Ambulatory Clinic Note
02/15/2007

Problems: Problems will be delineated below

Chief Complaint: Dysfunctional uterine bleeding

Subjective:
This is the initial clinic visit for this very pleasant 55-year-old black female. She states she went through menopause in 2004 uneventfully. Her husband died in April, 2006. In June of 2006 she had uterine bleeding for three days, then August through December she bled constantly. At the end of December she began bleeding again and is currently still having bleeding. She developed a craving for ice the last several months. Her weight is coming down she states because of changes in the way she eats, she was up to 400 she is down now to 367. Remainder of her problems will be delineated below.

Past Medical History: No known allergies

Medications:
1. Norvasc 10 mg
2. Hydrochlorothiazide 25 mg
3. Altace 5 mg

Operations: None

Hospitalizations: None

Habits: No tobacco. No alcohol. No illegal drugs.

Usual childhood disease with sequela.

Family History: Positive for hypertension

Review of Systems:
Head and Neck: She saw an ophthalmologist in 2004. No complaints of headache.
Pulmonary: Denies pneumonia, bronchitis or tuberculosis
Cardiovascular: States she has been hypertensive for about a year, currently on the medicines above. Blood pressure today is 154/71. Denies myocardial infract, hyperlipidemia, chest pain or shortness of breath.
Gastrointestinal: She had a colonoscopy in 08/2005 for screening. Denies reflux disease or bowel problems. Her weight is down, she states when she graduated from high school she weighed about 200 pounds.
Genitourinary: Gravida 1 para 1, child weighed two-pounds was premature for unknown reason in 1970. Denies gestational diabetes. Last mammogram was several years ago, she has one scheduled coming up.

Extremities: She has some intermittent back pain and knee pain. She has an x-ray from 06/2006 of her left knee, which shows degenerative joint disease.
Psychosocial: She works as a supervisor for a local medical office.
Lives alone in a house. Alert and oriented.

Objective:
Well-developed morbidly obese black female.
Vital Signs: Height: 69 inches, Weight: 350, blood pressure: 154/71, pulse: 84, respirations: 18.
HEENT: Pupils are equal round and reactive to light, fundi benign, sclerae clear. Oropharynx: mucus membranes are moist without lesions.
Lymphatics: None palpated
Neck: Carotids are equal
Lungs: Clear
Cardiovascular: Regular rate and rhythm without murmurs
Gastrointestinal: Abdomen above plane, soft, non-tender, no hepatosplenomegaly.
Musculoskeletal: Extremities: Trace pretibial edema. Dorsalis pedis and posterior tibial pulses are 2+ and equal. Feet are in good repair.

Assessment:
1. Dysfunctional uterine bleeding
2. Hypertension
3. Degenerative joint disease
4. Pica

Plan/Diagnostic:
1. CBC
2. Chem 14

Plan/Therapeutic:
1. Norvasc 10 mg daily
2. Hydrochlorothiazide 25 mg daily
3. Zestril 20 mg daily

Patient Education:
1. Since the patient probably has anemia told her to get over-the-counter iron and take it three times a day.
2. Discussed weight loss, a good weight for her she thinks would be 200 pounds.
3. We will see her back in one month.
4. Get this lab work done and get her records from doctor.

Labs: Hgb 5.1, creat 1.1 – will get into GYN ASAP.

Pathology Report
02/21/2007

Clinical History: Menorrhagia

Specimen: Endometrial biopsy

Gross Description:
Received in formalin labeled Patient and "endometrial biopsy" is 2.5 x 2 x 0.6 cm of irregular hemorrhagic tissue fragments which are filtered and submitted in total in cassettes A1 and A2.

Microscopic Description:
Microscopic examination is performed.

Final Diagnosis:
Endometrium (Biopsy): Endometrioid adenocarcinoma, FIGO grade 2.

