HISTORY:, The patient was in the intensive care unit setting; he was intubated and sedated. The patient is a 55-year-old patient, who was admitted secondary to a diagnosis of pancreatitis, developed hypotension and possible sepsis and respiratory as well as renal failure and found to be intubated. He has been significantly hypotensive during his stay in the intensive care unit and has had minimal urine output. His creatinine has gone from 2.1 to 4.2 overnight and the patient also developed florid acidosis and hypokalemia. Nephrology input has been requested for management of acute renal failure and acidosis.,PAST MEDICAL HISTORY:,1. Pancreatitis.,2. Poison ivy. The patient has recently been on oral steroids.,3. Hypertension.,MEDICATIONS: , Include Ambien, prednisone, and blood pressure medication, which is not documented in the record at the moment.,INPATIENT MEDICATIONS: , Include Protonix IV, half-normal saline at 125 mL an hour, D5W with 3 ounces of bicarbonate at 150 mL an hour. The patient was initially on dopamine, which has now been discontinued. The patient remains on Levophed and Invanz 1 g IV q.24 h.,PHYSICAL EXAMINATION:, Vitals, emergency room presentation, the blood pressure was 82/45. His blood pressure in the ICU had dipped down into the 60s systolic, most recent blood pressure is 108/67 and he has been maintained on 100% FiO2. The patient has had minimal urine output since admission. HEENT, the patient is intubated at the moment. Neck examination, no overt lymph node enlargement. No jugular venous distention. Lungs examination is benign in terms of crackles. The patient has

some harsh breath sounds secondary to being intubated. CVS, S1 and S2 are fairly regular at the moment. There is no pericardial rub. Abdominal examination, obese, but benign. Extremity examination reveals no lower extremity edema. CNS, the patient is intubated and sedated.,LABORATORY DATA: , Blood work, sodium 152, potassium 2.7, bicarbonate 13, BUN 36, and creatinine 4.2. The patient's BUN and creatinine yesterday were 23 and 2.1 respectively. H&H; of 17.7 and 51.6, white cell count of 8.4 from earlier on this morning. The patient's liver function tests are all out of whack and his alkaline phosphatase is 226, ALT is 539, CK 1103, INR 1.66, and ammonia level of 55. Latest ABGs show a pH of 7.04, bicarbonate of 10.7, pCO2 of 40.3, and pO2 of 120.7.,ASSESSMENT:,1. Acute renal failure, which in all probability is secondary to acute tubular necrosis and sepsis and significant hypotension, but the patient is at the moment on 100% FiO2. He has been given intravenous fluid at a high rate to replete intravascular volume and to hopefully address his acidosis. The patient also has significant acidosis and his creatinine has increased from 2.1 to 4.2 overnight. Given the fact that he would need dialytic support for his electrolyte derangements and for volume control, I would suggest continuous venovenous hemodiafiltration as opposed to conventional hemodialysis as the patient will not be able to tolerate conventional hemodialysis given his hemodynamic instability.,2. Hypotension, which is significant and is related to his sepsis. Now the patient has been maintained on Levophed and high rate of intravenous fluid at the moment.,3.

Acidosis, which is again secondary to his renal failure. The patient was administered intravenous bicarbonate as mentioned above. Dialytic support in the form of continuous venovenous hemodiafiltration was highly recommended for possible correction of his electrolyte derangements.,4. Pancreatitis, which has been managed by his gastroenterologist.,5. Sepsis, the patient is on broad-spectrum antibiotic therapy.,6. Hypercalcemia. The patient has been given calcium chloride. We will need to watch for rebound hypercalcemia.,7. Hypoalbuminemia.,8. Hypokalemia, which has been repleted.,RECOMMENDATIONS: , Again include continuation of IV fluid and bicarbonate infusion as well as transfer to the Piedmont Hospital for continuous venovenous hemodiafiltration.