REASON FOR CONSULTATION:, Renal failure evaluation for possible dialysis therapy.,HISTORY OF PRESENT ILLNESS:, This is a 47-year-old gentleman, who works offshore as a cook, who about 4 days ago noted that he was having some swelling in his ankles and it progressively got worse over the past 3 to 4 days, until he was swelling all the way up to his mid thigh bilaterally. He also felt like he could not make much urine, and his wife, who is a nurse instructed him to force fluids. While he was there, he was drinking cranberry juice, some Powerade, but he also has a history of weightlifting and had been taking on a creatine protein drink on a daily basis for some time now. He presented here with very decreased urine output until a Foley catheter was placed and about 500 mL was noted in his bladder. He did have a CPK level of about 234 while his BUN and creatinine on admission were 109 and 6.9. Despite IV hydration fluids, his potassium has gone up from 5.4 to 6.1. He did not put out any significant urine and his weight was documented at 103 kg. He was given a dose of Kayexalate. His potassium came down to like about 5.9 and urine studies were ordered. His urinalysis did show that he had microscopic hematuria and proteinuria and his protein-creatinine ratio was about 9 gm of protein consistent with nephrotic range proteinuria. He did have a low albumin of 1.9. He denied any nonsteroidal usage, any recreational drug abuse, and his urine drug screen was unremarkable, and he denied any history of hypertension or any other medical problems. He has not had any blood work except for drug screens that are required by work and no work up by any

primary care physician because he has not seen one for primary care. He is very concerned because his mother and father were both on dialysis, which he thinks were due to diabetes and both parents have expired. He denied any hemoptysis, gross hematuria, melena, hematochezia, hemoptysis, hematemesis, no seizures, no palpitations, no pruritus, no chest pain. He did have a decrease in his appetite, which all started about Thursday. We were asked to see this patient in consultation by Dr. X because of his renal failure and the need for possible dialysis therapy. He was significantly hypertensive on admission with a blood pressure of 162/80.,PAST MEDICAL HISTORY: , Unremarkable.,PAST SURGICAL HISTORY: , Unremarkable.,FAMILY HISTORY: , Both mother and father were on dialysis of end-stage renal disease.,SOCIAL HISTORY: , He is married. He does smoke despite understanding the risks associated with smoking a pack every 6 days. Does not drink alcohol or use any recreational drug use. He was on no prescribed medications. He did have a fairly normal PSA of about 119 and I had ordered a renal ultrasound which showed fairly normal-sized kidneys and no evidence of hydronephrosis or mass, but it was consistent with increased echogenicity in the cortex, findings representative of medical renal disease.,PHYSICAL EXAMINATION:,Vital signs: Blood pressure is 153/77, pulse 66, respiration 18, temperature 98.5.,General: He was alert and oriented x 3, in no apparent distress, well-developed male.,HEENT: Normocephalic, atraumatic. Pupils are equal, round, and reactive to light. Extraocular muscles intact.,Neck:

Supple. No JVD, adenopathy, or bruit.,Chest: Clear to auscultation.,Heart: Regular rate and rhythm without a rub.,Abdomen: Soft, nontender, nondistended. Positive bowel sounds.,Extremities: Showed no clubbing, cyanosis. He did have 2+ pretibial edema in both lower extremities.,Neurologic: No gross focal findings.,Skin: Showed no active skin lesions.,LABORATORY DATA: , Sodium 138, potassium 6.1, chloride 108, CO2 22, glucose 116, BUN 111, creatinine 7.29, estimated GFR 10 mL/minute. Calcium 7.4 with an albumin of 1.9. Mag normal at 2.2. Urine culture negative at 12 hours. His Random urine sodium was low at 12. Random urine protein was 4756, and creatinine in the urine was 538. Urine drug screen was unremarkable. Troponin was within normal limits. Phosphorus slightly elevated at 5.7. CPK level was 234, white blood cells 6.5, hemoglobin 12.2, platelet count 188,000 with 75% segs. PT 10.0, INR 1.0, PTT at 27.3. B-natriuretic peptide 718. Urinalysis showed 3+ protein, 4+ blood, negative nitrites, and trace leukocytes, 5 to 10 wbc's, greater than 100 rbc's, occasional fine granular casts, and moderate transitional cells.,IMPRESSION:,1. Acute kidney injury of which etiology is unknown at this time, with progressive azotemia unresponsive to IV fluids.,2. Hyperkalemia due to renal failure, slowly improving with Kayexalate.,3. Microscopic hematuria with nephrotic range proteinuria, more consistent with a glomerulonephropathy nephritis.,4. Hypertension.,PLAN: , I will give him Kayexalate 15 gm p.o. q.6h. x 2 more doses since he is responding and his potassium is already down to 5.2. I will also recheck a

urinalysis, consult the surgeon in the morning for temporary hemodialysis catheter placement, and consult case managers to start work on a transfer to ABCD Center per the patient and his wife's request, which will occur after his second dialysis treatment if he remains stable. We will get a BMP, phosphorus, mag, CBC in the morning since he was given 80 mg of Lasix for fluid retention. We will also give him 10 mg of Zaroxolyn p.o. Discontinue all IV fluids. Check an ANCA hepatitis profile, C3 and C4 complement levels along with CH 50 level. I did discuss with the patient and his wife the need for kidney biopsy and they would like the kidney biopsy to be performed closer to home at Ochsner where his family is, since he only showed up here because of the nearest hospital located to his offshore job. I do agree with getting him transferred once he is stable from his hyperkalemia and he starts his dialysis.,I appreciate consult. I did discuss with him the importance of the kidney biopsies to direct treatment, finding the underlying etiology of his acute renal failure and to also give him prognostic factors of renal recovery.