you can reassure her and she can go to annual paps. Generally proliferative endometrium in a 37 yo will coincide with anovulatory bleeding
if she has menorrhagia or menometarrhagia she may need cyclic provera to normalize her cycles and I also counsel these patients that initially their bleeding may worsen but over the course of 2-3 months of tx should improve." "BUSSEY-GRANT, MARGARET E" "" "" "great thank you!")

("064" "GEORGE, ARLENE E" "" "Adult Medicine" "ARE THERE ANY CONTRAINDICATIONS TO ASTHMA AND DVTS WITH THE ANTHRAX VACCINE?" "SMITH, LAURIE J" "WRAMC" "Allergy" "did you get an answer to this?" "GEORGE, ARLENE E" "" "Adult Medicine" "NO")

("065" "FRIEDMANN, JEANNIE" "" "Nursing" "I have a 15 yo pt. who received her first depo injection on 3 Mar 00. She is c/o severe HA, dizziness, nervousness and fatigue since the time of
injection. It has stayed basically the same, not worse, not better. She notes no changes in activity or other triggers for her sx. She is taking tylenol which provides some relief for HA^s. It is so bad that her mother brought her in today requesting I give her an excuse from school until this stops
because she feels it isn^t safe for her to walk home from school and she hasn^t had a day at school without feeling sick. This sounds pretty severe to me. I^ve called Upjohn Co. and they have no advise. What can I suggest to her, and should I refer her for further evaluation? Thanks for your prompt assistance." "OLIVER, THOMAS G" "" "" "I will forward this to the PEDs endo team. Thanks" "FENTON, CYDNEY L" "WRAMC" "Pediatric Endocrinology" "She appears to be one of the unfortunate women who is having problems with the Depo. All of her symptoms can be explained by the depo shot, however, because her headache is so severe she should have a good fundiscopic examintion to rule out the presence of increased ICP (pseudutumor cerebri). Therapeutic interventions should include discontinuing of the medication and treatment of her migraine....motrin or naprosyn or imitrex, etc. If her exam reveals evidence of papilledema medroxyprogesterone therapy should not be re-initiated." "STAFFORD, ELISABETH M" "" "Pediatrics" "If she had pseudotumor cerebri, I would have neurology involved in the management at that point" "FRIEDMANN, JEANNIE" "" "Nursing" "Dr. Fenton, Thanks for your reply. May I refer this pt. to see you? To which clinic would I write the referral and whom should I call to schedule an appt. Thanks very much." "FENTON, CYDNEY L" "WRAMC" "Pediatric Endocrinology" "Yes of course we would be very happy to see her. After you enter the consult
for pediatric endocrinology she can try Sierra or better yet call and they can schedule an appointment to see us." "SVEC, RITA L" "WRAMC" "Pediatric Endocrinology" "Since we have no ped endo clinic this week due to USUHS research day, she should come into either adolescent clinic at NNMC (or general peds clinic at). If she can^t go to school, she needs to be seen this week.")

("066" "DENNIS, BETH L" "" "Family Practice" "I have a 43 yo BF previously seen at ENDO and had FNA of left lobe nodule that was benign. this was in 98. Since then it seems nodule is enlarging and she did not fu there as directed. Recently got US which shows 3 x 1.8 x 2.5
cm solid heterogenous mass in LLL. There was a 7mm mass in the 98 US but by the description it is hard to tell if this is the same thing. TSH is normal. Re-referral placed. Does she need to get in quicker? Any thing else needed? Do you want nuc scans first?" "BURCH, HENRY B" "" "Endocrinology" "Do you know who she saw previously? If you send her name and last 4, we can

determine this and book her for an appropriate appt." "DENNIS, BETH L" "" "Family Practice" "It was booked to Tourtelot but reference was made to Dr Utica? signed by a 3rd year student only." "BURCH, HENRY B" "" "Endocrinology" "Neither are here now. Please send her name/number and we^ll book this and call her." "DENNIS, BETH L" "" "Family Practice" "Please let me know what you think. Thanks for your assistance" "BURCH, HENRY B" "" "Endocrinology" "She^s scheduled for this Friday 24 Mar @ 08:00. She has been notified.
We^ll let you know what we think; I suspect she will need a repeat FNA." "DENNIS, BETH L" "" "Family Practice" "Thanks! She^s going to see me the following Tues")

("067" "SCOTT, PAUL T" "West Point" "" "Hi, I would like you opinion on the evaluation and treatment of the following patient please. A 9yo female presented to the ER with complaint of fever, sl cough, and right sided flank pain for 4 days. No dysuria and no gross hematuria, no other sx. Pe revealed Temp 103.1, tachycardia and mod ruq tenderness to palpation but no rebound. UA was 1.015, tr blood with 0-2 rbc, prot 30, nitrite +, small LE, 5-10 wbc, moderate bacteria, and 5-10 squamous cells. This was a clean catch specimen. Urine culture grew 100, 000 E-coli. LFT^s, amylase, and lipase were normal. wbc was 8.3 with 68N, 3B, 12L with normal h/h and plt. KUB was normal. The patient was treated with 10days of septra and put on septra prophylaxis. Renal u/s was normal. Repeat cx at three days for test of cure was negative. The patient was referred for VCUG but the pt/mother aborted the procedure due to pain. Currently they do not want to do the procedure. My questions are: 1. Do you agree that this clinical picture was consistent with
pyelonephritis? 2. Do you recommend VCUG? 3. Do you have any experience with sedation for a procedure like this? And would sedation affect the results of the VCUG? What would you recommend to use for sedation? 4. Do you recommend VCUG for siblings of this patient? Thank you for your assistance with this patient. Paul Scott" "YUAN, CHRISTINA M" "WRAMC" "Nephrology" "Please let me refer this to Dr. Yao, our pediatric nephrologist." "SCOTT, PAUL T" "West Point" "" "Dr. Yuan-did you forward this message to Dr. Yao? Thank you. paul" "YAO, LYNNE PEI" "WRAMC" "Nephrology" "Yes, Dr. Scott, I did receive your message, and thought I replied already. Sorry! To answer your questions: 1. As you know, the diagnosis of pyelonephritis is clinical, and based on your description it sounds as though she probably had pyelonephritis. 2. In children who develop pyelonephritis vesico-ureteral reflux (VUR) is a common associated finding, esp. in children less than 6-7 years of age. Because of this we recommend VCUG testing for children less than 6-7 years of age with first time UTI or if the history strongly suggests a history of pyelonephritis or UTI as an infant. Did this child have UTI/pyelo in the past? If NOT, then VCUG testing is NOT an absolute. 3. VCUG testing should be done while the child is awake as voiding dynamics change when the child is asleep. Therefore, VCUG testing cannot be done with sedation. 4. I do not recommend screening her siblings for reflux unless they have a past history of UTI.")

("068" "MELVIN, KRISTAL C" "" "Nursing" "This is a request for help from any and all neurologists. I saw 9mo female today, s/p fall injury 1 week ago. Mother did not report fall injury at the time, probably because of fear of neglect charges. Child fell sbout 3 feet, from parents bed to hardwood floor and now has soft, raised area on left side of head. Our on-cal pediatirician, Dr Bassey, told me that we need to schedule CT for this age group through the sedation unit. The sedation unit tells me that they are heavily booked for this week. My questions are: Can this child (no neuro changes) wait until next week for CT? Or, can CT be safely done without sedation or in another way? Thank you for input and advice." "DIFAZIO, MARC P" "WRAMC" "Pediatric Neurology" "I would be concerned regarding this history of fear of neglect -- I would recommend that it be done sooner than later, and expedited through the sedation unit, if at all possible. It is likely to be normal from an intracranial standpoint, but even a simple linear fracture should be delineated and followed because of the possibility of a leptomeningeal cyst. I will forward this to MAJ Coughlin, who is extremely busy, but may be able to help us. I would not wait for an outpatient schedule to open up if the schedule is full. Is Dr. Bassey able to help you facilitate this? Let us know if we can help. md" "MELVIN, KRISTAL C" "" "Nursing" "Thank you, the concern of neglect is Dr. Bassey^s main reason for wanting this sooner. I appreciate your advice and assistance. I will call the sedation unti again later today to see if any openings have come up, or if
they can work this child in." "MITCHELL, MICHAEL H" "WRAMC" "Neurology" "alternative is for PCM to req admission ward 51, esp if ch protective issues are of conern.." "MELVIN, KRISTAL C" "" "Nursing" "thank you, I will keep that in mind for future use.")

("069" "BIGBEE, JOHN A" "" "" "I have seen a 39y/o female a few times since 8/99 for persistent fatigue which is having some effects on her ADLs. Her physical exam is not revealing
of significant abnormalities. Her lab data show a normal FBS, normal TSHx3, normal T3 and low Free T4 x3; TC is 236, TG 331, HDL 48 and LDL 122. She is not anemic and has had had fluctuating ALT levels with a negative chronic hepatitis panel. Stress and depression could certainly be factors but is there any recommendation regarding the free T4 findings? Thanks for your assistance." "BERNET, VICTOR J" "WRAMC" "Endocrinology" "We would really need to see all the lab results in order to give you any intelligent feedback. Please provide name and last 4 of SSN" "BURCH, HENRY B" "WRAMC" "Endocrinology" "I agree w/ Dr Bernet. Since the differential of a low FT4 and normal TSH ranges from something as simple as a drug effect to something as serious as pituitary insufficiency from a CNS tumor, a consult to see us is certainly
warranted." "BIGBEE, JOHN A" "" "" "Thanks for your advice, if you can review the labs to date. Have a good weekend." "BIGBEE, JOHN A" "" "" "I have given this aptient a consult as recommended. Could your receptionist call her. Thanks for your help." "BERNET, VICTOR J" "WRAMC" "Endocrinology" "It would be best for pt to and arraange the appt with our front desk. Thanks" "BIGBEE, JOHN A" "" "" "Thanks again for your assistance")

("070" "HORWHAT, JOHN D" "" "" "I have a patient referred to Dr Wong that is coming up from Harrisonburg VAarea for a pneumatic dilation for achalasia. As part of his evaluation down there he had a CT of chest/abdo that revealed interstitial changes/groundglass appearance in antr sup seg RUL, sup segs both lower lobes as well as lingular division of LUL. The reading radiologist down there mentioned suchthings as endobronchial spread of infection, hypersensitivity, UIP, DIP, LIPand endobronchial spread of tumor such that the patient had scheduled himself to see a pulmonary doc down there on 7 April. Since he will be coming up here around 11 AM on the 29th and likely staying overnight after his achalasia dilation, I was sending this note out to see if there was anyone in your clinic that could see him while he was here. I think that he stands a much greater chance of these CT findings being related to aspiration from his food and fluid filled achalasia esophagus than the cancer that he is fearing, but would appreciate your expert opinions and save him from payingout for another civilian encounter. He has a hx of DM, MI/CABG in 1980and prostate ca. He is reported to be on Novolin, ecotrin, nitro patch, pepcid, lupron and calan with no allergies. Sorry, I don^t have much more than that. Dave Horwhat" "ROOP, STUART A" "WRAMC" "Pulmonary" "I will give them a call." "HORWHAT, JOHN D" "" "" "Thanks. I failed to mention that he is not in our CHCS yet." "HNATIUK, OLEH W" "WRAMC" "Pulmonary" "John, I agree with your assessment regarding the probable cause of hisinterstitial changes and also agree that he needs to be seen by apulmonologist. Determining the difference noninvasively is not easy, butStuart should be up to the challenge.....Thanks for the referral. OWH"

"O^NEIL, KEVIN M" "Bethesda/Naval" "Pulmonary" "There are also associations with atypical mycobacterial infections and esophageal disease as well to consider.")

("071" "PARKER, CHRISTOPHER T" "" "" "Assessment of the potential for neurologic injury is especially important in patients with advanced RA requiring general anesthesia because of the risk of cervical cord compression during intubation. Plain lateral radiographs of the cervical spine, with views taken in flexion and extension, are used to assess the degreee of instability.... operative stabliization of the cervical spine should be done to minimize the risk of irreversible paralysis,
REGARDLESS of whether neurologic signs or symptoms are present in patients who have AA subluxation and a posterior atlanto-odontoid interval of 14mm or less..., basilar invagination of 5mm or more, .. and >8mm in the anterior AA interval (From Rheumatology MSKAP and Boden SD Spine 1994;19:2275-80.) I remember it as 9+5=14 (all the important numbers are there) to rheum and pm and r" "ROEBUCK, JON D" "" "Rheumatology" "thanks Chris, will put this in the save mailbox (and hopefully long term memory)" "BRAVERMAN, STEVEN E" "WRAMC" "PM&R" "Thanks for including us, Chris." "KIM, ANN" "WRAMC" "PM&R" "thanks for the information." "ALGEO, DONALD W" "" "" "u da man, Thanks Chris this is very helpul for clarification. Don")

("072" "ZEIEN, TIMOTHY J II" "Fort Belvoir" "Internal Medicine" "I have a 55 yo w.f. with hx of TAH in 1987, placed on HRT in 1991, and s/pantrectomy/vagotomy for DU in 1997 c/b dumping syndrome. Her weight is 102lbs now and it was approx 130 in 1996. She has difficulty maintaining her weight due to the dumping syndrome. She takes cholestyramine and an estrogenpatch (I switched over to a patch around a year ago b/c she was having hotflashes on the estrogen pills and I was concerned about absorption) I ordered a BMD study which showed a T score of -2.5 in the femoral neck and-3.0 in the vertebral spine. Her urine calcium is 106, upep=no pattern seen, p1-p3, spep, cbc, tft^s, vitamin d, pth all normal.I am trying to determine whether there is a secondary cause for herosteoporosis or whether it may be due to malabsorption of her meds bycholestyramine vs dumping. Do you recommend a further w/u or just adding amed like calcitonin to tx regimen along wth calcium and vitamin D." "BERNET, VICTOR J" "WRAMC" "Endocrinology" "Sounds like someone we would love to see at least once. She might be a great candidate for IV pamidronate infusions. Sounds like you did a good r/o forsecondary causes although would have to see the specific results.Malabsorption could definitely be playing a role. Her oral calcium should bemaximized and we might have specific recommendations on calcium supp lementsetc. Also, did you do Vit D levels?" "OLIVER, THOMAS G" "" "" "If this lady landed in our lap with the following studies, it would make our lives easier: Serum-B 12/folate/homocysteine/methylmalonic acid/uric acid, 25 & 1, 25 vit D Urine-calcium/PO4/crea/protein/uric acid/urea nitrogen/cortisol/upep(24hr study please.
Stool: culture/wbc/fat. Probably also would like to see PT/PTT, prealbumin. Depending on why she had ulcer disease, might include an H. pylori IgG. I^m guessing, if she is on a resin, that you have a lipid panel. Thanks, Tom" "ZEIEN, TIMOTHY J II" "Fort Belvoir" "Internal Medicine" "Thanks for the responses. The pt has decided to go to NNMC since that^s where her ulcer surgery was performed. I^ll order the above studies.")

("073" "ONEIL, TERI M" "" "" "How do we get a patient in for sleep study. I gave apatient a consult for a sleep study consult and they were given three different numbers to try and make this appt. None of the numbers worked. Sierra didn^t know what to do with it. WRAMC info gave them a wrong number. What is the proper way to send this young woman who has been living on ambiens nightly for sleep and needs a sleep study? Thanks MAJ O^Neil" "TOEDT, DOMINIQUE M" "" "" "the sleep lab at WRAMC is sun by Pulm. If on your first attempt you did consult to s-sleep study, try s-pulm or have pt call If she^s not active duty, she may get referred out. I have had several pts go to the Wash Sleep Center. However, if sh^e having to take ambien, then her problem sounds like insomnia, and you can^t do a sleep study on someone who doesn^t sleep. If clinically indicated, try neuro or psych." "ONEIL, TERI M" "" "" "Thanks Dominique. I remember when someone came once to talk about sleep disorders and they commented that ambiens should not be used for permanent sleeping difficulties. This patient has multiple problems such as Restless leg syndrome and someone took her off of depakote so she has had more sleeping difficulties. I did send her back to neuro for that, but I will try pulmonary for the sleep too. Thanks so much. Teri" "MELVIN, KRISTAL C" "" "Nursing" "A few mos ago I saw a woman who had not slept without Ativan for over 3 years. I asked neuro about this and they said she needed a sleep study to see if she really does have insomnia or just perceives this. The neurologist from Bethesda arranged for her to have this done there. The way they do it for the patient to get a neuro cons first, then they set up the sleep study. I hope this helps. Kristal" "ONEIL, TERI M" "" "" "Kristal, I bet I saw that same patient... Maybe could be another one. So neuro did the sleep study. I thought ENT did it for some reason but Since this woman is going to neuro I am going to have her ask them about the sleep study. This woman I am presently seeing has the Restless leg syndrome and leg pain. I wanted to do a bone scan on her because I think if she didn^t have the pain she could sleep. When she was on Depakote she could sleep and she felt better, but someone took her off she said ^because they didn^t want to follow her levels^. I am leaving so I didn^t want to put her back on it and not follow her. Neurontin is another seizure med that may help with this restless leg
syndrome plus it causes somulence. I haven^t used it so I don^t feel comfortable with it but I will let neuro decide what they want to do . Thanks guys. Teri")

("074" "BETT, BARI J" "" "" "I have a 66 y o w f with 2-3 year h/o of onycholysis and sl greenish discoloration of great toenails, L > R, no debris, no crumbling, unable to culture anything, no thickening of nail, just loosening, sl whitish sl greenish color on distal half of nails. She was given sporanox but got red bumps after 3 days. I think this looks more like pseudomonas of nail rather than onychomycosis. what do you think and what do you suggest as tx? thanks." "SPERLING, LEONARD C" "USUHS" "Dermatology" "just going with the odds, she probably has onychomycosis and the pseudomonas is a secondary invader. Sporanox should not be started without KOH or culture confirmation of a dermatophyte. If you can^t accomplish this, referral to
derm is appropriate. That^s what we^re trained to do." "BETT, BARI J" "" "" "ok, I will send a referral.")

("075" "FOOTE, JOHN H" "Landstuhl" "" "I have a question regarding a 24 yo lady who recently had a +PPD and started INH 24 Mar 00. She saw me today for a Physical so that she can work in child developement services as a caretaker. She had a normal CxR 2 weeks ago. She has no symptoms and no complaints. Question: 1. Can she be cleared to work as a caregiver? 2. If, not now, when could she be cleared? John Foote, MD" "REYNOLDS, ANDREW J" "Landstuhl" "" "Infectiousness of TB is related to the amount of AFB they put in the air. Pt^s tht are considered infectious have: 1. Active cough 2. Positive AFB on sputum 3. Undergoing cough-inducing procedures or aerosol-generating procedures 4. Have active TB and are not receiving therapy She doesn^t appear to have active TB and does not have a cough or positive CXR. I would consider her to be NON-infectious and would allow her to go back to work. Would stress importance of education, compliance, return for new sxs, etc." "FOOTE, JOHN H" "Landstuhl" "" "Thank you for the information." "COX, KARIN A" "WRAMC" "" "I appreciate your concern regarding this issue. There are no regulations civilian

or military limiting work activities solely based on a positive PPD result. Provider Exclusion/Readmittance Criteria A child care provider should be temporarily excluded from providing care to children if she or he has one or more of the following conditions. Condition/ Exclude from Child Care Facility Chickenpox Until 6 days after the start of rash or when sores have dried/crusted. Shingles Only if sores cannot be covered by clothing or a dressing; if not, exclude until sores have crusted and are dry. A person with active shingles
should not care for immune suppressed children. Rash with fever or joint pain Until diagnosed not to be measles or rubella. Measles Until 5 days after rash starts. Rubella Until 6 days after rash starts. Mumps Until 9 days after glands begin to swell.Diarrheal illness If 3 or more episodes of loose stools during previous 24 hours, or if diarrhea is accompanied by fever, until diarrhea resolves. Vomiting If 2 or more epidsodes of vomiting during the previous 24 hours, or if accompanied by a fever, until vomiting resolves or is determined to be due to such noninfectious conditions as pregnancy or a digestive disorder.
Hepatitis A For 1 week after jaundice appears or as directed by health department, especially when no symptoms are present. Pertussis Until after 5 days of antibiotic therapy. Impetigo (a skin infection) Until 24 hours after antibiotic treatment begins and lesions are not
draining. Active Tuberculosis (TB) Until the local health department approves return to the facility. Strep throat (or other streptococcal infection) Until 24 hours after initial antibiotic treatment Scabies/head lice/etc. Until 24 hours after treatment has begun. Purulent conjunctivitis. Until 24 hours after treatment has begun. Other conditions mandated by state public health law. Sorry about the format of this cut and paste job. I am not savvy enough to reformat this, but hope this helps. It is taken from the CDC. Please feel free to consult with any occupational health nurse or physician about medical issues relating to employment. If I can be of further assistance, please let me know. Karin Cox, MD")

("077" "MANNO, SALVATORE A" "Landstuhl" "" "Sir or Maam, I am writing with regard to a pt. I have at our health clinic. The pt. is a 15 y\o male who 6 weeks ago began to experience dysuria with associated hematuria. The pt. was originally seen at Vilseck^s TMC and was treated as haveing a UTI. The pt. about 5 days later began to experience suprapubic pain and flank pain. He then was seen in our clinic where labs were completed and eventually showed a 24 TP excretion of 534mg. The pt. was sent to the German economy and seen at Weiden hospital where the MOP states blood work, renal us, and ua^s were completed. The pt. was then released and told to f\u if the hematuria and dysuria reoccured while a working diagnosis was to be formulated. The symptoms reappeared and the pt. returned to the hospital where he was told he probably passed a stone. The MOP is exteremely unhappy with the care and came to our clinic seeking a referral to American doctors. The german hospital report is still being translated. prior to sending the pt., to your office would you like any additional labs or radiologicc work-up completed. Thank you." "YUAN, CHRISTINA M" "WRAMC" "Nephrology" "Will refer to our pediatric nephrologist, Dr. Lynne Yao. Do you mean that the patient is coming to WRAMC to be seen?" "YAO, LYNNE PEI" "WRAMC" "Pediatric-Nephrology" "It sounds as though this patient may have passed a kidney stone, however the history is unclear to me. It may be worthwhile for the patient to be evaluated by your urologist before referral back to the US to see me. A 24 hour urine protein of 534 mg may be elevated, but may be as simple as orthostatic proteinuria. Does this patient have hypertension? Dyuria, flank, and suprapubic pain on not usually a characteristic finding with acute or chronic glomerular diseaseThanks. If it is easier for your, I am also on the outlook global address list to send e-mail. Thanks. Lynne Yao, MD Chief, pediatric nephrology" "YAO, LYNNE PEI" "" "Pediatric Nephrology" "Received your tel. message, but unfortunately am unable to connect to DSN overseas. I^m still unclear about the history on this patient, and therefore not sure that it is necessary for him to be A/E here. 1. Does this patient have a history of elevated BP?
2. Does this patient currently have hematuria or an elevated urine protein/creatinine ratio? 3. Does this patient have elevated serum chemistries? These are easy but important tests that should be run prior to sending him here. If these tests are normal it is unlikely that an evaluation by me
would be any more helpful than an evaluation by a urologist. I would be happy to discuss this case with you personally, if you could send me your commercial number that would be helpful. Also, I^d be happy to discuss this case with your FP staff physician if this would help clarify the situation. Another option would be to send him to see the pediatric staff at Landstuhl for evaluation. Please don^t take this to mean that I do not want to see the patient, but I^m not sure that sending him back at government expense is the best solution currently based on the clinical situation. Thanks for your help. Lynne Yao, MD")

("078" "YOON, KUNCHUL" "West Point" "Pediatrics" "I admitted 6 week old infant with hx of fever of 102 F and cold sx. Sepsis w/u including spinal fluid study negative except blood culture:strep. viridance. Patient is doing well, no fever, eating well. Question:Shall I continue Rocephin or D/C ABX assuming this is contamination? Thank you, Dr. Yoon Staff Pediatrician" "WORTMANN, GLENN W" "WRAMC" "Infectious Diseases" "Sorry for the delay in responding... and page the pediatric ID fellow on call to discuss the case." "GOLDBERG, DAVID I" "" "Pediatrics" "Actually Glen you beat me to the punch. My apologies for the delay in answering your question. Outside of certain high risk patients to include immunosuppressed patients and neonates, strep viridans is usually considered to be a contaminant from the skin or oropharynx. In the child with a clinical viral process, and who is being evaluated for R/O Serious Bacterial Illness due to age alone and has a normal physical exam (ie no new heart murmer), the presence of strep viridans can be considered non-pathogenic and therapy can be halted.")

("079" "ALLARD, SUSAN T" "" "" "My patient is a 27yoBF seeking clearance for authorization as a daycare provider. She has no known history of any childhood communicable diseases, but her mother is no longer alive to confirm/deny this. Pt does not have a copy of her immunization records and does not think she can get a copy. I thought I could give her a tetanus booster and MMR and check a varicella titer, but the daycare also wants polio. should I instead check titers of rubella, rubeola, varicella and mumps? And polio too? and give her a tetanus booster? My supervising physician thought also that maybe it would just be easier to refer her to immunization/allergy and let the consulting physician decide. I^d appreciate your input as to the appropriate way for me to procede with my patient. thanks, " "SMITH, LAURIE J" "WRAMC" "Allergy" "we usually do not do titers, but rather immunize according to requirements and have occupational health or primary md do the titers. She should have one adult dose of polio vaccine; if she has not, give it. you should do the rubella, rubeola, mumps, varicella titers. she propably needs hep a in day care and possibly even hep b. ok to do tetanus booster if it has been 10 yrs." "ALLARD, SUSAN T" "" "" "Thank-you so much for your prompt reply and the useful info. I had thought of the hep A and B^s but for some reason neglected to do anything further that ^think^ about them. Again, thanks.")

("080" "AARONSON, JACOB W" "" "Family Practice" "Pt is a 55 y/o female NOT on HRT with one episode of vaginal bleeding for 7 days for the first time after menopause 4 years ago. US showed normal endometrial strip (3-4mm) except in the region of the fundus where there was a heterogeneously, slightly hyperechoic region measuring a maximum of 1.5 cm - This either represents a

submucosal fibroid or thickening of the endometrium (distinction between these possibility is not clear). Near the superior-posterior aspect of the region of the endometrial cavity, there is a focal hyperechoic nodular structure measuring 7 mm in size. On transverse image, this appears either at the periphery of the endometrial cavity or immediately adjacent to it and could, therefore, represent a submucosal fibroid versus focal endometrial lesion. EMB showed ^fragments of benign endometrial glands and stroma^. Is this work up complete, can I attribute
her episode of bleeding to a probable fibroid, or should I have her see a gynecologist? I would appreciate your input. Jacob Aaronson, DO" "LOCKROW, ERNEST G" "" "" "You can ask 12 different gynecologists this question and probably get 12 different answers. The endometrial biopsy is reassuring but does not preclude malignancy in light of a possible anatomical cause of her postmenopausal bleeding although the risk of malignancy is less than 1% at this point. The most reasurring thing to do is to look inside the cavity either with office hysteroscopy or in the OR and determine that it is in fact a submucosal fibroid. If the patient has persistent postmenopausal bleeding then I would absolutely refer her to gynecology. hope that helps." "AARONSON, JACOB W" "" "Family Practice" "This does help. I always want to do what I can within the primary care
setting and refer appropriately. I will refer her to gynecology. Thank you, ")

("081" "RAMSEY, ROBERT L" "WRAMC" "Internal Medicine" "This very nice 73 yo lady is very hard of hearing and is missing a lot. It is hard to take care of her and explain her medical regimen to her because she can^t hear well. She is poorly educated and has been afraid of hearing aides because she thinks it involves surgery. I put in a cln order but she really can^t navigate the system well on her own. Can someone call her with an appt when her time comes?" "MACNEIL, DONNA M" "WRAMC" "Pediatric-Audiology" "Dr. Ramsey, I will give her a call. Thanks.
Donna MacNeil" "RAMSEY, ROBERT L" "WRAMC" "Internal Medicine" "Thanks!")

("082" "BETT, BARI J" "" "" "I have a 10 y o girl with 5 mo h/o plantar skin lesion of the heel of L foot. Lesions began as peeling and cracking of skin of sole at heel and eval as dyshydrotic eczema and treated w westcort. It seems to help a bit, but then recurred w thickining and cracking. She has a well-demarcated area of thickening and cracking of the sole of the foot only at the heel. The rest ofthe skin of the soles is normal as is rest of skin. Could this be a moccasin type tinea? what do you suggest?" "SPERLING, LEONARD C" "USUHS" "Dermatology" "unlikely to be tinea in a 10 yo girl. Does she have a history of atopy? Could it be a wart?" "BETT, BARI J" "" "" "No, I don^t think it is a wart as it covers the entire heel going up the sides a bit. but I suppose it could be atopy, altho the rest of her skin except this heel is normal. I will refer her for you all to take a look. It is quite striking. (and annoying to the patient).")

("083" "DICERBO, JULIE P" "" "" "I have a 38 yo male with a chronic daily headache x 3 months, sx worsening with no focal neuro signs. MRI was reported as essentially normal, apart
from probable hypoplasia or occluded r vertebral artery, but without parenchymal changes. Is this finding of any immediate concern? Pt has an appt with neuro mid April. Sorry this history is minimal. I have no chart available to refresh my memory, and I^ve not been successful in reaching the patient to check on status. thanks" "MARINI, ANN M" "" "" "If the patient complains of focal neurological signs such as facial numbness, double vision etc, patient should be seen in Neuro clinic immediately or sent to the emergency room. There are patients with headache as harbinger of cerebrovascular disease. Patients with posterior circulation disease can also have headaches. Hypoplastic vertebrals can occur but in the presence of new headaches, patient needs careful history regarding neuro sx." "LABUTTA, ROBERT J" "WRAMC" "Neurology" "Agree with above. Vertebral artery hypoplasia is common, but quantifying the concern is based upon information that would be included in a complete H & P. Previous HA prior to 3 months ago, hx of trauma (even minor), sensory symptoms or signs, oculosympathetic paresis, ...would be some of the things that I would like to know.")

("084" "BUSSEY-GRANT, MARGARET E" "Fort Lee" "Family Practice" "Dear Rheumatology, A 31yo wm with psoriatic arthritis came in for a flight physical today. By regulation he is unfit for airborne due to his psoriasis But he was on jump status before the diagnosis. Does he need to have his wings clipped or can he be cleared to jump. He is on training here at FT Lee, VA and his perm duty station is Kentucky (no MTF avail). He is asymptomatic on indocin. Please advise. Thank you-Margaret Bussey-Grant (FP Ft Lee)" "ROEBUCK, JON D" "" "Rheumatology" "I believe that as long as he can function in his MOS with standard treatment measures that he can still be cleared for duty. I will verify this with senior staff in the department and leave an additional message. Jon" "DENNIS, GREGORY J" "" "" "His psoriasis must be pretty bad if it makes him unfit. Remember, while there are many physical conditions listed in AR 40-501, all may not require an MEB for referral to the Physical Evaluation Board (PEB) where fitness or
unfitness is determined under the authority of the U.S. Army Physical Disability Agency. In the absence of symptoms that indicate impairment from psoriatic arthritis, it is not necessary to functionally restrict his activities, unless you perceive that he or others are at risk for injury." "BUSSEY-GRANT, MARGARET E" "Fort Lee" "Family Practice" "Great will clear him! Thank you!")

("085" "HASAN, BAZIGHA" "" "Family Practice" "42 YOF SMOKER HAS ALLERGIC RHINITIS NOTICED TO HAVE PLATELET COUNT OF 120 DURINF ROUTINE EXAM, REPEATS SINCE THEN AT ONE AND THREE MTHS INTERVAL HAVE BEEN 130, OOO AND126.OOO.SHOULD ANYTHING BE DONE AND WHAT" "LEGUIZAMO, JORGE P" "" "" "would repeat cbc in a blue top r/o clumping. Blood smear to eval for hemolysis (DIC, TTP, HUS), ANA (SLE), TSH, PT/PTT (DIC), HIV, b12/folate, physical exam for splenomegaly. alcohol history, drug hx (ie estrogen, thiazides, b blockers, heparin, gold, ASA), iron (rare with iron deficiency, but reported), RF (RA may present with splenomegaly, arthritis, low platelets), If other cell lines are normal, destruction is more common. If other cell lines are down, sequestration or marrow problems may be present. Let us know is you need anything else J Leguizamo h/o fellow" "MURPHY, TIMOTHY J" "" "" "what is the mean platelet volume--MPV? Dr. Diehl would be proud.....")

("086" "ALLARD, SUSAN T" "" "" "I have a 27yoWF with depression and mood disorder, chronic constipation, and hx of anorexia a few years ago requiring hospitalization, but not currently active, and with new onset of generally feeling fatigued, sometimes dizzy, with
memory loss and on no medications. She takes topamax, Celexa and folic acid and topical acne medications. PMHx sig for kidney infection in the past year. FamHx sig for early onset multiple sclerosis, HTN, DM and ADHD and breast and colon cancers. Today she was found to have the following labs with a low BUN and creatinine

	12/99	9/99	11/98
NA	140	141	139	140
K+	4.3	3.5	3.8	3.8
Cl-	108	109	105	104

CO2	23	21	24	27
GLuc	81	111	77	78
BUN	3	4	3	8
CR	0.6	0.6	0.7	0.6

My supervising physician recommended I recheck her LFTs which were normal last September and albumin (also normal in the past) and to query her eating habits. She states she eats only 1-2 meals a day and drinks a lot of soda (maybe 8 glasses per day). Wer also checked the PDR to see if this were possibly a problem with either celexa or Topamax, but could find none. She asked me to ask for your thoughts. Is this low BUN worrisome and what other things should I be looking for other
than starvation and liver function abnormalities. And is there anything further we should be looking at for her? Or do we not follow any further? She is about 113 pounds and probably 5^4in or so with BP 110/60 and pulse 69. Thanks so much for your assistance. Sue Allard PA-C" "ABBOTT, KEVIN C" "WRAMC" "Nephrology" "Except for labs number two which showed a CO2 of 21 and a K of 3.5, I don^t see a net trend. I think referring her to nutrtition (if not already done) could be helpful, although if she has a signficant behavioural disorder she might not be receptive. Low BUN and CR and her low weight, along with the history, certainly suggest under nutrition and a possible active eating disorder. She doesn^t have an alkalosis to suggest chronic vomiting but you might check the backs of her front teeth for erosions." "YUAN, CHRISTINA M" "WRAMC" "Nephrology" "Her BUN is low, and her creatinine is also--both are in the normal range for a woman who probably doesn^t have a lot of muscle mass, and probably has a low protein diet." "ALLARD, SUSAN T" "" "" "Thank-you both for your replies. Will use this information in caring for her. Doesn^t sound like there^s much else to be looking for. With appreciation!!")

("087" "FRIEDRICHS, RITA A" "Fort Belvoir" "Internal Medicine" "I have a question regarding estrogen and MS. I follow a 44 yo woman with MS for about 5-6 years, probably relapsing/remitting, who has been on avonex for several years and has been stable. She read on the internet that estrogen was helpful for MS and was given an rx for prempro by her previous pcm. She has been taking this for several years, with no sig change in her symptoms. She is NOT menopausal. I think that there have been studies suggesting improved cognitivie function in postmenopausal women with MS when they use estrogen replacement, and some recent animal studies using estriol. However, I am not aware of the use of low dose estrogen in premenopausal woman with MS. My concern in this patient is that I am unclear on the benefits she is receiving from this regimen, and that at this dose of estrogen, she is at risk for thrombotic complications without the contraceptive benefits. Are there any benefits for estrogen use in premenopausal women with MS or any beenfits of oral contraceptives in premenopausal women with MS. (Of note, this patient does not seem to have flares of her MS with her menstrual cycles). Thanks. RAF" "DOUGHERTY, DAVID S" "" "" "It is my opinion that there is no value added for estrogen in pre or post menopausal MS as it relates to the primary demyelinative process. If questions about her disease should arise, a referral to the MS clinic at NNMC might be indicated." "FRIEDRICHS, RITA A" "Fort Belvoir" "Internal Medicine" "THanks for your response" "LABUTTA, ROBERT J" "WRAMC" "Neurology" "Rita, ")

("088" "DICERBO, JULIE P" "" "" "I have a 48 yo female with premature ovarian failure 10 yrs ago, who has never been on hrt. Her bone density study shows -2.1 score at lumbar vertebrae and 0.3 at femoral neck with a finding of osteopenia. She has agreed to start hrt. She has no contraindications to hrt. She will be taking 1500 mg calcium. Is there any indication for an endocrinology consult for consideration of fosomax for this patient, or is hrt and calcium adequate at this point. Thanks" "VIGERSKY, ROBERT A" "WRAMC" "Endocrinology" "I don^t think she needs an endocrine consult at this point. I would follow her bone density over the next 18-24 months and, if there is no significant improvement, consider Fosamax or another bisphosphonate. Make sure she is getting Vit D along with her calcium supplement." "BERNET, VICTOR J" "WRAMC" "Endocrinology" "A multivitamin will have 400IU of Vit D")

("089" "STROOP, DEEANN M" "" "Family Practice" "I HAD A FIRST TIME PATIENT TODAY WHO CAME IN REQUESTING A REFILL OF HER ERT (CURRENTLY ON PREMARIN 0.625 QD AND ESTRATEST HS QOD). DURRING HER EVALUATION I FOUND SHE HAD HAD A TAH/BSO IN 85 FOR DUB. IN 1990, SHE UNDERWENT A RIGHT MRM FOR T1N0M0 INFILTRATING DUCTAL CA THAT WAS ESTROGEN RECEPTOR +. SHE DID NOT HAVE CHEMO OR TAMOXIFEN. SHE HAS SINCE HAD AN IMPLANT. SHE C/O DECREASED LIBIDO SINCE HER SURGERY AND IN 1998 WAS PLACED ON PREMARIN. ESTRATEST HS WAS ADDED A FEW MONTHS LATER. SHE HAS BEEN ON IT SINCE WITH GOOD RESPONSE IN REGUARDS TO HER LIBIDO AND LUBRICATION. SHE IS NO LONGER FOLLOWED BY ANY OF THE SPECIALIST. I WAS UNCOMFORTABLE PRESCRIBING ERT TO AN ER+ BREAST CA PATIENT EVEN 10 YEARS OUT. IS THIS AN OK THING TO DO? IS THERE A REASON TO USE THE MEDS THE WAY SHE HAS BEEN INSTEAD OF JUST USING ESTRATEST HS QD? PLEASE HELP. THANKS! DEEANN STROOP, MD" "ARMSTRONG, ALICIA Y" "WRAMC" "Ob/Gyn" "Although she is 10 years out I will still consult a Medical Oncologist before prescribing HRT" "MURPHY, TIMOTHY J" "" "" "A very interesting and CONTROVERSIAL topic- The standard-of-care practice (in this country) has been to avoid HRT in all women with a diagnosis of invasive breast cancer. This, however, did not come about from evidence-based medicine. In fact, in the past year there have been 3-4 retrospective trials from the US which suggests that HRT does NOT increase recurrent breast cancer risk. THere is currently one (non-US) based randamized trial ongoing that will address the safety of HRT in breast cancer survivors. THus the definitive answer still awaits..... One could argue that this patients greatest risk is from cardiovascular disease (lifetime risk of breast cancer is 1:8 women, lifetime risk of C-V disease is 1:3 women). So if this were my patient I would have to have (and document) a detailed discussion weighing the pros and cons of HRT v. no HRT. She should speak with an oncologist....She can call (or you can refer) Tricare for an appt.")

("090" "YAVOREK, TRUDY A" "West Point" "" "I care for a 22 yo WF with a H/O a femur stress fracture. She is oligomenorrhic and refused to take OCP^s. She denies an eating disorder. She is a cross country runner and has another stress fractur in the past. Her recent DEXA scan shows osteoporsis of her veterbral bodies. Is she a canidate for Fosamax or is there any other treatment/studies we should be doing??? Her baseline blood chemistries are normal. T Yavorek, MD" "BERNET, VICTOR J" "WRAMC" "Endocrinology" "Was she osteoporotic by both lateral and a-p dexa views ? Or was it just the lateral? Was the calcium well within normal limits adjusted for albumin? TFTs? Urine Cr/Ca excretion. Hx of major fxs beyond the stress fxs? Any long term meds? If she is a cadet about to go onto active duty, it would probably be prudent to allow us to see her and assess before she heads outinto her career and can^t see a specialists as easily if she ends up somewhere remote. Is jump school in her future?")

("091" "SAGUIL, AARON A" "" "Family Practice" "To whom it may concern, I have a question regarding vitamin supplements. My patient, whose PMH is significant for TIA, has been told that Lifeguard antioxidant therapy is better than conventional formulations a la centrum, in that it is better absorbed and more natural in its preparation. I believe it to be a powder as opposed to a

tablet and thus (she was told) it is better absorbed. Do any of you know if these claims are substantiated? The cost on the preparation is greater than conventional tablets and I don^t want for my patient to waste her money. Thank you, Aaron Saguil, " "SMITH, SANDRA E" "WRAMC" "Nutrition Care" "I^ll forward this to Nagal Wahab, nutrition support phamacist in case she has any comments." "BUKHARI, ASMA S" "" "" "There is a very good article on vitamin supplementation in ^Nutrition Action^ newsletter. Let me know if you need a copy to pass it on to your pts." "SAGUIL, AARON A" "" "Family Practice" "I would very much like to read this article; if you could, please fax it to me at .... and I will forward it to the patient. In the meantime, do you have any specific thoughts regarding the current case? I^d appreciate your input. Aaron" "WAHAB, NAGLA A" "WRAMC" "Pharmacy" "I don^t think these claims can be subtantiated. If better absorption is a consideration then a liquid vitamin would be best. We carry here at WRAMC
a multivitamin supplement in a liquid preparation. Asma, I would like to see a copy of the article. Thanks.")

("092" "SCOTT, CHRISTINE T" "Fort Meade" "Pediatrics" "We have a problem with a Diabetic patient getting Durable Medical Equipment and I thought you might have some ideas on how we can help her get the equipment she needs. The following is a note from our HBA who has been trying to work this issue..... She is legally blind and needs voice activated or voice response equipment in order to monitor/control her diabetic condition and her blood pressure. I had originally referred it to the Tricare Service Center Supervisor to determine if such equipment was available anywhere within the Network system. He researched and determined it was not and said basically the patient would have to pay out of pocket upfront and then have it filed to TRICARE for reimbursement. I believe he even spoke to the beneficiary at one point and she informed him it was available through Lighthouse for the Blind. He suggested in addition to the usual paperwork that Dr. Toedt also put a referral in the system stating the circumstances as a backup for claims processing purposes. The problem now seems to be centered around the fact that the patient
says she cannot afford to make payment up front and there was then discussion about disability, case management, etc. I have made several attempts to reach the patient and have been unsuccessful. I can direct her to some assistance in applying for Social Security Disability, etc, but that does not resolve the immediate concern. The bottom line now seems to be: she is enrolled to Prime to us, she is in critical need of this equipment (irregardless of whether she may be
eligible for disability through any other source) and she cannot afford to make payment to then be reimbursed. What do we do in this situation? HELP !! Any ideas from our endocrinologists would be greatly appreciated - I am sure you must see diabetics who are legally blind from their disease...." "BURCH, HENRY B" "WRAMC" "Endocrinology" "I can appreciate your efforts for this patient, but I haven^t encountered this situation before. I will forward this to CPT James and COL Jill Phillips to see if they have any suggestions. It seems to me that an answer needs to come from the admin. side of the house." "VIGERSKY, ROBERT A" "WRAMC" "Endocrinology" "I would call the Boehringer-Mannheim rep., Paul Kelly, to see if they can do something to expedite this or provide a loaner." "JAMES, GINA J" "" "" "calling paul kelly was my exact answer. i actually have an appt with him this afternoon, and will seek his advice....i will keep you posted!" "JAMES, GINA J" "" "" "if someone could give me the patient^s name and phone number, i will try to hook them up with a voice-mate monitor via the roche company. please don^t send the pt^s info over the e-mail....my phone number is 202-782-5209. cpt james" "BERNET, VICTOR J" "WRAMC" "Endocrinology" "Names can be sent when on the same CHCS system as Ft meade is. Pt names can^t be sent in per internet which is different." "SCOTT, CHRISTINE T" "Fort Meade" "Pediatrics" "Thank you for your help. I^ll send the patient^s name under a separate, closed message.")

("093" "TOFFERI, JEANNE K" "Fort Knox" "Internal Medicine" "I am seeing a basci trainee who swears he has DI (why this wasn^t a problem before he came in escapes me). I did a 24 hour urine which was remarkable for having 14 liters with 1.8gm of protein. We can separate him
based on the proteinuria, but I am curious if he does have DI, so I did a water deprivation test. We had a little difficulty admin-wise, so it was not quite text-book. We started after 5-7 hours without H2O;

time	urine osm	serum osm
0944	301	298
1111	351	300
1205	448	296
1303	450	298
1358	478	294
	after vasopressin	
1456	513	--

I didn^t think he needed the vasopressin as it looked pretty nrl to me. I think this is a normal test. AM I right? Thanks, Jean (This guy wants an excuse to get out of training.)" "VIGERSKY, ROBERT A" "WRAMC" "Endocrinology" "I agree that this looks like a normal response and would not do any further workup except perhaps a 1 day admission to document I&O under observation." "TOFFERI, JEANNE K" "Fort Knox" "Internal Medicine" "So, this guy^s brother in law (a general surgeon) calls me up and says since I did not do a hypertonic saline infusion, I have missed the correct dx of DI. This isn^t what my textbook says, but have I done enough?" "BERNET, VICTOR J" "WRAMC" "Endocrinology" "Water Dep would be the gold standard in my book." "TOFFERI, JEANNE K" "Fort Knox" "Internal Medicine" "Thanks!" "KRIEGER, DAVID D" "Fort Knox" "" "I signed this soldier^s MED 200 today. He^s gone. Krieger" "TOFFERI, JEANNE K" "Fort Knox" "Internal Medicine" "Thank you.")

("094" "JACKSON, JEFFREY L" "WRAMC" "Internal Medicine" "Dear Rheum Service, I^m doing a cute study looking at national databases to see what impact (if any) the AHCPR guidelines on management of acute low back pain had on physician behaviors. I^d like to exclude rheumatologic causes of low back pain, accordingly, I^ve excluded folks from the set who have: Anklyosing Spond, Rheumatoid Arthritis, Sacroillitis. I^ve also excluded folks with UTI and fibromyalgia. Are there any other specific diagnosis that I^d be well advised to delete..." "OGLESBY, ROBERT J" "" "Rheumatology" "Reiter^s, Psoriatic, Enteropathic arthritis can all present with back discomfort in the realm of the spondyloarthropathies. Chris Parker has been working with a group on guidelines for the evaluation of back pain and he may have some further thoughts from those discussions." "DENNIS, GREGORY J" "" "" "Jeff when you say rheumatologic are you using that to designate inflammatory causes? Point being, we evaluate many noninflammatory causes as well." "PARKER, CHRISTOPHER T" "" "" "Agree with Dr. Oglesby and Dr. Dennis^ question. We are infrequently a involved as the first echelon of DX/TX for acute low back pain in new patients. We do frequently deal with acute LBP of mechanical etiologies within our patients with inflammatory or noninflammatory diseases with do not neccessarily involve the spinal joints." "JACKSON, JEFFREY L" "WRAMC" "Internal Medicine" "I have about 12 million office visits with GP/FP/IMED docs between 1990-1997 for acute low back pain. I^m interested in finding out whether these docs changed

their behaviors (medicine, xrays, physical therapy, etc) as a consequence of the AHCPR low back pain guidelines that were released in 1994. I want to exclude patients who are given inflammatory diagnoses, such as AS,
Reiters, etc. I have the ICD-9 diagnoses for all the patients (up to 3). I am looking for input on inflammatory diagnoses I should go in and exclude." "PARKER, CHRISTOPHER T" "" "" "exclude those that Dr. Oglesby mentioned." "JACKSON, JEFFREY L" "WRAMC" "Internal Medicine" "Thanks...")

("095" "OTT, WILLIAM A" "West Point" "" "I have a 35 y.o. female who is getting married and is concerned about transmitting HSV II to her spouse, even though she does not have any active lesions. She was told that she had genital herpes when she was younger, but since then has never had a recurrence. She also came to the office looking for a blood test that would demonstrate that she definately had prior exposure to HSV II. The serum HSV II IgM was 1.42 and IgG >3. She wants to know how to prevent the spread of the HSV and whether or not taking
prophylaxis would help prevent shedding of the virus (to her partner)in the future. Are there times where you would recommend prophylaxis for the sole reseaon to prevent future outbreaks and thus hopefully reduce the chance of transmission to another person in a patient as mentioned above?" "HAWKES, CLIFTON A" "WRAMC" "INFECTIOUS DISEASE" "Since she has reportedly not had a recurrence for a number of years, preventing future outbreaks does not appear to a major issue, but rather asymptomatic shedding. The incidence of shedding in otherwise healthy women has been estimated at about 1% of days or a little higher. It is higher among patients with frequent symptomatic recurrences and in the months immediately following an initial episode, neither of which applies to this patient based upon her history. She may be shedding very infrequently, if at all, but there is no way to predict which days she is or is not shedding. The cost of Acyclovir at 400 mg bid is about $1400 and Valtrex at 500 mg QD is about $1000. The decision to start suppressive therapy in this clinical scenario has to be handled on an individual basis. Cost is not prohibitive, but should be a consideration; same applies to drug resistance concerns. There may be significant psychosocial issues associated with this, especially those that may impact upon this patients sexual relationship with her partner (e.g. fear of transmitting herpes leading to diminished sex drive and reduced sexual frequency), in which case suppression may be of substantial benefit. I^m afraid I can^t give you a yes or no answer on this one, but we would be happy to see her here in our clinic." "OTT, WILLIAM A" "West Point" ""

"Did you receive the message from 3/29 at 13:03?" "HAWKES, CLIFTON A" "WRAMC" "INFECTIOUS DISEASE" "I did not." "GALU, FRANCES" "West Point" "Information Management" "we were having email transmission problems at Keller, I am pasting Dr. Ott^s message below: Fran ^I have a 35 y.o. female who is getting married and is concerned about transmitting HSV II to her spouse, even though she does not have any active lesions. She was told that she had genital herpes when she was younger, but since then has never had a recurrence. She also came to the office looking for a blood test that would demonstrate that she definately had prior exposure to HSV II. The serum HSV II IgM was 1.42 and IgG >3. She wants to know how to prevent the spread of the HSV and whether or not taking prophylaxis would help prevent shedding of the virus (to her partner)in the
future. Are there times where you would recommend prophylaxis for the sole reseaon to prevent future outbreaks and thus hopefully reduce the chance of transmission (to another person) in a patient as mentioned above?" "OTT, WILLIAM A" "West Point" "" "Fran, any word on the transmission problems at Keller...seems like it^s still not going through to WRAMC." "GALU, FRANCES" "West Point" "Information Management" "Dr. Ott, the messages are going through, how about you do a cut and paste and send a new message. Fran" "HAWKES, CLIFTON A" "WRAMC" "INFECTIOUS DISEASE" "Dr. Ott what is your fax number?" "OTT, WILLIAM A" "West Point" "" "914-938-2993 or 914-938-6080." "OTT, WILLIAM A" "West Point" "" "I received your fax and response. For some reason, your response never got up to Keller (CHCS). The fax included your response. Thanks!" "HAWKES, CLIFTON A" "WRAMC" "INFECTIOUS DISEASE" "Always welcome.")

("096" "BURES, SERGIO" "West Point" "Internal Medicine" "I am an internist trying to answer some GYN questions for an aquaintance. The pt is a 31 y/o female G1P0 with long time hx of irregular Q6-7 week menses regulated for several years with BCP until 1 yr ago. At that time she underwent serology eval for amenorrhea which later evolved into irregular menses as well as US with presumptive diagnosis of PCO given nml TSH, Prolactin etc. She has no hirsutism, obesity or glucose intol and is taking no meds. Recently she became pregnant and suffered a miscarriage at about 6-7 weeks. She very much wishes to get pregnant again and our question is wether given her hx of likely (not clinically obvious) PCO should she receive progesterone vs clomid before/during her next pregnancy attempt to try and compensate for a possible luteal phase defect? If so what would be the safest agent and how proven is their safety? Your insight and possible references regarding these matters would be greatly appreciated given I am treading very uncharted waters for my specialty. Thanks again." "BERNET, VICTOR J" "WRAMC" "Endocrinology" "I have forwarded this message to Dr Alvero who is a Reproductive GYn here at
WRAMC." "ALVERO, RUBEN J" "WRAMC" "Ob/Gyn" "If there is an endocrinologic association with spontanenous abortion and PCO, it may have more to do with high LH levels seen in these patients. Nevertheless, if you treat the patient with clomiphene, there is circumstantial evidence that this treats the luteal phase deficiency by building up the granulosa cell mass that is then luteinized in the luteal phase and secretes the bulk of the progesterone. Bottom line: treat with
clomid. You can treat with Progesterone vaginal suppositories 100 mg bid but realize that this is highly empiric and, while safe in pregnancy, is also probably not effective. Hope this helps. Let me know if you have any further questions." "OLIVER, THOMAS G" "" "" "")

("097" "KUGLER, JOHN P" "Fort Belvoir" "Family Practice" "What would you recommend for f/u on a 42 yo female with past h/o goiter and hypothyroidism. Normal thyroid on physical exam, TSH=.81 on thyroid Rx (Levothyroxine .075 mgm). Thyroid USD normal except for a small 3 mm hypoechoic nodule in right midpole region which was felt to a possible small thyroid cyst
Do you recommend f/u USD? If so, at what interval? Thanks!" "BERNET, VICTOR J" "WRAMC" "Endocrinology" "Assuming there is no family hx of thyroid cancer or XRT/radiation exposure to the neck, you can follow the pt with serial physicial exam. Probably annual TSH and neck/thyroid exam. I would probably not repeat US unless a nodule became clinically palapble or sxs attributable to thyroid/nodule enlargement became evident. With a normal physical exam, what lead to the US in the first place? There is a 30-40% chance of finding a incidental nodule in a pt this age when doing US, so if the gland is easily palpable, we mostly don^t go to US." "BURCH, HENRY B" "WRAMC" "Endocrinology" "Thyroid US abnormalities such as these are found in 30% of the general population her age. Unless she had a history of thyroid XRT exposure, I^d follow her with palpation only." "KUGLER, JOHN P" "Fort Belvoir" "Family Practice" "A past h/o ^goiter^ and lack of specific documentation of this in the chart led me to order the USD. Thanks for the recommendations.")

("098" "DAVIS, RUSSELL O" "" "" "A quick question on one of my outpatients. She is a 60 some year old African American female who has an asymptomatic TSH of .097 from Dec 99. I am repeating nuc med TFTs at this time and had not planned on treatment at this time given she was asymptomatic, but would appreciate your input on this case. Also, interestingly, her LDL has

from the 130 to the 180 over the same time her TSH has gone from normal to low...I typically think of hypothyroidism being associated with HLD...any thoughts on this? Thanks!" "BURCH, HENRY B" "WRAMC" "Endocrinology" "There^s fairly good evidence of harm (afib, osteoporosis) with subclinical hyperthyroidism at this level. We are very much apt to search for the cause (thyroid exam, repeat tfts, anti-TPO ab^s, thyroid scan and uptake if repeat tfts confirm) and then treat according to the etiology with the objective of normalizing the TSH." "BURCH, HENRY B" "WRAMC" "Endocrinology" "Feel free to come by with her data to discuss with one of us." "DAVIS, RUSSELL O" "" "" "thanks!")

("099" "PALACIO, PETER E" "Fort Drum" "Ob/Gyn" "51yo WF G11P3081, not using HRT d/t complicated medical hx, with 3 years of dysfunctional uterine bleeding. Notes occasional vaginal spotting 2-3 times/year. Clinically perimenopausal with ongoing night sweats and hot flashes. 3/24/00 LH 6.01, FSH 17.2, Est level pending. S/P multiple evaluations of endometrium including D&C by civilian provider all benign. Most recent EMBX 4/99 disordered prolif EM, ECC benign.3/00 Pelvic US showed normal sized uterus with 8.8mm EM stripe, nl adnexa. Due to h/o CVA, unable to use combined HRT. 1.Can I use cyclic or continuous progesterone safely to control/eliminate bleeding episodes? Product insert states a contraindication with h/o thomboembolic disorders. 2.If unable to use progest agent or pt elects expectant management, what is the best way to follow and evaluate these bleeding events? Am I obligated to sample the EM with each episode? Can I follow with US? Do I need to evaluate these episodes in someone who is clinically and physiologically perimenopausal? In advance, thanks for your time and comments. Pete Palacio Ft Drum, Ob/Gyn" "DUNLOW, SUSAN G" "" "Ob/Gyn" "I would not hesitate to put her on cyclic progesterone therapy. I would use 5-10 mg provera on days 1-12 of each month.")

("100" "OSHIKI, MICHAEL S" "Fort Belvoir" "Family Practice" "I recently saw a 71 y/o gentleman with PMH significant for HTN, BPH and a previous cardiac murmur for a musculoskeletal problem. During his intake, his SBP was noted to be 185. When I went to re-take his BP manually, I noticed that the ausculatated pulse persisted even when the cuff was deflated and removed, and was true for bilaterally. On further exam, he has no carotid or renal bruits, and a very soft cardiac murmur (previously eval^d by echo). Good capillary refill, normal sensation and strength in hands bilaterally. 33 pack-year tobacco, quit in 1983. No significant claudication sx. According to the pt, he has a civilian cardiologist who he sees every 3 months, and takes his BP manually, and who has never commented on this. Is there any clinical significance to an asymptomatic brachial artery bruit? Is there any additional workup indicated? Thanks. Mike Oshiki" "O^DONNELL, SEAN D" "WRAMC" "Vascular Surgery" "not uncommon, would not pursue further. Sean")

("101" "WYNN, MICHAEL P" "Fairfax" "Family Practice" "I saw an 11 yo male for a school PE. during his unremarkable exam I noted tonsilar exudate, mild edema (1+), no cerival lymphadenopathy, afebrile and no c/o sore throat. I cultured the exudate and got one colony of GABS. I assume that he is a carrier, and doesn^t have acute pharyngitis. Do we treat carriers during the spring to prevent outbreaks? Is he at any risk of GABS sequal or a risk to close contacts? (no) in Pediatrics oct 1999, they mention Cefadroxil as more effective than PCN for carriers. I have read about using Clindamycin during spring time as well. I could not find anything more helpful on MDConsult. thanks for your answers. CPT Wynn" "HORN, CHARLES S" "Fort Belvoir" "Pediatrics" "As has been said in more spiritual circles ^Seek and and ye shall find.^ In this case, a lone colony of GABHS, and a question as to what it means! Mike, a one time positive culture does not define a ^carrier, ^ and in an asymptomatic person does not necessarily warrant treatment. Some of the accepted reasons for treatment of a GABS carrier include: 1) when the family has a history of rheumatic fever, 2) when there is back and forth spread of infection within a family, 3) when there are semiclosed community outbreaks, and 4) when tonsillectomy is being considered only because of chronicpositive cultures. These recommendations and other useful info about GABHScan be found in Contempory Pediatrics October 1992. Since then, however, Clinidamycin at 20 mg/kg/day divided TID for 10 days has been shown to be about 85% effective in eradicating GABHS from carriers (interestingly about the same effectiveness as the variety of penicillin, macrolide, andcephalosporins for treating acute symptomatic GAHBS infections.) Your patientis one that will open up debate and discussion from infectious disease, pharmacologic, and costs standpoint. I probably wouldn^t treat at this point." "POTH, MERRILY" "WRAMC" "Endocrine/Pediatrics" "No data that I know of that treatment is indicated--I would not culture this pt in the first place." "GOLDBERG, DAVID I" "" "Pediatrics" "The issue of the carrier state is one than only a navy line officer could love. In Pediatrics, it is right up there with what constitutes purulentrhinorrhea. There are few hard facts and lots of opinions. It is best to remember that the significance of streptococcal upper respiratory disease is in its nonsupporative sequelae, ie rheumatic fever and acuteglomerulanephritis and not in its ability to cause sore throats. Treatment is based on preventing the above sequlae and not making the throat better(although it does). The prevelance of positive throat cultures inasymptomatic children is between 15-30%. And carriage of Strep does not lead to cario/renal disease. Management of strep carriers is problomatic. To determine if the patient is a carrier with a viral pharyngitis one can obtain serology, but this is costly, painful and expensive. One has to rely on symptoms, time of year, what^s happening in the school/community, and past hx of the patient. In the case above your patient is asymptomatic and we are in the latespring when the prevelance of infection is low. I would not treat this child but I would note that at this time he is a probable asymptomatic carrier. In the future with the proper sx^s I would culture him and treat with PN if the culture or rna strep test is positive. If there is no clinical response in 48hrs I switch to a cephalosporin or clindamycin. I would not reculture him after therapy. Elimination of the carriage state should be reserved to the times outlined by Dr. Horn.Hope this does not confuse you. C Ped ID Svce" "WYNN, MICHAEL P" "Fairfax" "Family Practice" "super, thanks I will look for the 1992 article and have more information for this family.")

("102" "BURCH, HENRY B" "WRAMC" "Endocrinology" "I^m preparing a lecture on the management of thyroid nodules in pregnancy. For patients with FNAs showing thyroid cancer we generally recommend thyroidectomy in the 2nd trimester. Is anyone aware of any good references
reviewing the maternal and fetal risk associated with surgery in the first and third trimesters? H. Burch" "ARMSTRONG, ALICIA Y" "WRAMC" "Ob/Gyn" "I will forward to Dr.s Rosa and Satin, two of our Maternal Fetal Medicine specialists" "SATIN, ANDREW J" "" "" "Rita Driggers reviewed literature on surgery for thyroid cancer in pregnancy, J reproduct med..... The only reasons not to act in first trimester is fear of being blamed for miscarriage related to surgery. Concern in third trimester is related to risk of preterm labor. i suspect both risks are over rated in surgery not involving abdomen/ pelvis or large blood loss. Nevertheless, there is not a hugh amount of data out there. Andy Satin" "BURCH, HENRY B" "WRAMC" "Endocrinology" "Thank you!")

("103" "DUCH, PAUL" "Woodbridge" "Family Practice" "Would appreciate any opinion(s) on . 56 yo female with DM, and noted to have fluctuating, mildly elevated LFT^s 2-3x normal over past 10 years. I took the liberty of ordering a plethora of labs to eval to include: 1. hepatitis B and C serology negative 2. alpha-1 antitrypsin WNL 3. iron/ferritin WNL 4. ANA positive, DSDNA negative, ENA screen negative, liver microsomal AB negative, smooth muscle antibody AB positve at 1:160. 5. serum copper=211 (70-165)

initially, repeated one week later =2283 with ceruloplasmin WNL=43.5 (17.9-53.3). To summarize, pt has a positive ANA with positive ASMA. Also pt has an elevated serum copper with a normal ceruloplasmin. Of course, these abnormalities were discovered in the w/u ofchronically mildly elevated LFT^s. Could this patient^s LFT^s be due to an autoimmune process? Can you have Wilson^s disease with a normal ceruloplasmin? Appreciate your assistance!" "SJOGREN, MARIA H" "WRAMC" "Gastroenterology" "The combination of + ANA & ASMA makes it more likely to be an autoimmune hepatitis. A liver biopsy will give the definitive answer. She is a bit outside the age range to doagnose Wilson^s. Early 40^s is the limit, most are young adults or older children. Although ceruloplasmin may be normal in serum and still have Wilson^s, this situation is observed in liver failure, not in an outpatient. It has to do with massive cell destruction and spurious elevation of ceruloplasmin. The fact that her ceruloplasmin is normal rules out Wilson^s. Copper has been elevated in diseases like AIH, PBC and others. Interesting case. A liver biopsy will (hopefully) give you the diagnosis. If you need our assistance, call the Liver Clinic (202) 782-5262 for an appointment for your patient." "DUCH, PAUL" "Woodbridge" "Family Practice" "thank you very much for your timely and informative feedback. I will refer pt to GI Service for consideration of biopsy.")

("104" "BETT, BARI J" "" "" "I have a 53 y o w f nonsmoker gen good health, h/o htn on hctz who had a routine ua showing blood 7-9 rbc^s. A second ua showed tr blood 3-4 rbc^s and a third was normal. Do I need to work this up more or can I just recheck in 6-12 mo? Thanks." "STACKHOUSE, GEORGE B" "Fort Belvoir" "Urology" "Would work up if 2/3 U/a show greater than 5 RBC^s. She is borderline. Is she on HRT; does she have (iatrogenic) menses?? If she has 3-5 or greater on another u/a would send her on up." "BETT, BARI J" "" "" "no, she is only on atenolol and hctz. I will get a 4th ua and see if that helps us to decide.")

("105" "SCOTT, CHRISTINE T" "Fort Meade" "Pediatrics" "Is sickle cell trait considered a contraindication to the anthrax vaccine?" "LOESEVITZ, ARTHUR W" "WRAMC" "Allergy" "I am not aware of this being a contraindication." "RAINEY, JOANIE T" "" "" "Thanks Dr. Scott, I notified the SMs unit 1SG and passed this information on to him to relay to the SM.")

("106" "MILLER, GORDON" "West Point" "" "Sir/Ma^am, I have a 71 year old male with history of Hypertension, DM Type II, and Hypercholesterolemia and Old MI in 1981 who recently developed symptoms suggestive of angina. TMST demonstrated 2mm elevation in V1 with associated symptoms of SOB and pain. Patient desires to remain in military medical care system. Question: How do I go about sending him down there for evaluation if you accept him and because of the distance, if you decide to, can he get a cath during the same trip? Not trying to sound smart, but what to give the patient the information up front to prevent any misunderstandings. Thank you for your time. Gordon Miller" "HUDAK, CRAIG M" "" "" "We are more than happy to see him, and can certainly cath him on the same visit. Please provide his name and telephone number; I will forward this message to the April cath fellows and they should take it from there." "JESCHKE, ROBERT E" "" "Cardiology" "Will be happy to schedule the above as soon as I have a point of contact." "MILLER, GORDON" "West Point" "" "Sirs, No one has contacted the above patient as of yet. Please call him as his symptoms are still present. Dr. Miller" "JESCHKE, ROBERT E" "WRAMC" "Cardiology" "As I now have a number to contact, I well call him today, thank you." "MILLER, GORDON" "West Point" "" "Thanks alot.")

("107" "BURES, SERGIO" "West Point" "Internal Medicine" "I am an Internist at Keller Army Hospital. My question is what alternatives are available for Propulsid in tx of diabetic gastroparesis? Are there any reasonable and effective substitutes? How are you folks treating this disorder? Your input would be very helpful to our department. I thank you in advance." "SMITH, MILTON T" "WRAMC" "Gastroenterology" "No easy answer here. Reglan is about the only other alternative." "BURES, SERGIO" "West Point" "Internal Medicine" "Thanks")

("108" "BURES, SERGIO" "West Point" "Internal Medicine" "I am an internist at West Point and have a patient that wishes to complete her Pulmonary w/u at WRAMC. She is a 40 y/o female smoker s/p surgical menopause 8 yrs ago with recent onset night sweats and weight loss without cough found to have a RUL, rather peripheral nodule. Prior CXR reportedly negative and pt trying to locate them. Chest CT being done today. PPD negative with nml anergy panel. I want to refer her to you for further eval, bronch/tumor board eval etc per your discretion. Please advice on further labs or studies that would aid your evaluation so I can expedite things for her given she will have to stay in a hotel during her visit to your area. I can be reached telephonically at .... or via this message. I thank you in advance for your consideration on this matter. Sergio Bures CPT MC" "ROOP, STUART A" "WRAMC" "Pulmonary" "We would be very happy to see her. The CT scan, along with old CXRs if available would be the most valuable studies. We could see her as early as next week - ? Thursday afternoon 6 April, with possible bronchoscopy Friday. Stuart Roop" "BURES, SERGIO" "West Point" "Internal Medicine" "Thank you for your prompt response. She will be able to go Thursday afternnon 6 April. I have discussed the plan and possible bronch Friday and she is agreeable. We will try to gather as many old films as possible and of course her CXR and Contrast CT will come with her. If you could provide details of time and place I will pass them on to her. Thank you again for your response and assistance. Sergio" "ROOP, STUART A" "WRAMC" "Pulmonary" "We are on WD 77 (7th floor), pulmonary medicine clinic. I will see her then. Thanks." "BURES, SERGIO" "West Point" "Internal Medicine" "She will be there. Thanks again.")

