Arista|MD

eConsults

Explore a collection of eConsult responses across multiple specialty areas

EDITION III

eConsults

Explore a collection of eConsult responses across multiple specialty areas.

Arista|MD

eConsults by specialty

All patient, provider, and specialist details have been removed to de-identify these eConsults.

Cardiology

CHIEF COMPLAINT

Hypertension

COMMENTS TO SPECIALIST

Patient with uncontrolled hypertension; taking several medications including Amlodipine 10mg daily, Metoprolol 50mg twice per day (BID), HCTZ 12mg, Lisinopril 20mg, and Clonidine 0.2mg, all BID.

The patient has a history of hypertension and heart rate (HR) up to 130, unknown origin. Baseline heart rate is 80-130's.

The patient reports seeing a Cardiologist >2 years ago before coming to this facility but did not follow up. History of intravenous (IV) heroin use >10 years. No history of diabetes, smoking, or renal disease.

MAIN QUESTION

I would like further guidance as to how to better control the patient's blood pressure and any further actions to take in the patient's hypertension management.

Response from AristaMD eConsult Specialist

JONAH BIRDE, DO, CARDIOLOGY

NPI: 1000005001

SUMMARY

Treatment options are available at the primary care level.

DETAILS

For now, I would not change the medication regimen. Encourage weight loss, exercise, and a low salt diet. The blood pressure (BP) readings in your request are quite variable. We need an accurate baseline before making changes.

I have some recommendations for office-based blood pressure measurement, the accuracy of which is essential. I recommend manual measurement using an oscillometric device. Particular attention to cuff size and placement in obese patients is very important. BPs should be taken in the sitting position. For some patients, particularly older adults and diabetic patients, supine, sitting, and standing BPs are useful to detect orthostatic hypotension.

For office monitoring of antihypertensive therapy, the BP should optimally be measured at about the same time of day and before medications are taken to estimate the trough or nadir effect.

Extraneous variables influencing the BP should be avoided 30 minutes before evaluation. These include food intake, strenuous exercise (which can lower the BP), smoking, and caffeine ingestion. Taking the blood pressure in a cool room (12oC or 54oF) or while the patient is talking can raise the measured value by as much as 8 to 15 mmHg.

Even under optimal conditions, many patients are apprehensive when seeing the clinician, resulting in an acute rise in BP: 20-30% of patients with hypertension in the clinician's office are normotensive outside the office. This phenomenon, called "white coat" or isolated office hypertension, should be suspected in any asymptomatic patient with markedly elevated office BP in the absence of end-organ damage. The presence of white coat hypertension can be confirmed by 24-hour BP management by prison staff or self-recorded readings using an automated oscillometric device. Although these measurements may be inconsistent with manually obtained measures, the purpose here is to compare measures taken using the same instrument at different times under typical "home" conditions.

Once you have this baseline, should the concern for hypertension remain, please re-consult for further discussion. Thank you for the consult.

Jonah Birde, DO

Jonah Birde, DO, Cardiologist

05/22/22 14:15 PST

Response Time Stamp

Certified Diabetic Education

CHIEF COMPLAINT

Comorbid Dyslipidemia

COMMENTS TO SPECIALIST

51-year-old male with type 2 diabetes diagnosed in 2015. Comorbid of dyslipidemia. Last dilated retinal exam 8/2018. No diabetic retinopathy.

MAIN QUESTION

Please provide recommendations for management.

Response from eConsult Specialist

LESLIE THOMPSON, CDE SPECIALIST

NPI: 1000006002

SUMMARY

Treatment options are available at the primary care level.

DETAILS

Diagnostics: A1c within 3-6 months/ follow up lab order. Continue daily blood glucose checking/log.

Actions: Consider increasing Levemir or adding Bolus insulin Consider re-starting Januvia or adding a different hypoglycemic agent.

Patient Actions:

The patient makes positive lifestyle changes including taking steps to follow dietary guidelines and working towards an exercise goal of 30 min./ day. Consider changing insulin injection site from upper arm to abdominal region (2-3 inches away from naval). Insulin is best absorbed in the subcutaneous abdominal region.

