1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Tomasz R. Wiśniewski

DOB
09/03/1972

AGE/SEX
54 / Male

MRN / PATIENT ID
TRW-8850327

DATE OF SERVICE
11/02/2026

PROVIDER
Olivia Grant

CREDENTIALS
MD, PhD (Rheumatology / Vasculitis)

VISIT TYPE
Follow-Up — post-hospital, during rituximab induction

CARE SETTING
Hospital Follow-Up — Vasculitis Clinic

PRIMARY CARE PROVIDER, IF APPLICABLE
Derek Holm, MD

REFERRING PROVIDER, IF APPLICABLE
Inpatient nephrology (Dr. A. Nakamura)

INTERPRETER USED, IF APPLICABLE
Not required

CC CHIEF COMPLAINT

2 PRIMARY CONCERN

"I'm out of the hospital and on the steroid taper. My nose isn't bleeding anymore and I'm not coughing blood, but I'm wiped out and my legs are swollen. I want to know if my kidneys are coming back."

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

3a PRESENTATION & DISEASE ACTIVITY

Reason for Autoimmune Disease Evaluation:

Post-hospital follow-up for newly diagnosed PR3-ANCA granulomatosis with polyangiitis (GPA): kidney, lung, and sinus involvement. Monitoring induction therapy.

History of Present Illness:

Four months of crusting nasal congestion, bloody nasal discharge, and R ear fullness — treated as sinusitis with 3 antibiotic courses. Then 6 weeks of joint aches, 6 kg weight loss, and night sweats. Admitted 10/08/2026 with hemoptysis and Cr 3.4 (baseline 0.9). Kidney biopsy: pauci-immune crescentic GN. PR3-ANCA strongly positive. Treated with IV methylprednisolone 1 g ×3, rituximab 375 mg/m² weekly ×4 (doses 1–3 given, dose 4 due 11/05), avacopan 30 mg BID, and a reduced-dose prednisone taper. No plasma exchange. Discharged 10/19 with Cr 2.6.

Disease Activity / Flare Symptoms:

Improving. Hemoptysis stopped day 3 of admission. Nasal bleeding stopped; crusting less. Joint aches gone. Night sweats gone.

Constitutional Symptoms:

Marked fatigue (steroid and illness related). Appetite increased on steroids. No fever. Weight stable since discharge.

Musculoskeletal Symptoms:

Earlier migratory arthralgia (knees, wrists) resolved. Mild thigh weakness climbing stairs (possible steroid myopathy).

Skin / Mucosal Symptoms:

Palpable purpura on the lower legs during admission, now fading. No oral ulcers.

Eye / ENT Symptoms:

Nasal crusting improving with saline. Mild R hearing loss (middle-ear effusion seen by ENT inpatient). No eye redness or pain.

3b ORGAN-SYSTEM REVIEW

Cardiopulmonary Symptoms:

No hemoptysis since 10/11. Mild exertional dyspnea. Bilateral leg edema. No chest pain.

Renal / Urinary Symptoms:

Urine less red. Mild foaminess. Edema to the shins. Home BP 140s/80s. Kidney biopsy 10/10/2026 (see Pathology). Nephrology following.

Gastrointestinal / Hepatic Symptoms:

Mild heartburn on prednisone (on PPI). No abdominal pain or bleeding.

Neurologic Symptoms:

No numbness, foot drop, or neuropathy. Trouble sleeping on steroids.

Hematologic / Vascular Symptoms:

Anemia (transfused 1 unit inpatient). Bruising on the forearms. No thrombosis. Note: active vasculitis raises VTE risk.

Endocrine / Metabolic Context:

Steroid-induced hyperglycemia — home glucose 150–220 after lunch. No prior diabetes.

3c TREATMENT & BACKGROUND

Medication History and Response:

Prednisone 30 mg daily (week 4 of a reduced-dose taper). Avacopan 30 mg BID. Rituximab ×3 doses (4th due 11/05). Trimethoprim-sulfamethoxazole SS daily (PJP prophylaxis). Pantoprazole 40 mg. Calcium + vitamin D3 2,000 IU. Amlodipine 5 mg. Insulin glargine 10 units (started at discharge). Adherent. Avacopan covered by specialty pharmacy copay program.