("109" "OTT, WILLIAM A" "West Point" "" "I have a 38 y.o. caucasian female who I noticed had anemia on prior lab tests in the chart. She^s been on iron replacement for years according to her. I repeated her labs, and still noticed an anemia. I initiated a workup which is as follows: h/h 10.6/32.6 with normal indices, normal smear; Fe 27, TIBC 419, ferritin 5.0, LFTs WNL, ESR 25 and repeated 34 with neg ANA, retic 0.6, vitamin b12/folate WNL. Iron supplementation over the last few weeks has not improved the h/h nor the iron/ferritin level, but has helped her fatigue and lethargy. One thing that is still pending is the Hgb electrophoresis. Should I be pursuing anything else, or will this just be an iron deficiency anemia (normal indices though?) that requires better iron GI absorption?" "LEGUIZAMO, JORGE P" "" "" "If she has labs c/w iron deficiency, she needs Iron sulfate tid. The main problem with this pts is compliance because gi upset/constipation. You can try the formula at civilian pharmacies which have coating and stool softener or try pediatric solution 2.4 cc po tid. You should see improvement. If there is no improvement she may need IV iron and a small bowel eval (IBD, celiac disease can present with decreased iron absorption and she has menses-increased loss.")

("110" "MYERS, MADELEINE" "" "Nursing" "A 25 y/o AD male c/c Lt upper arm 2cm firm area post anthrax immunization 1 yr ago, nontender, nonbuldging. Soldier has gotton mixed feedback on what ought to be done. Since it is nontender I thought leave it be. When soldier called anthax immunization clinic (Dewitt) he was told to follow up in Dermatology for a case study to catalog it and possible removal. 1. Have you heard of this? 2. What would you do? Madeleine" "KRIVDA, STEPHEN J" "WRAMC" "Dermatology" "It is probably a vaccine related persistent subcutaneous nodule thought to be related to the fact that the vaccine is aluminum-adsorbed. This is seen in other aluminum-adsorbed vaccines and is thought to be an unusual rxn to aluminum. We have similar case pending X-ray microanalysis for aluminum at the AFIP. Send him over I^d like to see him. Steve")

("111" "SHANNON, STEVEN R" "WRAMC" "PM&R" "I have an AD VIP with significant ankle DJD/tendinitis who says he has an aspirin allergy (nothing ioted in CHCS) and has been told that he can^t take NSAIDs. Do the newer NSAIDs also have this

recommendation? Thanks, SRS" "OGLESBY, ROBERT J" "" "Rheumatology" "Yes, an allergic reaction to other NSAIDs or aspirin are contraindications for use as stated in the package inserts for the new COX-2 inhibitors. Of course, it does depend on what your patient is calling an allergic reaction?" "SHANNON, STEVEN R" "WRAMC" "PM&R" "Thanks for the reply - I^m told that this pt does/did have an anaphylactic type reaction. Although local steroid injection is usually considered
initially, I suppose oral steroids would be the only other oral anti-inflammatory option for tendinitis in someone with an ASA allergy?" "DENNIS, GREGORY J" "" "" "Perhaps we can review our literature to see if we can identify alternatives other than steroids." "SHANNON, STEVEN R" "WRAMC" "PM&R" "Thanks - I^m going to fwd this to COL Block, who is the MD coordinator for this VIP. COL Block, Just as a heads up, when I checked CHCS for this VIP^s allergic reaction, there were no allergies noted. Should this be noted in CHCS for this pt^s safety? SRS" "BLOCK, DALE K" "WRAMC" "Gastroenterology" "Thanks, Steve. Yes this should be noted and I will take care of that. I do not think thatthe patient will be amenable to po steroids. Not really following the ice and ultrasound. He is looking forward to the meeting with
Mr. Feathers. I^ll keep you informed and vice versa. Thanks again. Ken Block" "LOESEVITZ, ARTHUR W" "WRAMC" "Allergy" "It sounds like this patient deserves to be seen by our department to help sort out this problem." "SMITH, LAURIE J" "WRAMC" "Allergy" "I think I have seen this VIP and know about the problems.")
))

```
(load "init-file.lsp")

(load "list-of-specialties-for-demo.cl")
(load "location-information.lsp")
(load "specialty-table.lsp")

(load "consult-class.lsp")
(load "doctor-class.lsp")
(load "location-class.lsp")
(load "specialty-class.cl")

(load "ask-a-doc consults.lsp")
(load "consult-matcher.lsp")

;other
(load "consultant-data.cl")
(load "consultant-sites.cl")
;;;(load "consult-saving-utilities.cl")
(load "doc-table.lsp")
(load "location-info.cl")
(load "table-maker.cl")
(load "inquiry-result.cl")
(load "time-functions.lsp")
(load "warning-message-consult-type-dialog.cl")


(load "find-specialties")
(load "find-sites.cl")
(load "find-docs.cl")

(mapc #'(lambda (x) (create-consult-instance x)) *consults*)
(mapc #'(lambda (x) (process-consult-info (eval x)))
  (remove 'temp-consult (reverse (list-of-instances temp-consult)) :test #'equal))
(mapc #'(lambda (x) (setf (specialty (eval (car x))) (string (cadr x)))) *doctors-specialties*)
```

```
;; Code for the dialog :form3


(defclass consultant-data (dialog)
 ())

(defun consultant-data-cancel-button-on-click (dialog widget)
  (declare (ignore-if-unused dialog widget))
 (close dialog)
 t)

(defun consultant-data-start-button-on-click (dialog widget)
  (declare (ignore-if-unused dialog widget))

 t)
```

```
(setf consultant-sites
  '(
    ("Hospital" "Army" "Walter_Reed_Army_Medical_Center" "WRAMC" "DC " "20307" "5000" "US" "38.8951" "77.0369"
'("Audio" "Video" "Audio/Video" "Store/Forward" "Email"))
    ("Hospital" "" "Fort_Gordon" "Fort Gordon" "GA" "30905" "" "US" "33.364" "82.215" '("Audio" "Email"))
    ("Hospital" "Navy" "Bethesda_Naval_Hospital" "Bethesda" "MD " "20889" "5000" "US" "38.9808" "77.1006" '("Audio/Video"
"Store/Forward" "Email"))
    ("Hospital" "" "Landstuhl_Regional_Medical_Center" "Landstuhl" "" "APO AE 09180 " "" "FRG" "49.42" "-7.57"
'("Store/Forward" "Email"))
    ))
```

```
;;;consult-class.lsp


(defclass consult-request ()
 ((consult-number :initarg :consult-number
            :initform ""
            :accessor consult-number)
  (printname :initarg :printname
         :initform ""
              :accessor printname)
  (list-of-instances :initarg :list-of-instances
              :initform '()
              :accessor list-of-instances
              :allocation :class)
  (urgency :initarg :urgency
        :initform ""
        :accessor urgency)
  (clinical-information :initarg :clinical-information
                        :initform ""
                        :accessor clinical-information)
  ;;; referring information

  (referring :initarg :referring
         :initform ""
         :accessor referring)
  (referring-firstname :initarg :referring-firstname
                                  :initform ""
                                  :accessor referring-firstname)
  (referring-lastname :initarg :referring-lastname
              :initform ""
              :accessor referring-lastname)
  (referring-location :initarg :referring-location
              :initform ""
              :accessor referring-location)
  (referring-specialty :initarg :referring-specialty
               :initform ""
               :accessor referring-specialty)
  (respondents :initarg :respondents
          :initform '()
          :accessor respondents)
  (specialty :initarg :specialty
               :initform ""
               :accessor specialty)
  (diagnostic-codes :initarg :diagnostic-codes  ;;; ICD-9
             :initform '()
             :accessor diagnostic-codes)
  (procedure-codes :initarg :procedure-codes    ;;; CPTs
             :initform '()
             :accessor procedure-codes)

  (recommended-consultants :initarg :recommended-consultants
                                   :initform '()
                                   :accessor recommended-consultants)

  ;;; consultation report

  (diagnosis :initarg :diagnosis
               :initform ""
               :accessor diagnosis)
  (suggested-treatment :initarg :suggested-treatment
                                  :initform ""
                                  :accessor suggested-treatment)

  ;;; specialist information
  (specialist :initarg :specialist
         :initform ""
         :accessor specialist)
  (specialist-firstname :initarg :specialist-firstname
                                  :initform ""
                                  :accessor specialist-firstname)
```

```
  (specialist-lastname :initarg :specialist-lastname
                                  :initform ""
                                  :accessor specialist-lastname)
  (specialist-location :initarg :specialist-location
                                  :initform ""
                                  :accessor specialist-location)
  (trail :initarg :trail
      :initform '()
      :accessor trail)
  (time-requested :initarg time-requested
            :initform 0
            :accessor time-requested)
  (time-replied :initarg time-replied
            :initform 0
           :accessor time-replied)
  (comments :initarg :comments
        :initform ""
        :accessor comments)
  ))

(setf temp-consult (make-instance 'consult-request))

(defun create-consult-instance (info-list)
 (let* ((consult-no (nth 0 info-list))
     (consult-id-string (concatenate 'string "c" consult-no))
     (consult-number (string-to-symbol consult-id-string))
     (referring (nth 1 info-list))
     (referring-firstname (firstname-from-string referring))
     (referring-lastname (lastname-from-string referring))
     (referring-mi (mi-from-string referring))
     (referring-fullname (concatenate 'string referring-firstname "-" referring-mi "-" referring-lastname))
     (location (nth 2 info-list))
     (specialty (nth 3 info-list))
     (clinical-info (nth 4 info-list))
     (trail (subseq info-list 5))
     ;(no-of-responses (/ (length trail) 4))
     )
  (cond ((null (my-instancep (string-to-symbol referring-fullname)))
      (make-a-class-instance 'doctor (string-to-symbol referring-fullname))
      (setf (firstname (eval (string-to-symbol referring-fullname))) referring-firstname)
      (setf (lastname (eval (string-to-symbol referring-fullname))) referring-lastname)
      (setf (location (eval (string-to-symbol referring-fullname))) location)
      (setf (specialty (eval (string-to-symbol referring-fullname))) specialty))
     (t
      ))
  (cond ((member (string-to-symbol consult-id-string) (list-of-instances temp-consult) :test #'equal)
      (progn
       (setf (referring (eval (string-to-symbol consult-id-string))) referring)
       (setf (referring-location (eval (string-to-symbol consult-id-string))) location)
       (setf (referring-specialty (eval (string-to-symbol consult-id-string))) specialty)
       (setf (clinical-information (eval (string-to-symbol consult-id-string))) clinical-info)
       (setf (trail (eval (string-to-symbol consult-id-string))) trail)
       (consult-list-update consult-id-string (eval (string-to-symbol referring-fullname)))
       (setf (slot-value (eval (string-to-symbol referring-fullname)) 'referring-consults)
        (delete-duplicates (append
                  (referring-consults (eval (string-to-symbol referring-fullname)))
                  (list consult-number)) :test #'equal))
       ))
      (t
      (make-a-class-instance 'consult-request (string-to-symbol consult-id-string))
      (progn
       (eval `(setf (consult-number ,(string-to-symbol consult-id-string)) ,consult-no))
       (setf (referring (eval (string-to-symbol consult-id-string))) referring)
       (setf (referring-location (eval (string-to-symbol consult-id-string))) location)
       (setf (referring-specialty (eval (string-to-symbol consult-id-string))) specialty)
       (setf (clinical-information (eval (string-to-symbol consult-id-string))) clinical-info)
       (setf (trail (eval (string-to-symbol consult-id-string))) trail)
       (consult-list-update consult-id-string (eval (string-to-symbol referring-fullname)))
       (setf (slot-value (eval (string-to-symbol referring-fullname)) 'referring-consults)
        (delete-duplicates (append
```

```
                    (referring-consults (eval (string-to-symbol referring-fullname)))
                    (list consult-number)) :test #'equal))
        )))))

(defun process-consult-info (consult-instance)
 (let* ((trail (trail consult-instance))
     (no-of-responses (/ (length trail) 4)))
  (do ((i 0 (+ i 4)))
    ((> i (* (- no-of-responses 1) 4)))
   (let* ((data-string (subseq trail i (+ i 4)))
       (spec-name-string (nth 0 data-string))
       (specialist-firstname (firstname-from-string spec-name-string))
       (specialist-lastname (lastname-from-string spec-name-string))
       (specialist-mi (mi-from-string spec-name-string))
       (specialist-fullname (concatenate 'string specialist-firstname "-" specialist-mi "-" specialist-lastname))
       (specialist-symbol (string-to-symbol specialist-fullname))
       ; (specialist-instance (eval specialist-symbol))
       (spec-location (nth 1 data-string))
       (specialty (nth 2 data-string))
       ; (specialty-symbol (car (is-a-specialty (string-to-symbol specialty))))
       (consult-ci (nth 3 data-string)))
    (cond ((equal spec-name-string (referring consult-instance))
        (setf (clinical-information consult-instance)
         (concatenate 'string (clinical-information consult-instance) " *** " consult-ci)))

       ((member specialist-symbol (list-of-instances temp-doctor) :test #'equal)
      ;  (if specialty-symbol
      ;     (setf (list-of-words (eval specialty-symbol))
      ;       (concatenate 'string (list-of-words (eval specialty-symbol)) " " consult-ci)))
        (let ((specialist-instance (eval specialist-symbol)))

         (setf (location (eval specialist-symbol)) spec-location)
         (setf (specialty (eval specialist-symbol)) specialty)
         (cond ((equal spec-location "WRAMC")
             (setf (list-of-consultants walter_reed_army_medical_center)
              (delete-duplicates
               (append (list specialist-symbol)
                   (list-of-consultants walter_reed_army_medical_center))
              :test #'equal)))
            ((equal spec-location "Landstuhl")
             (setf (list-of-consultants landstuhl_regional_medical_center)
              (delete-duplicates
               (append (list specialist-symbol)
                   (list-of-consultants landstuhl_regional_medical_center))
              :test #'equal)))
            ((equal spec-location "Bethesda/Naval")
             (setf (list-of-consultants national_naval_medical_center)
              (delete-duplicates
               (append (list specialist-symbol)
                   (list-of-consultants national_naval_medical_center))
              :test #'equal)))
            ((equal spec-location "Ft.Gordon")
             (setf (list-of-consultants eisenhower_army_medical_center)
              (delete-duplicates
               (append (list specialist-symbol)
                   (list-of-consultants eisenhower_army_medical_center))
              :test #'equal)))
            (t
             ))
         (setf (list-of-consults specialist-instance)
          (remove-duplicates
           (append (list-of-consults specialist-instance)
               (list (printname consult-instance)))
           :test #'equal))
         (setf (specialist-consults specialist-instance)
          (remove-duplicates
           (append (specialist-consults specialist-instance)
               (list (printname consult-instance)))
           :test #'equal))
         (setf (respondents consult-instance)
```

```
    (remove-duplicates (append (respondents consult-instance)
                               (list specialist-symbol))
                       :test #'equal))
   (setf (consults-ci (eval specialist-symbol))
    (concatenate 'string (consults-ci (eval specialist-symbol))
     " *** " consult-ci))
   ))
  (t
  ; (if specialty-symbol
  ;    (setf (list-of-words (eval specialty-symbol))
  ;     (concatenate 'string (list-of-words (eval specialty-symbol)) " " consult-ci)))
  ; (print specialist-symbol)
  (make-a-class-instance 'doctor specialist-symbol)
  (let ((specialist-instance (eval specialist-symbol)))
   (setf (firstname (eval specialist-symbol)) specialist-firstname)
   (setf (lastname (eval specialist-symbol)) specialist-lastname)
   (setf (location (eval specialist-symbol)) spec-location)
  ;  (setf (specialty (eval specialist-symbol)) specialty)
   (cond ((equal spec-location "WRAMC")
         (setf (list-of-consultants walter_reed_army_medical_center)
          (bubble-sorter
           (delete-duplicates
            (append (list specialist-symbol)
                    (list-of-consultants walter_reed_army_medical_center))
            :test #'equal)
           #'(lambda (x) (lastname (eval x))) #'string-lessp)))
        ((equal spec-location "Landstuhl")
         (setf (list-of-consultants landstuhl_regional_medical_center)
          (bubble-sorter
           (delete-duplicates
            (append (list specialist-symbol)
                    (list-of-consultants landstuhl_regional_medical_center))
            :test #'equal)
           #'(lambda (x) (lastname (eval x))) #'string-lessp)))
        ((equal spec-location "Bethesda/Naval")
         (setf (list-of-consultants national_naval_medical_center)
          (delete-duplicates
           (append (list specialist-symbol)
                   (list-of-consultants national_naval_medical_center))
           :test #'equal)))
        ((equal spec-location "Ft.Gordon")
         (setf (list-of-consultants eisenhower_army_medical_center)
          (delete-duplicates
           (append (list specialist-symbol)
                   (list-of-consultants eisenhower_army_medical_center))
           :test #'equal)))
        (t
         ))
   (setf (list-of-consults specialist-instance)
    (remove-duplicates
     (append (list-of-consults specialist-instance)
             (list (printname consult-instance)))
     :test #'equal))
   (setf (specialist-consults specialist-instance)
    (remove-duplicates
     (append (specialist-consults specialist-instance)
             (list (printname consult-instance)))
     :test #'equal))
   (setf (respondents consult-instance)
    (remove-duplicates (append (respondents consult-instance)
                               (list specialist-symbol))
                       :test #'equal))
   (setf (consults-ci specialist-instance)
    (concatenate 'string (consults-ci specialist-instance)
     " *** " consult-ci))
   )
  ))))))

(setq *doctors-specialties*
```

```
'((kevin-m-o^neil PULMONARY)
 (andrew-j-reynolds          PULMONARY)
 (kevin-d-deweber            FAMILY-PRACTICE)
 (salvatore-a-manno          NEPHROLOGY)
 (sophia-l-yohe   NEPHROLOGY)
 (alicia-y-armstrong         OB/GYN)
 (andrew-d-montemarano   DERMATOLOGY)
 (ann-n-kim       PM&R)
 (arn-h-eliasson  PULMONARY-MEDICINE)
 (arthur-w-loesevitz         ALLERGY)
 (burkhardt-h-zorn           UROLOGY)
 (christina-m-yuan           NEPHROLOGY)
 (clifton-a-hawkes           INFECTIOUS-DISEASE)
 (cydney-l-fenton PEDIATRIC-ENDOCRINOLOGY)
 (dale-k-block    GASTROENTEROLOGY)
 (erin-m-bohen    NEPHROLOGY)
 (george-w-turiansky         DERMATOLOGY)
 (glenn-w-wortmann           INFECTIOUS-DISEASES)
 (henry-b-burch   ENDOCRINOLOGY)
 (james-m-ecklund            NEUROSURGERY)
 (jeffrey-l-jacksonINTERNAL-MEDICINE)
 (kevin-a-ceckowski          RENAL-TRANSPLANT-LICSW)
 (kevin-c-abbott  NEPHROLOGY)
 (kurt-l-maggio   DERMATOLOGY)
 (laurie-j-smith  ALLERGY)
 (marc-p-difazio  PEDIATRIC-NEUROLOGY)
 (margretta-m-diemer         INTERNAL-MEDICINE)
 (maria-h-sjogren GASTROENTEROLOGY)
 (mark-d-menich   ALLERGY)
 (mary-k-mather   DERMATOLOGY)
 (merrily-y-poth  ENDOCRINE/PEDIATRICS)
 (michael-h-mitchell         NEUROLOGY)
 (milton-t-smith  GASTROENTEROLOGY)
 (nagla-a-wahab   PHARMACY)
 (nancy-l-grass   INTERNAL-MEDICINE)
 (oleh-w-hnatiuk  PULMONARY)
 (pankaj-j-malik  CARDIOLOGY)
 (rita-l-svec     PEDIATRIC-ENDOCRINOLOGY)
 (robert-a-vigersky          ENDOCRINOLOGY)
 (robert-e-jeschke CARDIOLOGY)
 (robert-j-christie HEMATOLOGY/ONCOLOGY)
 (robert-j-labutta NEUROLOGY)
 (robert-l-ramsey INTERNAL-MEDICINE)
 (ruben-j-alvero  OB/GYN)
 (sandra-e-smith  NUTRITION-CARE)
 (sean-d-o^donnell           VASCULAR-SURGERY)
 (stephen-j-krivda DERMATOLOGY)
 (steven-e-braverman         PM&R)
 (steven-r-shannon           PM&R)
 (stuart-a-roop   PULMONARY)
 (thomas-m-wiley CARDIOLOGY)
 (thomas-r-furlow NEUROSURGERY)
 (victor-j-bernet ENDOCRINOLOGY)
 (william-e-duncan           ENDOCRINOLOGY)
 (william-f-kelly PULMONARY-MEDICINE)
 (w-s-frank       ALLERGY)
 (donna-m-macneil PEDIATRIC-AUDIOLOGY)
 (lynne-i-yao PEDIATRIC-NEPHROLOGY)
 (karin-a-cox PULMONARY)
 (david-g-mcleod UROLOGY)
 (thomas-g-oliver ENDOCRINOLOGY)
))
```

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```
;; Code for simply classifying both specialties and doctors

(defun get-num-matches (wordlist1 wordlist2)
        (length (intersection wordlist1 wordlist2))
)


(defun get-single-score (new-words database-words)
        (* 10000 (float (/ (get-num-matches new-words database-words) (length database-words))))
)


;; classifies new text according to the number of matches in the dataset
;; dataset format: association list ((CLASSA word word word...) (CLASSB word...))
(defun simple-classify (new-words dataset)
        (setq scores-list NIL)
        (dolist (class-set dataset)
                (let* ((curr-class (car class-set))
                                (curr-database-words (cdr class-set))
                                (curr-score (get-single-score new-words curr-database-words))
                               )

                                (push (list curr-class curr-score) scores-list)
                )
        )
        (sort scores-list #'(lambda (x y) (> (cadr x) (cadr y))))
)



;; returns a rearranged "scores-list" according to whether or not
;; key words appear in the "new-words" -- utilizes *keyword-list*
(defun rearrange-according-to-keywords (scores-list new-words)
        (let ((keyed-specialties NIL)
                (rearranged-list NIL)
                )
  (dolist (score-item scores-list)
    (let* (  (curr-spec (car score-item))
        (curr-keyword-list (assoc curr-spec *keyword-list*))
        )
      (if (not (null curr-keyword-list))
        (dolist (word new-words)
          (if (member word curr-keyword-list)
            (push curr-spec keyed-specialties)
          )
          )
      )
    )
  )
  keyed-specialties

;; rearrange the list
                (dolist (score-item (reverse scores-list))
                        (if (not (member (car score-item) keyed-specialties))
                                (push score-item rearranged-list)
                        )
                )
                (dolist (the-specialty keyed-specialties)
                        (push (list the-specialty 'KEYWORD-MATCH) rearranged-list)
                )

                rearranged-list
        )
)



(setq *keyword-list* '(
```

```
        (CARDIOLOGY CARDIOLOGY)
        (FAMILY-PRACTICE FAMILY)
        (ENDOCRINOLOGY ENDOCRINOLOGY)
        (NEPHROLOGY NEPHROLOGY)
        (NURSING NURSING)
        (PEDIATRICS PEDIATRICS)
        (GASTROENTEROLOGY GASTROENTEROLOGY)
        (INFECTIOUS-DISEASE INFECTIOUS)
        (DERMATOLOGY DERMATOLOGY)
        (RHEUMATOLOGY RHEUMATOLOGY)
        (PULMONARY PULMONARY)
        (PULMONARY-MEDICINE PULMONARY)
        (UROLOGY UROLOGY)
        )
)
```

```
(defmethod save-consult ((consult-instance 'consult-request))
 (let ((consult-no (consult-number consult-instance))
     (printname (prinname consult-instance))
     (clinical-info (clinical-information consult-instance))
     (referring (referring consult-instance))
     (referring-specialty (specialty consult-instance))
     (referring-location (location consult-instance))
     )

  ))
```

```
;; builds an association list for doctors and their combined clinical responses


