MedPOINT MANAGEMENT	**Clinical Protocol:** Scope-of-Adult-Primary-Care	
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PREPARED BY: Joanne Calegari	**APPROVED BY:** Richard Powell, M.D.	

PROTOCOL OVERVIEW

Routine follow up is a primary care responsibility. In cases where referral is appropriate, following diagnosis and initiation of any necessary treatment by the consultant, the primary care giver will again resume responsibility for routine follow up of the patient

INDICATIONS

According to the Milliman Care Guidelines Ambulatory Care Manual, the following are general scope-of-care guidelines by major specialty defining those services that fall within the scope of Primary Care Provider responsibilities.

Allergy

- Do a thorough allergy history including seasonal vs. perennial occurrence, home and work environmental history, identification of aggravating factors including decongestant nasal sprays, and perform physical examinations seeking evidence of allergic disease. Advise aggressive use of appropriate environmental controls before consultation.
- Treat seasonal allergies whose symptoms do not last more than six weeks per year or whose symptoms occur in two seasons but for less than six weeks each time. Treat the patients with antihistamines, decongestants, or inhaled anti-inflammatory agents including corticosteroids. Brief courses of oral corticosteroids may be necessary for severe symptoms.
- Treat chronic rhinitis aggressively with at least three sequential medication programs including antihistamines, decongestants, and inhaled corticosteroids or cromolyn. Refer to an otolaryngologist if mechanical obstruction is obvious (e.g., adenoids, tonsils, tumor or septal deviation). Consider consultation if nasal polyps have no response to nasal steroids.
- Treat hives aggressively for acute and chronic presentations. Acute episodes may require subcutaneous epinephrine and an intramuscular antihistamine or intravenous corticosteroids, or oral medication. If possible, causes such as an infection, foods, nonsteroidal anti-inflammatory drugs including aspirin, or other medication should be identified, removed, or avoided. Persistent, recurring, or chronic urticaria should be treated with antihistamines, local measures, and systemic corticosteroids if needed. Consultation should be sought if urticaria or angioedema are persistent for more than three months.
- Diagnose and treat asthma, including the reversal of acute episodes and the achievement of effective control of chronic asthma. Referral for the pulmonary function testing often is necessary. Treatment should consist if inhaled beta agonists and anti-inflammatories including corticosteroids. Consultation should also be sought if the patient is repeated emergency department or office visits for acute episodes, repeated or persistent use of oral corticosteroids, or more severe complications such as a need for hospitalization or intubation for respiratory failure.

