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KISUMU COUNTY REFERRAL HOSPITAL P. O. BOX 1818, KISUMU

IN-PATIENT/OUT-PATIENT CONTINUATION SHEET

IP NO: IP-163FC38771 NAME: NM-61994024F9 EXACT AGE: 50 yrs SEX: m ADDRESS: Ohnbezi DATE: 3/12/25

-CIC -Generalized body swelling -Inability to walk -Chest pain -Difficulty in breathing -Fatigue

HPI Patient reports that he was last well okay, three months before admission when he reported to have had bilateral lower limb swelling that had an insidious onset steadily rising from the lower legs going upward to the knees, waist and now affects the entire body. He reports that the swelling is associated with chest congestion and the swelling is concentrated in the inguinal areas.

-The patient also reports of inability to walk for the past four days that had a sudden onset without any associated relieving factors and there is associated bilateral knee pain.

-The patient also reports of chest pain felt at both chest areas not radiating anywhere associated with difficulty in breathing. He reports no cough, has chest congestion and reports no history of fainting.

-He reports of having no known chronic condition. -He also reports...

PAG-IBIG

CNS - No headache - No dizziness - No Fainting

CVS - No cough, PDB, Generalised Body Swelling No palpitation - No PMD

GIT - No anorexia, No diarrhoea, No constipation

GUT - Increased Frequency - No dysuria - Low urine Flow rate - Longer period of micturition

Mass - Joint pains

Skin - No wounds - Non remarkable

RLS - No cough - Has DIB - Has chest congestion

PMCHX

- Under admission
- Patient has been treated on anti-TB on 2 occasions in 1995 and early 2000 and he reports to have completed his medications
- No known drug & Food allergy

<::attestation: Signature Signed Signature: legible P. SIEHL Blue handwritten signature with a horizontal line beneath it, centered on a white background.::>

- Businessman
- Not married and living alone
- Divorced and the wife has the children

- Alcoholic who last taken alcohol on September 2025
- Reports to smoke

Family Hx - Patient is a FIFTH born in a family of Seven - Reports no known Chronic Familial disease

O/E No pallor No jaundice No oral thrush No lymphadenopathy No dehydration - Generalised body oedema - No finger clubbing - No flappy tremors - No varicose veins

S/E - CVS - S1 S2 heard - Neck pulse - R/S - Normal breath sounds P.A - Hard abdomen - Massacre puss

KISUMU COUNTY REFERRAL HOSPITAL P. O. BOX 1818 , KISUMU

CASE SUMMARY

IP NO: IP-8C861CC7A5		
NAME: NM-2A37161508		
EXACT AGE	47	
SEX	MALE	
ADDRESS:..	(text and dotted line)	
DATE:	Row of dots	

DATE OF ADMISSION .....

DATE OF DISCHARGE / DETAILS .....

CONSULTANT DR. KARA

DIAGNOSIS CHRONIC KIDNEY DISEASE / CONGESTIVE CARDIAC FAILURE

Patient came in with the following complaints, dyspnoea, inability to walk, difficulty in breathing, fatigue.

Intervention:

FHG: moderate anaemia Hb 6.7g/dl.

2ECS-8 albumin 26.4g/L, LDL 132.5, HDL 95.4, creatinine 530.2µmol/L, eGFR 9mL/min/1.73m²

A diagnosis of end stage kidney disease was made.

Medication: Spironolactone, Furosemide, Propranolol, Onata [illegible], Empagliflozin, Paracetamol,

SUMMARY:

Discharge Plan

1. Candesartan 1 tab OD x 1/2
2. P.O. Spironolactone 50mg OD x 1/2
3. P.O. Furosemide 40mg OD x 1/2
4. P.O. Empagliflozin 10mg OD x 1/2

Patient is being discharged for nephrology

management at JOOTRH Dr. A. Omollo [illegible] moi.