Nephrology CPC

Katrina Duplechain, M.D.
December 9, 2005
Case

Mrs. Y is a 53 y/o white female referred to nephrology for acute deterioration of renal function.

Patient has a 3 month h/o malaise, 20 lb weight loss, questionable peptic ulcer, erratic vomiting, some LE edema, and intermittent low-grade fevers.
Case

Because of these concerns, she underwent a cholecystectomy 2 months prior, showing cholecystitis and gall stones, but her sxss did not improve.
Case

- The patient’s serum creatinine in Oct 2003 was 0.9. In Oct 2004, at the time she began having these problems, her creatinine had risen to 1.9. Couple of weeks later, before her referral, her creatinine had risen into the 6’s.
Case

- ROS:
  - Changes in vision with flashes of light
  - BP has become low and she is off of her BP meds now
  - Polyuria and nocturia
  - Mild constipation
  - Erratic joint pain for several months, but with no true major inflammation
  - Anxiety and difficulty sleeping
Case

PMH:
- HTN for 3-4 yrs medicated with HCTZ
- Hyperlipidemia, not treated
- Mild chronic venous insufficiency
- Recurrent skin lesions on neck/leg with previous bx of a nasal lesion at outside institution with uncertain dx
Case

- **PSurgHx:**
  - Cholecystectomy with hernia repair 2 months prior
  - Tonsillectomy age 9
  - Tubal ligation age 39

- **Medications:**
  - Prilosec 20 mg QD
  - HCTZ stopped 6 wks prior to evaluation
  - Occasionall NSAID (Aleve, Ibuprofen, ASA) use – less than 1-2 per wk
Case

- **Soc Hx:**
  - Single, worked as a business assistant at A&M University
  - H/o smoking, but quit 20+ yrs ago
  - No alcohol or drug use

- **FHx:**
  - Father – died age 81 with pneumonia
  - Mother – died age 75 with PE
  - Brother – diabetes
  - Aunt – breast ca
  - Uncle – colon ca
Physical Exam

- Vitals: BP 150/80 with no orthostasis, P 68 regular, 5'7' wt 244 lbs, Afebrile
- Gen: AA, oriented, NAD, obese
- HEENT: nml eye exam
- Neck: No JVD, LAD, or carotid bruits
- CV: Reg rhythm without m/r/g
- Resp: Diminished breath sounds at bases, otherwise clear
- Abd: obese limited exam with no mass or tenderness
- Ext: good pulses
- Neuro: no focal deficits, CN intact
- Skin: chronic venous stasis of LE with 1+ edema; several large erythematous flaking lesions on R knee
Labs

- 3 days prior to admission:
  - UA (done by nephrology): few granular and hyaline casts present, few epithelial cells, 1+ protein, **NO WBCs, NO RBCs**
  - Bun 57, Creat 6.5, Na 136, K 3.3, Cl 98, Bicarb 22,
  - Hgb 9.4, Hct 28.0, Plt 153,000
  - PT/PTT nml
  - C3/C4 nml, ANA neg
  - Renal US: Unremarkable except for some questionable minor cysts
  - CXR: nml
Case

- Patient was admitted for further studies and diagnostic intervention.
Problem List

- Rapidly progressing renal failure
- Proteinuria
- Recurrent skin lesions
- Changes in vision
- Erratic joint pain
- Intermittent low-grade fevers
- Polyuria

- Nocturia
- 20 lb weight loss
- GI sx/s/vomiting
- HTN
- Hyperlipidemia
- Mild chronic venous insufficiency
- Hypokalemia
- anemia
Rapidly Progressive Renal Failure

- Glomerular Filtration Rate (GFR) – sum of filtration rates in all of functioning nephrons
- When GFR halves – creatinine doubles in a steady state; Problem – given the rapid deterioration of renal function, this is not a steady state
Rapidly Progressive Renal Failure – Cockcroft Gault Method

- Serum creat, wt, age, gender
- GFR 10/03 - 126.2 ccs/min
- Creat 10/03 – 0.9
- GFR 10/04 – 59.8 ccs/min
- Creat 10/04 – 1.9
- GFR 2 wk later – 17.5 ccs/min