Cardiology

- Interpret the electrocardiogram and chest x-ray, even if the provider does not perform the services.
- Recognize congenital and valvular disease by history and physical examination. Include electrocardiogram and chest x-ray in the evaluation if considering a diagnosis other than a functional systolic ejection murmur. Seek consultation if patients with murmurs are symptomatic, have confusing physical findings, abnormal electrocardiograms, or abnormal chest x-rays. Consult when congenital or valvular disease has been diagnosed for determining a plan of treatment and follow up.
- Provide education about and prophylaxis against acute rheumatic fever or bacterial endocarditis when appropriate. Also provide appropriate antibiotics and protocols for the patient.
- Refer neonates to a neonatologist or pediatric cardiologist for:
    - Cardiac murmur other than the typical soft systolic ejection murmur
    - Cyanosis which does not clear with crying
    - Congestive heart failure
    - Tachypnea in the absence of obvious pulmonary disease
    - The absence of the expected pattern of recovery from presumed respiratory disease
    - Diminished pulses in either upper or lower extremities
    - Arrhythmias
    - Syndromes or familial diseases associated with an increased incidence of cardiovascular disease
    - Growth failure of unknown cause
- Evaluate and treat coronary risk factors including diabetes, lipid disorders, hypertension and smoking
- Recognize and evaluate chest pain by history, physical examination, electrocardiogram, and chest x-ray. Consider consultation if the clinical picture is confusing, if new onset chest pain suggests angina pectoris, or if a stable pattern of chest pain changes with increased frequency or duration or decreased threshold for reoccurrence.
- Patients presenting with acute chest pain with rest pain, prolonged pain, increasing pain, or Class III-IV angina suggesting unstable angina or myocardial infarction should have immediate consultation, whether already admitted to a hospital, seen in a rapid treatment site emergency department, or outpatient setting.
- Treat hypertension aggressively to achieve good control. Consult if hypertension is refractory to treatment with three drugs, if cardiomegaly, chest pain, or congestive heart failure are associated, or if more critical complications such as encephalopathy, pulmonary edema, major vascular accidents, or rapid progressive nephropathy require immediate control. Consider consultation to nephrology if renal function is at all abnormal.
- Recognize and treat congestive heart failure, particularly maintenance treatment for those who are stable. Consult for patients with diastolic dysfunction, valvular disease, pericardial disease, or nonischemic cardiomyopathy. Consult for acute congestive heart failure associated with myocardial infarction, arrhythmia, ischemia, hypertension, or if the cause of acute congestive heart failure is unclear. Refer for refractory congestive heart failure or for consideration of transplantation. Resume ongoing care after consultation for most patients with heart failure.
- Determine if syncope is cardiovascular, i.e., valvular, arrhythmic, or autonomic. Workup includes history and physical examination, electrocardiogram, and chest x-ray.

<u>Dermatology</u>

- The resources and experience to diagnose and treat common skin diseases
    - The proper diagnosis of skin infections requires the capability to perform KOJI preparations, Tzanck smears, bacterial and fungal cultures (either in-office or by obtaining specimens appropriately and sending to a laboratory service).
- Diagnose actinic keratoses and treat them with liquid nitrogen cryotherapy or with fluorouracil cream or solution.

    - Refer lesions suggestive of malignant melanoma. Biopsy or refer dysplastic nevi. Excise or refer basal cell or squamous cell carcinomas or other suspicious lesions. Suspicious characteristics of lesions include observed or measured enlargement, irregular margins, color changes, multiple colors, bleeding, ulceration, itching, or pain.
    - Refer large or complicated lesions, lesions in immunocompromised patients, and lesions in high-risk areas including head, neck, face, ears, genital area, and burn scars.
- Treat acne according to extent and severity with appropriate medications (e.g., topical astringents, antibiotics, or tretinoin, oral antibiotics, or female hormones).
    - Consider at least three modalities over a three to six month period before considering referral.
- Treat painful or disabling verrucae or molluscum contagiosum with topical suspensions, electrocautery, or liquid nitrogen if treatment is necessary. Refer if treatment is unsuccessful for symptomatic.
- Diagnose and treat skin infections including cellulitis, dermatophytosis, herpes simplex, herpes zoster, impetigo, pediculosis, pityriasis rosea, scabies, and tinea versicolor. Refer if the diagnosis is uncertain, if there has been an unsatisfactory response to treatment, or for ophthalmic involvement with herpes.
- Diagnose and treat inflammatory dermatoses including allergic dermatitis, atopic dermatitis, contact dermatitis, perioral dermatitis, psoriasis, and seborrheic dermatitis. Refer psoriasis patients who may be candidates for phototherapy or systemic therapy because of either extensive involvement or unsatisfactory response to topical treatment.
- Treat dermal injuries such as minor burns, lacerations, bites, and stings.
- Treat common nail problems such as ingrown nails, trauma, onychia, and paronychia.
- Diagnose and treat hypertrichosis and hair loss. Refer for extensive alopecia areata or hair loss associated with infection or systemic disease.
- Counsel patients that the removal of certain lesions for nondiagnostic purposes is usually considered cosmetic by carriers and may not be covered. These lesions might include liver spots, spider veins, wrinkles, skin tags, uncomplicated cysts, flat asymptomatic warts, stable lipomas, seborrheic keratoses, noninflamed papilloma, hereditary hypertrichosis, tattoos, and non-changing pigmented lesions without special risk.

