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.

SPECIALTY
Cardiology

CHIEF COMPLAINT
Hypertension

COMMENTS TO SPECIALIST
Patient with uncontrolled hypertension; taking several medications, including:

- Amlodipine 10mg daily
- Metoprolol 50mg BID
- Hydrochlorothiazide (HCTZ) 12mg daily
- Lisinopril 20mg daily
- Clonidine 0.2mg BID

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

The patient reports seeing a Cardiologist >2 years ago, prior to this appointment but did not follow up. No history of diabetes, smoking or renal disease.

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

Response from eConsult Specialist

JONAH BIRDE, DO, CARDIOLOGY
NPI: 1000005001

Arista|MD

SUMMARY
Treatment options 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 provided in your request are quite variable. We need an accurate baseline before making changes.

I have some recommendations for office-based BP 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. BP should be taken in the sitting position. For some patients, particularly older adults and diabetic patients, supine, sitting and standing BP tests are useful in detecting 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 the ingestion of caffeine. Taking the BP in a cool room (12oC or 54oF) or while the patient is talking can raise the measured value by as much as 8 to 15mmHg.

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 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 request a follow up eConsult for further discussion.

Jonah Birde, DO

Jonah Birde, DO, Cardiologist

05/22/23 13:15 PST

Response Date Stamp

SPECIALTY
Dermatology

CHIEF COMPLAINT
Hidradenitis Suppurativa

COMMENTS TO SPECIALIST
A 26-year-old Caucasian male presents an 8-year history of Hidradenitis Suppurativa (HS). He does not have a primary care provider or dermatologist. The patient has made multiple visits to the ED for incisions and drainage but has never been hospitalized. He does not take any routine medications. Cocaine/marijuana use, Ethyl alcohol (EtOH) abuse 12 pack+ 1/5 daily prior to admission to this facility. He does not smoke cigarettes. He reports having over 25 incisions and drainages in the ED related to his HS.

HS affects the bilateral axilla, groin and lower back. He was started on Bactrim 3 days ago for an acute abscess to the right axilla.

The patient demonstrated a full range of motion in all extremities with no distress. The patient's vital signs were within normal limits and he denies any complaint other than the HS.

There is a 1cm nodule at 2 o'clock with a small amount of purulent/sanguineous drainage upon manual expression with a 2cm circumferential area of light erythema and warmth. There are varying degrees of induration/cyst-like features, mainly around the superior lesion, with multiple areas of ropelike scars and pitted skin in the R axilla. flat lesion at 8 o'clock with a soft peri-wound area draining a scant amount of purulent fluid.

MAIN QUESTION
Currently on Bactrim for acute infection. He needs long-term treatment. Please recommend a plan of care. See attached photos and diagnostics.

Response from eConsult Specialist

ANNA MCDONALD, MD, DERMATOLOGY
NPI: 1000000002

Arista|MD

SUMMARY

Treatment options available at the primary care level.

DETAILS

Start with doxycycline 100 BID x 90 days, topical Hibiclens and over-the-counter zinc 30 BID. If this treatment is not effective, try Humira next.

HS, or acne inversa, is a chronic destructive inflammatory disorder of the terminal follicular epithelium in apocrine gland-bearing regions. It is thought that follicular occlusion leads to the trapping of follicular contents, rupture and inflammation of the dermis, with bacterial superinfection in some cases. HS is more common in women, adults between the third and fourth decades of life, individuals of African descent and the socioeconomically disadvantaged.

The nodules of HS are often seen on the buttocks, breasts, groin and axillae. Usually, the onset of the disease occurs soon after puberty, and patients typically report recurring "boils." Symptoms may include local pain and tenderness during a flare-up and arthralgias. shaving, depilation, deodorants and mechanical irritation can worsen this condition, but skin irritation is usually not a major factor.

Obesity and cigarette smoking are associated with HS as well as a strong association with metabolic syndrome. Regional ileitis (Crohn's disease) is statistically associated with HS, while ulcerative colitis does not. A familial form of the disease has been supported by studies, including a molecular genetic study of 4 generations in a large Chinese family, through which a novel HS locus on chromosome 1p21.1-1q25.3 was identified. Furthermore, many patients report a positive family history. Rare cases of HS are associated with the reticulate pigmented anomaly of the flexures (Dowling-Degos disease) and heterozygous mutations of PSENEN (gamma-secretase protein presenilin precursor). HS-like lesions have been reported to occur very frequently during therapy with a gamma-secretase inhibitor.

