

Allergy & Immunology

[Date of Letter]

RE: [Patient Name]
DOB: 00/00/0000

Dear Dr. [Name]:

We were pleased to see [patient name] in evaluation of cough and runny nose. As you well know, the patient is a pleasant 4-year-old with asthma and rhinitis who has had symptoms since the age of 2-1/2. He was followed by Dr. Pratt for several months who initiated him on allergen hyposensitization in July of this year. He received two injections for trees, grasses, weeds, dog, molds and cockroach. He has not had any problems with the injections thus far. They wish to transfer care here and continue allergen hyposensitization. His symptoms are most prominent in the spring. He has coughing and shortness of breath now primarily with exertion. However, these symptoms are daily even with playing hard. He has no nocturnal awakenings. They do not use Ventolin. He has been prescribed Flovent and encouraged to use on multiple visits, although they are not using it. Mom had concerns about the steroid aspect of the inhaler. He also has sneezing, congestion, postnasal drainage and runny nose. His runny nose is the primary issue, although mom feels like it is not that bad now. He occasionally develops red, itchy eyes. He does routinely take Singulair. They have loratadine, but it has rarely been used. They have an EpiPen Jr. 2-pack because of his peanut and tree nut allergies. There was a prior question of egg and wheat sensitivity. He has no reactions when these foods are eaten. The ImmunoCAP test revealed levels that were low regarding clinical relevance for his age. His mother said he recently underwent an egg challenge and did fine. They do try to avoid all nuts carefully. As you know, the patient has neurofibromatosis-1 which has led to developmental delay and mother says a behavior disorder. He has a history of seizures. His last was in March. He has also had MRIs with suspicious lesions that are apparently being followed serially. He has frequent headaches. He had a tonsillectomy and adenoidectomy one month ago. This improved his nasal symptoms quite a lot. He has atopic dermatitis. He has had eczema since he was a baby. He particularly scratches his legs a lot, although he will have areas of skin involvement more diffusely. He gets a bath every other day. They use Irish Spring soap and Eucerin cream. They have hydrocortisone that they occasionally use as well. An immunodeficiency workup overall was unremarkable. Quantitative immunoglobulins and lymphocyte immunophenotyping were essentially normal. He had a sleep study that noted obstructive sleep apnea, but presumably this was prior to his tonsillectomy and adenoidectomy. His only other medication is Trileptal for his seizures. There are no known drug allergies. His stepfather smokes. There are no pets in the home. Mother has a prior history of asthma.

On evaluation here, the patient is pleasant and active and in no distress. Conjunctivae, tympanic membranes and oropharynx are clear. He has mild to moderate nasal congestion with pale lining and scant secretions. There is no adenopathy or sinus tenderness. He does, however, have a soft mobile lump on his right posterior inferior scalp, likely a little high to be a posterior cervical lymph node, but it may simply be a lymph node. They will follow this up with you. Lungs are clear to auscultation and percussion. The rest of the exam is unremarkable other than café-au-lait spots. No testing was done today.

IMPRESSION AND RECOMMENDATIONS:

1. **Asthma/perennial and seasonal allergic rhinoconjunctivitis.** I may have waited another year or two to begin allergen hyposensitization in a child with multiple other medical problems and with the

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recommended start age being 5; however, he has tolerated the injection protocol well, and certainly in the long run, allergen hyposensitization is the best chance to decrease medication requirements and have overall improvement in his allergic diseases. We reviewed the risks and benefits of immunotherapy and will continue the extracts per Dr. Pratt's formula. Because of his trouble with using metered-dose inhalers (Flovent), we switched him to Asmanex 110 strongly encouraging them to use it 2 puffs routinely once a day. We discussed the relative safety of low-dose inhaled steroids even for extended periods in children with asthma. Albuterol will continue to be his rescue medication. He will continue Singulair 4 mg daily. We encouraged routine use of cetirizine syrup 2 teaspoons daily for both his nasal symptoms and for his atopic dermatitis.

2. **Atopic dermatitis.** Hopefully, the routine antihistamine will better help itch control. We also discussed appropriate soak-and-seal skin care measures, as skin hydration is critical in controlling patients with eczema.
3. **Peanut/tree nut allergy.** He will continue strict avoidance. They already have an EpiPen 2-pack and have been trained in its appropriate use. The ImmunoCAP tests for egg and wheat were below levels felt to be relevant for his age based on studies by Hugh Sampson. He already has tolerated eating these foods. We encouraged continued liberalization of his diet (except nuts). He should get the flu vaccine. Unfortunately, we are out. Hopefully, this could be administered in your office, both the traditional seasonal flu vaccine as well as H1N1.

