Progress - CCC
Note Date:11/17/16
Signed by (RHEUMATOLOGIST), MD on 11/21/16 at 11:00 am Affiliation: MEDICAL CENTER

Vital Signs sheet entries for 11/17/16: BP: 123/74. Heart Rate: 83. Weight: 173 (With Clothes). BMI: 26.9. Pain Score: 0.
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Active Medication list as of 11/17/16:

Medications - Prescription
FLUOCINOLONE - fluocinolone 0.01 % topical cream. Apply to affected area twice a day Use for up to 2 weeks as needed for flares.
HYDROXYCHLOROQUINE - hydroxychloroquine 200 mg tablet. One tablet(s) by mouth daily
INSULIN LISPRO [HUMALOG] - Humalog 100 unit/mL subcutaneous cartridge. Insulin pump - (Prescribed by Other Provider)
LEVOTHYROXINE - levothyroxine 75 mcg tablet. 1 tablet(s) by mouth qam
LOSARTAN - losartan 50 mg tablet. 1 tablet(s) by mouth once a day am
ROSUVASTATIN [CRESTOR] - Crestor 40 mg tablet. 1 tablet(s) by mouth q pm - (Prescribed by Other Provider)

Medications - OTC
ASPIRIN [ENTERIC COATED ASPIRIN] - Enteric Coated Aspirin 81 mg tablet, delayed release. 1 Tablet(s) by mouth once a day - (OTC)
CETIRIZINE - cetirizine 10 mg tablet. One tablet(s) by mouth a day as needed - (Prescribed by Other Provider; Dose adjustment - no new Rx)
CHOLECALCIFEROL (VITAMIN D3) - cholecalciferol (vitamin D3) 2,000 unit capsule. 1 capsule(s) by mouth once a day - (OTC)
LACTOBACILLUS COMBINATION NO.4 [PROBIOTIC] - Dosage uncertain - (OTC)
MULTIVITAMIN - multivitamin tablet. 1 Tablet(s) by mouth once a day - (OTC)
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HISTORY OF PRESENT ILLNESS: I saw Ms. XXXXX in the Rheumatology Clinic in a follow-up appointment. Ms. XXXXX is a 57-year-old patient with the following problems:

1. Hypocomplementemic urticarial vasculitis. Presented with hives since early 2012, a skin biopsy was consistent with vasculitis. Her laboratory reported negative serology for HBV, HCV, ANCA, dsDNA, Ro, La, Sm, RNP, normal C1 inhibitor, C4 3, and

C2 <1.3, CU index 13.5 (<10.0). Initiated colchicine on 08/2012 increased up to 1.2 mg, and discontinued on 09/2012 due to failure and diarrhea. Initiated prednisone 15 mg on 08/22/12, and Plaquenil on 09/17/2012 after her ophthalmologist found no contraindication. By 10/2012, had improved and prednisone was tapered. By 12/2012 hand only few transient lesions, on 2.5 mg of prednisone and Plaquenil. By 02/2013 had discontinued the prednisone. On 04/2013 had no lesions, Plaquenil was reduced to 200 mg improvement was maintained. The patient was last seen on September 2015 with only scattered few transient short-lived lesions and normal C4. My impression was that the patient was in remission on 200 mg of Plaquenil, no evidence of internal organ involvement. Treatment was not modified.

2. Neuropathy. The patient reported paresthesia on right foot, hypoesthesia, and sensation of numbness, unilateral. Considering that diabetic mellitus will cause mostly a bilateral polyneuropathy, an EMG was requested to investigate the possibility of a mononeuritis multiplex.

3. Plaquenil monitoring. The patient had scheduled an ophthalmologic exam in December.

3. Reactive airway disease & OSA. On 07/2014, reported episodes of shortness of breath and fatigue. There were no abnormalities on exam, chest x-ray showed no cardiopulmonary disease. Pulmonary function tests and a CT scan of the chest were normal. This ruled out the possibility that her shortness of breath could be related to lung involvement from the HUV. Evaluated in Pulmonary on 09/2014, diagnosed reactive airway disease and prescribed inhaled steroids. A sleep study 10/22/14, that showed severe obstructive sleep apnea. Initiated CPAP in 01/2015.

4. Left middle DIP mucous cyst. If in the future represents a painful problem, it can be injected or surgically remove it.
5. Plantar fasciitis. The patient was advised to do exercises.
6. Status post right carpal tunnel syndrome.
7. Diabetes mellitus.
8. ID prophylaxis. Pneumovax 2001 at Joslin; negative HBV/HCV on 08/2012.

Since the last visit, the patient has had on November 24 an electromyography that showed abnormalities, a dedicated electromyography for upper extremities was recommended and was done on January 29.

Since the last visit, the patient developed a right fourth finger flexor tendonitis, for which she had a surgical release on May 11, 2016.

Ms. XXXXX presented today to the clinic stating that she is recovering uneventfully for the operation of the tendon. She reports that she has had only occasional urticarial lesions that may last for hours or at the most one day. She continues taking Plaquenil and reports no side effects.

The patient reports that she continues having a sensation of numbness on the lateral aspect of the right foot that is very persistent and on occasions the sensation ascends to the leg. These symptoms started around May 2015 after a 5-mile walk.

The patient reports that she has intermittent variable intensity numbness on the hands, sometimes is more predominant in the ulnar aspect, sometimes involves the entire hand, but is not severe. She has occasional sensation of numbness on the right triceps area. The patient reports that she used to have more symptoms related to neuropathy in arms, but since she had the C-spine surgery they improved substantially. The patient denies having weakness in either upper or lower extremities.