(setq *doc-words* '(
  (DALE-K-BLOCK THANKS STEVE YES THIS SHOULD BE NOTED AND I WILL TAKE CARE OF
   THAT I DO NOT THINK THATTHE PATIENT WILL BE AMENABLE TO PO STEROIDS NOT
   REALLY FOLLOWING THE ICE AND ULTRASOUND HE IS LOOKING FORWARD TO THE
   MEETING WITH FEATHERS I^LL KEEP YOU INFORMED AND VICE VERSA THANKS AGAIN
   KEN BLOCK
  )
  (STEVEN-R-SHANNON I HAVE AN AD VIP WITH SIGNIFICANT ANKLE DJD TENDINITIS WHO
   SAYS HE HAS AN ASPIRIN ALLERGY NOTHING IOTED IN CHCS AND HAS BEEN TOLD
   THAT HE CAN^T TAKE NSAIDS DO THE NEWER NSAIDS ALSO HAVE THIS
   RECOMMENDATION THANKS SRS THANKS FOR THE REPLY I^M TOLD THAT THIS PT DOES
   DID HAVE AN ANAPHYLACTIC TYPE REACTION ALTHOUGH LOCAL STEROID INJECTION IS
   USUALLY CONSIDERED I SUPPOSE ORAL STEROIDS WOULD BE THE ONLY OTHER ORAL
   ANTI INFLAMMATORY OPTION FOR TENDINITIS IN SOMEONE WITH AN ASA ALLERGY
   THANKS I^M GOING TO FWD THIS TO COL BLOCK WHO IS THE MD COORDINATOR FOR
   THIS VIP COL BLOCK JUST AS A HEADS UP WHEN I CHECKED CHCS FOR THIS VIP^S
   ALLERGIC REACTION THERE WERE NO ALLERGIES NOTED SHOULD THIS BE NOTED IN
   CHCS FOR THIS PT^S SAFETY SRS
  )
  (STEPHEN-J-KRIVDA IT IS PROBABLY A VACCINE RELATED PERSISTENT SUBCUTANEOUS
   NODULE THOUGHT TO BE RELATED TO THE FACT THAT THE VACCINE IS ALUMINUM
   ADSORBED THIS IS SEEN IN OTHER ALUMINUM ADSORBED VACCINES AND IS THOUGHT
   TO BE AN UNUSUAL RXN TO ALUMINUM WE HAVE SIMILAR CASE PENDING X RAY
   MICROANALYSIS FOR ALUMINUM AT THE AFIP SEND HIM OVER I^D LIKE TO SEE HIM
   STEVE
  )
  (ROBERT-E-JESCHKE WILL BE HAPPY TO SCHEDULE THE ABOVE AS SOON AS I HAVE A
   POINT OF CONTACT AS I NOW HAVE A NUMBER TO CONTACT I WELL CALL HIM TODAY
   THANK YOU
  )
  (GORDON-N-MILLER SIR MA^AM I HAVE A 71 YEAR OLD MALE WITH HISTORY OF
   HYPERTENSION DM TYPE II AND HYPERCHOLESTEROLEMIA AND OLD MI IN 1981 WHO
   RECENTLY DEVELOPED SYMPTOMS SUGGESTIVE OF ANGINA TMST DEMONSTRATED 2MM
   ELEVATION IN V1 WITH ASSOCIATED SYMPTOMS OF SOB AND PAIN PATIENT DESIRES
   TO REMAIN IN MILITARY MEDICAL CARE SYSTEM QUESTION HOW DO I GO ABOUT
   SENDING HIM DOWN THERE FOR EVALUATION IF YOU ACCEPT HIM AND BECAUSE OF THE
   DISTANCE IF YOU DECIDE TO CAN HE GET A CATH DURING THE SAME TRIP NOT
   TRYING TO SOUND SMART BUT WHAT TO GIVE THE PATIENT THE INFORMATION UP
   FRONT TO PREVENT ANY MISUNDERSTANDINGS THANK YOU FOR YOUR TIME GORDON
   MILLER SIRS NO ONE HAS CONTACTED THE ABOVE PATIENT AS OF YET PLEASE CALL
   HIM AS HIS SYMPTOMS ARE STILL PRESENT DR MILLER THANKS ALOT
  )
  (JOANIE-T-RAINEY THANKS DR SCOTT I NOTIFIED THE SMS UNIT 1SG AND PASSED THIS
   INFORMATION ON TO HIM TO RELAY TO THE SM
  )
  (ARTHUR-W-LOESEVITZ I AM NOT AWARE OF THIS BEING A CONTRAINDICATION IT
   SOUNDS LIKE THIS PATIENT DESERVES TO BE SEEN BY OUR DEPARTMENT TO HELP
   SORT OUT THIS PROBLEM
  )
  (GEORGE-B-STACKHOUSE WOULD WORK UP IF 2 3 U A SHOW GREATER THAN 5 RBC^S SHE
   IS BORDERLINE IS SHE ON HRT DOES SHE HAVE IATROGENIC MENSES IF SHE HAS 3 5
   OR GREATER ON ANOTHER U A WOULD SEND HER ON UP
  )
  (MARIA-H-SJOGREN THE COMBINATION OF ANA & ASMA MAKES IT MORE LIKELY TO BE AN
   AUTOIMMUNE HEPATITIS A LIVER BIOPSY WILL GIVE THE DEFINITIVE ANSWER SHE IS
   A BIT OUTSIDE THE AGE RANGE TO DOAGNOSE WILSON^S EARLY |40^S| IS THE LIMIT
   MOST ARE YOUNG ADULTS OR OLDER CHILDREN ALTHOUGH CERULOPLASMIN MAY BE
   NORMAL IN SERUM AND STILL HAVE WILSON^S THIS SITUATION IS OBSERVED IN
   LIVER FAILURE NOT IN AN OUTPATIENT IT HAS TO DO WITH MASSIVE CELL
   DESTRUCTION AND SPURIOUS ELEVATION OF CERULOPLASMIN THE FACT THAT HER
   CERULOPLASMIN IS NORMAL RULES OUT WILSON^S COPPER HAS BEEN ELEVATED IN
   DISEASES LIKE AIH PBC AND OTHERS INTERESTING CASE A LIVER BIOPSY WILL
   HOPEFULLY GIVE YOU THE DIAGNOSIS IF YOU NEED OUR ASSISTANCE CALL THE LIVER
   CLINIC 202 782 5262 FOR AN APPOINTMENT FOR YOUR PATIENT
  )
  (PAUL-L-DUCH WOULD APPRECIATE ANY OPINION S ON 56 YO FEMALE WITH DM AND
```

NOTED TO HAVE FLUCTUATING MILDLY ELEVATED LFT^S 2 |3X| NORMAL OVER PAST 10 YEARS I TOOK THE LIBERTY OF ORDERING A PLETHORA OF LABS TO EVAL TO INCLUDE 1 HEPATITIS B AND C SEROLOGY NEGATIVE 2 ALPHA 1 ANTITRYPSIN WNL 3 IRON FERRITIN WNL 4 ANA POSITIVE DSDNA NEGATIVE ENA SCREEN NEGATIVE LIVER MICROSOMAL AB NEGATIVE SMOOTH MUSCLE ANTIBODY AB POSITVE AT 1 160 5 SERUM COPPER=211 70 165 INITIALLY REPEATED ONE WEEK LATER =2283 WITH CERULOPLASMIN WNL=43 5 17 9 53 3 TO SUMMARIZE PT HAS A POSITIVE ANA WITH POSITIVE ASMA ALSO PT HAS AN ELEVATED SERUM COPPER WITH A NORMAL CERULOPLASMIN OF COURSE THESE ABNORMALITIES WERE DISCOVERED IN THE W U OFCHRONICALLY MILDLY ELEVATED LFT^S COULD THIS PATIENT^S LFT^S BE DUE TO AN AUTOIMMUNE PROCESS CAN YOU HAVE WILSON^S DISEASE WITH A NORMAL CERULOPLASMIN APPRECIATE YOUR ASSISTANCE! THANK YOU VERY MUCH FOR YOUR TIMELY AND INFORMATIVE FEEDBACK I WILL REFER PT TO GI SERVICE FOR CONSIDERATION OF BIOPSY
)
(ANDREW-J-SATIN RITA DRIGGERS REVIEWED LITERATURE ON SURGERY FOR THYROID CANCER IN PREGNANCY J REPRODUCT MED THE ONLY REASONS NOT TO ACT IN FIRST TRIMESTER IS FEAR OF BEING BLAMED FOR MISCARRIAGE RELATED TO SURGERY CONCERN IN THIRD TRIMESTER IS RELATED TO RISK OF PRETERM LABOR I SUSPECT BOTH RISKS ARE OVER RATED IN SURGERY NOT INVOLVING ABDOMEN PELVIS OR LARGE BLOOD LOSS NEVERTHELESS THERE IS NOT A HUGH AMOUNT OF DATA OUT THERE ANDY SATIN
)
(MERRILY-Y-POTH NO DATA THAT I KNOW OF THAT TREATMENT IS INDICATED I WOULD NOT CULTURE THIS PT IN THE FIRST PLACE
)
(MICHAEL-P-WYNN I SAW AN 11 YO MALE FOR A SCHOOL PE DURING HIS UNREMARKABLE EXAM I NOTED TONSILAR EXUDATE MILD EDEMA 1 NO CERIVAL LYMPHADENOPATHY AFEBRILE AND NO C O SORE THROAT I CULTURED THE EXUDATE AND GOT ONE COLONY OF GABS I ASSUME THAT HE IS A CARRIER AND DOESN^T HAVE ACUTE PHARYNGITIS DO WE TREAT CARRIERS DURING THE SPRING TO PREVENT OUTBREAKS IS HE AT ANY RISK OF GABS SEQUAL OR A RISK TO CLOSE CONTACTS NO IN PEDIATRICS OCT 1999 THEY MENTION CEFADROXIL AS MORE EFFECTIVE THAN PCN FOR CARRIERS I HAVE READ ABOUT USING CLINDAMYCIN DURING SPRING TIME AS WELL I COULD NOT FIND ANYTHING MORE HELPFUL ON MDCONSULT THANKS FOR YOUR ANSWERS CPT WYNN SUPER THANKS I WILL LOOK FOR THE 1992 ARTICLE AND HAVE MORE INFORMATION FOR THIS FAMILY
)
(SEAN-D-O^DONNELL NOT UNCOMMON WOULD NOT PURSUE FURTHER SEAN)
(MICHAEL-S-OSHIKI I RECENTLY SAW A 71 Y O GENTLEMAN WITH PMH SIGNIFICANT FOR HTN BPH AND A PREVIOUS CARDIAC MURMUR FOR A MUSCULOSKELETAL PROBLEM DURING HIS INTAKE HIS SBP WAS NOTED TO BE 185 WHEN I WENT TO RE TAKE HIS BP MANUALLY I NOTICED THAT THE AUSCULATATED PULSE PERSISTED EVEN WHEN THE CUFF WAS DEFLATED AND REMOVED AND WAS TRUE FOR BILATERALLY ON FURTHER EXAM HE HAS NO CAROTID OR RENAL BRUITS AND A VERY SOFT CARDIAC MURMUR PREVIOUSLY EVAL^D BY ECHO GOOD CAPILLARY REFILL NORMAL SENSATION AND STRENGTH IN HANDS BILATERALLY 33 PACK YEAR TOBACCO QUIT IN 1983 NO SIGNIFICANT CLAUDICATION SX ACCORDING TO THE PT HE HAS A CIVILIAN CARDIOLOGIST WHO HE SEES EVERY 3 MONTHS AND TAKES HIS BP MANUALLY AND WHO HAS NEVER COMMENTED ON THIS IS THERE ANY CLINICAL SIGNIFICANCE TO AN ASYMPTOMATIC BRACHIAL ARTERY BRUIT IS THERE ANY ADDITIONAL WORKUP INDICATED THANKS MIKE OSHIKI
)
(PETER-E-PALACIO 51YO WF G11P3081 NOT USING HRT D T COMPLICATED MEDICAL HX WITH 3 YEARS OF DYSFUNCTIONAL UTERINE BLEEDING NOTES OCCASIONAL VAGINAL SPOTTING 2 3 TIMES YEAR CLINICALLY PERIMENOPAUSAL WITH ONGOING NIGHT SWEATS AND HOT FLASHES 3 24 0 LH 6 1 FSH 17 2 EST LEVEL PENDING S P MULTIPLE EVALUATIONS OF ENDOMETRIUM INCLUDING D&C BY CIVILIAN PROVIDER ALL BENIGN MOST RECENT EMBX 4 99 DISORDERED PROLIF EM ECC BENIGN 3 0 PELVIC US SHOWED NORMAL SIZED UTERUS WITH 8 8MM EM STRIPE NL ADNEXA DUE TO H O CVA UNABLE TO USE COMBINED HRT 1 CAN I USE CYCLIC OR CONTINUOUS PROGESTERONE SAFELY TO CONTROL ELIMINATE BLEEDING EPISODES PRODUCT INSERT STATES A CONTRAINDICATION WITH H O DISORDERS 2 IF UNABLE TO USE PROGEST AGENT OR PT ELECTS EXPECTANT MANAGEMENT WHAT IS THE BEST WAY TO FOLLOW AND EVALUATE THESE BLEEDING EVENTS AM I OBLIGATED TO SAMPLE THE EM WITH EACH EPISODE CAN I FOLLOW WITH US DO I NEED TO EVALUATE THESE EPISODES IN SOMEONE WHO IS CLINICALLY AND PHYSIOLOGICALLY PERIMENOPAUSAL IN ADVANCE THANKS FOR YOUR TIME AND COMMENTS PETE PALACIO FT DRUM OB GYN
)
(RUSSELL-O-DAVIS A QUICK QUESTION ON ONE OF MY OUTPATIENTS SHE IS A 60 SOME

YEAR OLD AFRICAN AMERICAN FEMALE WHO HAS AN ASYMPTOMATIC TSH OF 97 FROM DEC 99 I AM REPEATING NUC MED TFTS AT THIS TIME AND HAD NOT PLANNED ON TREATMENT AT THIS TIME GIVEN SHE WAS ASYMPTOMATIC BUT WOULD APPRECIATE YOUR INPUT ON THIS CASE ALSO INTERESTINGLY HER LDL HAS FROM THE 130 TO THE 180 OVER THE SAME TIME HER TSH HAS GONE FROM NORMAL TO LOW I TYPICALLY THINK OF HYPOTHYROIDISM BEING ASSOCIATED WITH HLD ANY THOUGHTS ON THIS THANKS! THANKS!
)
(JOHN-P-KUGLER WHAT WOULD YOU RECOMMEND FOR F U ON A 42 YO FEMALE WITH PAST H O GOITER AND HYPOTHYROIDISM NORMAL THYROID ON PHYSICAL EXAM TSH= 81 ON THYROID RX LEVOTHYROXINE 75 MGM THYROID USD NORMAL EXCEPT FOR A SMALL 3 MM HYPOECHOIC NODULE IN RIGHT MIDPOLE REGION WHICH WAS FELT TO A POSSIBLE SMALL THYROID CYST YOU RECOMMEND F U USD IF SO AT WHAT INTERVAL THANKS! A PAST H O ^GOITER^ AND LACK OF SPECIFIC DOCUMENTATION OF THIS IN THE CHART LED ME TO ORDER THE USD THANKS FOR THE RECOMMENDATIONS
)
(RUBEN-J-ALVERO IF THERE IS AN ENDOCRINOLOGIC ASSOCIATION WITH SPONTANENOUS ABORTION AND PCO IT MAY HAVE MORE TO DO WITH HIGH LH LEVELS SEEN IN THESE PATIENTS NEVERTHELESS IF YOU TREAT THE PATIENT WITH CLOMIPHENE THERE IS CIRCUMSTANTIAL EVIDENCE THAT THIS TREATS THE LUTEAL PHASE DEFICIENCY BY BUILDING UP THE GRANULOSA CELL MASS THAT IS THEN LUTEINIZED IN THE LUTEAL PHASE AND SECRETES THE BULK OF THE PROGESTERONE BOTTOM LINE TREAT WITH YOU CAN TREAT WITH PROGESTERONE VAGINAL SUPPOSITORIES 100 MG BID BUT REALIZE THAT THIS IS HIGHLY EMPIRIC AND WHILE SAFE IN PREGNANCY IS ALSO PROBABLY NOT EFFECTIVE HOPE THIS HELPS LET ME KNOW IF YOU HAVE ANY FURTHER QUESTIONS
)
(JEFFREY-L-JACKSON DEAR RHEUM SERVICE I^M DOING A CUTE STUDY LOOKING AT NATIONAL DATABASES TO SEE WHAT IMPACT IF ANY THE AHCPR GUIDELINES ON MANAGEMENT OF ACUTE LOW BACK PAIN HAD ON PHYSICIAN BEHAVIORS I^D LIKE TO EXCLUDE RHEUMATOLOGIC CAUSES OF LOW BACK PAIN ACCORDINGLY I^VE EXCLUDED FOLKS FROM THE SET WHO HAVE ANKLYOSING SPOND RHEUMATOID ARTHRITIS SACROILLITIS I^VE ALSO EXCLUDED FOLKS WITH UTI AND FIBROMYALGIA ARE THERE ANY OTHER SPECIFIC DIAGNOSIS THAT I^D BE WELL ADVISED TO DELETE I HAVE ABOUT 12 MILLION OFFICE VISITS WITH GP FP IMED DOCS BETWEEN 1990 1997 FOR ACUTE LOW BACK PAIN I^M INTERESTED IN FINDING OUT WHETHER THESE DOCS CHANGED THEIR BEHAVIORS MEDICINE XRAYS PHYSICAL THERAPY ETC AS A CONSEQUENCE OF THE AHCPR LOW BACK PAIN GUIDELINES THAT WERE RELEASED IN 1994 I WANT TO EXCLUDE PATIENTS WHO ARE GIVEN INFLAMMATORY DIAGNOSES SUCH AS AS REITERS ETC I HAVE THE ICD 9 DIAGNOSES FOR ALL THE PATIENTS UP TO 3 I AM LOOKING FOR INPUT ON INFLAMMATORY DIAGNOSES I SHOULD GO IN AND EXCLUDE THANKS
)
(DAVID-D-KRIEGER I SIGNED THIS SOLDIER^S MED 200 TODAY HE^S GONE KRIEGER)
(JEANNE-K-TOFFERI I AM SEEING A BASCI TRAINEE WHO SWEARS HE HAS DI WHY THIS WASN^T A PROBLEM BEFORE HE CAME IN ESCAPES ME I DID A 24 HOUR URINE WHICH WAS REMARKABLE FOR HAVING 14 LITERS WITH 1 8GM OF PROTEIN WE CAN SEPARATE HIM ON THE PROTEINURIA BUT I AM CURIOUS IF HE DOES HAVE DI SO I DID A WATER DEPRIVATION TEST WE HAD A LITTLE DIFFICULTY ADMIN WISE SO IT WAS NOT QUITE TEXT BOOK WE STARTED AFTER 5 7 HOURS WITHOUT H2O TIME URINE OSM SERUM OSM 301 298 351 300 448 296 450 298 478 294 AFTER VASOPRESSIN 513 I DIDN^T THINK HE NEEDED THE VASOPRESSIN AS IT LOOKED PRETTY NRL TO ME I THINK THIS IS A NORMAL TEST AM I RIGHT THANKS JEAN THIS GUY WANTS AN EXCUSE TO GET OUT OF TRAINING SO THIS GUY^S BROTHER IN LAW A GENERAL SURGEON CALLS ME UP AND SAYS SINCE I DID NOT DO A HYPERTONIC SALINE INFUSION I HAVE MISSED THE CORRECT DX OF DI THIS ISN^T WHAT MY TEXTBOOK SAYS BUT HAVE I DONE ENOUGH THANKS! THANK YOU
)
(GINA-J-JAMES CALLING PAUL KELLY WAS MY EXACT ANSWER I ACTUALLY HAVE AN APPT WITH HIM THIS AFTERNOON AND WILL SEEK HIS ADVICE I WILL KEEP YOU POSTED! IF SOMEONE COULD GIVE ME THE PATIENT^S NAME AND PHONE NUMBER I WILL TRY TO HOOK THEM UP WITH A VOICE MATE MONITOR VIA THE ROCHE COMPANY PLEASE DON^T SEND THE PT^S INFO OVER THE E MAIL MY PHONE NUMBER IS 202 782 5209 CPT JAMES
)
(CHRISTINE-T-SCOTT WE HAVE A PROBLEM WITH A DIABETIC PATIENT GETTING DURABLE MEDICAL EQUIPMENT AND I THOUGHT YOU MIGHT HAVE SOME IDEAS ON HOW WE CAN HELP HER GET THE EQUIPMENT SHE NEEDS THE FOLLOWING IS A NOTE FROM OUR HBA WHO HAS BEEN TRYING TO WORK THIS ISSUE SHE IS LEGALLY BLIND AND NEEDS VOICE ACTIVATED OR VOICE RESPONSE EQUIPMENT IN ORDER TO MONITOR CONTROL

HER DIABETIC CONDITION AND HER BLOOD PRESSURE I HAD ORIGINALLY REFERRED IT TO THE TRICARE SERVICE CENTER SUPERVISOR TO DETERMINE IF SUCH EQUIPMENT WAS AVAILABLE ANYWHERE WITHIN THE NETWORK SYSTEM HE RESEARCHED AND DETERMINED IT WAS NOT AND SAID BASICALLY THE PATIENT WOULD HAVE TO PAY OUT OF POCKET UPFRONT AND THEN HAVE IT FILED TO TRICARE FOR REIMBURSEMENT I BELIEVE HE EVEN SPOKE TO THE BENEFICIARY AT ONE POINT AND SHE INFORMED HIM IT WAS AVAILABLE THROUGH LIGHTHOUSE FOR THE BLIND HE SUGGESTED IN ADDITION TO THE USUAL PAPERWORK THAT DR TOEDT ALSO PUT A REFERRAL IN THE SYSTEM STATING THE CIRCUMSTANCES AS A BACKUP FOR CLAIMS PROCESSING PURPOSES THE PROBLEM NOW SEEMS TO BE CENTERED AROUND THE FACT THAT THE PATIENT SHE CANNOT AFFORD TO MAKE PAYMENT UP FRONT AND THERE WAS THEN DISCUSSION ABOUT DISABILITY CASE MANAGEMENT ETC I HAVE MADE SEVERAL ATTEMPTS TO REACH THE PATIENT AND HAVE BEEN UNSUCCESSFUL I CAN DIRECT HER TO SOME ASSISTANCE IN APPLYING FOR SOCIAL SECURITY DISABILITY ETC BUT THAT DOES NOT RESOLVE THE IMMEDIATE CONCERN THE BOTTOM LINE NOW SEEMS TO BE SHE IS ENROLLED TO PRIME TO US SHE IS IN CRITICAL NEED OF THIS EQUIPMENT IRREGARDLESS OF WHETHER SHE MAY BE FOR DISABILITY THROUGH ANY OTHER SOURCE AND SHE CANNOT AFFORD TO MAKE PAYMENT TO THEN BE REIMBURSED WHAT DO WE DO IN THIS SITUATION HELP !! ANY IDEAS FROM OUR ENDOCRINOLOGISTS WOULD BE GREATLY APPRECIATED I AM SURE YOU MUST SEE DIABETICS WHO ARE LEGALLY BLIND FROM THEIR DISEASE THANK YOU FOR YOUR HELP I^LL SEND THE PATIENT^S NAME UNDER A SEPARATE CLOSED MESSAGE IS SICKLE CELL TRAIT CONSIDERED A CONTRAINDICATION TO THE ANTHRAX VACCINE
)
(NAGLA-A-WAHAB I DON^T THINK THESE CLAIMS CAN BE SUBTANTIATED IF BETTER ABSORPTION IS A CONSIDERATION THEN A LIQUID VITAMIN WOULD BE BEST WE CARRY HERE AT WRAMC MULTIVITAMIN SUPPLEMENT IN A LIQUID PREPARATION ASMA I WOULD LIKE TO SEE A COPY OF THE ARTICLE THANKS
)
(ASMA-S-BUKHARI THERE IS A VERY GOOD ARTICLE ON VITAMIN SUPPLEMENTATION IN ^NUTRITION ACTION^ NEWSLETTER LET ME KNOW IF YOU NEED A COPY TO PASS IT ON TO YOUR PTS
)
(SANDRA-E-SMITH I^LL FORWARD THIS TO NAGAL WAHAB NUTRITION SUPPORT PHAMACIST IN CASE SHE HAS COMMENTS
)
(AARON-A-SAGUIL TO WHOM IT MAY CONCERN I HAVE A QUESTION REGARDING VITAMIN SUPPLEMENTS MY PATIENT WHOSE PMH IS SIGNIFICANT FOR TIA HAS BEEN TOLD THAT LIFEGUARD ANTIOXIDANT THERAPY IS BETTER THAN CONVENTIONAL FORMULATIONS A LA CENTRUM IN THAT IT IS BETTER ABSORBED AND MORE NATURAL IN ITS PREPARATION I BELIEVE IT TO BE A POWDER AS OPPOSED TO A TABLET AND THUS SHE WAS TOLD IT IS BETTER ABSORBED DO ANY OF YOU KNOW IF THESE CLAIMS ARE SUBSTANTIATED THE COST ON THE PREPARATION IS GREATER THAN CONVENTIONAL TABLETS AND I DON^T WANT FOR MY PATIENT TO WASTE HER MONEY THANK YOU AARON SAGUIL I WOULD VERY MUCH LIKE TO READ THIS ARTICLE IF YOU COULD PLEASE FAX IT TO ME AT AND I WILL FORWARD IT TO THE PATIENT IN THE MEANTIME DO YOU HAVE ANY SPECIFIC THOUGHTS REGARDING THE CURRENT CASE I^D APPRECIATE YOUR INPUT AARON
)
(ALICIA-Y-ARMSTRONG ALTHOUGH SHE IS 10 YEARS OUT I WILL STILL CONSULT A MEDICAL ONCOLOGIST BEFORE PRESCRIBING HRT I WILL FORWARD TO DR S ROSA AND SATIN TWO OF OUR MATERNAL FETAL MEDICINE SPECIALISTS
)
(DEEANN-M-STROOP I HAD A FIRST TIME PATIENT TODAY WHO CAME IN REQUESTING A REFILL OF HER ERT CURRENTLY ON PREMARIN 0 625 QD AND ESTRATEST HS QOD DURRING HER EVALUATION I FOUND SHE HAD HAD A TAH BSO IN 85 FOR DUB IN 1990 SHE UNDERWENT A RIGHT MRM FOR T1N0M0 INFILTRATING DUCTAL CA THAT WAS ESTROGEN RECEPTOR SHE DID NOT HAVE CHEMO OR TAMOXIFEN SHE HAS SINCE HAD AN IMPLANT SHE C O DECREASED LIBIDO SINCE HER SURGERY AND IN 1998 WAS PLACED ON PREMARIN ESTRATEST HS WAS ADDED A FEW MONTHS LATER SHE HAS BEEN ON IT SINCE WITH GOOD RESPONSE IN REGUARDS TO HER LIBIDO AND LUBRICATION SHE IS NO LONGER FOLLOWED BY ANY OF THE SPECIALIST I WAS UNCOMFORTABLE PRESCRIBING ERT TO AN ER BREAST CA PATIENT EVEN 10 YEARS OUT IS THIS AN OK THING TO DO IS THERE A REASON TO USE THE MEDS THE WAY SHE HAS BEEN INSTEAD OF JUST USING ESTRATEST HS QD PLEASE HELP THANKS! DEEANN STROOP MD
)
(DAVID-S-DOUGHERTY IT IS MY OPINION THAT THERE IS NO VALUE ADDED FOR ESTROGEN IN PRE OR POST MENOPAUSAL MS AS IT RELATES TO THE PRIMARY DEMYELINATIVE PROCESS IF QUESTIONS ABOUT HER DISEASE SHOULD ARISE A REFERRAL TO THE MS CLINIC AT NNMC MIGHT BE INDICATED

)
(RITA-A-FRIEDRICHS I HAVE A QUESTION REGARDING ESTROGEN AND MS I FOLLOW A 44 YO WOMAN WITH MS FOR ABOUT 5 6 YEARS PROBABLY RELAPSING REMITTING WHO HAS BEEN ON AVONEX FOR SEVERAL YEARS AND HAS BEEN STABLE SHE READ ON THE INTERNET THAT ESTROGEN WAS HELPFUL FOR MS AND WAS GIVEN AN RX FOR PREMPRO BY HER PREVIOUS PCM SHE HAS BEEN TAKING THIS FOR SEVERAL YEARS WITH NO SIG CHANGE IN HER SYMPTOMS SHE IS NOT MENOPAUSAL I THINK THAT THERE HAVE BEEN STUDIES SUGGESTING IMPROVED COGNITIVIE FUNCTION IN POSTMENOPAUSAL WOMEN WITH MS WHEN THEY USE ESTROGEN REPLACEMENT AND SOME RECENT ANIMAL STUDIES USING ESTRIOL HOWEVER I AM NOT AWARE OF THE USE OF LOW DOSE ESTROGEN IN PREMENOPAUSAL WOMAN WITH MS MY CONCERN IN THIS PATIENT IS THAT I AM UNCLEAR ON THE BENEFITS SHE IS RECEIVING FROM THIS REGIMEN AND THAT AT THIS DOSE OF ESTROGEN SHE IS AT RISK FOR THROMBOTIC COMPLICATIONS WITHOUT THE CONTRACEPTIVE BENEFITS ARE THERE ANY BENEFITS FOR ESTROGEN USE IN PREMENOPAUSAL WOMEN WITH MS OR ANY BEENFITS OF ORAL CONTRACEPTIVES IN PREMENOPAUSAL WOMEN WITH MS OF NOTE THIS PATIENT DOES NOT SEEM TO HAVE FLARES OF HER MS WITH HER MENSTRUAL CYCLES THANKS RAF THANKS FOR YOUR RESPONSE
)
(BAZIGHA-A-HASAN 42 YOF SMOKER HAS ALLERGIC RHINITIS NOTICED TO HAVE PLATELET COUNT OF 120 DURINF ROUTINE EXAM REPEATS SINCE THEN AT ONE AND THREE MTHS INTERVAL HAVE BEEN 130 OOO AND126 OOO SHOULD ANYTHING BE DONE AND WHAT
)
(JULIE-P-DICERBO I HAVE A 38 YO MALE WITH A CHRONIC DAILY HEADACHE X 3 MONTHS SX WORSENING WITH NO FOCAL NEURO SIGNS MRI WAS REPORTED AS ESSENTIALLY NORMAL APART PROBABLE HYPOPLASIA OR OCCLUDED R VERTEBRAL ARTERY BUT WITHOUT PARENCHYMAL CHANGES IS THIS FINDING OF ANY IMMEDIATE CONCERN PT HAS AN APPT WITH NEURO MID APRIL SORRY THIS HISTORY IS MINIMAL I HAVE NO CHART AVAILABLE TO REFRESH MY MEMORY AND I^VE NOT BEEN SUCCESSFUL IN REACHING THE PATIENT TO CHECK ON STATUS THANKS I HAVE A 48 YO FEMALE WITH PREMATURE OVARIAN FAILURE 10 YRS AGO WHO HAS NEVER BEEN ON HRT HER BONE DENSITY STUDY SHOWS 2 1 SCORE AT LUMBAR VERTEBRAE AND 0 3 AT FEMORAL NECK WITH A FINDING OF OSTEOPENIA SHE HAS AGREED TO START HRT SHE HAS NO CONTRAINDICATIONS TO HRT SHE WILL BE TAKING 1500 MG CALCIUM IS THERE ANY INDICATION FOR AN ENDOCRINOLOGY CONSULT FOR CONSIDERATION OF FOSOMAX FOR THIS PATIENT OR IS HRT AND CALCIUM ADEQUATE AT THIS POINT THANKS
)
(DONNA-M-MACNEIL DR RAMSEY I WILL GIVE HER A CALL THANKS DONNA MACNEIL)
(SUSAN-T-ALLARD MY PATIENT IS A 27YOBF SEEKING CLEARANCE FOR AUTHORIZATION AS A DAYCARE PROVIDER SHE HAS NO KNOWN HISTORY OF ANY CHILDHOOD COMMUNICABLE DISEASES BUT HER MOTHER IS NO LONGER ALIVE TO CONFIRM DENY THIS PT DOES NOT HAVE A COPY OF HER IMMUNIZATION RECORDS AND DOES NOT THINK SHE CAN GET A COPY I THOUGHT I COULD GIVE HER A TETANUS BOOSTER AND MMR AND CHECK A VARICELLA TITER BUT THE DAYCARE ALSO WANTS POLIO SHOULD I INSTEAD CHECK TITERS OF RUBELLA RUBEOLA VARICELLA AND MUMPS AND POLIO TOO AND GIVE HER A TETANUS BOOSTER MY SUPERVISING PHYSICIAN THOUGHT ALSO THAT MAYBE IT WOULD JUST BE EASIER TO REFER HER TO IMMUNIZATION ALLERGY AND LET THE CONSULTING PHYSICIAN DECIDE I^D APPRECIATE YOUR INPUT AS TO THE APPROPRIATE WAY FOR ME TO PROCEDE WITH MY PATIENT THANKS THANK YOU SO MUCH FOR YOUR PROMPT REPLY AND THE USEFUL INFO I HAD THOUGHT OF THE HEP A AND B^S BUT FOR SOME REASON NEGLECTED TO DO ANYTHING FURTHER THAT ^THINK^ ABOUT THEM AGAIN THANKS I HAVE A 27YOWF WITH DEPRESSION AND MOOD DISORDER CHRONIC CONSTIPATION AND HX OF ANOREXIA A FEW YEARS AGO REQUIRING HOSPITALIZATION BUT NOT CURRENTLY ACTIVE AND WITH NEW ONSET OF GENERALLY FEELING FATIGUED SOMETIMES DIZZY WITH LOSS AND ON NO MEDICATIONS SHE TAKES TOPAMAX CELEXA AND FOLIC ACID AND TOPICAL ACNE MEDICATIONS PMHX SIG FOR KIDNEY INFECTION IN THE PAST YEAR FAMHX SIG FOR EARLY ONSET MULTIPLE SCLEROSIS HTN DM AND ADHD AND BREAST AND COLON CANCERS TODAY SHE WAS FOUND TO HAVE THE FOLLOWING LABS WITH A LOW BUN AND CREATININE 12 99 9 99 11 98 140 141 139 140 4 3 3 5 3 8 3 8 108 109 105 104 23 21 24 27 81 111 77 78 3 4 3 8 0 6 0 6 0 7 0 6 SUPERVISING PHYSICIAN RECOMMENDED I RECHECK HER LFTS WHICH WERE NORMAL LAST SEPTEMBER AND ALBUMIN ALSO NORMAL IN THE PAST AND TO QUERY HER EATING HABITS SHE STATES SHE EATS ONLY 1 2 MEALS A DAY AND DRINKS A LOT OF SODA MAYBE 8 GLASSES PER DAY WER ALSO CHECKED THE PDR TO SEE IF THIS WERE POSSIBLY A PROBLEM WITH EITHER CELEXA OR TOPAMAX BUT COULD FIND NONE SHE ASKED ME TO ASK FOR YOUR THOUGHTS IS THIS LOW BUN WORRISOME AND WHAT OTHER THINGS SHOULD I BE LOOKING FOR OTHER STARVATION AND LIVER FUNCTION ABNORMALITIES AND IS THERE ANYTHING FURTHER WE SHOULD

BE LOOKING AT FOR HER OR DO WE NOT FOLLOW ANY FURTHER SHE IS ABOUT 113 POUNDS AND PROBABLY 5^4IN OR SO WITH BP 110 60 AND PULSE 69 THANKS SO MUCH FOR YOUR ASSISTANCE SUE ALLARD PA C THANK YOU BOTH FOR YOUR REPLIES WILL USE THIS INFORMATION IN CARING FOR HER DOESN^T SOUND LIKE THERE^S MUCH ELSE TO BE LOOKING FOR WITH APPRECIATION!!
)
(DAVID-I-GOLDBERG ACTUALLY GLEN YOU BEAT ME TO THE PUNCH MY APOLOGIES FOR THE DELAY IN ANSWERING YOUR QUESTION OUTSIDE OF CERTAIN HIGH RISK PATIENTS TO INCLUDE IMMUNOSUPPRESSED PATIENTS AND NEONATES STREP VIRIDANS IS USUALLY CONSIDERED TO BE A CONTAMINANT FROM THE SKIN OR OROPHARYNX IN THE CHILD WITH A CLINICAL VIRAL PROCESS AND WHO IS BEING EVALUATED FOR R O SERIOUS BACTERIAL ILLNESS DUE TO AGE ALONE AND HAS A NORMAL PHYSICAL EXAM IE NO NEW HEART MURMER THE PRESENCE OF STREP VIRIDANS CAN BE CONSIDERED NON PATHOGENIC AND THERAPY CAN BE HALTED THE ISSUE OF THE CARRIER STATE IS ONE THAN ONLY A NAVY LINE OFFICER COULD LOVE IN PEDIATRICS IT IS RIGHT UP THERE WITH WHAT CONSTITUTES PURULENTRHINORRHEA THERE ARE FEW HARD FACTS AND LOTS OF OPINIONS IT IS BEST TO REMEMBER THAT THE SIGNIFICANCE OF STREPTOCOCCAL UPPER RESPIRATORY DISEASE IS IN ITS NONSUPPORATIVE SEQUELAE IE RHEUMATIC FEVER AND ACUTEGLOMERULANEPHRITIS AND NOT IN ITS ABILITY TO CAUSE SORE THROATS TREATMENT IS BASED ON PREVENTING THE ABOVE SEQULAE AND NOT MAKING THE THROAT BETTER ALTHOUGH IT DOES THE PREVELANCE OF POSITIVE THROAT CULTURES INASYMPTOMATIC CHILDREN IS BETWEEN 15 30% AND CARRIAGE OF STREP DOES NOT LEAD TO CARIO RENAL DISEASE MANAGEMENT OF STREP CARRIERS IS PROBLOMATIC TO DETERMINE IF THE PATIENT IS A CARRIER WITH A VIRAL PHARYNGITIS ONE CAN OBTAIN SEROLOGY BUT THIS IS COSTLY PAINFUL AND EXPENSIVE ONE HAS TO RELY ON SYMPTOMS TIME OF YEAR WHAT^S HAPPENING IN THE SCHOOL COMMUNITY AND PAST HX OF THE PATIENT IN THE CASE ABOVE YOUR PATIENT IS ASYMPTOMATIC AND WE ARE IN THE LATESPRING WHEN THE PREVELANCE OF INFECTION IS LOW I WOULD NOT TREAT THIS CHILD BUT I WOULD NOTE THAT AT THIS TIME HE IS A PROBABLE ASYMPTOMATIC CARRIER IN THE FUTURE WITH THE PROPER SX^S I WOULD CULTURE HIM AND TREAT WITH PN IF THE CULTURE OR RNA STREP TEST IS POSITIVE IF THERE IS NO CLINICAL RESPONSE IN 48HRS I SWITCH TO A CEPHALOSPORIN OR CLINDAMYCIN I WOULD NOT RECULTURE HIM AFTER THERAPY ELIMINATION OF THE CARRIAGE STATE SHOULD BE RESERVED TO THE TIMES OUTLINED BY DR HORN HOPE THIS DOES NOT CONFUSE YOU C PED ID SVCE
)
(GLENN-W-WORTMANN SORRY FOR THE DELAY IN RESPONDING AND PAGE THE PEDIATRIC ID FELLOW ON CALL TO DISCUSS THE CASE
)
(KUNCHUL-L-YOON I ADMITTED 6 WEEK OLD INFANT WITH HX OF FEVER OF 102 F AND COLD SX SEPSIS W U INCLUDING SPINAL FLUID STUDY NEGATIVE EXCEPT BLOOD CULTURE STREP VIRIDANCE PATIENT IS DOING WELL NO FEVER EATING WELL QUESTION SHALL I CONTINUE ROCEPHIN OR D C ABX ASSUMING THIS IS CONTAMINATION THANK YOU DR YOON STAFF PEDIATRICIAN
)
(SALVATORE-A-MANNO SIR OR MAAM I AM WRITING WITH REGARD TO A PT I HAVE AT OUR HEALTH CLINIC THE PT IS A 15 Y O MALE WHO 6 WEEKS AGO BEGAN TO EXPERIENCE DYSURIA WITH ASSOCIATED HEMATURIA THE PT WAS ORIGINALLY SEEN AT VILSECK^S TMC AND WAS TREATED AS HAVEING A UTI THE PT ABOUT 5 DAYS LATER BEGAN TO EXPERIENCE SUPRAPUBIC PAIN AND FLANK PAIN HE THEN WAS SEEN IN OUR CLINIC WHERE LABS WERE COMPLETED AND EVENTUALLY SHOWED A 24 TP EXCRETION OF 534MG THE PT WAS SENT TO THE GERMAN ECONOMY AND SEEN AT WEIDEN HOSPITAL WHERE THE MOP STATES BLOOD WORK RENAL US AND UA^S WERE COMPLETED THE PT WAS THEN RELEASED AND TOLD TO F U IF THE HEMATURIA AND DYSURIA REOCCURED WHILE A WORKING DIAGNOSIS WAS TO BE FORMULATED THE SYMPTOMS REAPPEARED AND THE PT RETURNED TO THE HOSPITAL WHERE HE WAS TOLD HE PROBABLY PASSED A STONE THE MOP IS EXTEREMELY UNHAPPY WITH THE CARE AND CAME TO OUR CLINIC SEEKING A REFERRAL TO AMERICAN DOCTORS THE GERMAN HOSPITAL REPORT IS STILL BEING TRANSLATED PRIOR TO SENDING THE PT TO YOUR OFFICE WOULD YOU LIKE ANY ADDITIONAL LABS OR RADIOLOGICC WORK UP COMPLETED THANK YOU
)
(KARIN-A-COX I APPRECIATE YOUR CONCERN REGARDING THIS ISSUE THERE ARE NO REGULATIONS CIVILIAN OR MILITARY LIMITING WORK ACTIVITIES SOLELY BASED ON A POSITIVE PPD RESULT PROVIDER EXCLUSION READMITTANCE CRITERIA A CHILD CARE PROVIDER SHOULD BE TEMPORARILY EXCLUDED FROM PROVIDING CARE TO CHILDREN IF SHE OR HE HAS ONE OR MORE OF THE FOLLOWING CONDITIONS CONDITION EXCLUDE FROM CHILD CARE FACILITY CHICKENPOX UNTIL 6 DAYS AFTER THE START OF RASH OR WHEN SORES HAVE DRIED CRUSTED SHINGLES ONLY IF SORES CANNOT BE COVERED BY CLOTHING OR A DRESSING IF NOT EXCLUDE UNTIL SORES HAVE CRUSTED AND ARE DRY A PERSON WITH ACTIVE SHINGLES SHOULD NOT CARE FOR

IMMUNE SUPPRESSED CHILDREN RASH WITH FEVER OR JOINT PAIN UNTIL DIAGNOSED NOT TO BE MEASLES OR RUBELLA MEASLES UNTIL 5 DAYS AFTER RASH STARTS RUBELLA UNTIL 6 DAYS AFTER RASH STARTS MUMPS UNTIL 9 DAYS AFTER GLANDS BEGIN TO SWELL DIARRHEAL ILLNESS IF 3 OR MORE EPISODES OF LOOSE STOOLS DURING PREVIOUS 24 HOURS OR IF DIARRHEA IS ACCOMPANIED BY FEVER UNTIL DIARRHEA RESOLVES VOMITING IF 2 OR MORE EPIDSODES OF VOMITING DURING THE PREVIOUS 24 HOURS OR IF ACCOMPANIED BY A FEVER UNTIL VOMITING RESOLVES OR IS DETERMINED TO BE DUE TO SUCH NONINFECTIOUS CONDITIONS AS PREGNANCY OR A DIGESTIVE DISORDER HEPATITIS A FOR 1 WEEK AFTER JAUNDICE APPEARS OR AS DIRECTED BY HEALTH DEPARTMENT ESPECIALLY WHEN NO SYMPTOMS ARE PRESENT PERTUSSIS UNTIL AFTER 5 DAYS OF ANTIBIOTIC THERAPY IMPETIGO A SKIN INFECTION UNTIL 24 HOURS AFTER ANTIBIOTIC TREATMENT BEGINS AND LESIONS ARE NOT DRAINING ACTIVE TUBERCULOSIS TB UNTIL THE LOCAL HEALTH DEPARTMENT APPROVES RETURN TO THE FACILITY STREP THROAT OR OTHER STREPTOCOCCAL INFECTION UNTIL 24 HOURS AFTER INITIAL ANTIBIOTIC TREATMENT SCABIES HEAD LICE ETC UNTIL 24 HOURS AFTER TREATMENT HAS BEGUN PURULENT CONJUNCTIVITIS UNTIL 24 HOURS AFTER TREATMENT HAS BEGUN OTHER CONDITIONS MANDATED BY STATE PUBLIC HEALTH LAW SORRY ABOUT THE FORMAT OF THIS CUT AND PASTE JOB I AM NOT SAVVY ENOUGH TO REFORMAT THIS BUT HOPE THIS HELPS IT IS TAKEN FROM THE CDC PLEASE FEEL FREE TO CONSULT WITH ANY OCCUPATIONAL HEALTH NURSE OR PHYSICIAN ABOUT MEDICAL ISSUES RELATING TO EMPLOYMENT IF I CAN BE OF FURTHER ASSISTANCE PLEASE LET ME KNOW KARIN COX MD
)
(ANDREW-J-REYNOLDS INFECTIOUSNESS OF TB IS RELATED TO THE AMOUNT OF AFB THEY PUT IN THE AIR PT^S THT ARE CONSIDERED INFECTIOUS HAVE 1 ACTIVE COUGH 2 POSITIVE AFB ON SPUTUM 3 UNDERGOING COUGH INDUCING PROCEDURES OR AEROSOL GENERATING PROCEDURES 4 HAVE ACTIVE TB AND ARE NOT RECEIVING THERAPY SHE DOESN^T APPEAR TO HAVE ACTIVE TB AND DOES NOT HAVE A COUGH OR POSITIVE CXR I WOULD CONSIDER HER TO BE NON INFECTIOUS AND WOULD ALLOW HER TO GO BACK TO WORK WOULD STRESS IMPORTANCE OF EDUCATION COMPLIANCE RETURN FOR NEW SXS ETC
)
(JOHN-H-FOOTE I HAVE A QUESTION REGARDING A 24 YO LADY WHO RECENTLY HAD A PPD AND STARTED INH 24 MAR 0 SHE SAW ME TODAY FOR A PHYSICAL SO THAT SHE CAN WORK IN CHILD DEVELOPEMENT SERVICES AS A CARETAKER SHE HAD A NORMAL CXR 2 WEEKS AGO SHE HAS NO SYMPTOMS AND NO COMPLAINTS QUESTION 1 CAN SHE BE CLEARED TO WORK AS A CAREGIVER 2 IF NOT NOW WHEN COULD SHE BE CLEARED JOHN FOOTE MD THANK YOU FOR THE INFORMATION
)
(LEONARD-C-SPERLING JUST GOING WITH THE ODDS SHE PROBABLY HAS ONYCHOMYCOSIS AND THE PSEUDOMONAS IS A SECONDARY INVADER SPORANOX SHOULD NOT BE STARTED WITHOUT KOH OR CULTURE CONFIRMATION OF A DERMATOPHYTE IF YOU CAN^T ACCOMPLISH THIS REFERRAL TO IS APPROPRIATE THAT^S WHAT WE^RE TRAINED TO DO UNLIKELY TO BE TINEA IN A 10 YO GIRL DOES SHE HAVE A HISTORY OF ATOPY COULD IT BE A WART
)
(TERI-M-ONEIL HOW DO WE GET A PATIENT IN FOR SLEEP STUDY I GAVE APATIENT A CONSULT FOR A SLEEP STUDY CONSULT AND THEY WERE GIVEN THREE DIFFERENT NUMBERS TO TRY AND MAKE THIS APPT NONE OF THE NUMBERS WORKED SIERRA DIDN^T KNOW WHAT TO DO WITH IT WRAMC INFO GAVE THEM A WRONG NUMBER WHAT IS THE PROPER WAY TO SEND THIS YOUNG WOMAN WHO HAS BEEN LIVING ON NIGHTLY FOR SLEEP AND NEEDS A SLEEP STUDY THANKS MAJ O^NEIL THANKS DOMINIQUE I REMEMBER WHEN SOMEONE CAME ONCE TO TALK ABOUT SLEEP DISORDERS AND THEY COMMENTED THAT AMBIENS SHOULD NOT BE USED FOR PERMANENT SLEEPING DIFFICULTIES THIS PATIENT HAS MULTIPLE PROBLEMS SUCH AS RESTLESS LEG AND SOMEONE TOOK HER OFF OF DEPAKOTE SO SHE HAS HAD MORE SLEEPING DIFFICULTIES I DID SEND HER BACK TO NEURO FOR THAT BUT I WILL TRY PULMONARY FOR THE SLEEP TOO THANKS SO MUCH TERI KRISTAL I BET I SAW THAT SAME PATIENT MAYBE COULD BE ANOTHER ONE SO NEURO DID THE SLEEP STUDY I THOUGHT ENT DID IT FOR SOME REASON BUT SINCE THIS WOMAN IS GOING TO NEURO I AM GOING TO HAVE HER ASK THEM ABOUT THE SLEEP STUDY THIS WOMAN I AM PRESENTLY SEEING HAS THE RESTLESS LEG SYNDROME AND LEG PAIN I WANTED TO DO A BONE SCAN ON HER BECAUSE I THINK IF SHE DIDN^T HAVE THE PAIN SHE COULD SLEEP WHEN SHE WAS ON DEPAKOTE SHE COULD SLEEP AND SHE FELT BETTER BUT SOMEONE TOOK HER OFF SHE SAID ^BECAUSE THEY DIDN^T WANT TO FOLLOW HER LEVELS^ I AM LEAVING SO I DIDN^T WANT TO PUT HER BACK ON IT AND NOT FOLLOW HER NEURONTIN IS ANOTHER SEIZURE MED THAT MAY HELP WITH THIS RESTLESS LEG PLUS IT CAUSES SOMULENCE I HAVEN^T USED IT SO I DON^T FEEL COMFORTABLE WITH IT BUT I WILL LET NEURO DECIDE WHAT THEY WANT TO DO THANKS GUYS TERI
)

(TIMOTHY-I-ZEIEN I HAVE A 55 YO W F WITH HX OF TAH IN 1987 PLACED ON HRT IN 1991 AND S PANTRECTOMY VAGOTOMY FOR DU IN 1997 C B DUMPING SYNDROME HER WEIGHT IS 102LBS NOW AND IT WAS APPROX 130 IN 1996 SHE HAS DIFFICULTY MAINTAINING HER WEIGHT DUE TO THE DUMPING SYNDROME SHE TAKES CHOLESTYRAMINE AND AN ESTROGENPATCH I SWITCHED OVER TO A PATCH AROUND A YEAR AGO B C SHE WAS HAVING HOTFLASHES ON THE ESTROGEN PILLS AND I WAS CONCERNED ABOUT ABSORPTION I ORDERED A BMD STUDY WHICH SHOWED A T SCORE OF 2 5 IN THE FEMORAL NECK AND 3 0 IN THE VERTEBRAL SPINE HER URINE CALCIUM IS 106 UPEP=NO PATTERN SEEN P1 P3 SPEP CBC TFT^S VITAMIN D PTH ALL NORMAL I AM TRYING TO DETERMINE WHETHER THERE IS A SECONDARY CAUSE FOR HEROSTEOPOROSIS OR WHETHER IT MAY BE DUE TO MALABSORPTION OF HER MEDS BYCHOLESTYRAMINE VS DUMPING DO YOU RECOMMEND A FURTHER W U OR JUST ADDING AMED LIKE CALCITONIN TO TX REGIMEN ALONG WTH CALCIUM AND VITAMIN D THANKS FOR THE RESPONSES THE PT HAS DECIDED TO GO TO NNMC SINCE THAT^S WHERE HER ULCER SURGERY WAS PERFORMED I^LL ORDER THE ABOVE STUDIES
)
(DONALD-W-ALGEO U DA MAN THANKS CHRIS THIS IS VERY HELPUL FOR CLARIFICATION DON
)
(ANN-N-KIM THANKS FOR THE INFORMATION)
(STEVEN-E-BRAVERMAN THANKS FOR INCLUDING US CHRIS)
(KEVIN-M-O^NEIL THERE ARE ALSO ASSOCIATIONS WITH ATYPICAL MYCOBACTERIAL INFECTIONS AND ESOPHAGEAL DISEASE AS WELL TO CONSIDER
)
(OLEH-W-HNATIUK JOHN I AGREE WITH YOUR ASSESSMENT REGARDING THE PROBABLE CAUSE OF HISINTERSTITIAL CHANGES AND ALSO AGREE THAT HE NEEDS TO BE SEEN BY APULMONOLOGIST DETERMINING THE DIFFERENCE NONINVASIVELY IS NOT EASY BUTSTUART SHOULD BE UP TO THE CHALLENGE THANKS FOR THE REFERRAL OWH
)
(STUART-A-ROOP I WILL GIVE THEM A CALL WE WOULD BE VERY HAPPY TO SEE HER THE CT SCAN ALONG WITH OLD CXRS IF AVAILABLE WOULD BE THE MOST VALUABLE STUDIES WE COULD SEE HER AS EARLY AS NEXT WEEK THURSDAY AFTERNOON 6 APRIL WITH POSSIBLE BRONCHOSCOPY FRIDAY STUART ROOP WE ARE ON WD 77 7TH FLOOR PULMONARY MEDICINE CLINIC I WILL SEE HER THEN THANKS
)
(JOHN-D-HORWHAT I HAVE A PATIENT REFERRED TO DR WONG THAT IS COMING UP FROM HARRISONBURG VAAREA FOR A PNEUMATIC DILATION FOR ACHALASIA AS PART OF HIS EVALUATION DOWN THERE HE HAD A CT OF CHEST ABDO THAT REVEALED INTERSTITIAL CHANGES GROUNDGLASS APPEARANCE IN ANTR SUP SEG RUL SUP SEGS BOTH LOWER LOBES AS WELL AS LINGULAR DIVISION OF LUL THE READING RADIOLOGIST DOWN THERE MENTIONED SUCHTHINGS AS ENDOBRONCHIAL SPREAD OF INFECTION HYPERSENSITIVITY UIP DIP LIPAND ENDOBRONCHIAL SPREAD OF TUMOR SUCH THAT THE PATIENT HAD SCHEDULED HIMSELF TO SEE A PULMONARY DOC DOWN THERE ON 7 APRIL SINCE HE WILL BE COMING UP HERE AROUND 11 AM ON THE 29TH AND LIKELY STAYING OVERNIGHT AFTER HIS ACHALASIA DILATION I WAS SENDING THIS NOTE OUT TO SEE IF THERE WAS ANYONE IN YOUR CLINIC THAT COULD SEE HIM WHILE HE WAS HERE I THINK THAT HE STANDS A MUCH GREATER CHANCE OF THESE CT FINDINGS BEING RELATED TO ASPIRATION FROM HIS FOOD AND FLUID FILLED ACHALASIA ESOPHAGUS THAN THE CANCER THAT HE IS FEARING BUT WOULD APPRECIATE YOUR EXPERT OPINIONS AND SAVE HIM FROM PAYINGOUT FOR ANOTHER CIVILIAN ENCOUNTER HE HAS A HX OF DM MI CABG IN 1980AND PROSTATE CA HE IS REPORTED TO BE ON NOVOLIN ECOTRIN NITRO PATCH PEPCID LUPRON AND CALAN WITH NO ALLERGIES SORRY I DON^T HAVE MUCH MORE THAN THAT DAVE HORWHAT THANKS I FAILED TO MENTION THAT HE IS NOT IN OUR CHCS YET
)
(MICHAEL-H-MITCHELL ALTERNATIVE IS FOR PCM TO REQ ADMISSION WARD 51 ESP IF CH PROTECTIVE ISSUES ARE OF CONERN
)
(MARC-P-DIFAZIO I WOULD BE CONCERNED REGARDING THIS HISTORY OF FEAR OF NEGLECT I WOULD RECOMMEND THAT IT BE DONE SOONER THAN LATER AND EXPEDITED THROUGH THE SEDATION UNIT IF AT ALL POSSIBLE IT IS LIKELY TO BE NORMAL FROM AN INTRACRANIAL STANDPOINT BUT EVEN A SIMPLE LINEAR FRACTURE SHOULD BE AND FOLLOWED BECAUSE OF THE POSSIBILITY OF A LEPTOMENINGEAL CYST I WILL FORWARD THIS TO MAJ COUGHLIN WHO IS EXTREMELY BUSY BUT MAY BE ABLE TO HELP US I WOULD NOT WAIT FOR AN OUTPATIENT SCHEDULE TO OPEN UP IF THE SCHEDULE IS FULL IS DR BASSEY ABLE TO HELP YOU FACILITATE THIS LET US KNOW IF WE CAN HELP MD
)
(KRISTAL-C-MELVIN THIS IS A REQUEST FOR HELP FROM ANY AND ALL NEUROLOGISTS I SAW 9MO FEMALE TODAY S P FALL INJURY 1 WEEK AGO MOTHER DID NOT REPORT FALL

INJURY AT THE TIME PROBABLY BECAUSE OF FEAR OF NEGLECT CHARGES CHILD FELL SBOUT 3 FEET FROM PARENTS BED TO HARDWOOD FLOOR AND NOW HAS SOFT RAISED AREA ON LEFT SIDE OF HEAD OUR ON CAL PEDIATIRICIAN DR BASSEY TOLD ME THAT WE NEED TO SCHEDULE CT FOR THIS AGE GROUP THROUGH THE SEDATION UNIT THE SEDATION UNIT TELLS ME THAT THEY ARE HEAVILY BOOKED FOR THIS WEEK MY QUESTIONS ARE CAN THIS CHILD NO NEURO CHANGES WAIT UNTIL NEXT WEEK FOR CT OR CAN CT BE SAFELY DONE WITHOUT SEDATION OR IN ANOTHER WAY THANK YOU FOR INPUT AND ADVICE THANK YOU THE CONCERN OF NEGLECT IS DR BASSEY^S MAIN REASON FOR WANTING THIS SOONER I APPRECIATE YOUR ADVICE AND ASSISTANCE I WILL CALL THE SEDATION UNTI AGAIN LATER TODAY TO SEE IF ANY OPENINGS HAVE COME UP OR IF CAN WORK THIS CHILD IN THANK YOU I WILL KEEP THAT IN MIND FOR FUTURE USE A FEW MOS AGO I SAW A WOMAN WHO HAD NOT SLEPT WITHOUT ATIVAN FOR OVER 3 YEARS I ASKED NEURO ABOUT THIS AND THEY SAID SHE NEEDED A SLEEP STUDY TO SEE IF SHE REALLY DOES HAVE INSOMNIA OR JUST PERCEIVES THIS THE NEUROLOGIST FROM BETHESDA ARRANGED FOR HER TO HAVE THIS DONE THERE THE WAY THEY DO IT FOR THE PATIENT TO GET A NEURO CONS FIRST THEN THEY SET UP THE SLEEP STUDY I HOPE THIS HELPS KRISTAL
)
(LYNNE-I-YAO YES DR SCOTT I DID RECEIVE YOUR MESSAGE AND THOUGHT I REPLIED ALREADY SORRY! TO ANSWER YOUR QUESTIONS 1 AS YOU KNOW THE DIAGNOSIS OF PYELONEPHRITIS IS CLINICAL AND BASED ON YOUR DESCRIPTION IT SOUNDS AS THOUGH SHE PROBABLY HAD PYELONEPHRITIS 2 IN CHILDREN WHO DEVELOP PYELONEPHRITIS VESICO URETERAL REFLUX VUR IS A COMMON ASSOCIATED FINDING ESP IN CHILDREN LESS THAN 6 7 YEARS OF AGE BECAUSE OF THIS WE RECOMMEND VCUG TESTING FOR CHILDREN LESS THAN 6 7 YEARS OF AGE WITH FIRST TIME UTI OR IF THE HISTORY STRONGLY SUGGESTS A HISTORY OF PYELONEPHRITIS OR UTI AS AN INFANT DID THIS CHILD HAVE UTI PYELO IN THE PAST IF NOT THEN VCUG TESTING IS NOT AN ABSOLUTE 3 VCUG TESTING SHOULD BE DONE WHILE THE CHILD IS AWAKE AS VOIDING DYNAMICS CHANGE WHEN THE CHILD IS ASLEEP THEREFORE VCUG TESTING CANNOT BE DONE WITH SEDATION 4 I DO NOT RECOMMEND SCREENING HER SIBLINGS FOR REFLUX UNLESS THEY HAVE A PAST HISTORY OF UTI IT SOUNDS AS THOUGH THIS PATIENT MAY HAVE PASSED A KIDNEY STONE HOWEVER THE HISTORY IS UNCLEAR TO ME IT MAY BE WORTHWHILE FOR THE PATIENT TO BE EVALUATED BY YOUR UROLOGIST BEFORE REFERRAL BACK TO THE US TO SEE ME A 24 HOUR URINE PROTEIN OF 534 MG MAY BE ELEVATED BUT MAY BE AS SIMPLE AS ORTHOSTATIC PROTEINURIA DOES THIS PATIENT HAVE HYPERTENSION DYURIA FLANK AND SUPRAPUBIC PAIN ON NOT USUALLY A CHARACTERISTIC FINDING WITH ACUTE OR CHRONIC GLOMERULAR DISEASETHANKS IF IT IS EASIER FOR YOUR I AM ALSO ON THE OUTLOOK GLOBAL ADDRESS LIST TO SEND E MAIL THANKS LYNNE YAO MD CHIEF PEDIATRIC NEPHROLOGY RECEIVED YOUR TEL MESSAGE BUT UNFORTUNATELY AM UNABLE TO CONNECT TO DSN OVERSEAS I^M STILL UNCLEAR ABOUT THE HISTORY ON THIS PATIENT AND THEREFORE NOT SURE THAT IT IS NECESSARY FOR HIM TO BE A E HERE 1 DOES THIS PATIENT HAVE A HISTORY OF ELEVATED BP 2 DOES THIS PATIENT CURRENTLY HAVE HEMATURIA OR AN ELEVATED URINE PROTEIN CREATININE RATIO 3 DOES THIS PATIENT HAVE ELEVATED SERUM CHEMISTRIES THESE ARE EASY BUT IMPORTANT TESTS THAT SHOULD BE RUN PRIOR TO SENDING HIM HERE IF THESE TESTS ARE NORMAL IT IS UNLIKELY THAT AN EVALUATION BY ME BE ANY MORE HELPFUL THAN AN EVALUATION BY A UROLOGIST I WOULD BE HAPPY TO DISCUSS THIS CASE WITH YOU PERSONALLY IF YOU COULD SEND ME YOUR COMMERCIAL NUMBER THAT WOULD BE HELPFUL ALSO I^D BE HAPPY TO DISCUSS THIS CASE WITH YOUR FP STAFF PHYSICIAN IF THIS WOULD HELP CLARIFY THE SITUATION ANOTHER OPTION WOULD BE TO SEND HIM TO SEE THE PEDIATRIC STAFF AT LANDSTUHL FOR EVALUATION PLEASE DON^T TAKE THIS TO MEAN THAT I DO NOT WANT TO SEE THE PATIENT BUT I^M NOT SURE THAT SENDING HIM BACK AT GOVERNMENT EXPENSE IS THE BEST SOLUTION CURRENTLY BASED ON THE CLINICAL SITUATION THANKS FOR YOUR HELP LYNNE YAO MD
)
(CHRISTINA-M-YUAN PLEASE LET ME REFER THIS TO DR YAO OUR PEDIATRIC NEPHROLOGIST WILL REFER TO OUR PEDIATRIC NEPHROLOGIST DR LYNNE YAO DO YOU MEAN THAT THE PATIENT IS COMING TO WRAMC TO BE SEEN HER BUN IS LOW AND HER CREATININE IS ALSO BOTH ARE IN THE NORMAL RANGE FOR A WOMAN WHO PROBABLY DOESN^T HAVE A LOT OF MUSCLE MASS AND PROBABLY HAS A LOW PROTEIN DIET
)
(PAUL-T-SCOTT HI I WOULD LIKE YOU OPINION ON THE EVALUATION AND TREATMENT OF THE FOLLOWING PATIENT PLEASE A 9YO FEMALE PRESENTED TO THE ER WITH COMPLAINT OF FEVER SL COUGH AND RIGHT SIDED FLANK PAIN FOR 4 DAYS NO DYSURIA AND NO GROSS HEMATURIA NO OTHER SX PE REVEALED TEMP 103 1 TACHYCARDIA AND MOD RUQ TENDERNESS TO PALPATION BUT NO REBOUND UA WAS 1 15 TR BLOOD WITH 0 2 RBC PROT 30 NITRITE SMALL LE 5 10 WBC MODERATE BACTERIA AND 5 10 SQUAMOUS CELLS THIS WAS A CLEAN CATCH SPECIMEN URINE CULTURE GREW

100 0 E COLI LFT^S AMYLASE AND LIPASE WERE NORMAL WBC WAS 8 3 WITH |68N| |3B| |12L| WITH NORMAL H H AND PLT KUB WAS NORMAL THE PATIENT WAS TREATED WITH 10DAYS OF SEPTRA AND PUT ON SEPTRA PROPHYLAXIS RENAL U S WAS NORMAL REPEAT CX AT THREE DAYS FOR TEST OF CURE WAS NEGATIVE THE PATIENT WAS REFERRED FOR VCUG BUT THE PT MOTHER ABORTED THE PROCEDURE DUE TO PAIN CURRENTLY THEY DO NOT WANT TO DO THE PROCEDURE MY QUESTIONS ARE 1 DO YOU AGREE THAT THIS CLINICAL PICTURE WAS CONSISTENT WITH 2 DO YOU RECOMMEND VCUG 3 DO YOU HAVE ANY EXPERIENCE WITH SEDATION FOR A PROCEDURE LIKE THIS AND WOULD SEDATION AFFECT THE RESULTS OF THE VCUG WHAT WOULD YOU RECOMMEND TO USE FOR SEDATION 4 DO YOU RECOMMEND VCUG FOR SIBLINGS OF THIS PATIENT THANK YOU FOR YOUR ASSISTANCE WITH THIS PATIENT PAUL SCOTT DR YUAN DID YOU FORWARD THIS MESSAGE TO DR YAO THANK YOU PAUL
)
(RITA-L-SVEC SINCE WE HAVE NO PED ENDO CLINIC THIS WEEK DUE TO USUHS RESEARCH DAY SHE SHOULD COME INTO EITHER ADOLESCENT CLINIC AT NNMC OR GENERAL PEDS CLINIC AT IF SHE CAN^T GO TO SCHOOL SHE NEEDS TO BE SEEN THIS WEEK
)
(ELISABETH-M-STAFFORD IF SHE HAD PSEUDOTUMOR CEREBRI I WOULD HAVE NEUROLOGY INVOLVED IN THE MANAGEMENT AT THAT POINT
)
(CYDNEY-L-FENTON SHE APPEARS TO BE ONE OF THE UNFORTUNATE WOMEN WHO IS HAVING PROBLEMS WITH THE DEPO ALL OF HER SYMPTOMS CAN BE EXPLAINED BY THE DEPO SHOT HOWEVER BECAUSE HER HEADACHE IS SO SEVERE SHE SHOULD HAVE A GOOD FUNDISCOPIC EXAMINTION TO RULE OUT THE PRESENCE OF INCREASED ICP PSEUDUTUMOR CEREBRI THERAPEUTIC INTERVENTIONS SHOULD INCLUDE DISCONTINUING OF THE MEDICATION AND TREATMENT OF HER MIGRAINE MOTRIN OR NAPROSYN OR IMITREX ETC IF HER EXAM REVEALS EVIDENCE OF PAPILLEDEMA MEDROXYPROGESTERONE THERAPY SHOULD NOT BE RE INITIATED YES OF COURSE WE WOULD BE VERY HAPPY TO SEE HER AFTER YOU ENTER THE CONSULT PEDIATRIC ENDOCRINOLOGY SHE CAN TRY SIERRA OR BETTER YET CALL AND THEY CAN SCHEDULE AN APPOINTMENT TO SEE US
)
(JEANNIE-E-FRIEDMANN I HAVE A 15 YO PT WHO RECEIVED HER FIRST DEPO INJECTION ON 3 MAR 0 SHE IS C O SEVERE HA DIZZINESS NERVOUSNESS AND FATIGUE SINCE THE TIME OF IT HAS STAYED BASICALLY THE SAME NOT WORSE NOT BETTER SHE NOTES NO CHANGES IN ACTIVITY OR OTHER TRIGGERS FOR HER SX SHE IS TAKING TYLENOL WHICH PROVIDES SOME RELIEF FOR HA^S IT IS SO BAD THAT HER MOTHER BROUGHT HER IN TODAY REQUESTING I GIVE HER AN EXCUSE FROM SCHOOL UNTIL THIS STOPS SHE FEELS IT ISN^T SAFE FOR HER TO WALK HOME FROM SCHOOL AND SHE HASN^T HAD A DAY AT SCHOOL WITHOUT FEELING SICK THIS SOUNDS PRETTY SEVERE TO ME I^VE CALLED UPJOHN CO AND THEY HAVE NO ADVISE WHAT CAN I SUGGEST TO HER AND SHOULD I REFER HER FOR FURTHER EVALUATION THANKS FOR YOUR PROMPT ASSISTANCE DR FENTON THANKS FOR YOUR REPLY MAY I REFER THIS PT TO SEE YOU TO WHICH CLINIC WOULD I WRITE THE REFERRAL AND WHOM SHOULD I CALL TO SCHEDULE AN APPT THANKS VERY MUCH
)
(LAURIE-J-SMITH DID YOU GET AN ANSWER TO THIS WE USUALLY DO NOT DO TITERS BUT RATHER IMMUNIZE ACCORDING TO REQUIREMENTS AND HAVE OCCUPATIONAL HEALTH OR PRIMARY MD DO THE TITERS SHE SHOULD HAVE ONE ADULT DOSE OF POLIO VACCINE IF SHE HAS NOT GIVE IT YOU SHOULD DO THE RUBELLA RUBEOLA MUMPS VARICELLA TITERS SHE PROPABLY NEEDS HEP A IN DAY CARE AND POSSIBLY EVEN HEP B OK TO DO TETANUS BOOSTER IF IT HAS BEEN 10 YRS I THINK I HAVE SEEN THIS VIP AND KNOW ABOUT THE PROBLEMS
)
(MARGARET-E-BUSSEY-GRANT DEAR GYN I HAVE A 37YO HF WITH FEB00 PAP RESULT OF ENDOMETRIAL CELLS OUT OF CYCLE AND FOLLOWING ENDOMETRIAL BX SIG FOR PROLIFERATIVE ENDOMETRIUM NO EVID HYPERPLASIA OR DYSPLASIA CAN I NOW REAASURE HER AND PLACE HER BACK ON HER YEARLY PAP SCHEDULE OR DOES SHE NEED CLOSER F U THANK YOU FOR YOUR HELP! GREAT THANK YOU! DEAR RHEUMATOLOGY A 31YO WM WITH PSORIATIC ARTHRITIS CAME IN FOR A FLIGHT PHYSICAL TODAY BY REGULATION HE IS UNFIT FOR AIRBORNE DUE TO HIS PSORIASIS BUT HE WAS ON JUMP STATUS BEFORE THE DIAGNOSIS DOES HE NEED TO HAVE HIS WINGS CLIPPED OR CAN HE BE CLEARED TO JUMP HE IS ON TRAINING HERE AT FT LEE VA AND HIS PERM DUTY STATION IS KENTUCKY NO MTF AVAIL HE IS ASYMPTOMATIC ON INDOCIN PLEASE ADVISE THANK YOU MARGARET BUSSEY GRANT FP FT LEE GREAT WILL CLEAR HIM! THANK YOU!
)
(ROBERT-J-LABUTTA BELIEVE IT OR NOT I WAS LOOKING AT THAT SUPPL TODAY I HAVE A COPY IN MY AGREE WITH ABOVE VERTEBRAL ARTERY HYPOPLASIA IS COMMON BUT

QUANTIFYING THE CONCERN IS BASED UPON INFORMATION THAT WOULD BE INCLUDED IN A COMPLETE H & P PREVIOUS HA PRIOR TO 3 MONTHS AGO HX OF TRAUMA EVEN MINOR SENSORY SYMPTOMS OR SIGNS OCULOSYMPATHETIC PARESIS WOULD BE SOME OF THE THINGS THAT I WOULD LIKE TO KNOW RITA
)
(MARK-D-MENICH THE DECEMBER 1998 ISSUE OF NEUROLOGY HAD A SUPPLEMENT THAT ADDRESSED THE USE OF IVIG IN NEUROLOGIC DISORDERS THE LIBRARY^S COPY IS IN A VERY THICK BOUND VOLUME THAT DOESN^T LEND ITSELF TO QUALITY COPYING DOES ANYONE HAVE A LOOSE COPY ON HIS OR HER JOURNAL SHELF THAT I COULD BORROW BRIEFLY TO MAKE A MORE READABLE COPY THANKS MARK MENICH WHAT A SYSTEM HUH ON MY WAY GOOD THANKS IT^S A DECENT INTRODUCTORY SUMMARY AND THE REFERENCES ARE NUMEROUS
)
(KEVIN-D-DEWEBER MY WIFE HAD SYMPTOMATIC NEPHROLITHIASIS FOR THE FIRST TIME LAST SUMMER ITRESOLVED WITH SYMPTOMATIC TREATMENT BUT BEFORE UNDERGOING HER PELVIC RECONSTRUCTION SURGERY AT MADIGAN SHE UNDERWENT AN IVP WHICH SHOWED NORESIDUAL STONES BUT SLIGHT HYDRONEPHROSIS ON THE RIGHT SHE FELT FINE UNTILLAST MONTH WHEN SHE DEVELOPED EPHROLITHIASIS THE KLEBSIELLA WAS ADEQUATLYTREATED WITH OFLOXACIN WITH NEGATIVE F U CULTURES AFTER 2 WKS BUT SHE CONTINUED TO HAVE SEVERE RENAL PAIN AN IVP RECENTLY SHOWED NO STONES BUTBILATERAL MEDULLARY NEPHROCALCINOSIS I^VE DONE A METABOLIC W U THAT HAS REVEALED NL SERUM CA MG PO4 NA BICARB CL BUN CR SLIGHTLY LOW K OF 3 5 AND NL PTH URINE 24 HR RESULTSINCLUDED HIGH CA AT 306 LOW CITRATE AT 16 LOW K AT 16 AND NORMAL NA 145 AND PO4 762 SHE CONTINUES TO BE VERY WEAK AND TO HAVE FLANK PAINS CONSTANT MOTRINUSAGE HAVE NOW LED TO CLASSIC ULCER SYMPTOMS AND SHE^S ON ZANTAC NOW FOR THAT AND TRAMADOL FOR PAIN WHICH CAUSES TOO MUCH SEDATION TO BE USEFUL I^M ASSUMING THE NEXT STEP IS TO TREAT HER WITH K CITRATE BUT I HAVE SOME QUESTIONS 1 SHOULD WE DO A NH4CL LOAD TEST TO R O TYPE I RTA 2 IS THE CITRATE CONTRAINDICATED GIVEN HER ULCER EVEN ORANGE JUICE UPSETS HER STOMACH 3 ARE THERE OTHER DIAGNOSES WE SHOULD CONSIDER 4 WILL THE NEPHROCALCINOSIS GO AWAY AFTER TREATMENT WITH CITRATE IFSO HOW LONG WILL IT TAKE AND HOW LONG CAN SHE EXPECT TO BE IN PAIN KEVIN DEWEBER MD FP SCHWEINFURT
)
(FRANCES-S-GALU DR OTT THIS WAS TRANSMITTED TO WRAMC WITHOUT ANY PROBLEMS YOU MIGHT WANT TO CALL WRAMC SINCE THIS PERSON MIGHT BE ON LEAVE OR TDY FRAN WE WERE HAVING EMAIL TRANSMISSION PROBLEMS AT KELLER I AM PASTING DR OTT^S MESSAGE BELOW FRAN ^I HAVE A 35 Y O FEMALE WHO IS GETTING MARRIED AND IS CONCERNED ABOUT TRANSMITTING HSV II TO HER SPOUSE EVEN THOUGH SHE DOES NOT HAVE ANY ACTIVE LESIONS SHE WAS TOLD THAT SHE HAD GENITAL HERPES WHEN SHE WAS YOUNGER BUT SINCE THEN HAS NEVER HAD A RECURRENCE SHE ALSO CAME TO THE OFFICE LOOKING FOR A BLOOD TEST THAT WOULD DEMONSTRATE THAT SHE DEFINATELY HAD PRIOR EXPOSURE TO HSV II THE SERUM HSV II IGM WAS 1 42 AND IGG >3 SHE WANTS TO KNOW HOW TO PREVENT THE SPREAD OF THE HSV AND WHETHER OR NOT TAKING PROPHYLAXIS WOULD HELP PREVENT SHEDDING OF THE VIRUS TO HER PARTNER IN THE ARE THERE TIMES WHERE YOU WOULD RECOMMEND PROPHYLAXIS FOR THE SOLE RESEAON TO PREVENT FUTURE OUTBREAKS AND THUS HOPEFULLY REDUCE THE CHANCE OF TRANSMISSION TO ANOTHER PERSON IN A PATIENT AS MENTIONED ABOVE DR OTT THE MESSAGES ARE GOING THROUGH HOW ABOUT YOU DO A CUT AND PASTE AND SEND A NEW MESSAGE FRAN
)
(MARK-D-SHALAUTA I^M ONE OF THE FPS FROM DEWITT I KNOW SOME DEPARTMENTS DO ELECTIVE PROCEDURES TO KEEP UP THEIR SKILLS AND PATIENTS PAY SOME OUT OF POCKET EXPENSE DOES DERM DO ANY HAIR REMOVAL TECHNIQUES FOR WOMEN EG UPPER LIP CHIN IF SO WHAT IS THE COST THANKS MARK THANKS SO MUCH!
)
(RENATA-A-ENGLER SORRY FOR DELAY IN RESPONSE THE MEASUREMENT OF LATEX SPECIFIC IGE CERTAINLY WOULD BE NICE TO KNOW BUT UP TO 15% OF IN VITRO SCREENING TESTS ARE NEGATIVE IN TRULY ALLERGIC INDIVIDUALS THE HISTORY HOWEVER IS MORE CONTACT IN NATURE AND MAY OR MAY NOT BE DUE TO LATEX THIS IS A TOUGH BENEFIT RISK RATIO CASE BUT AS YOUR SUBSEQUENT HISTORY DESCRIBED TOLERANCE TO INERT LATEX CONTAINING DEVICE USE SO I WOULD SUSPECT THIS TO BE THE CASE FOR THE VALVULOPLASTY CERTAINLY EVERY OTHER EXPOSURE DURING THE PROCEDURE SHOULD BE AS LATEX SAFE NOT LATEX FREE AS POSSIBLE DOCUMENTATION THAT NO ALTERNATIVE DEVICE NON LATEX COULD BE USED MOST OF THESE TYPES OF DEVICES DO NOT RELEASE THE ANTIGEN SO IN THAT REGARD I WOULD ALSO SUSPECT A LOW RISK FOR SERIOUS SYSTEMIC ANAPHYLAXIS HOWEVER THE THEORETICAL RISK EXISTS AND CERTAINLY ALL DRUGS TO TREAT THIS SHOULD BE READILY AVAILABLE INFORMED CONSENT IS ALSO INDICATED FOR THIS ISSUE AFTER DETAILS OF DEVICE LATEX CONTENT HAS BEEN CLARIFIED I AM

UNAWARE OF ANY CASE OF SYSTEMIC SYMPTOMS IN THIS HISTORY RELATED TO A CARDIAC PROCEDURE BUT CERTAINLY HAVE NOT DONE A LIT SEARCH I WOULD SEARCH ON THE CATHETER DEVICE TO BE USED AND ANAPHYLAXIS IMMEDIATE HYPERSENSITIVITY AND OR LATEX TO MAKE SURE THERE IS NOT SOME CASE REPORT OUT THERE WE HAVE MISSED
)
(W-S-FRANK SORRY FOR TARDY RESPONSE SOMEHOW I MISSED THIS ONE USUALLY CONTACT ALLERGY IS TO A COMPONENT OF THE GLOVES OTHER THAN THE LATEX POWDER ACCELERANT ETC WE USUALLY REFER SUCH PTS TO DERM FOR PATCH TESTING MY GUESS IS THAT YOU WILL PROBABLY BE ABLE TO PROCEED WITH THE VALVULOPLASTY BUT WE SHOULD SEE HER IN THIS CLINIC FIRST TO SCREEN HER FOR TRUE LATEX ALLERGY TOM
)
(ARN-H-ELIASSON THANKS FOR THE SCOOP BILL)
(WILLIAM-F-KELLY AS BRIEFLY MENTIONED AT WED AM CONFERENCE INH X 9 MONTHS WILL BE THE NEW RECOMMENDATION FOR LATENT TB INFECTION REGARDLESS OF HIV STATUS TWICE WEEKLY THERAPY IS AN ALTERNATE BUT ACCEPTABLE REGIMEN INH RESISTANT TB EXPOSURE IS TREATED WITH RIF PZA X 2 MONTHS OR RIF X 4 MONTHS GUIDELINES TO COME OUT IN APRIL ISSUE OF THE AMERICAN JOURNAL OF RESPIRATORY AND CRITICAL CARE MEDICINE SUPPLEMENT REF DR DAVID L
)
(PANKAJ-J-MALIK I HAVE A 55YR OLD PT WITH A HISTORY OF VON WILLEBRANDS DISEASE NO H O RECENT ACTIVE ACUTE BLEEDING HAS USED EACA DDAVP PRIOR TO DENTAL PROCEDURES WITH GENERALLY GOOD RESPONSE PT IS WONDERING IF WE HAVE ANYTHING NEW TO OFFER I WILL APPRECIATE ADVICE SHE HAS BEEN SEEN AT WRAMC HEME ONC IN THE PAST THANKS
)
(GEORGE-W-TURIANSKY MY USUAL TX CONSISTS OF A SHAVING PROFILE WITH WESTCORT CREAM ON THE DAYS THE PT USES A DEPILATORY OR CLIPPERS I DISCOURAGE USE OF A RAZOR BLADE IF PUSTULES OR CRUSTING EXIST I GET A SKIN CULTURE TO RULE OUT SECONDARY BACTERIAL INFECTION AND TX APPROPRIATELY ALTHOUGH SOME PEOPLE ADVOCATE THE USE OF RETIN A I FIND THIS CAUSES AN IRRITANT DERMATITIS IN THE SENSITIVE NECK AREA HYPERTROPHIC SCARS AND KELOIDS MAY OCCUR IN SOME INDIVIDUALS FOR WHICH INTRALESIONAL STEROIDS MAY BE USEFUL
)
(STEVEN-K-TOBLER I WAS CURIOUS ABOUT THE TREATEMTN FOR PFB TODAY I SAW A GENTLEMAN FOR LONG STANDING PFB HE HAD BEEN TOLD TO USE RETIN A IN THE PAST FOR THIS I LOOKED IN HABIF AND THEY RECOMMENDED GLYCOLIC ACID SHORT COURSE ABX AND POSSIBLE INTRALESIONAL STEROIDS BUT DIDN^T RECOMEND RETIN A DO YOU RECOMMEND RETIN A WHEN DO YOU USE TOPICAL STEROIDS THANKS
)
(SARAH-E-ATANASOFF I HAVE A 41YOBM WHO DONATED A KIDNEY TO HIS SISTER A FEW YEARS AGO HE HASNO MEDICAL PROBLEMS NO MEDS CREATININE 1 5 LAST YEAR 1 4 UA AND P1 O WWNL AS FAR AS FOLLOW UP HE IS PCSING AND HE REPORTS NO INSTRUCTION GIVENTTO HIM AS FAR AS HOW OFTEN TO GET LABWORK DRUGS TO AVOID ETC I REALIZETHAT HUMANS DO QUITE WELL WITH ONE KIDNEY EVEN PLAY PROFESSIONALBASKETBALL IN GENERAL WHAT GUIDANCE TO YOU GIVE THESE FOLKS OTHER THAN HYDRATION AND BEING CAUTIOUS WITH NON RENAL FRIENDLY MEDS THANKS SARAH THNKS
)
(MILTON-T-SMITH NOT SURE WHAT ALL THAT MEANS IT SOUNDS LIKE THE MAIN QUESTION IS WHETHER OR NOT HE HAS PROCTITIS YOU SHOULD PROBABLY REFER HIM TO GI ALONG WITH HIS BIOPSY SLIDES AND ENDOPHOTOS NO EASY ANSWER HERE REGLAN IS ABOUT THE ONLY OTHER ALTERNATIVE
)
(JOHN-S-EARWOOD 38YO MALE WHO WAS REFERRED TO ME FOR BRBPR FLEX SIG 2 WEEKS AFTER BLEEDING EPISODE SHOWED NO HEMORRHOIDS OR FISSURES PT DID HAVE AN IMFLAMED RECTAL EXTENDING 4 6CM FROM ANAL VERGE SO BIOPSIES WERE DONE MY THOUGHT WAS THAT THIS INFLAMATION WAS PROBABLY SECONDARY TO PREP BUT DECIDED TO BIOPSY TO BE COMPLETE THE BIOPSY SHOWED LAMINA PROPRIA EXPANSION BY HISTOCYTES AFB STAINS WERE NEGATIVE HOWEVER PAS AND GMS STAINS WERE POSITIVE PATHOLOGY STATED THAT THIS DID NOT APPEAR TO REPRESENT MICROORGANISMS PT HAD NO DIARRHEA WHAT FURTHER WORK UP NEEDS TO BE DONE PT WITH NO FURTHER BRBPR
)
(JAMES-M-ECKLUND DID THIS PATIENT GET AN APPOINTMENT THANKS)
(THOMAS-R-FURLOW THIS BENIGN NEOPLASM APPEARS MOST LIKELY TO BE AN INCIDENTAL READ SUBCLINICAL TUMOR THAT DOES NOT REQUIRE IMMEDIATE ATTENTION NEUROSURGICAL CONSULTATION SHOULD BE REQUESTED ON A ROUTINE BASIS VERY LIKELY THE TUMOR COULD BE FOLLOWED WITH PERIODIC IMAGING

STUDIES THOMAS W FURLOW
)
(ANTONIO-S-JIMENEZ MR 49 HAS A SMALL MENINGIOMA 1 5 TO 2 CM ON THE POSTERIOR FOSSA ARISING FROM THE POSTERIOR LIP OF THE FORAMEN MAGNUM NO SIGNS OR SYMPTOMS OF INCREASED INTRACEREBRAL PRESSURE OR FLOW OBSTRUCTION THIS PATIENT NEEDS TO BE EVALUATED BY NEUROSURGERY BUT I WOULD LIKE TO KNOW HOW SOON SHOULD HE BE SEEN THANK YOU JIMENEZ MD THANK YOU VERY MUCH FOR THE REPLY I WILL THEN FOLLOW YOUR INSTRUCTIONS
)
(ANDREW-D-MONTEMARANO ALSO TO STOP USING ALL MOUTH PRODUCTS INCLUDING TOOTHPASTE GUM RINSES ETC BAKING SODA MIXED WITH A SMALL AMOUNT OF WATER CAN BE USED AS A TOOTHPASTE NO WE DON^T DO ELECTROLYSIS OR LASER HAIR REMOVAL
)
(MARY-K-MATHER SOUNDS LIKE A POSSIBLE CONTACT SENSITIVITY HAVE HER D C LIPSTICK USE PLAIN VASELINE FOR MOISTURE CONSIDER REFERRAL TO DERM FOR EVAL AND POSSIBLE PATCH TESTING
)
(MARYLOU-U-GUERRINA THIS IS NOT A JOKE! I SAW A 51 Y O BF TODAY WITH C O BURNING LIPS FOR THE LAST MONTH WHICH WORSENS WITH EATING LIPS ARE USUALLY DRY BUT SHE HAS TRIED OTC PRODUCTS TO KEEP MOIST BUT THE BURNING PERSIST AND SHE SEES LITTLE BUMPS ON THEM WHEN THEY REALLY BURN EXAM IS NORMAL HELP I HAVE ASKED HER TO STOP USING LIPSTICK AND JUST APPLY CHAPSTICK TO KEEP MOIST ANY IDEAS WHAT MIGHT BE CAUSING THIS THANKS FOR YOUR ATTENTION AND FOR NOT LAUGHING
)
(BETH-L-DENNIS 70 YO MALE WITH 1 GM PROTEINURIA BUT NORMAL RENAL FUNCTION WAS EVAL FOR MICROSCOPIC HEMATURIA 2 3 YRS AGO AND FOUND TO HAVE RLP STONE WOULD THIS ALSO ACCOUNT FOR PROTEINURIA LOOKS LIKE HE^S HAD TRACE TO 1 PROTEIN IN UA FOR YEARS AS WELL HAS DM HTN CAD PAST HX GOUT CALCIUM NORMAL HCT OK WILL GET US AND UPEP THANKS! I HAVE A 43 YO BF PREVIOUSLY SEEN AT ENDO AND HAD FNA OF LEFT LOBE NODULE THAT WAS BENIGN THIS WAS IN 98 SINCE THEN IT SEEMS NODULE IS ENLARGING AND SHE DID NOT FU THERE AS DIRECTED RECENTLY GOT US WHICH SHOWS 3 X 1 8 X 2 5 SOLID HETEROGENOUS MASS IN LLL THERE WAS A 7MM MASS IN THE 98 US BUT BY THE DESCRIPTION IT IS HARD TO TELL IF THIS IS THE SAME THING TSH IS NORMAL RE REFERRAL PLACED DOES SHE NEED TO GET IN QUICKER ANY THING ELSE NEEDED DO YOU WANT NUC SCANS FIRST IT WAS BOOKED TO TOURTELOT BUT REFERENCE WAS MADE TO DR UTICA SIGNED BY A 3RD YEAR STUDENT ONLY PLEASE LET ME KNOW WHAT YOU THINK THANKS FOR YOUR ASSISTANCE THANKS! SHE^S GOING TO SEE ME THE FOLLOWING TUES
)
(THOMAS-M-WILEY WE WILL BE HAPPY TO SEE HIM IN THE CARDIOLOGY CLINIC)
(NANCY-L-GRASS I HAVE A PT 73 Y O FEMALE W PERSISTENT FE DEF ANEMIA GI W U TO INCLUDE EGD COLONOSCOPY AND SBFT ALL WNL AND NO VAGINAL BLEEDING NO HX OF GI SURGERY RESPONDS TO ORAL FE IF TAKEN BID BUT PT DOESN^T TOLERATE THIS DUE TO EFFECTS ON QD THERAPY HCT REMAINS IN 28 29 RANGE ANY THOUGHTS ON WHY SHE WOULD HAVE A PERSISTENT PROBLEM W FE DEFICIENCY W O SOURCE OF LOSS AND ADEQUATE INTAKE THANKS
)
(ROBERT-A-VIGERSKY I SEE NO REASON TO USE BCP^S IF ITS ONLY TO TREAT HER LIBIDO SINCE SHE IS NORMALLY MENSTRUATING THIS ALSO EXCLUDES ANY SIGNIFICANT HYPOTHALAMIC PITUITARY OVARIAN AXIS ABNORMALITY I WOULD CHECK A FREE TESTOSTERONE AND DHEA NOT DHEA SULFATE AND CORTISOL LEVEL TO EXCLUDE AN CAUSE I WOULD RECOMMEND THAT YOU OBTAIN A TESTOSTERONE ESTRADIOL BETA HCG TSH LH FSH LIVER FUNCTION TESTS AND SERUM CREATININE I AGREE THAT SCREENING FOR RECREATIONAL DRUGS MAY BE APPROPRIATE SINCE GYNECOMASTIA MAY BE CAUSED BY THC CONTAINED IN MARIHUANA ALSO THE USE OF ANABOLIC AGENTS LIKE ANDRO STENEDIONE OR ORAL SYNTHETIC ANDROGENS MAY CAUSE GYNECOMASTIA I WOULD ASK HIM ABOUT THEIR USE ONCE THESE STUDIES ARE DONE IT WOULD BE APPROPRIATE TO GET AN ENDOCRINE CONSULT I DON^T THINK SHE NEEDS AN ENDOCRINE CONSULT AT THIS POINT I WOULD FOLLOW HER BONE DENSITY OVER THE NEXT 18 24 MONTHS AND IF THERE IS NO SIGNIFICANT IMPROVEMENT CONSIDER FOSAMAX OR ANOTHER BISPHOSPHONATE MAKE SURE SHE IS GETTING VIT D ALONG WITH HER CALCIUM SUPPLEMENT I WOULD CALL THE BOEHRINGER MANNHEIM REP PAUL KELLY TO SEE IF THEY CAN DO SOMETHING TO EXPEDITE THIS OR PROVIDE A LOANER I AGREE THAT THIS LOOKS LIKE A NORMAL RESPONSE AND WOULD NOT DO ANY FURTHER WORKUP EXCEPT PERHAPS A 1 DAY ADMISSION TO DOCUMENT I&O UNDER OBSERVATION
)
(ERNEST-G-LOCKROW IF THE PT IS A NON SMOKER AND IS INTERESTED IN BCP^S I

GENERALLY WILL PLACE THEM ON A 20MCG PILL IE ALLESSE OR OTHER BRAND
TESTOSTERONE CREAM PROBABLY NO HARM AND IF THE PT CAN TOLERATE THE
GREASINESS THEN YOU CAN PRESCRIBE PROBABLY NO VALUE IN FOLLOWING
TESTOSTERONE LEVELS YES YOU CAN REASSURE HER AND SHE CAN GO TO ANNUAL PAPS
GENERALLY PROLIFERATIVE ENDOMETRIUM IN A 37 YO WILL COINCIDE WITH
ANOVULATORY BLEEDING SHE HAS MENORRHAGIA OR MENOMETARRHAGIA SHE MAY NEED
CYCLIC PROVERA TO NORMALIZE HER CYCLES AND I ALSO COUNSEL THESE PATIENTS
THAT INITIALLY THEIR BLEEDING MAY WORSEN BUT OVER THE COURSE OF 2 3 MONTHS
OF TX SHOULD IMPROVE YOU CAN ASK 12 DIFFERENT GYNECOLOGISTS THIS QUESTION
AND PROBABLY GET 12 DIFFERENT ANSWERS THE ENDOMETRIAL BIOPSY IS REASSURING
BUT DOES NOT PRECLUDE MALIGNANCY IN LIGHT OF A POSSIBLE ANATOMICAL CAUSE
OF HER POSTMENOPAUSAL BLEEDING ALTHOUGH THE RISK OF MALIGNANCY IS LESS
THAN 1% AT THIS POINT THE MOST REASURRING THING TO DO IS TO LOOK INSIDE
THE CAVITY EITHER WITH OFFICE HYSTEROSCOPY OR IN THE OR AND DETERMINE THAT
IT IS IN FACT A SUBMUCOSAL FIBROID IF THE PATIENT HAS PERSISTENT
POSTMENOPAUSAL BLEEDING THEN I WOULD ABSOLUTELY REFER HER TO GYNECOLOGY
HOPE THAT HELPS
)
(MAUREEN-L-SCHAFER 43YO LADY IN GOOD HEALTH C O LOSS OF LIBIDO NO INTEREST
IN SEXUAL ACTIVITY ALTHOUGH IS ABLE TO ORGASIM MENSES Q 26 28 DAYS PE
NEGATIVE NO PSYCHE SOCIAL ISSUES SURFACED TSH NORMAL TESTOSTERONE BELOW
NORMAL REQUEST ADVICE ON BCP AND CAN I ALSO USE TESTOSTERONE CREAM FOR
PATIENT ALL OTHER LABS WNL THANK
)
(MARGRETTA-M-DIEMER A PT OF MINE SAW ADVERTISEMENTS FOR A NEW DM DRUG CALLED
^ABANDIX^ DOES ANYONE KNOW WHAT THIS IS I TRIED TO DO A PUB MED SEARCH ON
THIS NAME AND GOT NOTHING THAT SOUNDS LIKELY HOW IS ROGLITZONE RE THE
LIVER
)
(KURT-L-MAGGIO WE^D BE HAPPY TO SEE HIM BUT WOULD REALLY NEED THE BIOPSY
REPORT TO AVOID ANOTHER BIOPSY AND NEEDLESS WAITING WISH BUT AGAIN I THINK
EVERYTHING HINGES ON THE BIOPSY REPORT WE ACTUALLY DO A LIMITED AMOUNT OF
THIS WORK NOW POTENTIAL CANDIDATES FOR HAIR REMOVAL ARE PATIENTS GENERALLY
WITH COARSE DARK HAIR WITH A VALID MEDICAL PROBLEM IE CHIN FOLLICULITIS IN
A WOMAN ETC PATIENTS CAN BE REFERRED TO ME ON A REGULAR CONSULT BOOKED
THROUGH SIERRA AND I WILL MAKE ARRANGEMENTS FOR THEIR TREATMENT AT THIS
TIME THERE IS NO EXPENSE TO PATIENTS OUR INTENTION IS TO PROVIDED A
LIMITED AMOUNT OF LASER HAIR REMOVAL ON A SPACE AVAILABLE BASIS FOR VALID
MEDICAL PROBLEMS IE CHIN FOLLICULITIS IN A WOMAN A MAN WHO DOES NOT WANT
HAIR ON HIS CHEST ANY MORE IS CLEARLY INAPPROPRIATE FOR EXAMPLE AS WE HAVE
LIMITED RESOURCES TIME AND TO PROVIDE THIS SERVICE
)
(JORGE-P-LEGUIZAMO I WOULD LIKE TO SEE HER BLOOD SMEAR AND MEET SOMEONE WITH
V K H SYNDROME WHICH IS NOT CLASSICALLY ASSOCIATED WITH ANEMIA IF YOU GIVE
ME HER NAME I WILL GET IN TOUCH WITH HER JORGE H O FELLOW I WOULD MAKE
SURE SHE IS NOT LOSING BLOOD IN THE URINE THERE ARE ALSO SOME CONDITIONS
THAT CAUSE DECREASED ABSORPTION OF IRON INCLUDING SMALL BOWEL DZ SUCH AS
CELIAC DISEASE THAT CAN BE SUBCLINICAL EVEN AT HER AGE IBD DOUBTFUL WITH
HER W U PARASITES ETC HAS GI DONE A SMALL BOWELL BX OR CELIAC DZ
SEROLOGIES FOR HER ANEMIA THE NEXT STEP CAN BE IV IRON DDAVP IS THE WAY TO
GO J LEGUIZAMO H O FELLOW WE USUALLY GET A 24 HRS URINE PROTEIN
ELECTROPHORESIS BETA2 MACROGLOBULIN LDH QUANTITATIVE IMMUNOGLOBULINS AND
SKELETAL SURVEY METASTATIC SURVEY X RAYS WE THEN DECIDE ON A BONE MARROW
BIOPSY LET ME KNOW IF YOU WANT TO GET THE TESTS AND THEN GET IN TOUCH WITH
ME OR I CAN SEE HIM NOW J LEGUIZAMO H O FELLOW IS THE BLOOD SMEAR NORMAL
IF YOU WANT WE CAN SEE HIM IT IS ALWAYS NICE TO SEE THE SMEAR SOUNDS GOOD
WOULD REPEAT CBC IN A BLUE TOP R O CLUMPING BLOOD SMEAR TO EVAL FOR
HEMOLYSIS DIC TTP HUS ANA SLE TSH PT PTT DIC HIV B12 FOLATE PHYSICAL EXAM
FOR SPLENOMEGALY ALCOHOL HISTORY DRUG HX IE ESTROGEN THIAZIDES B BLOCKERS
HEPARIN GOLD ASA IRON RARE WITH IRON DEFICIENCY BUT REPORTED RF RA MAY
PRESENT WITH SPLENOMEGALY ARTHRITIS LOW PLATELETS IF OTHER CELL LINES ARE
NORMAL DESTRUCTION IS MORE COMMON IF OTHER CELL LINES ARE DOWN
SEQUESTRATION OR MARROW PROBLEMS MAY BE PRESENT LET US KNOW IS YOU NEED
ANYTHING ELSE J LEGUIZAMO H O FELLOW IF SHE HAS LABS C W IRON DEFICIENCY
SHE NEEDS IRON SULFATE TID THE MAIN PROBLEM WITH THIS PTS IS COMPLIANCE
BECAUSE GI UPSET CONSTIPATION YOU CAN TRY THE FORMULA AT CIVILIAN
PHARMACIES WHICH HAVE COATING AND STOOL SOFTENER OR TRY PEDIATRIC SOLUTION
2 4 CC PO TID YOU SHOULD SEE IMPROVEMENT IF THERE IS NO IMPROVEMENT SHE
MAY NEED IV IRON AND A SMALL BOWEL EVAL IBD CELIAC DISEASE CAN PRESENT
WITH DECREASED IRON ABSORPTION AND SHE HAS MENSES INCREASED LOSS

)
(BARI-J-BETT I HAVE A 43 Y O B F WITH LONG H O CHRONIC ANEMIA AND H O VOGT
KOYANAGI HARADA SYNDROME VISION FINE EVERYONE IN FAMILY ANEMIC ALSO HCT
NOW 31 3 MCV 2 MCH 34 8 MCHC 35 4 WBC 5 3 IRON 13 LOW TIBC 389 B12 428
FOLATE 6 9 AND FERRITIN 20 6 LIGHT PERIODS NO KNOWN BLEEDING COULD NOT
FIND OUT IF V K H SYNDROME MAY CAUSE ANEMIA ALTHOUGH SHE IS ONLY ONE IN
FAMILY W THIS WHAT DO YOU SUGGEST FOR HER ANEMIA GIVE HER FESO4 AND SEE IF
SHE IMPROVES DO YOU WANT TO SEE HER SHE FEELS FINE AND HAS NO SYMPT THANKS
I HAVE A 66 Y O W F WITH 2 3 YEAR H O OF ONYCHOLYSIS AND SL GREENISH
DISCOLORATION OF GREAT TOENAILS L > R NO DEBRIS NO CRUMBLING UNABLE TO
CULTURE ANYTHING NO THICKENING OF NAIL JUST LOOSENING SL WHITISH SL
GREENISH COLOR ON DISTAL HALF OF NAILS SHE WAS GIVEN SPORANOX BUT GOT RED
BUMPS AFTER 3 DAYS I THINK THIS LOOKS MORE LIKE PSEUDOMONAS OF NAIL RATHER
THAN ONYCHOMYCOSIS WHAT DO YOU THINK AND WHAT DO YOU SUGGEST AS TX THANKS
OK I WILL SEND A REFERRAL I HAVE A 10 Y O GIRL WITH 5 MO H O PLANTAR SKIN
LESION OF THE HEEL OF L FOOT LESIONS BEGAN AS PEELING AND CRACKING OF SKIN
OF SOLE AT HEEL AND EVAL AS DYSHYDROTIC ECZEMA AND TREATED W WESTCORT IT
SEEMS TO HELP A BIT BUT THEN RECURRED W THICKINING AND CRACKING SHE HAS A
WELL DEMARCATED AREA OF THICKENING AND CRACKING OF THE SOLE OF THE FOOT
ONLY AT THE HEEL THE REST OFTHE SKIN OF THE SOLES IS NORMAL AS IS REST OF
SKIN COULD THIS BE A MOCCASIN TYPE TINEA WHAT DO YOU SUGGEST NO I DON^T
THINK IT IS A WART AS IT COVERS THE ENTIRE HEEL GOING UP THE SIDES A BIT
BUT I SUPPOSE IT COULD BE ATOPY ALTHO THE REST OF HER SKIN EXCEPT THIS
HEEL IS NORMAL I WILL REFER HER FOR YOU ALL TO TAKE A LOOK IT IS QUITE
STRIKING AND ANNOYING TO THE PATIENT I HAVE A 53 Y O W F NONSMOKER GEN
GOOD HEALTH H O HTN ON HCTZ WHO HAD A ROUTINE UA SHOWING BLOOD 7 9 RBC^S A
SECOND UA SHOWED TR BLOOD 3 4 RBC^S AND A THIRD WAS NORMAL DO I NEED TO
WORK THIS UP MORE OR CAN I JUST RECHECK IN 6 12 MO THANKS NO SHE IS ONLY
ON ATENOLOL AND HCTZ I WILL GET A 4TH UA AND SEE IF THAT HELPS US TO
DECIDE
)
(JUN-W-KIM WOULD YOU HELP ME CLARIFY THE CORRECT DOSE OF VIT D FOR
OSTEOPOROSIS I NOTICED THERE ARE AT LEAST 3 TYPES OF VIT D PREPARATIONS
DHT D2 ERGOCALCIFEROL AND CALCITRIOL AND THEIR UNITS ARE QUITE CONFUSING
SOME IN IU AND SOME IN MCG OR MG I HAVE RESEARCHED FEW ARTICLES AND
CHECKED OUR FORMULARY AND IT^S STILL SOMEWHAT CONFUSING WHICH WOULD YOU
MOST RECOMMEND FOR OSTEOPOROSIS FOR BOTH PREVENTION AND THERAPY AND WHAT
IS THE CORRECT DOSE THANKS THANKS DR BERNET
)
(ROGER-R-EMORY WE SEE THESE PATIENTS AS ROUTINE CONSULTATION HE NEEDS TO
HAVE A BASIC ENOCRINE EVALUATION PRIOR TO HIS VISIT
)
(PAUL-G-WELCH I^D HAVE QUESTIONS 1 WHY DOES HE HAVE A SOLITARY KIDNEY 2 WHY
IS HE HAVING INFECTIONS 3 WHAT SPECIFICALLY ARE THE ABNORMALITIES
DESCRIBED ON THE ULTRASOUND 4 WHAT IS HIS BUN AND CREATININE YOU MAY HAVE
ACCESS TO ONLY SOME OF THE ANSWERS TO THOSE QUESTIONS BUT THAT WOULD BE MY
QUESTIONS IF HE HAS ANY HYDRONEPHROSIS VESCICOURETERAL REFLUX AND
PYELONEPHRITIS MIGHT EXPLAIN SOME OF THESE PROBLEMS AND HIS TENDER KIDNEY
IF HYDRONEPHROSIS OR DILATED COLLECTING SYSTEM PRESENT WOULD OBTAIN LASIX
RENAL SCAN AND VCUG THE ANSWERS TO MY ABOVE QUESTIONS AND ADDITIONAL TESTS
WOULD DETERMINE IF HE NEEDS UROLOGIC OR NEPHROLOGY REFERRAL THANKS GET
ANNUAL CHECK UP WITH PRIMARY PROVIDER TO INCLUDE BLOOD PRESSURE URINALYSIS
AND BUN CR
)
(ELIZABETH-J-WINFIELD I HAVE A 26 YEAR OLD MALE WHO PRESENTED TO ME WITH
FLANK PAIN HISTORY OF SOLITARY KIDNEY WITH MAYBE YEARLY INFECTION NORMAL
CBC U A AND NEGATIVE CULTURE BUT VERY TENDER KIDNEY ULTRASOUND SHOWS SOME
ABNORMALITIES THAT I^M NOT FAMILIAR WITH MY QUESTION IS DOES HE NEED
FURTHER WORKUP FOLLOW UP HE HAS BEEN DOING OK SINCE WITHOUT TREATMENT BUT
I WANT TO MAKE SURE I^M NOT MISSING SOMETHING
)
(SERGIO-O-BURES I AM AN INTERNIST AT WEST POINT AND WOULD LIKE A BIT OF
CLARIFICATION ON A GENERAL CLINICAL MATTER IF A PATIENT PRESENTS WITH A
LESSION THAT IS SUSPICIOUS FOR PRIMRY SYPHILIS AND IT IS EARLY IN THE
COURSE <3 WEEKS WOULDN^T YOU EXPECT THE NONTREPONEMAL SCREENING TESTS TO
STILL NOT BE POSITIVE RPR AND VDRL IF SO AND YOU START TREATING
EMPIRICALLY HOW ARE YOU TO FOLLOW SERIAL VDRL TITERS TO CONFIRM RESOLUTION
WHAT IF THE INITIAL TEST IS NEGATIVE SINCE FTA IS POSITIVE EARLIER IS THIS
A BETTER SCREENING TEST EARLY ON YOUR HELP WITH THIS SOMEWHAT CONFUSING
MATTER WOULD BE GREATLY APPRECIATED THANKS I AM AN INTERNIST AT WEST POINT

AND HAVE BEEN REFERRED A FEMALE PT BY THE OB GYN SERVICE WHICH I HAVE A QUESTION ON SHE IS A 30 Y O PREGNANT FEMALE FIRST TRIMESTER WITHOUT C O INCIDENTALLY FOUND TO HAVE A LEUKOCYTOSIS UPON H & P THERE ARE NO ABN FINDINGS SEVERAL REPEAT CBC^S SHOW ELEVATED LEUKOCYTOSIS WITH NORMAL OR NEAR NORMAL SLIGHT BANDEMIA DIFFERENTIAL WBC 15 16 9 RANGE ESR WAS 12 UA NML PLATELETS HAVE REMAINED SLIGHTLY ELEVATED 410 450 I VIEWED THE PERIPHERAL SMEAR AND SAW SOME MEGAKARYOCYTES AND THOUGHT THE AUTOMATED DIFF COULD BE INTERPRETING THESE AS WBC^S IN THE TOTAL COUNT AND HENCE THE NML DIFF BUT I AM NOT SURE THAT MAKES SENSE I AM NOT AWARE OF LEUKOCYTOSIS DURING PREGNANCY AS A NORMAL OCCURRENCE IN HER LATEST CBC SHE HAS DEVELOPED A MILD ANEMIA WHICH I SUSPECT IS SECONDARY TO PLASMA VOL EXPANSION AND NORMAL AT THIS STAGE OF HER PREGNANCY GIVEN THE LACK OF PHYSICAL FINDINGS OR C O I AM INCLINED TO JUST FOLLOW THIS WITHOUT ANY MORE AGGRESSIVE W U AT THIS TIME BUT WANT TO MAKE SURE THIS IS NOT A MISTAKE AND SEE IF YOU HAVE ANY EXPERIENCE WITH THIS ANY HELP WOULD BE GREATLY APPRECIATED SERGIO I AM AN INTERNIST AT WEST POINT AND RAN INTO AN INTERESTING PT ON ROUTINE RETIEREMENT PHYSICAL TODAY PT IS A 50 Y O MALE WITH INCIDENTALLY FOUND ABNORMAL EKG JUNCTIONAL RYTHM LBBB WITH INTERMITTENT SINUS CONDUCTED BEATS WITH DIFFERING QRS MORPHOLOGY PT DENIES ANY CARDIAC HX OR PRIOR W U BUT ADMITS TO ABNORMAL EKG ON HIS OVER 40 PHYSICAL LAST EKG DONE 10 YRS AGO PT IS VERY ACTIVE RUNS 2 MILES A DAY AND DENIES ANY HX OF SYNCOPE PALPITATIONS OR LIGHTHEADEDNESS HE HAS AGREED TO OUTPATIENT REFERRAL TO WRAMC CARDIOLOGY FOR EVALUATION AND FURTHER W U TO INCLUDE POSSIBLE EP STUDY AND GIVEN HIS LACK OF SYMPTOMS I HAVE REFERRED HIM AS OUTPATIENT YOUR ASSISTANCE IN EXPEDITING HIS REFERRAL TO THE APPROPIATE SPECIALIST WOULD BE GREATLY APPRECIATED THANKS I AM AN INTERNIST TRYING TO ANSWER SOME GYN QUESTIONS FOR AN AQUAINTANCE THE PT IS A 31 Y O FEMALE G1P0 WITH LONG TIME HX OF IRREGULAR Q6 7 WEEK MENSES REGULATED FOR SEVERAL YEARS WITH BCP UNTIL 1 YR AGO AT THAT TIME SHE UNDERWENT SEROLOGY EVAL FOR AMENORRHEA WHICH LATER EVOLVED INTO IRREGULAR MENSES AS WELL AS US WITH PRESUMPTIVE DIAGNOSIS OF PCO GIVEN NML TSH PROLACTIN ETC SHE HAS NO HIRSUTISM OBESITY OR GLUCOSE INTOL AND IS TAKING NO MEDS RECENTLY SHE BECAME PREGNANT AND SUFFERED A MISCARRIAGE AT ABOUT 6 7 WEEKS SHE VERY MUCH WISHES TO GET PREGNANT AGAIN AND OUR QUESTION IS WETHER GIVEN HER HX OF LIKELY NOT CLINICALLY OBVIOUS PCO SHOULD SHE RECEIVE PROGESTERONE VS CLOMID BEFORE DURING HER NEXT PREGNANCY ATTEMPT TO TRY AND COMPENSATE FOR A POSSIBLE LUTEAL PHASE DEFECT IF SO WHAT WOULD BE THE SAFEST AGENT AND HOW PROVEN IS THEIR SAFETY YOUR INSIGHT AND POSSIBLE REFERENCES REGARDING THESE MATTERS WOULD BE GREATLY APPRECIATED GIVEN I AM TREADING VERY UNCHARTED WATERS FOR MY SPECIALTY THANKS AGAIN I AM AN INTERNIST AT KELLER ARMY HOSPITAL MY QUESTION IS WHAT ALTERNATIVES ARE AVAILABLE FOR PROPULSID IN TX OF DIABETIC GASTROPARESIS ARE THERE ANY REASONABLE AND EFFECTIVE SUBSTITUTES HOW ARE YOU FOLKS TREATING THIS DISORDER YOUR INPUT WOULD BE VERY HELPFUL TO OUR DEPARTMENT I THANK YOU IN ADVANCE THANKS I AM AN INTERNIST AT WEST POINT AND HAVE A PATIENT THAT WISHES TO COMPLETE HER PULMONARY W U AT WRAMC SHE IS A 40 Y O FEMALE SMOKER S P SURGICAL MENOPAUSE 8 YRS AGO WITH RECENT ONSET NIGHT SWEATS AND WEIGHT LOSS WITHOUT COUGH FOUND TO HAVE A RUL RATHER PERIPHERAL NODULE PRIOR CXR REPORTEDLY NEGATIVE AND PT TRYING TO LOCATE THEM CHEST CT BEING DONE TODAY PPD NEGATIVE WITH NML ANERGY PANEL I WANT TO REFER HER TO YOU FOR FURTHER EVAL BRONCH TUMOR BOARD EVAL ETC PER YOUR DISCRETION PLEASE ADVICE ON FURTHER LABS OR STUDIES THAT WOULD AID YOUR EVALUATION SO I CAN EXPEDITE THINGS FOR HER GIVEN SHE WILL HAVE TO STAY IN A HOTEL DURING HER VISIT TO YOUR AREA I CAN BE REACHED TELEPHONICALLY AT OR VIA THIS MESSAGE I THANK YOU IN ADVANCE FOR YOUR CONSIDERATION ON THIS MATTER SERGIO BURES CPT MC THANK YOU FOR YOUR PROMPT RESPONSE SHE WILL BE ABLE TO GO THURSDAY AFTERNNON 6 APRIL I HAVE DISCUSSED THE PLAN AND POSSIBLE BRONCH FRIDAY AND SHE IS AGREEABLE WE WILL TRY TO GATHER AS MANY OLD FILMS AS POSSIBLE AND OF COURSE HER CXR AND CONTRAST CT WILL COME WITH HER IF YOU COULD PROVIDE DETAILS OF TIME AND PLACE I WILL PASS THEM ON TO HER THANK YOU AGAIN FOR YOUR RESPONSE AND ASSISTANCE SERGIO SHE WILL BE THERE THANKS AGAIN

)

(GEORGE-E-PATTERSON WHAT IS THE UPPER LIMITS OF NORMAL OF PROLACTIN FOR A BREAST FEEDING WOMAN IN WORKING UP A POSSIBLE HIRSUTISM I DISCOVERED A PROLACTIN LEVEL OF 1970 YES THANK YOU FOR YOUR INPUT SHE IS 38 WITH A PRIOR HISTORY OF NORMAL MENSES SHE HAD STOPPED BREAST FEEDING 1 WEEK PRIOR TO WORK UP FOR XS HAIR I REPEATED HER PROLACTIN LEVEL RESULTS PENDING TFT^S WERE WNL TESTOSTERONE WAS 141 SHE WOULD PREFER NOT TO TRAVEL TO WRAMC AND I WILL REFER HER TO ENDOCRINOLOGY AT HERSHEY I HAVE TO DECIDE IF I SHOULD ORDER AN MRI BEFORE THAT REFERAL THANK YOU FOR ALL YOUR THOUGHTS

AND ANSWERS
)
(DAVID-L-JONES AGREE WILL STILL USE FOR BPH BUT IT IS STILL NOT A FIRST OR SECOND OR THIRD CHOICE FOR HTN DIURETIC REMAINS 1ST CHOICE AND WHEN NOT USED 1ST 2ND CHOICE BETA BLOCKERS ARE GREAT IN SOME GROUPS LISINOPRIL PRICE IS DOWN TO $0 14 TAB AND IT IS A GREAT CHOICE AS WELL
)
(PATRICK-G-O^MALLEY THE TRIAL DID NOT INCLUDE A PLACEBO ARM SO TO CONCLUDE THAT CARDURA IS CAUSING HARM IS NOT APPROPRIATE HOWEVER ITS A GREAT OPPORTUNITY TO GET THEM ON A BETTER DRUG SUCH AS THIAZIDES OR BETA BLOCKERS
)
(SWATI-M-DESAI YESTERDAY THERE WAS A NEWS ARTICLE ON TV ABOUT HOW CARDURA IS NOT ONLY AN INEFFECTIVE ANTIHYPERTENSIVE BUT ALSO INCREASES INCIDENCE OF CONGESTIVE HEART FAILURE JUST GET A TEL MESSAGE FROM A PT ON CARDURA ASKING WHETHER HE SHOULD STAY ON IT OR NOT I AM SURE MANY MORE WILL CALL WOULD LIKE EVERYONE^S OPINION ON THIS MATTER WHAT ABOUT ITS USE IN BPH ANY COMMENTS APPRECIATED CAN YOU EXPERTS ELABORATE MORE ON THIS SHOULD WE SWITCH PATIENTS ON CARDURA TO ANOTHER ANTIHYPERTENSIVE ANY GUIDELINES TO GO BY
)
(ERIC-P-SIPOS PINEAL CYSTS ARE A NORMAL VARIANT AND ARACHNOID CYSTS MAY ALSO OCCUR IN THIS REGION THE CHALLENGE IS TO DISTINGUISH THESE FROM NEOPLASTIC PROCESSES IN THE PINEAL REGION WHICH CAN BE CYSTIC AND CAN CAUSE MASS EFFECTS UPON ADJACENT STRUCTURES IN ASYMPTOMATIC PATIENTS SERIAL IMAGING CAN BE QUITE HELPFUL I RECOMMEND THAT THIS PATIENT SEE ONE OF THE NEUROSURGEONS AT WRAMC TO EVALUATE THE TWO CYSTIC STRUCTURES FURTHER AND TO GENERATE A MANAGEMENT PLAN
)
(HANNELORE-B-MANCIL MRI WAS DONE AT PNH FOR NEWLY ONSET HEADACHES FOLLOWING AN INTENSE WEIGHT LIFTING SESSION NO MASSES INFARCT OR HEMORRHAGE INCIDENTAL FINDING OF EXTRA CSF SPACE ON RIGHT TEMPORAL LOBE SUGGESTIVE OF A N ARACHNOID CYST NO SIZE GIVEN ALSO A |11X10| MM CYSTIC STRUCTURE IN THE PINEAL REGION SUGGESTIVE OF CYST IS THIS A COMMON FINDING F U IN 1 YEAR OK PATIENT IS A 32 YO AD WM WHO IS OTHERWISE HEALTHY HIS HEADACHES HAVE RESOLVED
)