Follow-up: Bring blood sugar logs to appointments and continue checking blood sugar daily. Continue following dietary guidelines and exercising 30 min/day. Continue small frequent meals and avoid large portions.

Diabetes Medications: Glipizide 2.5, Metformin, 2000 mg, Januvia 100 mg. Is the patient taking all of these medications?

Patient Questions:

1. The patient questionnaire indicates the patient is injecting insulin via syringe into the upper arm. The medication list doesn't include insulin. Can you verify what type of insulin and the insulin regimen the patient is taking?
2. Is the patient taking Januvia 100mg?
3. Related to home remedies, is he currently taking any OTC herbs or supplements?

Leslie Thompson, CDE 06/21/22 12:13 PST

Leslie Thompson, CDE Specialist — Response Time Stamp

RESPONSE TO REQUEST FOR INFORMATION

Thank you for the guidance. I confirmed that the patient is injecting 20 units of Levemir U-100 insulin. He is not taking Januvia. He has a pending lab order to continue with their Diabetes plan of care. The patient plans to complete the pending lab order.

Treavor Adams, MD 06/21/22 12:48 PST

Treavor Adams, MD — Response Time Stamp

Follow-up:

- Submit blood sugar logs. CDE will assess and make recommendations based on daily trends.
- In addition to walking, consider adding resistance/weight training to your exercise regimen.
- Check to see if the patient has any questions about the provided dietary recommendations.

Nutrition Education Plan:

The type and amount of carbohydrates matter for people living with diabetes. Carbohydrates are found in starches, fruits, and milk. Sweets and desserts can have large amounts of carbohydrates. Below are six dietary recommendations consistent with the ADA 2019 Standards of Care and are meant to help achieve safe blood sugar levels, improve mood and wellness, and encourage weight loss.

Dietary Recommendations:

1. Distribute your foods between 3 meals and 2-3 snacks. Eating too much at one time can increase blood sugar.
2. Eat reasonable portions of starch. Starchy foods eventually turn into sugar, so it's important to use portion control. 1-2 portions of starch can still be included at mealtime. Try choosing whole grains.
3. Try eating protein when you eat carbohydrates. Eating protein with carbohydrates can increase energy levels, make you feel fuller, and slow your body's absorption of carbohydrates. This will stabilize blood sugars and keep them from rising too quickly.
4. Limit specific dairy products. Milk and yogurt are healthy and are a good source of calcium. However, they are also high in carbohydrates. Sometimes blood sugar levels are higher in the morning, so avoid drinking milk with breakfast.
5. Limit fruit portions. Fruit is a healthy food, but it is high in natural sugar. You may eat 1-2 portions of fruit per day, but only eat one at a time. A portion of fruit is one very small piece of fruit or half of a large piece of fruit. Avoid canned fruit and dried fruit.
6. Strictly limit sweets, juice, added sugars, and desserts. Cakes, cookies, candies, and pastries have excessive sugar and offer little nutrition. Avoid regular sodas and sweetened beverages.

Goals:

1. Encourage the patient to keep blood sugar logs and continue checking blood sugar at least 2x each day per current management plan — preferably fasting and alternating meals (breakfast, lunch, and dinner).
2. Continue to exercise. Try to walk for at least 30 minutes per day. Try not to skip more than 2 days in a row. Try adding resistance such as weight training to build lean muscle mass.
3. Try following the dietary recommendations listed above. Try switching from 2-3 large meals to 4-6 smaller meals/snacks per day.

Leslie Thompson, CDE

06/22/22 13:15 PST

Leslie Thompson, CDE Specialist

Response Time Stamp

Endocrinology

CHIEF COMPLAINT
Hyponatremia

COMMENTS TO SPECIALIST
78-year-old male patient with persistent hyponatremia but asymptomatic. Urine and serum osmolality were normal one year ago when another provider worked up hyponatremia. Previously referred to nephrology for chronic kidney disease (CKD) and electrolyte imbalance but the patient had a poor visit and asked his PCP to manage CKD.

Since this is my first time seeing him, I would like your perspective: is this an endocrinology issue vs. nephrology or both?

