

# Yale University

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Re:

MR # 175 59 33

Service: Interstitial Lung Disease Clinic

Referring Physician: Joao Nascimento, M.D.

Date of Birth: 1/20/1963

Date of Service: 1/8/2004

## CLINIC SUMMARY:

### ASSESSMENT:

Ms. Lenor is a 40-year-old white female from Weston, Connecticut, who is referred by Dr. Nascimento of Bridgeport, Connecticut, for evaluation of interstitial lung disease in the setting of polymyositis. Ms. was evaluated at the Yale Interstitial Lung Disease Clinic on 11/10/03. At that time she presented with severe breathlessness, intractable cough, and a chest CT scan from 11/7/03 that showed predominantly lower lung zone reticular changes with some subpleural honeycombing and traction bronchiectasis. In addition, she had pulmonary function tests that were performed at an outside facility which revealed a severe restrictive ventilatory defect. Ms. has had a positive Jo-1-antibody in the past and has had elevated CPKs in the 11,000 range. She was being treated with prednisone 30 mg QD, azathioprine 100 mg and Remicade. We discussed the therapeutic options at that point in time. She had recently gone back on the Imuran and after her visit on 11/10/03 she began to show improvement in her cough. She returns today feeling dramatically better with her cough only intermittent and her breathlessness with exertion significantly improved. She is currently taking prednisone 20 mg QD, azathioprine 100 mg QD, and Remicade 9 vials monthly. We obtained pulmonary function tests which revealed a significant improvement in both her total lung capacity and her diffusing capacity on her present regimen.

We discussed further management options. My recommendation at the last visit had been to consider switching her to oral Cytoxan, but given that she has had such a dramatic improvement in her symptoms on the present regimen I would recommend continuing it. The dose of azathioprine at 100 mg is relatively low and it might be possible to increase that to 125 mg if her CPKs remain elevated. From the standpoint of her lung disease, I would continue the present regimen or increase the Imuran to 125 mg and repeat pulmonary function tests at 3 months. If there is ongoing improvement I would continue that regimen for an additional 3 months and then repeat the high resolution CT scan to see if there has been any impact on the diffuse parenchymal lung disease.

In summary, Ms. suffers from longstanding polymyositis and interstitial lung disease. On the current regimen of prednisone, Imuran, and Remicade she is doing well.

**DIAGNOSIS:**

1. Polymyositis.
2. Interstitial lung disease.
3. Raynaud's phenomenon.
4. Cataracts.

**RECOMMENDATIONS:**

1. Continue the present regimen.
2. Obtain bone densitometry.
3. Calcium and vitamin D supplementation.
4. Return to the Yale Interstitial Lung Disease Clinic in 3 months at which time we will repeat PFTs.

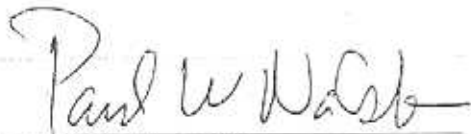
**CURRENT MEDICATIONS:** prednisone 20 mg QD, Imuran 100 mg QD, calcium and vitamin D, Remicade.

**PHYSICAL EXAMINATION:**

She is a well appearing female in no distress. Blood pressure is 92/50, heart rate is 68, oxygen saturation is 98% at rest. HEENT is unremarkable. She is mildly cushingoid. Auscultation of the chest reveals late inspiratory crackles at the bases. Cardiovascular exam shows a normal S1 and S2 with no murmurs, rubs or gallops. Abdomen is soft and nontender with no organomegaly.

**REVIEW OF AVAILABLE DATA:**

1. Pulmonary function tests reveal a forced vital capacity of 2.40 (57% predicted), and total lung capacity of 3.97 (62% predicted). Diffusing capacity is 16.42 (72% predicted) and when corrected for alveolar volume and hemoglobin it is 160% of predicted. When compared to 8/14/03 tests done at Norwalk Pulmonary Consultants, there is an improvement in FVC, total lung capacity, and diffusing capacity.



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cc: Joao Nascimento, M.D., Rheumatology and Internal Medicine Associates, 3203 Main Street, Bridgeport, CT 06606

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