Immunosuppression / Infection Risk:

No current infection. QuantiFERON, hepatitis B (sAg, core Ab), hepatitis C, and HIV negative before rituximab. Vaccines: influenza 09/2026 (before rituximab); pneumococcal and Shingrix not given — inactivated vaccines planned. No live vaccines.

Pregnancy / Reproductive Considerations, if applicable:

Not applicable — no plans for more children. Fertility not affected by rituximab (cyclophosphamide avoided).

Past Autoimmune and Medical History:

No prior autoimmune disease. Hyperlipidemia. Otherwise healthy before 2026.

Family History:

Sister — Hashimoto thyroiditis. No vasculitis.

Social / Occupational History:

High-school chemistry teacher, on medical leave until January. Never smoker. Rare alcohol. Married, two teenagers. Wife helps with medications. Commercial insurance.

Pertinent Negatives:

No fever, hemoptysis, chest pain, vision change, foot drop, digital ischemia, or new rash.

ROS AUTOIMMUNE DISEASE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Fatigue, fever, weight loss, night sweats, malaise, or appetite change
Positive — fatigue, more appetite. No fever or sweats now.

Joint pain, swelling, stiffness, back pain, muscle pain, or weakness
Positive — mild proximal leg weakness.

Rash, photosensitivity, oral/nasal ulcers, alopecia, Raynaud symptoms, nodules, purpura, or skin thickening
Positive — fading purpura, nasal crusting.

Dry eyes, dry mouth, eye pain, redness, photophobia, vision changes, or parotid swelling
Negative.

Chest pain, dyspnea, cough, pleuritic pain, palpitations, edema, or syncope
Positive — mild exertional dyspnea, leg edema.

Abdominal pain, diarrhea, blood in stool, dysphagia, reflux, nausea, or liver symptoms
Positive — mild reflux.

Hematuria, foamy urine, edema, hypertension, or decreased urine output
Positive — hematuria improving, foamy urine, edema, hypertension.

Numbness, tingling, weakness, headache, seizures, cognitive changes, or neurologic deficits
Insomnia only.

Bruising, bleeding, thrombosis symptoms, pregnancy loss history, or vascular symptoms
Positive — forearm bruising.

Medication side effects, infection symptoms, immunosuppression concerns, or adherence barriers
Positive — hyperglycemia, insomnia, myopathy concern.

O OBJECTIVE

5 ORGAN-SYSTEM EXAMINATION

5a VITALS

TEMPERATURE	BLOOD PRESSURE	HEART RATE
98.1 °F	146/88 mmHg	82 bpm
RESPIRATORY RATE	**OXYGEN SATURATION**	**HEIGHT**
16 /min	97% RA	183 cm

WEIGHT	BMI	PAIN SCORE, IF APPLICABLE
89.6 kg (discharge 87.0)	26.8	1/10

5b EXAMINATION

General Appearance:

Tired-appearing, cushingoid face. Walks independently. No distress.

Head / Eyes / Ears / Nose / Throat:

Crusting in both nostrils with friable mucosa; septum intact. No saddle-nose deformity. R tympanic membrane dull with effusion. No scleritis or oral ulcers.

Neck:

No lymphadenopathy.

Cardiovascular:

Regular, no murmur or rub. 2+ pitting edema to the shins. Pulses intact. No digital ischemia.

Pulmonary:

Few crackles at the R base. No wheeze or rub.

Abdomen:

Soft, non-tender.

Musculoskeletal:

No synovitis. Hip flexors 4+/5 on both sides; rises from a chair without using his arms (slowly). Distal strength 5/5.

Skin:

Fading brown macules (old purpura) on both lower legs; no new purpura. Forearm ecchymoses. Thin skin. No ulcers.

Neurologic:

Cranial nerves intact. Sensation intact. No mononeuritis. Mild proximal weakness as above.

Psychiatric:

Anxious about kidney function; mild irritability on steroids. Insight good. No safety concerns.

