CHIEF COMPLAINT:, ""My potassium is high"",HISTORY OF PRESENT ILLNESS:, A 47-year-old Latin American man presented to the emergency room after being told to come in for a high potassium value drawn the previous day. He had gone to an outside clinic the day prior to presentation complaining of weakness and fatigue. Labs drawn there revealed a potassium of 7.0 and he was told to come here for further evaluation. At time of his assessment in the emergency room, he noted general malaise and fatigue for eight months. Over this same time period he had subjective fevers and chills, night sweats, and a twenty-pound weight loss. He described anorexia with occasional nausea and vomiting of non-bilious material along with a feeling of light-headedness that occurred shortly after standing from a sitting or lying position. He denied a productive cough but did note chronic left sided upper back pain located in the ribs that was worse with cough and better with massage. He denied orthopnea or paroxysmal nocturnal dyspnea but did become dyspneic after walking 2-3 blocks where before he had been able to jog 2-3 miles. He also noted that over the past year his left testicle had been getting progressively more swollen and painful. He had been seen for this at the onset of symptoms and given a course of antibiotics without improvement. Over the last several months there had been chronic drainage of yellowish material from this testicle. He denied trauma to this area. He denied diarrhea or constipation, changes in his urinary habits, rashes or skin changes, arthritis, arthralgias, abdominal pain, headache or visual changes.,PAST

MEDICAL HISTORY:, None.,PAST SURGICAL HISTORY:, Mone.,MEDICATIONS:, Occasional acetaminophen.,ALLERGIES:, NKDA.,SOCIAL HISTORY:, He drank a 6 pack of beer per day for the past 30 years. He smoked a pack and a half of cigarettes per day for the past 35 years. He was currently unemployed but had worked as a mechanic and as a carpet layer in the past. He had been briefly incarcerated 5 years prior to admission. He denied intravenous drug use or unprotected sexual exposures.,FAMILY HISTORY:, There was a history of coronary artery disease and diabetes mellitus in the family.,PHYSICAL EXAM:,VITAL SIGNS - Temp 98.6° F, Respirations 16/minute Lying down - Blood pressure 109/70, pulse 70/minute Sitting - Blood pressure 78/65, pulse 79/minute Standing - Blood pressure 83/70, pulse 95/minute GENERAL: well developed, well nourished, no acute distress HEENT: Normocephalic, atraumatic. Sclerae anicteric. Oropharynx with hyperpigmented patches on the mucosa of the palate. No oral thrush. No lymphadenopathy. No jugular venous distension. No thyromegaly. Neck supple. LUNGS: Decreased intensity of breath sounds throughout without adventitious sounds. No dullness to percussion or changes in fremitus. CARDIOVASCULAR: Regular rate and rhythm. No murmurs, gallops, or rubs. Normal intensity of heart sounds. Normal peripheral pulses. ABDOMEN: Soft, non-tender, non-distended. Positive bowel sounds. No organomegaly. RECTAL: Normal sphincter tone. No masses. Normal prostate. Guaiac negative stool. GENITOURINARY: Left

testicle indurated and painful to palpation with slight amount of pustular drainage expressible on anterior aspect. Right testicle normal. EXTREMITIES: Marked clubbing noted in fingers and toes. No cyanosis or edema. No rash or arthritis. LYMPHATICS: 1 x 1 cm mobile, firm, non-tender lymph node noted in left inguinal region. Otherwise no other palpable lymphadenopathy.,CHEST X-RAY:, Ill-defined reticular densities in both apices. No pleural effusions. Cardiomediastinal silhouette within normal range.,CHEST CT SCAN:, Multiple bilateral apical nodules/masses. Largest 3.2 x 1.6 cm in left apex. Several of these masses demonstrate spiculation. There is an associated 1 cm lymph node in the prevascular space as well as subcentimeter nodes in the pretracheal and subcarinal regions. There is a subcarinal node that demonstrates calcifications.,ABDOMINAL CT SCAN: ,Multiple hypodense lesions are noted throughout the liver. The right adrenal gland is full, measuring 1.0 x 2.3 cm. Otherwise the spleen, pancreas, left adrenal, and kidneys are free of gross mass. No significant lymphadenopathy or abnormal fluid collections are seen.,TESTICULAR ULTRASOUND: ,There is an enlarged irregular inhomogenous left epididymis with increased vascularity throughout the left epididymis and testis. There is a large septated hydrocele on the left. The right epididymis and testis is normal.,HOSPITAL COURSE:, The above-mentioned studies were obtained. Further laboratory tests and a diagnostic procedure were performed.