REASON FOR RETURN VISIT: , Followup of left hand discomfort and systemic lupus erythematosus.,HISTORY OF PRESENT ILLNESS: , The patient is a 56-year-old female with a history of systemic lupus erythematosus, who was last seen in rheumatology clinic approximately 4 months ago for bilateral hand discomfort, left greater than right. The patient was seen on 10/30/07. She had the same complaint. She was given a trial of Elavil at bedtime because the thought was to see that represented ulnar or radial neuropathy. She was also given a prescription for Zostrix cream but was unable to get it filled because of insurance coverage. The patient reports some worsening of the symptoms especially involving at the dorsum of the left hand, and she points to the area that actually involves the dorsal aspect of the second, third, and fourth digits. The patient recently has developed what sounds like an upper respiratory problem with a nonproductive cough for 3 days, although she reports that she has had subjective fevers for the past 3 or 4 days, but has not actually taken the temperature. She has not had any night sweats or chills. She has had no recent problems with chest pain, chest discomfort, shortness of breath or problems with GU or GI complaints. She is returning today for routine followup evaluation.,CURRENT MEDICATIONS:,1. Plaquenil 200 mg twice a day.,2. Fosamax 170 mg once a week.,3. Calcium and vitamin D complex twice daily.,4. Folic acid 1 mg per day.,5. Trilisate 1000 mg a day.,6. K-Dur 20 mEq twice a day.,7. Hydrochlorothiazide 15 mg once a day.,8. Lopressor 50 mg one-half tablet twice a day.,9. Trazodone 100 mg at

bedtime.,10. Prempro 0.625 mg per day.,11. Aspirin 325 mg once a day.,12. Lipitor 10 mg per day.,13. Pepcid 20 mg twice a day.,14. Reglan 10 mg before meals and at bedtime.,15. Celexa 20 mg per day.,REVIEW OF SYSTEMS: , Noncontributory except for what was noted in the HPI and the remainder or complete review of systems is unremarkable.,PHYSICAL EXAMINATION:,VITAL SIGNS: Blood pressure 155/84, pulse 87, weight 223 pounds, and temperature 99.2. GENERAL: She is a well-developed, well-nourished female appearing her staged age. She is alert, oriented, and cooperative. HEENT: Normocephalic and atraumatic. There is no facial rash. No oral lesions. LUNGS: Clear to auscultation. CARDIOVASCULAR: Regular rate and rhythm without murmurs, rubs or gallops. EXTREMITIES: No cyanosis or clubbing. Sensory examination of the upper extremity decreased to light touch on the distal tips of the left second and third digits compared to the fifth digit. Positive Tinel sign. Full range of motion of the wrist with no evidence of motor atrophy or muscle loss.,LABORATORY DATA: ,WBC 5100, hemoglobin 11.1, hematocrit 32.8, and platelets 200,000. Westergren sedimentation rate of 47. Urinalysis is negative for protein and blood. Lupus serology is pending.,ASSESSMENT:,1. Systemic lupus erythematosus that is chronically stable at this point.,2. Carpal tunnel involving the left wrist with sensory change, but no evidence of motor change.,3. Upper respiratory infection with cough, cold, and congestion.,RECOMMENDATIONS:,1. The patient will have a trial of a resting wrist splint at night for the next 4 to

6 weeks. If there is no improvement, the patient will return for corticosteroid injection of her carpal tunnel.,2. Azithromycin 5-day dose pack.,3. Robitussin Cough and Cold Flu to be taken twice a day.,4. Atarax 25 mg at bedtime for sleep.,5. The patient will return to the rheumatology clinic for a routine followup evaluation in 4 months.