DA AUTOIMMUNE DISEASE ACTIVITY ASSESSMENT

6 ACTIVITY & ORGAN INVOLVEMENT

CURRENT AUTOIMMUNE DIAGNOSIS OR SUSPECTED DIAGNOSIS

PR3-ANCA GPA, newly diagnosed (10/2026)

ACTIVE ORGAN SYSTEMS INVOLVED

Kidney (improving); ENT (improving); lung (resolved hemorrhage)

FLARE STATUS	DISEASE SEVERITY
Induction phase, responding	Severe, organ-threatening at presentation
FUNCTIONAL LIMITATIONS	**PATIENT GLOBAL ASSESSMENT WHEN AVAILABLE**
Fatigue; on leave from work	6/10
PROVIDER GLOBAL ASSESSMENT WHEN AVAILABLE	**EXTRA-ARTICULAR OR SYSTEMIC MANIFESTATIONS**
4/10 (improving)	Purpura (fading), middle-ear effusion
EVIDENCE OF ORGAN-THREATENING DISEASE	**DAMAGE VERSUS ACTIVE INFLAMMATION**

Renal — eGFR 31, active sediment, falling

Biopsy: 30% sclerotic glomeruli (some permanent damage)

COMPARISON TO PRIOR DISEASE ACTIVITY

BVAS 22 at admission → 6 today

RESPONSE TO CURRENT THERAPY

Good early response

MM MEDICATION / IMMUNOSUPPRESSION MONITORING

7 SAFETY REVIEW

CURRENT IMMUNOSUPPRESSIVE, IMMUNOMODULATORY, BIOLOGIC, STEROID, OR SUPPORTIVE MEDICATIONS

Rituximab, avacopan, prednisone 30 mg, TMP-SMX, PPI, calcium/vitamin D

DOSE, ROUTE, FREQUENCY, AND ADHERENCE

As listed; adherent

TREATMENT RESPONSE AND RESIDUAL SYMPTOMS

Improving; residual nasal crusting, renal impairment

SIDE EFFECTS OR TOXICITY SYMPTOMS

Hyperglycemia, insomnia, mild myopathy, bruising

INFECTION HISTORY AND MEDICATION HOLDS

None

LAB MONITORING STATUS

CBC, CMP, LFTs, UA weekly during induction

TB, HEPATITIS, HIV, OR OTHER SCREENING WHEN RELEVANT

All negative before rituximab

VACCINE STATUS AND COUNSELING

Pneumococcal (PCV21) and Shingrix — give at least 2 weeks before next rituximab when possible

PREGNANCY INTENTIONS, CONTRACEPTION, OR LACTATION CONSIDERATIONS WHEN RELEVANT

Not applicable

EYE SCREENING FOR HYDROXYCHLOROQUINE WHEN APPLICABLE

Not applicable

BONE PROTECTION FOR CHRONIC STEROID USE WHEN APPLICABLE

Calcium/vitamin D; DEXA ordered

PERIOPERATIVE MEDICATION GUIDANCE WHEN APPLICABLE

Not applicable

REFILL NEEDS, INSURANCE ISSUES, AND MEDICATION ACCESS BARRIERS

Avacopan refill via specialty pharmacy; TMP-SMX renally dosed

ST SCREENING / ASSESSMENT TOOLS

8 SCORES & INTERPRETATION

BVAS/WG: 6 (renal 4, ENT 2), down from 22 at admission. Vasculitis Damage Index: 2 (eGFR below 50, hearing loss). HAQ-DI 0.75. Patient global 6/10. Pain 1/10. FACIT-Fatigue 28 (significant fatigue). PHQ-9 8, GAD-7 9 (mild) — offered support. FRAX: will calculate after DEXA. Adherence: wife-managed pill box, no missed doses. RAPID3, DAS28, SLEDAI, BASDAI not applicable.

L LABORATORY AND DIAGNOSTIC RESULTS

9 REVIEWED & ORDERED

Inflammatory Markers:

CRP 142 (10/08) → 18 → 6 mg/L today. ESR 96 → 34. C3 and C4 normal.