MAIN QUESTION
Do you think I should work him up for diabetes insipidus (DI)?

Response from eConsult Specialist

KATHLEEN BRYSON, MD, ENDOCRINOLOGY
NPI: 1000000011

SUMMARY

Treatment options are available at the primary care level.

DETAILS

This case was succinctly and well-presented.

Crucial data: 78-year-old man Type 2 diabetes on insulin. Sodium (Na) 128.
*Corrected: 128 + [1.6(272-100)/100] = 131 Cr 1.19

Discussion and Diagnosis:
A key point to remember: the kidney has only a limited capacity to dilute the urine (in good circumstances ~ 50 mOsm/kg) and this dilutional capacity worsens as we age. It is easy to create hyponatremia at this age by overconsumption of fluid. I assume the hyponatremia here is chronic, or at least more than several days.

Remember: rapid correction of hyponatremia can cause significant central nervous system (CNS) disease.

Another key point: hyperglycemia, due to water shifts from osmotic pressures, will cause apparent hyponatremia. Therefore, a corrected sodium concentration is necessary. In fact, I would be careful about searching too hard for SIADH (inappropriate ADH secretion), hypoadrenalism, etc. in the context of hyponatremia with significant hyperglycemia.

Diagnoses and Treatment recommendations:
First, given this is chronic and asymptomatic (a corrected level of ~ 131 mEq/L), I would not recommend acute treatment to improve serum sodium (unless confusion, seizure). Also, if the serum sodium remains 128 mEq/L and above it is probably okay, although I would consider the following:

I would work on getting the sugars (at least premeal) less than 200 mg/dl to get a better read on the level of hyponatremia. The patient should feel better with premeal sugars less than 200 mg/dl.

Kathleen Bryson, MD

03/20/22 08:46 PST

Kathleen Bryson, MD, Endocrinologist

Response Time Stamp

Gastroenterology

CHIEF COMPLAINT

Thrombocytopenia

COMMENTS TO SPECIALIST

The patient is a 46-year-old Hispanic male with a history of cerebrovascular accident (CVA), Hepatitis C virus (HCV), which is treatment-naïve, and congestive heart failure (CHF). Referred for management of liver disease, HCV, heart failure, worsening liver function tests (LFTs) and thrombocytopenia.

Aspartate aminotransferase to platelet ratio index (APRI) 4.3 pts.

MAIN QUESTION

Please review the attached documents and provide recommendations for further treatment and diagnostics.

Arista|MD

Response from eConsult Specialist

SHIVANI PATEL, MD, GASTROENTEROLOGY

NPI: 1000000012

SUMMARY

Treatment options are available at the primary care level.

DETAILS

Certainly, it can be low platelets due to portal hypertension from cirrhosis, given that notes mentioned possible radiologic evidence of cirrhosis on computed tomography (CT) four years ago and that he has HCV and abnormal LFTs.

There are no lab findings such as low albumin or elevated bilirubin, nor any reported physical signs or symptoms such as edema, ascites, or encephalopathy, to further suggest cirrhosis, but they need not be present.

- Agree with a sonogram of the abdomen.
- Check coagulation.
- Also, check alpha-fetoprotein (AFP) and fibrosis score / fibrotest if available, depending on your lab.
- Ensure no alcohol (EtOH) use.
- Agree with HCV evaluation for treatment.
- Screen for human immunodeficiency virus (HIV) and hepatitis-B virus (HBV) if not already done.

If there is no active bleeding or plan for an invasive procedure or surgery, then there is no need for treatment solely of the low platelet count, which may represent platelet sequestration in the spleen and does not necessarily imply an increased bleeding risk. The patient has a history of CVA and, therefore, still likely has a benefit > risk from remaining on anticoagulants and/or aspirin (ASA).

If cirrhosis is suspected, referral for esophagogastroduodenoscopy (EGD) to screen for esophageal varices is warranted.

If the above tests point away from cirrhosis or there is a concern for the risk/benefit of continued anticoagulant use, then a consult with Hematology may be warranted.