<u>Endocrinology</u>

- Manage most diabetics, Type 2 patients.
    - Provide patient education concerning diet, fluid balance, exercise, blood glucose monitoring, medication administration, skin care, and foot care.
    - Perform regular examinations including foot and skin examinations.
- Obtain consultation for patients with severe acidosis, altered mental status, or repeated episodes of diabetic ketoacidosis.
- Obtain consultation for:
    - Poor control manifested by recurrent hypoglycemia, marked hyperglycemia, or persistent elevation of glycohemoglobin
    - Consideration of intensive insulin or pump therapy
    - Periodic ophthalmological examinations to screen for and evaluate diabetic retinopathy
    - Management of complications as they arise, including peripheral neuropathy, skin lesions, impaired renal function, or cardiac ischemic symptoms or findings
- Diagnose and treat hyperthyroidism and hypothyroidism. Refer for radioiodine therapy or surgical therapy if considered appropriate. Refer for exophthalmos. Consult if refractory to initial treatment. Consult for hyperthyroidism during pregnancy, involving endocrinologist and obstetrician.
- Diagnose and treat multinodular goiter with thyroid suppression
- Consult for solitary thyroid nodules for consideration of FNA biopsy and possible surgery
- Refer suspected disorders of calcium metabolism, adrenal, gonadal, or pituitary dysfunction after obtaining appropriate testing; may be done with the advice of the intended endocrine consultant.

- Diagnose and treat osteoporosis; obtain consultation for:
    - Patients intolerant of usual treatment
    - Those with complicated or multiple fractures
    - Patients with abnormalities suggesting secondary cause, e.g., disorders of calcium metabolism
- Diagnose growth retardation
    - Interpret growth charts and obtain appropriate bone age x-rays
    - Refer only when established as either nonfamilial or, if familial, when abnormal bone age is documented
- Identify and treat significant hyperlipidemia and other lipid abnormalities
    - Refer if the patient has not responded to diet and medication, including two different medications, within one year. Consider earlier referral if the hyperlipidemia is quantitatively severe or if atherosclerosis is known.

Gastroenterology

- Diagnose abdominal pain by history, physical examination, and appropriate lab work. Referral to surgery is appropriate for suspected acute appendicitis or to gynecology for suspected pelvic disorder. GI consultation may be appropriate if the diagnosis remains uncertain or is refractory to initial therapy.
- Diagnose acute diarrhea with fecal leukocytes or stool culture. Treat infectious diarrhea if identified.
- Diagnose causes for protracted vomiting and nausea by examination, radiology, and laboratory. Treat with appropriate outpatient rectal or parenteral medications and IV fluids. Refer to a surgeon for suspected bowel obstruction.
- Diagnose and treat heartburn, upper abdominal pain, gastroesophageal reflux disease (GERD), or acid peptic disease. Refer for persistent or recurrent symptoms for over eight weeks despite therapy. Early referral may be appropriate for patients with new symptoms over the age of 50, patients with guaiac positive stool, or patients with dysphagia or weight loss.
- Diagnose irritable bowel syndrome by history, examination, laboratory or other tests, and, if needed, behavioral evaluation. Treat symptomatically. Refer if abnormalities are found, including bleeding or weight loss, or if symptoms are refractory to therapy.
- Diagnose jaundice by history, examination, and laboratory including hepatitis serology, ultrasound, or CT scan if indicated. Refer if jaundice is complicated by fever, is progressive, is associated with intractable ascites, or if there may be undiagnosed hepatocellular disease. Refer extrahepatic or intrahepatic bile duct obstruction for GI and surgical consultation.
- Diagnose and treat patients with pancreatitis, including conservative treatment for patients with chronic relapsing pancreatitis. Consult for patients with an initial episode of acute pancreatitis and consider early surgical consultation if the course is unfavorable or complicated. Consult for patients with malabsorption secondary to chronic pancreatitis.
- Manage stable inflammatory bowel disease with appropriate medications. Consultation is appropriate for the initial diagnosis, colonoscopy if indicated, or if control is not well maintained. Consult for acute exacerbations of inflammatory bowel disease.
- Screen for colon cancer according to a recommended schedule. Consultation for colonoscopy is appropriate for a patient in whom an adequately done stool specimen was positive for occult blood in the absence of diagnosed lower GI tract bleeding.