(SANDRA-A-YERKES IS HIS CPK CONTINUING TO GO UP THOSE LEVELS SOUND A LITTLE HIGH FOR JUST ROUTINE WEIGHT LIFTING AGREE WITH DR ENGEL THAT THIS GENTLEMAN HAS SEVERAL SYMPTOMS OF DEPRESSION WE ARE ALWAYS HAPPY TO EVALUATE AND ASSIT WITH TREATMENT
)
(CHARLES-R-ENGEL SUSPECT THAT HIS ELEVATED CK IS FROM LIFTING WEIGHTS IF HE DOES THAT WITH ANY REGULARITY THIS SOUNDS LIKE SOMEONE WITH SEVERAL SYMPTOMS TYPICAL OF DEPRESSION THAT IS ALSO PROBABLY THE MOST LIKELY DIAGNOSIS GIVEN A YOUR BASICALLY NEG WORKUP THUS FAR AND HIS SYMPTOMATOLOGY HE MAY NOT ACKNOWLEDGE A DEPRESSED MOOD BEST TO START WITH A QUESTION ABOUT ANHEDONIA ^STILL ENJOYING YOUR HOBBIES OR OTHER THINGS YOU NORMALLY ENJOY DOING ^ THEN GO TO SIG E CAPS SX OF DEPRESSION HE MAY NOT BE RECEPTIVE TO THE NOTION THAT HIS DIFFICULTY COULD BE PSYCHIATRIC HOWEVER AND I WOULD NOT FORCE IT ON HIM IF HE SEEMS UNRECEPTIVE BUT INSTEAD DESTIGMATIZE IT ^DEPRESSION IS A MEDICAL DISORDER AND SPECIFIC TREATMENTS ARE AVAILABLE WE JUST NEED TO FIGURE OUT WHAT IS RIGHT FOR YOU ^ AND CONVEY A SENSE OF OPTIMISM ABOUT EFFECTIVE TREATMENT IF HE IS UNRECEPTIVE ABOUT SEEING PSYCHIATRY ASSUMING ALL THIS FITS THAT I AM SAYING THEN IT IS POSSIBLE TO MANAGE HIM VERY WELL IN YOUR SETTING IF MILITARY FACTORS ARE IMPORTANT YOU CAN REASSURE HIM THAT AS LONG AS HE IS WORKING OKAY THEIR IS NO REASON THAT A DIAGNOSIS OF DEPRESSION SHOULD HURT HIS CAREER IN ANY WAY IT IS ONLY IF HIS WORK IS SUFFERING THAT THIS COULD BECOME AN ISSUE ASK HIM ABOUT HOPE FOR THE FUTURE IF HE HAS COMPELLING FUTURE PLANS AND IS FUNCTIONING OKAY ON THE JOB WITH NO HISTORY OF SUICIDE ATTEMPTS THEN I WOULD NOT BELABOR THE SUICIDE ISSUE UNTIL YOU KNOW HIM A BIT BETTER HOPE THAT IS USEFUL MY TWO CENTS WORTH IS THAT YOU TAKE A ^WATCHFUL WAITING^ APPROACH GET ANOTHER SET OF DATA POINTS IN 3 MONTHS AND WAIT FOR THIS TO ^DECLARE ITSELF^ IN SOME MORE DEFINITIVE WAY I CAN^T IMAGINE THAT THIS IS WILSON^S DZ VIRTUALLY ALL OF THEM ARE SEVERELY DEMENTED AT THIS MAN^S AGE THIS STRIKES ME AS A VERY TYPICAL SORT OF EVALUATION FOR CHRONIC MEDICALLY UNEXPLAINED PHYSICAL SYMPTOMS LOTS OF EQUIVOCAL FINDINGS THAT DON^T ADD UP KEEP YOU INTERESTED ENOUGH TO CONTINUE EXTENDING THE EVALUATION EXPERIENCE WITH THIS SORT OF PATIENT

LEADS ME TO SUGGEST THAT YOU WATCH HIM FOR A BIT BEFORE LAUNCHING NEW AND AGGRESSIVE EVALUATIONS UNLESS SOMEONE ON THIS THREAD THINKS THIS PRESENTATION ^ADDS UP^ IN SOME READILY APPARENT WAY AND TO RETURN IN A YR
)
(ROBERT-J-OGLESBY I GUESS A QUESTION TO ASK IS IF THE ^FATIGUE^ HE IS EXPERIENCING IS WEAKNESS AND IF THERE IS DOCUMENTATION OF WEAKNESS AS YOU KNOW THE DDX FOR THE IDIOPATHIC MYOPATHIES IS WIDE AND COVERS INFECTION TOXIN DRUG ENDOCRINE NEUROLOGIC AND CONNECTIVE TISSUE DISEASE ETIOLOGIES IN ADDITION TO THE CLASSIC BUT RARE INFLAMMATORY MYOPATHIES THIS IS AN INTERESTING CASE AND WE WILL BE GLAD TO HELP IN THE EVALUATION AT THIS POINT A RELATION TO HIS MEMORY PROBLEMS CANNOT BE ANSWERED YOU CAN GIVE US A CALL AND WE WILL BE GLAD TO FACILITATE AN APPOINTMENT FOR YOU EITHER THROUGH OUR ON CALL PHYSICIAN OR WITH ME DIRECTLY I APOLOGIZE FOR THE DELAY IN GETTING BACK TO YOU MR JACOBS HAS SEEN ME IN THE PAST I DO NOT HAVE ACCESS TO HIS FILE TODAY BUT RECALL ONLY A SLIGHT DECREASE IN HIS ALBULMIN IN THE PAST YEAR WITH AN SPEP IN THE FALL THAT DID NOT REVEAL ANY ABNORMAL BAND AT THAT TIME I WILL BE GLAD TO FOLLOW UP WITH HIM AT ANY TIME ROB OGLESBY I CALLED AND LEFT A MESSAGE FOR MR JACOBS TO CALL ME REITER^S PSORIATIC ENTEROPATHIC ARTHRITIS CAN ALL PRESENT WITH BACK DISCOMFORT IN THE REALM OF THE SPONDYLOARTHROPATHIES CHRIS PARKER HAS BEEN WITH A GROUP ON GUIDELINES FOR THE EVALUATION OF BACK PAIN AND HE MAY HAVE SOME FURTHER THOUGHTS FROM THOSE DISCUSSIONS YES AN ALLERGIC REACTION TO OTHER NSAIDS OR ASPIRIN ARE CONTRAINDICATIONS FOR USE AS STATED IN THE PACKAGE INSERTS FOR THE NEW COX 2 INHIBITORS OF COURSE IT DOES DEPEND ON WHAT YOUR PATIENT IS CALLING AN ALLERGIC REACTION
)
(JENNIFER-M-ARO 36YO WM W 3 MONTH H O SHORT TERM MEMORY LOSS FORGETS THINGS HIS WIFE JUST TOLD HIM FORGETS TO LOAD THE SECOND KID IN THE VAN BEFORE TAKING OFF DOWN THE STREET HAVING TO TAKE COPIOUS NOTES IN CLASS CGSC AND GRAD SCHOOL IN ORDER TO REMEMBER THE MATERIAL NEXT CLASS UNUSUAL FOR HIM SLEEPING VERY LIGHTLY W FREQUENT AWAKENINGS HOWEVER INITIATES SLEEP EASILY FEELS VERY FATIGUED LATELY ESPECIALLY AFTER WORKING OUT AND EXPERIENCING LONGER RECOVERY TIMES BETWEEN WEIGHT LIFTING SESSIONS DENIES RASH FEVER DRUGS ETOH JOINT MUSCLE PAIN DEPRESSED FEELING MARITAL PROBLEMS STRESS FHX THYROID RA CROHN^S DMPE WDWNWM NAD A&OX4MINI MENTAL STATUS 30 30ZUNG DEPRESSION SCREEN WNLLUNGS CTA COR RRR W O M R G ABD B9 EXT NO C C E NO TTP SKIN NO RASH GUAIAC NEGLAB CBC HIV RPR TSH RF ANA CERULOPLASM B12 FOLATE ALL WNLALT AST 50 70 CK 525 THEN 1099 THEN 799 DRAWN OVER COURSE OF 2 WEEKS PROGRESS NO WORSENING OF MEMORY IN LAST 6 WEEKS PT IS MAKING A CONCERTED EFFORT TO REMEMBER WHICH SEEMS TO BE HELPING HOWEVER IT TAKES MUCH MORE EFFORT THAN IT SHOULD HE THINKS NO CHANGE IN FATIGUE QUESTION WHAT DOES THIS CK REPRESENT AND COULD IT BE RELATED TO THE MEMORY PROBLEM OR FATIGUE WHERE ELSE SHOULD I LOOK THIS QUESTION WAS SENT FROM A FELLOW FP SHOULD I SEND TO G ASK A DOC OR DO YOU HAVE ANY ANSWERS JEN THANKS I WILL SEND ON TO THOSE SERVICES ON ASK A DOC AND SEE WHAT THEIR RECOMMENDATION IS THANK YOU FOR YOUR ASSISTANCE THANK YOU LATEST UPDATE ASO 166 ELEVATED FOR HIS AGE AS WAS THE ANTIDNASE B I^M NOT SURE WHAT TO MAKE OF THAT URINE COPPER 72 24 64 HE HAD A LOW NORMAL SERUM CERULOPLASMIN IN HIS INITIAL W U AT 25 7 AND THE INITIAL VISIT W AN INTERNEST WAS SUSPICIOUS FOR KAYSER FLEISCHER RINGS HOWEVER OPTOMETRY WASN^T OVERLY IMPRESSED TOLD HIM THEY HAD A DATA POINT AND TO RETURN IN A YR MY CONCERN IS THAT THIS IS AN UNUSUALLY LATE PRESENTATION OF WILSON^S DZ IN ITS EARLY STAGES AND WITH THE MEMORY DEFICITS AND INTERMITTENT RT HAND TWITCHING I^M CONCERNED THAT THIS COULD REPRESENT COPPER DEPOSITS ON THE BRAIN I^M SENDING HIM TO GI FOR DEFINITIVE EVAL FOR THIS IF THAT PROVES NEGATIVE WHAT IS YOUR OPINION AT THIS POINT
)
(DARRELL-J-APPLE 59YO M ADA HAS SINCE 1983 CREAT FLUCTUATING IN 1 1 TO 1 5 RANGE |1980^S| 1 3 1 4 1 0 1 4 1 1 1 4 |1990^S| 1 3 1 3 1 3 1 3 1 1 1 1 1 2 1 4 1 1 1 1 1 2 1 1 1 3100=1 5 2 3 00=1 2 2 23 0 =1 3 BUN RUNS IN 10 19 RANGE BEING 5^4IN 150 LB HE HAS HAD RECURRENT GOUT ATTACKS PLACED ON ALLOPURINOL 1986 BUT D C 1995 HAVING LFT ELEVATION BENEMID STARTED 9 17 96 CREAT OF 1 5 NOTED ABOVE WAS AFTER PT USED MOTRIN FOR GOUT ATTACK HE HAS SINCE BEEN OFF NSAID SPOT PROTEIN CREAT RATIO SHOWS PROTEIN 43MG GM CREAT U S OF KIDNEYS 3 3 0 WAS NORMAL X FOR BPH COCKROFT GAULT FORMULAE SHOWS CC 56 LAST U A 5 2 1 31 0 24HR U A LEVELS 1989 660MG 1996 496MG PER 24 HRS ON NO MEDS BP IS NORMAL PT DOES NOT HAVE DIABETES HAS BEEN USING NSAID PERIODICALLY OVER THE YEARS WOULD APPRECIATE YOUR SUGGESTIONS
)
(KAREN-A-WILLIAMS I HAVE A PATIENT THAT I^M NOT SURE WHAT TO DO WITH HIS

CHOLESTEROL HE^S A 43 YEAR OLD BLACK MALE WHO CAME IN FOR AN OVERSEAS SCREENING AND WE DID A PROFILE HE^S NEVER BEEN TESTED BEFORE HE^S IN EXCELLENT PHYSICAL SHAPE IS AN AVID WEIGHT LIFTER HE^S A RETIREE WIFE ON AD HIS DAD IN HIS |60^S| HAS A LARGE HEART BUT NO KNOWN HISTORY OF CAD OR HTN NO DIABETES EITHER HIS TOTAL CHOLESTEROL IS 309 BUT TRIGLYCERIDES ARE 84 AND HDL IS 107 WITH AN LDL OF 185 AND A VLDL OF 17 BASED ON THE BREAK DOWN IT^S ONLY THE LDL PUTTING HIM AT INCREASED RISK SHOULD THIS BE TREATED MEDICALLY I DIDN^T WANT TO SCREW UP HIS TG AND HDL HE^S ON NO OTHER MEDICATIONS AND IS OTHERWISE HEALTHY THANKS DR W
)
(FRANK-M-MOSES I DON^T DISAGREE HOWEVER IF THE POLYPS WERE ALL SMALL THAT IS <7 10MM AND THE LARGEST WAS HYPERPLASTIC HE REALLY IS AT ONLY AN AVERAGE RISK FOR IMPORTANT PROXIMAL LESIONS AND NOT AT HIGHER RISK BECAUSE OF YOUR FINDINGS
)
(MADELEINE-E-MYERS I AM COVERING FOR ANOTHER PRACTICTONER WITHOUT PRIOR KNOWLEDGE OF THIS PT LABS TSH 17 25 ANTI THRROGLOBU <2 0 ANTI THYROID PE 1870 0 AT PRESENT PT C C IS FATIGUE PAST HX AFTER GIVING BIRTH TO A SEVERELY MIS SHAPENED INFANT AND THE INFANT^S DEATH 6MO OLD PT BEGAN TO HAVE PANIC ANXEITY IRRITABLITY NERVOUNESS AND INSOMMIA WOULD SHOULD MY NEXT STEP BE SHOULD I REDO LABS TREAT FOR HYPOTHYROIDISM ORDER A THYROID SCAN REFER TO ENDOCRINOLOGIST ASAP THANK YOU FOR YOUR TIME AND ENERGY A 25 Y O AD MALE C C LT UPPER ARM 2CM FIRM AREA POST ANTHRAX IMMUNIZATION 1 YR AGO NONTENDER NONBULDGING SOLDIER HAS GOTTON MIXED FEEDBACK ON WHAT OUGHT TO BE DONE SINCE IT IS NONTENDER I THOUGHT LEAVE IT BE WHEN SOLDIER CALLED ANTHAX IMMUNIZATION CLINIC DEWITT HE WAS TOLD TO FOLLOW UP IN DERMATOLOGY FOR A CASE STUDY TO CATALOG IT AND POSSIBLE REMOVAL 1 HAVE YOU HEARD OF THIS 2 WHAT WOULD YOU DO MADELEINE
)
(HENRY-B-BURCH THE FASTEST WAY TO MAKE AN APPT IS TO ENTER THE CONSULT IN CHCS AND HAVE HIM CALL OUR FRONT DESK TO BOOK IF THE TIMING ISN^T SATISFACTORY CALL THIS NUMBER AND ASK TO SPEAK TO OUR ON CALL PHYSICIAN AGREE THE EARLY SYMPTOMS MAY HAVE BEEN DUE TO THYROTOXICOSIS FROM POSTPARTUM THYROIDITIS IN WHICH CASE SHE MAY HAVE RECOVERY OF NORMAL THYROID FUNCTION WERE TFTS DONE DURING HER PERIOD OF ANXIETY ETC I WOULD STILL TREAT HER WITH THYROID HORMONE IF THIS WERE PPT BUT WOULD PROBABLY WITHDRAWAL AND RETEST AFTER 1 YEAR A COMMON STARTING DOSE WOULD BE BETWEEN 0 5 AND 0 1 MG ONCE DAILY DEPENDING ON THE PATIENT AGE SIZE ETC THE TFTS ARE ADJUSTED FROM THERE WE WOULD BE HAPPY TO SEE HER TO ASSIST IN HER MANAGEMENT I BET SHE MEANS AVANDIA OR ROSIGLITAZONE INSULIN SENSITIZER MUCH BETTER THAN TROGLITAZONE BUT A COUPLE OF RECENT REPORTS OF HEPATOTOXICITY DRUG COMPANY RECOMMENDS Q 2 MO LFTS X 1 YEAR THEN DEFINITELY A BIT TOO MUCH!! THE EXACT TARGET DEPENDS ON A NUMBER OF FACTORS SUCH AS HER AGE AT DIAGNOSIS SHE WAS IN THE LOW RISK AGE GROUP < 45 SIZE OF THE TUMOR LOCAL INVASION ETC EVEN IN A HIGH RISK FOR RECURRENCE PATIENT IT^S RARE TO HAVE TO ELEVATE THE FREE T4 TO ABOVE THE UPPER NORMAL LIMIT TO OBTAIN A MAXIMALLY SUPPRESSED TSH I WOULD STOP HER LT4 FOR A WEEK AND THEN RESTART AT 0 2 MG D ADJUSTING PER TFTS WE SHOULD SEE HER IN FOLLOW UP TO HELP DEFINE A TARGET TSH AND IMAGING SCHEDULE DO YOU KNOW WHO SHE SAW PREVIOUSLY IF YOU SEND HER NAME AND LAST 4 WE CAN THIS AND BOOK HER FOR AN APPROPRIATE APPT NEITHER ARE HERE NOW PLEASE SEND HER NAME NUMBER AND WE^LL BOOK THIS AND CALL HER SHE^S SCHEDULED FOR THIS FRIDAY 24 MAR @ 8 0 SHE HAS BEEN NOTIFIED WE^LL LET YOU KNOW WHAT WE THINK I SUSPECT SHE WILL NEED A REPEAT FNA I AGREE W DR BERNET SINCE THE DIFFERENTIAL OF A LOW FT4 AND NORMAL TSH RANGES FROM SOMETHING AS SIMPLE AS A DRUG EFFECT TO SOMETHING AS SERIOUS AS PITUITARY INSUFFICIENCY FROM A CNS TUMOR A CONSULT TO SEE US IS CERTAINLY I CAN APPRECIATE YOUR EFFORTS FOR THIS PATIENT BUT I HAVEN^T ENCOUNTERED THIS SITUATION BEFORE I WILL FORWARD THIS TO CPT JAMES AND COL JILL PHILLIPS TO SEE IF THEY HAVE ANY SUGGESTIONS IT SEEMS TO ME THAT AN ANSWER NEEDS TO COME FROM THE ADMIN SIDE OF THE HOUSE THYROID US ABNORMALITIES SUCH AS THESE ARE FOUND IN 30% OF THE GENERAL POPULATION HER AGE UNLESS SHE HAD A HISTORY OF THYROID XRT EXPOSURE I^D FOLLOW HER WITH PALPATION ONLY THERE^S FAIRLY GOOD EVIDENCE OF HARM AFIB OSTEOPOROSIS WITH SUBCLINICAL HYPERTHYROIDISM AT THIS LEVEL WE ARE VERY MUCH APT TO SEARCH FOR THE CAUSE THYROID EXAM REPEAT TFTS ANTI TPO AB^S THYROID SCAN AND UPTAKE IF REPEAT TFTS CONFIRM AND THEN TREAT ACCORDING TO THE ETIOLOGY WITH THE OBJECTIVE OF NORMALIZING THE TSH FEEL FREE TO COME BY WITH HER DATA TO DISCUSS WITH ONE OF US I^M PREPARING A LECTURE ON THE MANAGEMENT OF THYROID NODULES IN PREGNANCY FOR PATIENTS WITH FNAS SHOWING THYROID CANCER WE GENERALLY RECOMMEND THYROIDECTOMY IN THE 2ND TRIMESTER

IS ANYONE AWARE OF ANY GOOD REFERENCES THE MATERNAL AND FETAL RISK ASSOCIATED WITH SURGERY IN THE FIRST AND THIRD TRIMESTERS H BURCH THANK YOU!
)
(BRENDA-S-HARPER WILL FAX OUR SOP)
(CHARLES-S-HORN BECAUSE OF THE INCONSISTENCY AND SUBSEQUENT INACCURACIES OF PRACTICES OF DOING MEASUREMENTS AND VITAL SIGNS AMONG THE FAMILY HEALTH CENTERS OF THE DEWITT HEALTH CARE SYSTEM FOR OUR 25 0 CHILDREN WE DEVELOPED AND DISTRIBUTED GUIDELINES FOR THESE BASED ON AGES REASON FOR VISIT ETC IN FACT THEY WERE A COMPILATION AND COMPARABLE PRACTICE IF YOU WILL OF WHAT WAS BEING DONE AT WRAMC AND NNMC IF YOU GIVE ME YOUR FAX NUMBER WE WILL GLADLY SEND YOU A COPY ONE SHEET THAT CAN BE DISPLAYED IN YOUR VITAL SIGNS ROOMS THANK YOU FOR YOUR INTEREST COL H PED WILL SEND ONE YOUR WAY TODAY AS HAS BEEN SAID IN MORE SPIRITUAL CIRCLES ^SEEK AND AND YE SHALL FIND ^ IN THIS CASE A LONE COLONY OF GABHS AND A QUESTION AS TO WHAT IT MEANS! MIKE A ONE TIME POSITIVE CULTURE DOES NOT DEFINE A ^CARRIER ^ AND IN AN ASYMPTOMATIC PERSON DOES NOT NECESSARILY WARRANT TREATMENT SOME OF THE ACCEPTED REASONS FOR TREATMENT OF A GABS CARRIER INCLUDE 1 WHEN THE FAMILY HAS A HISTORY OF RHEUMATIC FEVER 2 WHEN THERE IS BACK AND FORTH SPREAD OF INFECTION WITHIN A FAMILY 3 WHEN THERE ARE SEMICLOSED COMMUNITY OUTBREAKS AND 4 WHEN TONSILLECTOMY IS BEING CONSIDERED ONLY BECAUSE OF CHRONICPOSITIVE CULTURES THESE RECOMMENDATIONS AND OTHER USEFUL INFO ABOUT GABHSCAN BE FOUND IN CONTEMPORY PEDIATRICS OCTOBER 1992 SINCE THEN HOWEVER CLINIDAMYCIN AT 20 MG KG DAY DIVIDED TID FOR 10 DAYS HAS BEEN SHOWN TO BE ABOUT 85% EFFECTIVE IN ERADICATING GABHS FROM CARRIERS INTERESTINGLY ABOUT THE SAME EFFECTIVENESS AS THE VARIETY OF PENICILLIN MACROLIDE ANDCEPHALOSPORINS FOR TREATING ACUTE SYMPTOMATIC GAHBS INFECTIONS YOUR PATIENTIS ONE THAT WILL OPEN UP DEBATE AND DISCUSSION FROM INFECTIOUS DISEASE PHARMACOLOGIC AND COSTS STANDPOINT I PROBABLY WOULDN^T TREAT AT THIS POINT
)
(DEBRA-L-BAVARI FOR THE GENERAL PEDIATRIC CLINIC DO YOU HAVE AN SOP FOR SCRRENING WEIGHTS ON CHILDREN ONE YEAR AND UNDER I E ALWAYS IN ONSIE AND DRY DIAPER IN ONSIE ONLY ALWAYS UNCLOTHED ETC THANK YOU THAT WOULD BE FANTASTIC EXACTLY WHAT I WOULD LIKE FOR HERE AT DETRICK TO MY ATTENTION PLEASE I HAVE A GUIDELINE FROM PREVIOUS CIVILIAN PRACTICE BUT IT WOULD BE MUCH EASIER TO INITIATE AN ALREADY ESTABLISHED MILITARY ITEM THANK YOU DEBRA B
)
(KENT-C-HOLTZMULLER WHAT IS YOUR NORMAL FOR AFP I WOULD GET A CT OF THE LIVER IF IT IS OVER THE NORMAL THANKS I RECOMMEND THAT HE JUST PROCEED WITH A COLONOSCOPY NOT ALL THE POLYPS WERE BIOPSIED AND THERE IS A CHANCE ONE IS AN ADENOMA GIVEN HIS AGE AND THE FLEX SIG FINDINGS I WOULD BE ON THE AGGRESSIVE SIDE
)
(WILLIAM-A-OTT IN LATE 10 99 I E MAILED YOU ABOUT A 71 Y O MALE WITH HEP B SAG EAG CAB E AB S AB AND YOU RECOMMENDED FOLLOWING HIM TWICE YEARLY WITH AFPS AND ONCE YEARLY WITH US LIVER HERE^S AN UPDATE HIS US WAS NORMAL 1999 HIS LFT^S HAVE REMAINED UNCHANGED WITH AST BEING SLIGHTLY ELEVATED UNCHANGED LAST DONE 1999 AND HIS AFP HAS RISEN FROM 7 8 TO 8 3 AND NOW TO 13 4 2 0 HIS HBV DNA WAS >2000 PG ML 2 0 WHAT WOULD BE THE NEXT STEP CT LIVER CONSULTATION LESS THAN 8 1 I^LL GET THE CT DONE AND CONTACT YOU THEN WITH THE RESULTS CT OF ABDOMEN WITHOUT CONTRAST WAS COMPLETELY NORMAL EXCEPT FOR A SMALL LEFT PLEURAL EFFUSION FYI PT IS S P CABG APPROX 3 4 MONTHS AGO WHAT^S THE NEXT STEP IN THIS CASE CONTINUE TO FOLLOW THE AFP GIVEN THAT THE CT IS ESSENTIALLY NORMAL AND THE LFTS ARE NORMAL THANKS FOR YOUR RESPONSE I^LL LET YOU KNOW THE RESULTS OF THE MR IN 3 MONTHS I HAVE A 30 Y O AFRICAN AMERICAN SOLDIER WHO I HAPPENED TO INCIDENTALLY NOTICE AN ANEMIA IN HIS PAST BLOOD TESTS WHEN INQUIRED ABOUT IT HE HAD NO THAT IT EXISTED HIS H H WAS 12 6 14 18 AND 37 5 42 52 WITH A WHITE COUNT OF 4 2 4 8 10 8 DONE IN 1999 NO SIG FAMILY HX NO SIGNS AND SYMPTOMS I INITIATED A BRIEF W U AND HIS REPEAT H H WAS 13 9 40 8 WITH A WBC OF 4 0 LOOKING BACK IN THE RECORDS HE HAD AN EARLIER 1999 H H OF 15 0 AND 45 3 WITH A WBC OF 3 7 EVERY CBC HAD NORMAL INDICES HIS RECENT FERRITIN TIBC VIT B12 FOLATE TSH LFTS WERE ALL WNL HIS SICKLEDEX WAS NEG SHOULD I BE PURSING HIS ANEMIA ANYMORE AND WHAT OF THE LEUKOCYTOSIS ON EACH CBC HIV NEG 1999 SHOULD I BE CONCERNED ABOUT THAT OR ASSUME IN AN OTHERWISE HEALTHY FIT SOLDIER THAT THIS IS NORMAL FOR HIM HIS SMEAR WAS COMPLETELY NORMAL SHOULD I REPEAT THE LAB IN A FEW WEEKS AND IF STILL ABNORMAL THEN REFER I HAVE A 35 Y O FEMALE WHO IS GETTING MARRIED AND IS CONCERNED ABOUT TRANSMITTING HSV II TO HER

SPOUSE EVEN THOUGH SHE DOES NOT HAVE ANY ACTIVE LESIONS SHE WAS TOLD THAT SHE HAD GENITAL HERPES WHEN SHE WAS YOUNGER BUT SINCE THEN HAS NEVER HAD A RECURRENCE SHE ALSO CAME TO THE OFFICE LOOKING FOR A BLOOD TEST THAT WOULD DEMONSTRATE THAT SHE DEFINATELY HAD PRIOR EXPOSURE TO HSV II THE SERUM HSV II IGM WAS 1 42 AND IGG >3 SHE WANTS TO KNOW HOW TO PREVENT THE SPREAD OF THE HSV AND WHETHER OR NOT TAKING WOULD HELP PREVENT SHEDDING OF THE VIRUS TO HER PARTNER IN THE FUTURE ARE THERE TIMES WHERE YOU WOULD RECOMMEND PROPHYLAXIS FOR THE SOLE RESEAON TO PREVENT FUTURE OUTBREAKS AND THUS HOPEFULLY REDUCE THE CHANCE OF TRANSMISSION TO ANOTHER PERSON IN A PATIENT AS MENTIONED ABOVE DID YOU RECEIVE THE MESSAGE FROM 3 29 AT 13 3 FRAN ANY WORD ON THE TRANSMISSION PROBLEMS AT KELLER SEEMS LIKE IT^S STILL NOT GOING THROUGH TO WRAMC 914 938 2993 OR 914 938 6080 I RECEIVED YOUR FAX AND RESPONSE FOR SOME REASON YOUR RESPONSE NEVER GOT UP TO KELLER CHCS THE FAX INCLUDED YOUR RESPONSE THANKS! I HAVE A 38 Y O CAUCASIAN FEMALE WHO I NOTICED HAD ANEMIA ON PRIOR LAB TESTS IN THE CHART SHE^S BEEN ON IRON REPLACEMENT FOR YEARS ACCORDING TO HER I REPEATED HER LABS AND STILL NOTICED AN ANEMIA I INITIATED A WORKUP WHICH IS AS FOLLOWS H H 10 6 32 6 WITH NORMAL INDICES NORMAL SMEAR FE 27 TIBC 419 FERRITIN 5 0 LFTS WNL ESR 25 AND REPEATED 34 WITH NEG ANA RETIC 0 6 VITAMIN B12 FOLATE WNL IRON SUPPLEMENTATION OVER THE LAST FEW WEEKS HAS NOT IMPROVED THE H H NOR THE IRON FERRITIN LEVEL BUT HAS HELPED HER FATIGUE AND LETHARGY ONE THING THAT IS STILL PENDING IS THE HGB ELECTROPHORESIS SHOULD I BE PURSUING ANYTHING ELSE OR WILL THIS JUST BE AN IRON DEFICIENCY ANEMIA NORMAL INDICES THOUGH THAT REQUIRES BETTER IRON GI ABSORPTION

)

(KENNETH-H-INGRAM DR M NOT A PROBLEM! LET US KNOW IF WE CAN BE OF FURTHER ASSISTANCE

)

(BRAD-J-DAVIS WHAT^S THE PATIENT^S NAME SSN I^D LIKE TO REVIEW THE INSTRUMENT RESULTS

)

(MICHAEL-D-MAGUIRE I^M FOLLOWING A PATIENT WHO HAS A HISTORY OF MYOPATHY WITH MULTIPLE STATINS BEFORE TRYING HIM ON YET ANOTHER HIS PREFERENCE OR NIACIN I REPEATED CK ISOENZYMES WITH THE FOLLOWING RESULTS TOTAL CK 271 CK BB 0 CK MB 4 CK MM 96 ARE THERE OTHER UNMEASURED SUBFRACTIONS ACCOUNTING FOR THE MISSING 171 WILLIAM R W GOT CUT OFF HE HAD VERY SIMILAR NUMBERS ON 24 NOV 99 WITH A TOTAL OF 233 BB OF 0 MB OF 4 AND MM OF 96 HE^S ALSO HAD AN INCONCLUSIVE MUSCLE BIOPSY THAT^S ALSO IN CHCS FORGET IT GUYS I MUSTA BEEN SMOKING SOMETHING FUNNY WHEN I SENT THIS MESSAGE BUT IT FINALLY HIT ME AS STRANGE THAT THE MB AND MM^S WERE IDENTICAL ON BOTH AND I LOOKED MORE CAREFULLY AND SEE THAT THEY^RE EXPRESSED AS %^S NOT IU^S SO THEY DO ADD UP GLAD I CAUGHT THAT BEFORE YOU TOLD ME OR I^D FEEL EVEN DUMBER! HE^S STILL INTERESTING BOTH BECAUSE OF VERY PROLONGED TIMES TO NORMALIZE AFTER CK^S GO UP AND BECAUSE HIS BROTHER HAS THE SAME PROBLEM RHEUM HAS BEEN INVOLVED AND NOBODY CAN COME UP WITH ANYTHING EXOTIC IT^S JUST TOO BAD HE HAS CAD CAN^T TAKE STAINS OR RESINS AND ALSO IS ALLERGIC TO ASA AND CLOPIDEGREL

)

(CRAIG-M-HUDAK TRY THE NCEP GUIDELINES! IF THESE ARE NOT CLEAR TO YOU PLEASE RESPOND BACK IT^S HARD TO MAKE AN ARGUMENT FOR PHARMACOLOGIC RX IN THIS GUY! IF YOU STRICTLY FOLLOW THE NCEP GUIDELINES AS HE HAS NO RISK FACTORS THE HDL NEGATES AGE SEX THE TARGET LDL IS 160 INITIATING DRUG RX AT 190 AS HIS HDL IS SUPERNORMAL I GUESS HE^S NOT ABUSING ANABOLIC STEROIDS! I THINK I WOULD JUST COUNSEL HIM ON A HEART HEALTHY LIFESTYLE AND SEND HIM ON HIS WAY AND PLAN ON CHECKING A REPEAT LIPID PANEL IN 5 YEARS AS THESE VALUES ARE A LITTLE UNUSUAL YOU MIGHT ALSO CONSIDER CHECKING A REPEAT LIPID PANEL NOW FOR CONFIRMATION WAS THIS ARM PREMATURELY TERMINATEED TACHYPHYLAXIS IS A PROBLEM FOR ALPHA BLOCKERS FO THIS TYPE SO THEY ARE NOT GREAT DRUGS FOR HTN BUT THEIR HEMODYNAMIC PROFILE IS FAVORABLE SUCH THAT THEIR USE WAS EXAMINED IN AN EARLY CHF TRIAL W O BENEFIT BUT W O HARM SO I^M A LITTLE SURPRISED COMMENT ON STATISTICAL SIGNIFICANCE I HAVE A PATIENT A 45 YO HAWAIIAN WOMAN WITH MITRAL STENOSIS WHO WOULD BENEFIT FROM A BALLOON MITRAL VALVULOPLASTY THE BALLOON INVOLVED IS MADE OF LATEX JUST RECENTLY SHE DEVELOPED WHAT SOUNDS LIKE A CONTACT ALLERGY TO LATEX SHE WORKS AS A DENTAL HYGEINIST AND WITH PROLONGED USE OF LATEX CONTAINING GLOVES HYPO ALLERGENIC OR NOT POWDER FREE OR NOT BUT NOT WITH LATEX FREE GLOVES SHE DEVELOPS A RASH ONLY ON HER HANDS NO RASH ELSEWHERE NO BRONCHOSPASM NO HYPOTENSION NO MUCOUS MEMBRANE SX IS PUTTING A LATEX BALLOON IN HER BLOODSTREAM CONTRAINDICATED I WAS WONDERING WHEN YOU GUYS WOULD CHIME IN! I^M AT TRIPLER AND HAVE A LIMITED TIME WINDOW FOR TREATING THIS PATIENT

I^VE HAD INPUT FROM ALLERGY AND DERM UNFORTUNATELY BECAUSE OF PATIENT^S WORK SCHEDULE THEY HAVE NOT FULLY EVALUATED HER SHE UNDERWENT REPEAT TEE WITH A RUBBER TIPPED PROBE YESTERDAY WITH NO UNUSUAL PROBLEMS OTHER THAN ANXIETY ALLERGY RECOMMENDED RAST LATEX BLOOD TESTING WON^T HAVE THE RESULTS PROBABLY UNTIL AFTER THE PROCEDURE THE GENERAL CONSENSUS HERE SEEMS TO BE GO AHEAD AND PROCEED WITH CAUTION AND THE PATIENT HAS BEEN SO INFORMED AND PREMEDICATION WOULD PROBABLY NOT BE USEFUL SHE HAD HER PROCEDURE TODAY I PREMEDICATED WITH SOLUMEDROL AND PO BENADRYL AND TAGAMET AND AVOIDED LATEX AS MUCH AS POSSIBLE SHE HAD AN UNEVENTFUL PROCEDURE THANKS FOR THE HELP! WE ARE MORE THAN HAPPY TO SEE HIM AND CAN CERTAINLY CATH HIM ON THE SAME VISIT PLEASE PROVIDE HIS NAME AND TELEPHONE NUMBER I WILL FORWARD THIS MESSAGE TO THE APRIL CATH FELLOWS AND THEY SHOULD TAKE IT FROM THERE

)

(LARRY-H-WASHINGTON IN GENERAL DO PATIENTS WITH HIGH LDL LEVELS OFFSET BY HIGH HDL LEVELS STILL REQUIRE CHOLESTEROL LOWERING MEDICATION PLEASE PROVIDE REFERENCES AS I HAVE NOT BEEN ABLE TO FIND THE ANSWER TO THIS QUESTION THROUGH MY SOURCES THANKS LARRY H

)

(HARRY-D-MCKINNON DEAR SIR MADAM I HAVE A 60 YEAR OLD MALE THAT I ORIGINALLY SAW FOR COMPLAINT OF ERECTILE DYSFUNCTION HE HAS PAST MEDICAL HISTORY SIGNIFICANT FOR TOBACCO ABUSE 50 PACK YEARS ANXIETY DISORDER PHYSICAL EXAM NORMAL MEDS INCLUDE ASPIRIN 325MG QD MULTIVITAMIN AND SERTRALINE PRN FOR ANXIETY HAS NOT TAKEN IN SEVERAL WEEKS I DID RECOMMENDED LABS FOR ED SCREENING AND HIS PROLACTIN WAS ELEVATED TO 19 4 I DID REPEAT WHICH IS PENDING DO YOU HAVE ANY RECOMMENDATIONS FOR THIS GENTLEMAN WOULD YOU LIKE TO SEE HIM THANKS HARRY MCK

)

(HOWARD-G-OAKS WE WOULD BE PLEASED TO EVALUATE THE PATIENT AND REVIEW THE HISTORY IN GENERAL LOCAL ANAESTHETIC REACTIONS ARE TOXIC REACTIONS RESULTING FROM RAPID DRUG ABSORPTION RATHER THAN AN ANAPHYLACTIC EVENT FROM IGE MEDIATED ALLERGY LARGE LOCAL REACTIONS AND CONTACT DERMATITIS FROM DELAYED TYPE HYPERSENSITIVITY ARE THE PRINCIPAL IMMUNOLOGICALLY MEDIATED REACTIONS FROM LOCAL ANESTHETIC AGENTS THE PERFORMANCE OF SKIN TESTING TO LOCAL ANESTHETICS CAN HELP DETERMINE WHETHER THE PATIENT IS AT HIGHER RISK THAN THE GENERAL POPULATION OF EXPERIENCING AN IGE MEDIATED ADVERSE EVENT ON REEXPOSURE TO THE DRUG YOU COULD HAVE THE PARENTS TO ARRANGE AN APPOINTMENT WITH ME DR H PLEASE HAVE THEM PLAN TO BRING IN WHATEVER DOCUMENTATION OF THE EVENT THEY HAVE OPTIMALLY THE PATIENT SHOULD BE OFF ANTIHISTAMINES FOR AT LEAST THREE DAYS PRIOR TO EVALUATION IN CASE SKIN TESTING IS PERFORMED THANKS HGO

)

(JENNIFER-E-FRANK I SAW A 10 YEAR OLD BOY WITH A SUSPECTED ALLERGIC REACTION TO A TOPICAL ANESTHETIC USED BY HIS DENTIST IT CONTAINED BENZOCAINE IN A POLYETHYLENE GLYCOL BASE DOES HE NEED FURTHER TESTING TO ASCERTAIN PARTICULARLY WHAT COMPONENT OF THE MED HE IS ALLERGIC TO THANKS DR OAKS THANK YOU FOR YOUR RESPONSE I CALLED THE MOM AND ASKED HER TO MAKE AN APPT WITH YOU JENNIFER FRANK

)

(CHRISTOPHER-P-CHENEY NO CHANGES HAVE BEEN MADE BUT I WAS THE ONE WHO GENERATED THE GUIDELINE ALTHOUGHT CISAPRIDE IS ON IT I RARELY USED IT AN NOW DO NOT USE IT AT ALL I DOUBT ACIPHEX WILL GET ON THE FORMULA IN THE NEAR FUTURE ADDITION OF THAT MEDICATION ARE DECIDED CENTRALLY IN SAN ANTONIO I WOULD HAVE A HIGH INDEX OF SUSPICION THAT HE HAS AN UNDERLYING HEPATOCELLULAR CARCINOMA THAT HAS YET TO BE DETECTED BY CT SCAN MY NEXT STEP WOULD BE TO REPEAT AFP IN 3 MONTHS AND IF IT CONTINUES TO RISE CONSIDER AN MRI SCAN WITH GADILLIUM VS REPEAT CT SCAN I NEED TO GET IN TOUCH WITH LTC V DO YOU HAVE IS EMAIL ADDRESS OR PHONE THANKS THANKS FOR THE INFORMATION I AGREE A BARIUM ENEMA WOULD BE OF NO USE TO YOU AT THIS POINT HOWEVER DON^T BE SURPRISED THAT ALL THE POLYPS YOU SAW IN THAT LOCATION TURN OUT TO BE HYPERPLASTIC COL MOSES BRINGS UP A GOOD POINT IN THAT CHEAPEST ALTERNATIVE IS TO HAVE A REPEAT FLEX SIGM WITH BX OF ALL POLYPS HOWEVER HE IS OVER 55 AND A FLEX SIGM IS EQUIVALENT TO A UNILATERAL MAMMOGRAM

)

(JAMES-W-KIKENDALL I DON^T THINK THE GUIDELINES HAVE BEEN REVISED THAT IS A PROBLEM WITH GUIDELINES THEY GO OUT OF DATE FASTER THAN THEY CAN BE WRITTEN AND IT MAY TAKE YEARS FOR EVERYONE IN THE NARMC TO AGREE THEY NEED TO BE REVISED THEN MORE YEARS TO AGREE ON THE REVISIONS I WOULD RELEGATE PROPULCID TO THE GARBAGE HEAP AS FAR AS TREATING GERD GOES ACIPHEX IS

BEING TOUTED AS AN IMPROVEMENT BUT IT IS PROBABLY NOT VERY SIGNIFICANT AS FAR AS REAL CLINICAL RESULTS GO IT WOULD DEPEND ON COST AND WHATEVER THE PHARMACY DECIDED TO MAKE AVAILABLE I DON^T HAVE A LOT OF INFORMATION ON ACIPHEX
)
(DOMINIQUE-M-TOEDT I^D LIKE TO KNOW A FEW THINGS 1 ARE THERE ANY CHANGES TO THE NARMC GERD CPG 2 IS PROPULCID STILL SECOND LINE GIVEN THE COMPANY HAS STOPPED PROMOTING IT DUE TO PROVIDERS NOT PAYING ATTENTION TO EKG AND DRUG INTERACTIONS 3 HAVE YOU CONSIDERED ACIPHEX AS AN ALTERNATIVE TO PRILOSEC 40MG NO ANSWERS HI CPK COULD INDICATE A ACQUIRED MUSCLE ENZYME DEFICIENCY WOULD REFER TO RHEUM FOR BIOPSY FOR THAT BUT I DON^T THINK THAT EXPLAINS MEMORY I WOULD SEND TO PSYCH FOR PSYCHOMETRIC TESTING ALSO CONSIDER SLEEP APNEA AS ETIOLOGY I HAVE A 43 YO WF S P THYROIDECTOMY 1994 FOR PAPILLARY FOLLICULAR THYROID CA HAS BEEN ON SUPPRESSION TX HER CURRENT DOSE IS 4 MG HER TSH=< 5 FT4=2 78 HI IS THIS TARGET OR IS SHE ON A BIT TOO MUCH THE SLEEP LAB AT WRAMC IS SUN BY PULM IF ON YOUR FIRST ATTEMPT YOU DID CONSULT TO S SLEEP STUDY TRY S PULM OR HAVE PT CALL IF SHE^S NOT ACTIVE DUTY SHE MAY GET REFERRED OUT I HAVE HAD SEVERAL PTS GO TO THE WASH SLEEP CENTER HOWEVER IF SH^E HAVING TO TAKE AMBIEN THEN HER PROBLEM SOUNDS LIKE INSOMNIA AND YOU CAN^T DO A SLEEP STUDY ON SOMEONE WHO DOESN^T SLEEP IF CLINICALLY INDICATED TRY NEURO OR PSYCH
)
(JOHN-P-DEUEL DEAR SIRS I HAVE A 53 YO MALE PT WHO HAS RECENTLY RETURNED FROM EAST TIMOR AND WAS FOUND TO HAVE AN ASYMPTOMATIC INFECTION WITH E HSTOLITICA ON 2 SUCCESSIVE ROUTINE STOOL CULTURES I AM INQUIRING RE TREATMENT OPTION WITH IODOQUINOL 650 TID FOR 20 DAYS THIS DRUGS POTENTIAL SIDE EFFECTS OR OPTION FOR NONTREATMENT JOHN D
)
(DAVID-R-POLLY AGREE THAT HE SHOULD BE SEEN)
(KATHLEEN-A-MCHALE SURE WOULD LOVE TO SEE HIM)
(JOHN-N-SPAIN SIR WILL THEY HAVE AN APO ADDRESS WILL THEY BE LOCATED AT THE EMBASSY COMPOUND ARE THEY > 65 YEARS OLD SEVERAL POSSIBILITIES BASED ON ANSWERS SIR SIR THE NATIONAL MAIL ORDER PHARMACY ONLY MAILS TO STATESIDE ADDRESSES OR APO SO THAT OPTION IS OUT IF THEY DO GET AN APO THAT OPTION WILL BE AVIALABLE SINCE THEY ARE UNDER 65 ONE OPTION IS TO HAVE ANOTHER PERSON BACK IN THE STATES DROP OFF AND PICK UP THEIR RXS AND MAIL TO THEM THIS REPRESENTATIVE WOULD HAVE TO HAVE A COPY OF EACH ID CARD AND A STATEMENT SIGNED BY THEM SAYING THERE AUTHORIZED TO PICK UP THE RXS THIS IS THE OPTION I THINK THEY WILL HAVE TO GO WITH I DON^T KNOW IF THEY CAN WORK OUT SOMETHING WITH THE LOCAL EMBASSY THE PENTAGON PHARMACY DOES ASSIST MEMBERS WORKING AT THE EMBASSY HOWEVER THEY ARE NOT EMPLOYEES SO I DON^T KNOW HOW MUCH LUCK THEY WILL HAVE
)
(AMIR-E-HARARI I WILL CONTACT THE PT AND SEE HER ON MONDAY OR TUESDAY AMIR HARARI
)
(JOHN-A-BIGBEE I SAW A |47Y| O FEMALE IN CLINIC YESTERDAY FOR THE FIRST TIME SHE HAD BEEN SEEN BY ANOTHER HCP HERE ON 2 18 00COUGH PARESTHESIAS IN FINGERS AND PAIN IN HANDS A CHEST X RAY WAS ORDERED ON 2 18 0 AND READ AS SHOWING DEVIATION OF THE TRACHEA TO THE LEFT IN THE UPPER THORAX DR PONTIUS RECOMMENDED CT OF CHEST YESTERDAY THE PATIENT WAS CONCERNED ABOUT AN ACUTE ONSET FULLNESS IN THE RIGHT SIDE OF HER NECK ANTERIORLY WHICH HURTS WHEN SHE COUGHS SHE HAS AN ENLARGED RIGHT LOBE OF THE THYROID IN MY OPINION OF SUDDEN ONSET THE MASS IS SENSITIVE BUT NOT VERY TENDER BLOOD WORK ORDERED ON 2 18 0 SHOWS A TSH OF 1 75 AND FREE T4 OF 0 84 CBC SHOWS A WBC=3 9 HGB=12 2 HCT=36 4 P1 P2 AND P3 ARE NORMAL I ORDERED AN US AND THE CT RECOMMENDED COULD YOUR CLINIC ARRANGE AN APPOINTMENT FOR THIS PATIENT THANKS FOR THE QUICK RESPONSE I HAVE BEEN SEEING A PATIENT FOR SEVERAL MONTHS AND NEED YOUR ASSISTANCE IN MANAGEMENT MY CONCERNS ARE ABOUT A RAPID WEIGHT GAIN WITH A HABITUS VERY SUGGESTIVE OF CUSHINGS SYNDROME HE IS DIABETIC IN POOR CONTROL AND HYPERTENSIVE ALSO WITH POOR CONTROL I HAVE ORDERED 24 HOUR CORTISOL AND CREATININE AND RANDOM SERUM CORTISOL IS THERE POSSIBILITY YOU COULD SEE THIS PATIENT THANKS FOR THE SWIFT RESPONSE I SAW A |19Y| O MALE TODAY WITH SIGNIFICANT GYNECOMASTIA BILATERALLY HAS HAD THIS FOR YEARS BUT NEVER ADDRESSED REGARDING POSSIBLE TREATMENT DOES YOUR SEE DEPENDENTS FOR POSSIBLE BREAST REVISION REDUCTION WITH THIS DIAGNOSIS THE PROBLEM IS A PROBLEM TO THE PATIENT I HAVE SEEN A |73Y| O MALE RECENTLY WHO WAS GIVEN A PUNCH BIOPSY AT THE VAC DERMATOLOGY DEPARTMENT THE PATIENT STATES IT WAS DONE TO RULE OUT CANCER WHEN I SAW HIM FOR THE FIRST TIME HE HAD A LARGE ERYTHEMATOUS AREA WITH ULCERATION CENTRALLY I

GAVE HIM ANTIBIOTICS AND DOME BURROW SOAKS AND ADIVESED HIM TO CONTACT THE DERMATOLOGIST OF RECORD THE DERMATOLOGY DEPARTMENT AT THE VAC IS CLOSED UNTIL 21MARCH THIS INFECTIOUS PROCESS IS NO BETTER BUT NO WORSE IN MY OPINION WOULD THERE BE ANY POSSIBILITY YOUR CLINIC SEE HIM BEFORE THE 21ST THANKS FOR THE SWIFT REPLY I^LL CONTACT THE PATIENT TO SEE IF HE CAN GET THE BIOPSY REPORT I AM SEEING A PATIENT WHO IS FOLLOWED IN RHEUMATOLOGY AT WRAMC HE IS ON METHOTREXATE FOR RA AS PART OF EVALUATION FOR A LOW ALBUMIN WITH FEVER OR LOSS HE HAS BEEN FOUND TO HAVE A IGG LAMBDA MONOCLONAL GAMMOPATHY HE IS NOT ANEMIC IS THERE ANYTHING WHICH NEED BE DONE FURTHER FOR THIS FINDING I THINK HE IS DUE A RHEUMATOLOGY FOLLOW UP NEXT MONTH THANKS FOR YOUR ASSISTANCE JOHN ROB PERHAPS IT MIGHT BE BETTER IF YOU COULD SEE MR JACOBS AND GET THE ABOVE TESTS SUBMITTED DOWN THERE HAVING SEEN HIM ALREADY AND WITH HIM DUE IN SOON TO YOUR CLINIC THAT MIGHT BE BEST LET ME KNOW IF YOU NEED A CONSULT SUBMITTED FOR THE TRICARE WICKETS THANKS FOR YOU BOTH FOR YOUR SWIFT RESPONSES I HAVE SEEN A |39Y| O FEMALE A FEW TIMES SINCE 8 99 FOR PERSISTENT FATIGUE WHICH IS HAVING SOME EFFECTS ON HER ADLS HER PHYSICAL EXAM IS NOT REVEALING SIGNIFICANT ABNORMALITIES HER LAB DATA SHOW A NORMAL FBS NORMAL TSHX3 NORMAL T3 AND LOW FREE T4 X3 TC IS 236 TG 331 HDL 48 AND LDL 122 SHE IS NOT ANEMIC AND HAS HAD HAD FLUCTUATING ALT LEVELS WITH A NEGATIVE CHRONIC HEPATITIS PANEL STRESS AND DEPRESSION COULD CERTAINLY BE FACTORS BUT IS THERE ANY RECOMMENDATION REGARDING THE FREE T4 FINDINGS THANKS FOR YOUR ASSISTANCE THANKS FOR YOUR ADVICE IF YOU CAN REVIEW THE LABS TO DATE HAVE A GOOD WEEKEND I HAVE GIVEN THIS APTIENT A CONSULT AS RECOMMENDED COULD YOUR RECEPTIONIST CALL HER THANKS FOR YOUR HELP THANKS AGAIN FOR YOUR ASSISTANCE
)
(GREGORY-J-DENNIS THE RATIONALE BEHIND SCREENING TESTS IS THAT IF ANY OF THEM ARE POSITIVE FURTHER EVALUATION SHOULD BE PERFORMED IN ORDER TO ATTEMPT TO CONFIRM A SPECIFIC DIAGNOSIS RAYNAUDS PHENOMENON IS A CLINICAL SIGN THAT SERVES AS A HARBINGER OF A IMMUNOLOGIC DYSFUNCTION MOST OFTEN ASSOCIATED WITH THE CONNECTIVE TISSUE DISEASES THE PRESENCE OF A POSITIVE ANA IN THIS INDIVIDUAL WARRANTS ADDITIONAL SEROLOGICAL EVALUATION PRIMARILY FOR PROGNOSTICATION AND PATIENT EDUCATION WE WILL BE HAPPY TO ASSIST WITH BOTH THANK YOU FOR THE REFERRAL WE WILL REVIEW OUR CLINIC FILE AND GET BACK TO YOU SHORTLY HIS PSORIASIS MUST BE PRETTY BAD IF IT MAKES HIM UNFIT REMEMBER WHILE THERE ARE MANY PHYSICAL CONDITIONS LISTED IN AR 40 501 ALL MAY NOT REQUIRE AN MEB FOR REFERRAL TO THE PHYSICAL EVALUATION BOARD PEB WHERE FITNESS OR IS DETERMINED UNDER THE AUTHORITY OF THE U S ARMY PHYSICAL DISABILITY AGENCY IN THE ABSENCE OF SYMPTOMS THAT INDICATE IMPAIRMENT FROM PSORIATIC ARTHRITIS IT IS NOT NECESSARY TO FUNCTIONALLY RESTRICT HIS ACTIVITIES UNLESS YOU PERCEIVE THAT HE OR OTHERS ARE AT RISK FOR INJURY JEFF WHEN YOU SAY RHEUMATOLOGIC ARE YOU USING THAT TO DESIGNATE INFLAMMATORY CAUSES POINT BEING WE EVALUATE MANY NONINFLAMMATORY CAUSES AS WELL PERHAPS WE CAN REVIEW OUR LITERATURE TO SEE IF WE CAN IDENTIFY ALTERNATIVES OTHER THAN STEROIDS
)
(JON-D-ROEBUCK MEASURES TO AVOID COLD INDUCED VASOSPASM ARE CERTAINLY A GOOD START IF THIS SOLDIER HAS ANY OTHER FEATURES TO SUGGEST A SYSTEMIC INFLAMMATORY CONDITION IE RASH MUCOSAL SORES ARTHRITIS SICCA SYMPTOMS ETC SPECIFIC ANTIBODY TESTING TO INCLUDE ANA TITER DOUBLE STRANDED DNA AND EXTRACTABLE NUCLEAR ANTIGENS WOULD BE INDICATED URINALYSIS SHOULD BE DONE IF NOT ALREADY TO SCREEN FOR PROTEINURIA OR ACTIVE SEDIMENT IN ANY EVENT WE WOULD BE HAPPY TO EVALUATE HER HERE AT WALTER REED THERE ARE ACTIVE DUTY SLOTS AVAILABLE NOW IF YOU WOULD LIKE TO ENTER A CONSULT THANKS CHRIS WILL PUT THIS IN THE SAVE MAILBOX AND HOPEFULLY LONG TERM MEMORY I BELIEVE THAT AS LONG AS HE CAN FUNCTION IN HIS MOS WITH STANDARD TREATMENT MEASURES THAT HE CAN STILL BE CLEARED FOR DUTY I WILL VERIFY THIS WITH SENIOR STAFF IN THE DEPARTMENT AND LEAVE AN ADDITIONAL MESSAGE JON
)
(KATHIE-D-MCCROARY I SAW A PT WHO C O BILATERAL PAIN COLD WHITE FINGERS AND TOES EPISODES ARE TRIGGERED BY COLD BUT ALSO OCCUR WHEN NOT COLD OR NOT UNDER EMOTIONAL SRESS I DID THE LABS SUGGESTED FOR RAYNAUD^S BY GRIFFITHS CBC ESR RF ANA ALL WERE WNL EXCEPT A POS ANA THIS IS A 31 YR OLD AD FEMALE THE PRIMARY REASON FOR HER VISIT WAS NON SPECIFIC GI COMPLAINTS SHE HAD BEEN ON 6 CONSECUTIVE COURSES OF ABX FOR VARIOUS COMPLAINTS STREP X 2 UTI BACTERIAL VAGINOSIS HER BOWEL COMPLAINTS WERE IMPROVING AFTER A WEEK OF BENTYL OTHERWISE THIS PT IS HEALTHY WITH NO OTHER MEDICAL PROBLEMS I KNOW THAT THE ANA IS A NON SPECIFIC TEST BUT NOW THAT I GOT IT I JUST WANTED TO MAKE SURE THAT THERE IS NOTHING ELSE THAT I NEED TO DO I CONSULTED WITH OUR CLINIC INTERNAL MED DOCTOR SHE ADVISED THAT NO FURTHER WORK UP IS

NEEDED OTHER THAN COUNSELING THE PT TO PROTECT HER EXTREMITIES FROM THE COLD I JUST WANTED TO SEE IF YOU CONCUR THANKS MAJ MY FNP THANK YOU FOR YOUR PROMPT AND INFORMATIVE RESPONSES I REALLY APPRECIATE THE GUIDANCE I WILL GIVE THE PATIENT A CONSULT MAJ MCCROARY I AM AN FNP I SAW A 29 YR OLD AD MALE 2 WEEKS AGO WHO C O A LUMP ON HIS CHEST HE HAD BEEN SEEN AT A CIVILIAN ER ONE DAY PRIOR FOR THE SAME COMPLAINT HE WAS DC^D W O A DX AND REFERRED TO HIS PCM WHEN I SAW HIM HE HAD A SMOOTH MOBILE PAINLESS 3IN X 3IN SOLID FEELING MASS BEHIND THE AREOLAR REGION ON HIS R CHEST HE HAD NO FEVER PAIN ERYTHEMA ETC HE DENIED THE USE OF MEDS RX OTC OR SUPPLEMENTS I DIDN^T SPECIFICALLY ASK RE RECREATIONAL DRUGS PMH NEG OTHER THAN CHRONIC MUSCULOSKELETAL COMPLAINTS FOR WHICH HE IS CURRENTLY UNDERGOING A MED BOARD FOR I SENT HIM TO RAD FOR AN ULTRASOUND THE REPORT SAID DENSE TISSUE RAD THEN DID A BILATERAL MAMMO WHICH SHOWED GYNECOMASTIA R > L SINCE I HAVE NEVER MANAGED AN ADULT MALE WITH GYNECOMASTIA I LOOKED UP THE RECOMMENDED W O IN GRIFFITHS 5 MIN CONSULT IT STATES LAB EVAL IS RARELY NEEDED HOWEVER BHCG TESTOSTERONE LH ESTRADIOL PROLACTIN LFTS TSH CHROMOSOMAL STUDIES MAY BE INDICATED I HAVE REASON TO SUSPECT THAT RECREATIONAL DRUG USE MAY BE A FACTOR SINCE HE IS BEING ALLOWED TO GO TO A CIVILIAN SCHOOL WHILE UNDERGOING A MEB WITH ONLY PHONE CONTACT TO HIS UNIT AND LIVES IN BALTIMORE HE ALSO HAS VERY DIFFICULT TO TRACK DOWN HE LIVES WITH HIS MOTHER I HAVE CALLED THE RESIDENCE SEVERAL TIMES HE HAS NOT BEEN HOME FOR >5DAYS AND HIS MOTHER HAS NO IDEA WHERE HE IS MY QUESTION TO YOU IS WHAT IF ANY OF THE ENDOCRINE RELATED TESTS ARE APPROPRIATE SHOULD I SEND HIM TO YOU BEFORE OR AFTER THE RESULTS ARE IN AND SHOULD I HAVE HIS UNIT DO A DRUG SCREEN ON HIM ANY HELP IS APPRECIATED MAJ M THANKS FOR THE ASSISTANCE MAJ MCCROARY
)
(SUSAN-G-DUNLOW COL ARMSTRONG IS HERE WITH ME RE&I SUBSPECIALIST RECOMMENDS SHE GOES TOMED ENDOCRINE TO HAVE HER CHOL ISSUES ADDRESSED PRIOR TO ANY REFERRAL TORE&I I WOULD NOT HESITATE TO PUT HER ON CYCLIC PROGESTERONE THERAPY I WOULD USE 5 10 MG PROVERA ON DAYS 1 12 OF EACH MONTH
)
(THOMAS-G-OLIVER PLEASE SUPPLY A PHONE NUMBER OR PAGER WHICH DOES NOT DOUBLE AS A FAX I WOULD BE HAPPY TO CHAT ABOUT THIS PATIENT THANKS TOM I HAVE REPLIED TO THE CURRENT QUESTION NO FURTHER REPLIES ARE NECESSARY SHE WILL CALL AGAIN WITH ADDITIONAL QUESTIONS THANKS I WILL FORWARD THIS TO THE PEDS ENDO TEAM THANKS IF THIS LADY LANDED IN OUR LAP WITH THE FOLLOWING STUDIES IT WOULD MAKE OUR LIVES EASIER SERUM B 12 FOLATE HOMOCYSTEINE METHYLMALONIC ACID URIC ACID 25 & 1 25 VIT D URINE CALCIUM PO4 CREA PROTEIN URIC ACID UREA NITROGEN CORTISOL UPEP 24HR STUDY PLEASE STOOL CULTURE WBC FAT PROBABLY ALSO WOULD LIKE TO SEE PT PTT PREALBUMIN DEPENDING ON WHY SHE HAD ULCER DISEASE MIGHT INCLUDE AN H PYLORI IGG I^M GUESSING IF SHE IS ON A RESIN THAT YOU HAVE A LIPID PANEL THANKS TOM
)
(KATHRYN-N-COSTELLO IN PROCESS OF INITIAL INFERTILITY EVAL IN 26 YR OLD PRESUMED ANOVULATOY OLIGOMENORRHEIC MILDLY OVERWT 170 5 FT 7 IN CHOLESTEROL NOTED TO BE 321 HDL 41LDL 250 TRIGLYCERIDES 148 SMOKES 1 PPDTO KEEP THE REST OF HX BRIEF ALL OTHER LABS AND EXAM WNLSHE OBVIOUSLY NEEDS TO STOP SMOKING REDUCE WT BUT HOW WOULD YOU ADDRESS THE CHOLESTEROL IN ONE WHO IS ANXIOUS TO CONCEIVE STATINS ARE CONTRAINDICATED INPREGNANCY SO IS A TRIAL OF CLOMID OUT COULD SHE TAKE CLOMID AND DELAY RX OFCHOLESTEROL FOCUS ON CHOLESTEROL AND ADDRESS INFERTILITY AT A LATER DATE BUT THE CHOLESTEROL WILL PROBABLY REQUIRE LONG TERM RX SHE PROBABLY FITS PICTURE OF PCO SYNDROME TO A THANK YOU IN ADVANCE FOR YOUR INPUT KATHY COSTELLO NURSE PRACTITIONER OK I AGREE NEEDS MED F U PRIOR TO PURSUE INFERTILITY BUT WHAT DO YOU FOLKS DO WITH LADIES WITH SUCH HIGH LDLS WHO REQUIRE RX WHICH IS CONTRAINDICATED WITH PREGNANCY K COSTELLO
)
(DENNIS-S-PEPPAS I WOULD LIKE TO SEE THIS CHILD FOR A POSSIBLE ORCHIOPEXY THANKS D P TASHA PLEASE CALL THE PARENT AND SCHEDULE AN APPOINTMENT WITH ME THANKS
)
(JACOB-W-AARONSON PT IS A 4 Y O MALE WITH FOLLOWING EXAM RIGHT TESTICLE NORMALLY DESCENDED LEFT TESTICLE JUST BARELY PALPABLE AT OPENING OF INGUINAL CANAL BUT DEFINATELY PALPABLE AND NORMAL IN SIZE AND TEXTURE CREMASTERIC REFLEX WAS VERY STRONG AND TESTICLE WOULD EASILY DISAPPEAR INTO CANAL WITH PALPATION MOTHER STATES THIS HAS BEEN ADDRESSED IN THE PAST BUT NO FURTHER W O HAS OCCURRED IS THERE ANY CONCERN THANK YOU JACOB AARONSON THANK YOU SO MUCH FOR YOUR RESPONSE I WILL PUT IN AN OFFICIAL CONSULT BUT YOU CAN CALL THE PATIENT^S MOTHER IF THAT IS BETTER FOR YOU

THANKS AGAIN LET ME KNOW THE OUTCOME PLEASE SO I CAN GET A FEEL FOR WHAT IS AN APPROPRIATE CONSULT JACOB A I AGREE I WILL EMAIL YOU FROM NOW ON AS I HAVE IN THE PAST PT IS A 3 Y O MALE WITH DANDY WALKER SYNDROME DX^D AT BIRTH WITH NO APPARENTSIGNIFICANT FINDINGS OTHERWISE HE HAS A MILD SPEECH DELAY THAT IS BEINGADDRESSED ON ROUTINE EXAM PARTIALLY AT MOTHER^S CONCERN FOR A FUNNYLOOKING BACK THERE IS A RIGHT SIDEBENT SACRUM WITH A GENTLE RIGHT LATERALCURVE UP TO THE LOWER MID THORACIC WHERE THERE IS A RATHER SHARP CURVE TO THE RIGHT WITH COMPENSATION IN THE UPPER THRORACIC AND C SPINE NO OTHER OBVIOUS REMARKABLE FINDINGS MOTHER STATES THAT HE IS NORMALLY ACTIVE AND DOES NOTC O PAIN USUALLY THOUGH WHEN HE OCCASIONALLY DOES MOTHER CAN^T DETERMINE WHERE HE IS NORMALLY COOPERATIVE FOR A 3 Y O BUT EXAM WAS PRETTY MUCH LIMITED TO A STRUCTURAL EXAM ANY SUGGESTIONS FOR NECESSARY WORK UP IMAGING IS THERE A CORRELATION WITH DANDY WALKER SYNDROME SHOULD HE BE SEEN BY PEDSORTHO WOULD APPRECIATE ANY INPUT JACOB A FAMILY MEDICINE THANK YOU FOR YOUR RESPONSE I WILL CONTACT MOTHER AND PUT A REFERRAL INTO THE SYSTEM IN CASE YOU WOULD LIKE TO CONTACT HIS MOTHER HERE IS THE NECESSARY INFO I APPRECIATE YOU SEEING HIM LET ME KNOW WHAT YOU DECIDE TO DO I RECENTLY PERFORMED A FLEX SIG ON A 55 Y O MALE NON SMOKER OTHERWISE HEALTHY FINDING 4 WIDE BASED MUCOSAL COLORED POLYPS AT 15 CM THE PATIENT WAS UNABLE TO TOLERATE SCOPE PASSAGE BEYOND 35 CM THE LARGEST POLYP WAS BIOPSIED AFTER ATTEMPTS WERE MADE AT THE MUCH SMALLER OTHERS BIOPSY WAS RETURNED AS HYPERPLASTIC WHAT WOULD RECOMMEND AT THIS POINT SHOULD A BE BE PERFORMED OR A COLONOSCOPY WOULD APPRECIATE ANY INPUT JACOB THANK YOU FOR YOUR RESPONSES I FAVORED COLONOSCOPY IN THE FIRST PLACE BUT I WANTED TO MAKE SURE IT WAS AN APPROPRIATE REFERRAL THANKS FOR THE RESPONSES PT IS A 55 Y O FEMALE NOT ON HRT WITH ONE EPISODE OF VAGINAL BLEEDING FOR 7 DAYS FOR THE FIRST TIME AFTER MENOPAUSE 4 YEARS AGO US SHOWED NORMAL ENDOMETRIAL STRIP 3 4MM EXCEPT IN THE REGION OF THE FUNDUS WHERE THERE WAS A HETEROGENEOUSLY SLIGHTLY HYPERECHOIC REGION MEASURING A MAXIMUM OF 1 5 CM THIS EITHER REPRESENTS A SUBMUCOSAL FIBROID OR THICKENING OF THE ENDOMETRIUM DISTINCTION BETWEEN THESE POSSIBILITY IS NOT CLEAR NEAR THE SUPERIOR POSTERIOR ASPECT OF THE REGION OF THE ENDOMETRIAL CAVITY THERE IS A FOCAL HYPERECHOIC NODULAR STRUCTURE MEASURING 7 MM IN SIZE ON TRANSVERSE IMAGE THIS APPEARS EITHER AT THE PERIPHERY OF THE ENDOMETRIAL CAVITY OR IMMEDIATELY ADJACENT TO IT AND COULD THEREFORE REPRESENT A SUBMUCOSAL FIBROID VERSUS FOCAL ENDOMETRIAL LESION EMB SHOWED ^FRAGMENTS OF BENIGN ENDOMETRIAL GLANDS AND STROMA^ IS THIS WORK UP COMPLETE CAN I ATTRIBUTE EPISODE OF BLEEDING TO A PROBABLE FIBROID OR SHOULD I HAVE HER SEE A GYNECOLOGIST I WOULD APPRECIATE YOUR INPUT JACOB AARONSON DO THIS DOES HELP I ALWAYS WANT TO DO WHAT I CAN WITHIN THE PRIMARY CARE AND REFER APPROPRIATELY I WILL REFER HER TO GYNECOLOGY THANK YOU

)

(JOHN-D-CASLER AN ENT CONSULT WOULD CERTAINLY BE REASONABLE SHE COULD BE SEEN AT KACC HOW DO YOU KNOW SHE HAS STENOSIS OF HER SALIVARY DUCTS DID SHE HAVE ASIALOGRAM THIS IS OFTEN ASSOCIATED WITH RHEUMATOLOGIC CONDITIONS HAS THATBEEN ADDRESSED THANKS AN ENT REFERRAL WOULD BE HELPFUL THANKS

)

(DANIEL-R-FISK THIS SIZE ENDOMETRIAL STRIPE IS NOT NORMAL IN THIS AGE RANGE AND WILL REQUIRE FURTHER INVESTIGATION BEYOND EMB EVEN PLEASE DO SEND HER TO US AT HER EARLIEST CONVENIENCE AND THANKS FOR THE REFERRAL DO YOU NEED PHONE NUMBERS AGREE WITH ABOVE LIBIDO IS MORE THAN A QUESTION OF TESTOSTERONE LEVELS AND SUPPLEMENTS I BELIEVE IT HAS MUCH MUCH MORE TO DO WITH THE STRENGTH OF THE RELATIONSHIP AND OTHER LIFE FACTORS THAN ANY HORMONAL LEVELS EVER WILL A BAND AID SOLUTION TO A MUCH DEEPER PROBLEM IN MY BOOK

)

(CAROL-C-GIBSON I HAVE A 73 YO F WHO HAD AN ENDOMETERIAL BX DONE LAST YEAR FOR AN ENDOMETERIAL STRIPE THAT MEASURED 1 5CM EMB WAS WNL PT HAD ANOTHER SONO DONE THIS YEAR TO EVAL AND MEASURE THE ENDOMETERIAL STRIPE AND IT MEASURRED 1 3CM WOULD LIKE TO SEND THIS PT FOR ANOTHER EMB BUT WOULD LIKE TO KNOW WHETHER OR NOT IT IS INDICATED OVARIES WERE NOT VISUALIZED ON SONO BUT BOTH ADNEXA WERE UNREMARKABLE AS PER SONO REPORT PLEASE GIVE YOUR OPINION ALSO HOW LONG SHOULD A POST MENOPAUSAL PT STAY ON ESTRATEST THERE ARE SOME PTS WHO HAVE BEEN ON IT FOR ATLEAST 6 MONTHS TO A YEAR WOULD LIKE TO KNOW THE ANSWER TO THIS BECAUSE I THOUGHT IT WAS FOR SHORT TERM USE ANY OTHER SUGGESTIIONS FOR HELP IN PTS COMPLAINTS OF DECREASED SEXUAL LIBIDO I HEARD THAT WELLBUTRIN SP WAS A MEDICATION THAT COULD HELP WITH INCREASING SEXUAL LIBIDO THE DRUG THAT IS USED FOR DEPRESSION BUT WOULD LIKE TO KNOW OF ANY GENERAL INTERVENTIONS ANY HELP THAT YOU COULD GIVE ME WOULD BE

GREATLY APPRECIATED THANKS THANKS FOR RESPONDING I WILL TELL THE PT THAT SHE WILL HAVE TO BE SEEN I HAVE THE PHONE NUMBERS PT CONTACTED TODAY AND SHE WILL MAKE AN APPT HER NAME IS ROSELLA CRANE 30 724 DR FISK WHAT ABOUT MY OTHER QUESTION THANKS
)
(CHRISTOPHER-T-PARKER A RHEUMATOLOGIST THE DDX FOR MIGRAINE HEAD PAIN IS LARGE AS IS SOB WITH CHEST PAIN AND INCLUDES ALL OF THE COMMON ETIOLOGIES AND THOSE WITH AUTOIMMUNITY RHEUMATOLOGY SUPPORT IS DESIGNED TO ANSWER THE LATTER AND IS A SUBSPECIALTY OF MEDICINE DUE TO THE FREQUENCY OF THE FORMER ESPECIALLY GIVEN THE COMPLEXITY OF THIS TYPE OF PATIENT ANY TIME YOU ARE FACED WITH THIS CHALLENGE WE ARE EASILY REACHED BY CALLING AND SAYING YOU ARE DR X AND WOULD LIKE TO SPEAK TO THE ROC RHEUMATOLOGIST ON CALL ASSESSMENT OF THE POTENTIAL FOR NEUROLOGIC INJURY IS ESPECIALLY IMPORTANT IN PATIENTS WITH ADVANCED RA REQUIRING GENERAL ANESTHESIA BECAUSE OF THE RISK OF CERVICAL CORD COMPRESSION DURING INTUBATION PLAIN LATERAL RADIOGRAPHS OF THE CERVICAL SPINE WITH VIEWS TAKEN IN FLEXION AND EXTENSION ARE USED TO ASSESS THE DEGREEE OF INSTABILITY OPERATIVE STABLIIZATION OF THE CERVICAL SPINE SHOULD BE DONE TO MINIMIZE THE RISK OF IRREVERSIBLE PARALYSIS REGARDLESS OF WHETHER NEUROLOGIC SIGNS OR SYMPTOMS ARE PRESENT IN PATIENTS WHO HAVE AA SUBLUXATION AND A POSTERIOR ATLANTO ODONTOID INTERVAL OF 14MM OR LESS BASILAR INVAGINATION OF 5MM OR MORE AND >8MM IN THE ANTERIOR AA INTERVAL FROM RHEUMATOLOGY MSKAP AND BODEN SD SPINE 1994 19 2275 80 I REMEMBER IT AS 9 5=14 ALL THE IMPORTANT NUMBERS ARE THERE TO RHEUM AND PM AND R AGREE WITH DR OGLESBY AND DR DENNIS^ QUESTION WE ARE INFREQUENTLY A INVOLVED AS THE FIRST ECHELON OF DX TX FOR ACUTE LOW BACK PAIN IN NEW PATIENTS WE DO FREQUENTLY DEAL WITH ACUTE LBP OF MECHANICAL ETIOLOGIES WITHIN OUR PATIENTS WITH INFLAMMATORY OR NONINFLAMMATORY DISEASES WITH DO NOT NECCESSARILY INVOLVE THE SPINAL JOINTS EXCLUDE THOSE THAT DR OGLESBY MENTIONED
)
(ARLENE-E-GEORGE WHT SHOULD I LOOK FOR IN A PATIENT WITH LUPUS WITHINCREASING FREQUENCY OF MIGRAINE HA WITH SOB NECK AND CHEST PAIN CXR CBC AND P1 WERE NORMAL NO THIS WAS MEANT FOR RHEUM 30 Y FEMALE WITH 12YR HISTORY OF DRY MOUTH WITH STENOSIS OF SALIVARY DUCTS WHAT DO YOU RECOMMEND I TRY AS CONSERVATIVE MANAGEMENT IS THIS ANADDRESSED BY ENT SHE WAS EVALUATED BY A DENTIST I AM WORKING HER UP FOR SJOGRENS SLE ARE THERE ANY CONTRAINDICATIONS TO ASTHMA AND DVTS WITH THE ANTHRAX VACCINE NO
)
(CHARLES-A-KELLY IF THE PAINS ARE INDEED PAROXYSMAL AS YOU HAVE DESCRIBED A TRIAL OF OTHER ANTI EPILEPIC MEDS IS WARRENTED WOULD CONSIDER TEGRETOL 200 MG INCREASING EVERY TWO WEEKS TO 200 400 TID OR DILANTIN 100 BID R TID IF THIS FAILS YOU CAN REFER THE PATIENT TO ME CHUCK KELLY NEUROPHYSIOLOGY STAFF
)
(ROBERT-L-GAUER I HAVE A PT WITH SEVERE SHOOTING LEG PAIN FROM HIS DIABETES HE HAS TRIED GABAPENTIN AND TCAS ANY OTHER THOUGHTS
)
(JON-B-WOODS CHILDREN ON HIGH DOSE CORTICOSTEROIDS GREATER THAN 2MG KG DAY OF PREDNISONE EQUIVALENT FOR A CHILD <10KG OR GREATER THAN 20MG DAY FOR A HILD>10KG ONCE OFF STEROIDS FOR 2 WEEKS IT IS PROBABLY SAFE AND EFFECTIVE TO GIVE THE VACCINE SEE THE 1997 REDBOOK REPORT OF THE COMMITTEE OF INFECTIOUS DISEASES OF THE AAP
)
(PRAKASH-D-ADAWADKAR THIS IS A 6 YR OLD MALE WHO PRESENTED FIRST TIME WITH STREP THROAT IN 5 6 DAYS HE PRESENTED WITH PURPURA ON LOWER EXT DX HSP HE WAS TREATED WITH STEROIDS 2NDARY TO BLOOD IN THE STOOLS HIS UA WAS ALWAYS NL AFTER 2 WEEKS HE WAS COMPLETELY RECOVERED LAST WEEK HE DEVELOPED URI SX TODAY HE STARTED WITH PURPRIC RASH AGAIN THIS TIME IT IS MILDER THAN BEFORE MOTHER WANTS TO GIVE HIM VARICELLA IMMUNIZATION SINCE IT IS ALIVE ATTENUETED VIRAL VACC I WOULD LIKE TO KNOW HOW TO RESPONCE TO THIS PT NEVER HAD VARICELLA AS PER M0M 1 TO OBTAIN VARICELLA TITER 2 TO GIVE HIM VARICELLA VACC 3 IF OK TO GIVE VACCINE WHEN IT IS SAFE 4 OTHER THANKS
)
(ANN-M-MARINI I WOULD LIKE TO KNOW WHETHER SHE HAS A HISTORY OF MIGRAINE COMPLICATED HOW LONG SX LAST NEUROLOGICAL EXAMINATION STROKE RISK FACTORS AND MORE DETAILED HISTORY I WOULD SUGGEST THAT SHE NEEDS TO BE SEEN IN NEUROLOGY PLEASE LET ME KNOW IF YOU WOULD LIKE US TO SEE HER I WILL SEE HER ON MONDAY I ALREADY CALLED HER AND SCHEDULED AN APPOINTMENT SHE WAS ADMITTED TO NEUROLOGY IN JAN 1999 ALSO SHE SAID THAT SHE HAS HAD THESE EPISODES SINCE 1982 NO STROKE ON HER CT SCAN UNCLEAR WHAT THESE EPISODES

ARE DUE TO BUT HAVING THEM FOR SO LONG WITHOUT EVIDENCE OF STROKE IS GRATIFYING MY POINT ABOUT THE SCINTILLATIONS IS THAT SHE WAS AROUND 57 WHEN THEY STARTED AND EASILY COULD BE AURA WITHOUT MIGRAINE I AGREE WITH YOUR ASSESSMENT THAT SHE IS ANXIOUS SHE TOLD ME THAT IN 1982 SHE HAD A RETINAL HEMORRHAGE AND IS FRIGHTENED THAT THE SCINTILLATIONS MAY BE A HARBINGER OF ANOTHER HEMORRHAGE I DID NOT GET THE SENSE THAT HER COGNITION HAS DECLINED BUT THIS TOO CAN BE EVALUATED OK WE MAY BE SPLITTING HAIRS HERE BUT SHE COULD NOT CORRELATE HEADACHE WITH AURA SO THAT IS WHY I BELIEVE THESE EVENTS MAY BE AURA WITHOUT MIGRAINE HOPEFULLY I WILL KNOW MORE WHEN I SEE HER ON MONDAY THANKS DR WILDER MS W DID NOT SHOW UP THIS MORNING I SCHEDULED HER APPOINTMENT FOR 10 30AM OK EVERYONE SHOULD KNOW THAT ALTHOUGH SUPPLEMENTS HAVE REASONABLE INFORMATION IN THEM THEY ARE NOT PEER REVIEWED THUS THE INFORMATION SHOULD BE TAKEN WITH THAT PROBLEM IN MIND IF THE PATIENT COMPLAINS OF FOCAL NEUROLOGICAL SIGNS SUCH AS FACIAL NUMBNESS DOUBLE VISION ETC PATIENT SHOULD BE SEEN IN NEURO CLINIC IMMEDIATELY OR SENT TO THE EMERGENCY ROOM THERE ARE PATIENTS WITH HEADACHE AS HARBINGER OF CEREBROVASCULAR DISEASE PATIENTS WITH POSTERIOR CIRCULATION DISEASE CAN ALSO HAVE HEADACHES HYPOPLASTIC VERTEBRALS CAN OCCUR BUT IN THE PRESENCE OF NEW HEADACHES PATIENT NEEDS CAREFUL HISTORY REGARDING NEURO SX

)

(JAY-S-WILDER 78YO WF HTN CONTROLLED PHX TIA |1Y| AGO WHILE ON ECASA 325 BID INPT EVAL BY NEURO AND SWITCHED TO PLAVIX 75MG QD HAD HER STEREOTYPIC TIA SXS AGAIN LAST WK TRANSITORY FORTIFICATION SCINTILLATION FOLLOWED BY HATBAND LIKE TIGHTEN SS AND THEN L LOWER FACIAL NUMBNESS FOR AFEW HRS MIGRAINE NO SXS SINCE WHAT IS NEXT ADD ASA SWITCH TO TICLID SWITCH TO PERSANTINE ASA WOULD APPRECIATE YOUR SEEING HER SINCE ATYPICAL FEATURES FOR TIA THANKS WOULD YOU LIKE ME TO CALL HER I GOT OUT HER INPT RECORD INTERESTINGLY SHE DESCRIBED THE SCINTILLATIONS THEN TOO I AM ALSO CONCERN RE POSS COGNITIVE DECLINE BUT I DID NOT HAVE TIME TO DO A MMSE SHE HAS ALWAYS HAD ANXIOUS HESITANT AFFECT WE WERE ON THE SAME WAVELENGTH THIS WHY I EMPHASIZED THE SCINTILLATIONS TOO I WILL BOAST THAT I MENTIONED MIGRAINE IN MY ORIGINAL MESSAGE I AM LOOKING FOWARD TO YOUR ASSESSMENT THANKS I TALKED TO HER IN PERSON ON FRI AND HANDED HER THE REFERRAL FORM WITH DATE & TIME I WILL CALL HER TO FIND OUT WHAT HAPPENED I JUST SPOKE TO HER OVER THE WKEND SHE REALIZED SHE AHD A CONFLICTING APPT AT NNMC FOR A F U FOR MGUS AND SHE WENT THERE THIS AM SHE SAID SHE CALLED THE NEURO CL AND WAS TOLD THEY DID NOT HAVE HER DONE FOR AN APPT I TOLD HER ONE OF US WOULD CONTACT HER AGAIN WITH A NEW NEURO APPT I FOUND THE NHLBI NEWS RELEASE ON THIS IT^S FROM THE ALLHAT STUDY COMPARING CHLORTHALIDONE CARDURA AMLODIPINE & LISINOPRIL AFTER 2 |6Y| F U OF 42 0 PTS OVER 55YO BROAD DEMOGRAPHICS PTS WITH AT LEAST ONE OTHER CORONARY RISK FACTOR THE USERS OF CARDURA HAD 25% MORE CARDIOVASCULAR EVENTS AND WERE |2X^S| AS LIKELY TO BE HOSP FOR CHF AS USEERS OF CHLORTHALIDONE NO DIFFERENCE IN INCIDENCE OF MI OR DEATH THEY CONCLUDED CARDURA AND OTHER ALPHA BLOCKERS SHOULD NOT BE THE FIRST FOR HTN AND NOT BE USED AS MONOTX NO DATA FOR USE IN COMBINED TX NO RELEVANT DATA FOR THE PT WITH BPH NO OTHER DATA FROM THIS ONGOING STUDY WAS RELEASED THEY DID TERMINATE THE CARDURA ARM SO IT MUST HAVE BEEN A SIGNIFICANT FINDING

)

(CARL-R-WILLIS GREETINGS DR OWENS AGREE THAT THE DIFF WOULD HELP A LEUKEMOID REACTION BY DEFINITION IS INCLUSIVE OF A LUEKOCYTOSIS OF > |50K| STEROID INDUCED WAS ALSO MY FIRST THOUGHT BUT WOULD EXPECT EARLY BAND FORMS WHICH CAN ALSO BE SEEN WITH LEUKEMOID REACTIONS MAY BE RESOLVING A LAP SCORE MAY HELP YOU TO DIFFER BETWEEN AN INFECTIOUS INFLAMMATORY ETIOLOGY AND CML UNLIKELY GIVEN AGREE WITH DR M SHOULD BE SEEN PROMPTLY BY A HEMATOLOGIST ONCOLOGIST I AGREE WITH DR LEGUIZAMO NEWER FACTOR CONCENTRATES ARE AVAILABLE BUT IF HE IS RESPONSIVE TO DDAVP THAT IS BEST OPTION

)

(TIMOTHY-J-MURPHY WOULD LIKE TO KNOW THE ACTUAL BREAKDOWN OF HIS DIFFERENTIAL ARE THERE BASOPHILS IN HIS PERIPHERAL BLOOD LOOKING AT THE SMEAR AND OBTTAINING A DIFFERENTIAL IS IMPERATIVE MEGAKARYOCYTES ARE NOT SEEN IN PERIPHERAL BLOOD EVER WOULD MAKE SURE SHE DOES NOT HAVE A UTI CYSTITIS WOULD WANT TO KNOW THE EXACT DIFFERENTIAL ON BLOOD BANDS METAMYELOCYTES LYMPHOCYTES BASOPHILS WOULD ALSO WANT TO HAVE AN EARLIER CBC PRIOR TO PREGNANCY IF POSSIBLE WHAT IS THE MEAN PLATELET VOLUME MPV DR DIEHL WOULD BE PROUD A VERY INTERESTING AND CONTROVERSIAL TOPIC THE STANDARD OF CARE PRACTICE IN THIS COUNTRY HAS BEEN TO AVOID HRT IN ALL WOMEN WITH A DIAGNOSIS OF INVASIVE BREAST CANCER THIS HOWEVER DID NOT COME ABOUT FROM EVIDENCE BASED MEDICINE IN FACT IN THE PAST YEAR THERE HAVE

BEEN 3 4 RETROSPECTIVE TRIALS FROM THE US WHICH SUGGESTS THAT HRT DOES NOT INCREASE RECURRENT BREAST CANCER RISK THERE IS CURRENTLY ONE NON US BASED RANDAMIZED TRIAL ONGOING THAT WILL ADDRESS THE SAFETY OF HRT IN BREAST CANCER SURVIVORS THUS THE DEFINITIVE ANSWER STILL AWAITS ONE COULD ARGUE THAT THIS PATIENTS GREATEST RISK IS FROM CARDIOVASCULAR DISEASE LIFETIME RISK OF BREAST CANCER IS 1 8 WOMEN LIFETIME RISK OF C V DISEASE IS 1 3 WOMEN SO IF THIS WERE MY PATIENT I WOULD HAVE TO HAVE AND DOCUMENT A DETAILED DISCUSSION WEIGHING THE PROS AND CONS OF HRT V NO HRT SHE SHOULD SPEAK WITH AN ONCOLOGIST SHE CAN CALL OR YOU CAN REFER TRICARE FOR AN APPT
)
(CLIFTON-A-HAWKES FROM THE ID PERSPECTIVE I CANNOT THINK OF ANY OTHER DIAGNOSTIC TEST MY FIRST THOUGHT WAS AS YOU CONSIDERED STEROID INDUCED MY SECOND CONSIDERATION WAS A PERFORATED VISCOUS THAT WAS WALLED OFF BUT CT SCAN OF THE ABDOMEN SHOULD HAVE IDENTIFIED THAT INDIUM SCAN IS SOMETIMES USEFUL BUT I DO NOT THINK THE COST IS JUSTIFIED IF HE IS GOING TO HAVE A DEFINITIVE PROCEDURE AND YOU ARE NOT PRESSURED TO START ANTIBIOTICS IN THE SETTING OF FEVER I ASSUME HE IS OFF ALL STEROIDS NOW OPTIONS FOR TREATMENT ARE IODOQUINOL AS YOU MENTIONED AND PAROMAMYCIN I DON^T THINK NONTREATMENT IS AN OPTION I^M ASSUMING HE IS AN ASYMPTOMATIC CYST PASSER BUT IF HE IS COMING BACK TO LIVE IN THE U S A NONENDEMIC AREA FOR E HISTO HE SHOULD BE TREATED IF HE WAS GOING TO REMAIN IN AN ENDEMIC REGION TREATMENT WOULD NOT BE INDICATED SINCE HE WOULD BECOME REINFECTED DIAGNOSTICALLY I THINK THERE ARE TWO IMPORTANT THINGS TO DO IN THIS PATIENT RIGHT NOW ONE IS SCRAPING LESION FOR DARKFIELD EXAMINATION IF POSSIBLE SECOND IS HAVING THE LABORATORY PERFORM APPROPRIATE MODIFICATIONS IN THE TESTING PROCEDURE TO RULE OUT PROZONE PHENOMENA WHICH COULD GIVE YOU A FALSE NEGATIVE RESULT FTA DOES APPEAR TO BE MORE IN PRIMARY DISEASE THAN VDRL 85% VS 70% HOWEVER BOTH SHOULD BE CHECKED MHA TP IS LESS SENSITIVE THAN BOTH OF THESE IN PRIMARY DISEASE IF TESTS ARE NEGATIVE MAKE SURE YOU HAVE CAREFULLY RULED OUT OTHER DISEASES IN THE DIFFERENTIAL INCLUDING HERPES SIMPLEX CHANCROID LGV CONDYLOMA ACCUMINATA SINCE SHE HAS REPORTEDLY NOT HAD A RECURRENCE FOR A NUMBER OF YEARS PREVENTING FUTURE OUTBREAKS DOES NOT APPEAR TO A MAJOR ISSUE BUT RATHER ASYMPTOMATIC SHEDDING THE INCIDENCE OF SHEDDING IN OTHERWISE HEALTHY WOMEN HAS BEEN ESTIMATED AT ABOUT 1% OF DAYS OR A LITTLE HIGHER IT IS HIGHER AMONG PATIENTS WITH FREQUENT SYMPTOMATIC RECURRENCES AND IN THE MONTHS IMMEDIATELY FOLLOWING AN INITIAL EPISODE NEITHER OF WHICH APPLIES TO THIS PATIENT BASED UPON HER HISTORY SHE MAY BE SHEDDING VERY INFREQUENTLY IF AT ALL BUT THERE IS NO WAY TO PREDICT WHICH DAYS SHE IS OR IS NOT SHEDDING THE COST OF ACYCLOVIR AT 400 MG BID IS ABOUT $1400 AND VALTREX AT 500 MG QD IS ABOUT $1000 THE DECISION TO START SUPPRESSIVE THERAPY IN THIS CLINICAL SCENARIO HAS TO BE HANDLED ON AN INDIVIDUAL BASIS COST IS NOT PROHIBITIVE BUT SHOULD BE A CONSIDERATION SAME APPLIES TO DRUG RESISTANCE CONCERNS THERE MAY BE SIGNIFICANT PSYCHOSOCIAL ISSUES ASSOCIATED WITH THIS ESPECIALLY THOSE THAT MAY IMPACT UPON THIS PATIENTS SEXUAL RELATIONSHIP WITH HER PARTNER E G FEAR OF TRANSMITTING HERPES LEADING TO DIMINISHED SEX DRIVE AND REDUCED SEXUAL FREQUENCY IN WHICH CASE SUPPRESSION MAY BE OF SUBSTANTIAL BENEFIT I^M AFRAID I CAN^T GIVE YOU A YES OR NO ANSWER ON THIS ONE BUT WE WOULD BE HAPPY TO SEE HER HERE IN OUR CLINIC I DID NOT DR OTT WHAT IS YOUR FAX NUMBER ALWAYS WELCOME
)
(NICOLE-M-OWENS HAVE A 65 YO MAN WITH COPD ASCAD HX OF COLON CANCER WITH HEMICOLECTOMY ONE YEAR AGO HAS HAD A PERSISTENT LEUCOYCTOSIS SINCE AN ADMISSION FOR COPD EXACERBATION IN JANUARY WBC COUNT ON ADMISSION WAS ACTUALLY NORMAL ROSE TO |34K| AFTER STEROIDS AND HAD GRADUALLY DECREASED OVER SIX WEEKS TO 12 BUT IS NOW BACK UP TO 18 NORMAL DIFF NO ABNORMAL FORMS ON PERIPHERAL SMEAR THE PT FEELS WELL HAS NO FEVERS LYMPHADENOPATHY SKIN RASH CXR REPEATEDLY NEGATIVE BLOOD CULTURES X2 AND URINE CULTURE NEGATIVE DID A CT SCAN OF HIS BELLY BECAUSE OF AN EPISODE OF ABDOMINAL PAIN WHICH REVEALED EITHER A NEW PANCREATIC TAIL LESION OR RECURRENCE OF HIS COLON CANCER NO DIVERTICULITIS ABSCESS OR LIVER LESIONS SEEN HE IS GOING FOR AN EX LAP IN TWO WEEKS WOULD YOU RECOMMEND ANY FURTHER EVALUATION PRIOR TO SURGERY EITHER ID OR BONE MARROW IS THIS LIKELY A LEUKEMOID REACTION TO WHATEVER IS IN HIS BELLY THANKS
)
(DAVID-G-MCLEOD YES PLEASE SEND HER THANK YOU FOR THE REFERRAL PLEASE REFER US ANY PATIENTS THIS WAY AND DON^T BOTHER WITH ANY OF THAT TRYCARE CRAP PLEASE
)
(TRUDY-A-YAVOREK DR MCLEOD CAN THE FEMALE CADET WHO I E MAILED YOU ABOUT THAT IS GROWING BETS STREP GP B IN HER URINE COME SEE YOU THIS MONDAY 6

MARCH SHE HAS A H O RECURRENT UTI BUT NOE C O BACK PAIN ALSO SHE HAS A H O UROLOGICAL SURGERY AS A CHILD FOR RECURRENT UTIS IF SHE CAN COME MONDAY WHERE AND WHEN SHOULD SHE REPORT I CARE FOR A 22 YO WF WITH A H O A FEMUR STRESS FRACTURE SHE IS OLIGOMENORRHIC AND REFUSED TO TAKE OCP^S SHE DENIES AN EATING DISORDER SHE IS A CROSS COUNTRY RUNNER AND HAS ANOTHER STRESS FRACTUR IN THE PAST HER RECENT DEXA SCAN SHOWS OSTEOPORSIS OF HER VETERBRAL BODIES IS SHE A CANIDATE FOR FOSAMAX OR IS THERE ANY OTHER TREATMENT STUDIES WE SHOULD BE DOING HER BASELINE BLOOD CHEMISTRIES ARE NORMAL T YAVOREK MD
)
(KEVIN-A-CECKOWSKI THIS PATIENT WAS COUNSELED ABOUT SIGNING UP FOR MEDICARE WHILE THE SEASON IS OPEN THROUGH 31 MARCH 2000 WE WERE ABLE TO GET MEDICARE ON THE PHONE AND HE WILL BE FINED A PENALTY BECAUSE HE HAS NOT PAID INTO THE SYSTEM FOR 11 YEARS HIS PREMIUMS WILL BE HIGHER PROBABLY PAY 63 0 PER MONTH INSTEAD OF THE USUAL $43 0 PER MONTH FOR MEDICARE B PREMIUM WHICH PAYS FOR HIS DIALYSIS IN THE CIVILIAN SECTOR HE IS HAVING MEDICARE OFFICE MAIL HIS HOME IN GERMANY THE FORMS HE IS REALLY IN A TIGHT SPOT FOR HIS WIFE IS A GERMAN NATIONAL AND HAS A VERY GOOD JOB IN GERMANY SHE ALSO SPEAKS VERY LITTLE ENGLISH THEY WERE MARRIED WHILE HE WAS RETIRED AND IN GERMANY SO SHE REALLY DOES NOT WISH TO BE RELOCATED BACK IN THE STATES THIS COULD CHANGE MEDICARE WILL NOT PAY IN GERMANY HE DOES NOT HAVE ANY OTHER INSURANCE HE USES THE GERMAN HEALTH CARE SYSTEM PD IS APPROX $2 0 0 PER MONTH HERE IN THE STATES HEMODIALYSIS IS APPROX $4 0 0 PER MONTH OF THAT MEDICARE COVERS 80% OF THE COST 20% IS COVERED BY THE PATIENT OR HIS HER SUPPLEMENTAL INSURANCE PT WAS ADVISED ABOUT ALL THE ABOVE HE STATED THAT HE WOULD THINK ABOUT WHAT HE IS GOING TO DO HE HAS VERY LITTLE SUPPORT HERE IN THE STATES AND I DO NOT SEE HIM LIVING BY HIMSELF WITHOUT HIS WIFE BUT THAT MAY BE WHAT HE HAS TO DO I THOUGHT HE WAS OLDER THAN 65 MUST BE CONFUSING HIM WITH SOMEONE ELSE SORRY FOR THE CONFUSION ON HIS AGE MEDICARE PENALTY IF HE IS 65 THAN HE NEEDS TO BEGIN PAYING FOR HIS MEDICARE PREMIUM NOW I BELIEVE I HAVE THE WIFE INFO CORRECT PRIVATE PAY IN GERMANY OR MOVING BACK TO CONUS ARE HIS TWO OPTIONS
)
(ERIN-M-BOHEN I WOULD NOT ASSUME THAT HIS PROTEINURIA CAN BE EXPLAINED BY NEPHROLITHIASIS EARLY DIABETIC NEPHROPATHY OR HYPERTENSIVE NEPHROSCLEROSIS CAN CAUSE LOW GRADE PROTEINURIA WE WOULD BE HAPPY TO SEE HIM IN NEPHROLOGY CLINIC
)
(DAVID-A-FRIAR |65Y| MALE EVALUATED AT WRAMC 2 WEEKS AGO HAS SEVERE CHF EF <15% HAS ASCITIES HAS CRI WORSENING PRESUMABLY DUE TO RENAL ARTERY STENOSIS HAD RENAL ARTERY PTCA X2 CONTROL OF CHF LEADS TO UREMIC SYNDROME CONTROL OF UREMIC SYNDROME LEADS TO CHF TOLD NEEDS DIALYSIS RETURNED TO GERMANY TO DISCUSS WITH FAMILY CAN T AFFORD DIALYSIS ON ECONOMY HERE WANTS TO KNOW IF CAN COME TO WRAMC AND BE STARTED ON PERITONEAL DIALYSIS THEN RETURN HERE FOR F U WITH LOCAL NEPHROLOGIST WHILE OBTAINING DIALYSIS SOLUTION FROM OUR MEDDAC IS THIS MEDICALLY REASONABLE CAN A GENERAL SURGEON PLACE THE PERITONEAL CATHETER HERE HOW MUCH DOES THE DIALYSATE COST WILL THIS BANKRUPT OUR ALREADY BANKRUPT MEDDAC TO SUPPLY THIS FLUID TO HIM HE IS AWARE THAT HE CANNOT BE FOLLOW BY US INTERNIST FOR DIALYSIS ISSUES OR COMPLICATIONS
)
(BURKHARDT-H-ZORN WOULD GET A IVP AND HAVE HER SCHEDULED FOR A CYSTOSCOPY WE WILL OBTAIN A CYTOLOGY AT THAT TIME
)
(ROBERT-L-RAMSEY A 59 YO FEMALE SMOKER HAS PERSISTENT BACK PAIN ESPECIALLY IN LCVA AREA AND PERSISTENT MICROHEMATURIA SHOULD I GET AN IMAGING STUDY OF HER KIDNEYS BEFORE SENDING HER TO YOU AND IF SO WHAT STUDY 2 OF OUR RETIREES ARE MOVING TO ABU DHABI UNITED ARAB EMIRATES THEY ARE ON DIABETES MEDS DO WE HAVE A MECHANISM TO SEND THEM MEDS THANKS! NO APO ADDRESS THEY ARE WORKING ON A CONTRACT AT THE MILITARY HOSPITAL LIVING ON THE ECONOMY BOTH UNDER 65 THAT IS VERY HELPFUL THANKS A LOT THIS VERY NICE 73 YO LADY IS VERY HARD OF HEARING AND IS MISSING A LOT IT IS HARD TO TAKE CARE OF HER AND EXPLAIN HER MEDICAL REGIMEN TO HER BECAUSE SHE CAN^T HEAR WELL SHE IS POORLY EDUCATED AND HAS BEEN AFRAID OF HEARING AIDES BECAUSE SHE THINKS IT INVOLVES SURGERY I PUT IN A CLN ORDER BUT SHE REALLY CAN^T NAVIGATE THE SYSTEM WELL ON HER OWN CAN SOMEONE CALL HER WITH AN APPT WHEN HER TIME COMES THANKS!
)
(ROBERT-J-CHRISTIE THE ROLE OF RALOXIFENE IN THIS SETTING IS BEING EXPLORED THERE ARE NO DATA ON THE RELATIVE BENEFITS RISKS OF RALOXIFENE IN WOMEN

WHO HAVE COMPLETED 5 YEARS OF TAM I WOULD DEFER TO ENDO AS FAR AS ALTERNATIVE THERAPIES CERTAINLY SHE MAY BE A CANDIDATE FOR ALENDRONATE
)
(WILLIAM-E-DUNCAN WE CANNOT RECOMMEND SPECIFIC THERAPY WITHOUT EVALUATING THE PATIENT WE WOULD BE GLAD TO ANSWER QUESTIONS ABOUT SPECIFIC THERAPIES WOULD RECOMMEND REFERRING HER TO US FOR EVALUATION DID YOU WANT THIS TO GO TO ENDOCRINOLOGY ASK A DOC NOT SURE IF THERE IS A CAUSE AND EFFECT NEED TO ASSESS THE MEDICATIONS HE IS TAKING HIS THYROID STATUS RENAL STATUS ETC COULD YOU REFER HIM TO US PLEASE ASK HIM TO REPEAT HIS PROLACTIN LEVEL TESTOSTERONE FSH LH NUC1 PROFILE P1 P2 P3 THANKS WE WOULD BE VERY HAPPY TO SEE THIS PATIENT HOW LONG POST PARTUM IS SHE ANY FAMILY HISTORY OF THYROID OR AUTOIMMUNE DISEASE WOULD REPEAT TSH AND IF ELEVATED BEGIN TREATMENT WITH THYROID HORMONE NO REASON TO DO A THYROID SCAN
)
(VICTOR-J-BERNET RUN THE BMD RESULTS BY US AGAIN T SCORE YOUNG NLS Z SCORE AGE MATCHED I FORWARDED IT NO CONTRAST WITH THAT CT PLEASE DR HARARI COMMENT FURTHER AFTER HIS ASSESSMNET OKAY WE REPEATED HIS LABS THIS TIME THE NOREPI CAME BACK AT 146 15 80 AND DOPAMINE WAS 447 65 400 AND NORMETANEPHRINE 732 82 500 AND TOATL METANEPHRINES 915 NRL 120 700 HIS URINE VOL WAS 1500 CC AND HE HAS A CREATININE CLEARANCE OF 204 ML MIN BASED ON HIS URINE AND SERUM CREATININES DID HE OVER COLLECT AS FAR AS HIS SPELLS HE GETS BRIEF PERIODS OF SHAKING SWEATING AND FLUSHING WHICH LAST LESS THATN 15 MIN AND THESE OCCUR WITHOUT ANY RELATIONSHIP TO ACTIVITY MEALS SLEEP ETC AND OCCUR APPPPROX QWEEK I HAVE NOT GOTTEN THE PLAMSA CATHCOLS WOULD YOU STILL RECOMMEND OR IS THIS ENOUGH INFO TO GO TO THE OR CAN^T REMEMBER THE WHOLE CASE JEANNIE URINES ARE SUSPICIOUS I WOULD USE CR INDEX TO DECIDE IF HE OVER COLLECTED USE CR KG BODY WT 20 25 MG KG DAY IS NORMAL IN A MALE SERUM MEASUREMENTS WOULD STILL BE HELPFUL AND SOMETIME THE LEVELS HELP DECIDE IF A CONFRIMATORY STIM OR SUPPRESSION TEST IS NEEDED BY THE WAY DID YOU IMAGINE THE ADRENALS YET IF SO WAS THERE A SUBSTABTIAL LESION ACTUALLY WE WOULD PROBABLY STILL WAIT ON IMAGING UNTIL WE ARE CONVINCED OF A PHEO CHEMICALLY VIC HOW LONG HAS SHE BEEN BREAST FEEDING THE LAST I CHECKED PROLACTINS ACTUALLY TEND TOWARD NORMAL W IN SEVERAL MONTHS POSTPARTUM EVEN WITH CONTINUED BREAST FEEDING I WILL CHECK SOME REFERENCES BUT 1970 SEEMS AWFUL HIGH DID SHE HAVE NL MENSES PRE PREGNANCY OR GALACTORRHEA HX OF PITUITASRY DISORDER THE IS ALSO A SYNDROME OF MACROPROLACTINEMIA WHERE THE PROLACTIN MOLECULE IS ABNORMALLY LARGE AND CANNOT BE READILY EXCRETED BUT NOT SURE WHAT LEVELS ARE SEEN WITH THAT RARE CONDITION PRL MAY INCRAESE TO AROUND 100 300 RANGE SOON AFTER SUCKLING BUT THEN RETURNS CLOSE TO NORMAL RANGE A MINIMALLY ELEVATED PROLACTIN MIGHT NOT WORRY ME I WOULD THINK THAT LEVEL SUSPICIOUS FOR A MACROPROLACTINOMA I WOULD DEFINITELY REPEAT X 2 PLUS CONSIDER TFTS 24 HR UFC WITH CR SOMATOMEDIN C AND REFERRAL TO US THANKS SORRY TO HEAR WE WON^T SEE HER WE HAVE SEEN A LOT OF PTIUITARY CASES OVER THE YEARS AND WOULD HAVE BEEN HAPPY TO WORK HER IN PROMPTLY BUT I CAN UNDERSTAND THE RELUCTANCE TO DRIVE A DISTANCE I WOULD LEAN TOWARDS GETTING A MRI OF THE SELLA WITH GADOLINIUM ESP IF REPEAT PRL IS AS HIGH AGAIN THE RECOMMENDED DOSE IS 400 TO 800 IU QD OF VITAMIN D A MVI HAS 400 IU THE PHARMACY DID AWAY WITH THE 400 IU VIT D TABS THAT WE SOMETIMES GAVE TO PTS WITH THEIR MVI PHARMACIES SOLUTION TO GET 800 IU IS TO TAKE 2 MVI PER DAY THEY SWEAR THAT NO ONE WILL GET TOXIC WITH TAKING TWO MVI DAY ANOTHER WAY IS TO HAVE PTS PURCHASE CALCIUM SUPLLEMENST WITH 200 IU VIT D THEN THEY CAN TAKE MVI VIT D 400 IU PLUS TWO CACLIUM TABS WITH CALCIUM 500 MG EA AND VIT D 200 IU EACH FOR A TOTAL OF 800 IU TYPICALLY WE USE THE OTHER PREPARATIONS YOU SEE ON CHCS FOR MORE PROMINENT VIT D DEFICIENCY STATES NEW ONE ON ME WE WOULD REALLY NEED TO SEE ALL THE LAB RESULTS IN ORDER TO GIVE YOU ANY INTELLIGENT FEEDBACK PLEASE PROVIDE NAME AND LAST 4 OF SSN IT WOULD BE BEST FOR PT TO AND ARRAANGE THE APPT WITH OUR FRONT DESK THANKS SOUNDS LIKE SOMEONE WE WOULD LOVE TO SEE AT LEAST ONCE SHE MIGHT BE A GREAT CANDIDATE FOR IV PAMIDRONATE INFUSIONS SOUNDS LIKE YOU DID A GOOD R O FORSECONDARY CAUSES ALTHOUGH WOULD HAVE TO SEE THE SPECIFIC RESULTS MALABSORPTION COULD DEFINITELY BE PLAYING A ROLE HER ORAL CALCIUM SHOULD BEMAXIMIZED AND WE MIGHT HAVE SPECIFIC RECOMMENDATIONS ON CALCIUM SUPP LEMENTSETC ALSO DID YOU DO VIT D LEVELS A MULTIVITAMIN WILL HAVE 400IU OF VIT D WAS SHE OSTEOPOROTIC BY BOTH LATERAL AND A P DEXA VIEWS OR WAS IT JUST THE LATERAL WAS THE CALCIUM WELL WITHIN NORMAL LIMITS ADJUSTED FOR ALBUMIN TFTS URINE CR CA EXCRETION HX OF MAJOR FXS BEYOND THE STRESS FXS ANY LONG TERM MEDS IF SHE IS A CADET ABOUT TO GO ONTO ACTIVE DUTY IT WOULD PROBABLY BE PRUDENT TO ALLOW US TO SEE HER AND ASSESS BEFORE SHE HEADS OUTINTO HER CAREER AND CAN^T SEE A SPECIALISTS AS EASILY IF SHE ENDS UP

SOMEWHERE REMOTE IS JUMP SCHOOL IN HER FUTURE NAMES CAN BE SENT WHEN ON
THE SAME CHCS SYSTEM AS FT MEADE IS PT NAMES CAN^T BE SENT IN PER INTERNET
WHICH IS DIFFERENT WATER DEP WOULD BE THE GOLD STANDARD IN MY BOOK I HAVE
FORWARDED THIS MESSAGE TO DR ALVERO WHO IS A REPRODUCTIVE GYN HERE AT
ASSUMING THERE IS NO FAMILY HX OF THYROID CANCER OR XRT RADIATION EXPOSURE
TO THE NECK YOU CAN FOLLOW THE PT WITH SERIAL PHYSICIAL EXAM PROBABLY
ANNUAL TSH AND NECK THYROID EXAM I WOULD PROBABLY NOT REPEAT US UNLESS A
NODULE BECAME CLINICALLY PALAPBLE OR SXS ATTRIBUTABLE TO THYROID NODULE
ENLARGEMENT BECAME EVIDENT WITH A NORMAL PHYSICAL EXAM WHAT LEAD TO THE US
IN THE FIRST PLACE THERE IS A 30 40% CHANCE OF FINDING A INCIDENTAL NODULE
IN A PT THIS AGE WHEN DOING US SO IF THE GLAND IS EASILY PALPABLE WE
MOSTLY DON^T GO TO US
)
(PADMA-A-GOWDA 58 YR OLD FEMALE WITH S P MASRECTOMY FOR BREAST CA ON
TOMOXIFEN FOR 5 YRS ALSO HAS SEVERE ASTHMA ON SX STEROIDS FROM TIME TO
TIME D C TOMOXIFEN RECENTLY BONE DENSITY STUDIED SHOWED OSTEOPENIA AND
INCREASED RISK OF FRCTURE HAS O 8 IN COMPARION OF T SCORE 2 0 AGE MATCHED
PT HAS DUB FOR WHICH TAKES DEPO Q 3 MONTHS ON CALCIUM 1ND EXERCISES
QUESTION IS WHAT OTHER MODALITY FOR OSTEOPOROSIS RX THANKS
)
(KEVIN-C-ABBOTT THAT IS A TOUGH ONE GIVEN HIS NON NEPHROTIC RANGE
PROTEINURIA HOWEVER HIS SERUM CREATININE OF 1 9 MOST LIKELY REPRESENTS
ABNORMALLY LOW RENAL FUNCTION CRCL SHOULD BE >110 CC MIN 1 73 M2 BSA
WHETHER OR NOT WE WOULD TREAT HIM IF HE HAD A GLOMERULAR DISEASE WOULD
DEPEND ON THE NATURE OF DISEASE IF HE HAD LUPUS WE PROBABLY WOULD NOT ALL
PATIENTS WITH LUPUS NEPHRITIS HAVE A POSITIVE ANA SO IN GENERAL I THINK A
RENAL BIOPSY WOULD BE A CONSIDERATION IN THIS CASE ALTHOUGH HE COULD HAVE
HYPERTENSIVE NEPHROSCLEROSIS ALTHOUGH I WOULD MORE SUSPICOUS FOR A
GLOMERULAR DISEASE GIVEN HIS ALMOST 1 GM OF PROTEINURIA PRIOR TO ACE WE
WOULD BE HAPPY TO SEE HIM HERE IF YOU WOULD LIKE TO SEND HIM REPEAT TESTS
HERE UPR 480 MG 24HR UCR 2565 MG H4HR CR 1 9 CRCL 93UA NEGATIVE BPS NOT
ANY DIFFERENT FROM TIME OF DIAGNOSIS 144 84 132 88 134 |771| PLAN TO BUMP
UP HIS ACEI BENAZEPRIL FOR ELEVATIONS BEYOND GOAL BP MY QUESTION IS DOES
HE NEED FURTHER W U IE RENAL BIOPSY OR IS THIS BORDERLINE TO STAGE I HTN
THE MOST LIKELY CAUSE FOR HIS PROTEINURIA THAT IS A TOUGH ONE GIVEN HIS
NON NEPHROTIC RANGE PROTEINURIA HOWEVER HISSERUM CREATININE OF 1 9 MOST
LIKELY REPRESENTS ABNORMALLY LOW RENAL FUNCTION CRCL SHOULD BE >110 CC MIN
1 73 M2 BSA WHETHER OR NOT WE WOULD TREAT HIMIF HE HAD A GLOMERULAR
DISEASE WOULD DEPEND ON THE NATURE OF DISEASE IF HEHAD LUPUS WE PROBABLY
WOULD NOT ALL PATIENTS WITH LUPUS NEPHRITIS HAVE APOSTIIVE ANA SO IN
GENERAL I THINK A RENAL BIOPSY WOULD BE A CONSIDERATIONIN THIS CASE
ALTHOUGH HE COULD HAVE HYPERTENSIVE NEPHROSCLEROSIS ALTHOUGH IWOULD MORE
MORE SUSPICOUS FOR A GLOMERULAR DISEASE GIVEN HIS ALMOST 1 GM OF
PROTEINURIA PRIOR TO ACE WE WOULD BE HAPPY TO SEE HIM HERE IF YOU WOULD
LIKE TO SEND HIM WHEN WE SAW MR S HERE HIS CRCL WAS 23 CC MIN DEVELOPING
ESRD IS SOMETHING PATIENTS RETIRING IN GERMANY DO NOT PLAN FOR HIS WIFE
STILL WORKS IN THE GERMAN COMMUNITY AND WAS UNWILLING TO MOVE HE WOULD NOT
EVEN CALL HER ABOUT HIS HEALTH PROBLEMS WHILE HE WAS HERE! HE SAID HE
WANTED TO DISCUSS IT WITH HER IN PERSON MR S WOULD NEED TO MOVE TO THE U S
PERMANENTLY FOR HIS DIALYSIS CARE I AM SURE IT WOULD NOT BE PAID FOR FROM
THE LRMC OR WRAMC BUDGET SINCE MEDICARE IS THE PAYER IN THE U S AS A
DIABETIC HE WOULD NEED INITIATION AT 15 CC MIN WE ESTIMATE THIS WILL BE IN
2 3 MONTHS BUT COULD HAPPEN SOONER PD CATHETERS SHOULD GENERALLY BE PLACED
NO MORE THAN 2 WEEKS AHEAD OF THEIR ANTICIPATED NEED THEREFORE MR S NEEDS
TO DECIDE IF HE WILL MOVE TO THE U S PERMANENTLY IF HE WISHES TO RECEIVE
ESRD CARE THAT IS ALL WE CAN DO HE SAW OUR RENAL SOCIAL WORKER MR CI
BEFORE HE LEFT FOR GERMANY AND WAS COUNSELED ON THESE ISSUES I WILL ALSO
FOWARD THIS MESSAGE THROUGH MR CI AND DR T WHO WAS THE FELLOW ON SERVICE
WHEN MR S WAS ADMITTED HERE THANKS AND LET US KNOW IF THERE IS ANYTHING
ELSE WE CAN DO WE WOULD BE HAPPY TO SEE HIM IT SOUNDS AS IF HE HAS
MODERATE CRI WITH NON NEPHROTIC RANGE PROTEINURIA SINCE HE IS OVER 40 A
UPEP AND SPEP WOULD BE IN ORDER ALONG WITH AN US WE WOULD BE HAPPY TO DO
THAT HERE OUR WAITING TIME FOR NEW AD APPOINTMENTS SHOULD BE VERY SHORT
IT^S POSSIBLE BUT WITHOUT PRIOR QUANTITATION WE DON^T REALLY KNOW IF THIS
REPRESENTS A PROGRESSIVE INCREASE SINCE HE^S OVER 40 WOULD RECHECK A RENAL
US CHECK UPEP IF HE IS ANEMIC OR HAS HIGH CALCIUM HOW IS IS BP DOES HE
HAVE PERSISTENT HEMATURIA EXCEPT FOR LABS NUMBER TWO WHICH SHOWED A CO2 OF
21 AND A K OF 3 5 I DON^T SEE A NET TREND I THINK REFERRING HER TO
NUTRTITION IF NOT ALREADY DONE COULD BE HELPFUL ALTHOUGH IF SHE HAS A
SIGNFICANT BEHAVIOURAL DISORDER SHE MIGHT NOT BE RECEPTIVE LOW BUN AND CR

AND HER LOW WEIGHT ALONG WITH THE HISTORY CERTAINLY SUGGEST UNDER NUTRITION AND A POSSIBLE ACTIVE EATING DISORDER SHE DOESN^T HAVE AN ALKALOSIS TO SUGGEST CHRONIC VOMITING BUT YOU MIGHT CHECK THE BACKS OF HER FRONT TEETH FOR EROSIONS
)
(SOPHIA-L-YOHE I WANT TO RUN A CASE PAST YOU TO SEE IF YOU THINK ANY FURTHER WORK UP NEEDS TO BE DONE THIS IS A 26 Y O AD BM WHO HAD PROTEINURIA 3 98 HE DENIED ANY USE OF NSAIDS AND HIS ONLY MEDICATIONS WERE INH W B12 FOR PPD CONVERSION AT THAT TIMEUPR WAS 996 MG 24HR UCR 2361 MG 24HR & CR 1 8 FOR CLCR 91 RENAL US WASNORMAL EXCEPT FOR RT KIDNEY 9 9CM AND LT 11 9 CM REPEAT US SHOWED ONLY 1CMDIFFERENCE IN SIZE BETWEEN THE TWO HE DID NOT HAVE RENAL BIOPSY ANDPRESUMPTIVE CAUSE WAS HYPERTENSION BPS WERE MILDLY ELEVATED IN THE |130S| HE WAS STARTED ON AN ACE INHIBITOR TO CONTROL BP TO GOAL 115 125 |70S| AND FORPROTEINURIA OF NOTE HE HAD UA NEGATIVE FOR PROTEIN 12 96 BUT UA W 3 PROTIEN AND CR 1 9 12 97 MY QUESTION IS DOES HE NEED FURTHER W U IE RENAL BIOPSY OR IS THIS BORDERLINE TO STAGE I HTN THE MOST LIKELY CAUSE FOR HIS PROTEINURIA
)))