Shivani Patel, MD

05/05/22 15:40 PST

Shivani Patel, MD, Gastroenterologist

Response Time Stamp

Geriatric Medicine

Cognitive Impairment

COMMENTS TO SPECIALIST

A 79-year-old female presents to the clinic this morning in follow-up regarding a review of recent head CT and ultrasound results. The patient does have a past medical history, including primary biliary cirrhosis, osteopenia and Raynaud's disease. The patient was seen and an assessment was performed as well as an eConsult was submitted last year related to her ongoing memory loss. At that time, it was recommended the patient have a head CT or head MRI to aid in the underlying structural cause contributing to her symptoms. Her MoCA test revealed a score of 22 out of 30. As the year progressed, her forgetfulness has become more prevalent. The family also noted that the patient's forgetfulness is slightly worse and did agree to have a head CT performed. This was suggested approximately 1 year ago, but the patient and her husband deferred this option.

We reviewed the CT results during this visit, which do indicate cognitive impairment is related to atrophy, mild cerebellar and cerebral atrophy, chronic periventricular and sub-cortical deep white matter microvascular ischemic disease, which I suspect may indicate some underlying dementia. Regarding this patient's exam findings and head CT results, I did advise both the patient and her husband that she has underlying dementia. Last year around this time, we discussed medications to aid in treating what appeared to be underlying dementia: Aricept, Exelon, and Donzipil.

MAIN QUESTION

I want further input regarding a possible diagnosis and treatment options for probable dementia. Please review all notes related to the patient's memory loss from last year for a baseline of the patient's status.

Please review head CT results and recent labs performed.

Response from eConsult Specialist

Dana Richards, MD, Geriatric Medicine

NPI: 1000000002

SUMMARY

Treatment options are available at the primary care level.

DETAILS

The most likely etiology is the underlying cerebrovascular disease (Vascular Cognitive Impairment). Age-related cerebral atrophy may be a normal finding. Still, it may also be accelerated by the underlying microvascular disease - in Alzheimer's dementia temporal lobe atrophy tends to be more prominent, and MRI may be better at identifying the hallmark features, such as mixed cognitive impairment (vascular and AD type) is also a possibility.

Consider contributing factors like presumptive underlying depression as the patient is on Sertraline (assess if depression is well controlled as it may easily mimic MCI/dementia).

Consider reassessing potential contributing medications such as alprazolam and Ambien. Many elderly patients experience significant neurocognitive symptoms as a result of benzodiazepine use as well as benzodiazepine withdrawal. I suggest taking extra care to document the patient's medication history, include the patient's family to determine actual benzodiazepine use in recent months. Ambien may also contribute to cognitive dysfunction. Review another potential over-the-counter medication the patient might be taking that can affect cognitive function (especially those with anticholinergic side effects, such as antihistamines, etc.).

Cognitive impairment may be multi-factorial:

Consider vision and hearing assessment if not recently done, as impairment in either one can contribute to decreased cognition, making MCI appear worse than it is. Undiagnosed alcohol consumption is also not uncommon in the elderly, resulting in cognitive dysfunction. Consider verifying through additional history, if needed. If the patient has persistent bradycardia, this may also affect the patient's cognition. Consider reassessing the choice of blood pressure medication if that's a concern. Beta-blockers may also contribute to decreased energy and mood.

Follow-up/monitoring:

Use MMSE for longitudinal follow-up and functional assessment (ADLs and IADLs). The range of MMSE and MoCA scores for MCI vs. dementia vary. I recommend ranges MMSE 19-23, MoCA 11-21, or Clinical Dementia Rating of 1 for diagnosis of mild dementia. Take the patient's education into account, as the cut of scores differs significantly based on educational levels. A mild dementia diagnosis may warrant additional pharmacotherapy.

Treatment:

Continue ASA and blood pressure management with a target systolic blood pressure of 135-140. Recommend diet modification and increase physical activity to improve cholesterol. As far as cholinesterase inhibitors, data suggest that they have a minor impact in slowing cognitive decline in patients with VCI and vascular dementia. Once a decision to add a cholinesterase inhibitor is made, if the

DETAILS (continued...)

patient's cognitive testing suggests mild dementia; consider starting Donepezil 5 mg PO QD, increasing it to 10 mg PO QD after one month (monitor for GI side effects and bradycardia, especially if the patient will be kept on her beta-blocker).