Autoimmune Serologies:

c-ANCA positive; PR3 above 100 U/mL (10/2026). MPO negative. Anti-GBM negative. ANA negative. RF weakly positive.

Organ Monitoring Labs:

Cr 3.4 → 2.6 (discharge) → 2.3 today (eGFR 31). K 4.9. Albumin 3.1. UA: 2+ blood, 25–50 RBC/hpf (was above 100, with RBC casts). UPCR 1.4 g/g (was 2.6). Hb 10.2. CK normal. TSH normal.

Medication Monitoring Labs:

WBC 9.8 (steroid effect), lymphocytes 0.6. Platelets 288. AST 28, ALT 36 (avacopan LFT watch — normal). IgG 640 mg/dL (low-normal). CD19 B cells undetectable. Glucose 212 random.

Infectious Screening:

QuantiFERON negative. HBsAg, anti-HBc, HCV, and HIV negative (10/2026).

Imaging:

CT chest 10/09: bilateral ground-glass consistent with alveolar hemorrhage, plus a 2.1 cm R lower lobe nodule. CT sinus: mucosal thickening, no bone erosion. Repeat CT chest ordered for 12/2026. Renal ultrasound: normal-sized kidneys. DEXA ordered.

Cardiopulmonary Testing:

EKG normal. Echo inpatient: normal, no pericardial effusion. PFTs not done.

Pathology / Biopsy:

Kidney biopsy 10/10/2026: pauci-immune focal necrotizing and crescentic GN. 22 glomeruli: 9 cellular crescents, 7 globally sclerotic (32%). Moderate interstitial fibrosis (25%). Berden class: mixed.

Prior Records Reviewed:

Discharge summary, nephrology, ENT, and pulmonology inpatient notes, biopsy report, infusion records, PCP sinusitis visits (06–08/2026).

A ASSESSMENT

10 AUTOIMMUNE DISEASE INTERPRETATION

1) PR3-ANCA granulomatosis with polyangiitis, severe generalized disease: pauci-immune crescentic GN, diffuse alveolar hemorrhage, sinonasal and middle-ear disease, cutaneous vasculitis. Biopsy-proven. 2) Differential (anti-GBM disease, lupus nephritis, infection-related GN, drug-induced ANCA) excluded by serology and biopsy. 3) Activity: responding well to rituximab + avacopan + reduced-dose steroids. BVAS 22 → 6. Alveolar hemorrhage resolved. Kidney function improving (Cr 3.4 → 2.3; less hematuria and proteinuria). Not yet in remission. 4) Damage: 32% sclerotic glomeruli and 25% fibrosis limit full renal recovery — CKD likely. 5) Lung nodule probably vasculitic; reimage to confirm resolution. 6) Steroid toxicity: hyperglycemia, myopathy, insomnia, fluid retention — the avacopan regimen allows a faster taper. 7) Infection risk: high (rituximab, steroids, lymphopenia, low IgG). PJP prophylaxis in place. Vaccines due. 8) Bone health and cardiovascular risk: needs DEXA and BP control.

P PLAN

11 MANAGEMENT BY PROBLEM & ORGAN SYSTEM

Diagnostic plan,

Weekly CBC, CMP, LFTs, UA, and UPCR through week 8, then every 2 weeks. PR3 titer monthly (trend only, not used to guide treatment alone). CT chest in 12/2026. PFTs once stable. Audiology.

Disease-specific treatment plan,

Rituximab dose 4 on 11/05 (premedication). Continue avacopan 30 mg BID for 52 weeks (LFTs every 4 weeks). Maintenance: rituximab 500 mg every 6 months starting month 6, for 18–24 months total.

Flare management plan,

If hemoptysis returns, Cr rises more than 0.3, or hematuria worsens: call the same day → admit. Exclude infection before escalating.

Medication monitoring plan,

Labs as above. IgG every 3 months (consider IVIG if below 300 with infections). Avacopan: watch LFTs and drug interactions (avoid strong CYP3A4 inducers/inhibitors). Medication list reconciled.

Steroid-sparing plan,

Prednisone taper: 30 → 20 mg next week, then reduce by 5 mg every 2 weeks to 5 mg by week 12, then 2.5 mg ×2 weeks, then stop (avacopan-backed). Home glucose monitoring; PCP adjusting insulin. Morning dosing for sleep.