Comment: Concurs

Ambulatory Clinic Note
03/29/2007

Problems:
1. Menorrhagia
2. Hypertension
3. Degenerative joint disease

Chief Complaint:
1. Dysfunctional uterine bleeding

Subjective:
This 54-year-old black female was initially seen in the clinic on 02/15 with complaints of pica, at that time her hemoglobin was 5.1. She has gotten into the GYN Clinic. There are results of pathology reports which show adenocarcinoma of the endometrium. They transfused her. On 02/22 when she was seen in the GYN Clinic her hemoglobin was 4.9. She is feeling much better after the transfusion; she is scheduled to go into the hospital on the 4th. Blood pressure is under good control. Her weight has come down three pounds.

Objective:
Well-developed obese female
Height: 69 inches
Weight: 364 lbs
Blood pressure: 134/64
Pulse: 64
Respirations: 18
HEENT: Pupils are equal round and reactive to light
Lungs: Clear
Cardiovascular: Distant heart tones
Extremities: No edema

Assessment:
1. Dysfunctional uterine bleeding
2. Anemia
3. Hypertension

Plan/Diagnostic:
No labs today

Plan/Therapeutic:
1. Norvasc 10 mg daily
2. Hydrochlorothiazide 50 mg daily
3. Zestril 20 mg daily
4. Continue medications from GYN, which are Megace and ____.

Patient Education:
1. Discussed her upcoming surgery
2. We will see her back in two months

Radiology Report
03/31/2007

Chest PA & Lat Routine

Reason for Exam: Neoplasm

Diagnostic Radiology Read
PA and lateral chest. There are no hilar, mediastinal or soft tissue abnormalities. There is moderate hypertrophic spondylosis throughout the thoracic spine with a dorsal kyphosis. The heart is not enlarged. The aorta is somewhat tortuous and ectatic. The lungs are clear of any acute infiltrates.

Impression: Negative chest for age

Operative Report
04/04/2007

Preoperative Diagnosis:
1. Grade II endometrioid cancer of the endometrium
2. Morbid obesity

Postoperative Diagnosis:
1. Grade II endometrioid cancer of the endometrium
2. Morbid obesity
3. Intraoperative acute blood loss

Anesthesia: General endotracheal

Procedure:
1. Exploratory laparotomy
2. Total abdominal hysterectomy
3. Omental biopsy
4. Peritoneal cytology

Transfusion: Three units packed red blood cells

Findings: On frozen section she had approximately a 12-week size fibroid uterus. She had tumor grossly involving the entire surface of the corpus and with some extension into the endocervical canal with no myometrial or cervical stromal invasion; it was Grade II. She weighed approximately 350 pounds and as such extremely difficult to perform the operation leading to a larger blood loss. Intraoperative hemoglobin was 8, at which point we ordered two units of packed red blood cells. There was no gross extra uterine disease, there was no ascites. There was no palpable adenopathy.

Procedure: Patient placed in supine position administered general endotracheal anesthesia, prepped and draped in the usual fashion with Foley catheter inserted and left to gravity drainage. Vertical incision was performed approximately 8 cm above the umbilicus and 10 cm below, carried down through layers until the peritoneal cavity was entered. Peritoneal cytology was obtained, a 6 x 6 x 2 cm portion of omentum was removed, pedicle was tied off with #2-0 silk. Uterus was elevated by clamps; Bookwalter retractor was used for exposure, nonetheless it was very difficult and there were dense adhesions between the rectosigmoid and the posterior aspect of the uterus. Tubes and ovaries were agglutinated to the sidewall of the pelvis. Sharp dissection was required to mobilize the adnexae and to separate the rectosigmoid from the posterior aspect of the uterus. Retroperitoneum was incised allowing entry in retroperitoneal space, the round ligaments isolated, clamped, divided and ligated with #0 chromic. Infundibulopelvic ligaments are isolated, clamped, divided and ligated with #0 chromic. Initially, there was moderate hydronephrosis on the left. After we had the uterus removed, that went down to normal caliber. There was no dilatation to the right ureter. Uterine vessels were clamped, divided and suture ligated with #0 chromic as were the cardinal and uterosacrals. The