Neurological exam and consultation: Perform a detailed neurological exam and consultation for insight into the diagnosis/treatment of cognitive decline, if appropriate.

Safety assessment: Assessment for falls, wandering, cooking, money management, and driving safety. Review goals of care and advance directives if not already in place. Offer caregiver-support resources to the patient's family.

Other geriatric assessment recommendations:

Review bowel history. It's not uncommon for MCI patients to report normal bowel frequency when it may be significantly decreased. Episodic constipation with overflow diarrhea is not uncommon. This might explain some of the patient's recent GI history/complaints. If constipation is indeed present, consider Dulcolax daily since the patient has tolerated it well. Fiber may be consumed as a part of a regular diet; However, fiber supplements are not recommended for the elderly since their water intake is generally inadequate, which may result in increased constipation with fiber supplements.

ENT referral for chronic sinus disease. If a fungal infection is present, an in-office procedure may reduce symptoms and eliminate the need for an antihistamine/decongestant.

The patient's calculated GFR is 50. Monitor renal function and adjust medication dose accordingly. Discontinue omeprazole, as PPIs can worsen renal function with prolonged use.

Reduce pill burden by reassessing all medications (including OTC) and supplements. Consider stopping vitamin D since the patient is taking Calcium + D, and vitamin D levels were normal/elevated on the previous testing.

Dana Richards, MD

02/10/22 10:29 PST

Dana Richards, MD, Geriatric Medicine Specialist

Response Time Stamp

Hematology

CHIEF COMPLAINT

Leukocytosis

COMMENTS TO SPECIALIST

A 20-year-old male with h/o asthma and obesity with repeated lymphocyte count.

MAIN QUESTION

Please advise on further workup and treatment.

Response from eConsult Specialist

JANET NOAH, MD, HEMATOLOGY/ONCOLOGY

NPI: 1000000009

SUMMARY

Treatment options are available at the primary care level.

DETAILS

Hello, thank you for the opportunity to review this case. Your patient has persistent stable lymphocytosis with ALC above 4,000 on two occasions. The rest of the CBC is normal.

The differential diagnosis for lymphocytosis includes reactive causes - infections (viral -Epstein-Barr virus (EBV), other viruses including HIV, Human T-lymphotropic virus (HTLV), hepatitis; mycobacterial, pertussis, and syphilis), asplenia, thymoma, inflammatory conditions, polyclonal B cell lymphocytosis - seen in young to middle-aged female smokers, or clonal hematologic disorders.

Given persistent lymphocytosis with absolute lymphocyte count (ALC) above 4000, further evaluation is needed.

I would start with a pathologist review of the peripheral blood smear and peripheral blood flow cytometry. This is a peripheral blood test done in most reference labs (green top tube) which evaluates for clonal B or T cell population, sometimes called a leukemia-lymphoma evaluation. This test identifies leukemia-lymphoma based on the cell surface markers. If peripheral blood flow cytometry is negative, a lymphoproliferative disorder is very unlikely.

The next step would be to check for HIV, HTLV, EBV, HBV, and hepatitis C virus (HCV) serologies. If these tests are also negative, I would consider evaluation for an autoimmune disorder, given the presence of other autoimmune conditions.

I hope this helps. Please let me know if you have any further questions.

Janet Noah, MD

03/03/22 18:55 PST

Janet Noah, MD, Hematologist & Oncologist

Response Time Stamp

Neurology

CHIEF COMPLAINT

Stroke or Cerebrovascular Accident (CVA)

COMMENTS TO SPECIALIST

The patient presented in the ED two days ago complaining of a headache and an unsteady feeling. She felt difficulty with her balance and some right-sided weakness. The ED noted an elevated blood pressure of 178/90. The evaluation included labs and computerized tomography (CT) scan.