```
;;; doctor-class.lsp


(defclass doctor
  ()

 ((printname :initarg :printname
         :initform ""
         :accessor printname)
  (list-of-instances :initarg :list-of-instances
                :initform '()
                :accessor list-of-instances
                :allocation :class)
  (medical-group :initarg :medical-group
            :initform ""
            :accessor medical-group)
  (lastname :initarg :lastname
                :initform ""
                :accessor lastname)
  (firstname :initarg :firstname
                :initform ""
                :accessor firstname)
  (id :initarg :id
    :initform ""
    :accessor id)
  (location :initarg :location
        :initform ""
        :accessor location)
  (assignment :initarg :assignment
          :initform ""
          :accessor assignment)
  (cpts :initarg :cdts
      :initform '()
      :accessor cdts)
  (icd9s :initarg :icd9s
       :initform '()
       :accessor icd9s)
  (specialty :initarg :specialty
         :initform ""
         :accessor specialty)
  (referring-consults :initarg :referring-consults
                :initform '()
                :accessor referring-consults)
  (specialist-consults :initarg :specialist-consults
                :initform '()
                :accessor specialist-consults)
  (list-of-consults :initarg :list-of-consults
               :initform '()
               :accessor list-of-consults)
  (consults-ci :initarg :consults-ci
          :initform ""
          :accessor consults-ci)
 ))


(make-a-class-instance 'doctor 'temp-doctor)

(defun make-specialist (data-string)
 (let* ((spec-name-string (nth 0 data-string))
      (specialist-firstname (firstname-from-string spec-name-string))
      (specialist-lastname (lastname-from-string spec-name-string))
      (specialist-mi (mi-from-string spec-name-string))
      (specialist-fullname (concatenate 'string specialist-firstname "-" specialist-mi "-" specialist-lastname))
      (spec-location (nth 1 data-string))
      (specialty (nth 2 data-string)))
  (cond ((null (my-instancep (string-to-symbol specialist-fullname)))
       (make-a-class-instance 'doctor (string-to-symbol specialist-fullname))
       (setf (location (eval (string-to-symbol specialist-fullname))) spec-location)
       (setf (specialty (eval (string-to-symbol specialist-fullname))) specialty)
```

```
        (cond ((equal spec-location "WRAMC")
             (setf (list-of-consultants walter_reed_army_medical_center)
              (append (list (string-to-symbol specialist-fullname))
                   (list-of-consultants walter_reed_army_medical_center))))
            (t
             ))
        )
        (t
        nil))))

(defun consult-list-update (consult-number doctor-instance)
 (let ((old-consults (list-of-consults doctor-instance))
     (old-referring-consults (referring-consults doctor-instance))
     (old-specialist-consults (specialist-consults doctor-instance)))
  (setf (slot-value doctor-instance 'list-of-consults)
   (delete-duplicates (append old-consults (list consult-number)) :test #'equal))))
```

```
;;; code for init.lsp

(setf *class-list* '(patient consult-request doctor specialist referring location specialty-class))


(defun string-to-symbol (the-string)
 (if (equal "" (string-trim '(#\Space) the-string)) nil
    (with-input-from-string (s the-string) (read s))))

(defun explode (object)
 (mapcar #'(lambda (char) (intern (string char)))
       (internal-explode object #'prin1)))

(defun internal-explode (object printer)
 (coerce (with-output-to-string (out-strm)
        (let ((*print-length* nil)
                (*print-level* nil))
         (funcall printer object out-strm)))
       'list))

(defun implode (char-list)
 (values (intern (coerce (mapcar #'(lambda (char)
                                                (coerce char 'character))
                                        char-list)
                                'string))))

(defun my-instancep (item)
 (let ((exploded-item (explode item)))
  (if (equal (car exploded-item) '\#)
   (let* ((x (position '\# (cdr exploded-item)))
        (class-item (string-to-symbol (string (implode (subseq exploded-item 2 (- x 1)))))))
     (if (member class-item *class-list*) T nil))
   nil)))


(defun round-float (num decimal-places)
          (setq tempnum (round (* num (expt 10 decimal-places))))
          (float (/ tempnum (expt 10 decimal-places)))
)



(defun make-a-class-instance (class-name instance-name)
 (eval `(setq ,instance-name (make-instance (quote ,class-name))))
 (setf (printname (eval instance-name)) (string instance-name))
 (eval `(setf (slot-value ,instance-name 'list-of-instances)
       (delete-duplicates
        (append (list (string-to-symbol (printname ,instance-name)))
             (slot-value ,instance-name 'list-of-instances))
        :test #'equal)))
 )

(defun find-the-first-blank (the-string)
 (if (not (equal the-string ""))
  (position '\ (explode the-string))))

(defun list-to-string (the-list)
 (if (listp the-list)
  (if (null (car the-list)) ""
     (if (null (cdr the-list)) (princ-to-string (car the-list))
       (concatenate 'string (princ-to-string (car the-list)) " " (list-to-string (cdr the-list)))))
  ""))


(defun string-to-list (the-string)
 (if (equal (string-trim '(#\Space) the-string) "") nil
    (let ((the-blank (find-the-first-blank the-string)))
     (cond (the-blank
          (append (list (string-trim '(#\Space) (subseq the-string 0 the-blank)))
               (string-to-list (subseq the-string the-blank))))
```

```
        (t
         (list the-string))))))


(defun string-to-clean-list (the-string)
 (let ((clean-list NIL)
       (x 1))
  (with-input-from-string (s the-string)
   (loop while x do
       (progn
        (let ((word (read s)))
          (if (equal word 'ENDOFSELECTION)
            (setq x NIL)
           (push word clean-list)
           )
          )
         )
        )
   )
  (reverse clean-list)
  )
 )


(defun bubble-sorter (the-list access-function pred)
 (cond (access-function
            (let* ((n (length the-list))
                       (temp nil))
             (do ((i 0 (+ i 1)))
                       ((> i (- n 2))
                        the-list)
              (do ((j (+ i 1) (+ j 1)))
                        ((> j (- n 1))
                         t)
                       (let* ((x (nth i the-list))
                            (y (nth j the-list)))
                        (cond ((not (funcall pred (funcall access-function x)
                                                  (funcall access-function y)))
                                    (setf temp x)
                                    (setf (nth i the-list) y)
                                    (setf (nth j the-list) temp))))))))
           (t
            (let* ((n (length the-list))
                       (temp nil))
             (do ((i 0 (+ i 1)))
                       ((> i (- n 2))
                        the-list)
              (do ((j (+ i 1) (+ j 1)))
                        ((> j (- n 1))
                         t)
                       (let* ((x (nth i the-list))
                            (y (nth j the-list)))
                        (cond ((not (funcall pred x y))
                                    (setf temp x)
                                    (setf (nth i the-list) y)
      (setf (nth j the-list) temp)))))))))

(defun bubble-sorter-2 (the-list access-function1 pred1 access-function2 pred2)
 (cond ((and access-function1 access-function2)
      (let* ((n (length the-list))
          (temp nil))
       (do ((i 0 (+ i 1)))
         ((> i (- n 2))
          the-list)
        (do ((j (+ i 1) (+ j 1)))
          ((> j (- n 1))
           t)
          (let* ((x (nth i the-list))
              (y (nth j the-list)))
```

```
            (cond ((not (funcall pred1 (funcall access-function1 x)
                               (funcall access-function1 y)))
                   (setf temp x)
                   (setf (nth i the-list) y)
                   (setf (nth j the-list) temp))
                  (t
                   (cond ((not (funcall pred2 (funcall access-function2 x)
                                        (funcall access-function2 y)))
                          (setf temp x)
                          (setf (nth i the-list) y)
                          (setf (nth j the-list) temp))))))))
      ))
     (t
      (let* ((n (length the-list))
             (temp nil))
        (do ((i 0 (+ i 1)))
            ((> i (- n 2))
             the-list)
          (do ((j (+ i 1) (+ j 1)))
              ((> j (- n 1))
               t)
            (let* ((x (nth i the-list))
                   (y (nth j the-list)))
              (cond ((not (funcall pred1 x y))
                     (setf temp x)
                     (setf (nth i the-list) y)
                     (setf (nth j the-list) temp)))))))))