The patient will follow up with us for allergen hyposensitization. Thank you for allowing us to participate in his care. If you have questions or concerns, please feel free to contact us.

Sincerely,

Physician's Name

XXX/mt

D: 00/00/0000

T: 00/00/0000 Prepared by 360 Transcription Corp. (309) 963-5619

Allergy & Immunology

[Date of Letter]

RE: [Patient Name]
DOB: 00/00/0000

Dear Dr. [Name]:

The patient returned on 10/26/2009 for followup of food allergy. He was initially seen three years ago when evaluated for atopic dermatitis and found sensitive to eggs and peanuts. On a subsequent visit, he was tested, challenged and successfully immunized to the MMR vaccine. He has been doing well over the following three years, tolerating eggs in baked goods and probably having tolerated egg at preschool (per his older sister's observation). It is unclear whether he has ever had a peanut, avoiding both peanuts and tree nuts.

Selected skin testing today was negative to egg white, egg yolk and all tree nuts while remaining positive to peanut as well as to house dust mites. After discussing both his history and the negative predictive value of skin testing, I believe it is safe to reintroduce egg into his diet. There is also no evidence for tree nut allergy; however, it is safest to continue peanut avoidance considering retesting and possibly an in-office challenge in the future. Lastly, we also discussed environmental control strategies for house dust mites. Follow up one year/p.r.n.

Thank you for allowing me to participate in the care of your patient. Please call if you have any questions or concerns.

Sincerely,

Physician's Name
XXX/mt

D: 00/00/0000

T: 00/00/0000 Prepared by 360 Transcription Corp. (309) 963-5619

Allergy & Immunology

[Date of Letter]

RE: [Patient Name]
DOB: 00/00/0000

Dear Dr. [Name]:

We were pleased to see Ms. [patient name] in evaluation of chronic cough. As you well know, she is a very pleasant 31-year-old who developed a cough in April of this year. She has a spasmodic chest cough that causes nocturnal awakenings almost every night. She has spells most days as well. Overall, the cough has waxed and waned for the last six months. The cough is somewhat worse with exertion. She feels it occurs at the base of her throat or occasionally deeper. She took a course of antibiotics and multiple cough medicines, all without much benefit. She has also taken loratadine for a couple of months without much relief either. In addition to the cough, she has congestion, sneezing, postnasal drainage and runny nose. She develops watery eyes also. She has never had asthma or allergy symptoms in the past. She denies any reflux complaints. She is otherwise healthy. She is attempting pregnancy. There are no known drug allergies. She is a business analyst for Caterpillar. She has never smoked. There are two cats that are allowed in the bedroom. They have been in the home for eight years. There is no family history of allergies or asthma.

On evaluation here, the patient is pleasant and in no distress. There is mild conjunctival injection. Tympanic membranes and oropharynx are clear. There is moderate nasal congestion with pink lining and clear secretions. She has no adenopathy or sinus tenderness. Lungs are clear to auscultation and percussion. Skin testing was all negative. Spirometry was normal with an FEV1 of 2.68 (99%), FVC 3.14 (92%), ratio 0.85.

IMPRESSION AND RECOMMENDATIONS:

- Cough.** This is likely multifactorial and contributed to by postnasal drainage as well as a probable component of cough-variant asthma. Her lung function is normal today. Patients with cough-variant asthma can have deceptively normal-looking spirometries. The spasmodic nature of her cough including nocturnal awakenings and an exertional component are suggestive of lower airways inflammation. She will use prednisone 20 mg b.i.d. for 5 days. We placed her on Pulmicort 180 mg 2 puffs b.i.d. (This is category B in pregnancy, and she hopes to become pregnant soon.) She will use Xopenex prior to exercise and p.r.n. as a trial. To target the postnasal drainage, she will use Flonase 2 daily. Once she becomes pregnant, Caterpillar likely will approve its change to Rhinocort which is category B also.
- Nonallergic rhinitis.** All the skin tests were negative. Allergic inflammation does not appear to be the underlying diathesis. We discussed both allergic and nonallergic airways inflammation. As noted, she will use the Flonase.

If her cough is recalcitrant, we would consider an underlying component of reflux. Thank you for allowing us to participate in her care. If you have questions or concerns, please feel free to contact us.