bladder freed of the upper vagina. The vagina was clamped, divided and suture ligated with #0 chromic. Additional figure-of-eight closed cuff and ensured hemostasis. Areas of oozing from the rectosigmoid mesentery were controlled with figure-of-eight of #0 chromic. Other areas of oozing were controlled with electrocoagulation and hemoclips. Excellent hemostasis was verified. Due to some of the oozing nature in the posterior peritoneum and cul-de-sac, we applied Gelfoam and thrombin with good hemostasis. All instruments intact and material were removed. Abdominal wall was closed with loop #1 PDS in Smead's fashion with one suture starting from the bottom and one from the top and tied in the midline. Subcutaneous tissue was irrigated, skin approximated with skin staples. Sterile dressing applied over the wound. Foley catheter left to gravity drainage. The estimated blood loss was 900 cc. Urine output 400 cc. Fluid administered 4000 cc of crystalloid and two units of packed red blood cells. Complications none. Patient tolerated the procedure well and left the operating room in good condition for recovery.

Pathology Report
04/04/2007

Clinical History: 54-year-old female with endometrial cancer (grade 2)

Specimen:
A. Uterus
B. Left tube and ovary
C. Omentum

Gross Description:

A. Received fresh for frozen section diagnosis labeled Patient and "uterus" is a 772 gram uterus with attached right adnexa, 15 cm from ectocervix to cornu, 9 cm from left to right and 9.5 cm from anterior to posterior. The serosa is tan pink to hemorrhagic and smooth to shaggy with numerous adhesions as well as 5 subserosal nodules from 0.6 x 0.5 x 0.4 cm to 7 x 5 x 4.5 cm. The nodules have a tan to tan yellow focally hemorrhagic cut surface. The cervical mucosa is tan pink and smooth to erythematous with a 3.8 x 3.6 cm endocervical tissue and cervical cuff as well as an up to 1.8 cm vaginal cuff extending from the anterior rim. The os is slit-like and up to 0.5 cm. Extending from the endocervical canal, 2.5 cm from the ectocervical mucosa, and involving the entire endometrial surface, is an 11 x 6.5 cm tan lobulated tumor mass ranging in thickness from 0.2 cm to 1 cm. Within the endometrial cavity there is a 5.5 x 4.5 x 4 cm polypoid tan tumor mass. The myometrium is tan pink, diffusely trabeculated and up to 5 cm. There are 9 intramural nodules, from 0.6 x 0.4 x 0.4 cm to 1.8 x 1.5 x 1.5 cm. They have tan white whorled cut surfaces. The right tubo-ovarian complex has a fimbriated fallopian tube 5.5 cm long and averaging 0.6 cm in diameter. The serosa is tan pink and smooth with minimal adhesions and the lumen is pinpoint. The 4 x 2 x 1.5 cm right ovary has a tan yellow, smooth serosa with minimal adhesions and the ovarian parenchyma appears grossly unremarkable. The paracervical and parametrial soft tissues are inked. Representative sections are submitted as follows.

A1 6 o'clock cervix
A2 12 o'clock cervix
A3 Subserosal nodules (3)
A4 Subserosal nodule (1)
A5, 6 Posterior lower uterine segment bisected
A7, 8 Anterior lower uterine segment bisected
A9 Shaved sections of right parametrial tissue (2)
A10 Shaved sections right parametrial tissue (2)
A11-13 Shaved sections left parametrial tissue (2)
A14 Base of polypoid mass (1)
A15 Additional section of polypoid mass base (1)
A16 Section polypoid mass
A17-20 Posterior endomyometrium
A22-24 Anterior endomymetrium (1)
A25 Intramural nodules (3)

A26 Tumor posterior endocervix
A27 Tumor at anterior endocervix
A28 Right adnexa (2)

B. Received in formalin labeled Patient and "left tube and ovary" is a tubo-ovarian complex consisting of a nonfimbriated fallopian tube segment 7 cm long and 0.9 cm in diameter. The serosa is tan pink to diffusely hemorrhagic and shaggy with multiple adhesions. The lumen appears dilated up to 0.8 cm and contains hemorrhagic material. There is attached paratubal fatty tissue as well as a 4 x 2 x 1.5 cm ovary. The ovary has a tan pink to hemorrhagic smooth and shaggy serosa with focal adhesions and the ovarian parenchyma appears grossly unremarkable. Representative sections are submitted as follows.