(defun make-string-of-given-length (item-name new-item-length) ; item-name must be a string
 (let ((old-item-length (length item-name)))
  (cond ((< old-item-length new-item-length)
         (generate-blank-string (- new-item-length old-item-length)))
        (t
         ""))))

(defun add-blank-strings-to (item-string number-added)
 (concatenate 'list
              (list item-string)
              (generate-list-with
               (generate-blank-string (length item-string)) number-added)))

(defun generate-blank-string (string-length)
 (if (= string-length 0) nil
  (concatenate 'string " " (generate-blank-string (- string-length 1)))))

(defun eliminate-character (the-character the-string)
 (let ((char-pos (search the-character the-string)))
  (cond (char-pos
         (concatenate 'string
          (subseq the-string 0 char-pos)
          " "
          (eliminate-character the-character (subseq the-string (+ 1 char-pos)))))
        (t
         the-string))))


;; this method is used to parse strings delimited by ':' characters
;; (ex: ":patient name:patient description:referring location")
;;;(defun get-first-word-between-colons (the-string)
;;;;            (let ((returnstring "")
                  ;;;;    (colon-pos (search ":" the-string)))
                        ;;;;            (cond (char-pos
                                               ;;;;            (concatenate 'string subseq the-string 0 char-pos



(defun put-colon-string-into-list (the-string)
            (setf the-string (subseq the-string 1))

            (setq returnlist NIL)
```

```
        (setq currpos 0)
        (dotimes (n (length the-string))
                (if (equal (char the-string n) #\:) (progn
                        (push (subseq the-string currpos n) returnlist)
                        (setf currpos (+ n 1))
                ))
        )
        (push (subseq the-string currpos) returnlist)

        (reverse returnlist)
)



(defun eliminate-several-characters (character-list the-string)
 (do ((i 0 (+ i 1)))
    ((> i (- (length character-list) 1)) the-string)
  (setf the-string (eliminate-character (nth i character-list) the-string))))


(defun firstname-from-string (patient-string)
 (let* ((exploded-string (explode patient-string))
      (z (position '\ exploded-string))
      (comma-position (position '\, exploded-string))
      (end-of-firstname (nth 1 (cumulative-distribution (find-the-position-of-the-blanks patient-string)))))
  (subseq patient-string (+ comma-position 1) (if end-of-firstname (- end-of-firstname 1)
                        (length patient-string)))))

(defun lastname-from-string (patient-string)
 (let* ((exploded-string (explode patient-string))
      (comma-position (position '\, exploded-string)))
  (if comma-position
   (string (implode (subseq exploded-string 1 comma-position)))
   patient-string)))

(defun mi-from-string (patient-string)
 (subseq patient-string (- (length patient-string) 1)))

(defun find-the-position-of-the-blanks (the-string)
 (let ((item (if (not (equal the-string ""))
          (let* ((exploded-string (explode the-string))
              (x (position '\ exploded-string)))
           (if x
            (append (list x) (find-the-position-of-the-blanks (subseq the-string x))))))))
  item))

(defun cumulative-distribution (the-list)
 (do ((i 0 (+ i 1))
    (output '()))
   ((> i (- (length the-list) 1)) output)
  (setf output
      (append output (list (+ (nth i the-list) (if (null (last output)) 0 (nth 0 (last output))))))))))


;;; takes a long string of words and puts it into a list of symbols for the classifier
(defun string-to-word-list (string)
        (setf string (eliminate-bad-chars string))
        (setq string-list (string-to-list string))
        (setq return-list NIL)
        (dolist (item string-list)
                (setq sym (string-to-symbol item))
                (if (not (null sym)) (push sym return-list))
        )
        (reverse return-list)
)


(defun eliminate-bad-chars (string)
        (eliminate-several-characters '("+" "#" ";" "." "," ":" "(" ")" "/" "'" "`" "-" "?") string)
```

```
)


(defun format-scores (score-list number-to-take)
 (setq string-list NIL)
 (dotimes (n number-to-take)
  (let* ((curr-item (nth n score-list))
       (item-string (concatenate 'string (princ-to-string (car curr-item)) "  (" (princ-to-string (nth 1 curr-item)) ")"))
       )
   (push item-string string-list)
   )
  )
 (reverse string-list)
 )

(defun format-just-specialties (score-list number-to-take)
 (setq string-list NIL)
 (dotimes (n number-to-take)
  (let* ((curr-item (nth n score-list))
       (item-string (princ-to-string (car curr-item)))
       )
   (push item-string string-list)
   )
  )
 (reverse string-list)
 )
```

```
;; Code for the warning-message-dialog :inquiry-result


(defun inquiry-result-cancel-button-on-click (dialog widget)
  (declare (ignore-if-unused dialog widget))
 (close dialog)
 t)
```

```
(in-package :user)

; load CBR program here
(load "CBRloader.cl")
(format t "FINISHED")

;initialization
(eval-when (compile load eval)
  (require :jlinker)
  (format t "BBB")
  (use-package :javatools.jlinker))


(format t "~%GGTS CBR~%To begin interaction with Java, type: (start-listening)")


;advertise method allows for Java/Lisp communication
(defun advertise (&optional (port 3360) (host "localhost"))
  (jlinker-init :lisp-advertises
                        :lisp-host host
                        :lisp-port port
                        :verbose t
            )
)


; this method runs a loop so Lisp is always
; listening for a Java connection
(defun start-listening()
  (loop while t do (progn
            (if (not (jlinker-query)) (progn
              (advertise)
            ))
              (sleep 1) ;pause to allow for disconnecting
  ))
)
```

```
(setq *doctors-specialties*
   '((kevin-m-o^neil PULMONARY)
     (andrew-j-reynolds          PULMONARY)
     (kevin-d-deweber            FAMILY-PRACTICE)
     (salvatore-a-manno          NEPHROLOGY)
     (sophia-l-yohe    NEPHROLOGY)
     (alicia-y-armstrong         OB/GYN)
     (andrew-d-montemarano    DERMATOLOGY)
     (ann-n-kim        PM&R)
     (arn-h-eliasson   PULMONARY-MEDICINE)
     (arthur-w-loesevitz         ALLERGY)
     (burkhardt-h-zorn           UROLOGY)
     (christina-m-yuan           NEPHROLOGY)
     (clifton-a-hawkes           INFECTIOUS-DISEASE)
     (cydney-l-fenton PEDIATRIC-ENDOCRINOLOGY)
     (dale-k-block     GASTROENTEROLOGY)
     (erin-m-bohen     NEPHROLOGY)
     (george-w-turiansky         DERMATOLOGY)
     (glenn-w-wortmann           INFECTIOUS-DISEASES)
     (henry-b-burch    ENDOCRINOLOGY)
     (james-m-ecklund            NEUROSURGERY)
     (jeffrey-l-jacksonINTERNAL-MEDICINE)
     (kevin-a-ceckowski          RENAL-TRANSPLANT-LICSW)
     (kevin-c-abbott   NEPHROLOGY)
     (kurt-l-maggio    DERMATOLOGY)
     (laurie-j-smith   ALLERGY)
     (marc-p-difazio   PEDIATRIC-NEUROLOGY)
     (margretta-m-diemer         INTERNAL-MEDICINE)
     (maria-h-sjogren GASTROENTEROLOGY)
     (mark-d-menich ALLERGY)
     (mary-k-mather    DERMATOLOGY)
     (merrily-y-poth   ENDOCRINE/PEDIATRICS)
     (michael-h-mitchell         NEUROLOGY)
     (milton-t-smith   GASTROENTEROLOGY)
     (nagla-a-wahab    PHARMACY)
     (nancy-l-grass    INTERNAL-MEDICINE)
     (oleh-w-hnatiuk   PULMONARY)
     (pankaj-j-malik   CARDIOLOGY)
     (rita-l-svec      PEDIATRIC-ENDOCRINOLOGY)
     (robert-a-vigersky          ENDOCRINOLOGY)
     (robert-e-jeschke CARDIOLOGY)
     (robert-j-christie HEMATOLOGY/ONCOLOGY)
     (robert-j-labutta NEUROLOGY)
     (robert-l-ramsey INTERNAL-MEDICINE)
     (ruben-j-alvero   OB/GYN)
     (sandra-e-smith   NUTRITION-CARE)
     (sean-d-o^donnell           VASCULAR-SURGERY)
     (stephen-j-krivda DERMATOLOGY)
     (steven-e-braverman         PM&R)
     (steven-r-shannon           PM&R)
     (stuart-a-roop    PULMONARY)
     (thomas-m-wiley CARDIOLOGY)
     (thomas-r-furlow NEUROSURGERY)
     (victor-j-bernet  ENDOCRINOLOGY)
     (william-e-duncan           ENDOCRINOLOGY)
     (william-f-kelly  PULMONARY-MEDICINE)
     (w-s-frank        ALLERGY))
   )
```

```
;;; location-class.lsp


(defclass location
  ()
 ((printname :initarg :printname
         :initform ""
         :accessor printname)
  (list-of-instances :initarg :list-of-instances
              :initform '()
              :accessor list-of-instances
              :allocation :class)
  (longitude :initarg :longitude
         :initform 0
         :accessor longitude)
  (latitude :initarg :latitude
        :initform 0
        :accessor latitude)
  (type-of-facility :initarg :type-of-facility
             :initform ""
             :accessor type-of-facility)
  (specialties :initarg :specialties
          :initform '()
          :accessor specialties)
  (modality :initarg :modality
        :initform '()
        :accessor modality)
  (service :initarg :service
       :initform ""
       :accessor service)
  (name :initarg :name
     :initform ""
     :accessor name)
  (city :initarg :city
     :initform ""
     :accessor city)
  (state :initarg :state
      :initform ""
      :accessor state)
  (code1 :initarg :code1
      :initform ""
      :accessor code1)
  (code2 :initarg :code2
      :initform ""
      :accessor code2)
  (country :initarg :country
       :initform ""
       :accessor country)
  (current-location :initarg :current-location
             :initform ""
             :accessor current-location)
  (pending-consults :initarg :pending-consults
             :initform '()
             :accessor pending-consults)
  (replied-consults :initarg :replied-consults
             :initform '()
             :accessor replied-consults)
  (list-of-consultants :initarg :list-of-consultants
              :initform '()
              :accessor list-of-consultants)
))

;;; latitude is North or South
;;; longitude is West or East

;;; North or West are positive
;;; South or East are negative
```

```
;(setq madrid-SP (make-instance 'location :longitude 0.064577182 :latitude 0.705694794))
;(setq wellington-NZ (make-instance 'location :longitude -3.050544644 :latitude -0.720530093))

;(setq pittsburgh-pa (make-instance 'location :longitude "80" :latitude (princ-to-string (float (+ 40 (/ 26 60))))))
;(setq Kuwait (make-instance 'location :longitude "-47.992" :latitude "29.324"))

(defun distance-between (lat1 long1 lat2 long2)
 (if (or (null lat1)
       (null long1)
       (null lat2)
       (null long2))
    nil
  (let* ((lat-city1 (/ (* lat1 pi) 180))
       (long-city1 (/ (* long1 pi) 180))
       (lat-city2 (* lat2 (/ pi 180)))
       (long-city2 (* long2 (/ pi 180)))
       (earth-radius 3963.205)
       (argument (+ (* (cos (- long-city1 long-city2)) (cos lat-city1) (cos lat-city2))
                  (* (sin lat-city1) (sin lat-city2)))))
    (* earth-radius (acos argument)))
  ))


(setf temp-location (make-instance 'location))

(defun make-location (data-string)
 (let* ((type-of-facility (nth 0 data-string))
      (service (nth 1 data-string))
      (description (nth 2 data-string))
      (name (make-name-from-description description))
      (city (nth 3 data-string))
      (state (nth 4 data-string))
      (code1 (nth 5 data-string))
      (code2 (nth 6 data-string))
      (country (nth 7 data-string))
      (latitude (nth 8 data-string))
      (longitude (nth 9 data-string))
      (modality (nth 10 data-string))
      (specialties (nth 11 data-string)))
  (cond ((null (my-instancep (string-to-symbol name)))
       (make-a-class-instance 'location (string-to-symbol name))
       (setf (type-of-facility (eval (string-to-symbol name))) type-of-facility)
       (setf (service (eval (string-to-symbol name))) service)
       (setf (name (eval (string-to-symbol name))) description)
       (setf (city (eval (string-to-symbol name))) city)
       (setf (state (eval (string-to-symbol name))) state)
       (setf (code1 (eval (string-to-symbol name))) code1)
       (setf (code2 (eval (string-to-symbol name))) code2)
       (setf (country (eval (string-to-symbol name))) country)
       (setf (latitude (eval (string-to-symbol name))) latitude)
       (setf (longitude (eval (string-to-symbol name))) longitude)
       (setf (modality (eval (string-to-symbol name))) modality)
       (setf (specialties (eval (string-to-symbol name))) specialties)
       (setf (current-location (eval (string-to-symbol name)))
         (if (equal (current-location (eval (string-to-symbol name))) "") city))
       )
       (t
       nil))))


(defun make-name-from-description (the-string)
 (let ((n (find-the-first-blank the-string)))
  (cond ((null n) the-string)
       (t
       (make-name-from-description
        (concatenate 'string (subseq the-string 0 (- n 1)) "_" (subseq the-string n))
        )))))

(mapc #'(lambda (x) (make-location x)) *locations*)
```

```
;; Code for the location-info :location-info


(defclass location-info (dialog)
 ())

(defun facility-save-information-on-click (dialog widget)
 (declare (ignore-if-unused dialog widget))
 (let* ((facility (dialog-field (location-info) :facility-value))
       (facility-symbol (string-to-symbol facility))
       (service (dialog-field (location-info) :service-value))
       (type (dialog-field (location-info) :type-value))
       (city (dialog-field (location-info) :city-value))
       (state (dialog-field (location-info) :state-value))
       (latitude (dialog-field (location-info) :latitude-value))
       (longitude (dialog-field (location-info) :longitude-value))
       (country (dialog-field (location-info) :country-value))
       (code1 (dialog-field (location-info) :code1-value))
       (code2 (dialog-field (location-info) :code2-value))
       (deployment-location (dialog-field (location-info) :deployment-location-value))
       (modality (dialog-field (location-info) :modality-value))
       (specialties (dialog-field (location-info) :specialty-value)))
  (if (not (member facility-symbol (list-of-instances temp-location)))
      (progn
       (make-a-class-instance 'location facility-symbol)
       (eval `(setf (service ,facility-symbol) (quote ,service)))
       (eval `(setf (type-of-facility ,facility-symbol) (quote ,type)))
       (eval `(setf (city ,facility-symbol) (quote ,city)))
       (eval `(setf (state ,facility-symbol) (quote ,state)))
       (eval `(setf (latitude ,facility-symbol) (quote ,latitude)))
       (eval `(setf (longitude ,facility-symbol) (quote ,longitude)))
       (eval `(setf (country ,facility-symbol) (quote ,country)))
       (eval `(setf (code1 ,facility-symbol) (quote ,code1)))
       (eval `(setf (code2 ,facility-symbol) (quote ,code2)))
       (eval `(setf (current-location ,facility-symbol) (quote ,deployment-location)))
       (eval `(setf (modality ,facility-symbol) (quote ,modality)))
       (eval `(setf (specialties ,facility-symbol) (quote ,specialties))))
    (progn
     (eval `(setf (service ,facility-symbol) (quote ,service)))
     (eval `(setf (type-of-facility ,facility-symbol) (quote ,type)))
     (eval `(setf (city ,facility-symbol) (quote ,city)))
     (eval `(setf (state ,facility-symbol) (quote ,state)))
     (eval `(setf (latitude ,facility-symbol) (quote ,latitude)))
     (eval `(setf (longitude ,facility-symbol) (quote ,longitude)))
     (eval `(setf (country ,facility-symbol) (quote ,country)))
     (eval `(setf (code1 ,facility-symbol) (quote ,code1)))
     (eval `(setf (code2 ,facility-symbol) (quote ,code2)))
     (eval `(setf (current-location ,facility-symbol) (quote ,deployment-location)))
     (eval `(setf (modality ,facility-symbol) (quote ,modality)))
     (eval `(setf (specialties ,facility-symbol) (quote ,specialties)))))
  )
 t)


(defun facility-close-button-on-click (dialog widget)
 (declare (ignore-if-unused dialog widget))
 (close dialog)
 t)

(defun facility-clear-form-button-on-click (dialog widget)
 (declare (ignore-if-unused dialog widget))
 (eval `(set-dialog-field (location-info) :facility-value ""))
 (eval `(set-dialog-field (location-info) :service-value ""))
 (eval `(set-dialog-field (location-info) :type-value ""))
 (eval `(set-dialog-field (location-info) :city-value ""))
 (eval `(set-dialog-field (location-info) :state-value ""))
 (eval `(set-dialog-field (location-info) :latitude-value ""))
 (eval `(set-dialog-field (location-info) :longitude-value ""))
 (eval `(set-dialog-field (location-info) :country-value ""))
```

```
(eval `(set-dialog-field (location-info) :code1-value ""))
(eval `(set-dialog-field (location-info) :code2-value ""))
(eval `(set-dialog-field (location-info) :deployment-location-value ""))
(eval `(set-dialog-field (location-info) :modality-value ""))
(eval `(set-dialog-field (location-info) :specialty-value ""))
t)
```

```
;;; location-information.lsp

(setq *locations* '(("Hospital" "TRICARE" "Landstuhl_Regional_Medical_Center" "Landstuhl" "" "APO AE 09180 " "" "FRG"
"49.42" "-7.57" '("Audio" "Video" "Audio/Video" "Store/Forward" "Email")
          '("CARDIOLOGY" "DENTISTRY" "DERMATOLOGY" "GULF-WAR" "OB/GYN" "PATHOLOGY" "PEDIATRICS"
"PERINATOLOGY" "PREVENTIVE-MEDICINE" "PSYCHIATRY" "PULMONARY" "RADIOLOGY" ))
          ("Hospital" "Army" "Walter_Reed_Army_Medical_Center" "WRAMC" "DC " "20307" "5000" "US" "38.8951"
"77.0369" '("Audio" "Video" "Audio/Video" "Store/Forward" "Email")
          '("ALLERGY" "IMMUNOLOGY" "ANESTHESIOLOGY" "AUDIOLOGY" "CARDIOLOGY"
"CARDIOTHORACIC"
          "CLINICAL-PATHOLOGY" "COLORECTAL-SURGEON" "COMMUNITY-HEALTH-NURSE" "CRITICAL-
CARE" "DENTISTRY" "DERMATOLOGY" "DIAGNOSTIC-RADIOLOGY"
          "EMERGENCY-MEDICAL" "ENDOCRINOLOGY" "ENDOCRINE/PEDIATRICS" "ETHICS"
"GASTROENTEROLOGY" "GENERAL-INTERNIST" "GENERAL-SURGEON"
          "GENETICIST" "GULF-WAR" "GYN-ONCOLOGY" "HAND-SURGEON" "HEALTH-PHYSICS"
"HEMATOLOGY" "INTERNAL-MEDICINE" "INFECTIOUS-DISEASE" "NEPHROLOGY"
          "NEUROLOGY-ADULT" "NEUROLOGY-CHILD" "NEUROPSYCHOLOGY" "NEUROSURGEON" "NUCLEAR-
MEDICINE" "NUTRITION" "OB/GYN"
          "OCCUPATIONAL-HEALTH" "OCCUPATIONAL-THERAPY" "ONCOLOGY" "OPHTHALMOLOGY"
"OPTOMETRY" "ORGAN-TRANSPLANT" "ORTHOPAEDIC-SURGEON"
          "OTOLARYNGOLOGY/ENT" "PAIN-MANAGEMENT" "PATHOLOGY" "PATHOLOGY-ANATOMIC"
"PEDIATRICS"
          "PEDIATRIC-ENDOCRINOLOGY" "PEDIATRIC-GASTROENTEROLOGY" "PHARMACY" "PHYSICAL-MED-
REHABS" "PHYSICAL-THERAPY" "PODIATRY"
          "PREVENTIVE-MEDICINE" "PSYCHIATRY-ADULT" "PSYCHIATRY-CHILD" "PSYCHOLOGY"
"PSYCHOLOGY-CHILD" "PULMONARY" "RADIATION-ONCOLOGY"
          "RADIOLOGY" "RECONSTRUCTIVE-SURGEON" "REFERRAL-SERVICE" "RHEUMATOLOGY" "SPEECH-
PATHOLOGY" "TELEMEDICINE"
          "UROLOGY-ADULT" "VASCULAR-SURGERY"))
         ("Hospital" "Navy" "National_Naval_Medical_Center" "Bethesda" "MD " "20889" "5000" "US" "38.9808" "77.1006"
'("Audio" "Video" "Audio/Video" "Store/Forward" "Email")
          '("ALLERGY" "IMMUNOLOGY" "ANESTHESIOLOGY" "AUDIOLOGY" "CARDIOLOGY"
"CARDIOTHORACIC"
          "CLINICAL-PATHOLOGY" "COLORECTAL-SURGEON" "COMMUNITY-HEALTH-NURSE" "CRITICAL-
CARE" "DENTISTRY" "DERMATOLOGY" "DIAGNOSTIC-RADIOLOGY"
          "EMERGENCY-MEDICAL" "ENDOCRINOLOGY" "ENDOCRINE/PEDIATRICS" "ETHICS"
"GASTROENTEROLOGY" "GENERAL-INTERNIST" "GENERAL-SURGEON"
          "GENETICIST" "GULF-WAR" "GYN-ONCOLOGY" "HAND-SURGEON" "HEALTH-PHYSICS"
"HEMATOLOGY" "INTERNAL-MEDICINE" "INFECTIOUS-DISEASE" "NEPHROLOGY"
          "NEUROLOGY-ADULT" "NEUROLOGY-CHILD" "NEUROPSYCHOLOGY" "NEUROSURGEON" "NUCLEAR-
MEDICINE" "NUTRITION" "OB/GYN"
          "OCCUPATIONAL-HEALTH" "OCCUPATIONAL-THERAPY" "ONCOLOGY" "OPHTHALMOLOGY"
"OPTOMETRY" "ORGAN-TRANSPLANT" "ORTHOPAEDIC-SURGEON"
          "OTOLARYNGOLOGY/ENT" "PAIN-MANAGEMENT" "PATHOLOGY" "PATHOLOGY-ANATOMIC"
"PEDIATRICS" "PEDIATRIC-NEPHROLOGY"
          "PEDIATRIC-ENDOCRINOLOGY" "PEDIATRIC-GASTROENTEROLOGY" "PHARMACY" "PHYSICAL-MED-
REHABS" "PHYSICAL-THERAPY" "PODIATRY"
          "PREVENTIVE-MEDICINE" "PSYCHIATRY-ADULT" "PSYCHIATRY-CHILD" "PSYCHOLOGY"
"PSYCHOLOGY-CHILD" "PULMONARY" "RADIATION-ONCOLOGY"
          "RADIOLOGY" "RECONSTRUCTIVE-SURGEON" "REFERRAL-SERVICE" "RHEUMATOLOGY" "SPEECH-
PATHOLOGY" "TELEMEDICINE"
          "UROLOGY-ADULT" "VASCULAR-SURGERY"))
         ("Hospital" "Army" "Eisenhower_Army_Medical_Center" "Fort Gordon" "GA" "30905" "" "US" "33.364" "82.215"
'("Audio" "Video" "Audio/Video" "Store/Forward" "Email")
          '("ALLERGY" "IMMUNOLOGY" "ANESTHESIOLOGY" "AUDIOLOGY" "CARDIOLOGY"
"CARDIOTHORACIC" "COMMUNITY-HEALTH-NURSE"
          "DERMATOLOGY" "DIAGNOSTIC-RADIOLOGY" "ENDOCRINOLOGY" "GASTROENTEROLOGY"
"GENERAL-INTERNIST"
          "GENERAL-SURGEON" "GYN-ONCOLOGY" "HAND-SURGEON" "HEMATOLOGY" "INFECTIOUS-DISEASE"
"INTERNAL-MEDICINE" "NEPHROLOGY"
          "NEUROLOGY-ADULT" "NEUROLOGY-CHILD" "NEUROPSYCHOLOGY" "NEUROSURGEON" "NUCLEAR-
MEDICINE" "NUTRITION"
          "OB/GYN" "OCCUPATIONAL-HEALTH" "OCCUPATIONAL-THERAPY" "ONCOLOGY"
"OPHTHALMOLOGY" "OPTOMETRY"
          "ORTHOPAEDIC-SURGEON" "OTOLARYNGOLOGY/ENT" "PATHOLOGY-ANATOMIC" "PATHOLOGY-
CLINICAL" "PHARMACY"
          "PHYSICAL-MED-REHABS" "PHYSICAL-THERAPY" "PODIATRY" "PREVENTIVE-MEDICINE"
"PSYCHIATRY-ADULT"
          "PSYCHIATRY-CHILD" "PSYCHOLOGY" "PSYCHOLOGY-CHILD" "PULMONARY-MEDICINE"
"RADIATION-ONCOLOGY" "RADIOLOGY"
```

```
            "RECONSTRUCTIVE-SURGEON" "REFERRAL-SERVICE" "RHEUMATOLOGY" "SPEECH-PATHOLOGY"
"UROLOGY-ADULT"
            "VASCULAR-SURGERY"))
           ("Hospital" "" "Fort_Belvoir" "Fort Belvoir" "VA" ""  "" "US" "38.7" "77.1" '("Audio" "Email"))
           ("Clinic" "" "Woodbridge_Clinic" "Woodbridge" "MD" "" "" "US" "38.658" "77.250" '("Audio" "Email"))
           ("Hospital" "Army" "Keller_Army_Community_Hospital" "West Point" "NY" "" "" "US" "41.402" "73.973"  '("Audio"
"Email"))
           ("Hospital" "Army" "Ireland_Army_Community_Hospital" "Fort Knox" "KY" "40121" "" "US" "37.908" "85.946"
'("Audio" "Email"))
           ("Clinic" "Army" "Guthrie_Ambulatory_Health_Care_Clinic" "Fort Drum" "NY" "" "" "US" "44.163" "75.851" '("Audio"
"Email"))
           ("Clinic" "Army" "Fairfax_clinic" "Fairfax" "VA" "" "" "US" "38.848" "77.304" '("Audio" "Email"))
           ("Clinic" "TRICARE" "DiLorenzo_TRICARE_Health_clinic" "Pentagon" "DC" "" "" "US" "38.85" "77.04"
'("Audio/Video" "Store/Forward" "Email"))
           ("Clinic" "Army" "Kimbrough_Army_Community_Clinic" "Fort Meade" "MD " "20755" "5000" "US" "39.0822"
"76.7601" '("Audio" "Email"))
           ("Clinic" "Army" "Kenner_Army_Clinic" "Fort Lee" "VA" "23801" "5260" "US" "37.255" "77.3372" '("Audio"
"Email"))
           ("Hospital" "Army" "McDonald_Army_Community_Hospital" "Fort Eustis" "VA " "23604" "5567" "US" "37.1626"
"76.5808" '("Audio" "Email"))
           ("Hospital" "Army" "Womack_Army_Medical_Center" "Fort Bragg" "NC" "28310" "5000" "US" "35.121" "79.181"
'("Audio" "Email"))
           ("Clinic" "Army" "Fort_Monmouth" "Fort Monmout" "NJ" "" "" "US" "40.323" "74.039" '("Audio" "Email"))
           ("Clinic" "Army" "Andrew_Rader_Health_clinic" "Fort Myer" "VA" "22211" "" "US" "38.887" "77.088" '("Audio"
"Email"))
           ("Clinic" "Army" "Fort_Detrick" "Fort Detrick" "MD " "21702" "" "US" "39.478" "77.4561" '("Audio/Video"
"Store/Forward" "Email"))

           ("Clinic" "Army" "SHAPE_Health_Care_Facility" "Mons" "" "APO AE 09705" "" "Belgium" "50.58" "-4.05" '("Audio"
"Email"))
           ("Clinic" "Army" "Vicenza_Health_Clinic" "Vicenza" "" "APO AE 09630" "" "Italy" "45.33" "-11.33" '("Audio"
"Email"))
           ("clinic" "Army" "Kleber_clinic" "Klebe" "" "" "" "FRG" "53.465" "-12.20" '("Audio" "Email"))
           ("Clinic" "Army" "livorno_health_clinic" "Livorno" "" "" "" "Italy" "" "" '("Audio" "Email"))
           ("Clinic" "Army" "Baumholder_clinic" "Baumholder" "" "APO AE 09034 " "" "FRG" "49.61666667" "-7.033333333"
'("Audio" "Email"))
           ("Clinic" "Army" "Dexheim_clinic" "Dexheim" "" "APO AE 09111 " "" "FRG" "49.854" "-8.317" '("Audio" "Email"))
           ("Clinic" "Army" "Camp_Darby_Health_Clinic" "Livorno" "" "APO AE 09613" "" "Italy" "43.33" "-10.19" '("Audio"
"Email"))
           ("Clinic" "Army" "Bad_Kreuznach_clinic" "Bad Kreuznach" "" "APO AE 09252 " "" "FRG" "49.52" "-7.51" '("Audio"
"Email"))
           ("Clinic" "Army" "Wiesbaden_clinic" "Wiesbaden" "" "APO AE 09096 " "" "FRG" "50.05" "-8.14" '("Audio" "Email"))
           ; ("Clinic" "Army" "NATO_health_clinic" "" "" "" "" "Belgium" "" "" '("Audio" "Email"))
           ("Hospital" "Army" "Blanchfield_army_community_hospital" "Fort Campbell" "KY" "42223" "" "US" "36.613" "87.632"
'("Audio" "Email"))
           ("Hospital" "Army" "Fox_army_community_hospital" "Redstone Arsenal" "AL" "" "" "US" "" "" '("Audio" "Email"))
           ("Clinic" "Army" "Lawrence_Joel_army_health_clinic" "Fort McPherson" "" "" "" "US" "" "" '("Audio" "Email"))
           ("Hospital" "Army" "Lyster_army_hospital" "Fort Rucker" "AL" "" "" "US" "" "" '("Audio" "Email"))
           ("Hospital" "Army" "Martin_army_community_hospital" "Fort Benning" "" "" "" "US" "" "" '("Audio" "Email"))
           ("Clinic" "Army" "Moncrief_army_health_clinic" "Fort Jackson" "SC" "" "" "US" "" "" '("Audio" "Email"))
           ("Clinic" "Army" "Rodriguez_army_health_clinic" "Fort Buchanan" "Puerto Rico" "" "" "US" "" "" '("Audio" "Email"))
           ("Hospital" "Army" "Winn_army_community_hospital" "Fort Stewart" "GA" "31314" "" "US" "" "" '("Audio" "Email"))
           ("Clinic" "Army" "SOUTHCOM_clinic" "Miami" "FL" "" "" "US" "" "" '("Audio" "Email"))
           ; ("Moody_AFB_347th_MG" "" "FL" "" "" "US" "" "" '("Audio" "Email"))
           ; ("Shaw_AFB_20th_MG" "" "FL" "" "" "US" "" "" '("Audio" "Email"))
           ; ("MacDill_AFB_6th_MG" "Tampa Bay" "FL" "" "" "US" "" "" '("Audio" "Email"))
           ; ("Patrick_AFB_45th_MG" "" "FL" "" "" "US" "" "" '("Audio" "Email"))
           ("Hospital" "Navy" "Charleston_naval_hospital" "North Charleston" "SC" "" "" "US" "" "" '("Audio" "Email"))
           ("Hospital" "Navy" "Beaufort_naval_hospital" "Beaufort" "SC" "" "" "US" "" "" '("Audio" "Email"))
           ; ("Ambulatory Care Center" "Navy" "Kings_Bay_naval_submarine_base" "" "FL" "" "" "US" "" "" '("Audio" "Email"))
           ("Hospital" "Navy" "Jacksonville_naval_hospital" "Jacksonville" "FL" "" "" "US" "" "" '("Audio" "Email"))
           ("Clinic" "Navy" "Mayport_branch_medical_clinic" "" "FL" "" "" "US" "" "" '("Audio" "Email"))
           ("Hospital" "Navy" "Roosevelt_Roads_naval_hospital" "" "FL" "" "" "US" "" "" '("Audio" "Email"))


           ))


(defvar *consultant-sites*
  '((Eisenhower_Army_Medical_Center)
```

```
    (Landstuhl_Regional_Medical_Center)
    (National_Naval_Medical_Center)
    (Walter_Reed_Army_Medical_Center)))

(setq *NARMC* '((Guthrie_Ambulatory_Health_Care_Clinic) ; North Atlantic Regional Medical Command
            (Keller_army_community_hospital)
            (Fort_Monmouth)
            (Kimbrough_Army_Community_Clinic)
            (Walter_Reed_army_medical_center)
            (Fort_Belvoir)
            (Kenner_Army_Clinic)
            (McDonald_Army_Community_Hospital)
            (Womack_Army_Medical_Center)
            (Ireland_army_community_hospital)
            (DiLorenzo_TRICARE_health_clinic)
            (Andrew_Rader_health_clinic)
            (National_naval_medical_center)
            (Fairfax_clinic)
            (Woodbridge_Clinic)
            (Fort_Detrick)
            ))

(setq *LRMC* '((Landstuhl_regional_medical_center) ; Landstuhl Regional Medical Center
            (SHAPE_Health_Care_Facility)
            (Vicenza_Health_Clinic)
            (Kleber_clinic)
            (Baumholder_clinic)
            (Dexheim_clinic)
            (Livorno_health_clinic)
            (Bad_Kreuznach_clinic)
            (Wiesbaden_clinic)
            ; (NATO_health_clinic)
            ))

(setq *SEMHS* '((Eisenhower_Army_Medical_Center) ; Southeast Military Health System
            (Blanchfield_army_community_hospital)
            (Fox_army_community_hospital)
            (Lawrence_Joel_army_health_clinic)
            (Lyster_army_hospital)
            (Martin_army_community_hospital)
            (Moncrief_army_health_clinic)
            (Rodriguez_army_health_clinic)
            (Winn_army_community_hospital)
            (SOUTHCOM_clinic)
            ; (Moody_AFB_347th_MG)
            ; (Shaw_AFB_20th_MG)
            ; (MacDill_AFB_6th_MG)
            ; (Patrick_AFB_45th_MG)
            (Charleston_naval_hospital)
            (Beaufort_naval_hospital)
            ; (Kings_Bay_naval_submarine_base)
            (Jacksonville_naval_hospital)
            ;(Mayport_branch_medical_clinic)
            ;(Roosevelt_Roads_naval_hospital)
            ))
```

```
(setq *specialties*
    '((ADULT-MEDICINE)
     (ALLERGY ALLERGIST ALLERGY/INMUNOLOGY)
     (IMMUNOLOGY INMUNOLOGIST ALLERGY/INMUNOLOGY)
     (ANESTHESIOLOGY ANESTHESIOLOGIST)
     (AUDIOLOGY AUDIOLOGIST PEDIATRIC-AUDIOLOGY)
     (PEDIATRIC-AUDIOLOGY AUDIOLOGY AUDIOLOGIST)
     (AUDIOLOGIST AUDIOLOGY PEDIATRIC-AUDIOLOGY)
     (CARDIOLOGY CARDIOLOGIST)
     (CARDIOLOGIST CARDIOLOGY)
     (CARDIOTHORACIC)
     (CLINICAL-PATHOLOGY PATHOLOGIST PATHOLOGY/CLINICAL)
     (COLORECTAL-SURGEON)
     (COMMUNITY-HEALTH-NURSE COMMUNITY-HEALTH)
     (CRITICAL-CARE CRITICAL-CARE-MEDICINE CCM)
     (DENTISTRY DENTIST)
     (DERMATOLOGY DERMATOLOGIST)
     (DIAGNOSTIC-RADIOLOGY RADIOLOGY/DIAGNOSTIC)
     (EMERGENCY-MEDICAL EMERGENCY)
     (ENDOCRINOLOGY ENDOCRINOLOGIST)
     (ENDOCRINE/PEDIATRICS PEDIATRIC-ENDOCRINOLOGIST PEDIATRIC-ENDOCRINOLOGY)
     (PEDIATRIC-ENDOCRINOLOGIST ENDOCRINE/PEDIATRICS PEDIATRIC-ENDOCRINOLOGY)
     (PEDIATRIC-ENDOCRINOLOGY ENDOCRINE/PEDIATRICS PEDIATRIC-ENDOCRINOLOGIST)
     (ETHICS)
     (FAMILY-PRACTICE FP FAMILY-MEDICINE)
     (GASTROENTEROLOGY GASTROENTEROLOGIST)
     (PEDIATRIC-GASTROENTEROLOGY GASTROENTEROLOGY/PEDIATRICS PEDIATRIC-GASTROENTEROLOGIST)
     (GASTROENTEROLOGY/PEDIATRICS PEDIATRIC-GASTROENTEROLOGY PEDIATRIC-GASTROENTEROLOGIST)
     (PEDIATRIC-GASTROENTEROLOGIST GASTROENTEROLOGY/PEDIATRICS PEDIATRIC-GASTROENTEROLOGY)
     (GENERAL-INTERNIST INTERNIST INTERNAL-MEDICINE)
     (GENERAL-SURGEON)
     (GENETICIST)
     (GERIATRICS)
     (GULF-WAR)
     (GYN-ONCOLOGY)
     (HAND-SURGEON)
     (HEALTH-PHYSICS)
     (HEMATOLOGY HEMATOLOGIST)
     (INFORMATION-MANAGEMENT MANAGEMENT INFORMATION)
     (INTERNAL-MEDICINE GENERAL-INTERNIST)
     (INFECTIOUS-DISEASES INFECTIOUS-DISEASE PEDIATRIC-INFECTIOUS-DISEASE)
     (INFECTIOUS-DISEASE INFECTIOUS-DISEASES PEDIATRIC-INFECTIOUS-DISEASES)
     (NEPHROLOGY NEPHROLOGIST PEDIATRIC-NEPHROLOGY)
     (NEPHROLOGIST NEPHROLOGY PEDIATRIC-NEPHROLOGY)
     (PEDIATRIC-NEPHROLOGY NEPHROLOGIST NEPHROLOGY)
     (NEUROLOGY NEUROLOGY-ADULT ADULT-NEUROLOGY)
     (NEUROLOGY-ADULT NEUROLOGY ADULT-NEUROLOGY)
     (ADULT-NEUROLOGY NEUROLOGY-ADULT NEUROLOGY)
     (NEUROLOGY-CHILD CHILD-NEUROLOGY PEDIATRIC-NEUROLOGY)
     (PEDIATRIC-NEUROLOGY NEUROLOGY-CHILD CHILD-NEUROLOGY)
     (CHILD-NEUROLOGY NEUROLOGY-CHILD PEDIATRIC-NEUROLOGY)
     (NEUROPSYCHOLOGY)
     (NEUROSURGERY NEUROSURGEON)
     (NEUROSURGEON NEUROSURGERY)
     (NUCLEAR-MEDICINE)
     (NURSING)
     (NUTRITION NUTRITION-CARE)
     (NUTRITION-CARE NUTRITION)
     (OB/GYN OBSTETRICS GYNECOLOGY OBSTETRICS/GYNECOLOGY)
     (OCCUPATIONAL-HEALTH)
     (OCCUPATIONAL-THERAPY)
     (ONCOLOGY ONCOLOGIST HEMATOLOGY/ONCOLOGY)
     (HEMATOLOGY/ONCOLOGY ONCOLOGY ONCOLOGIST)
     (ONCOLOGIST ONCOLOGY HEMATOLOGY/ONCOLOGY)
     (OPHTHALMOLOGY OPHTHALMOLOGIST)
     (OPTOMETRY OPTOMETRIST)
     (ORGAN-TRANSPLANT)
     (ORTHOPAEDICS ORTHOPAEDIC-SURGEON)
```

```
      (ORTHOPAEDIC-SURGEON ORTHOPAEDICS)
      (OTOLARYNGOLOGY/ENT OTORYNGOLOGIST ENT OTOLARINGOLOGY-SERVICE)
      (PAIN-MANAGEMENT PM&R)
      (PM&R PAIN-MANAGEMENT)
      (PATHOLOGY-ANATOMIC PATHOLOGY PATHOLOGY/ANATOMIC)
      (PATHOLOGY/ANATOMIC PATHOLOGY-ANATOMIC PATHOLOGY)
      (PATHOLOGY PATHOLOGY-ANATOMIC PATHOLOGY/ANATOMIC)
      (PERINATOLOGY)
      (PEDIATRICS PEDIATRICIAN)
      (PEDIATRICIAN PEDIATRICS)
      (PHARMACY)
      (PHYSICAL-MED-REHABS)
      (PHYSICAL-THERAPY)
      (PODIATRY)
      (PREVENTIVE-MEDICINE)
      (PRIMARY-CARE)
      (PSYCHIATRY)
      (PSYCHIATRY-ADULT ADULT-PSYCHIATRY)
      (PSYCHIATRY-CHILD CHILD-PSYCHIATRY)
      (PSYCHOLOGY PSYCHOLOGIST)
      (PSYCHOLOGY-CHILD CHILD-PSYCHOLOGIST)
      (PULMONARY PULMONARY-MEDICINE)
      (PULMONARY-MEDICINE PULMONARY)
      (RADIATION-ONCOLOGY)
      (RADIOLOGY RADIOLOGIST)
      (RADIOLOGIST RADIOLOGY)
      (RECONSTRUCTIVE-SURGEON RECONSTRUCTIVE-SURGERY)
      (RECONSTRUCTIVE-SURGERY RECONSTRUCTIVE-SURGEON)
      (REFERRAL-SERVICE REFERRAL)
      (RENAL-TRANSPLANT-LICSW)
      (RHEUMATOLOGY RHEUMATOLOGIST)
      (SPEECH-PATHOLOGY)
      (TELEMEDICINE)
      (UROLOGY UROLOGY-ADULT ADULT-UROLOGY)
      (UROLOGY-ADULT UROLOGY ADULT-UROLOGY)
      (ADULT-UROLOGY UROLOGY-ADULT UROLOGY)
      (VASCULAR-SURGERY VASCULAR-SURGEON)
      ))

(defclass specialty-class ()
  ((printname :initarg :printname
          :initform ""
          :accessor printname)
   (list-of-instances :initarg :list-of-instances
                :initform '()
                :accessor list-of-instances
                :allocation :class)
   (synonyms :initarg :synonyms
          :initform '()
          :accessor synonyms)
   (list-of-words :initarg :list-of-words
              :initform '()
              :accessor list-of-words)
  ))

(setq unassigned-specialty (make-instance 'specialty-class))
(setq temp-specialty (make-instance 'specialty-class))

(mapc #'(lambda (x) (let ((specialty-name (car x))
                  (synonyms (cdr x)))
              (cond ((null (my-instancep specialty-name))
                   (make-a-class-instance 'specialty-class specialty-name)
                   (setf (synonyms (eval specialty-name)) synonyms))
                  (t
                   (setf (synonyms (eval specialty-name)) synonyms)))))
 *specialties*)

(defmethod is-a-synonym  (word (specialty-instance specialty-class))
  (let ((synonyms (synonyms specialty-instance)))
    (if synonyms
```

```
    (if (not (null (remove nil
                   (mapcar #'(lambda (x) (search (nstring-upcase (string word)) (string x)))
                    synonyms)
                   :test #'equal)))
      T
     nil))))

(defun find-existing-specialty (sugg-spec)
 (remove nil
     (mapcar #'(lambda (x) (if (or (member sugg-spec (synonyms (eval x)) :test #'equal)
                        (equal sugg-spec x))
                    x))
      (list-of-instances temp-specialty))
     :test #'equal))

(defun is-a-specialty (word)
 (remove nil
     (mapcar #'(lambda (x) (if (or (is-a-synonym word (eval x))
                        (equal (nstring-upcase (string word)) (printname (eval x))))
                    x)) (list-of-instances temp-specialty))
     :test #'equal))

(defun is-a-specialty-in-a-list (word the-list)
 (remove nil
     (mapcar #'(lambda (x) (cond ((null (my-instancep x))
                        (make-a-class-instance 'specialty-class x)
                        (if (or (is-a-synonym word (eval x))
                              (equal (nstring-upcase (string word)) (printname (eval x))))
                          x))
                       (t
                        (if (or (is-a-synonym word (eval x))
                              (equal (nstring-upcase (string word)) (printname (eval x))))
                          x))))
      the-list)
     :test #'equal))

(defun same-specialty (word1 word2) ;; word1 and word2 are symbols
 (if (and (is-a-specialty word1) (is-a-specialty word2))
    (if (or (is-a-synonym word1 (eval word2))
         (is-a-synonym word2 (eval word1))
         (equal word1 word2))
         t)))
```

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(setq *specialty-words* '(
  (ENDOCRINE/PEDIATRICS NO DATA THAT I KNOW OF THAT TREATMENT IS INDICATED I
   WOULD NOT CULTURE THIS PT IN THE FIRST PLACE
  )
  (VASCULAR-SURGERY NOT UNCOMMON WOULD NOT PURSUE FURTHER SEAN)
  (NUTRITION-CARE I^LL FORWARD THIS TO NAGAL WAHAB NUTRITION SUPPORT PHAMACIST
   IN CASE SHE HAS COMMENTS
  )
  (PEDIATRIC-AUDIOLOGY DR RAMSEY I WILL GIVE HER A CALL THANKS DONNA MACNEIL)
  (INFECTIOUS-DISEASE SORRY FOR THE DELAY IN RESPONDING AND PAGE THE
   PEDIATRIC ID FELLOW ON CALL TO DISCUSS THE CASE
  )
  (PEDIATRIC-NEPHROLOGY IT SOUNDS AS THOUGH THIS PATIENT MAY HAVE PASSED A
   KIDNEY STONE HOWEVER THE HISTORY IS UNCLEAR TO ME IT MAY BE WORTHWHILE FOR
   THE PATIENT TO BE EVALUATED BY YOUR UROLOGIST BEFORE REFERRAL BACK TO THE
   US TO SEE ME A 24 HOUR URINE PROTEIN OF 534 MG MAY BE ELEVATED BUT MAY BE
   AS SIMPLE AS ORTHOSTATIC PROTEINURIA DOES THIS PATIENT HAVE HYPERTENSION
   DYURIA FLANK AND SUPRAPUBIC PAIN ON NOT USUALLY A CHARACTERISTIC FINDING
   WITH ACUTE OR CHRONIC GLOMERULAR DISEASETHANKS IF IT IS EASIER FOR YOUR I
   AM ALSO ON THE OUTLOOK GLOBAL ADDRESS LIST TO SEND E MAIL THANKS LYNNE YAO
   MD CHIEF PEDIATRIC NEPHROLOGY RECEIVED YOUR TEL MESSAGE BUT UNFORTUNATELY
   AM UNABLE TO CONNECT TO DSN OVERSEAS I^M STILL UNCLEAR ABOUT THE HISTORY
   ON THIS PATIENT AND THEREFORE NOT SURE THAT IT IS NECESSARY FOR HIM TO BE
   A E HERE 1 DOES THIS PATIENT HAVE A HISTORY OF ELEVATED BP 2 DOES THIS
   PATIENT CURRENTLY HAVE HEMATURIA OR AN ELEVATED URINE PROTEIN CREATININE
   RATIO 3 DOES THIS PATIENT HAVE ELEVATED SERUM CHEMISTRIES THESE ARE EASY
   BUT IMPORTANT TESTS THAT SHOULD BE RUN PRIOR TO SENDING HIM HERE IF THESE
   TESTS ARE NORMAL IT IS UNLIKELY THAT AN EVALUATION BY ME BE ANY MORE
   HELPFUL THAN AN EVALUATION BY A UROLOGIST I WOULD BE HAPPY TO DISCUSS THIS
   CASE WITH YOU PERSONALLY IF YOU COULD SEND ME YOUR COMMERCIAL NUMBER THAT
   WOULD BE HELPFUL ALSO I^D BE HAPPY TO DISCUSS THIS CASE WITH YOUR FP STAFF
   PHYSICIAN IF THIS WOULD HELP CLARIFY THE SITUATION ANOTHER OPTION WOULD BE
   TO SEND HIM TO SEE THE PEDIATRIC STAFF AT LANDSTUHL FOR EVALUATION PLEASE
   DON^T TAKE THIS TO MEAN THAT I DO NOT WANT TO SEE THE PATIENT BUT I^M NOT
   SURE THAT SENDING HIM BACK AT GOVERNMENT EXPENSE IS THE BEST SOLUTION
   CURRENTLY BASED ON THE CLINICAL SITUATION THANKS FOR YOUR HELP LYNNE YAO
   MD
  )
  (PM&R THANKS FOR INCLUDING US CHRIS THANKS FOR THE INFORMATION I HAVE AN AD
   VIP WITH SIGNIFICANT ANKLE DJD TENDINITIS WHO SAYS HE HAS AN ASPIRIN
   ALLERGY NOTHING IOTED IN CHCS AND HAS BEEN TOLD THAT HE CAN^T TAKE NSAIDS
   DO THE NEWER NSAIDS ALSO HAVE THIS RECOMMENDATION THANKS SRS THANKS FOR
   THE REPLY I^M TOLD THAT THIS PT DOES DID HAVE AN ANAPHYLACTIC TYPE
   REACTION ALTHOUGH LOCAL STEROID INJECTION IS USUALLY CONSIDERED I SUPPOSE
   ORAL STEROIDS WOULD BE THE ONLY OTHER ORAL ANTI INFLAMMATORY OPTION FOR
   TENDINITIS IN SOMEONE WITH AN ASA ALLERGY THANKS I^M GOING TO FWD THIS TO
   COL BLOCK WHO IS THE MD COORDINATOR FOR THIS VIP COL BLOCK JUST AS A HEADS
   UP WHEN I CHECKED CHCS FOR THIS VIP^S ALLERGIC REACTION THERE WERE NO
   ALLERGIES NOTED SHOULD THIS BE NOTED IN CHCS FOR THIS PT^S SAFETY SRS
  )
  (PULMONARY I WILL GIVE THEM A CALL JOHN I AGREE WITH YOUR ASSESSMENT
   REGARDING THE PROBABLE CAUSE OF HISINTERSTITIAL CHANGES AND ALSO AGREE
   THAT HE NEEDS TO BE SEEN BY APULMONOLOGIST DETERMINING THE DIFFERENCE
   NONINVASIVELY IS NOT EASY BUTSTUART SHOULD BE UP TO THE CHALLENGE THANKS
   FOR THE REFERRAL OWH THERE ARE ALSO ASSOCIATIONS WITH ATYPICAL
   MYCOBACTERIAL INFECTIONS AND ESOPHAGEAL DISEASE AS WELL TO CONSIDER WE
   WOULD BE VERY HAPPY TO SEE HER THE CT SCAN ALONG WITH OLD CXRS IF
   AVAILABLE WOULD BE THE MOST VALUABLE STUDIES WE COULD SEE HER AS EARLY AS
   NEXT WEEK THURSDAY AFTERNOON 6 APRIL WITH POSSIBLE BRONCHOSCOPY FRIDAY
   STUART ROOP WE ARE ON WD 77 7TH FLOOR PULMONARY MEDICINE CLINIC I WILL SEE
   HER THEN THANKS
  )
  (PEDIATRIC-NEUROLOGY I WOULD BE CONCERNED REGARDING THIS HISTORY OF FEAR OF
   NEGLECT I WOULD RECOMMEND THAT IT BE DONE SOONER THAN LATER AND EXPEDITED
   THROUGH THE SEDATION UNIT IF AT ALL POSSIBLE IT IS LIKELY TO BE NORMAL
   FROM AN INTRACRANIAL STANDPOINT BUT EVEN A SIMPLE LINEAR FRACTURE SHOULD
   BE AND FOLLOWED BECAUSE OF THE POSSIBILITY OF A LEPTOMENINGEAL CYST I WILL
   FORWARD THIS TO MAJ COUGHLIN WHO IS EXTREMELY BUSY BUT MAY BE ABLE TO HELP
   US I WOULD NOT WAIT FOR AN OUTPATIENT SCHEDULE TO OPEN UP IF THE SCHEDULE
   IS FULL IS DR BASSEY ABLE TO HELP YOU FACILITATE THIS LET US KNOW IF WE
```

CAN HELP MD
)
(PEDIATRIC-ENDOCRINOLOGY SHE APPEARS TO BE ONE OF THE UNFORTUNATE WOMEN WHO IS HAVING PROBLEMS WITH THE DEPO ALL OF HER SYMPTOMS CAN BE EXPLAINED BY THE DEPO SHOT HOWEVER BECAUSE HER HEADACHE IS SO SEVERE SHE SHOULD HAVE A GOOD FUNDISCOPIC EXAMINTION TO RULE OUT THE PRESENCE OF INCREASED ICP PSEUDUTUMOR CEREBRI THERAPEUTIC INTERVENTIONS SHOULD INCLUDE DISCONTINUING OF THE MEDICATION AND TREATMENT OF HER MIGRAINE MOTRIN OR NAPROSYN OR IMITREX ETC IF HER EXAM REVEALS EVIDENCE OF PAPILLEDEMA MEDROXYPROGESTERONE THERAPY SHOULD NOT BE RE INITIATED YES OF COURSE WE WOULD BE VERY HAPPY TO SEE HER AFTER YOU ENTER THE CONSULT PEDIATRIC ENDOCRINOLOGY SHE CAN TRY SIERRA OR BETTER YET CALL AND THEY CAN SCHEDULE AN APPOINTMENT TO SEE US SINCE WE HAVE NO PED ENDO CLINIC THIS WEEK DUE TO USUHS RESEARCH DAY SHE SHOULD COME INTO EITHER ADOLESCENT CLINIC AT NNMC OR GENERAL PEDS CLINIC AT IF SHE CAN^T GO TO SCHOOL SHE NEEDS TO BE SEEN THIS WEEK
)
(NEUROLOGY BELIEVE IT OR NOT I WAS LOOKING AT THAT SUPPL TODAY I HAVE A COPY IN MY ALTERNATIVE IS FOR PCM TO REQ ADMISSION WARD 51 ESP IF CH PROTECTIVE ISSUES ARE OF CONERN AGREE WITH ABOVE VERTEBRAL ARTERY HYPOPLASIA IS COMMON BUT QUANTIFYING THE CONCERN IS BASED UPON INFORMATION THAT WOULD BE INCLUDED IN A COMPLETE H & P PREVIOUS HA PRIOR TO 3 MONTHS AGO HX OF TRAUMA EVEN MINOR SENSORY SYMPTOMS OR SIGNS OCULOSYMPATHETIC PARESIS WOULD BE SOME OF THE THINGS THAT I WOULD LIKE TO KNOW RITA
)
(INFORMATION-MANAGEMENT DR OTT THIS WAS TRANSMITTED TO WRAMC WITHOUT ANY PROBLEMS YOU MIGHT WANT TO CALL WRAMC SINCE THIS PERSON MIGHT BE ON LEAVE OR TDY FRAN WE WERE HAVING EMAIL TRANSMISSION PROBLEMS AT KELLER I AM PASTING DR OTT^S MESSAGE BELOW FRAN ^I HAVE A 35 Y O FEMALE WHO IS GETTING MARRIED AND IS CONCERNED ABOUT TRANSMITTING HSV II TO HER SPOUSE EVEN THOUGH SHE DOES NOT HAVE ANY ACTIVE LESIONS SHE WAS TOLD THAT SHE HAD GENITAL HERPES WHEN SHE WAS YOUNGER BUT SINCE THEN HAS NEVER HAD A RECURRENCE SHE ALSO CAME TO THE OFFICE LOOKING FOR A BLOOD TEST THAT WOULD DEMONSTRATE THAT SHE DEFINATELY HAD PRIOR EXPOSURE TO HSV II THE SERUM HSV II IGM WAS 1 42 AND IGG >3 SHE WANTS TO KNOW HOW TO PREVENT THE SPREAD OF THE HSV AND WHETHER OR NOT TAKING PROPHYLAXIS WOULD HELP PREVENT SHEDDING OF THE VIRUS TO HER PARTNER IN THE ARE THERE TIMES WHERE YOU WOULD RECOMMEND PROPHYLAXIS FOR THE SOLE RESEAON TO PREVENT FUTURE OUTBREAKS AND THUS HOPEFULLY REDUCE THE CHANCE OF TRANSMISSION TO ANOTHER PERSON IN A PATIENT AS MENTIONED ABOVE DR OTT THE MESSAGES ARE GOING THROUGH HOW ABOUT YOU DO A CUT AND PASTE AND SEND A NEW MESSAGE FRAN
)
(ALLERGY SORRY FOR TARDY RESPONSE SOMEHOW I MISSED THIS ONE USUALLY CONTACT ALLERGY IS TO A COMPONENT OF THE GLOVES OTHER THAN THE LATEX POWDER ACCELERANT ETC WE USUALLY REFER SUCH PTS TO DERM FOR PATCH TESTING MY GUESS IS THAT YOU WILL PROBABLY BE ABLE TO PROCEED WITH THE VALVULOPLASTY BUT WE SHOULD SEE HER IN THIS CLINIC FIRST TO SCREEN HER FOR TRUE LATEX ALLERGY TOM THE DECEMBER 1998 ISSUE OF NEUROLOGY HAD A SUPPLEMENT THAT ADDRESSED THE USE OF IVIG IN NEUROLOGIC DISORDERS THE LIBRARY^S COPY IS IN A VERY THICK BOUND VOLUME THAT DOESN^T LEND ITSELF TO QUALITY COPYING DOES ANYONE HAVE A LOOSE COPY ON HIS OR HER JOURNAL SHELF THAT I COULD BORROW BRIEFLY TO MAKE A MORE READABLE COPY THANKS MARK MENICH WHAT A SYSTEM HUH ON MY WAY GOOD THANKS IT^S A DECENT INTRODUCTORY SUMMARY AND THE REFERENCES ARE NUMEROUS DID YOU GET AN ANSWER TO THIS WE USUALLY DO NOT DO TITERS BUT RATHER IMMUNIZE ACCORDING TO REQUIREMENTS AND HAVE OCCUPATIONAL HEALTH OR PRIMARY MD DO THE TITERS SHE SHOULD HAVE ONE ADULT DOSE OF POLIO VACCINE IF SHE HAS NOT GIVE IT YOU SHOULD DO THE RUBELLA RUBEOLA MUMPS VARICELLA TITERS SHE PROPABLY NEEDS HEP A IN DAY CARE AND POSSIBLY EVEN HEP B OK TO DO TETANUS BOOSTER IF IT HAS BEEN 10 YRS I AM NOT AWARE OF THIS BEING A CONTRAINDICATION IT SOUNDS LIKE THIS PATIENT DESERVES TO BE SEEN BY OUR DEPARTMENT TO HELP SORT OUT THIS PROBLEM I THINK I HAVE SEEN THIS VIP AND KNOW ABOUT THE PROBLEMS
)
(PULMONARY-MEDICINE AS BRIEFLY MENTIONED AT WED AM CONFERENCE INH X 9 MONTHS WILL BE THE NEW RECOMMENDATION FOR LATENT TB INFECTION REGARDLESS OF HIV STATUS TWICE WEEKLY THERAPY IS AN ALTERNATE BUT ACCEPTABLE REGIMEN INH RESISTANT TB EXPOSURE IS TREATED WITH RIF PZA X 2 MONTHS OR RIF X 4 MONTHS GUIDELINES TO COME OUT IN APRIL ISSUE OF THE AMERICAN JOURNAL OF RESPIRATORY AND CRITICAL CARE MEDICINE SUPPLEMENT REF DR DAVID L THANKS FOR THE SCOOP BILL

)
(NEUROSURGERY THIS BENIGN NEOPLASM APPEARS MOST LIKELY TO BE AN INCIDENTAL READ SUBCLINICAL TUMOR THAT DOES NOT REQUIRE IMMEDIATE ATTENTION NEUROSURGICAL CONSULTATION SHOULD BE REQUESTED ON A ROUTINE BASIS VERY LIKELY THE TUMOR COULD BE FOLLOWED WITH PERIODIC IMAGING STUDIES THOMAS W FURLOW DID THIS PATIENT GET AN APPOINTMENT THANKS
)
(DERMATOLOGY WE^D BE HAPPY TO SEE HIM BUT WOULD REALLY NEED THE BIOPSY REPORT TO AVOID ANOTHER BIOPSY AND NEEDLESS WAITING WISH BUT AGAIN I THINK EVERYTHING HINGES ON THE BIOPSY REPORT SOUNDS LIKE A POSSIBLE CONTACT SENSITIVITY HAVE HER D C LIPSTICK USE PLAIN VASELINE FOR MOISTURE CONSIDER REFERRAL TO DERM FOR EVAL AND POSSIBLE PATCH TESTING ALSO TO STOP USING ALL MOUTH PRODUCTS INCLUDING TOOTHPASTE GUM RINSES ETC BAKING SODA MIXED WITH A SMALL AMOUNT OF WATER CAN BE USED AS A TOOTHPASTE MY USUAL TX CONSISTS OF A SHAVING PROFILE WITH WESTCORT CREAM ON THE DAYS THE PT USES A DEPILATORY OR CLIPPERS I DISCOURAGE USE OF A RAZOR BLADE IF PUSTULES OR CRUSTING EXIST I GET A SKIN CULTURE TO RULE OUT SECONDARY BACTERIAL INFECTION AND TX APPROPRIATELY ALTHOUGH SOME PEOPLE ADVOCATE THE USE OF RETIN A I FIND THIS CAUSES AN IRRITANT DERMATITIS IN THE SENSITIVE NECK AREA HYPERTROPHIC SCARS AND KELOIDS MAY OCCUR IN SOME INDIVIDUALS FOR WHICH INTRALESIONAL STEROIDS MAY BE USEFUL NO WE DON^T DO ELECTROLYSIS OR LASER HAIR REMOVAL WE ACTUALLY DO A LIMITED AMOUNT OF THIS WORK NOW POTENTIAL CANDIDATES FOR HAIR REMOVAL ARE PATIENTS GENERALLY WITH COARSE DARK HAIR WITH A VALID MEDICAL PROBLEM IE CHIN FOLLICULITIS IN A WOMAN ETC PATIENTS CAN BE REFERRED TO ME ON A REGULAR CONSULT BOOKED THROUGH SIERRA AND I WILL MAKE ARRANGEMENTS FOR THEIR TREATMENT AT THIS TIME THERE IS NO EXPENSE TO PATIENTS OUR INTENTION IS TO PROVIDED A LIMITED AMOUNT OF LASER HAIR REMOVAL ON A SPACE AVAILABLE BASIS FOR VALID MEDICAL PROBLEMS IE CHIN FOLLICULITIS IN A WOMAN A MAN WHO DOES NOT WANT HAIR ON HIS CHEST ANY MORE IS CLEARLY INAPPROPRIATE FOR EXAMPLE AS WE HAVE LIMITED RESOURCES TIME AND TO PROVIDE THIS SERVICE JUST GOING WITH THE ODDS SHE PROBABLY HAS ONYCHOMYCOSIS AND THE PSEUDOMONAS IS A SECONDARY INVADER SPORANOX SHOULD NOT BE STARTED WITHOUT KOH OR CULTURE CONFIRMATION OF A DERMATOPHYTE IF YOU CAN^T ACCOMPLISH THIS REFERRAL TO IS APPROPRIATE THAT^S WHAT WE^RE TRAINED TO DO UNLIKELY TO BE TINEA IN A 10 YO GIRL DOES SHE HAVE A HISTORY OF ATOPY COULD IT BE A WART IT IS PROBABLY A VACCINE RELATED PERSISTENT SUBCUTANEOUS NODULE THOUGHT TO BE RELATED TO THE FACT THAT THE VACCINE IS ALUMINUM ADSORBED THIS IS SEEN IN OTHER ALUMINUM ADSORBED VACCINES AND IS THOUGHT TO BE AN UNUSUAL RXN TO ALUMINUM WE HAVE SIMILAR CASE PENDING X RAY MICROANALYSIS FOR ALUMINUM AT THE AFIP SEND HIM OVER I^D LIKE TO SEE HIM STEVE
)
(PRIMARY-CARE 36YO WM W 3 MONTH H O SHORT TERM MEMORY LOSS FORGETS THINGS HIS WIFE JUST TOLD HIM FORGETS TO LOAD THE SECOND KID IN THE VAN BEFORE TAKING OFF DOWN THE STREET HAVING TO TAKE COPIOUS NOTES IN CLASS CGSC AND GRAD SCHOOL IN ORDER TO REMEMBER THE MATERIAL NEXT CLASS UNUSUAL FOR HIM SLEEPING VERY LIGHTLY W FREQUENT AWAKENINGS HOWEVER INITIATES SLEEP EASILY FEELS VERY FATIGUED LATELY ESPECIALLY AFTER WORKING OUT AND EXPERIENCING LONGER RECOVERY TIMES BETWEEN WEIGHT LIFTING SESSIONS DENIES RASH FEVER DRUGS ETOH JOINT MUSCLE PAIN DEPRESSED FEELING MARITAL PROBLEMS STRESS FHX THYROID RA CROHN^S DMPE WDWNWM NAD A&OX4MINI MENTAL STATUS 30 30ZUNG DEPRESSION SCREEN WNLLUNGS CTA COR RRR W O M R G ABD B9 EXT NO C C E NO TTP SKIN NO RASH GUAIAC NEGLAB CBC HIV RPR TSH RF ANA CERULOPLASM B12 FOLATE ALL WNLALT AST 50 70 CK 525 THEN 1099 THEN 799 DRAWN OVER COURSE OF 2 WEEKS PROGRESS NO WORSENING OF MEMORY IN LAST 6 WEEKS PT IS MAKING A CONCERTED EFFORT TO REMEMBER WHICH SEEMS TO BE HELPING HOWEVER IT TAKES MUCH MORE EFFORT THAN IT SHOULD HE THINKS NO CHANGE IN FATIGUE QUESTION WHAT DOES THIS CK REPRESENT AND COULD IT BE RELATED TO THE MEMORY PROBLEM OR FATIGUE WHERE ELSE SHOULD I LOOK THIS QUESTION WAS SENT FROM A FELLOW FP SHOULD I SEND TO G ASK A DOC OR DO YOU HAVE ANY ANSWERS JEN THANKS I WILL SEND ON TO THOSE SERVICES ON ASK A DOC AND SEE WHAT THEIR RECOMMENDATION IS THANK YOU FOR YOUR ASSISTANCE THANK YOU LATEST UPDATE ASO 166 ELEVATED FOR HIS AGE AS WAS THE ANTIDNASE B I^M NOT SURE WHAT TO MAKE OF THAT URINE COPPER 72 24 64 HE HAD A LOW NORMAL SERUM CERULOPLASMIN IN HIS INITIAL W U AT 25 7 AND THE INITIAL VISIT W AN INTERNEST WAS SUSPICIOUS FOR KAYSER FLEISCHER RINGS HOWEVER OPTOMETRY WASN^T OVERLY IMPRESSED TOLD HIM THEY HAD A DATA POINT AND TO RETURN IN A YR MY CONCERN IS THAT THIS IS AN UNUSUALLY LATE PRESENTATION OF WILSON^S DZ IN ITS EARLY STAGES AND WITH THE MEMORY DEFICITS AND INTERMITTENT RT HAND TWITCHING I^M CONCERNED THAT THIS COULD REPRESENT COPPER DEPOSITS ON THE BRAIN I^M

