HISTORY OF PRESENT ILLNESS: , This is a 70-year-old female with a past medical history of chronic kidney disease, stage 4; history of diabetes mellitus; diabetic nephropathy; peripheral vascular disease, status post recent PTA of right leg, admitted to the hospital because of swelling of the right hand and left foot. The patient says that the right hand was very swollen, very painful, could not move the fingers, and also, the left foot was very swollen and very painful, and again could not move the toes, came to emergency room, diagnosed with gout and gouty attacks. I was asked to see the patient regarding chronic kidney disease.,PAST MEDICAL HISTORY:,1. Diabetes mellitus type 2.,2. Diabetic nephropathy.,3. Chronic kidney disease, stage 4.,4. Hypertension.,5. Hypercholesterolemia and hyperlipidemia.,6. Peripheral vascular disease, status post recent, last week PTA of right lower extremity.,SOCIAL HISTORY:, Negative for smoking and drinking.,CURRENT HOME MEDICATIONS:, NovoLog 20 units with each meal, Lantus 30 units at bedtime, Crestor 10 mg daily, Micardis 80 mg daily, Imdur 30 mg daily, Amlodipine 10 mg daily, Coreg 12.5 mg b.i.d., Lasix 20 mg daily, Ecotrin 325 mg daily, and calcitriol 0.5 mcg daily.,REVIEW OF SYSTEMS: , The patient denies any complaints, states that the right hand and left foot was very swollen and very painful, and came to emergency room. Also, she could not urinate and states as soon as they put Foley in, 500 mL of urine came out. Also they started her on steroids and colchicine, and the pain is improving and the swelling is getting better. Denies any fever and chills. Denies any

dysuria, frequency or hematuria. States that the urine output was decreased considerably, and she could not urinate. Denies any cough, hemoptysis or sputum production. Denies any chest pain, orthopnea or paroxysmal nocturnal dyspnea.,PHYSICAL EXAMINATION:,General: The patient is alert and oriented, in no acute distress.,Vital Signs: Blood pressure 126/67, temperature 97.9, pulse 71, and respirations 20. The patient's weight is 105.6 kg.,Head: Normocephalic.,Neck: Supple. No JVD. No adenopathy.,Chest: Symmetric. No retractions.,Lungs: Clear.,Heart: RRR with no murmur.,Abdomen: Obese, soft, and nontender. No rebound. No guarding.,Extremity: She has 2+ pretibial edema bilaterally at the lower extremity, but also the left foot, in dorsum of left foot and also right hand is swollen and very tender to move the toes and also fingers in those extremities.,LAB TESTS: , Showed that urine culture is negative up to date. The patient's white cell is 12.7, hematocrit 26.1. The patient has 90% segs and 0% bands. Serum sodium 133, potassium 5.9, chloride 100, bicarb 21, glucose 348, BUN 57, creatinine is 2.39, calcium 8.9, and uric acid yesterday was 10.9. Sed rate was 121. BNP was 851. Urinalysis showed 15 to 20 white cells, 3+ protein, 3+ blood with 25 to 30 red blood cells also.,IMPRESSION:,1. Urinary tract infection.,2. Acute gouty attack.,3. Diabetes mellitus with diabetic nephropathy.,4. Hypertension.,5. Hypercholesterolemia.,6. Peripheral vascular disease, status post recent PTA in the right side.,7. Chronic kidney disease, stage 4.,PLAN: , At this time is I agree with treatment. We will

add allopurinol 50 mg daily. This is secondary to the patient is already on colchicine, and also we will discontinue Micardis, we will increase Lasix to 40 b.i.d., and we will follow with the lab results.