REASON FOR VISIT:, Followup on chronic kidney disease.,HISTORY OF PRESENT ILLNESS:, The patient is a 78-year-old gentleman with stage III chronic kidney disease who on his last visit with me presented with classic anginal symptoms. He was admitted to hospital and found to have an acute myocardial infarction. He had a complex hospital course, which resulted in cardiac catheterization and two stents being placed. His creatinine did pop above up to 3 but then came back to baseline. His hospital stay was also complicated by urinary retention requiring a catheter and Flomax. He returns today to re-establish care. Of note, he was noted to have atrial fibrillation while hospitalized and had massive epistaxis.,ALLERGIES:, None.,MEDICATIONS: , Starlix 120 mg b.i.d., Compazine b.i.d., aspirin 81 mg daily, Plavix 75 mg daily, glipizide 15 mg b.i.d., multivitamin daily, potassium 10 mEq daily, Cozaar 25 mg daily, Prilosec 20 mg daily, digoxin 0.125 mg every other day, vitamin C 250 mg daily, ferrous sulphate 325 mg b.i.d., metoprolol 6.25 mg daily, Lasix 80 mg b.i.d., Flomax 0.4 mg daily, Zocor 80 mg daily, and Tylenol p.r.n.,PAST MEDICAL HISTORY:,1. Stage III CKD with baseline creatinine in the 2 range.,2. Status post MI on May 30, 2006.,3. Coronary artery disease status post stents of the circumflex.,4. Congestive heart failure.,5. Atrial fibrillation.,6. COPD.,7. Diabetes.,8. Anemia.,9. Massive epistaxis.,REVIEW OF SYSTEMS:, Cardiovascular: No chest pain. He has occasional dyspnea on exertion. No orthopnea. No PND. He has occasional edema of his right leg. He has been dizzy and his dose of metoprolol has been gradually

decreased. GU: No hematuria, foamy urine, pyuria, frequency, dysuria, weak stream or dribbling.,PHYSICAL EXAMINATION: , VITAL SIGNS: Pulse 70. Blood pressure 114/58. Weight 79.5 kg. GENERAL: He is in no apparent distress. HEART: Irregularly irregular. No murmurs, rubs, or gallops. LUNGS: Clear bilaterally. ABDOMEN: Soft, nontender, and nondistended. EXTREMITIES: Trace edema on the right.,LABORATORY DATA: , Dated 07/05/06, hematocrit is 30.2, platelets 380, sodium 139, potassium 4.9, chloride 100, CO2 28, BUN 38, creatinine 2.2, glucose 226, calcium 9.7, and albumin 3.7.,IMPRESSION:,1. Stage III chronic kidney disease with return to baseline GFR of 31 mL/min. He is on an ARB.,2. Coronary artery disease, status post stenting.,3. Hypertension. Blood pressures are on the low side at present. I hesitate to increase his Cozaar although I would do this if tolerated in the future.,4. Anemia of renal disease. He is to start Aranesp.,5. ? Atrial fibrillation. We discussed anticoagulation issues involved with chronic Afib. He may be popping in and out or this could just be a sinus arrhythmia.,PLAN:,1. Check EKG.,2. Start Aranesp 60 mcg every two weeks.,3. Otherwise see him in four months.,4. If EKG shows atrial fibrillation, I wanted to talk to Dr. XYZ about Coumadin.