REVIEW OF SYSTEMS: Otherwise negative.

PAST MEDICAL HISTORY:
1. Insulin-dependent diabetes mellitus.
2. Hashimoto's thyroiditis.
3. Herpes zoster.
4. Hyperlipidemia.
5. Hypertension.
6. Low back pain.
7. Chronic urticaria.
8. Whiplash.

PAST SURGICAL HISTORY:
1. Right shoulder rotator cuff tendinopathy. Labral tear. Right shoulder arthroscopic subacromial decompression. Debridement of labral tear 03/2204.
2. Left shoulder impingement with partial rotator cuff tear. Left shoulder arthroscopic sub acromial decompression. Debridement of partial rotator cuff tear 05/2001.
3. Anterior cervical diskectomy C5-C6, C6-C7. 05/2009 Anterior cervical interbody reconstruction with biomechanical device C5-C6 and C6-C7.

Anterior cervical arthrodesis C5-C6, C6-C7.
Anterior cervical plate instrumentation C5, C6, C7.
Application of local autograft for fusion augmentation.
Globus Providence anterior cervical plate with screw fixation, 28 mm plate, 12-mm screws.
DePuy Spine VG-2 interbody biomechanical device: lordotic, 5/7 mm x2.
4. Right carpal tunnel release 07/2010.
5. Tenosynovectomy, left posterior tibial tendon; arthrotomy 05/1993
6. synovectomy, left ankle 05/1993. Right ring finger A1 pulley release and synovectomy.

SOCIAL HISTORY: The patient does not smoke, has two drinks a week. No recreational drug use. Has not received transfusions. A program manager at a local hospital. Single with no children.

PHYSICAL EXAMINATION:
GENERAL: The patient was alert, oriented, in no acute distress.
HEENT: No alopecia. Pupils equal, round and reactive, extraocular muscles intact. Conjunctivae pink. Mouth moist, no oropharyngeal lesions.
NECK: Supple, no adenopathy, no thyromegaly, no bruits.
LUNGS: Clear to auscultation.
HEART: Regular rate and rhythm, normal S1 and S2, no murmurs.
ABDOMEN: Soft, non-tender, no hepatosplenomegaly.
EXTREMITIES: No cyanosis, no edema, distal pulses 2+.
NEUROLOGIC: Intact cranial nerves II through XII. Motor power 5/5 proximal and distal. Sensory intact to touch and vibration in upper extremities, a sensation of hypoesthesia in the lateral aspect of the right foot, reduction of vibration perception on the right foot.
MUSCULOSKELETAL: No swollen or tender joints.
SKIN: No inflammatory lesions.

LABORATORY DATA: Joslin, December 1, 2015, BUN 10, creatinine 0.5, ALT 19, AST 20, albumin 4.4, alkaline phosphatase 69.

EMG, November 24, 2015. Impression: Abnormal study. There is electrophysiologic evidence for a chronic generalized predominantly sensory axonal polyneuropathy. The absence of a left tibial motor response and right radial sensory response may be suggestive of the diagnosis of underlying mononeuropathy multiplex.

EMG, February 29, 2016. Impression: Abnormal study. There is

evidence for a mild left median neuropathy at the left wrist as in carpal tunnel syndrome. The data is also suggestive of mild cervical radiculopathies affecting C7-8 myotomes bilaterally. Compared to the previous study performed on November 24, 2015, the electrophysiologic data continue to demonstrate a generalized polyneuropathy affecting sensory greater than motor fibers. The abnormalities seen in this study, however, are more demyelinating as opposed to axonal in nature. The previous absent right radial response was able to be elicited. There were no clear asymmetries, focal finding to suggest mononeuritis multiplex.

ASSESSMENT AND PLAN: A 57-year-old patient with the following problems:

1. Hypocomplementemic urticarial vasculitis. The patient has been in treatment with Plaquenil 200 mg; that has resulted in excellent control of the urticarial vasculitis, as the patient has had only a few scattered and transient lesions. Her C4 has recovered to more normal levels and the patient has not presented with nephropathy or other internal organ involvement. I have advised to continue with 200 mg of Plaquenil.

2. Neuropathy. The patient has diabetes mellitus and I suspected that will have polyneuropathy. She has cervical spondylosis status post-surgery, her electromyography showed evidence of cervical radiculopathy. There is also evidence of left carpal tunnel syndrome. The electromyography in upper extremities is not consistent with mono neuritis multiplex; there is absence of the left tibial motor response with an axonal neuropathy. The electromyography in upper extremities is more consistent with demyelinating polyneuropathy, it would be expected that the diabetic neuropathy could be more axonal. Considering these two findings, the question is whether at least the left tibial motor response could be related to vasculitis, and whether the patient has a demyelinating neuropathy independent to the neuropathy secondary to DM, cervical radiculopathy and carpal tunnel. I have advised the patient to have an evaluation in Neurology to further advice on the nature of these abnormalities. If it is concluded that they could be of an immune nature or indeed vasculitic, her treatment will be modified. The patient was in agreement.

3. Plaquenil monitoring, last ophthalmologic exam August 2016.

I am planning to see Ms. XXXXX in six months or before if treatment for neuropathy is necessary.

(RHEUMATOLOGIST), MD

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Cc: PRIMARY CARE DOCTOR, MD