Organ-specific plan,

Renal: nephrology co-management; add furosemide 20 mg daily for edema; BP target below 130/80 — add lisinopril 5 mg once Cr is stable (nephrology to start in 2 weeks). ENT: saline irrigations, mupirocin to nasal crusts; myringotomy if hearing does not improve. Pulmonary: repeat CT.

Infection prevention plan,

Continue TMP-SMX for 6 months after the last rituximab (renally adjusted). PCV21 and Shingrix dose 1 today. Household influenza and COVID vaccines. Call for fever of 100.4 °F or above.

Cardiovascular and metabolic risk plan,

BP as above. Continue atorvastatin. Glucose management with PCP; expect insulin to stop as steroids taper.

Bone health plan,

DEXA within 4 weeks. Check 25-OH vitamin D. Bisphosphonate choice deferred given eGFR 31 — denosumab may be preferred if treatment is indicated.

Pregnancy/reproductive plan,

Not applicable.

Lifestyle and supportive care plan,

PT for proximal strengthening. Low-sodium (below 2 g) diet with moderate protein (renal dietitian). Sleep hygiene. Referral to vasculitis support group and behavioral health. Return to work planned for January 2027.

Referral and care coordination plan

Nephrology (2 weeks), ENT (4 weeks), audiology, pulmonology (after CT), renal dietitian, PT, behavioral health, PCP.

Patient education

Explained GPA as treatable but relapsing; maintenance therapy lowers relapse risk. Written flare and infection plan. Go to the ED for coughing blood, shortness of breath, fever with chills, or very low urine output.

F FOLLOW-UP

12 REASSESSMENT PLAN

Rituximab infusion 11/05. Weekly labs with nurse review. Clinic in 4 weeks (BVAS, kidney function, steroid taper, DEXA review). CT chest in 12/2026. Maintenance rituximab in month 6. Urgent precautions as above.

TB TIME DOCUMENTATION & BILLING

13 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT
70 minutes

AUTOIMMUNE DISEASE COUNSELING TIME
20 minutes

MEDICATION / IMMUNOSUPPRESSION COUNSELING TIME
15 minutes

CARE COORDINATION TIME
12 minutes (nephrology, ENT, PCP)

RECORDS REVIEW TIME, IF APPLICABLE
15 minutes

LAB / IMAGING REVIEW TIME, IF APPLICABLE
8 minutes

PROCEDURE TIME, IF APPLICABLE
Not applicable

13a BILLING CONSIDERATIONS — E/M / AUTOIMMUNE DISEASE CODING

E/M LEVEL
99215 + G2211

INFUSION MANAGEMENT CODE(S), IF APPLICABLE
Rituximab infusion billed separately at the infusion center

PROCEDURE CODE(S), IF APPLICABLE
90677 + 90471 (PCV21); 90750 + 90472 (Shingrix)

MEDICATION MONITORING / HIGH-RISK DRUG THERAPY DOCUMENTATION, IF APPLICABLE
Rituximab, avacopan, high-dose steroids — intensive toxicity monitoring

CARE COORDINATION CODE(S), IF APPLICABLE
Not separately billed

BASIS FOR BILLING
Medical Decision Making (high) + Medication monitoring

ICD-10 DIAGNOSIS CODES
M31.31 — Wegener's granulomatosis with renal involvement

[SECONDARY ORGAN INVOLVEMENT / MEDICATION MONITORING / SYMPTOM DIAGNOSIS CODE(S), IF APPLICABLE]
N18.32 — CKD stage 3b; R04.89 — Pulmonary hemorrhage, resolved (history); H65.91 — Nonsuppurative otitis media, right; R73.9 — Hyperglycemia; Z79.52 — Long-term systemic steroids; Z79.69 — Long-term use of other immunomodulators/immunosuppressants

SO

SIGNATURE

14 PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY
Olivia Grant	MD, PhD	Rheumatology / Autoimmune Disease Medicine

DATE	TIME
11/02/2026	14:20

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