SENDING HIM TO GI FOR DEFINITIVE EVAL FOR THIS IF THAT PROVES NEGATIVE
WHAT IS YOUR OPINION AT THIS POINT
)
(PEDIATRICS BECAUSE OF THE INCONSISTENCY AND SUBSEQUENT INACCURACIES OF
PRACTICES OF DOING MEASUREMENTS AND VITAL SIGNS AMONG THE FAMILY HEALTH
CENTERS OF THE DEWITT HEALTH CARE SYSTEM FOR OUR 25 0 CHILDREN WE
DEVELOPED AND DISTRIBUTED GUIDELINES FOR THESE BASED ON AGES REASON FOR
VISIT ETC IN FACT THEY WERE A COMPILATION AND COMPARABLE PRACTICE IF YOU
WILL OF WHAT WAS BEING DONE AT WRAMC AND NNMC IF YOU GIVE ME YOUR FAX
NUMBER WE WILL GLADLY SEND YOU A COPY ONE SHEET THAT CAN BE DISPLAYED IN
YOUR VITAL SIGNS ROOMS THANK YOU FOR YOUR INTEREST COL H PED WILL SEND ONE
YOUR WAY TODAY WILL FAX OUR SOP IF SHE HAD PSEUDOTUMOR CEREBRI I WOULD
HAVE NEUROLOGY INVOLVED IN THE MANAGEMENT AT THAT POINT I ADMITTED 6 WEEK
OLD INFANT WITH HX OF FEVER OF 102 F AND COLD SX SEPSIS W U INCLUDING
SPINAL FLUID STUDY NEGATIVE EXCEPT BLOOD CULTURE STREP VIRIDANCE PATIENT
IS DOING WELL NO FEVER EATING WELL QUESTION SHALL I CONTINUE ROCEPHIN OR D
C ABX ASSUMING THIS IS CONTAMINATION THANK YOU DR YOON STAFF PEDIATRICIAN
ACTUALLY GLEN YOU BEAT ME TO THE PUNCH MY APOLOGIES FOR THE DELAY IN
ANSWERING YOUR QUESTION OUTSIDE OF CERTAIN HIGH RISK PATIENTS TO INCLUDE
IMMUNOSUPPRESSED PATIENTS AND NEONATES STREP VIRIDANS IS USUALLY
CONSIDERED TO BE A CONTAMINANT FROM THE SKIN OR OROPHARYNX IN THE CHILD
WITH A CLINICAL VIRAL PROCESS AND WHO IS BEING EVALUATED FOR R O SERIOUS
BACTERIAL ILLNESS DUE TO AGE ALONE AND HAS A NORMAL PHYSICAL EXAM IE NO
NEW HEART MURMER THE PRESENCE OF STREP VIRIDANS CAN BE CONSIDERED NON
PATHOGENIC AND THERAPY CAN BE HALTED WE HAVE A PROBLEM WITH A DIABETIC
PATIENT GETTING DURABLE MEDICAL EQUIPMENT AND I THOUGHT YOU MIGHT HAVE
SOME IDEAS ON HOW WE CAN HELP HER GET THE EQUIPMENT SHE NEEDS THE
FOLLOWING IS A NOTE FROM OUR HBA WHO HAS BEEN TRYING TO WORK THIS ISSUE
SHE IS LEGALLY BLIND AND NEEDS VOICE ACTIVATED OR VOICE RESPONSE EQUIPMENT
IN ORDER TO MONITOR CONTROL HER DIABETIC CONDITION AND HER BLOOD PRESSURE
I HAD ORIGINALLY REFERRED IT TO THE TRICARE SERVICE CENTER SUPERVISOR TO
DETERMINE IF SUCH EQUIPMENT WAS AVAILABLE ANYWHERE WITHIN THE NETWORK
SYSTEM HE RESEARCHED AND DETERMINED IT WAS NOT AND SAID BASICALLY THE
PATIENT WOULD HAVE TO PAY OUT OF POCKET UPFRONT AND THEN HAVE IT FILED TO
TRICARE FOR REIMBURSEMENT I BELIEVE HE EVEN SPOKE TO THE BENEFICIARY AT
ONE POINT AND SHE INFORMED HIM IT WAS AVAILABLE THROUGH LIGHTHOUSE FOR THE
BLIND HE SUGGESTED IN ADDITION TO THE USUAL PAPERWORK THAT DR TOEDT ALSO
PUT A REFERRAL IN THE SYSTEM STATING THE CIRCUMSTANCES AS A BACKUP FOR
CLAIMS PROCESSING PURPOSES THE PROBLEM NOW SEEMS TO BE CENTERED AROUND THE
FACT THAT THE PATIENT SHE CANNOT AFFORD TO MAKE PAYMENT UP FRONT AND THERE
WAS THEN DISCUSSION ABOUT DISABILITY CASE MANAGEMENT ETC I HAVE MADE
SEVERAL ATTEMPTS TO REACH THE PATIENT AND HAVE BEEN UNSUCCESSFUL I CAN
DIRECT HER TO SOME ASSISTANCE IN APPLYING FOR SOCIAL SECURITY DISABILITY
ETC BUT THAT DOES NOT RESOLVE THE IMMEDIATE CONCERN THE BOTTOM LINE NOW
SEEMS TO BE SHE IS ENROLLED TO PRIME TO US SHE IS IN CRITICAL NEED OF THIS
EQUIPMENT IRREGARDLESS OF WHETHER SHE MAY BE FOR DISABILITY THROUGH ANY
OTHER SOURCE AND SHE CANNOT AFFORD TO MAKE PAYMENT TO THEN BE REIMBURSED
WHAT DO WE DO IN THIS SITUATION HELP !! ANY IDEAS FROM OUR
ENDOCRINOLOGISTS WOULD BE GREATLY APPRECIATED I AM SURE YOU MUST SEE
DIABETICS WHO ARE LEGALLY BLIND FROM THEIR DISEASE THANK YOU FOR YOUR HELP
I^LL SEND THE PATIENT^S NAME UNDER A SEPARATE CLOSED MESSAGE AS HAS BEEN
SAID IN MORE SPIRITUAL CIRCLES ^SEEK AND AND YE SHALL FIND ^ IN THIS CASE
A LONE COLONY OF GABHS AND A QUESTION AS TO WHAT IT MEANS! MIKE A ONE TIME
POSITIVE CULTURE DOES NOT DEFINE A ^CARRIER ^ AND IN AN ASYMPTOMATIC
PERSON DOES NOT NECESSARILY WARRANT TREATMENT SOME OF THE ACCEPTED REASONS
FOR TREATMENT OF A GABS CARRIER INCLUDE 1 WHEN THE FAMILY HAS A HISTORY OF
RHEUMATIC FEVER 2 WHEN THERE IS BACK AND FORTH SPREAD OF INFECTION WITHIN
A FAMILY 3 WHEN THERE ARE SEMICLOSED COMMUNITY OUTBREAKS AND 4 WHEN
TONSILLECTOMY IS BEING CONSIDERED ONLY BECAUSE OF CHRONICPOSITIVE CULTURES
THESE RECOMMENDATIONS AND OTHER USEFUL INFO ABOUT GABHSCAN BE FOUND IN
CONTEMPORY PEDIATRICS OCTOBER 1992 SINCE THEN HOWEVER CLINIDAMYCIN AT 20
MG KG DAY DIVIDED TID FOR 10 DAYS HAS BEEN SHOWN TO BE ABOUT 85% EFFECTIVE
IN ERADICATING GABHS FROM CARRIERS INTERESTINGLY ABOUT THE SAME
EFFECTIVENESS AS THE VARIETY OF PENICILLIN MACROLIDE ANDCEPHALOSPORINS FOR
TREATING ACUTE SYMPTOMATIC GAHBS INFECTIONS YOUR PATIENTIS ONE THAT WILL
OPEN UP DEBATE AND DISCUSSION FROM INFECTIOUS DISEASE PHARMACOLOGIC AND
COSTS STANDPOINT I PROBABLY WOULDN^T TREAT AT THIS POINT THE ISSUE OF THE
CARRIER STATE IS ONE THAN ONLY A NAVY LINE OFFICER COULD LOVE IN
PEDIATRICS IT IS RIGHT UP THERE WITH WHAT CONSTITUTES PURULENTRHINORRHEA
THERE ARE FEW HARD FACTS AND LOTS OF OPINIONS IT IS BEST TO REMEMBER THAT

THE SIGNIFICANCE OF STREPTOCOCCAL UPPER RESPIRATORY DISEASE IS IN ITS NONSUPPORATIVE SEQUELAE IE RHEUMATIC FEVER AND ACUTEGLOMERULANEPHRITIS AND NOT IN ITS ABILITY TO CAUSE SORE THROATS TREATMENT IS BASED ON PREVENTING THE ABOVE SEQULAE AND NOT MAKING THE THROAT BETTER ALTHOUGH IT DOES THE PREVELANCE OF POSITIVE THROAT CULTURES INASYMPTOMATIC CHILDREN IS BETWEEN 15 30% AND CARRIAGE OF STREP DOES NOT LEAD TO CARIO RENAL DISEASE MANAGEMENT OF STREP CARRIERS IS PROBLOMATIC TO DETERMINE IF THE PATIENT IS A CARRIER WITH A VIRAL PHARYNGITIS ONE CAN OBTAIN SEROLOGY BUT THIS IS COSTLY PAINFUL AND EXPENSIVE ONE HAS TO RELY ON SYMPTOMS TIME OF YEAR WHAT^S HAPPENING IN THE SCHOOL COMMUNITY AND PAST HX OF THE PATIENT IN THE CASE ABOVE YOUR PATIENT IS ASYMPTOMATIC AND WE ARE IN THE LATESPRING WHEN THE PREVELANCE OF INFECTION IS LOW I WOULD NOT TREAT THIS CHILD BUT I WOULD NOTE THAT AT THIS TIME HE IS A PROBABLE ASYMPTOMATIC CARRIER IN THE FUTURE WITH THE PROPER SX^S I WOULD CULTURE HIM AND TREAT WITH PN IF THE CULTURE OR RNA STREP TEST IS POSITIVE IF THERE IS NO CLINICAL RESPONSE IN 48HRS I SWITCH TO A CEPHALOSPORIN OR CLINDAMYCIN I WOULD NOT RECULTURE HIM AFTER THERAPY ELIMINATION OF THE CARRIAGE STATE SHOULD BE RESERVED TO THE TIMES OUTLINED BY DR HORN HOPE THIS DOES NOT CONFUSE YOU C PED ID SVCE IS SICKLE CELL TRAIT CONSIDERED A CONTRAINDICATION TO THE ANTHRAX VACCINE
)
(CARDIOLOGIST GOT CUT OFF HE HAD VERY SIMILAR NUMBERS ON 24 NOV 99 WITH A TOTAL OF 233 BB OF 0 MB OF 4 AND MM OF 96 HE^S ALSO HAD AN INCONCLUSIVE MUSCLE BIOPSY THAT^S ALSO IN CHCS
)
(CLINICAL-PATHOLOGY WHAT^S THE PATIENT^S NAME SSN I^D LIKE TO REVIEW THE INSTRUMENT RESULTS
)
(CARDIOLOGY I^M FOLLOWING A PATIENT WHO HAS A HISTORY OF MYOPATHY WITH MULTIPLE STATINS BEFORE TRYING HIM ON YET ANOTHER HIS PREFERENCE OR NIACIN I REPEATED CK ISOENZYMES WITH THE FOLLOWING RESULTS TOTAL CK 271 CK BB 0 CK MB 4 CK MM 96 ARE THERE OTHER UNMEASURED SUBFRACTIONS ACCOUNTING FOR THE MISSING 171 WILLIAM R W FORGET IT GUYS I MUSTA BEEN SMOKING SOMETHING FUNNY WHEN I SENT THIS MESSAGE BUT IT FINALLY HIT ME AS STRANGE THAT THE MB AND MM^S WERE IDENTICAL ON BOTH AND I LOOKED MORE CAREFULLY AND SEE THAT THEY^RE EXPRESSED AS %^S NOT IU^S SO THEY DO ADD UP GLAD I CAUGHT THAT BEFORE YOU TOLD ME OR I^D FEEL EVEN DUMBER! HE^S STILL INTERESTING BOTH BECAUSE OF VERY PROLONGED TIMES TO NORMALIZE AFTER CK^S GO UP AND BECAUSE HIS BROTHER HAS THE SAME PROBLEM RHEUM HAS BEEN INVOLVED AND NOBODY CAN COME UP WITH ANYTHING EXOTIC IT^S JUST TOO BAD HE HAS CAD CAN^T TAKE STAINS OR RESINS AND ALSO IS ALLERGIC TO ASA AND CLOPIDEGREL WE WILL BE HAPPY TO SEE HIM IN THE CARDIOLOGY CLINIC I HAVE A 55YR OLD PT WITH A HISTORY OF VON WILLEBRANDS DISEASE NO H O RECENT ACTIVE ACUTE BLEEDING HAS USED EACA DDAVP PRIOR TO DENTAL PROCEDURES WITH GENERALLY GOOD RESPONSE PT IS WONDERING IF WE HAVE ANYTHING NEW TO OFFER I WILL APPRECIATE ADVICE SHE HAS BEEN SEEN AT WRAMC HEME ONC IN THE PAST THANKS WILL BE HAPPY TO SCHEDULE THE ABOVE AS SOON AS I HAVE A POINT OF CONTACT AS I NOW HAVE A NUMBER TO CONTACT I WELL CALL HIM TODAY THANK YOU
)
(ALLERGY-IMMUNOLOGY WE WOULD BE PLEASED TO EVALUATE THE PATIENT AND REVIEW THE HISTORY IN GENERAL LOCAL ANAESTHETIC REACTIONS ARE TOXIC REACTIONS RESULTING FROM RAPID DRUG ABSORPTION RATHER THAN AN ANAPHYLACTIC EVENT FROM IGE MEDIATED ALLERGY LARGE LOCAL REACTIONS AND CONTACT DERMATITIS FROM DELAYED TYPE HYPERSENSITIVITY ARE THE PRINCIPAL IMMUNOLOGICALLY MEDIATED REACTIONS FROM LOCAL ANESTHETIC AGENTS THE PERFORMANCE OF SKIN TESTING TO LOCAL ANESTHETICS CAN HELP DETERMINE WHETHER THE PATIENT IS AT HIGHER RISK THAN THE GENERAL POPULATION OF EXPERIENCING AN IGE MEDIATED ADVERSE EVENT ON REEXPOSURE TO THE DRUG YOU COULD HAVE THE PARENTS TO ARRANGE AN APPOINTMENT WITH ME DR H PLEASE HAVE THEM PLAN TO BRING IN WHATEVER DOCUMENTATION OF THE EVENT THEY HAVE OPTIMALLY THE PATIENT SHOULD BE OFF ANTIHISTAMINES FOR AT LEAST THREE DAYS PRIOR TO EVALUATION IN CASE SKIN TESTING IS PERFORMED THANKS HGO
)
(GASTROENTEROLOGY I DON^T THINK THE GUIDELINES HAVE BEEN REVISED THAT IS A PROBLEM WITH GUIDELINES THEY GO OUT OF DATE FASTER THAN THEY CAN BE WRITTEN AND IT MAY TAKE YEARS FOR EVERYONE IN THE NARMC TO AGREE THEY NEED TO BE REVISED THEN MORE YEARS TO AGREE ON THE REVISIONS I WOULD RELEGATE PROPULCID TO THE GARBAGE HEAP AS FAR AS TREATING GERD GOES ACIPHEX IS BEING TOUTED AS AN IMPROVEMENT BUT IT IS PROBABLY NOT VERY SIGNIFICANT AS FAR AS REAL CLINICAL RESULTS GO IT WOULD DEPEND ON COST AND WHATEVER THE PHARMACY DECIDED TO MAKE AVAILABLE I DON^T HAVE A LOT OF INFORMATION ON

ACIPHEX NO CHANGES HAVE BEEN MADE BUT I WAS THE ONE WHO GENERATED THE GUIDELINE ALTHOUGHT CISAPRIDE IS ON IT I RARELY USED IT AN NOW DO NOT USE IT AT ALL I DOUBT ACIPHEX WILL GET ON THE FORMULA IN THE NEAR FUTURE ADDITION OF THAT MEDICATION ARE DECIDED CENTRALLY IN SAN ANTONIO WHAT IS YOUR NORMAL FOR AFP I WOULD GET A CT OF THE LIVER IF IT IS OVER THE NORMAL THANKS I WOULD HAVE A HIGH INDEX OF SUSPICION THAT HE HAS AN UNDERLYING HEPATOCELLULAR CARCINOMA THAT HAS YET TO BE DETECTED BY CT SCAN MY NEXT STEP WOULD BE TO REPEAT AFP IN 3 MONTHS AND IF IT CONTINUES TO RISE CONSIDER AN MRI SCAN WITH GADILLIUM VS REPEAT CT SCAN I NEED TO GET IN TOUCH WITH LTC V DO YOU HAVE IS EMAIL ADDRESS OR PHONE THANKS THANKS FOR THE INFORMATION I RECOMMEND THAT HE JUST PROCEED WITH A COLONOSCOPY NOT ALL THE POLYPS WERE BIOPSIED AND THERE IS A CHANCE ONE IS AN ADENOMA GIVEN HIS AGE AND THE FLEX SIG FINDINGS I WOULD BE ON THE AGGRESSIVE SIDE I AGREE A BARIUM ENEMA WOULD BE OF NO USE TO YOU AT THIS POINT HOWEVER DON^T BE SURPRISED THAT ALL THE POLYPS YOU SAW IN THAT LOCATION TURN OUT TO BE HYPERPLASTIC I DON^T DISAGREE HOWEVER IF THE POLYPS WERE ALL SMALL THAT IS <7 10MM AND THE LARGEST WAS HYPERPLASTIC HE REALLY IS AT ONLY AN AVERAGE RISK FOR IMPORTANT PROXIMAL LESIONS AND NOT AT HIGHER RISK BECAUSE OF YOUR FINDINGS COL MOSES BRINGS UP A GOOD POINT IN THAT CHEAPEST ALTERNATIVE IS TO HAVE A REPEAT FLEX SIGM WITH BX OF ALL POLYPS HOWEVER HE IS OVER 55 AND A FLEX SIGM IS EQUIVALENT TO A UNILATERAL MAMMOGRAM NOT SURE WHAT ALL THAT MEANS IT SOUNDS LIKE THE MAIN QUESTION IS WHETHER OR NOT HE HAS PROCTITIS YOU SHOULD PROBABLY REFER HIM TO GI ALONG WITH HIS BIOPSY SLIDES AND ENDOPHOTOS THE COMBINATION OF ANA & ASMA MAKES IT MORE LIKELY TO BE AN AUTOIMMUNE HEPATITIS A LIVER BIOPSY WILL GIVE THE DEFINITIVE ANSWER SHE IS A BIT OUTSIDE THE AGE RANGE TO DOAGNOSE WILSON^S EARLY |40^S| IS THE LIMIT MOST ARE YOUNG ADULTS OR OLDER CHILDREN ALTHOUGH CERULOPLASMIN MAY BE NORMAL IN SERUM AND STILL HAVE WILSON^S THIS SITUATION IS OBSERVED IN LIVER FAILURE NOT IN AN OUTPATIENT IT HAS TO DO WITH MASSIVE CELL DESTRUCTION AND SPURIOUS ELEVATION OF CERULOPLASMIN THE FACT THAT HER CERULOPLASMIN IS NORMAL RULES OUT WILSON^S COPPER HAS BEEN ELEVATED IN DISEASES LIKE AIH PBC AND OTHERS INTERESTING CASE A LIVER BIOPSY WILL HOPEFULLY GIVE YOU THE DIAGNOSIS IF YOU NEED OUR ASSISTANCE CALL THE LIVER CLINIC 202 782 5262 FOR AN APPOINTMENT FOR YOUR PATIENT NO EASY ANSWER HERE REGLAN IS ABOUT THE ONLY OTHER ALTERNATIVE THANKS STEVE YES THIS SHOULD BE NOTED AND I WILL TAKE CARE OF THAT I DO NOT THINK THATTHE PATIENT WILL BE AMENABLE TO PO STEROIDS NOT REALLY FOLLOWING THE ICE AND ULTRASOUND HE IS LOOKING FORWARD TO THE MEETING WITH FEATHERS I^LL KEEP YOU INFORMED AND VICE VERSA THANKS AGAIN KEN BLOCK
)
(ORTHOPAEDICS SURE WOULD LOVE TO SEE HIM)
(PHARMACY SIR WILL THEY HAVE AN APO ADDRESS WILL THEY BE LOCATED AT THE EMBASSY COMPOUND ARE THEY > 65 YEARS OLD SEVERAL POSSIBILITIES BASED ON ANSWERS SIR SIR THE NATIONAL MAIL ORDER PHARMACY ONLY MAILS TO STATESIDE ADDRESSES OR APO SO THAT OPTION IS OUT IF THEY DO GET AN APO THAT OPTION WILL BE AVIALABLE SINCE THEY ARE UNDER 65 ONE OPTION IS TO HAVE ANOTHER PERSON BACK IN THE STATES DROP OFF AND PICK UP THEIR RXS AND MAIL TO THEM THIS REPRESENTATIVE WOULD HAVE TO HAVE A COPY OF EACH ID CARD AND A STATEMENT SIGNED BY THEM SAYING THERE AUTHORIZED TO PICK UP THE RXS THIS IS THE OPTION I THINK THEY WILL HAVE TO GO WITH I DON^T KNOW IF THEY CAN WORK OUT SOMETHING WITH THE LOCAL EMBASSY THE PENTAGON PHARMACY DOES ASSIST MEMBERS WORKING AT THE EMBASSY HOWEVER THEY ARE NOT EMPLOYEES SO I DON^T KNOW HOW MUCH LUCK THEY WILL HAVE I DON^T THINK THESE CLAIMS CAN BE SUBTANTIATED IF BETTER ABSORPTION IS A CONSIDERATION THEN A LIQUID VITAMIN WOULD BE BEST WE CARRY HERE AT WRAMC MULTIVITAMIN SUPPLEMENT IN A LIQUID PREPARATION ASMA I WOULD LIKE TO SEE A COPY OF THE ARTICLE THANKS
)
(ARTHRITIS THE RATIONALE BEHIND SCREENING TESTS IS THAT IF ANY OF THEM ARE POSITIVE FURTHER EVALUATION SHOULD BE PERFORMED IN ORDER TO ATTEMPT TO CONFIRM A SPECIFIC DIAGNOSIS RAYNAUDS PHENOMENON IS A CLINICAL SIGN THAT SERVES AS A HARBINGER OF A IMMUNOLOGIC DYSFUNCTION MOST OFTEN ASSOCIATED WITH THE CONNECTIVE TISSUE DISEASES THE PRESENCE OF A POSITIVE ANA IN THIS INDIVIDUAL WARRANTS ADDITIONAL SEROLOGICAL EVALUATION PRIMARILY FOR PROGNOSTICATION AND PATIENT EDUCATION WE WILL BE HAPPY TO ASSIST WITH BOTH THANK YOU FOR THE REFERRAL
)
(RHEUMATOLOGY MEASURES TO AVOID COLD INDUCED VASOSPASM ARE CERTAINLY A GOOD START IF THIS SOLDIER HAS ANY OTHER FEATURES TO SUGGEST A SYSTEMIC INFLAMMATORY CONDITION IE RASH MUCOSAL SORES ARTHRITIS SICCA SYMPTOMS ETC SPECIFIC ANTIBODY TESTING TO INCLUDE ANA TITER DOUBLE STRANDED DNA AND

EXTRACTABLE NUCLEAR ANTIGENS WOULD BE INDICATED URINALYSIS SHOULD BE DONE IF NOT ALREADY TO SCREEN FOR PROTEINURIA OR ACTIVE SEDIMENT IN ANY EVENT WE WOULD BE HAPPY TO EVALUATE HER HERE AT WALTER REED THERE ARE ACTIVE DUTY SLOTS AVAILABLE NOW IF YOU WOULD LIKE TO ENTER A CONSULT I GUESS A QUESTION TO ASK IS IF THE ^FATIGUE^ HE IS EXPERIENCING IS WEAKNESS AND IF THERE IS DOCUMENTATION OF WEAKNESS AS YOU KNOW THE DDX FOR THE IDIOPATHIC MYOPATHIES IS WIDE AND COVERS INFECTION TOXIN DRUG ENDOCRINE NEUROLOGIC AND CONNECTIVE TISSUE DISEASE ETIOLOGIES IN ADDITION TO THE CLASSIC BUT RARE INFLAMMATORY MYOPATHIES THIS IS AN INTERESTING CASE AND WE WILL BE GLAD TO HELP IN THE EVALUATION AT THIS POINT A RELATION TO HIS MEMORY PROBLEMS CANNOT BE ANSWERED YOU CAN GIVE US A CALL AND WE WILL BE GLAD TO FACILITATE AN APPOINTMENT FOR YOU EITHER THROUGH OUR ON CALL PHYSICIAN OR WITH ME DIRECTLY I APOLOGIZE FOR THE DELAY IN GETTING BACK TO YOU MR JACOBS HAS SEEN ME IN THE PAST I DO NOT HAVE ACCESS TO HIS FILE TODAY BUT RECALL ONLY A SLIGHT DECREASE IN HIS ALBULMIN IN THE PAST YEAR WITH AN SPEP IN THE FALL THAT DID NOT REVEAL ANY ABNORMAL BAND AT THAT TIME I WILL BE GLAD TO FOLLOW UP WITH HIM AT ANY TIME ROB OGLESBY I CALLED AND LEFT A MESSAGE FOR MR JACOBS TO CALL ME THANKS CHRIS WILL PUT THIS IN THE SAVE MAILBOX AND HOPEFULLY LONG TERM MEMORY I BELIEVE THAT AS LONG AS HE CAN FUNCTION IN HIS MOS WITH STANDARD TREATMENT MEASURES THAT HE CAN STILL BE CLEARED FOR DUTY I WILL VERIFY THIS WITH SENIOR STAFF IN THE DEPARTMENT AND LEAVE AN ADDITIONAL MESSAGE JON REITER^S PSORIATIC ENTEROPATHIC ARTHRITIS CAN ALL PRESENT WITH BACK DISCOMFORT IN THE REALM OF THE SPONDYLOARTHROPATHIES CHRIS PARKER HAS BEEN WITH A GROUP ON GUIDELINES FOR THE EVALUATION OF BACK PAIN AND HE MAY HAVE SOME FURTHER THOUGHTS FROM THOSE DISCUSSIONS YES AN ALLERGIC REACTION TO OTHER NSAIDS OR ASPIRIN ARE CONTRAINDICATIONS FOR USE AS STATED IN THE PACKAGE INSERTS FOR THE NEW COX 2 INHIBITORS OF COURSE IT DOES DEPEND ON WHAT YOUR PATIENT IS CALLING AN ALLERGIC REACTION
)
(OB/GYN COL ARMSTRONG IS HERE WITH ME RE&I SUBSPECIALIST RECOMMENDS SHE GOES TOMED ENDOCRINE TO HAVE HER CHOL ISSUES ADDRESSED PRIOR TO ANY REFERRAL TORE&I ALTHOUGH SHE IS 10 YEARS OUT I WILL STILL CONSULT A MEDICAL ONCOLOGIST BEFORE PRESCRIBING HRT IF THERE IS AN ENDOCRINOLOGIC ASSOCIATION WITH SPONTANENOUS ABORTION AND PCO IT MAY HAVE MORE TO DO WITH HIGH LH LEVELS SEEN IN THESE PATIENTS NEVERTHELESS IF YOU TREAT THE PATIENT WITH CLOMIPHENE THERE IS CIRCUMSTANTIAL EVIDENCE THAT THIS TREATS THE LUTEAL PHASE DEFICIENCY BY BUILDING UP THE GRANULOSA CELL MASS THAT IS THEN LUTEINIZED IN THE LUTEAL PHASE AND SECRETES THE BULK OF THE PROGESTERONE BOTTOM LINE TREAT WITH YOU CAN TREAT WITH PROGESTERONE VAGINAL SUPPOSITORIES 100 MG BID BUT REALIZE THAT THIS IS HIGHLY EMPIRIC AND WHILE SAFE IN PREGNANCY IS ALSO PROBABLY NOT EFFECTIVE HOPE THIS HELPS LET ME KNOW IF YOU HAVE ANY FURTHER QUESTIONS 51YO WF G11P3081 NOT USING HRT D T COMPLICATED MEDICAL HX WITH 3 YEARS OF DYSFUNCTIONAL UTERINE BLEEDING NOTES OCCASIONAL VAGINAL SPOTTING 2 3 TIMES YEAR CLINICALLY PERIMENOPAUSAL WITH ONGOING NIGHT SWEATS AND HOT FLASHES 3 24 0 LH 6 1 FSH 17 2 EST LEVEL PENDING S P MULTIPLE EVALUATIONS OF ENDOMETRIUM INCLUDING D&C BY CIVILIAN PROVIDER ALL BENIGN MOST RECENT EMBX 4 99 DISORDERED PROLIF EM ECC BENIGN 3 0 PELVIC US SHOWED NORMAL SIZED UTERUS WITH 8 8MM EM STRIPE NL ADNEXA DUE TO H O CVA UNABLE TO USE COMBINED HRT 1 CAN I USE CYCLIC OR CONTINUOUS PROGESTERONE SAFELY TO CONTROL ELIMINATE BLEEDING EPISODES PRODUCT INSERT STATES A CONTRAINDICATION WITH H O DISORDERS 2 IF UNABLE TO USE PROGEST AGENT OR PT ELECTS EXPECTANT MANAGEMENT WHAT IS THE BEST WAY TO FOLLOW AND EVALUATE THESE BLEEDING EVENTS AM I OBLIGATED TO SAMPLE THE EM WITH EACH EPISODE CAN I FOLLOW WITH US DO I NEED TO EVALUATE THESE EPISODES IN SOMEONE WHO IS CLINICALLY AND PHYSIOLOGICALLY PERIMENOPAUSAL IN ADVANCE THANKS FOR YOUR TIME AND COMMENTS PETE PALACIO FT DRUM OB GYN I WOULD NOT HESITATE TO PUT HER ON CYCLIC PROGESTERONE THERAPY I WOULD USE 5 10 MG PROVERA ON DAYS 1 12 OF EACH MONTH I WILL FORWARD TO DR S ROSA AND SATIN TWO OF OUR MATERNAL FETAL MEDICINE SPECIALISTS
)
(FAMILY-PRACTICE PT IS A 4 Y O MALE WITH FOLLOWING EXAM RIGHT TESTICLE NORMALLY DESCENDED LEFT TESTICLE JUST BARELY PALPABLE AT OPENING OF INGUINAL CANAL BUT DEFINATELY PALPABLE AND NORMAL IN SIZE AND TEXTURE CREMASTERIC REFLEX WAS VERY STRONG AND TESTICLE WOULD EASILY DISAPPEAR INTO CANAL WITH PALPATION MOTHER STATES THIS HAS BEEN ADDRESSED IN THE PAST BUT NO FURTHER W O HAS OCCURRED IS THERE ANY CONCERN THANK YOU JACOB AARONSON THANK YOU SO MUCH FOR YOUR RESPONSE I WILL PUT IN AN OFFICIAL CONSULT BUT YOU CAN CALL THE PATIENT^S MOTHER IF THAT IS BETTER FOR YOU

THANKS AGAIN LET ME KNOW THE OUTCOME PLEASE SO I CAN GET A FEEL FOR WHAT IS AN APPROPRIATE CONSULT JACOB A I AGREE I WILL EMAIL YOU FROM NOW ON AS I HAVE IN THE PAST I SAW A PT WHO C O BILATERAL PAIN COLD WHITE FINGERS AND TOES EPISODES ARE TRIGGERED BY COLD BUT ALSO OCCUR WHEN NOT COLD OR NOT UNDER EMOTIONAL SRESS I DID THE LABS SUGGESTED FOR RAYNAUD^S BY GRIFFITHS CBC ESR RF ANA ALL WERE WNL EXCEPT A POS ANA THIS IS A 31 YR OLD AD FEMALE THE PRIMARY REASON FOR HER VISIT WAS NON SPECIFIC GI COMPLAINTS SHE HAD BEEN ON 6 CONSECUTIVE COURSES OF ABX FOR VARIOUS COMPLAINTS STREP X 2 UTI BACTERIAL VAGINOSIS HER BOWEL COMPLAINTS WERE IMPROVING AFTER A WEEK OF BENTYL OTHERWISE THIS PT IS HEALTHY WITH NO OTHER MEDICAL PROBLEMS I KNOW THAT THE ANA IS A NON SPECIFIC TEST BUT NOW THAT I GOT IT I JUST WANTED TO MAKE SURE THAT THERE IS NOTHING ELSE THAT I NEED TO DO I CONSULTED WITH OUR CLINIC INTERNAL MED DOCTOR SHE ADVISED THAT NO FURTHER WORK UP IS NEEDED OTHER THAN COUNSELING THE PT TO PROTECT HER EXTREMITIES FROM THE COLD I JUST WANTED TO SEE IF YOU CONCUR THANKS MAJ MY FNP THANK YOU FOR YOUR PROMPT AND INFORMATIVE RESPONSES I REALLY APPRECIATE THE GUIDANCE I WILL GIVE THE PATIENT A CONSULT MAJ MCCROARY PT IS A 3 Y O MALE WITH DANDY WALKER SYNDROME DX^D AT BIRTH WITH NO APPARENTSIGNIFICANT FINDINGS OTHERWISE HE HAS A MILD SPEECH DELAY THAT IS BEINGADDRESSED ON ROUTINE EXAM PARTIALLY AT MOTHER^S CONCERN FOR A FUNNYLOOKING BACK THERE IS A RIGHT SIDEBENT SACRUM WITH A GENTLE RIGHT LATERALCURVE UP TO THE LOWER MID THORACIC WHERE THERE IS A RATHER SHARP CURVE TO THE RIGHT WITH COMPENSATION IN THE UPPER THRORACIC AND C SPINE NO OTHER OBVIOUS REMARKABLE FINDINGS MOTHER STATES THAT HE IS NORMALLY ACTIVE AND DOES NOTC O PAIN USUALLY THOUGH WHEN HE OCCASIONALLY DOES MOTHER CAN^T DETERMINE WHERE HE IS NORMALLY COOPERATIVE FOR A 3 Y O BUT EXAM WAS PRETTY MUCH LIMITED TO A STRUCTURAL EXAM ANY SUGGESTIONS FOR NECESSARY WORK UP IMAGING IS THERE A CORRELATION WITH DANDY WALKER SYNDROME SHOULD HE BE SEEN BY PEDSORTHO WOULD APPRECIATE ANY INPUT JACOB A FAMILY MEDICINE THANK YOU FOR YOUR RESPONSE I WILL CONTACT MOTHER AND PUT A REFERRAL INTO THE SYSTEM IN CASE YOU WOULD LIKE TO CONTACT HIS MOTHER HERE IS THE NECESSARY INFO I APPRECIATE YOU SEEING HIM LET ME KNOW WHAT YOU DECIDE TO DO I SAW A 10 YEAR OLD BOY WITH A SUSPECTED ALLERGIC REACTION TO A TOPICAL ANESTHETIC USED BY HIS DENTIST IT CONTAINED BENZOCAINE IN A POLYETHYLENE GLYCOL BASE DOES HE NEED FURTHER TESTING TO ASCERTAIN PARTICULARLY WHAT COMPONENT OF THE MED HE IS ALLERGIC TO THANKS DR OAKS THANK YOU FOR YOUR RESPONSE I CALLED THE MOM AND ASKED HER TO MAKE AN APPT WITH YOU JENNIFER FRANK I RECENTLY PERFORMED A FLEX SIG ON A 55 Y O MALE NON SMOKER OTHERWISE HEALTHY FINDING 4 WIDE BASED MUCOSAL COLORED POLYPS AT 15 CM THE PATIENT WAS UNABLE TO TOLERATE SCOPE PASSAGE BEYOND 35 CM THE LARGEST POLYP WAS BIOPSIED AFTER ATTEMPTS WERE MADE AT THE MUCH SMALLER OTHERS BIOPSY WAS RETURNED AS HYPERPLASTIC WHAT WOULD RECOMMEND AT THIS POINT SHOULD A BE BE PERFORMED OR A COLONOSCOPY WOULD APPRECIATE ANY INPUT JACOB THANK YOU FOR YOUR RESPONSES I FAVORED COLONOSCOPY IN THE FIRST PLACE BUT I WANTED TO MAKE SURE IT WAS AN APPROPRIATE REFERRAL THANKS FOR THE RESPONSES WOULD YOU HELP ME CLARIFY THE CORRECT DOSE OF VIT D FOR OSTEOPOROSIS I NOTICED THERE ARE AT LEAST 3 TYPES OF VIT D PREPARATIONS DHT D2 ERGOCALCIFEROL AND CALCITRIOL AND THEIR UNITS ARE QUITE CONFUSING SOME IN IU AND SOME IN MCG OR MG I HAVE RESEARCHED FEW ARTICLES AND CHECKED OUR FORMULARY AND IT^S STILL SOMEWHAT CONFUSING WHICH WOULD YOU MOST RECOMMEND FOR OSTEOPOROSIS FOR BOTH PREVENTION AND THERAPY AND WHAT IS THE CORRECT DOSE THANKS THANKS DR BERNET 70 YO MALE WITH 1 GM PROTEINURIA BUT NORMAL RENAL FUNCTION WAS EVAL FOR MICROSCOPIC HEMATURIA 2 3 YRS AGO AND FOUND TO HAVE RLP STONE WOULD THIS ALSO ACCOUNT FOR PROTEINURIA LOOKS LIKE HE^S HAD TRACE TO 1 PROTEIN IN UA FOR YEARS AS WELL HAS DM HTN CAD PAST HX GOUT CALCIUM NORMAL HCT OK WILL GET US AND UPEP THANKS! MR 49 HAS A SMALL MENINGIOMA 1 5 TO 2 CM ON THE POSTERIOR FOSSA ARISING FROM THE POSTERIOR LIP OF THE FORAMEN MAGNUM NO SIGNS OR SYMPTOMS OF INCREASED INTRACEREBRAL PRESSURE OR FLOW OBSTRUCTION THIS PATIENT NEEDS TO BE EVALUATED BY NEUROSURGERY BUT I WOULD LIKE TO KNOW HOW SOON SHOULD HE BE SEEN THANK YOU JIMENEZ MD THANK YOU VERY MUCH FOR THE REPLY I WILL THEN FOLLOW YOUR INSTRUCTIONS I AM AN FNP I SAW A 29 YR OLD AD MALE 2 WEEKS AGO WHO C O A LUMP ON HIS CHEST HE HAD BEEN SEEN AT A CIVILIAN ER ONE DAY PRIOR FOR THE SAME COMPLAINT HE WAS DC^D W O A DX AND REFERRED TO HIS PCM WHEN I SAW HIM HE HAD A SMOOTH MOBILE PAINLESS 3IN X 3IN SOLID FEELING MASS BEHIND THE AREOLAR REGION ON HIS R CHEST HE HAD NO FEVER PAIN ERYTHEMA ETC HE DENIED THE USE OF MEDS RX OTC OR SUPPLEMENTS I DIDN^T SPECIFICALLY ASK RE RECREATIONAL DRUGS PMH NEG OTHER THAN CHRONIC MUSCULOSKELETAL COMPLAINTS FOR WHICH HE IS CURRENTLY UNDERGOING A MED BOARD FOR I SENT HIM TO RAD FOR AN ULTRASOUND THE REPORT SAID DENSE TISSUE RAD THEN DID A BILATERAL MAMMO WHICH SHOWED GYNECOMASTIA

R > L SINCE I HAVE NEVER MANAGED AN ADULT MALE WITH GYNECOMASTIA I LOOKED UP THE RECOMMENDED W O IN GRIFFITHS 5 MIN CONSULT IT STATES LAB EVAL IS RARELY NEEDED HOWEVER BHCG TESTOSTERONE LH ESTRADIOL PROLACTIN LFTS TSH CHROMOSOMAL STUDIES MAY BE INDICATED I HAVE REASON TO SUSPECT THAT RECREATIONAL DRUG USE MAY BE A FACTOR SINCE HE IS BEING ALLOWED TO GO TO A CIVILIAN SCHOOL WHILE UNDERGOING A MEB WITH ONLY PHONE CONTACT TO HIS UNIT AND LIVES IN BALTIMORE HE ALSO HAS VERY DIFFICULT TO TRACK DOWN HE LIVES WITH HIS MOTHER I HAVE CALLED THE RESIDENCE SEVERAL TIMES HE HAS NOT BEEN HOME FOR >5DAYS AND HIS MOTHER HAS NO IDEA WHERE HE IS MY QUESTION TO YOU IS WHAT IF ANY OF THE ENDOCRINE RELATED TESTS ARE APPROPRIATE SHOULD I SEND HIM TO YOU BEFORE OR AFTER THE RESULTS ARE IN AND SHOULD I HAVE HIS UNIT DO A DRUG SCREEN ON HIM ANY HELP IS APPRECIATED MAJ M THANKS FOR THE ASSISTANCE MAJ MCCROARY I^M ONE OF THE FPS FROM DEWITT I KNOW SOME DEPARTMENTS DO ELECTIVE PROCEDURES TO KEEP UP THEIR SKILLS AND PATIENTS PAY SOME OUT OF POCKET EXPENSE DOES DERM DO ANY HAIR REMOVAL TECHNIQUES FOR WOMEN EG UPPER LIP CHIN IF SO WHAT IS THE COST THANKS MARK THANKS SO MUCH! I HAVE A 43 YO BF PREVIOUSLY SEEN AT ENDO AND HAD FNA OF LEFT LOBE NODULE THAT WAS BENIGN THIS WAS IN 98 SINCE THEN IT SEEMS NODULE IS ENLARGING AND SHE DID NOT FU THERE AS DIRECTED RECENTLY GOT US WHICH SHOWS 3 X 1 8 X 2 5 SOLID HETEROGENOUS MASS IN LLL THERE WAS A 7MM MASS IN THE 98 US BUT BY THE DESCRIPTION IT IS HARD TO TELL IF THIS IS THE SAME THING TSH IS NORMAL RE REFERRAL PLACED DOES SHE NEED TO GET IN QUICKER ANY THING ELSE NEEDED DO YOU WANT NUC SCANS FIRST IT WAS BOOKED TO TOURTELOT BUT REFERENCE WAS MADE TO DR UTICA SIGNED BY A 3RD YEAR STUDENT ONLY PLEASE LET ME KNOW WHAT YOU THINK THANKS FOR YOUR ASSISTANCE THANKS! SHE^S GOING TO SEE ME THE FOLLOWING TUES PT IS A 55 Y O FEMALE NOT ON HRT WITH ONE EPISODE OF VAGINAL BLEEDING FOR 7 DAYS FOR THE FIRST TIME AFTER MENOPAUSE 4 YEARS AGO US SHOWED NORMAL ENDOMETRIAL STRIP 3 4MM EXCEPT IN THE REGION OF THE FUNDUS WHERE THERE WAS A HETEROGENEOUSLY SLIGHTLY HYPERECHOIC REGION MEASURING A MAXIMUM OF 1 5 CM THIS EITHER REPRESENTS A SUBMUCOSAL FIBROID OR THICKENING OF THE ENDOMETRIUM DISTINCTION BETWEEN THESE POSSIBILITY IS NOT CLEAR NEAR THE SUPERIOR POSTERIOR ASPECT OF THE REGION OF THE ENDOMETRIAL CAVITY THERE IS A FOCAL HYPERECHOIC NODULAR STRUCTURE MEASURING 7 MM IN SIZE ON TRANSVERSE IMAGE THIS APPEARS EITHER AT THE PERIPHERY OF THE ENDOMETRIAL CAVITY OR IMMEDIATELY ADJACENT TO IT AND COULD THEREFORE REPRESENT A SUBMUCOSAL FIBROID VERSUS FOCAL ENDOMETRIAL LESION EMB SHOWED ^FRAGMENTS OF BENIGN ENDOMETRIAL GLANDS AND STROMA^ IS THIS WORK UP COMPLETE CAN I ATTRIBUTE EPISODE OF BLEEDING TO A PROBABLE FIBROID OR SHOULD I HAVE HER SEE A GYNECOLOGIST I WOULD APPRECIATE YOUR INPUT JACOB AARONSON DO THIS DOES HELP I ALWAYS WANT TO DO WHAT I CAN WITHIN THE PRIMARY CARE AND REFER APPROPRIATELY I WILL REFER HER TO GYNECOLOGY THANK YOU DEAR RHEUMATOLOGY A 31YO WM WITH PSORIATIC ARTHRITIS CAME IN FOR A FLIGHT PHYSICAL TODAY BY REGULATION HE IS UNFIT FOR AIRBORNE DUE TO HIS PSORIASIS BUT HE WAS ON JUMP STATUS BEFORE THE DIAGNOSIS DOES HE NEED TO HAVE HIS WINGS CLIPPED OR CAN HE BE CLEARED TO JUMP HE IS ON TRAINING HERE AT FT LEE VA AND HIS PERM DUTY STATION IS KENTUCKY NO MTF AVAIL HE IS ASYMPTOMATIC ON INDOCIN PLEASE ADVISE THANK YOU MARGARET BUSSEY GRANT FP FT LEE GREAT WILL CLEAR HIM! THANK YOU! 42 YOF SMOKER HAS ALLERGIC RHINITIS NOTICED TO HAVE PLATELET COUNT OF 120 DURINF ROUTINE EXAM REPEATS SINCE THEN AT ONE AND THREE MTHS INTERVAL HAVE BEEN 130 OOO AND126 OOO SHOULD ANYTHING BE DONE AND WHAT I HAD A FIRST TIME PATIENT TODAY WHO CAME IN REQUESTING A REFILL OF HER ERT CURRENTLY ON PREMARIN 0 625 QD AND ESTRATEST HS QOD DURRING HER EVALUATION I FOUND SHE HAD HAD A TAH BSO IN 85 FOR DUB IN 1990 SHE UNDERWENT A RIGHT MRM FOR T1N0M0 INFILTRATING DUCTAL CA THAT WAS ESTROGEN RECEPTOR SHE DID NOT HAVE CHEMO OR TAMOXIFEN SHE HAS SINCE HAD AN IMPLANT SHE C O DECREASED LIBIDO SINCE HER SURGERY AND IN 1998 WAS PLACED ON PREMARIN ESTRATEST HS WAS ADDED A FEW MONTHS LATER SHE HAS BEEN ON IT SINCE WITH GOOD RESPONSE IN REGUARDS TO HER LIBIDO AND LUBRICATION SHE IS NO LONGER FOLLOWED BY ANY OF THE SPECIALIST I WAS UNCOMFORTABLE PRESCRIBING ERT TO AN ER BREAST CA PATIENT EVEN 10 YEARS OUT IS THIS AN OK THING TO DO IS THERE A REASON TO USE THE MEDS THE WAY SHE HAS BEEN INSTEAD OF JUST USING ESTRATEST HS QD PLEASE HELP THANKS! DEEANN STROOP MD TO WHOM IT MAY CONCERN I HAVE A QUESTION REGARDING VITAMIN SUPPLEMENTS MY PATIENT WHOSE PMH IS SIGNIFICANT FOR TIA HAS BEEN TOLD THAT LIFEGUARD ANTIOXIDANT THERAPY IS BETTER THAN CONVENTIONAL FORMULATIONS A LA CENTRUM IN THAT IT IS BETTER ABSORBED AND MORE NATURAL IN ITS PREPARATION I BELIEVE IT TO BE A POWDER AS OPPOSED TO A TABLET AND THUS SHE WAS TOLD IT IS BETTER ABSORBED DO ANY OF YOU KNOW IF THESE CLAIMS ARE SUBSTANTIATED THE COST ON THE PREPARATION IS GREATER THAN CONVENTIONAL TABLETS AND I DON^T WANT FOR MY PATIENT TO WASTE HER MONEY

THANK YOU AARON SAGUIL I WOULD VERY MUCH LIKE TO READ THIS ARTICLE IF YOU COULD PLEASE FAX IT TO ME AT AND I WILL FORWARD IT TO THE PATIENT IN THE MEANTIME DO YOU HAVE ANY SPECIFIC THOUGHTS REGARDING THE CURRENT CASE I^D APPRECIATE YOUR INPUT AARON WHAT WOULD YOU RECOMMEND FOR F U ON A 42 YO FEMALE WITH PAST H O GOITER AND HYPOTHYROIDISM NORMAL THYROID ON PHYSICAL EXAM TSH= 81 ON THYROID RX LEVOTHYROXINE 75 MGM THYROID USD NORMAL EXCEPT FOR A SMALL 3 MM HYPOECHOIC NODULE IN RIGHT MIDPOLE REGION WHICH WAS FELT TO A POSSIBLE SMALL THYROID CYST YOU RECOMMEND F U USD IF SO AT WHAT INTERVAL THANKS! A PAST H O ^GOITER^ AND LACK OF SPECIFIC DOCUMENTATION OF THIS IN THE CHART LED ME TO ORDER THE USD THANKS FOR THE RECOMMENDATIONS I RECENTLY SAW A 71 Y O GENTLEMAN WITH PMH SIGNIFICANT FOR HTN BPH AND A PREVIOUS CARDIAC MURMUR FOR A MUSCULOSKELETAL PROBLEM DURING HIS INTAKE HIS SBP WAS NOTED TO BE 185 WHEN I WENT TO RE TAKE HIS BP MANUALLY I NOTICED THAT THE AUSCULATATED PULSE PERSISTED EVEN WHEN THE CUFF WAS DEFLATED AND REMOVED AND WAS TRUE FOR BILATERALLY ON FURTHER EXAM HE HAS NO CAROTID OR RENAL BRUITS AND A VERY SOFT CARDIAC MURMUR PREVIOUSLY EVAL^D BY ECHO GOOD CAPILLARY REFILL NORMAL SENSATION AND STRENGTH IN HANDS BILATERALLY 33 PACK YEAR TOBACCO QUIT IN 1983 NO SIGNIFICANT CLAUDICATION SX ACCORDING TO THE PT HE HAS A CIVILIAN CARDIOLOGIST WHO HE SEES EVERY 3 MONTHS AND TAKES HIS BP MANUALLY AND WHO HAS NEVER COMMENTED ON THIS IS THERE ANY CLINICAL SIGNIFICANCE TO AN ASYMPTOMATIC BRACHIAL ARTERY BRUIT IS THERE ANY ADDITIONAL WORKUP INDICATED THANKS MIKE OSHIKI I SAW AN 11 YO MALE FOR A SCHOOL PE DURING HIS UNREMARKABLE EXAM I NOTED TONSILAR EXUDATE MILD EDEMA 1 NO CERIVAL LYMPHADENOPATHY AFEBRILE AND NO C O SORE THROAT I CULTURED THE EXUDATE AND GOT ONE COLONY OF GABS I ASSUME THAT HE IS A CARRIER AND DOESN^T HAVE ACUTE PHARYNGITIS DO WE TREAT CARRIERS DURING THE SPRING TO PREVENT OUTBREAKS IS HE AT ANY RISK OF GABS SEQUAL OR A RISK TO CLOSE CONTACTS NO IN PEDIATRICS OCT 1999 THEY MENTION CEFADROXIL AS MORE EFFECTIVE THAN PCN FOR CARRIERS I HAVE READ ABOUT USING CLINDAMYCIN DURING SPRING TIME AS WELL I COULD NOT FIND ANYTHING MORE HELPFUL ON MDCONSULT THANKS FOR YOUR ANSWERS CPT WYNN SUPER THANKS I WILL LOOK FOR THE 1992 ARTICLE AND HAVE MORE INFORMATION FOR THIS FAMILY WOULD APPRECIATE ANY OPINION S ON 56 YO FEMALE WITH DM AND NOTED TO HAVE FLUCTUATING MILDLY ELEVATED LFT^S 2 |3X| NORMAL OVER PAST 10 YEARS I TOOK THE LIBERTY OF ORDERING A PLETHORA OF LABS TO EVAL TO INCLUDE 1 HEPATITIS B AND C SEROLOGY NEGATIVE 2 ALPHA 1 ANTITRYPSIN WNL 3 IRON FERRITIN WNL 4 ANA POSITIVE DSDNA NEGATIVE ENA SCREEN NEGATIVE LIVER MICROSOMAL AB NEGATIVE SMOOTH MUSCLE ANTIBODY AB POSITVE AT 1 160 5 SERUM COPPER=211 70 165 INITIALLY REPEATED ONE WEEK LATER =2283 WITH CERULOPLASMIN WNL=43 5 17 9 53 3 TO SUMMARIZE PT HAS A POSITIVE ANA WITH POSITIVE ASMA ALSO PT HAS AN ELEVATED SERUM COPPER WITH A NORMAL CERULOPLASMIN OF COURSE THESE ABNORMALITIES WERE DISCOVERED IN THE W U OFCHRONICALLY MILDLY ELEVATED LFT^S COULD THIS PATIENT^S LFT^S BE DUE TO AN AUTOIMMUNE PROCESS CAN YOU HAVE WILSON^S DISEASE WITH A NORMAL CERULOPLASMIN APPRECIATE YOUR ASSISTANCE! THANK YOU VERY MUCH FOR YOUR TIMELY AND INFORMATIVE FEEDBACK I WILL REFER PT TO GI SERVICE FOR CONSIDERATION OF BIOPSY
)
(OTOLARYNGOLOGY-SERVICE AN ENT REFERRAL WOULD BE HELPFUL THANKS)
(OTOLARYNGOLOGY AN ENT CONSULT WOULD CERTAINLY BE REASONABLE SHE COULD BE SEEN AT KACC HOW DO YOU KNOW SHE HAS STENOSIS OF HER SALIVARY DUCTS DID SHE HAVE ASIALOGRAM THIS IS OFTEN ASSOCIATED WITH RHEUMATOLOGIC CONDITIONS HAS THATBEEN ADDRESSED THANKS
)
(NURSING I HAVE A 73 YO F WHO HAD AN ENDOMETERIAL BX DONE LAST YEAR FOR AN ENDOMETERIAL STRIPE THAT MEASURED 1 5CM EMB WAS WNL PT HAD ANOTHER SONO DONE THIS YEAR TO EVAL AND MEASURE THE ENDOMETERIAL STRIPE AND IT MEASURRED 1 3CM WOULD LIKE TO SEND THIS PT FOR ANOTHER EMB BUT WOULD LIKE TO KNOW WHETHER OR NOT IT IS INDICATED OVARIES WERE NOT VISUALIZED ON SONO BUT BOTH ADNEXA WERE UNREMARKABLE AS PER SONO REPORT PLEASE GIVE YOUR OPINION ALSO HOW LONG SHOULD A POST MENOPAUSAL PT STAY ON ESTRATEST THERE ARE SOME PTS WHO HAVE BEEN ON IT FOR ATLEAST 6 MONTHS TO A YEAR WOULD LIKE TO KNOW THE ANSWER TO THIS BECAUSE I THOUGHT IT WAS FOR SHORT TERM USE ANY OTHER SUGGESTIIONS FOR HELP IN PTS COMPLAINTS OF DECREASED SEXUAL LIBIDO I HEARD THAT WELLBUTRIN SP WAS A MEDICATION THAT COULD HELP WITH INCREASING SEXUAL LIBIDO THE DRUG THAT IS USED FOR DEPRESSION BUT WOULD LIKE TO KNOW OF ANY GENERAL INTERVENTIONS ANY HELP THAT YOU COULD GIVE ME WOULD BE GREATLY APPRECIATED THANKS THANKS FOR RESPONDING I WILL TELL THE PT THAT SHE WILL HAVE TO BE SEEN I HAVE THE PHONE NUMBERS PT CONTACTED TODAY AND SHE WILL MAKE AN APPT HER NAME IS ROSELLA CRANE 30 724 DR FISK WHAT ABOUT MY OTHER QUESTION THANKS IN PROCESS OF INITIAL INFERTILITY EVAL IN 26 YR

OLD PRESUMED ANOVULATOY OLIGOMENORRHEIC MILDLY OVERWT 170 5 FT 7 IN
CHOLESTEROL NOTED TO BE 321 HDL 41LDL 250 TRIGLYCERIDES 148 SMOKES 1 PPDTO
KEEP THE REST OF HX BRIEF ALL OTHER LABS AND EXAM WNLSHE OBVIOUSLY NEEDS
TO STOP SMOKING REDUCE WT BUT HOW WOULD YOU ADDRESS THE CHOLESTEROL IN ONE
WHO IS ANXIOUS TO CONCEIVE STATINS ARE CONTRAINDICATED INPREGNANCY SO IS A
TRIAL OF CLOMID OUT COULD SHE TAKE CLOMID AND DELAY RX OFCHOLESTEROL FOCUS
ON CHOLESTEROL AND ADDRESS INFERTILITY AT A LATER DATE BUT THE CHOLESTEROL
WILL PROBABLY REQUIRE LONG TERM RX SHE PROBABLY FITS PICTURE OF PCO
SYNDROME TO A THANK YOU IN ADVANCE FOR YOUR INPUT KATHY COSTELLO NURSE
PRACTITIONER OK I AGREE NEEDS MED F U PRIOR TO PURSUE INFERTILITY BUT WHAT
DO YOU FOLKS DO WITH LADIES WITH SUCH HIGH LDLS WHO REQUIRE RX WHICH IS
CONTRAINDICATED WITH PREGNANCY K COSTELLO I AM COVERING FOR ANOTHER
PRACTICTONER WITHOUT PRIOR KNOWLEDGE OF THIS PT LABS TSH 17 25 ANTI
THRROGLOBU <2 0 ANTI THYROID PE 1870 0 AT PRESENT PT C C IS FATIGUE PAST
HX AFTER GIVING BIRTH TO A SEVERELY MIS SHAPENED INFANT AND THE INFANT^S
DEATH 6MO OLD PT BEGAN TO HAVE PANIC ANXEITY IRRITABLITY NERVOUNESS AND
INSOMMIA WOULD SHOULD MY NEXT STEP BE SHOULD I REDO LABS TREAT FOR
HYPOTHYROIDISM ORDER A THYROID SCAN REFER TO ENDOCRINOLOGIST ASAP THANK
YOU FOR YOUR TIME AND ENERGY THIS IS NOT A JOKE! I SAW A 51 Y O BF TODAY
WITH C O BURNING LIPS FOR THE LAST MONTH WHICH WORSENS WITH EATING LIPS
ARE USUALLY DRY BUT SHE HAS TRIED OTC PRODUCTS TO KEEP MOIST BUT THE
BURNING PERSIST AND SHE SEES LITTLE BUMPS ON THEM WHEN THEY REALLY BURN
EXAM IS NORMAL HELP I HAVE ASKED HER TO STOP USING LIPSTICK AND JUST APPLY
CHAPSTICK TO KEEP MOIST ANY IDEAS WHAT MIGHT BE CAUSING THIS THANKS FOR
YOUR ATTENTION AND FOR NOT LAUGHING I HAVE A 15 YO PT WHO RECEIVED HER
FIRST DEPO INJECTION ON 3 MAR 0 SHE IS C O SEVERE HA DIZZINESS NERVOUSNESS
AND FATIGUE SINCE THE TIME OF IT HAS STAYED BASICALLY THE SAME NOT WORSE
NOT BETTER SHE NOTES NO CHANGES IN ACTIVITY OR OTHER TRIGGERS FOR HER SX
SHE IS TAKING TYLENOL WHICH PROVIDES SOME RELIEF FOR HA^S IT IS SO BAD
THAT HER MOTHER BROUGHT HER IN TODAY REQUESTING I GIVE HER AN EXCUSE FROM
SCHOOL UNTIL THIS STOPS SHE FEELS IT ISN^T SAFE FOR HER TO WALK HOME FROM
SCHOOL AND SHE HASN^T HAD A DAY AT SCHOOL WITHOUT FEELING SICK THIS SOUNDS
PRETTY SEVERE TO ME I^VE CALLED UPJOHN CO AND THEY HAVE NO ADVISE WHAT CAN
I SUGGEST TO HER AND SHOULD I REFER HER FOR FURTHER EVALUATION THANKS FOR
YOUR PROMPT ASSISTANCE DR FENTON THANKS FOR YOUR REPLY MAY I REFER THIS PT
TO SEE YOU TO WHICH CLINIC WOULD I WRITE THE REFERRAL AND WHOM SHOULD I
CALL TO SCHEDULE AN APPT THANKS VERY MUCH THIS IS A REQUEST FOR HELP FROM
ANY AND ALL NEUROLOGISTS I SAW 9MO FEMALE TODAY S P FALL INJURY 1 WEEK AGO
MOTHER DID NOT REPORT FALL INJURY AT THE TIME PROBABLY BECAUSE OF FEAR OF
NEGLECT CHARGES CHILD FELL SBOUT 3 FEET FROM PARENTS BED TO HARDWOOD FLOOR
AND NOW HAS SOFT RAISED AREA ON LEFT SIDE OF HEAD OUR ON CAL PEDIATIRICIAN
DR BASSEY TOLD ME THAT WE NEED TO SCHEDULE CT FOR THIS AGE GROUP THROUGH
THE SEDATION UNIT THE SEDATION UNIT TELLS ME THAT THEY ARE HEAVILY BOOKED
FOR THIS WEEK MY QUESTIONS ARE CAN THIS CHILD NO NEURO CHANGES WAIT UNTIL
NEXT WEEK FOR CT OR CAN CT BE SAFELY DONE WITHOUT SEDATION OR IN ANOTHER
WAY THANK YOU FOR INPUT AND ADVICE THANK YOU THE CONCERN OF NEGLECT IS DR
BASSEY^S MAIN REASON FOR WANTING THIS SOONER I APPRECIATE YOUR ADVICE AND
ASSISTANCE I WILL CALL THE SEDATION UNTI AGAIN LATER TODAY TO SEE IF ANY
OPENINGS HAVE COME UP OR IF CAN WORK THIS CHILD IN THANK YOU I WILL KEEP
THAT IN MIND FOR FUTURE USE A FEW MOS AGO I SAW A WOMAN WHO HAD NOT SLEPT
WITHOUT ATIVAN FOR OVER 3 YEARS I ASKED NEURO ABOUT THIS AND THEY SAID SHE
NEEDED A SLEEP STUDY TO SEE IF SHE REALLY DOES HAVE INSOMNIA OR JUST
PERCEIVES THIS THE NEUROLOGIST FROM BETHESDA ARRANGED FOR HER TO HAVE THIS
DONE THERE THE WAY THEY DO IT FOR THE PATIENT TO GET A NEURO CONS FIRST
THEN THEY SET UP THE SLEEP STUDY I HOPE THIS HELPS KRISTAL A 25 Y O AD
MALE C C LT UPPER ARM 2CM FIRM AREA POST ANTHRAX IMMUNIZATION 1 YR AGO
NONTENDER NONBULDGING SOLDIER HAS GOTTON MIXED FEEDBACK ON WHAT OUGHT TO
BE DONE SINCE IT IS NONTENDER I THOUGHT LEAVE IT BE WHEN SOLDIER CALLED
ANTHAX IMMUNIZATION CLINIC DEWITT HE WAS TOLD TO FOLLOW UP IN DERMATOLOGY
FOR A CASE STUDY TO CATALOG IT AND POSSIBLE REMOVAL 1 HAVE YOU HEARD OF
THIS 2 WHAT WOULD YOU DO MADELEINE
)
(ADULT-MEDICINE WHT SHOULD I LOOK FOR IN A PATIENT WITH LUPUS WITHINCREASING
FREQUENCY OF MIGRAINE HA WITH SOB NECK AND CHEST PAIN CXR CBC AND P1 WERE
NORMAL NO THIS WAS MEANT FOR RHEUM 30 Y FEMALE WITH 12YR HISTORY OF DRY
MOUTH WITH STENOSIS OF SALIVARY DUCTS WHAT DO YOU RECOMMEND I TRY AS
CONSERVATIVE MANAGEMENT IS THIS ANADDRESSED BY ENT SHE WAS EVALUATED BY A
DENTIST I AM WORKING HER UP FOR SJOGRENS SLE ARE THERE ANY
CONTRAINDICATIONS TO ASTHMA AND DVTS WITH THE ANTHRAX VACCINE NO
)

(NEUROPHYSIOLOGY IF THE PAINS ARE INDEED PAROXYSMAL AS YOU HAVE DESCRIBED A TRIAL OF OTHER ANTI EPILEPIC MEDS IS WARRENTED WOULD CONSIDER TEGRETOL 200 MG INCREASING EVERY TWO WEEKS TO 200 400 TID OR DILANTIN 100 BID R TID IF THIS FAILS YOU CAN REFER THE PATIENT TO ME CHUCK KELLY NEUROPHYSIOLOGY STAFF
)
(PEDIATRIC-INFECTIOUS-DISEASE CHILDREN ON HIGH DOSE CORTICOSTEROIDS GREATER THAN 2MG KG DAY OF PREDNISONE EQUIVALENT FOR A CHILD <10KG OR GREATER THAN 20MG DAY FOR A HILD>10KG ONCE OFF STEROIDS FOR 2 WEEKS IT IS PROBABLY SAFE AND EFFECTIVE TO GIVE THE VACCINE SEE THE 1997 REDBOOK REPORT OF THE COMMITTEE OF INFECTIOUS DISEASES OF THE AAP
)
(INFECTIOUS-DISEASE FROM THE ID PERSPECTIVE I CANNOT THINK OF ANY OTHER DIAGNOSTIC TEST MY FIRST THOUGHT WAS AS YOU CONSIDERED STEROID INDUCED MY SECOND CONSIDERATION WAS A PERFORATED VISCOUS THAT WAS WALLED OFF BUT CT SCAN OF THE ABDOMEN SHOULD HAVE IDENTIFIED THAT INDIUM SCAN IS SOMETIMES USEFUL BUT I DO NOT THINK THE COST IS JUSTIFIED IF HE IS GOING TO HAVE A DEFINITIVE PROCEDURE AND YOU ARE NOT PRESSURED TO START ANTIBIOTICS IN THE SETTING OF FEVER I ASSUME HE IS OFF ALL STEROIDS NOW OPTIONS FOR TREATMENT ARE IODOQUINOL AS YOU MENTIONED AND PAROMAMYCIN I DON^T THINK NONTREATMENT IS AN OPTION I^M ASSUMING HE IS AN ASYMPTOMATIC CYST PASSER BUT IF HE IS COMING BACK TO LIVE IN THE U S A NONENDEMIC AREA FOR E HISTO HE SHOULD BE TREATED IF HE WAS GOING TO REMAIN IN AN ENDEMIC REGION TREATMENT WOULD NOT BE INDICATED SINCE HE WOULD BECOME REINFECTED DIAGNOSTICALLY I THINK THERE ARE TWO IMPORTANT THINGS TO DO IN THIS PATIENT RIGHT NOW ONE IS SCRAPING LESION FOR DARKFIELD EXAMINATION IF POSSIBLE SECOND IS HAVING THE LABORATORY PERFORM APPROPRIATE MODIFICATIONS IN THE TESTING PROCEDURE TO RULE OUT PROZONE PHENOMENA WHICH COULD GIVE YOU A FALSE NEGATIVE RESULT FTA DOES APPEAR TO BE MORE IN PRIMARY DISEASE THAN VDRL 85% VS 70% HOWEVER BOTH SHOULD BE CHECKED MHA TP IS LESS SENSITIVE THAN BOTH OF THESE IN PRIMARY DISEASE IF TESTS ARE NEGATIVE MAKE SURE YOU HAVE CAREFULLY RULED OUT OTHER DISEASES IN THE DIFFERENTIAL INCLUDING HERPES SIMPLEX CHANCROID LGV CONDYLOMA ACCUMINATA SINCE SHE HAS REPORTEDLY NOT HAD A RECURRENCE FOR A NUMBER OF YEARS PREVENTING FUTURE OUTBREAKS DOES NOT APPEAR TO A MAJOR ISSUE BUT RATHER ASYMPTOMATIC SHEDDING THE INCIDENCE OF SHEDDING IN OTHERWISE HEALTHY WOMEN HAS BEEN ESTIMATED AT ABOUT 1% OF DAYS OR A LITTLE HIGHER IT IS HIGHER AMONG PATIENTS WITH FREQUENT SYMPTOMATIC RECURRENCES AND IN THE MONTHS IMMEDIATELY FOLLOWING AN INITIAL EPISODE NEITHER OF WHICH APPLIES TO THIS PATIENT BASED UPON HER HISTORY SHE MAY BE SHEDDING VERY INFREQUENTLY IF AT ALL BUT THERE IS NO WAY TO PREDICT WHICH DAYS SHE IS OR IS NOT SHEDDING THE COST OF ACYCLOVIR AT 400 MG BID IS ABOUT $1400 AND VALTREX AT 500 MG QD IS ABOUT $1000 THE DECISION TO START SUPPRESSIVE THERAPY IN THIS CLINICAL SCENARIO HAS TO BE HANDLED ON AN INDIVIDUAL BASIS COST IS NOT PROHIBITIVE BUT SHOULD BE A CONSIDERATION SAME APPLIES TO DRUG RESISTANCE CONCERNS THERE MAY BE SIGNIFICANT PSYCHOSOCIAL ISSUES ASSOCIATED WITH THIS ESPECIALLY THOSE THAT MAY IMPACT UPON THIS PATIENTS SEXUAL RELATIONSHIP WITH HER PARTNER E G FEAR OF TRANSMITTING HERPES LEADING TO DIMINISHED SEX DRIVE AND REDUCED SEXUAL FREQUENCY IN WHICH CASE SUPPRESSION MAY BE OF SUBSTANTIAL BENEFIT I^M AFRAID I CAN^T GIVE YOU A YES OR NO ANSWER ON THIS ONE BUT WE WOULD BE HAPPY TO SEE HER HERE IN OUR CLINIC I DID NOT DR OTT WHAT IS YOUR FAX NUMBER ALWAYS WELCOME
)