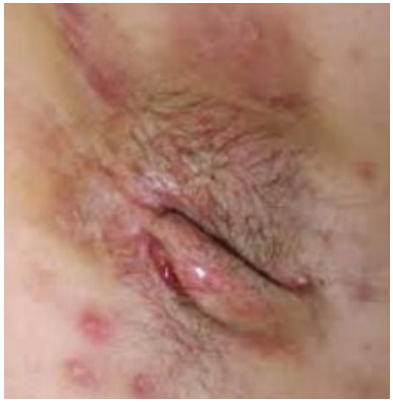
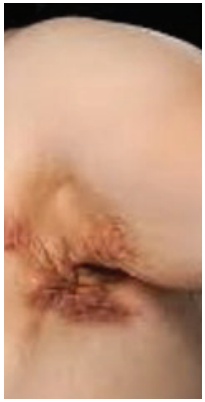
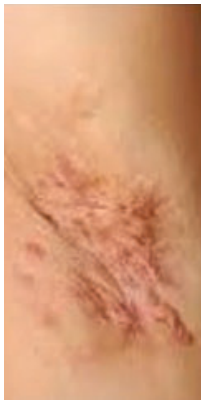
HS shares similar clinical features (severe inflammation, occlusion of the follicle and scarring) with dissecting cellulitis of the scalp and acne conglobata. These 3 conditions are collectively referred to as the follicular occlusion triad, and more than 1 may occur in a given patient. Some consider the pilonidal sinus (pilonidal cyst) an additional group member.

Syndromes include PASH (pyoderma gangrenosum, acne and HS), PAPASH (pyogenic arthritis, pyoderma gangrenosum, acne and HS) and PsAPASH (psoriatic arthritis, pyoderma gangrenosum acne and HS). With a prevalence of up to 1% in some population-based studies, HS is a common disease.

For patients with moderate disease, consider a longer course of oral antibiotics over several months, such as doxycycline (100mg twice daily), minocycline or tetracycline. An alternative antibiotic treatment option includes combination therapy with oral clindamycin and rifampin. The combination of moxifloxacin 400mg once daily, metronidazole 500mg 3 times daily and rifampin 300mg twice daily for 6 weeks has been found in a case series to confer an excellent response in mild to moderate disease, but relapses may occur.

Dapsone at 25-150mg daily doses was also effective in a small series of patients. Additional considerations include hormonal therapies, including oral contraceptives, spironolactone and finasteride (5mg/day for 3 months) in the appropriate patient setting. For those with severe disease, systemic retinoids, such as isotretinoin 1mg/kg daily benefit some patients, as does acitretin in doses up to 25mg twice daily.

Biologic agents, including anti-TNF drugs, may also be helpful. Adalimumab, a TNF-alpha inhibitor administered via subcutaneous injection, has been approved by the FDA to treat moderate to severe HS in adults. A Cochrane review and updated summary found both adalimumab and infliximab to be effective treatments, with high-quality evidence of the benefit of weekly dosing (40mg) of adalimumab and moderate-quality evidence of the use of infliximab (5mg/kg at weeks 0, 2 and 6). Further studies are needed. Anakinra, ustekinumab, bermekimab and apremilast have yielded positive results in early, small studies.

SPECIALTY
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. The patient had a poor visit and asked his primary care provider (PCP) to manage CKD.

MAIN QUESTION
Since this is my first time seeing him, I would like your perspective. Is this an endocrine issue vs. nephrology, or both?

Should I work him up for diabetes insipidus (DI)? Let me know if you need additional information.

Response from eConsult Specialist

KATHLEEN BRYSON, MD, ENDOCRINOLOGY
NPI: 1000000011

SUMMARY
Treatment options available at the primary care level.

DETAILS
This case was succinct and well-presented.

Crucial data: 78-year-old man with 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 ~50mOsm/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, a 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. I would be careful about searching too hard for SIADH (inappropriate antidiuretic hormone (ADH) secretion), hypoadrenalism, etc., in the context of hyponatremia with significant hyperglycemia.

Diagnoses and Treatment Recommendations:
First, given that this is chronic and asymptomatic (a corrected level of ~131mEq/L), I would not recommend acute treatment to improve serum sodium (unless there is confusion or seizure). Also, if the serum sodium remains 128mEq/L and above, it is probably OK. Although I would work on getting the sugars (at least premeal) to less than 200mg per decilitre (dL) to get a better read on the level of hyponatremia.The patient should feel better with premeal sugars of less than 200mg daily.

Kathleen Bryson, MD

Kathleen Bryson, MD, Endocrinologist

03/20/23 08:46 PST
Response Date Stamp

SPECIALTY
Gastroenterology

CHIEF COMPLAINT
Thrombocytopenia

COMMENTS TO SPECIALIST
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 (LFT) 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.

Response from eConsult Specialist

SHIVANI PATEL, MD, GASTROENTEROLOGY
NPI: 1000000012

Arista|MD

SUMMARY
Treatment options 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 greater than a risk from remaining on anticoagulants
and/or aspirin.