B1 Cross sections of fallopian tube on end (4)
B2, 3 Sections of ovary (1)

C. Received in formalin labeled Patient and "omentum" is an 11.5 x 5 x 1 cm irregular portion of omentum. The specimen consists of lobulated fat with no lesion or nodule grossly identified. Representative sections are submitted in C1. (2)

Microscopic Description
Microscopic examination performed.

Frozen Section Diagnosis:

AFS. Uterus: Endometrial adenocarcinoma, intermediate cytologic grade; superficial; no gross invasion. Grossly apparent involvement of the endocervical canal. Tumor occupies the entire endometrial cavity in association with the large (5.5 cm) polyp. Tumor epithelial thickness ranges from 2 mm to 1 cm.

Final Diagnosis:

A. Uterus and Cervix: Adenocarcinoma, intermediate grade with superficial invasion (2 of 50 mm). Tumor extension into the fibromuscular tissue of lower uterine segment, cervix (anterior) and the submucosal vaginal cuff tissues. Involves the entire endometrial cavity as well as a polyp (5.5 x 4.5 x 4 cm) with invasion of the myometrial stalk. Invasion of the anterior myometrium at the lower uterine segment extending to less than 1 mm of the surgical margin (full thickness invasion). No vascular invasion seen. Perineural invasion present. TNM Stage T3b, NX, MX. Right fallopian tube and ovary: No evidence of carcinoma.
B. Left fallopian tube and ovary: Unremarkable fallopian tube and ovary
C. Omentum, biopsy: No evidence of metastatic carcinoma

Addendum Comment:
Immunoperoxidase stains for P53 are performed and are essentially negative with rare and focal and weak positivity.

CAP SurgPath Cancer Case Summary
Endometrium: Hysterectomy, with or without other organs or tissue

MACROSCOPIC
Specimen Type: Radical hysterectomy (includes parametria)
Tumor Site
Specify location(s), if known: Entire endometrial cavity.
Tumor Size
Dimension: 11 x 6.5 x 2 cm with a 5.5 cm polyp

Other Organs Present (check all that apply)
___None
_x_Right ovary
_x_Left ovary
_x_Right fallopian tube
_x_Left fallopian tube
___Urinary bladder
___Vagina
___Rectum
___Other (s) (specify):_________________

MICROSCOPIC
Histologic Type: Endometrioid adenocarcinoma, not otherwise characterized
Histologic Grade, if applicable (Grading system below applies primarily to endometrioid carcinoma): G2: 6% to 50% nonsquamous solid growth
Myometrial Invasion: Invasion present
Specify depth of invasion: 2 mm
Specify myometrial thickness: 50 mm

EXTENT OF INVASION
Primary Tumor (T)
T3b: Involvement of vagina (direct extension or metastasis), rectal or bladder wall (without mucosal involvement), or pelvic wall(s) (frozen pelvis)
Regional Lymph Nodes (N)
NX: Cannot be assessed
Distant Metastasis (M)
MX: Cannot be assessed

Margins: Uninvolved by invasive carcinoma
Distance of invasive carcinoma from closest margin: 1 mm
Venous/Lymphatic (Large/Small Vessel) Invasion: Absent
Additional Pathologic Findings (check all that apply): None identified

Comment:

Pathology Report
04/04/2007

Clinical History: 54 year-old female with endometrial cancer (grade 2)

Specimen: Peritoneal Washing

Gross Description:
Peritoneal Washing
45 cc, Fixed in 1 cc heparin, bloody, cloudy, clotted
1 thinprep
1 Cell block
1 Wright stain
5 Slides total

Final Diagnosis:
Peritoneum (washing): Negative for malignant cells. Abundant blood.