She reports that she is feeling better today. She still has a slight headache and has never been diagnosed with hypertension. However, she had some elevated blood pressure during her ED visit. She continues to smoke cigarettes. She has a history of prediabetes. Blood pressure 158/96. Generally well-developed, well-nourished, alert, oriented in no distress. During the exam, she was normal for:

- Cranial nerves II through XII
- Finger to nose
- Reflexes
- Pupil, equal, round, reactive to light and accommodation (PERRLA)
- Extraocular Movements Intact (EOMI)
- Mouth and throat

Her neck is supple, and her chest is clear. Her heart has a regular rate and rhythm without a murmur. She had no extremities with edema. A Romberg test was negative.

Her visit note, ER notes, and labs are attached. Her abnormal CT scan is attached, which shows extensive asymmetric and patchy hypodensities involving the periventricular, deep, and subcortical white matter.

MAIN QUESTION

The current plan is to check magnetic resonance imaging (MRI), echocardiogram, carotid ultrasound, and Lyme test, and continue aspirin 1 per day. Please advise regarding the appropriateness of the plan. Does the patient need a face-to-face visit with a neurologist?

Arista|MD

Response from eConsult Specialist

RICHARD STEVENS, MD, NEUROLOGIST

NPI: 1000500002

SUMMARY

Treatment options are available at the primary care level.

DETAILS

Thank you for the detailed records.

The patient should have vessel imaging studies done — magnetic resonance Angiogram (MRA) of the head/neck — to evaluate for underlying vasculitis contributing to symptoms.

Please check:

- B12/folate levels
- Antinuclear antibodies (ANA)
- Anti-double stranded DNA (anti-dsDNA)
- Erythrocyte sedimentation rate (ESR)
- Human immunodeficiency virus (HIV)
- Lyme titers

The findings could also be related to chronic hypertension. The patient's goal blood pressure should be <140/90.

I agree with your recommendation of a daily aspirin of 81 mg. Add statin to maintain low-density lipoprotein (LDL) < 100.

Patient management in primary care is appropriate if diagnostic results are within normal limits (WNL). Send for face-to-face evaluation if results are of concern.

Richard Stevens, MD

02/12/22 10:28 PST

Richard Stevens, MD, Neurologist

Response Time Stamp

SPECIALTY

Psychiatry & Addiction Medicine

CHIEF COMPLAINT

Alcohol Misuse

COMMENTS TO SPECIALIST

The patient is a 53-year-old female. Past medical history includes hypokalemia, anxiety, depression, obstructive sleep apnea (OSA), pulmonary hypertension (PH), and congestive heart failure (CHF).

The patient was seen at the emergency room for alcohol withdrawal. She was vomiting, with no headache and minor dizziness. Minor chest pain. Per the emergency note, patient states she “sips on vodka all day and is unsure of actual intake.”

She has been prescribed Naltrexone but does not take it.

MAIN QUESTION

Please review this case and provide recommendations for the ongoing management of this patient.

Arista|MD

Response from eConsult Specialist

ELLIE McCANDLES, MD, PHD, PSYCHIATRY & ADDICTION MEDICINE

NPI: 1000000013

SUMMARY

Treatment options are available at the primary care level.

DETAILS

This patient definitely meets the criteria for alcohol use disorder with exacerbations of significant chronic illness due to excessive alcohol intake. She has multiple comorbidities.

Naltrexone is probably the most appropriate medication option as it does not require absolute abstinence from alcohol. Depending on other history, such as alcohol withdrawal, she may not be a candidate for outpatient detoxification. A tapering strategy would likely be safer. The fact that she is not taking it probably should not be considered a treatment failure. It has few side effects. Nausea usually resolves if the dose is titrated from 1/4 or 1/2 of a 50 mg tablet per day over a few days. It is a good option if she can be convinced to resume taking it.

If she finds the naltrexone effective but has a hard time with compliance, then Vivitrol (naltrexone injection) would be an option at a significantly higher expense. This would have its own compliance issues as the patient must come in for monthly injections. This is most often started as part of a detox program. Inpatient detoxification can be considered with a 90-day program having better outcomes than 30 days or shorter.

Abstinence-based treatment or detox is always an option. For alcohol use disorders, this is usually an inpatient procedure due to the risk of seizures and the controlled medications used like phenobarbital or benzodiazepines. Some outpatient protocols do require daily monitoring. Abstinence-based treatment has fallen out of favor with many Addiction Medicine specialists who favor evidence-based treatments.