General Surgery

- Offer, maintain, and audit a screening mammography program for the primary care practice. Assure follow-up of results, either directly or coordinated with mammography provider.
- Diagnose and evaluate severity of inguinal and abdominal wall hernias. Review treatment options and refer for surgery if desired.

- Diagnose and evaluate symptoms and severity of hiatal hernias and reflux esophagitis. Recognize appropriate referral needs.
- Diagnose and treat peptic ulcer disease, including consultation for perforation or obstruction, persistent or recurrent bleeding, or intractability.
- Diagnose symptomatic gallbladder disease by history, physical examination, and ultrasound. Refer if significantly symptomatic.
- Do initial evaluation of acute abdominal pain that may need surgical intervention. Recognize need for early referral, do essential early tests, and stabilize the patient.
- Diagnose and treat nausea, vomiting, or obstipation and consult for possible gastric outlet, small bowel, or colonic obstruction.
- Treat uncomplicated perirectal disease such as hemorrhoids and anal fissures with diet, suppositories, and sitz baths. Refer for perirectal abscess, fistula in ano, persistent bleeding, or prolapsing hemorrhoids.
- Perform incision and drainage of simple soft tissue infections, if trained. Recognize and refer possibly deep or refractory nonresponding soft tissue infections, especially in diabetics or immunocompromised hosts. Recognize and manage or refer complex infections of the hand or fingers.
- Consult for inflammatory bowel disease. After the gastroenterologist establishes the initial diagnosis and treatment plan, the primary care physician may manage uncomplicated disease. Obtain surgical consultation for complications such as obstruction from stricture, persistent bleeding, perirectal disease, toxic megacolon, and consideration for surgical resection in patients with long-standing ulcerative colitis.

Hematology

- Recognize various anemias and diagnose the type.
- Recognize hypochromic microcytic anemia. Diagnose and treat iron deficiency anemia and identify the cause. Refer for hypochromic microcytic anemia not due to iron deficiency or not responsive to treatment.
- Recognize macrocytic anemias. Diagnose and treat vitamin B12 and folic acid deficiency. Refer for macrocytic anemias the cause of which is unknown, or refractory to treatment with vitamin B12 and folic acid.
- Recognize anemia of chronic disease.

Nephrology

- Evaluate renal failure by laboratory tests and imaging if appropriate.
    - If evaluation is indicated because of increased serum creatinine, include urinalysis, a 24 hour urine for creatinine clearance and protein excretion, and renal ultrasound to look for obstructive uropathy.
    - Consult for acute renal failure, progressive renal failure, or nephritic syndrome with any renal failure. Consult for an approximately 50% reduction in creatinine clearance and consider earlier consultation in diabetes. Refer for obstructive uropathy and end-stage renal disease, to urology or nephrology as appropriate.
    - Evaluate proteinuria with 24-hour urine and other laboratory tests. Consult if proteinuria exceeds 1 g in 24 hours, or if hematuria or elevated BUN or serum creatinine are present.
    - Refer if hypertension is associated with renal failure, is severe or of sudden onset, or is unresponsive to the first-three drug regimen.
    - Evaluate and treat common electrolyte and acid-base abnormalities.