Urology Consultation Report
04/04/2007

Reason for Consultation: Acute renal failure, hypotension, anemia, hypomagnesemia

History of Present Illness:
The patient is a very pleasant 54-year-old lady status post removal of her uterus, tubes, ovaries, and omentum for endometrial carcinoma that is invasive. History is taken by extensive review of the medical records, discussing with patient, and patient's family. It is apparent that perioperatively she had some episodes of hypotension as low as 93/65, there is some significant blood loss documented. Intraoperatively, blood pressure was as low as 80/40, postoperatively the patient has abdominal discomfort, some nausea, no vomiting, denies chest pain or shortness of breath. She feels rather poorly, weak, tired, and dizzy; there's been no melena or hematemesis or bright red blood by way of rectum.

Physical Examination:
Constitutional: Feeling poorly.
HEENT: Negative. Eyes negative.
Cardiac: Negative
GI: Negative
GU: As above, no gross hematuria, dysuria or frequency, or urgency
Musculoskeletal: Back pain
Skin: Negative
Psychiatric: Negative
Neuro: Negative

Past Medical History: Significant for hypertension, obesity, anemia, and arthritis

Past Surgical History: Non-documented

Social History: Denies any drug abuse

Family History: No diabetes, nobody on dialysis

Objective:
General: Middle aged lady in no distress at the time of examination
Vital Signs: Blood pressure earlier 86/48, 78/51, currently 107/58, temperature 98.1
HEENT: No scleral icterus. Oropharynx clear.
Neck: Supple
Lungs: Clear to auscultation bilateral, no wheezing, rhonchi, or crackles, dullness to percussion.
Heart: Regular rhythm and rate, S1, S2 no gallops, no rubs, clicks, or murmurs.
Abdomen: With positive bowel sounds, soft, mild lower abdominal tenderness, no rebound, no guarding, no hepatosplenomegaly.
Extremities: Without clubbing, cyanosis, or edema
Skin: Warm and dry

Neurological Exam: Is grossly intact, no lymphadenopathy, she had diminished range of motion in her knees.

Laboratory Data:
On the 31st showing a BUN 21, creatinine at 1.1, this morning there is a BUN at 24, creatinine at 2.1, sodium 144, potassium 4.0,___115, bicarb 22, magnesium 1.5, iron saturation 11%, TIBC 204, white count 14.4, hemoglobin 7.6. Chest x-ray showing this morning poor inspiratory film right basilar atelectasis.

Assessment and Plan:
1. Acute renal failure, I suspect this is related to the transient hypotension she has experienced; probably due to significant blood loss. Will go ahead and transfuse her given her significant anemia. Will check an H&H after her last unit, and give her more blood if it is less than 8. Iron studies are consistent with chronic blood loss on top of the acute blood loss, which will be addressed with IV iron and Epo 30,000 units of q now. Will go ahead and check urine, electrolytes, sodium, potassium, chloride, will change IV fluids to normal saline 100 cc per hour after the blood transfusion for two liters to repeat intravascular volume. Given her decreased GFR, we will go ahead and stop the Lovenox. We are going to stop the oral iron sulfate, stop the Hydrochlorothiazide/Norvasc given the hypotension, and closely monitor for the duration. Her magnesium will be replaced with 2 grams IV with saline and repeat in the morning.

Thank you for allowing me to participate in the care of this very nice, but unfortunate lady; will follow with hoped improvement and recovery.

Ambulatory Clinic Note
06/26/2007

Problems:
1. Endometrial carcinoma
2. Anemia
3. History of renal failure

Chief Complaint: Vomiting

Subjective:
This 54-year-old black female was last seen in the clinic in February. She underwent exploratory lap, TAH w/ S O on 4/4/07. She had significant blood loss during the procedure and received 3 units packed cells.

