HISTORY OF PRESENT ILLNESS:, The patient is a 74-year-old white woman who has a past medical history of hypertension for 15 years, history of CVA with no residual hemiparesis and uterine cancer with pulmonary metastases, who presented for evaluation of recent worsening of the hypertension. According to the patient, she had stable blood pressure for the past 12-15 years on 10 mg of lisinopril. In August of 2007, she was treated with doxorubicin and, as well as Procrit and her blood pressure started to go up to over 200s. Her lisinopril was increased to 40 mg daily. She was also given metoprolol and HCTZ two weeks ago, after she visited the emergency room with increased systolic blood pressure. Denies any physical complaints at the present time. Denies having any renal problems in the past.,PAST MEDICAL HISTORY:, As above plus history of anemia treated with Procrit. No smoking or alcohol use and lives alone.,FAMILY HISTORY:, Unremarkable.,PRESENT MEDICATIONS: , As above.,REVIEW OF SYSTEMS: , Cardiovascular: No chest pain. No palpitations. Pulmonary: No shortness of breath, cough, or wheezing. Gastrointestinal: No nausea, vomiting, or diarrhea. GU: No nocturia. Denies having gross hematuria. Salt intake is minimal. Neurological: Unremarkable, except for history of old CVA.,PHYSICAL EXAMINATION: , Blood pressure today is 182/78. Examination of the head is unremarkable. Neck is supple with no JVD. Lungs are clear. There is no abdominal bruit. Extremities 1+ edema bilaterally.,LABORATORY DATA:, Urinalysis done in the office shows 1+ proteinuria; same is

shown by urinalysis done at Hospital. The creatinine is 0.8. Renal ultrasound showed possible renal artery stenosis and a 2 cm cyst in the left kidney. MRA of the renal arteries was essentially unremarkable with no suspicion for renal artery stenosis.,IMPRESSION AND PLAN:, Accelerated hypertension. No clear-cut etiology for recent worsening since renal artery stenosis was ruled out by negative MRA. I could only blame Procrit initiation, as well as possible fluid retention as a cause of the patient's accelerated hypertension. She was started on hydrochlorothiazide less than two weeks ago with some improvement in her hypertension. At this point, I would not pursue a diagnosis of renal artery stenosis. Since she is maxed out on lisinopril and her pulse is 60, I would not increase beta-blocker or ACE inhibitor. I will continue HCTZ at 24 mg daily. The patient was also given a sample of Tekturna, which would hopefully improve her systolic blood pressure. The patient was told to be stick with her salt intake. She will report to me in 10 days with the result of her blood pressure. She will also repeat an SMA7 to rule out possible hyperkalemia due to Tekturna.