Neurology

- Perform neurologic history and examination including mental status examination, evaluation of cranial nerves, motor and sensory function, coordination, gait and reflexes.
- Diagnose and treat cluster, migraine, and tension-type headaches. Consult for a change in headache pattern, altered mental state, focal neurologic finding, unclear diagnosis, or unsatisfactory response to treatment.
- Diagnose neuropathies, radiculopathies, and myelopathies. Provide initial treatment of neuropathy and radiculopathy. Obtain consultation about treatment for myelopathy and myopathics. Consult for any diagnosis of unclear etiology or for an unsatisfactory response to treatment.

Obstetrics and Gynecology

- Evaluate acute abdominal pain, trying to distinguish gynecologic from gastrointestinal causes.
    - Evaluation includes a thorough obstetrical and gynecological history, including menstrual, sexual, and reproductive histories, as well as symptoms.
    - Perform pelvic and rectal examinations, and order laboratory tests including urine, blood, smears, cultures, and pregnancy testing. Ultrasound is indicated if diagnosis remains unclear.
    - Consult for suspected or confirmed ectopic pregnancy, for pelvic pain associated with abnormal vaginal bleeding, or for an uncertain diagnosis that would benefit from another opinion or from laparoscopy.
- Diagnose premenstrual syndrome based on history and symptom calendars, and manage with hormones, NSAIDs, diuretics, anudepressants, and other symptomatic treatment as appropriate. Refer refractory cases.

Ophthalmology

- Perform a thorough ophthalmologic history including symptoms and best-corrected visual acuity.
- Be able to perform a basic eye examination including external examination of lids, conjunctiva, sclera, cornea and iris; alternate cover testing; gross extraocular movements; papillary responses; distant and near visual acuity; confrontation visual field tests; undilated fundus examination; and red reflex examination in pediatrics.
- Diagnose and treat allergic and infectious conjunctivitis including bacterial, chlamydial, and viral conjunctivitis.
- Refer suspected iritis and inflammation unresponsive to treatment for conjunctivitis within two or three days.
- Consult for regular, periodic retinal examinations for patients with diabetes and for patients taking hydroxychloroquine sulfate.

Orthopedics

- Evaluate atraumatic low back pain with history and examination and identify any emergent or urgent condition. Otherwise, manage patient's early course of treatment with early mobilization, appropriate medication, and education. Generally, avoid radiologic studies unless symptoms are progressive or red flags are present. Use PT and rehabilitation referrals appropriately.
- Treat sprains, strains, and overuse syndromes with rest, ice, nonsteroidal anti-inflammatory drugs, analgesics, and specific supports or physical measures.
    - Wrist sprains generally improve with conservative care, such as anti-inflammatory and splinting. Evaluate for fracture after acute injury or in the presence of localized symptoms.
    - Evaluate knee sprains for evidence of intra-articular injuries, such as joint effusion, hemarthrosis, or instability. Treat simple knee sprains with elevation, restricted weight bearing, a removable knee splint, and exercises that may be introduced in one to three physical therapy visits.

  - Treat ankle sprains with elevation, restricted weight bearing, splinting, and exercises that may be introduced in one to three physical therapy visits. Refer severe sprains, especially if examination shows joint instability.
- Diagnose and treat acute regional inflammatory problems such as lateral epicondylitis, Achilles tendonitis, and plantar fasciitis with rest, ice, nonsteroidal anti-inflammatory drugs, and activity restrictions directed at pain avoidance.
  - Evaluate need for short term physical therapy treatment.
  - One or two physical therapy visits to teach an effective stretching program are often helpful.
- Treat chronic hip, knee, ankle, heel, and elbow problems in adults. Consider referral for children with persistent problems.
  - In addition to rest and medication, appropriate measures may include weight reduction, correction of poor posture, nonimpact exercise, stretching to improve flexibility, and assistive devices.
  - Referral should occur if there is a fracture, a sceptic necrosis, a locked knee, an unstable joint, obvious or apparent ligament tear, a history of trauma with persisting dysfunction or deformity, acute or subacute effusions, or progressive disability despite conservative treatment.
- Manage chronic pain problems if consultation has ruled out surgical intervention.
- Diagnose and treat common foot problems.
  - Conservative care should include education about hygiene, proper cutting of toenails, removal of ingrown toenails, and the treatment of corns and calluses including paring, chemical treatment, and education for home debridement by the patient.
  - Patients with bunions, diabetic neuropathy or peripheral vascular disease should have particular attention to appropriate footwear.
  - Treat superficial infections of the foot. Refer for deep abscess, suspicion of gangrene, or osteomyelitis.
  - Examine the feet of diabetic patients at regular intervals, annually at a minimum.
  - Recommend over-the-counter arch support devices, heel cups, or insole products as appropriate. If these and a conservative treatment program are ineffective, refer to an orthopedist, medical musculoskeletal specialist or podiatrist for consultation and possible fabrication of custom foot orthoses.