Sincerely,

Physician's Name
XXX/mt

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T: 00/00/0000 Prepared by 360 Transcription Corp. (309) 963-5619

Allergy & Immunology

[Date of Letter]

RE: [Patient Name]
DOB: 00/00/0000

Dear Dr. [Name]:

We were pleased to see Mr. [patient name] in evaluation of rash and swelling. As you well know, the patient is a pleasant 54-year-old who on about September 7th developed tongue, lip and eye swelling. He also itched severely and may have had a few red bumps. He eventually went to urgent care on September 10th where he was given prednisone for three days. His Monopril was also discontinued. He had been on the ACE inhibitor for ten years. Prior to the onset of the symptoms, he had been on no new medications. He takes the same multivitamin as he has done for years. There was no change in the home environment including skin and laundry care products. They onset of symptoms did not correlate with food ingestion. There was no antecedent fever or other symptoms suggestive of an infection. After the three days of prednisone, he developed an increase in his baseline congestion, shortness of breath and cough. He also complained of tingling in his lips and tongue. He was encouraged to take his Advair 500 more consistently around that time. He has had a very persistent irritated painful burning tongue for most of the last two months. He has had ankle swelling and puffy fingers. Unfortunately, in the last eight weeks, he has been on prednisone 20 mg t.i.d. most of the time. Attempts at decreasing the dose led to a flare of respiratory symptoms. He has not had a recurrence of itching. He has not had a recurrence of frank angioedema either. He has been on fexofenadine for seven or eight years. He has ProAir, which does not help much. His blood pressure medicine was switched to amlodipine. He was just placed on Lasix four days ago because of his pedal edema. He was given Nasacort which he tried for only one day three weeks ago. He was given Diflucan which he only took for three or four days. About ten days ago, he ate peanuts. About 30 minutes later, he developed shortness of breath and tongue swelling. He had a second episode shortly thereafter following peanut ingestion. He has been avoiding these nuts since that time. He has heartburn symptoms about twice a week. ImmunoCAP testing revealed a level of 7 for peanuts. Everything else was at low and likely clinically irrelevant levels for foods. An environmental panel revealed a particularly high level of IgE to bluegrass. He has hypertension and a history of nephrolithiasis. He has a couple of EpiPens. He said Toradol was given in the ER when he was in for kidney stones. He thought it was pushed too fast and caused his blood pressure to drop. He has avoided Toradol since that time. He has taken ibuprofen p.r.n. for years without incidents. He has been withholding it over the last month and has continued to have symptoms as above. He is a business agent for the Teamsters. He has an 80-pack year tobacco use history and still smokes two packs a day. There is a dog that is outdoors only. There is no family history of allergies, asthma or angioedema.

On evaluation here, the patient is pleasant and in no distress. He is overweight. His blood pressure is 148/92. There is mild conjunctival injection. Tympanic membranes and oropharynx are clear. There is mild nasal congestion with pink lining and scant secretions. His tongue is erythematous with prominent furrows. He also has oropharyngeal thrush. There is no sinus tenderness or adenopathy. Lungs are clear to auscultation and percussion. He has mild bilateral ankle edema. The rest of the exam is unremarkable. We skin tested to additional tree nuts and both almond and Brazil nut came up. Skin prick testing to dust mite was negative. Spirometry on prednisone was normal with an FEV1 of 3.71 (99%), FVC 4.73 (90%), ratio 0.78.

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RE: [Patient Name]

DOB: 00/00/0000

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IMPRESSION AND RECOMMENDATIONS:

1. **Angioedema/possible urticaria.** I certainly agree with the avoidance of ACE inhibitors in anybody with a history of angioedema. This may not have been the only inciting event, but it can certainly lower the threshold to potentially life-threatening recurrences. Some of his stuttering symptoms over the last couple of months may have been from unidentified nut exposure. The dramatic rapid symptoms only occurred about ten days ago. It is since that time that he has been avoiding nuts. We provided information from the Food Allergy Network as well as reviewed appropriate use of an EpiPen. I also think some of his symptoms are due to adverse effects of the prednisone itself and also steroid withdrawal syndrome. Environmental sensitivities may also be a factor in his prior itching. For now, he will use Xyzal 5 mg q.a.m. and hydroxyzine 25-50 mg nightly and q.6 h. p.r.n. Because of his history, he may resume p.r.n. ibuprofen use. His story is not consistent with category of sensitivity to NSAIDs.
2. **Peanut/tree nut allergy.** As noted, he was given information regarding avoidance, and the epinephrine use was reviewed.
3. **Oropharyngeal thrush.** This is likely a significant factor in his persistent tongue irritation in the last couple of months. He will use Diflucan 200 mg daily for a week and repeat for an additional week if it has not completely cleared. Unfortunately, he was not rinsing after use of Advair. We reviewed appropriate oral hygiene.
4. **Chronic obstructive pulmonary disease/asthma.** Of course, we encouraged him to stop smoking and discussed with him its ill effects. He will continue high-dose Advair for now. I suspect that over the next several months the dose may be decreased. He will try Maxair as his rescue inhaler since he did not have very good technique or help with the ProAir.
5. **Allergic rhinitis.** In addition to the antihistamines, we encouraged routine use of Nasacort 2 daily and noted that it may take one to two weeks for maximum effects.

