HISTORY OF PRESENT ILLNESS: , This is a 48-year-old black male with stage IV chronic kidney disease, likely secondary to HIV nephropathy who presents to clinic for followup having missed prior clinic appointments. He was last seen in this clinic on 05/29/2007 by Dr. X. This is the first time that I have met the patient. The patient's history of renal insufficiency dates back to 06/2006 when he was hospitalized for an HIV-associated complication. He is unclear of the exact reason for his hospitalization at that time, but he was diagnosed with renal insufficiency and was followed in our Renal Clinic for approximately one year. He had a baseline creatinine during that time of between 3.2 to 3.3. When he was initially diagnosed with renal insufficiency, he had been noncompliant with his HAART regimen. Since that time, he has been very compliant with treatment for his HIV and is seeing Dr. Y in our Infectious Disease Clinic. He is currently on three-drug antiretroviral therapy. His last CD4 count in 03/2008 was 350. He has had no HIV complications since he was last seen in our clinic. The patient is also followed by Dr. Z at the outpatient VA Clinic, here in ABCD, although he has not seen her in approximately one year. The patient has an AV fistula that was placed in late 2006. The latest blood work that I have is from 06/11/2008 and shows a serum creatinine of 3.8, which represents a GFR of 22 and a potassium of 5.9. These laboratories were drawn by his infectious disease doctor and the results prompted their recommendation for him to return to our clinic for further evaluation. The only complaint that the patient has at this time is some difficulty sleeping. He

was given Ambien by his primary care doctor, but this has not helped significantly with his difficulty sleeping. He says that he has trouble getting to sleep. The Ambien will allow him to sleep for about two hours, and then he is awake again. He is tired during the day, but is not taking any daytime naps. He has no history of excessive snoring or apneic periods. He has no history of falling asleep at work or while driving. He has never had a formal sleep study. He does continue to work in sales at a local butcher shop.,REVIEW OF SYSTEMS: ,He denies any change in his appetite. He has actually gained some weight in recent months. He denies any nausea, vomiting, or abdominal discomfort. He denies any pruritus. He denies any lower extremity edema. All other systems are reviewed and negative.,PAST MEDICAL HISTORY:,1. Stage IV chronic kidney disease with most recent GFR of 22.,2. HIV diagnosed in 09/2006 with the most recent CD4 count of 350 in 03/2008.,3. Hyperlipidemia.,4. Hypertension.,5. Secondary hyperparathyroidism.,6. Status post right upper extremity AV fistula in the fall of 2006.,7. History of a right brachial plexus palsy.,8. Recent lower back pain, status post lumbar steroid injection.,ALLERGIES:, HE SAYS THAT VITAMIN D HAS CAUSED HEADACHES.,MEDICATIONS:,1. Kaletra daily.,2. Epivir one daily.,3. Ziagen two daily.,4. Lasix 20 mg b.i.d.,5. Valsartan 20 mg b.i.d.,6. Ambien 10 mg q.h.s.,SOCIAL HISTORY: , He lives here in ABCD. He is employed at the sales counter of a local butcher shop. He continues to smoke one pack of cigarettes daily, as he has for the past 28 years. He denies any alcohol or illicit substances.,FAMILY

HISTORY:, His mother is deceased. He said that she had some type of paralysis before she died. His father is deceased at age 64 of a head and neck cancer. He has a 56-year-old brother with type-two diabetes and blindness secondary to diabetic retinopathy. He has a 41-year-old brother who has hypertension. He has a sister who has thyroid disease.,PHYSICAL EXAMINATION:,VITAL SIGNS: Weight is 191 pounds. His temperature is 97.1. Pulse is 94. Blood pressure by automatic cuff 173/97, by manual cuff 180/90.,HEENT: His oropharynx is clear without thrush or ulceration.,NECK: Supple without lymphadenopathy or thyromegaly.,HEART: Regular with normal S1 and S2. There are no murmurs, rubs, or gallops. He has no JVD.,LUNGS: Clear to auscultation bilaterally without wheezes, rhonchi, or crackles.,ABDOMEN: Soft, nontender, nondistended, without abdominal bruit or organomegaly.,MUSCULOSKELETAL: He has difficulty with abduction of his right shoulder.,ACCESS: He has a right forearm AV fistula with an audible bruit and a palpable thrill. There is no sign of stenosis. The vascular access looks like it is ready to use.,EXTREMITIES: No peripheral edema.,SKIN: No bruises, petechiae, or rash.,LABS: ,Sodium was 140, potassium 5.9, chloride 114, bicarbonate 18. BUN is 49, creatinine 4.3. GFR is 19. Albumin 3.2. Protein 7. AST 17, ALT 16, alkaline phosphatase 106. Total bilirubin 0.4. Calcium 9.1., phosphorus 4.7, PTH of 448. The corrected calcium was 9.7. WBC is 8.9, hemoglobin 13.4, platelet 226. Total cholesterol 234, triglycerides 140, LDL 159, HDL 47. His ferritin is 258, iron is 55, and percent sat is

24.,IMPRESSION: ,This is a 48-year-old black male with stage IV chronic kidney disease likely secondary to HIV nephropathy, although there is no history of renal biopsy, who has been noncompliant with the Renal Clinic and presents today for followup at the recommendation of his Infection Disease doctors.,RECOMMENDATIONS:,1. Renal. His serum creatinine is progressively worsening. His creatinine was 3.2 the last time we saw him in 05/2007 and today is 4.3. This represents a GFR of 19. This is stage IV chronic kidney disease. He does have vascular access and this appears to be ready to use. He is having some difficulty sleeping and it is possible that this represents some early signs of uremia. Otherwise, he has no signs or symptoms of uremia at this time. I am going to touch base with the dialysis educator and try to get The patient in to the dialysis teaching classes. He has already received some literature for the dialysis teaching, but has not yet enrolled in the classes. I have encouraged him to continue to exercise his right forearm. I am also going to contact the transplant coordinator and see if he can be evaluated for possible transplant. Given his progression of his chronic kidney disease, I will anticipate that he will need to start dialysis soon.,2. Hypertension. I have added labetolol 100 mg b.i.d. to his antihypertensive regimen. He shows no signs at this point of volume overload, although if he does demonstrate this in the future, his Lasix could be increased. Goal blood pressure would be less than 130/80.,3. Hyperkalemia. I am going to instruct him in a low-potassium diet and decrease his valsartan to 20 mg daily. I will have him

return in one week to recheck his potassium. If his potassium continues to remain elevated, he may require initiation of dialysis for this.,4. Bone metabolism. His PTH is elevated and I am going to add PhosLo 800 mg t.i.d. with meals. His corrected calcium is 9.7, and I would like to avoid calcium-containing phosphate bonders in this situation.,5. Acid base. His bicarbonate is 18 and I will initiate the sodium bicarbonate 650 mg three tablets t.i.d.,6. Anemia. His hemoglobin is at goal for this stage of chronic kidney disease. His iron stores are adequate.