<u>Otolaryngology</u>

- Diagnose and treat tonsillitis and streptococcal infections, including scarlet fever. Perform and read throat cultures and streptococcus screens in the office. Refer for consideration of tonsillectomy when appropriate.
- Evaluate and treat other oropharyngeal infections such as stomatitis, herpangina, or herpes simplex.
- Diagnose otitis externa and treat it topically. Refer if the patient fails to improve in 48 hours, or immediately if patient is diabetic or immunocompromised, or has herpes zoster, or persistent otalgia.
- Diagnose and treat acute otitis media appropriately and monitor response to therapy.
  - Treat persistent effusion, recurrent otitis media, or persistent infections appropriately. Perform or refer for tympanocentesis as needed.
  - Evaluate hearing and possible hearing loss or delayed speech and articulation in growing children.
  - Diagnose and arrange referral for mastoiditis or chronic draining ear or hearing loss in adults.
- Diagnose and treat acute and chronic sinusitis appropriately, limiting use of unnecessary antibiotics and imaging. Refer as appropriate either early for high-risk infections or later for persistence of symptoms after multiple different treatment failures.
- Diagnose and treat allergic or vasomotor rhinitis appropriately with antihistamines, decongestants, or inhaled corticosteroids as necessary. Refer as needed to allergist or ENT for failure to respond to several combination regimens.

- Remove ear wax with hydrogen peroxide, curettement, or irrigation, but avoid irrigation if an eardrum may be perforated.
- Treat nasal polyps with measures including nasal or oral corticosteroids. Refer as needed if polyps are obstructive or unresponsive.
- Diagnose and treat acute parotitis and acute salivary gland infections with antibiotics. Refer if a mass or hardness suggest abscess, calculus, or neoplasm. Refer for failure to respond to antibiotics within one week or for recurrent infections.
- Treat hearing loss attributed to fluid or wax. Refer for acute, persistent, progressive, unilateral, or post-traumatic hearing loss.
- Treat acute hoarseness. Refer if hoarseness is associated with trauma, stridor, dysphagia, significant fever, or is persistent.
- Diagnose and treat acute vertigo. Refer if vertigo is associated with unilateral hearing loss, tinnitus, facial weakness, ear drainage, or central nervous system abnormalities. Refer for Mnire's disease unresponsive to salt restriction and dieresis.
- Diagnose and treat Bell's palsy. Refer as appropriate for care of the eye during the acute illness, and for neurologic follow-up for patients with incomplete recovery.
- Refer also for:
    - Noninflammatory head and neck masses
    - Apparent inflammatory head and neck masses with progressive painless enlargement
    - Any upper airway obstruction
    - Persistent head and neck pain
    - Hemoptysis

