

REASON FOR VISIT: , Acute kidney failure.,HISTORY OF PRESENT ILLNESS: , The patient is a 68-year-old Korean gentleman with a history of coronary artery disease, hypertension, diabetes and stage III CKD with a creatinine of 1.8 in May 2006 corresponding with the GFR of 40-41 mL/min. The patient had blood work done at Dr. XYZ's office on June 01, 2006, which revealed an elevation in his creatinine up to 2.3. He was asked to come in to see a nephrologist for further evaluation. I am therefore asked by Dr. XYZ to see this patient in consultation for evaluation of acute on chronic kidney failure. The patient states that he was actually taking up to 12 to 13 pills of Chinese herbs and dietary supplements for the past year. He only stopped about two or three weeks ago. He also states that TriCor was added about one or two months ago but he is not sure of the date. He has not had an ultrasound but has been diagnosed with prostatic hypertrophy by his primary care doctor and placed on Flomax. He states that his urinary dribbling and weak stream had not improved since doing this. For the past couple of weeks, he has had dizziness in the morning. This is then associated with low glucose. However the patient's blood glucose this morning was 123 and he still was dizzy. This was worse on standing. He states that he has been checking his blood pressure regularly at home because he has felt so bad and that he has gotten under 100/60 on several occasions. His pulses remained in the 60s.,ALLERGIES: , None.,MEDICATIONS: , Imdur 20 mg two to three times daily, nitroglycerin p.r.n., insulin 70/30 40/45 units daily, Zetia 10 mg

daily, ? Triglide 50 mg daily, Prevacid 30 mg daily, Plavix 75 mg daily, potassium 10 mEq daily, Lasix 60 mg daily, folate 1 mg b.i.d., Niaspan 500 mg daily, atenolol 50 mg daily, enalapril 10 mg b.i.d., glyburide 10 mg b.i.d., Xanax 0.25 mg b.i.d., aspirin 325 mg daily, Tylenol p.r.n., Zantac 150 mg b.i.d., Crestor 5 mg daily, TriCor 145 mg daily, Digitek 0.125 mg daily, Celexa 20 mg daily, and Flomax 0.4 mg daily.,PAST

MEDICAL HISTORY:;1. Coronary artery disease status post CABG x 5 in December 2001.,2. Three stents last placed approximately 2002.,3. Heart failure, ejection fraction of 30%.,4. Hypertension since 1985.,5. Diabetes since 1985 with history of laser surgery.,6. Moderate mitral regurgitation.,7. GI bleed.,8. Hyperlipidemia.,9. BPH.,10. Back surgery.,11. Sleep apnea.,SOCIAL HISTORY: , He is a former tailor from Korea. He is divorced. He has one daughter who has brain injury status post severe seizure as a child. He is the primary caregiver. No drug abuse. He quit tobacco and alcohol 15 years ago.,FAMILY HISTORY: , Parents both died in Korea. Has one sister with hypertension and the other sister lives in Detroit and is healthy.,REVIEW OF SYSTEMS: , He has lost about 10 pounds over the past month. He has been fatigue and weak with no appetite. He has occasional chest pain and dyspnea on exertion on fast walking. His lower extremity edema has improved with higher doses of furosemide. He does complain of some early satiety. He complains of urinary frequency, nocturia, weak stream and dribbling. He has never passed the stone. He gets dizzy when his blood sugars are in the 40s to 60s but now this is continuing with him running,

glucose is in the 120s. He has some right back pain today and complains of farsightedness. The remainder of review of systems is done and negative per the patient.,PHYSICAL EXAMINATION:, VITAL SIGNS: Pulse 78. Blood pressure 116/60. Height 5'7"" per the patient. Weight 78.6 kg. Supine pulse 60 with blood pressure 128/55. Standing pulse 60 with blood pressure of 132/50. GENERAL: He is in no apparent distress, but he is dizzy on standing for prolonged period. Eyes: Pupils equal, round and reactive to light. Extraocular movements are intact. Sclerae not icteric. HEENT: He wears upper and lower dentures. Lips acyanotic. Hearing is grossly intact. Oropharynx is otherwise clear. NECK: Supple. No JVD. No bruits. No masses. HEART: Regular rate and rhythm. No murmurs, rubs or gallops. LUNGS: Clear bilaterally. ABDOMEN: Active bowel sounds. Soft, nontender, and nondistended. No suprapubic tenderness. EXTREMITIES: No clubbing, cyanosis or edema. MUSCULOSKELETAL: 5/5 strength bilaterally. No synovitis, arthritis or gait disturbance. SKIN: Old scars in his low back as well as his left lower extremity. No active rashes, purpura or petechiae. Midline sternotomy scar is well healed. NEUROLOGIC: Cranial nerves II through XII are intact. Reflexes are poor to 1+ bilaterally. 10 g monofilament sensation is intact except for the big toes bilaterally. No asterixis. Finger-to-nose testing is intact. PSYCHIATRIC: Fully alert and oriented.,LABORATORY DATA:, December 2004, creatinine was 1.5. Per report May 2006, creatinine was 1.8 with a BUN of 28. Labs dated 06/01/06, hematocrit was 32.3, white blood

cell count 7.2, platelets 263,000, sodium 139, potassium 4.9, chloride 100, CO2 25, BUN 46, creatinine 2.3, glucose 162, albumin 4.7, LFTs are normal. CK was elevated at 653. A1c is 7.6%. LDL cholesterol is 68, HDL is 35. Urinalysis reveals microalbumin to creatinine ratio 59.8. UA was otherwise negative with a pH of 5. Today his urinalysis showed specific gravity 1.020, negative glucose, bilirubin, ketones and blood, 30 mg/dL of protein, pH of 5, negative nitrates, leukocyte esterase. Microscopic exam was bland., IMPRESSION:, 1. Acute on chronic kidney failure. He has underlying stage III CKD with the GFR approximately 41 mL/min. He has episodic hypotension at home and low diastolic pressure here. His weight is down 2 to 3 Kg from June and he may be prerenal. He also has a history of prostatic hypertrophy and obstruction must be investigated. I am also concerned about his use of Chinese herbs which can cause chronic interstitial nephritis. There is no evidence of pyuria today although this can present with a fairly bland sediment. An additional concern is that TriCor can cause an artifactual increase in the creatinine due to changes in metabolism. I think this would be a diagnosis of exclusion., 2. Orthostatic hypotension. He is maintaining systolic but his diastolic pressures are gotten in to a point where he may not be perfusing his brain well., 3. Elevated creatine kinase consistent with myositis. It could be a result of Crestor alone or combination of TriCor and Crestor. I do not think this is enough to cause rhabdomyolysis, however., RECOMMENDATIONS:, 1. The patient was cautioned about using NSAIDs and told to avoid any further

Chinese herbs.,2. Recheck labs including CBC with differential, SPEP, uric acid and renal panel.,3. Decrease atenolol to 25 mg daily.,4. Decrease enalapril to 10 mg daily.,5. Decrease Lasix to 20 mg daily.,6. Stop Crestor.,7. Check renal ultrasound.,8. See him back in two weeks for review of the studies.