(RENAL-TRANSPLANT-LICSW THIS PATIENT WAS COUNSELED ABOUT SIGNING UP FOR MEDICARE WHILE THE SEASON IS OPEN THROUGH 31 MARCH 2000 WE WERE ABLE TO GET MEDICARE ON THE PHONE AND HE WILL BE FINED A PENALTY BECAUSE HE HAS NOT PAID INTO THE SYSTEM FOR 11 YEARS HIS PREMIUMS WILL BE HIGHER PROBABLY PAY 63 0 PER MONTH INSTEAD OF THE USUAL $43 0 PER MONTH FOR MEDICARE B PREMIUM WHICH PAYS FOR HIS DIALYSIS IN THE CIVILIAN SECTOR HE IS HAVING MEDICARE OFFICE MAIL HIS HOME IN GERMANY THE FORMS HE IS REALLY IN A TIGHT SPOT FOR HIS WIFE IS A GERMAN NATIONAL AND HAS A VERY GOOD JOB IN GERMANY SHE ALSO SPEAKS VERY LITTLE ENGLISH THEY WERE MARRIED WHILE HE WAS RETIRED AND IN GERMANY SO SHE REALLY DOES NOT WISH TO BE RELOCATED BACK IN THE STATES THIS COULD CHANGE MEDICARE WILL NOT PAY IN GERMANY HE DOES NOT HAVE ANY OTHER INSURANCE HE USES THE GERMAN HEALTH CARE SYSTEM PD IS APPROX $2 0 0 PER MONTH HERE IN THE STATES HEMODIALYSIS IS APPROX $4 0 0 PER MONTH OF THAT MEDICARE COVERS 80% OF THE COST 20% IS COVERED BY THE PATIENT OR HIS HER SUPPLEMENTAL INSURANCE PT WAS ADVISED ABOUT ALL THE ABOVE HE STATED THAT HE WOULD THINK ABOUT WHAT HE IS GOING TO DO HE HAS VERY LITTLE SUPPORT HERE IN THE STATES AND I DO NOT SEE HIM LIVING BY HIMSELF WITHOUT

HIS WIFE BUT THAT MAY BE WHAT HE HAS TO DO I THOUGHT HE WAS OLDER THAN 65 MUST BE CONFUSING HIM WITH SOMEONE ELSE SORRY FOR THE CONFUSION ON HIS AGE MEDICARE PENALTY IF HE IS 65 THAN HE NEEDS TO BEGIN PAYING FOR HIS MEDICARE PREMIUM NOW I BELIEVE I HAVE THE WIFE INFO CORRECT PRIVATE PAY IN GERMANY OR MOVING BACK TO CONUS ARE HIS TWO OPTIONS
)
(UROLOGY WOULD GET A IVP AND HAVE HER SCHEDULED FOR A CYSTOSCOPY WE WILL OBTAIN A CYTOLOGY AT THAT TIME I WOULD LIKE TO SEE THIS CHILD FOR A POSSIBLE ORCHIOPEXY THANKS D P TASHA PLEASE CALL THE PARENT AND SCHEDULE AN APPOINTMENT WITH ME THANKS WOULD WORK UP IF 2 3 U A SHOW GREATER THAN 5 RBC^S SHE IS BORDERLINE IS SHE ON HRT DOES SHE HAVE IATROGENIC MENSES IF SHE HAS 3 5 OR GREATER ON ANOTHER U A WOULD SEND HER ON UP DR MCLEOD CAN THE FEMALE CADET WHO I E MAILED YOU ABOUT
THAT IS GROWING BETS STREP GP B IN HER URINE COME SEE YOU THIS MONDAY 6 MARCH SHE HAS A H O RECURRENT UTI BUT NOE C O BACK PAIN ALSO SHE HAS A H O UROLOGICAL SURGERY AS A CHILD FOR RECURRENT UTIS IF SHE CAN COME MONDAY WHERE AND WHEN SHOULD SHE REPORT
)

(INTERNAL-MEDICINE A 59 YO FEMALE SMOKER HAS PERSISTENT BACK PAIN ESPECIALLY IN LCVA AREA AND PERSISTENT MICROHEMATURIA SHOULD I GET AN IMAGING STUDY OF HER KIDNEYS BEFORE SENDING HER TO YOU AND IF SO WHAT STUDY 78YO WF HTN CONTROLLED PHX TIA |1Y| AGO WHILE ON ECASA 325 BID INPT EVAL BY NEURO AND SWITCHED TO PLAVIX 75MG QD HAD HER STEREOTYPIC TIA SXS AGAIN LAST WK TRANSITORY FORTIFICATION SCINTILLATION FOLLOWED BY HATBAND LIKE TIGHTEN SS AND THEN L LOWER FACIAL NUMBNESS FOR AFEW HRS MIGRAINE NO SXS SINCE WHAT IS NEXT ADD ASA SWITCH TO TICLID SWITCH TO PERSANTINE ASA WOULD APPRECIATE YOUR SEEING HER SINCE ATYPICAL FEATURES FOR TIA THANKS WOULD YOU LIKE ME TO CALL HER I GOT OUT HER INPT RECORD INTERESTINGLY SHE DESCRIBED THE SCINTILLATIONS THEN TOO I AM ALSO CONCERN RE POSS COGNITIVE DECLINE BUT I DID NOT HAVE TIME TO DO A MMSE SHE HAS ALWAYS HAD ANXIOUS HESITANT AFFECT WE WERE ON THE SAME WAVELENGTH THIS WHY I EMPHASIZED THE SCINTILLATIONS TOO I WILL BOAST THAT I MENTIONED MIGRAINE IN MY ORIGINAL MESSAGE I AM LOOKING FOWARD TO YOUR ASSESSMENT THANKS I TALKED TO HER IN PERSON ON FRI AND HANDED HER THE REFERRAL FORM WITH DATE & TIME I WILL CALL HER TO FIND OUT WHAT HAPPENED I JUST SPOKE TO HER OVER THE WKEND SHE REALIZED SHE AHD A CONFLICTING APPT AT NNMC FOR A F U FOR MGUS AND SHE WENT THERE THIS AM SHE SAID SHE CALLED THE NEURO CL AND WAS TOLD THEY DID NOT HAVE HER DONE FOR AN APPT I TOLD HER ONE OF US WOULD CONTACT HER AGAIN WITH A NEW NEURO APPT 2 OF OUR RETIREES ARE MOVING TO ABU DHABI UNITED ARAB EMIRATES THEY ARE ON DIABETES MEDS DO WE HAVE A MECHANISM TO SEND THEM MEDS THANKS! NO APO ADDRESS THEY ARE WORKING ON A CONTRACT AT THE MILITARY HOSPITAL LIVING ON THE ECONOMY BOTH UNDER 65 THAT IS VERY HELPFUL THANKS A LOT I FOUND THE NHLBI NEWS RELEASE ON THIS IT^S FROM THE ALLHAT STUDY COMPARING CHLORTHALIDONE CARDURA AMLODIPINE & LISINOPRIL AFTER 2 |6Y| F U OF 42 0 PTS OVER 55YO BROAD DEMOGRAPHICS PTS WITH AT LEAST ONE OTHER CORONARY RISK FACTOR THE USERS OF CARDURA HAD 25% MORE CARDIOVASCULAR EVENTS AND WERE |2X^S| AS LIKELY TO BE HOSP FOR CHF AS USEERS OF CHLORTHALIDONE NO DIFFERENCE IN INCIDENCE OF MI OR DEATH THEY CONCLUDED CARDURA AND OTHER ALPHA BLOCKERS SHOULD NOT BE THE FIRST FOR HTN AND NOT BE USED AS MONOTX NO DATA FOR USE IN COMBINED TX NO RELEVANT DATA FOR THE PT WITH BPH NO OTHER DATA FROM THIS ONGOING STUDY WAS RELEASED THEY DID TERMINATE THE CARDURA ARM SO IT MUST HAVE BEEN A SIGNIFICANT FINDING THE TRIAL DID NOT INCLUDE A PLACEBO ARM SO TO CONCLUDE THAT CARDURA IS CAUSING HARM IS NOT APPROPRIATE HOWEVER ITS A GREAT OPPORTUNITY TO GET THEM ON A BETTER DRUG SUCH AS THIAZIDES OR BETA BLOCKERS I AM AN INTERNIST AT WEST POINT AND WOULD LIKE A BIT OF CLARIFICATION ON A GENERAL CLINICAL MATTER IF A PATIENT PRESENTS WITH A LESSION THAT IS SUSPICIOUS FOR PRIMRY SYPHILIS AND IT IS EARLY IN THE COURSE <3 WEEKS WOULDN^T YOU EXPECT THE NONTREPONEMAL SCREENING TESTS TO STILL NOT BE POSITIVE RPR AND VDRL IF SO AND YOU START TREATING EMPIRICALLY HOW ARE YOU TO FOLLOW SERIAL VDRL TITERS TO CONFIRM RESOLUTION WHAT IF THE INITIAL TEST IS NEGATIVE SINCE FTA IS POSITIVE EARLIER IS THIS A BETTER SCREENING TEST EARLY ON YOUR HELP WITH THIS SOMEWHAT CONFUSING MATTER WOULD BE GREATLY APPRECIATED THANKS I AM AN INTERNIST AT WEST POINT AND HAVE BEEN REFERRED A FEMALE PT BY THE OB GYN SERVICE WHICH I HAVE A QUESTION ON SHE IS A 30 Y O PREGNANT FEMALE FIRST TRIMESTER WITHOUT C O INCIDENTALLY FOUND TO HAVE A LEUKOCYTOSIS UPON H & P THERE ARE NO ABN FINDINGS SEVERAL REPEAT CBC^S SHOW ELEVATED LEUKOCYTOSIS WITH NORMAL OR NEAR NORMAL SLIGHT BANDEMIA DIFFERENTIAL WBC 15 16 9 RANGE ESR WAS 12 UA NML PLATELETS HAVE REMAINED SLIGHTLY ELEVATED 410 450 I

VIEWED THE PERIPHERAL SMEAR AND SAW SOME MEGAKARYOCYTES AND THOUGHT THE AUTOMATED DIFF COULD BE INTERPRETING THESE AS WBC^S IN THE TOTAL COUNT AND HENCE THE NML DIFF BUT I AM NOT SURE THAT MAKES SENSE I AM NOT AWARE OF LEUKOCYTOSIS DURING PREGNANCY AS A NORMAL OCCURRENCE IN HER LATEST CBC SHE HAS DEVELOPED A MILD ANEMIA WHICH I SUSPECT IS SECONDARY TO PLASMA VOL EXPANSION AND NORMAL AT THIS STAGE OF HER PREGNANCY GIVEN THE LACK OF PHYSICAL FINDINGS OR C O I AM INCLINED TO JUST FOLLOW THIS WITHOUT ANY MORE AGGRESSIVE W U AT THIS TIME BUT WANT TO MAKE SURE THIS IS NOT A MISTAKE AND SEE IF YOU HAVE ANY EXPERIENCE WITH THIS ANY HELP WOULD BE GREATLY APPRECIATED SERGIO A PT OF MINE SAW ADVERTISEMENTS FOR A NEW DM DRUG CALLED ^ABANDIX^ DOES ANYONE KNOW WHAT THIS IS I TRIED TO DO A PUB MED SEARCH ON THIS NAME AND GOT NOTHING THAT SOUNDS LIKELY HOW IS ROGLITZONE RE THE LIVER I HAVE A PT 73 Y O FEMALE W PERSISTENT FE DEF ANEMIA GI W U TO INCLUDE EGD COLONOSCOPY AND SBFT ALL WNL AND NO VAGINAL BLEEDING NO HX OF GI SURGERY RESPONDS TO ORAL FE IF TAKEN BID BUT PT DOESN^T TOLERATE THIS DUE TO EFFECTS ON QD THERAPY HCT REMAINS IN 28 29 RANGE ANY THOUGHTS ON WHY SHE WOULD HAVE A PERSISTENT PROBLEM W FE DEFICIENCY W O SOURCE OF LOSS AND ADEQUATE INTAKE THANKS I AM AN INTERNIST AT WEST POINT AND RAN INTO AN INTERESTING PT ON ROUTINE RETIEREMENT PHYSICAL TODAY PT IS A 50 Y O MALE WITH INCIDENTALLY FOUND ABNORMAL EKG JUNCTIONAL RYTHM LBBB WITH INTERMITTENT SINUS CONDUCTED BEATS WITH DIFFERING QRS MORPHOLOGY PT DENIES ANY CARDIAC HX OR PRIOR W U BUT ADMITS TO ABNORMAL EKG ON HIS OVER 40 PHYSICAL LAST EKG DONE 10 YRS AGO PT IS VERY ACTIVE RUNS 2 MILES A DAY AND DENIES ANY HX OF SYNCOPE PALPITATIONS OR LIGHTHEADEDNESS HE HAS AGREED TO OUTPATIENT REFERRAL TO WRAMC CARDIOLOGY FOR EVALUATION AND FURTHER W U TO INCLUDE POSSIBLE EP STUDY AND GIVEN HIS LACK OF SYMPTOMS I HAVE REFERRED HIM AS OUTPATIENT YOUR ASSISTANCE IN EXPEDITING HIS REFERRAL TO THE APPROPIATE SPECIALIST WOULD BE GREATLY APPRECIATED THANKS I HAVE A 41YOBM WHO DONATED A KIDNEY TO HIS SISTER A FEW YEARS AGO HE HASNO MEDICAL PROBLEMS NO MEDS CREATININE 1 5 LAST YEAR 1 4 UA AND P1 O WWNL AS FAR AS FOLLOW UP HE IS PCSING AND HE REPORTS NO INSTRUCTION GIVENTTO HIM AS FAR AS HOW OFTEN TO GET LABWORK DRUGS TO AVOID ETC I REALIZETHAT HUMANS DO QUITE WELL WITH ONE KIDNEY EVEN PLAY PROFESSIONALBASKETBALL IN GENERAL WHAT GUIDANCE TO YOU GIVE THESE FOLKS OTHER THAN HYDRATION AND BEING CAUTIOUS WITH NON RENAL FRIENDLY MEDS THANKS SARAH THNKS I WAS CURIOUS ABOUT THE TREATEMTN FOR PFB TODAY I SAW A GENTLEMAN FOR LONG STANDING PFB HE HAD BEEN TOLD TO USE RETIN A IN THE PAST FOR THIS I LOOKED IN HABIF AND THEY RECOMMENDED GLYCOLIC ACID SHORT COURSE ABX AND POSSIBLE INTRALESIONAL STEROIDS BUT DIDN^T RECOMEND RETIN A DO YOU RECOMMEND RETIN A WHEN DO YOU USE TOPICAL STEROIDS THANKS I HAVE A 55 YO W F WITH HX OF TAH IN 1987 PLACED ON HRT IN 1991 AND S PANTRECTOMY VAGOTOMY FOR DU IN 1997 C B DUMPING SYNDROME HER WEIGHT IS 102LBS NOW AND IT WAS APPROX 130 IN 1996 SHE HAS DIFFICULTY MAINTAINING HER WEIGHT DUE TO THE DUMPING SYNDROME SHE TAKES CHOLESTYRAMINE AND AN ESTROGENPATCH I SWITCHED OVER TO A PATCH AROUND A YEAR AGO B C SHE WAS HAVING HOTFLASHES ON THE ESTROGEN PILLS AND I WAS CONCERNED ABOUT ABSORPTION I ORDERED A BMD STUDY WHICH SHOWED A T SCORE OF 2 5 IN THE FEMORAL NECK AND 3 0 IN THE VERTEBRAL SPINE HER URINE CALCIUM IS 106 UPEP=NO PATTERN SEEN P1 P3 SPEP CBC TFT^S VITAMIN D PTH ALL NORMAL I AM TRYING TO DETERMINE WHETHER THERE IS A SECONDARY CAUSE FOR HEROSTEOPOROSIS OR WHETHER IT MAY BE DUE TO MALABSORPTION OF HER MEDS BYCHOLESTYRAMINE VS DUMPING DO YOU RECOMMEND A FURTHER W U OR JUST ADDING AMED LIKE CALCITONIN TO TX REGIMEN ALONG WTH CALCIUM AND VITAMIN D THANKS FOR THE RESPONSES THE PT HAS DECIDED TO GO TO NNMC SINCE THAT^S WHERE HER ULCER SURGERY WAS PERFORMED I^LL ORDER THE ABOVE STUDIES THIS VERY NICE 73 YO LADY IS VERY HARD OF HEARING AND IS MISSING A LOT IT IS HARD TO TAKE CARE OF HER AND EXPLAIN HER MEDICAL REGIMEN TO HER BECAUSE SHE CAN^T HEAR WELL SHE IS POORLY EDUCATED AND HAS BEEN AFRAID OF HEARING AIDES BECAUSE SHE THINKS IT INVOLVES SURGERY I PUT IN A CLN ORDER BUT SHE REALLY CAN^T NAVIGATE THE SYSTEM WELL ON HER OWN CAN SOMEONE CALL HER WITH AN APPT WHEN HER TIME COMES THANKS! I HAVE A QUESTION REGARDING ESTROGEN AND MS I FOLLOW A 44 YO WOMAN WITH MS FOR ABOUT 5 6 YEARS PROBABLY RELAPSING REMITTING WHO HAS BEEN ON AVONEX FOR SEVERAL YEARS AND HAS BEEN STABLE SHE READ ON THE INTERNET THAT ESTROGEN WAS HELPFUL FOR MS AND WAS GIVEN AN RX FOR PREMPRO BY HER PREVIOUS PCM SHE HAS BEEN TAKING THIS FOR SEVERAL YEARS WITH NO SIG CHANGE IN HER SYMPTOMS SHE IS NOT MENOPAUSAL I THINK THAT THERE HAVE BEEN STUDIES SUGGESTING IMPROVED COGNITIVIE FUNCTION IN POSTMENOPAUSAL WOMEN WITH MS WHEN THEY USE ESTROGEN REPLACEMENT AND SOME RECENT ANIMAL STUDIES USING ESTRIOL HOWEVER I AM NOT AWARE OF THE USE OF LOW DOSE ESTROGEN IN PREMENOPAUSAL WOMAN WITH MS MY CONCERN IN THIS PATIENT IS THAT I AM UNCLEAR ON THE BENEFITS SHE IS

RECEIVING FROM THIS REGIMEN AND THAT AT THIS DOSE OF ESTROGEN SHE IS AT RISK FOR THROMBOTIC COMPLICATIONS WITHOUT THE CONTRACEPTIVE BENEFITS ARE THERE ANY BENEFITS FOR ESTROGEN USE IN PREMENOPAUSAL WOMEN WITH MS OR ANY BEENFITS OF ORAL CONTRACEPTIVES IN PREMENOPAUSAL WOMEN WITH MS OF NOTE THIS PATIENT DOES NOT SEEM TO HAVE FLARES OF HER MS WITH HER MENSTRUAL CYCLES THANKS RAF THANKS FOR YOUR RESPONSE I AM SEEING A BASCI TRAINEE WHO SWEARS HE HAS DI WHY THIS WASN^T A PROBLEM BEFORE HE CAME IN ESCAPES ME I DID A 24 HOUR URINE WHICH WAS REMARKABLE FOR HAVING 14 LITERS WITH 1 8GM OF PROTEIN WE CAN SEPARATE HIM ON THE PROTEINURIA BUT I AM CURIOUS IF HE DOES HAVE DI SO I DID A WATER DEPRIVATION TEST WE HAD A LITTLE DIFFICULTY ADMIN WISE SO IT WAS NOT QUITE TEXT BOOK WE STARTED AFTER 5 7 HOURS WITHOUT H2O TIME URINE OSM SERUM OSM 301 298 351 300 448 296 450 298 478 294 AFTER VASOPRESSIN 513 I DIDN^T THINK HE NEEDED THE VASOPRESSIN AS IT LOOKED PRETTY NRL TO ME I THINK THIS IS A NORMAL TEST AM I RIGHT THANKS JEAN THIS GUY WANTS AN EXCUSE TO GET OUT OF TRAINING SO THIS GUY^S BROTHER IN LAW A GENERAL SURGEON CALLS ME UP AND SAYS SINCE I DID NOT DO A HYPERTONIC SALINE INFUSION I HAVE MISSED THE CORRECT DX OF DI THIS ISN^T WHAT MY TEXTBOOK SAYS BUT HAVE I DONE ENOUGH THANKS! THANK YOU DEAR RHEUM SERVICE I^M DOING A CUTE STUDY LOOKING AT NATIONAL DATABASES TO SEE WHAT IMPACT IF ANY THE AHCPR GUIDELINES ON MANAGEMENT OF ACUTE LOW BACK PAIN HAD ON PHYSICIAN BEHAVIORS I^D LIKE TO EXCLUDE RHEUMATOLOGIC CAUSES OF LOW BACK PAIN ACCORDINGLY I^VE EXCLUDED FOLKS FROM THE SET WHO HAVE ANKLYOSING SPOND RHEUMATOID ARTHRITIS SACROILLITIS I^VE ALSO EXCLUDED FOLKS WITH UTI AND FIBROMYALGIA ARE THERE ANY OTHER SPECIFIC DIAGNOSIS THAT I^D BE WELL ADVISED TO DELETE I HAVE ABOUT 12 MILLION OFFICE VISITS WITH GP FP IMED DOCS BETWEEN 1990 1997 FOR ACUTE LOW BACK PAIN I^M INTERESTED IN FINDING OUT WHETHER THESE DOCS CHANGED THEIR BEHAVIORS MEDICINE XRAYS PHYSICAL THERAPY ETC AS A CONSEQUENCE OF THE AHCPR LOW BACK PAIN GUIDELINES THAT WERE RELEASED IN 1994 I WANT TO EXCLUDE PATIENTS WHO ARE GIVEN INFLAMMATORY DIAGNOSES SUCH AS AS REITERS ETC I HAVE THE ICD 9 DIAGNOSES FOR ALL THE PATIENTS UP TO 3 I AM LOOKING FOR INPUT ON INFLAMMATORY DIAGNOSES I SHOULD GO IN AND EXCLUDE THANKS I AM AN INTERNIST TRYING TO ANSWER SOME GYN QUESTIONS FOR AN AQUAINTANCE THE PT IS A 31 Y O FEMALE G1P0 WITH LONG TIME HX OF IRREGULAR Q6 7 WEEK MENSES REGULATED FOR SEVERAL YEARS WITH BCP UNTIL 1 YR AGO AT THAT TIME SHE UNDERWENT SEROLOGY EVAL FOR AMENORRHEA WHICH LATER EVOLVED INTO IRREGULAR MENSES AS WELL AS US WITH PRESUMPTIVE DIAGNOSIS OF PCO GIVEN NML TSH PROLACTIN ETC SHE HAS NO HIRSUTISM OBESITY OR GLUCOSE INTOL AND IS TAKING NO MEDS RECENTLY SHE BECAME PREGNANT AND SUFFERED A MISCARRIAGE AT ABOUT 6 7 WEEKS SHE VERY MUCH WISHES TO GET PREGNANT AGAIN AND OUR QUESTION IS WETHER GIVEN HER HX OF LIKELY NOT CLINICALLY OBVIOUS PCO SHOULD SHE RECEIVE PROGESTERONE VS CLOMID BEFORE DURING HER NEXT PREGNANCY ATTEMPT TO TRY AND COMPENSATE FOR A POSSIBLE LUTEAL PHASE DEFECT IF SO WHAT WOULD BE THE SAFEST AGENT AND HOW PROVEN IS THEIR SAFETY YOUR INSIGHT AND POSSIBLE REFERENCES REGARDING THESE MATTERS WOULD BE GREATLY APPRECIATED GIVEN I AM TREADING VERY UNCHARTED WATERS FOR MY SPECIALTY THANKS AGAIN I AM AN INTERNIST AT KELLER ARMY HOSPITAL MY QUESTION IS WHAT ALTERNATIVES ARE AVAILABLE FOR PROPULSID IN TX OF DIABETIC GASTROPARESIS ARE THERE ANY REASONABLE AND EFFECTIVE SUBSTITUTES HOW ARE YOU FOLKS TREATING THIS DISORDER YOUR INPUT WOULD BE VERY HELPFUL TO OUR DEPARTMENT I THANK YOU IN ADVANCE THANKS I AM AN INTERNIST AT WEST POINT AND HAVE A PATIENT THAT WISHES TO COMPLETE HER PULMONARY W U AT WRAMC SHE IS A 40 Y O FEMALE SMOKER S P SURGICAL MENOPAUSE 8 YRS AGO WITH RECENT ONSET NIGHT SWEATS AND WEIGHT LOSS WITHOUT COUGH FOUND TO HAVE A RUL RATHER PERIPHERAL NODULE PRIOR CXR REPORTEDLY NEGATIVE AND PT TRYING TO LOCATE THEM CHEST CT BEING DONE TODAY PPD NEGATIVE WITH NML ANERGY PANEL I WANT TO REFER HER TO YOU FOR FURTHER EVAL BRONCH TUMOR BOARD EVAL ETC PER YOUR DISCRETION PLEASE ADVICE ON FURTHER LABS OR STUDIES THAT WOULD AID YOUR EVALUATION SO I CAN EXPEDITE THINGS FOR HER GIVEN SHE WILL HAVE TO STAY IN A HOTEL DURING HER VISIT TO YOUR AREA I CAN BE REACHED TELEPHONICALLY AT OR VIA THIS MESSAGE I THANK YOU IN ADVANCE FOR YOUR CONSIDERATION ON THIS MATTER SERGIO BURES CPT MC THANK YOU FOR YOUR PROMPT RESPONSE SHE WILL BE ABLE TO GO THURSDAY AFTERNNON 6 APRIL I HAVE DISCUSSED THE PLAN AND POSSIBLE BRONCH FRIDAY AND SHE IS AGREEABLE WE WILL TRY TO GATHER AS MANY OLD FILMS AS POSSIBLE AND OF COURSE HER CXR AND CONTRAST CT WILL COME WITH HER IF YOU COULD PROVIDE DETAILS OF TIME AND PLACE I WILL PASS THEM ON TO HER THANK YOU AGAIN FOR YOUR RESPONSE AND ASSISTANCE SERGIO SHE WILL BE THERE THANKS AGAIN
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(HEMATOLOGY/ONCOLOGY THE ROLE OF RALOXIFENE IN THIS SETTING IS BEING EXPLORED THERE ARE NO DATA ON THE RELATIVE BENEFITS RISKS OF RALOXIFENE IN

WOMEN WHO HAVE COMPLETED 5 YEARS OF TAM I WOULD DEFER TO ENDO AS FAR AS ALTERNATIVE THERAPIES CERTAINLY SHE MAY BE A CANDIDATE FOR ALENDRONATE GREETINGS DR OWENS AGREE THAT THE DIFF WOULD HELP A LEUKEMOID REACTION BY DEFINITION IS INCLUSIVE OF A LUEKOCYTOSIS OF > |50K| STEROID INDUCED WAS ALSO MY FIRST THOUGHT BUT WOULD EXPECT EARLY BAND FORMS WHICH CAN ALSO BE SEEN WITH LEUKEMOID REACTIONS MAY BE RESOLVING A LAP SCORE MAY HELP YOU TO DIFFER BETWEEN AN INFECTIOUS INFLAMMATORY ETIOLOGY AND CML UNLIKELY GIVEN AGREE WITH DR M SHOULD BE SEEN PROMPTLY BY A HEMATOLOGIST ONCOLOGIST I AGREE WITH DR LEGUIZAMO NEWER FACTOR CONCENTRATES ARE AVAILABLE BUT IF HE IS RESPONSIVE TO DDAVP THAT IS BEST OPTION

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(ENDOCRINOLOGY RUN THE BMD RESULTS BY US AGAIN T SCORE YOUNG NLS Z SCORE AGE MATCHED WE CANNOT RECOMMEND SPECIFIC THERAPY WITHOUT EVALUATING THE PATIENT WE WOULD BE GLAD TO ANSWER QUESTIONS ABOUT SPECIFIC THERAPIES WOULD RECOMMEND REFERRING HER TO US FOR EVALUATION DID YOU WANT THIS TO GO TO ENDOCRINOLOGY ASK A DOC I FORWARDED IT NO CONTRAST WITH THAT CT PLEASE DR HARARI COMMENT FURTHER AFTER HIS ASSESSMNET OKAY WE REPEATED HIS LABS THIS TIME THE NOREPI CAME BACK AT 146 15 80 AND DOPAMINE WAS 447 65 400 AND NORMETANEPHRINE 732 82 500 AND TOATL METANEPHRINES 915 NRL 120 700 HIS URINE VOL WAS 1500 CC AND HE HAS A CREATININE CLEARANCE OF 204 ML MIN BASED ON HIS URINE AND SERUM CREATININES DID HE OVER COLLECT AS FAR AS HIS SPELLS HE GETS BRIEF PERIODS OF SHAKING SWEATING AND FLUSHING WHICH LAST LESS THATN 15 MIN AND THESE OCCUR WITHOUT ANY RELATIONSHIP TO ACTIVITY MEALS SLEEP ETC AND OCCUR APPPPROX QWEEK I HAVE NOT GOTTEN THE PLAMSA CATHCOLS WOULD YOU STILL RECOMMEND OR IS THIS ENOUGH INFO TO GO TO THE OR CAN^T REMEMBER THE WHOLE CASE JEANNIE URINES ARE SUSPICIOUS I WOULD USE CR INDEX TO DECIDE IF HE OVER COLLECTED USE CR KG BODY WT 20 25 MG KG DAY IS NORMAL IN A MALE SERUM MEASUREMENTS WOULD STILL BE HELPFUL AND SOMETIME THE LEVELS HELP DECIDE IF A CONFRIMATORY STIM OR SUPPRESSION TEST IS NEEDED BY THE WAY DID YOU IMAGINE THE ADRENALS YET IF SO WAS THERE A SUBSTABTIAL LESION ACTUALLY WE WOULD PROBABLY STILL WAIT ON IMAGING UNTIL WE ARE CONVINCED OF A PHEO CHEMICALLY VIC NOT SURE IF THERE IS A CAUSE AND EFFECT NEED TO ASSESS THE MEDICATIONS HE IS TAKING HIS THYROID STATUS RENAL STATUS ETC COULD YOU REFER HIM TO US PLEASE ASK HIM TO REPEAT HIS PROLACTIN LEVEL TESTOSTERONE FSH LH NUC1 PROFILE P1 P2 P3 THANKS WE WOULD BE VERY HAPPY TO SEE THIS PATIENT THE FASTEST WAY TO MAKE AN APPT IS TO ENTER THE CONSULT IN CHCS AND HAVE HIM CALL OUR FRONT DESK TO BOOK IF THE TIMING ISN^T SATISFACTORY CALL THIS NUMBER AND ASK TO SPEAK TO OUR ON CALL PHYSICIAN HOW LONG POST PARTUM IS SHE ANY FAMILY HISTORY OF THYROID OR AUTOIMMUNE DISEASE WOULD REPEAT TSH AND IF ELEVATED BEGIN TREATMENT WITH THYROID HORMONE NO REASON TO DO A THYROID SCAN AGREE THE EARLY SYMPTOMS MAY HAVE BEEN DUE TO THYROTOXICOSIS FROM POSTPARTUM THYROIDITIS IN WHICH CASE SHE MAY HAVE RECOVERY OF NORMAL THYROID FUNCTION WERE TFTS DONE DURING HER PERIOD OF ANXIETY ETC I WOULD STILL TREAT HER WITH THYROID HORMONE IF THIS WERE PPT BUT WOULD PROBABLY WITHDRAWAL AND RETEST AFTER 1 YEAR A COMMON STARTING DOSE WOULD BE BETWEEN 0 5 AND 0 1 MG ONCE DAILY DEPENDING ON THE PATIENT AGE SIZE ETC THE TFTS ARE ADJUSTED FROM THERE WE WOULD BE HAPPY TO SEE HER TO ASSIST IN HER MANAGEMENT HOW LONG HAS SHE BEEN BREAST FEEDING THE LAST I CHECKED PROLACTINS ACTUALLY TEND TOWARD NORMAL W IN SEVERAL MONTHS POSTPARTUM EVEN WITH CONTINUED BREAST FEEDING I WILL CHECK SOME REFERENCES BUT 1970 SEEMS AWFUL HIGH DID SHE HAVE NL MENSES PRE PREGNANCY OR GALACTORRHEA HX OF PITUITASRY DISORDER THE IS ALSO A SYNDROME OF MACROPROLACTINEMIA WHERE THE PROLACTIN MOLECULE IS ABNORMALLY LARGE AND CANNOT BE READILY EXCRETED BUT NOT SURE WHAT LEVELS ARE SEEN WITH THAT RARE CONDITION PRL MAY INCRAESE TO AROUND 100 300 RANGE SOON AFTER SUCKLING BUT THEN RETURNS CLOSE TO NORMAL RANGE A MINIMALLY ELEVATED PROLACTIN MIGHT NOT WORRY ME I WOULD THINK THAT LEVEL SUSPICIOUS FOR A MACROPROLACTINOMA I WOULD DEFINITELY REPEAT X 2 PLUS CONSIDER TFTS 24 HR UFC WITH CR SOMATOMEDIN C AND REFERRAL TO US THANKS SORRY TO HEAR WE WON^T SEE HER WE HAVE SEEN A LOT OF PTIUITARY CASES OVER THE YEARS AND WOULD HAVE BEEN HAPPY TO WORK HER IN PROMPTLY BUT I CAN UNDERSTAND THE RELUCTANCE TO DRIVE A DISTANCE I WOULD LEAN TOWARDS GETTING A MRI OF THE SELLA WITH GADOLINIUM ESP IF REPEAT PRL IS AS HIGH AGAIN THE RECOMMENDED DOSE IS 400 TO 800 IU QD OF VITAMIN D A MVI HAS 400 IU THE PHARMACY DID AWAY WITH THE 400 IU VIT D TABS THAT WE SOMETIMES GAVE TO PTS WITH THEIR MVI PHARMACIES SOLUTION TO GET 800 IU IS TO TAKE 2 MVI PER DAY THEY SWEAR THAT NO ONE WILL GET TOXIC WITH TAKING TWO MVI DAY ANOTHER WAY IS TO HAVE PTS PURCHASE CALCIUM SUPLLEMENST WITH 200 IU VIT D THEN THEY CAN TAKE MVI VIT D 400 IU PLUS TWO CACLIUM TABS WITH CALCIUM 500 MG EA AND VIT D 200 IU EACH FOR A TOTAL OF 800 IU TYPICALLY WE USE THE OTHER PREPARATIONS YOU SEE

ON CHCS FOR MORE PROMINENT VIT D DEFICIENCY STATES NEW ONE ON ME I BET SHE MEANS AVANDIA OR ROSIGLITAZONE INSULIN SENSITIZER MUCH BETTER THAN TROGLITAZONE BUT A COUPLE OF RECENT REPORTS OF HEPATOTOXICITY DRUG COMPANY RECOMMENDS Q 2 MO LFTS X 1 YEAR THEN I SEE NO REASON TO USE BCP^S IF ITS ONLY TO TREAT HER LIBIDO SINCE SHE IS NORMALLY MENSTRUATING THIS ALSO EXCLUDES ANY SIGNIFICANT HYPOTHALAMIC PITUITARY OVARIAN AXIS ABNORMALITY I WOULD CHECK A FREE TESTOSTERONE AND DHEA NOT DHEA SULFATE AND CORTISOL LEVEL TO EXCLUDE AN CAUSE I WOULD RECOMMEND THAT YOU OBTAIN A TESTOSTERONE ESTRADIOL BETA HCG TSH LH FSH LIVER FUNCTION TESTS AND SERUM CREATININE I AGREE THAT SCREENING FOR RECREATIONAL DRUGS MAY BE APPROPRIATE SINCE GYNECOMASTIA MAY BE CAUSED BY THC CONTAINED IN MARIHUANA ALSO THE USE OF ANABOLIC AGENTS LIKE ANDRO STENEDIONE OR ORAL SYNTHETIC ANDROGENS MAY CAUSE GYNECOMASTIA I WOULD ASK HIM ABOUT THEIR USE ONCE THESE STUDIES ARE DONE IT WOULD BE APPROPRIATE TO GET AN ENDOCRINE CONSULT DEFINITELY A BIT TOO MUCH!! THE EXACT TARGET DEPENDS ON A NUMBER OF FACTORS SUCH AS HER AGE AT DIAGNOSIS SHE WAS IN THE LOW RISK AGE GROUP < 45 SIZE OF THE TUMOR LOCAL INVASION ETC EVEN IN A HIGH RISK FOR RECURRENCE PATIENT IT^S RARE TO HAVE TO ELEVATE THE FREE T4 TO ABOVE THE UPPER NORMAL LIMIT TO OBTAIN A MAXIMALLY SUPPRESSED TSH I WOULD STOP HER LT4 FOR A WEEK AND THEN RESTART AT 0 2 MG D ADJUSTING PER TFTS WE SHOULD SEE HER IN FOLLOW UP TO HELP DEFINE A TARGET TSH AND IMAGING SCHEDULE DO YOU KNOW WHO SHE SAW PREVIOUSLY IF YOU SEND HER NAME AND LAST 4 WE CAN THIS AND BOOK HER FOR AN APPROPRIATE APPT NEITHER ARE HERE NOW PLEASE SEND HER NAME NUMBER AND WE^LL BOOK THIS AND CALL HER SHE^S SCHEDULED FOR THIS FRIDAY 24 MAR @ 8 0 SHE HAS BEEN NOTIFIED WE^LL LET YOU KNOW WHAT WE THINK I SUSPECT SHE WILL NEED A REPEAT FNA WE WOULD REALLY NEED TO SEE ALL THE LAB RESULTS IN ORDER TO GIVE YOU ANY INTELLIGENT FEEDBACK PLEASE PROVIDE NAME AND LAST 4 OF SSN I AGREE W DR BERNET SINCE THE DIFFERENTIAL OF A LOW FT4 AND NORMAL TSH RANGES FROM SOMETHING AS SIMPLE AS A DRUG EFFECT TO SOMETHING AS SERIOUS AS PITUITARY INSUFFICIENCY FROM A CNS TUMOR A CONSULT TO SEE US IS CERTAINLY IT WOULD BE BEST FOR PT TO AND ARRAANGE THE APPT WITH OUR FRONT DESK THANKS SOUNDS LIKE SOMEONE WE WOULD LOVE TO SEE AT LEAST ONCE SHE MIGHT BE A GREAT CANDIDATE FOR IV PAMIDRONATE INFUSIONS SOUNDS LIKE YOU DID A GOOD R O FORSECONDARY CAUSES ALTHOUGH WOULD HAVE TO SEE THE SPECIFIC RESULTS MALABSORPTION COULD DEFINITELY BE PLAYING A ROLE HER ORAL CALCIUM SHOULD BEMAXIMIZED AND WE MIGHT HAVE SPECIFIC RECOMMENDATIONS ON CALCIUM SUPP LEMENTSETC ALSO DID YOU DO VIT D LEVELS I DON^T THINK SHE NEEDS AN ENDOCRINE CONSULT AT THIS POINT I WOULD FOLLOW HER BONE DENSITY OVER THE NEXT 18 24 MONTHS AND IF THERE IS NO SIGNIFICANT IMPROVEMENT CONSIDER FOSAMAX OR ANOTHER BISPHOSPHONATE MAKE SURE SHE IS GETTING VIT D ALONG WITH HER CALCIUM SUPPLEMENT A MULTIVITAMIN WILL HAVE 400IU OF VIT D WAS SHE OSTEOPOROTIC BY BOTH LATERAL AND A P DEXA VIEWS OR WAS IT JUST THE LATERAL WAS THE CALCIUM WELL WITHIN NORMAL LIMITS ADJUSTED FOR ALBUMIN TFTS URINE CR CA EXCRETION HX OF MAJOR FXS BEYOND THE STRESS FXS ANY LONG TERM MEDS IF SHE IS A CADET ABOUT TO GO ONTO ACTIVE DUTY IT WOULD PROBABLY BE PRUDENT TO ALLOW US TO SEE HER AND ASSESS BEFORE SHE HEADS OUTINTO HER CAREER AND CAN^T SEE A SPECIALISTS AS EASILY IF SHE ENDS UP SOMEWHERE REMOTE IS JUMP SCHOOL IN HER FUTURE I CAN APPRECIATE YOUR EFFORTS FOR THIS PATIENT BUT I HAVEN^T ENCOUNTERED THIS SITUATION BEFORE I WILL FORWARD THIS TO CPT JAMES AND COL JILL PHILLIPS TO SEE IF THEY HAVE ANY SUGGESTIONS IT SEEMS TO ME THAT AN ANSWER NEEDS TO COME FROM THE ADMIN SIDE OF THE HOUSE I WOULD CALL THE BOEHRINGER MANNHEIM REP PAUL KELLY TO SEE IF THEY CAN DO SOMETHING TO EXPEDITE THIS OR PROVIDE A LOANER NAMES CAN BE SENT WHEN ON THE SAME CHCS SYSTEM AS FT MEADE IS PT NAMES CAN^T BE SENT IN PER INTERNET WHICH IS DIFFERENT I AGREE THAT THIS LOOKS LIKE A NORMAL RESPONSE AND WOULD NOT DO ANY FURTHER WORKUP EXCEPT PERHAPS A 1 DAY ADMISSION TO DOCUMENT I&O UNDER OBSERVATION WATER DEP WOULD BE THE GOLD STANDARD IN MY BOOK I HAVE FORWARDED THIS MESSAGE TO DR ALVERO WHO IS A REPRODUCTIVE GYN HERE AT ASSUMING THERE IS NO FAMILY HX OF THYROID CANCER OR XRT RADIATION EXPOSURE TO THE NECK YOU CAN FOLLOW THE PT WITH SERIAL PHYSICIAL EXAM PROBABLY ANNUAL TSH AND NECK THYROID EXAM I WOULD PROBABLY NOT REPEAT US UNLESS A NODULE BECAME CLINICALLY PALAPBLE OR SXS ATTRIBUTABLE TO THYROID NODULE ENLARGEMENT BECAME EVIDENT WITH A NORMAL PHYSICAL EXAM WHAT LEAD TO THE US IN THE FIRST PLACE THERE IS A 30 40% CHANCE OF FINDING A INCIDENTAL NODULE IN A PT THIS AGE WHEN DOING US SO IF THE GLAND IS EASILY PALPABLE WE MOSTLY DON^T GO TO US THYROID US ABNORMALITIES SUCH AS THESE ARE FOUND IN 30% OF THE GENERAL POPULATION HER AGE UNLESS SHE HAD A HISTORY OF THYROID XRT EXPOSURE I^D FOLLOW HER WITH PALPATION ONLY THERE^S FAIRLY GOOD EVIDENCE OF HARM AFIB OSTEOPOROSIS WITH SUBCLINICAL HYPERTHYROIDISM AT THIS LEVEL WE ARE VERY MUCH APT TO SEARCH

FOR THE CAUSE THYROID EXAM REPEAT TFTS ANTI TPO AB^S THYROID SCAN AND UPTAKE IF REPEAT TFTS CONFIRM AND THEN TREAT ACCORDING TO THE ETIOLOGY WITH THE OBJECTIVE OF NORMALIZING THE TSH FEEL FREE TO COME BY WITH HER DATA TO DISCUSS WITH ONE OF US I^M PREPARING A LECTURE ON THE MANAGEMENT OF THYROID NODULES IN PREGNANCY FOR PATIENTS WITH FNAS SHOWING THYROID CANCER WE GENERALLY RECOMMEND THYROIDECTOMY IN THE 2ND TRIMESTER IS ANYONE AWARE OF ANY GOOD REFERENCES THE MATERNAL AND FETAL RISK ASSOCIATED WITH SURGERY IN THE FIRST AND THIRD TRIMESTERS H BURCH THANK YOU!
)
(GERIATRICS 58 YR OLD FEMALE WITH S P MASRECTOMY FOR BREAST CA ON TOMOXIFEN FOR 5 YRS ALSO HAS SEVERE ASTHMA ON SX STEROIDS FROM TIME TO TIME D C TOMOXIFEN RECENTLY BONE DENSITY STUDIED SHOWED OSTEOPENIA AND INCREASED RISK OF FRCTURE HAS O 8 IN COMPARION OF T SCORE 2 0 AGE MATCHED PT HAS DUB FOR WHICH TAKES DEPO Q 3 MONTHS ON CALCIUM 1ND EXERCISES QUESTION IS WHAT OTHER MODALITY FOR OSTEOPOROSIS RX THANKS
)
(NEPHROLOGY THAT IS A TOUGH ONE GIVEN HIS NON NEPHROTIC RANGE PROTEINURIA HOWEVER HIS SERUM CREATININE OF 1 9 MOST LIKELY REPRESENTS ABNORMALLY LOW RENAL FUNCTION CRCL SHOULD BE >110 CC MIN 1 73 M2 BSA WHETHER OR NOT WE WOULD TREAT HIM IF HE HAD A GLOMERULAR DISEASE WOULD DEPEND ON THE NATURE OF DISEASE IF HE HAD LUPUS WE PROBABLY WOULD NOT ALL PATIENTS WITH LUPUS NEPHRITIS HAVE A POSITIVE ANA SO IN GENERAL I THINK A RENAL BIOPSY WOULD BE A CONSIDERATION IN THIS CASE ALTHOUGH HE COULD HAVE HYPERTENSIVE NEPHROSCLEROSIS ALTHOUGH I WOULD MORE SUSPICOUS FOR A GLOMERULAR DISEASE GIVEN HIS ALMOST 1 GM OF PROTEINURIA PRIOR TO ACE WE WOULD BE HAPPY TO SEE HIM HERE IF YOU WOULD LIKE TO SEND HIM REPEAT TESTS HERE UPR 480 MG 24HR UCR 2565 MG H4HR CR 1 9 CRCL 93UA NEGATIVE BPS NOT ANY DIFFERENT FROM TIME OF DIAGNOSIS 144 84 132 88 134 |771| PLAN TO BUMP UP HIS ACEI BENAZEPRIL FOR ELEVATIONS BEYOND GOAL BP MY QUESTION IS DOES HE NEED FURTHER W U IE RENAL BIOPSY OR IS THIS BORDERLINE TO STAGE I HTN THE MOST LIKELY CAUSE FOR HIS PROTEINURIA THAT IS A TOUGH ONE GIVEN HIS NON NEPHROTIC RANGE PROTEINURIA HOWEVER HISSERUM CREATININE OF 1 9 MOST LIKELY REPRESENTS ABNORMALLY LOW RENAL FUNCTION CRCL SHOULD BE >110 CC MIN 1 73 M2 BSA WHETHER OR NOT WE WOULD TREAT HIMIF HE HAD A GLOMERULAR DISEASE WOULD DEPEND ON THE NATURE OF DISEASE IF HEHAD LUPUS WE PROBABLY WOULD NOT ALL PATIENTS WITH LUPUS NEPHRITIS HAVE APOSTIIVE ANA SO IN GENERAL I THINK A RENAL BIOPSY WOULD BE A CONSIDERATIONIN THIS CASE ALTHOUGH HE COULD HAVE HYPERTENSIVE NEPHROSCLEROSIS ALTHOUGH IWOULD MORE MORE SUSPICOUS FOR A GLOMERULAR DISEASE GIVEN HIS ALMOST 1 GM OF PROTEINURIA PRIOR TO ACE WE WOULD BE HAPPY TO SEE HIM HERE IF YOU WOULD LIKE TO SEND HIM WHEN WE SAW MR S HERE HIS CRCL WAS 23 CC MIN DEVELOPING ESRD IS SOMETHING PATIENTS RETIRING IN GERMANY DO NOT PLAN FOR HIS WIFE STILL WORKS IN THE GERMAN COMMUNITY AND WAS UNWILLING TO MOVE HE WOULD NOT EVEN CALL HER ABOUT HIS HEALTH PROBLEMS WHILE HE WAS HERE! HE SAID HE WANTED TO DISCUSS IT WITH HER IN PERSON MR S WOULD NEED TO MOVE TO THE U S PERMANENTLY FOR HIS DIALYSIS CARE I AM SURE IT WOULD NOT BE PAID FOR FROM THE LRMC OR WRAMC BUDGET SINCE MEDICARE IS THE PAYER IN THE U S AS A DIABETIC HE WOULD NEED INITIATION AT 15 CC MIN WE ESTIMATE THIS WILL BE IN 2 3 MONTHS BUT COULD HAPPEN SOONER PD CATHETERS SHOULD GENERALLY BE PLACED NO MORE THAN 2 WEEKS AHEAD OF THEIR ANTICIPATED NEED THEREFORE MR S NEEDS TO DECIDE IF HE WILL MOVE TO THE U S PERMANENTLY IF HE WISHES TO RECEIVE ESRD CARE THAT IS ALL WE CAN DO HE SAW OUR RENAL SOCIAL WORKER MR CI BEFORE HE LEFT FOR GERMANY AND WAS COUNSELED ON THESE ISSUES I WILL ALSO FOWARD THIS MESSAGE THROUGH MR CI AND DR T WHO WAS THE FELLOW ON SERVICE WHEN MR S WAS ADMITTED HERE THANKS AND LET US KNOW IF THERE IS ANYTHING ELSE WE CAN DO WE WOULD BE HAPPY TO SEE HIM IT SOUNDS AS IF HE HAS MODERATE CRI WITH NON NEPHROTIC RANGE PROTEINURIA SINCE HE IS OVER 40 A UPEP AND SPEP WOULD BE IN ORDER ALONG WITH AN US WE WOULD BE HAPPY TO DO THAT HERE OUR WAITING TIME FOR NEW AD APPOINTMENTS SHOULD BE VERY SHORT I^D HAVE QUESTIONS 1 WHY DOES HE HAVE A SOLITARY KIDNEY 2 WHY IS HE HAVING INFECTIONS 3 WHAT SPECIFICALLY ARE THE ABNORMALITIES DESCRIBED ON THE ULTRASOUND 4 WHAT IS HIS BUN AND CREATININE YOU MAY HAVE ACCESS TO ONLY SOME OF THE ANSWERS TO THOSE QUESTIONS BUT THAT WOULD BE MY QUESTIONS IF HE HAS ANY HYDRONEPHROSIS VESCICOURETERAL REFLUX AND PYELONEPHRITIS MIGHT EXPLAIN SOME OF THESE PROBLEMS AND HIS TENDER KIDNEY IF HYDRONEPHROSIS OR DILATED COLLECTING SYSTEM PRESENT WOULD OBTAIN LASIX RENAL SCAN AND VCUG THE ANSWERS TO MY ABOVE QUESTIONS AND ADDITIONAL TESTS WOULD DETERMINE IF HE NEEDS UROLOGIC OR NEPHROLOGY REFERRAL THANKS IT^S POSSIBLE BUT WITHOUT PRIOR QUANTITATION WE DON^T REALLY KNOW IF THIS REPRESENTS A PROGRESSIVE INCREASE SINCE HE^S OVER 40 WOULD RECHECK A RENAL US CHECK UPEP IF HE IS ANEMIC OR HAS HIGH

CALCIUM HOW IS IS BP DOES HE HAVE PERSISTENT HEMATURIA I WOULD NOT ASSUME THAT HIS PROTEINURIA CAN BE EXPLAINED BY NEPHROLITHIASIS EARLY DIABETIC NEPHROPATHY OR HYPERTENSIVE NEPHROSCLEROSIS CAN CAUSE LOW GRADE PROTEINURIA WE WOULD BE HAPPY TO SEE HIM IN NEPHROLOGY CLINIC GET ANNUAL CHECK UP WITH PRIMARY PROVIDER TO INCLUDE BLOOD PRESSURE URINALYSIS AND BUN CR PLEASE LET ME REFER THIS TO DR YAO OUR PEDIATRIC NEPHROLOGIST YES DR SCOTT I DID RECEIVE YOUR MESSAGE AND THOUGHT I REPLIED ALREADY SORRY! TO ANSWER YOUR QUESTIONS 1 AS YOU KNOW THE DIAGNOSIS OF PYELONEPHRITIS IS CLINICAL AND BASED ON YOUR DESCRIPTION IT SOUNDS AS THOUGH SHE PROBABLY HAD PYELONEPHRITIS 2 IN CHILDREN WHO DEVELOP PYELONEPHRITIS VESICO URETERAL REFLUX VUR IS A COMMON ASSOCIATED FINDING ESP IN CHILDREN LESS THAN 6 7 YEARS OF AGE BECAUSE OF THIS WE RECOMMEND VCUG TESTING FOR CHILDREN LESS THAN 6 7 YEARS OF AGE WITH FIRST TIME UTI OR IF THE HISTORY STRONGLY SUGGESTS A HISTORY OF PYELONEPHRITIS OR UTI AS AN INFANT DID THIS CHILD HAVE UTI PYELO IN THE PAST IF NOT THEN VCUG TESTING IS NOT AN ABSOLUTE 3 VCUG TESTING SHOULD BE DONE WHILE THE CHILD IS AWAKE AS VOIDING DYNAMICS CHANGE WHEN THE CHILD IS ASLEEP THEREFORE VCUG TESTING CANNOT BE DONE WITH SEDATION 4 I DO NOT RECOMMEND SCREENING HER SIBLINGS FOR REFLUX UNLESS THEY HAVE A PAST HISTORY OF UTI WILL REFER TO OUR PEDIATRIC NEPHROLOGIST DR LYNNE YAO DO YOU MEAN THAT THE PATIENT IS COMING TO WRAMC TO BE SEEN EXCEPT FOR LABS NUMBER TWO WHICH SHOWED A CO2 OF 21 AND A K OF 3 5 I DON^T SEE A NET TREND I THINK REFERRING HER TO NUTRTITION IF NOT ALREADY DONE COULD BE HELPFUL ALTHOUGH IF SHE HAS A SIGNFICANT BEHAVIOURAL DISORDER SHE MIGHT NOT BE RECEPTIVE LOW BUN AND CR AND HER LOW WEIGHT ALONG WITH THE HISTORY CERTAINLY SUGGEST UNDER NUTRITION AND A POSSIBLE ACTIVE EATING DISORDER SHE DOESN^T HAVE AN ALKALOSIS TO SUGGEST CHRONIC VOMITING BUT YOU MIGHT CHECK THE BACKS OF HER FRONT TEETH FOR EROSIONS HER BUN IS LOW AND HER CREATININE IS ALSO BOTH ARE IN THE NORMAL RANGE FOR A WOMAN WHO PROBABLY DOESN^T HAVE A LOT OF MUSCLE MASS AND PROBABLY HAS A LOW PROTEIN DIET

)
)
)

```
;; miscellaneous functions


; return number of entries in a consult
(defun num-entries (consult)
        (setq total (round (/ (length consult) 4)))
        total
)


(defun format-list-to-range (list)
 (let ((string-list nil))
  (dolist (item list)
   (push (string-capitalize (princ-to-string item)) string-list)
   )
  (reverse string-list)
  )
 )


(defun format-list-to-range-2 (list)  ;; version 2 deals with lists of lists
 (let ((string-list nil)
    (item-string ""))
  (dolist (item list)
   (setf item-string (princ-to-string item))
   (push (string-capitalize (subseq item-string 1 (- (length item-string) 1))) string-list)
   )
  (reverse string-list)
  )
 )


; group by doctor  (use words in replies, etc)
(defun make-doc-table (consult-list)
        (setq count 0)
        (setq doc-table (make-hash-table :test #'equal))
        (dolist (consult consult-list)
                (format t "~A " (incf count))
                (dotimes (n (num-entries consult))
                        (format t "e ")
                        (setq spec-name-string (nth (+ 1 (* n 4)) consult))

                        (setq specialist-firstname (firstname-from-string spec-name-string))
                (setq specialist-lastname (lastname-from-string spec-name-string))
                (setq specialist-mi (mi-from-string spec-name-string))
                (setq specialist-fullname-string (concatenate 'string specialist-firstname "-" specialist-mi "-" specialist-
lastname))
                        (setq specialist-fullname (string-to-symbol specialist-fullname-string))
                        (setq words (nth (+ 4 (* n 4)) consult))
                        (if (gethash specialist-fullname doc-table)
                                (setf (gethash specialist-fullname doc-table)
                                        (append (gethash specialist-fullname doc-table) (string-to-word-list words)))
                                        ;;(concatenate 'string (gethash specialist-fullname doc-table) " " words))
                                (setf (gethash specialist-fullname doc-table) (string-to-word-list words))
                                ;;(setf (gethash specialist-fullname doc-table) words)
                        )

                )

        )

        doc-table
)




; group by specialty (specialty's words = words spoken by any doc in the given specialty)
```

```
(defun make-specialty-table (consult-list)
        (setq count 0)
        (setq spec-table (make-hash-table :test #'equal))
        (dolist (consult consult-list)
                (format t "~A " (incf count))
                (dotimes (n (num-entries consult))
                        (format t "e ")
                        (setq spec-string (replace-spaces-with-hyphens (nth (+ 3 (* n 4)) consult)))
                        (setq specialty-symbol (string-to-symbol spec-string))
                        (setq words (nth (+ 4 (* n 4)) consult))
                        (if (gethash specialty-symbol spec-table)
                                (setf (gethash specialty-symbol spec-table)
                                        (append (gethash specialty-symbol spec-table) (string-to-word-list words)))
                                        ;;(concatenate 'string (gethash specialty-symbol spec-table) " " words))
                                (setf (gethash specialty-symbol spec-table) (string-to-word-list words))
                                ;;(setf (gethash specialty-symbol spec-table) words)
                        )

                )

        )

        spec-table
)


(defun list-all-words (assoc-list) ;; in format ((CLASS word word) (CLASS word...))
        (setq wordlist NIL)
        (dolist (item assoc-list)
                (setf wordlist (append (cdr item) wordlist))
        )
        (remove-duplicates wordlist)
 )



(defun make-location-doctors-table (consult-list)
 (setq the-hash (make-hash-table :test #'equal))
 (dolist (consult consult-list)
  (dotimes (entry-number (num-entries consult))
   (let* ((curr-location-string (nth (+ 2 (* entry-number 4)) consult))
        (curr-doc-string (nth (+ 1 (* entry-number 4)) consult))

        (doc-firstname (firstname-from-string curr-doc-string))
        (doc-lastname (lastname-from-string curr-doc-string))
        (doc-mi (mi-from-string curr-doc-string))
        (doc-fullname-string (concatenate 'string doc-firstname "-" doc-mi "-" doc-lastname))
        (curr-doc (string-to-symbol doc-fullname-string))


        (curr-location (REPLACE-SPACES-WITH-UNDERSCORES curr-location-string))

        (hash-entry (string-to-symbol curr-location))
        )

    (if (null hash-entry) (progn (format t "~A ~A~%" entry-number consult) (read)))

    (if (not (null curr-doc)) (setf (gethash hash-entry the-hash) (remove-duplicates (append (list curr-doc) (gethash hash-entry the-
hash)))))
    )
   )
  )
 the-hash
 )



(defun classify-from-list-of-docs (words doc-list)
 (let* ((all-scores (simple-classify words *doc-words*))
```

```
      (new-score-list nil)
      )
   (dolist (score all-scores)
    (if (member (car score) doc-list)
      (push score new-score-list)
    )
   )
   (reverse new-score-list)
   )
 )


;; simply lists all specialties in *specialty-words* and displays # words in its dataset
(defun list-specialty-info ()
        (dolist (item *specialty-words*)
                (let* (     (spec (car item))
                            (numwords (length (cdr item)))
                            )

                            (format t "~A (~A)~%" spec numwords)
                )
        )
)
```

```
;;; TIME-FUNCTIONS.LSP


(defun universal-time-decoder (universal-time)
  (multiple-value-bind (second minute hour date month year day-of-week
                              daylight-saving-time-p time-zone)
      (decode-universal-time universal-time)
    (list day-of-week month date year hour minute second time-zone daylight-saving-time-p)))

(defparameter *time-zone*
  (let ((time-info (universal-time-decoder (get-universal-time))))
    (if (nth 8 time-info) (- (nth 7 time-info) 1) (nth 7 time-info))))


(defun universal-time-from-date (the-date) ;;; "03/31/1994"
  (cond ((= (length the-date) 8)
         (let* ((mm (string-to-symbol (subseq the-date 0 2)))
                (dd (string-to-symbol (subseq the-date 2 4)))
                (yyyy (string-to-symbol (subseq the-date 4))))
           (encode-universal-time 0 0 0 dd mm (if (< yyyy 1900) 1900 yyyy) *time-zone*)))
        ((= (length the-date) 10)
         (let* ((mm (string-to-symbol (subseq the-date 0 2)))
                (dd (string-to-symbol (subseq the-date 3 5)))
                (yyyy (string-to-symbol (subseq the-date 6))))
           (encode-universal-time 0 0 0 dd mm (if (< yyyy 1900) 1900 yyyy) *time-zone*)))))


(defun universal-time-from-date-and-time (the-date the-time) ;;; "03/31/1994" "0800"
  (if (null (numberp (string-to-symbol the-time)))
      (warning-msg)
    (cond ((or (equal "" (string-trim '(#\Space) the-date))
               (equal "" (string-trim '(#\Space) the-time)))
           nil)
          (t
           (let* ((mm (string-to-symbol (subseq the-date 0 2)))
                  (dd (string-to-symbol (subseq the-date 3 5)))
                  (yyyy (string-to-symbol (subseq the-date 6)))
                  (hh (string-to-symbol (if (= (length the-time) 4)
                                            (subseq the-time 0 2)
                                          (if (= (length the-time) 3)
                                              (subseq the-time 0 1)
                                            "0"))))
                  (mn (string-to-symbol (if (= (length the-time) 4)
                                            (subseq the-time 2)
                                          (if (= (length the-time) 3)
                                              (subseq the-time 1)
                                            the-time)))))
             (encode-universal-time 0 mn hh dd mm yyyy *time-zone*))))))

(defun date-from-universal-time (universal-time)
  (let* ((time-list (universal-time-decoder universal-time))
         (string-dd (princ-to-string (nth 1 time-list)))
         (dd (if (= (length string-dd) 2) string-dd
               (concatenate 'string "0" string-dd)))
         (string-mm (princ-to-string (nth 2 time-list)))
         (mm (if (= (length string-mm) 2) string-mm
               (concatenate 'string "0" string-mm))))
    (string-to-symbol
     (concatenate 'string dd "/" mm "/"
                  (princ-to-string (nth 3 time-list))))))


(defun time-from-universal-time (universal-time)
  (if (= universal-time 0) 0
      (let* ((all-time (universal-time-decoder universal-time))
             (string-hh (princ-to-string (nth 4 all-time)))
             (hh (if (= (length string-hh) 2) string-hh
                   (concatenate 'string "0" string-hh)))
             (string-mn (princ-to-string (nth 5 all-time)))
             (mn (if (= (length string-mn) 2) string-mn
```

```
                (concatenate 'string "0" string-mn))))
    (string-to-symbol (concatenate 'string hh mn)))))

(defun time-with-seconds-from-universal-time (universal-time)
 (if (= universal-time 0) 0
   (let* ((all-time (universal-time-decoder universal-time))
          (string-hh (princ-to-string (nth 4 all-time)))
          (hh (if (= (length string-hh) 2) string-hh
                (concatenate 'string "0" string-hh)))
          (string-mn (princ-to-string (nth 5 all-time)))
          (mn (if (= (length string-mn) 2) string-mn
                (concatenate 'string "0" string-mn)))
          (string-secs (princ-to-string (nth 6 all-time)))
          (secs (if (= (length string-secs) 2) string-secs
                    (concatenate 'string "0" string-secs))))
     (concatenate 'string hh ":" mn ":"secs))))


(defun minutes-from-time (the-time)
 (let ((string-time (princ-to-string the-time)))
  (if (< (length string-time) 2)
   (string-to-symbol string-time)
   (string-to-symbol (subseq string-time (- (length string-time) 2) )))))

(defun hours-from-time (the-time)
 (let ((string-time (princ-to-string the-time)))
  (if (< (length string-time) 3) 0
    (string-to-symbol (subseq string-time 0 (- (length string-time) 2))))))

(defun or-schedule-name-from-universal-time (universal-time)
 (let* ((time-list (universal-time-decoder universal-time))
      (mm (princ-to-string (nth 1 time-list)))
      (dd (princ-to-string (nth 2 time-list)))
      (yyyy (princ-to-string (nth 3 time-list))))
  (string-to-symbol
   (concatenate 'string
          "OR"
          mm
          (if (= (length dd) 2) dd (concatenate 'string "0" dd))
          yyyy
          ))))

(defun schedule-name-from-universal-time (universal-time)
 (let* ((time-list (universal-time-decoder universal-time))
      (mm (princ-to-string (nth 1 time-list)))
      (dd (princ-to-string (nth 2 time-list)))
      (yyyy (princ-to-string (nth 3 time-list))))
  (string-to-symbol
   (concatenate 'string
          "jei"
          (if (= (length mm) 2) mm (concatenate 'string "0" mm))
          (if (= (length dd) 2) dd (concatenate 'string "0" dd))
          yyyy
                  ".txt"
          ))))


(defun year-from-universal-time (universal-time)
 (let ((time-list (universal-time-decoder universal-time)))
  (nth 3 time-list)))

(defun month-from-universal-time (universal-time)
 (let ((time-list (universal-time-decoder universal-time)))
  (nth 1 time-list)))

(defun day-from-universal-time (universal-time)
 (let ((time-list (universal-time-decoder universal-time)))
  (nth 2 time-list)))
```

```
(defun day-of-the-week-from-universal-time (universal-time)
 (nth 0 (universal-time-decoder universal-time)))


(defun next-cleaning-time (the-time)  ;; time is returned in Universal Time format, the-time - 5, 10, 12
 (let* ((time-now (get-universal-time))                    ;; 5.5 is 530 ...
      (current-time (universal-time-decoder time-now))
      (mm (nth 1 current-time))
      (dd (nth 2 current-time))
      (yyyy (nth 3 current-time))
      (hh (nth 4 current-time))
      (mn (nth 5 current-time))
            (hr-the-time (floor the-time))
            (min-the-time (round (* 60 (- the-time hr-the-time))))
      (the-time-in-unitime (encode-universal-time  0 min-the-time hr-the-time dd mm yyyy *time-zone*)))
  (if (< time-now the-time-in-unitime)
    the-time-in-unitime
    (+ 86400 the-time-in-unitime))))

(defparameter *date* (date-from-universal-time (get-universal-time)))

(defun eight-oclock-in-universal-time (universal-time)
  (let* ((time-list (universal-time-decoder universal-time))
       (mm (nth 1 time-list))
       (dd (nth 2 time-list))
       (yyyy (nth 3 time-list)))
    (encode-universal-time 0 0 8 dd mm yyyy *time-zone*)))

(defun twelve-oclock-in-universal-time (universal-time)
  (let* ((time-list (universal-time-decoder universal-time))
       (mm (nth 1 time-list))
       (dd (nth 2 time-list))
       (yyyy (nth 3 time-list)))
    (encode-universal-time 0 0 0 dd mm yyyy *time-zone*)))
```

```
;; Code for the dialog :form2


(defclass warning-message-dialog (dialog)
 ())

(defun warning-message-consult-type-dialog-cancel-button-on-click (dialog widget)
 (declare (ignore-if-unused dialog widget))
 (close dialog)
 t)
```