Psychiatry

- Obtain developmental and psychosocial histories and perform mental status examinations when indicated by psychiatric or somatic presentations, in addition to complete medical history and physical examination. Important somatic presentations include fatigue, anorexia, overeating, headaches, pains, digestive, problems, altered sleep patterns, and acquired sexual problems.
- Determine whether crises such as suicidal ideation with active planning, threats of physical harm, or psychomotor agitation exist. Patients with these findings need further evaluation and treatment in a supervised setting, e.g., an emergency department or mental health center.
    - Arrange urgent referral for patients at risk of self-harm, either due to suicidal situation, a manic episode, or due to psychosis.
- Diagnose and evaluate common causes of dementia. Differentiate from delirium and depression. Manage general medical factors that improve or worsen dementia. Provide supportive counsel and referral to community services for patient, family, and caregivers. Refer for specialty consultation as appropriate.
- Identify patients with chemical dependency problems (alcoholism, other substance abuse or addition).
- Recognize the potential role of antecedent medication in psychiatric presentations, including dementia, and remove potentially offending agents.
- Referral and consultation for:
    - Persistent substance abuse; refer to an intensive outpatient recovery program.
    - Any patient with a new psychotic disorder
    - Any patient with suicidal ideation with an active plan
    - Patients with severe dissociative disorders such as multiple personality disorder.

Pulmonary

- Evaluate symptoms and findings including chest pain, cough, dyspnea, hypersomnolence, increased or decreased breath sounds, rales, wheezes, cyanosis, or clubbing.

- Obtain pulmonary function tests when appropriate, with or without bronchodilators. Tests may be done in-office or by referral for testing.
- Diagnose and treat asthma:
    - Reversal of acute episodes and the achievement of effective control of persistent asthma. Treatment should be consistent of inhaled beta agonists and anti-inflammatories including corticosteroids depending on the severity of the asthma.
    - Provide appropriate education about environmental controls, avoidance of asthma triggers, proper inhalant technique, and home peak flow measurements.
- Diagnose and treat acute bronchitis and pneumonia. Consult for poor response to treatment.
- Diagnose and treat chronic obstructive pulmonary disease, chronic bronchitis, and emphysema with inhaled or oral bronchodilators, corticosteroids, and periodic antibiotics, as appropriate. Obtain pulmonary function tests, peak flow rates, arterial blood gases, and drug levels as appropriate. Refer patients for respiratory failure or poor response to treatment. Examples of poor response include frequent emergency department visits, frequent or sustained use of oral corticosteroids, progressive dyspnea, hypoxemia, or hypercapnia, or unexplained functional impairment.
- Manage home aerosol medications, oxygen use, and respiratory therapy as needed.
- Diagnose possible tuberculosis or fungal infections with skin tests, sputum tests, and serological tests. Provide appropriate antituberculosis prophylaxis. Refer for treatment of these conditions.
- Recognize opportunistic infections as possible manifestations of immunodeficiency including AIDS.
- Order chest x-rays, special views, and CT scans as appropriate.
- Promote smoking cessation by repeated advice, screening pulmonary function testing, and controlled nicotine administration. Programs for behavior modification or education may be advantageous if available.
- Consider referral and consultation for:
    - Persistently difficult asthma as manifested by chronic cough, continued or progressive symptoms, nocturnal awakening due to asthma, repeated absence from school or work, limited activity, repeated emergency department or office visits for acute episodes, repeated or persistent use of oral corticosteroids, or more severe complications such as the need for hospitalization or intubation for respiratory failure.
    - Consideration of bronchoscopy, percutaneous lung biopsy, pleural biopsy, or supraclavicular node biopsy.
    - Unexplained pleural effusion, hemoplysis, lung masses, sarcoidosis, unusual infections, interstitial lung disease or acute lung injury.