Gabapentin can be used for anxiety associated with alcohol withdrawal. This would be most appropriate if the patient significantly curtails her drinking as it is a CNS depressant. Higher doses can cause edema, so 900 to 1800 mg per day would likely be the maximal dosing. Antabuse is an option; however, this requires abstinence and is not used as commonly these days. Acamprosate (Campral) is used to address cravings, usually after detox. Sometimes topiramate is used off-label for alcohol use disorder. This may be something that would be considered in conjunction with psychiatry.

This patient is a good candidate for oral naltrexone (also known as the Sinclair Method) to help reduce the amount of alcohol consumed. It will also reduce concerns of alcohol withdrawal complications, including seizures. The dose of naltrexone is typically 50 mg per day and does not have to be taken every day.

Many people take it only when they are going to be drinking, such as on weekends. Common side effects include nausea, so have the patient take 1/2 pill a day for a couple of days at first.

DETAILS (continued...)

Naltrexone is not a DEA scheduled medication, is not addictive, and practically has very little toxicity, although monitoring liver function periodically is recommended. The patient cannot be dependent on opioids, or it will cause precipitated withdrawal. There is a good YouTube lecture by a woman named Claudia Christian (search: “TED Talk Sinclair Method”). Vivitrol is an extended-release monthly injection of naltrexone that can be used for patients who need more help with compliance.

An additional option that can be added is gabapentin 300 mg tid, which helps with anxiety, insomnia, and restless leg and can be taken indefinitely. There is anecdotal evidence that baclofen is effective for some patients in higher doses and is easily prescribed.

Point-of-care urine drug screen to r/o other substance use such as opiates and benzos.

Use CIWA-AR Assessment for Alcohol Withdrawal screening questions to evaluate the risk of alcohol withdrawal. Patients with scores <8 typically do not require medication for withdrawal. This applies if the patient is going to stop drinking altogether.

The patient should find a peer support or 12-step program that they fit in with, including AA, Smart Recovery, Secular Recovery, or chemical dependency counseling. Most of these meetings are going to be virtual these days. Virtual meetings are not as effective as in-person meetings but are more accessible online.

Follow-up within a few weeks to gauge the patient’s progress. If testing is required, ETOH urine levels are not sensitive enough to determine compliance as alcohol is cleared within hours. Serum gamma-glutamyltransferase (GGT) or urine Ethyl glucuronide (EtG) / ethyl sulfate (EtS) will detect ETOH metabolites several days after use. Elevated liver function test (LFT) or fatty liver should be re-evaluated periodically over months.

Pulmonology

CHIEF COMPLAINT

Asthma

COMMENTS TO SPECIALIST

A 37-year-old female patient presenting for asthma. The patient reports that she developed asthma as an adult five years ago and that her asthma is not well-controlled.

A cough wakes her from sleep five nights per week. Symptoms have not improved after multiple medications.

In the clinic, she has slight wheezing upon auscultation, a hoarse voice, and partial pressure of oxygen (PO2) is 94%.

MAIN QUESTION

I think the next step would be to add a long-acting muscarinic antagonist (LAMA), but I am concerned that the patient has not seen improvement after adding medications.

Do you recommend additional testing?

Arista|MD

Response from eConsult Specialist

MABEL SMITH-DAVIS, MD, PULMONOLOGY

NPI: 1000000514

SUMMARY

Treatment options are available at the primary care level.

DETAILS

Recommendations:

Ensure that she is on the highest dose of Advair; either Advair discus 500/50 (1 puff Twice daily) or Advair HFA (hydrofluoroalkane) 230/21 (2 puffs twice daily).

- Agree with continuing montelukast and other allergy medication.
- Consider a short course of oral prednisone (40 mg daily x 5 days).
- If on high-dose Advair and still symptomatic, reasonable to add LAMA.

I recommend a complete blood count (CBC) with differential and serum IgE (immunoglobulin -E) levels and verifying inhaler use. If not improving on high-dose ICS/LAMA/LABA and montelukast, I would recommend an in-person evaluation by a pulmonologist.