There is not an H&P or Discharge summary available from that hospitalization. The consult note states she went into renal failure, was discharged with a creat of 1.1, HBG 9.8. She underwent radiation therapy, evidently uneventfully. One week ago she developed nausea and vomiting. For the last 4 days she has been unable to hold anything down. Her weight was 359 on April 7 and today she weighs 298. She states someone gave her some nausea pills, but they have not helped decrease her vomiting. She states she had a bowel movement this morning. She has history of hypertension. The remainder of her past medical history is uneventful.

Objective:
General: Well-developed, obese black female sitting in a chair, vomiting bilious material.
Vital Signs: Weight 298, blood pressure 106/62, pulse 94, respirations 18, temperature 96.8.
HEENT: PERRL. Sclerae muddy
Lungs: Clear
CV: Distant heart tones.
GI: Bowel sounds are decreased, tender to deep palpation. Surgical wound in the umbilicus is malodorous.
Extremities: No edema

Assessment:
1. Nausea and vomiting
2. Possible small bowel obstruction
3. Endometrial CA

Plan:
Doctor was called, as he was the last person to see the patient and the history that indeed she had uneventful radiation therapy and that this is a new problem with her bowel. She was seen and evaluated by doctor. We will send her to the emergency room for evaluation. This was discussed with the patient. She was sent for CBC and Chem-14. This was discussed with the patient and her husband. We will see her back after this hospitalization.

Discharge Summary

Date of Admission: 06/26/2007

Date of Discharge: 07/05/2007

Admission Diagnosis:
1. Acute renal failure
2. Anion gap metabolic acidosis
3. Hypertension

Discharge Diagnosis:
1. Acute renal failure
2. Hypertension
3. Anemia

Consultant: Nephrology

History and Physical:
This is a 54-year-old female African American patient who has come to the hospital with nausea and vomiting of 2 weeks' duration, extreme fatigue, and 70 pounds weight loss since April 2007. Currently, the patient feels improved, passes urine adequately and without difficulty. No history of bleeding.

Physical Examination at Discharge:
Generally: She was stable. Body habitus was obese.
Vital Signs: Temperature 97.3, pulse rate 67, respiratory rate 18, blood pressure 126/83, oxygen saturation 99.
HEENT: Pupils are reactive and equal. Extraocular muscles are intact.
Chest: Resonant to percussion, clear to auscultation
CVS: JVP not elevated, S1 and S2 well heard no murmur or gallop rhythm
Musculoskeletal system: Patient has a slight pitting edema on the legs.

Past Medical History: Hypertension, endometrial CA, anemia, acute renal failure.

Past Surgical History:
In April, 2007, Exploratory laparotomy with total abdominal hysterectomy and bilateral salpingo-oophorectomy for Endometrial CA during which 3 units of blood was also transfused.

Course and Hospital Stay:
The patient was treated with sterile saline flashes and later central line was placed.
Weight at admission was 298 lbs.
Weight at discharge was 321 lbs at upright position.
At admission BUN: 235 and creatinine: 22.3. BUN/creatinine ration: 10.5.

At discharge BUN: 32, creatinine: 2.0. BUN/creatinine ratio: 16.0, which showed a marked improvement in her renal function from admission. Blood cultures were positive for Staphylococcus epidermidis at the first sample and the second blood culture was positive for bacillus gram-positive rod, for which she was treated with cefepime and the patient was negative for blood culture at discharge. In the meantime, she was started on iron sucrose and erythropoietin on a weekly basis for her anemia. Multivitamins and folate was supplemented. Her electrolytes were monitored on a daily basis and were supplemented. The patient was discharged in a stable condition.