Evaluation and treatment best performed by Primary Care Physician

- Sleep apnea, evaluation and initial management
- Most asthma management

<u>Rheumatology</u>

- Diagnose diseases by history, physical examination, laboratory tests, and x-rays.
    - Treat those conditions with nonsteroidal anti-inflammatory drugs or medications directed at underlying metabolic disorder.
    - Consult for small joint arthrocentesis, an episode of crystal arthopathy unresponsive to nonsteroidal anti-inflammatory drugs, recurrent episodes despite appropriate treatment, progressive erosive arthritis, or deforming or disabling tophi.
    - Diagnose and treat early rheumatoid arthritis and other inflammatory arthritic diseases with all available modalities, including anti-inflammatory medications and physical therapy. Consult initially if diagnosis is unclear or if manifestations are severe or fail to respond to initial therapy in several months. Refer if patient needs continuous corticosteroids or if extra-articular

manifestations occur. Refer for procedures with joint injections or if surgical treatment is being considered.

- Diagnose and treat degenerative joint disease with analgesics, nonsteroidal anti-inflammatory drugs, and the judicious use of steroid injections. Consult if patient fails to respond to conservative therapy or diagnosis is in doubt.
- Diagnose temporal arteritis and provide initial steroid therapy. Consult to confirm diagnosis and plan further treatment.
- Diagnose non articular, regional, musculoskeletal syndromes:
    - Syndromes of spinal origin
    - Bursitis, tendonitis
    - Fibromyalgia
    - Overuse syndromes
    - Soft tissue syndromes
    - Traumatic injuries as appropriate
- Treat musculoskeletal syndromes appropriately, e.g., with ice, rest when appropriate, limited physical therapy and stretching, analgesics, nonsteroidal anti-inflammatory drugs, muscle relaxants, or antidepressants. Consult if progressive dysfunction or intractable pain continue despite standard treatment measures.

Urology

- Diagnose and treat initial and recurrent urinary tract infections including pyelonephritis in children and adults. Perform follow up examinations to ensure clearing of the infection. Manage persistent or recurrent infections and consult as appropriate.
- Diagnose and treat sexually transmitted diseases, including appropriate testing for Chlamydia and gonorrhea. Manage public health issues, e.g., treatment of partners. Refer for urethral stricture or other complications.
- Evaluate gross and microscopic hematuria. Refer if imaging shows a mass or stone, for abnormal cytology, or if hematuria is unexplained and persistent or recurrent.
- Evaluate urinary incontinence by detailed history and physical examination. Refer if anatomic or neurologic abnormalities are identified or if the condition is unresponsive to treatment.
- Diagnose and treat prostatitis. Document presence or absence of infection. Consult for recurrent infections.
- Evaluate for prostatic obstructive symptoms, enlargement, induration, or nodules by history and examination. If obstructive or other symptoms are present, order a PSA. Discuss the limitations and potential risks and benefits of PSA screening. If obstructive symptoms from benign prostatic hyperplasia are at least moderate and bothersome to the patient, consider medical treatment. Refer if DRE is suspicious for malignancy regardless of PSA level, or for elevated PSA, or for moderate to severe obstructive symptoms persist and are bothersome to the patient despite nonsurgical treatment.
- Diagnose and treat epididymitis with appropriate antibiotics and symptomatic treatment including NSAIDs. Recognize and refer immediately for emergencies, e.g., acute onset of testicular pain in younger males suggesting testicular torsion.
- Differentiate extra testicular masses from testicular masses by physical examination, transillumination, and scrotal ultrasound if suspicious of a testicular tumor. Consult for all testicular masses, and for hydroceles, spermatoceles, and varicoceles if their bulk causes significant symptoms.

Vascular Surgery

- Diagnose varicose veins of the lower extremities by history, physical examinations, and possible duplex Doppler. Treat conservatively with weight loss and stockings. Refer for severe pain, intractable ulceration, or recurrent bleeding.

- Diagnose and manage mild to moderate peripheral vascular disease. Refer arterial problems such as gangrene, or ischemic rest pain.
- Diagnose and evaluate asymptomatic carotid bruits. Diagnose transient ischemic attacks by history and physical examination and obtain carotid imaging when indicated. Consider neurologic consultation. Refer if a classic ischemic attack or recurrent attacks are associated with a carotid lesion appropriate for surgery.