Discussion:

From your excellent description of her symptom burden, it sounds like her asthma is not adequately controlled on her current regimen, including ICS/LABA (Advair) and montelukast. Stepwise management of asthma includes escalating doses of inhaled corticosteroids. It is unclear to me what dose of Advair she is currently on, but I recommend escalating her to the highest recommended dose. This would consist of either Advair 500/50 (1 puff twice daily) or Advair HFA 230/21 (2 puffs twice daily).

If she does have coexisting allergies and worsening asthma, then treatment with antihistamines, intranasal steroids, and montelukast are likely indicated. If all the above is true, aside from verifying proper inhaler use, it would be reasonable to prescribe a short course of oral corticosteroids to achieve better symptom control. It would also be helpful to evaluate her for other possible treatment options with a serum IgE and eosinophil level. If she is on high-dose ICS/LABA/LAMA and still not achieving good symptom control, then a referral to a pulmonologist for an in-person evaluation would be reasonable.

Mable Smith-Davis, MD

Mable Smith-Davis, MD, Pulmonologist

08/11/22 12:22 PST

Response Time Stamp

Rheumatology

CHIEF COMPLAINT

Rheumatoid Arthritis

COMMENTS TO SPECIALIST

A 41-year-old female patient with a known history of rheumatoid arthritis (RA) was seeing a rheumatologist until she lost her insurance in 2019. The patient would like to restart methotrexate.

Prior RA notes indicate the patient decided to discontinue using the prescription due to nausea. The patient denies that she discontinued and states her rheumatologist told her the prescription was not effective enough. I am comfortable restarting methotrexate. However, this patient has mild, elevated liver function test (LFT) and a known diagnosis of fatty liver. Weight loss is advised.

Enbrel is available with patient assistance, but she wants a trial of methotrexate due to convenience and price. The patient refuses an in-person rheumatology consult due to cost. I am unable to obtain more than 2 years of rheumatology history – the prior history was destroyed. Initial labs, as well as more recent labs, are attached. Other attachments include LFT, chest X-ray, eye exam, etc.

MAIN QUESTION

Would you advise a methotrexate trial, given abnormal LFT vs another disease-modifying antirheumatic drug (DMARD).

If methotrexate is restarted, how often should the patient receive an LFT? At what threshold should abnormal LFT occur before I stop methotrexate? Alternative DMARD is advised. Please outline recommended monitoring schedule. The patient's last CXR and purified protein derivative (PPD) was 11/2020.

Arista|MD

Response from eConsult Specialist

JACOB RODGERS, MD, RHEUMATOLOGY

NPI: 1000000006

SUMMARY

Treatment options are available at the primary care level.

DETAILS

This patient will not be able to achieve clinical remission of her RA with monotherapy with methotrexate at a safe dosage, given her already fatty liver and baseline alanine transaminase (ALT) in the 50s. Ideally, she should go back on Enbrel as it has proven effective in the past, especially given high titer cyclic citrullinated peptide (CCP) antibodies predicting an aggressive course. Alternative to tumor necrosis factor (TNF) alpha inhibitor will be oral Xeljanz 5 mg BID if her insurance covers it.

If she cannot afford copays, methotrexate can be reasonably started at 12.5 mg weekly and folic acid at 1 mg daily except on the day of methotrexate. Plaquenil can also be added to 200 mg once or twice a day as tolerated for adjunctive effect.

I usually monitor LFT and complete blood count (CBC) 6-8 weeks after starting or after any adjustment in dosages. In this case, request an LFT and CBC after 3 months. If the patient's results are stable, repeat LFT and CBC every 3 months.

Discontinue methotrexate or reduce dosage when liver enzymes reach 2 times the baseline, and in this case, above 50 for aspartate aminotransferase (AST) or above 100 for ALT.

With Xeljanz, checking CBC, LFT and creatinine (Cr) check every 3-4 months would be fine.

Jacob Rodgers

Jacob Rodgers, MD, Rheumatologist

03/18/22 07:31 PST

Response Time Stamp

Arista|MD

For more information about eConsult service, contact us at
info@aristamd.com or visit www.aristamd.com.