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

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

Shivani Patel, MD

Shivani Patel, MD, Gastroenterologist

05/16/23 15:40 PST
Response Date Stamp

SPECIALTY
Hematology

CHIEF COMPLAINT
Leukocytosis

COMMENTS TO SPECIALIST
20-year-old male with a history of 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

Arista|MD

SUMMARY

Treatment options available at the primary care level.

DETAILS

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

The differential diagnosis for lymphocytosis includes reactive causes - infections (Epstein-Barr virus (EBV) and 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.

Further evaluation is needed given persistent lymphocytosis with ALC above 4000.

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 evaluate 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 unlikely.

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

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

Janet Noah, MD

Janet Noah, MD, Hematologist & Oncologist

04/04/23 18:55 PST
Response Date Stamp

SPECIALTY
Hepatology

CHIEF COMPLAINT
Elevated Liver Function Test

COMMENTS TO SPECIALIST
49-year-old female with type 2 diabetes who has had long history of elevated alkaline phosphate. She reports that this has been going on for the last few years.

Her calcium is also elevated. The patient denies taking any supplements. Please see attached labs and visit note.

MAIN QUESTION
Please advise on how to proceed in a reasonable fashion for this patient with no insurance. She cannot afford an expensive workup.

Response from eConsult Specialist

KEVIN AGATE, MD, HEPATOLOGY
NPI: 1000000024

SUMMARY

Treatment options available at the primary care level.

DETAILS

Thank you for asking me to provide my recommendation regarding this patient.

Given her metabolic syndrome, increased body weight, insulin resistance, hypercholesterolemia and hyperlipidemia, the most likely diagnosis is non-alcoholic fatty liver disease. In this setting, alkaline phosphate, Gamma-Glutamyl Transferase (GGT), Aspartate Transferase (AST) and Alanine Transaminase (ALT) may be elevated in a pattern similar to this patient.

You have checked GGT, which shows that at least some of the alkaline phosphate is liver derived. However, the bone component of the alkaline phosphate is also elevated. It might be valuable to check an Anti-Mitochondrial Antibody (AMA) to rule out Primary Biliary Cholangitis (PBC), often referred to as primary biliary cirrhosis. I recognize that the patient has limited medical coverage. However, a baseline ultrasound would be valuable for assessing any biliary, gallbladder or liver abnormalities. Please see my suggestions below.

The patient needs improved diabetes control with a low glycemic or Mediterranean diet and weight loss. She should start an exercise program. If her liver tests improve with this regimen, a more extensive evaluation of her liver condition is not indicated. There is no contraindication to start a statin with careful attention to her liver enzymes.

She has been exposed to hepatitis A virus (HAV), but she should be vaccinated for HBV.

If her liver enzymes do not improve with weight loss, diet and exercise, she may need more advanced liver imaging, such as Magnetic Resonance Imaging (MRI)/ Magnetic Resonance Cholangio Pancreatography (MRCP).

The patient needs improved diabetes control; Hemoglobin A1C (HgA1C) is >6. She should be attentive to a low glycemic diet and start an exercise program. She can start a statin.

Kevin Agate, MD

Kevin Agate, MD, Hepatologist

06/02/23 18:52 PST

Response Date Stamp

SPECIALTY
Nephrology

CHIEF COMPLAINT
Kidney Stone

COMMENTS TO SPECIALIST
26-year-old patient with a current left 4mm non-obstructive nephrolith. Scheduled for lithotripsy last month but the patient canceled the appointment. The patient has a significant history of kidney stones treated with lithotripsy.

He complains of discomfort but has no issues with normal daily activities. If the stone is nonobstructive, is it necessary to clear it?

MAIN QUESTION
Is lithotripsy medically necessary at this time?

Response from eConsult Specialist

GABRIEL FLORES, MD, NEPHROLOGY
NPI: 1000000046

Arista|MD

SUMMARY
Treatment options available at the primary care level.

DETAILS
If imaging shows no obstruction or hydronephrosis, the stone can be left for future management. There is a chance that this stone could come downstream and pass, which is unlikely to go unnoticed by the patient.

Incidental hypertension can also be a sign of unilateral obstruction or hydronephrosis when the patient has no prior history of hypertension.

Watch for signs and symptoms of obstruction. In addition, follow up any fever, flank pain or gross hematuria should be worked up quickly with a CT Urogram.

It would be advisable to follow-up with a repeat CT Urogram in 3 months.

Gabriel Flores, MD

Gabriel Flores, MD, Nephrologist

06/14/23 18:55 PST
Response Date Stamp

SPECIALTY
Neurology

CHIEF COMPLAINT
Headache: Post Trauma to Head

COMMENTS TO SPECIALIST
The patient suffered a traumatic subarachnoid hemorrhage (SAH) four months ago after an altercation. He states that he hit his head on concrete with subsequent loss of consciousness (LOC) for several minutes.