Discharge Condition: Stable

Medications at Discharge:
1. Ferrous sulfate 325 mg by mouth 3 times a day
2. Multivitamins 1 tablet by mouth per day
3. Folic acid 1 mg by mouth per day
4. Magnesium oxide 800 mg by mouth per day for 3 days
5. Norvasc 10 mg by mouth daily
6. Lisinopril 20 mg by mouth daily
7. Levaquin 250 mg by mouth daily for 3 days

Follow up: Patient discharged with follow up to her primary care physician.
The patient was advised not to take any nonsteroidal anti-inflammatory drugs or ibuprofen.

US Kidneys Report
06/27/2007

Reason for Exam: Other: Abnormal or suspicious clinical findings, symptoms, or laboratory/diagnostic results, not specified

Rad CGD US Read

Ultrasound of the kidneys 6/27/2007

Clinical Information: Acute renal failure

Right Kidney: The right kidney size approximated 12.1 cm with diffuse increased echotexture of the renal parenchyma. No evidence of significant hydronephrosis.

Left Kidney: The left kidney size approximated 10.6 cm with increased echotexture of the renal parenchyma. No evidence of significant hydronephrosis.

Impression: Increased echotexture of the renal parenchyma of both kidneys which could be compatible with that of medical renal disease. No evidence of hydronephrosis.

Radiology Report
07/05/2007

US Abdomen

Reason for Exam: Other: Abnormal or suspicious clinical findings, symptoms, or laboratory/diagnostic results, not specified

Rad CGD US Read
Scanning of the abdomen demonstrates the liver to be top normal at 19 cm craniocaudad. The liver may be slightly fatty infiltrated.

There is fairly dense shadowing from the gallbladder fossa possibly due to gallbladder packed with stones although bowel can occasionally present with similar appearance. Follow up study is recommended in this regard.

The common duct measures 3 mm.

The pancreas is not visualized due to bowel gas.

The spleen is not enlarged.

The proximal aorta and IVC are grossly normal in appearance.

The right kidney measures 11.9 and the left kidney measures 11 cm longitudinally with no mass or hydronephrosis.

Impression:
1. Dense shadowing from the gallbladder fossa possibly related to a gallbladder packed with stones although occasionally bowel can present with a similar appearance. Follow up limited study of the gallbladder might be considered.
2. The pancreas is not visualized due to bowel gas.
3. The liver is slightly enlarged and probably fatty infiltrated.

Ambulatory Clinic Note
08/22/2007

Problems:
1 Hypertension
2 Degenerative joint disease
3 Renal insufficiency
4 Cancer of the endometrium

Chief Complaint: Hypertension

Subjective:
This 55-year-old morbidly obese black female was hospitalized June 26 – July 5 for dehydration and acute renal failure. Her discharge lab work showed hemoglobin of 7.6 with a creatinine of 2.0. She underwent TAH with S O in April 2007 for endometrial cancer and had radiation therapy. She was seen in this office on the day of admission with constant vomiting and dehydration. She was admitted. Today her blood pressure is under good control. Her weight is stable at 320. Her weight has come down from her initial weight in the clinic of 367. Currently she is on a 2000-calorie diet with low salt. No complaints. Bowel habits are normal. She has recently seen her gynecologist.

Objective:
General: Well-developed, morbidly obese black female in no acute distress.
Vital Signs: Height 5 feet 9 inches, weight 320, blood pressure 128/61, pulse 66, respirations 20.
HEENT: PERRL. Oropharynx reveals mucous membranes are moist and without lesions.
Lungs: Clear
CV: Distant heart tones.
GI: Abdomen soft, nontender
Extremities: No edema

Assessment:
1. Hypertension
2. Renal insufficiency

Plan: Diagnostic CBC, Chem-8

Therapeutic
1. Norvasc 10 mg daily
2. Zestril 20 mg daily
3. Ferrous sulfate t.i.d.
4. Folate 1 mg daily

Patient Education: Discussed diet. Recommended continued weight loss.
Labs: Creat. 1.6, Hgb 9.4 – Improving. No changes.

Return to clinic in 3 months, or earlier p.r.n.