He also has occasional reflux symptoms. If his mouth irritation and chest complaints are not resolved with the above measures, we would plan routine medicine for GERD.

We requested followup in approximately three to four weeks. Thank you for allowing us to participate in Mr. [name]'s care. If you have questions or concerns, please feel free to contact us.

Sincerely,

Physician's Name

XXX/mt

D: 00/00/0000

T: 00/00/0000 Prepared by 360 Transcription Corp. (309) 963-5619

Allergy & Immunology

[Date]

RE: [Patient Name]

Major Symptoms:

1. Four episodes of hives and lip swelling.
2. Associated itchy throat.
3. Wheeze and dyspnea while running.

Diagnoses:

1. Recurrent urticaria and angioedema.
2. Query food allergy.
3. Airway hyperresponsiveness; exercise-induced bronchospasm.
4. History of penicillin, sulfa and clindamycin allergy.

Test results:

Allergy skin testing to panel of foods was negative. Previous ImmunoCAP positive to house dust mites, Alternaria mold and ragweed. Methacholine challenge dated 11/21/2008 positive at a PC20 of 14.5 mg/mL.

Recommendations:

1. Environmental control for house dust mites.
2. Discussed differential diagnosis of urticaria and angioedema.
3. Diary of ingestions and exposures associated with any recurrence.
4. EpiPen p.r.n. allergic emergencies.

Remarks:

The patient is a 21-year-old Bradley University student who developed lip swelling progressing to diffuse urticaria and extremely itchy throat on September 15th while eating Chinese food. This resolved over several hours with OTC Benadryl. She went on to have three more episodes within a two-week period, some but not all associated with eating. However, there has been no recurrence through all of October. Although she does appear atopic, no food sensitivities were identified on a panel of approximately 50 food extracts. ImmunoCAP testing did identify ragweed sensitivity, and these events did occur during the middle of the ragweed season, although such a cluster of acute responses in isolation would be very unusual for airborne allergens unless this was serving as a cofactor along with another as yet unidentified trigger. Initial recommendations as above. Secondly, she also describes some wheeze and dyspnea while running in the past, although tolerating other exercise very well including the elliptical machine. As mentioned, she is atopic and methacholine challenge was borderline positive but not clearly diagnostic of asthma. Given the current lack of symptoms, I agreed that conservative followup is reasonable.

Physician's Name
XXX/mt

D: 00/00/0000

T: 00/00/0000 Prepared by 360 Transcription Corp. (309) 963-5619

Allergy & Immunology

[Date]

RE: [Patient Name]

Major Symptoms:

1. Dyspnea with activity.
2. Occasional cough.
3. Nasal congestion and postnasal drainage.
4. Rhinorrhea.

Diagnoses:

1. Probable asthma.
2. Nonallergic rhinitis.

Test results:

Allergy skin testing: Negative. Spirometry: FEV1 1.48 (73% predicted), FVC 1.83 (81% predicted) with mid flows at 56% predicted. Post-bronchodilator FEV1 increased 25% to 1.85 (91% predicted). Nasal smear: Many WBCs, occasional eosinophils.

Recommendations:

1. Asthma education.
2. Asmanex 220 mcg 2 daily x2 weeks and then 1 daily.
3. Proventil HFA 2 puffs q.4 h. p.r.n. and trial before exercise.

Remarks:

The patient is a 9-year-old who presents for evaluation of possible exercise-induced asthma. Mother states that he has always become easily winded, ever since preschool, but he is now old enough to notice it more. There is no clear wheezing but occasionally a cough. He does tend to develop URI symptoms in the fall describing an episode a few years ago at a family camp in Michigan when nebulized bronchodilators were used. Despite a suggestive history, he appears nonatopic. Nevertheless, spirometry did reveal mild reversible obstruction and this, along with his history, suggests asthma. Initial recommendations above with followup in one to two months.

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