The patient reports that his new-onset dizziness and headaches that occurred over the past 2 days are similar to the symptoms that he experienced post-SAH. The patient reports that dizziness is occasional and related to standing or sudden movements of the head.

- He does report occasional nausea and blurry vision; denies vomiting and palpitations.
- He reports that headaches are "throbbing" in nature and affect the entire circumference of the head.
- Mitigating factors include the use of Tylenol and rest.

MAIN QUESTION
Is medication tapering appropriate for this patient? If so, how should the drug be tapered?

Response from eConsult Specialist
RICHARD STEVENS, MD, NEUROLOGY
NPI: 1000500002

Arista|MD

SUMMARY
Treatment options available at the primary care level.

DETAILS
Please obtain updated CT scan of the head to rule out acute bleed, given the patient's past medical history.

Nortriptyline 10mg at bedtime is a good option. Counsel the patient regarding common side effects:

- Dry eyes
- Dry mouth
- Sedation

I recommend Fioricet PRN for breakthrough headache pain.

Feel free to consult me with the results of CT, regarding response to medication and for additional recommendations based on this information.

Thank you for this interesting case.

Richard Stevens, MD

Richard Stevens, MD, Neurologist

02/21/23 10:28 PST
Response Date Stamp

SPECIALTY
Psychiatry & Addiction

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, pulmonary hypertension and congestive heart failure.

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 has not taken it.

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

Response from eConsult Specialist

ELLIE McCANDLES, MD, PhD, PSYCHIATRY & ADDICTION MEDICINE
NPI: 1000000514

Arista|MD

SUMMARY

Treatment options available at the primary care level.

DETAILS

This patient meets the criteria for alcohol use disorder with exacerbations of significant chronic illness due to excessive alcohol intake and 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. Since she is not taking it, we should not consider this a treatment failure. It has few side effects. Nausea usually resolves if the dose is titrated from 1/4 or 1/2 of a 50mg tablet daily over a few days. If she can be convinced to resume taking it, it is a good option.

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 1800mg per day would likely be the maximal dosing.

- Antabuse is an option. However, this requires abstinence and is not commonly used.
- 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 (known as the Sinclair Method) to reduce the amount of alcohol 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 can not 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 300mg tid which helps with anxiety, insomnia and restless leg. It can be taken indefinitely.

There is anecdotal evidence that baclofen is effective for some patients in higher doses and is easily prescribed.

Perform a point-of-care urine drug screen to rule out other substance use, such as opiates and benzodiazepines.

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 completely.

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 they 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 GGT or urine Ethyl Glucuronide (EtG)/Ethyl Sulfate (EtS) will detect ETOH metabolites several days after use. Elevated LFT or fatty liver should be reevaluated periodically over months.

Ellie McCandles, MD, PhD

Ellie McCandles, MD, PhD, Psychiatrist & Addiction Medicine Specialist

01/25/23 15:40 PST

Response Date Stamp

SPECIALTY
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 with 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 available at the primary care level.

DETAILS

Recommendations:

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

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

I recommend a CBC with differential and serum Immunoglobulin -E (IgE) levels and verifying inhaler use. If not improving on high-dose inhaled corticosteroids (ICS), LAMA, Long-Acting Beta Agonist (LABA) and montelukast, I would recommend an in-person evaluation by a pulmonologist.

Discussion:

From your excellent description of her symptom burden, it does sound 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. I need clarification on 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

01/09/23 12:17 PST

Response Date Stamp

SPECIALTY
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 that her rheumatologist told her the prescription was not effective enough. I am comfortable restarting methotrexate. However, this patient has mild, elevated 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 its 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 prior history 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. other 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?

If alternative Disease-Modifying Antirheumatic Drug (DMARD) is advised, please outline recommended monitoring schedule. The patient's last Chest Radiography (CXR) and Purified Protein Derivative (PPD) was 11/2020.

Response from eConsult Specialist

JACOB RODGERS, MD, RHEUMATOLOGY
NPI: 1000000006

Arista|MD

SUMMARY
Treatment options available at the primary care level.

DETAILS
This patient will not be able to achieve clinical remission of her RA with monotherapy 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 to be effective in the past, especially given high titer Cyclic Citrullinated Peptide (CCP) antibodies predicting an aggressive course. An alternative to tumor necrosis factor (TNF) alpha inhibitor will be oral Xeljanz 5mg BID if her insurance covers it.

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

I normally monitor LFT and CBC 6-8 weeks after starting or after any dosage adjustment. 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, MD

Jacob Rodgers, MD, Rheumatologist

03/18/23 9:31 PST

Response Date Stamp

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