18 March 2011
09:30

S: C.E. is a 64 year-old white male with a history of renal insufficiency, DVT is his left lower extremity, sleep apnea, and IBS who presents for a 3 month follow up of hypertension. He does have 3 acute complaints today. First, C.E. states that he has had increased swelling in his left lower extremity for the past 3 weeks. He has had this problem off and on since his DVT several years ago. He is unaware of any precipitating event, the swelling is not painful, and it seems to be worse at the end of the day than in the morning. He denies chest pain, shortness of breath, and recent changes in his diet. Second, C.E. states that he has been having more "stomach growling" and bloating for the past several weeks. This has been a chronic component of his IBS, but is causing more problems and discomfort for the past few weeks. He denies changes in his bowel habits, melena, and hematochezia. He normally has 2-3 bowel movements per day. He states that he has had no "heartburn," but he does have chronic halitosis and is unable to tell if he has had had a sour taste in his mouth. He has been using his CPAP every night. Finally, C.E. states that his mood has been depressed lately, and describes a prominent anhedonia by saying "all I enjoy doing is eating." He denies suicidal and homicidal ideations.

PMH: Essential hypertension, chronic renal insufficiency, hyperlipidemia, obstructive sleep apnea, renal cell carcinoma, DVT of left lower extremity.

Preventive health: Not discussed at this visit.

Social Hx: Drinks alcohol on weekends, "2-3 beers" with his wife. Does not smoke or use illicit drugs.

Meds:

1. Acetaminophen 500 mg QD.
2. Amlodipine 10 mg QD.
3. Aspirin 81 mg QD
4. Furuosemide 40 mg QD.
5. Hydralazine 25 mg BID.
6. Metoprolol 100 mg BID.
7. Simvastatin 40 mg QHS.
8. Spironolactone 25 mg QD.

Allergies: NKDA.

O:

- Vitals: BP 120/80. Temp 97.3°F. HR 78. RR 16. Weight 225 lbs, up 3 lbs from last visit. BMI 34.2.
- General: Patient is alert and oriented X3 in no acute distress. Very pleasant gentleman who was a pleasure to work with.
- HEENT: Sclera not injected. TMs pearly grey with normal light reflex. No nasal congestion. Throat is non-erythematous.
- CV: RRR without murmurs/rubs/gallops.
- Resp: CTA in all fields bilaterally without wheeze/rhonchi/crackles.
- Abd: Soft, non-tender, non-distened without hepatosplenomegaly, or pulsations. Patient does have multiple rubbery, mobile, non-tender small masses diffusely thorough abdomen. Bowel sounds present. No bruit.
- Extremities: 3+ edema in LLE. 2+ edema in RLE. Peripheral pulses 2+ bilaterally. Patellar reflex 2+ bilaterally. Once again, there are several rubbery, mobile, non-tender masses present.

Diagnostic Testing: None at this visit.

A: My impression is of a 64 year-old male with hypertension, post-phlebotic venous insufficiency, sleep apnea, and IBS who is now showing signs of depression.

I do not believe that this patient is having a recurrence of his previous DVT at this time. Dr. Nordstrom, the patient's regular primary care physician, also examined the patient and has noted that C.E. generally has more edema in the LLE than on the right and that the amount of edema he is experiencing now only appears to be mildly changed, if at all. The patient did admit that he has not been wearing his compression stockings, and does have RLE edema as well. He also takes amlodipine, which likely contributes to the edema. I feel the most likely explanation for these findings is venous insufficiency, and the left is worse than the right due to damage from the previous clot.

C.E. has a pain predominant IBS that is more consistent with diarrhea than constipation. His primary concern is feeling "bloated" but does admit to some discomfort as well. He denies many of the behaviors associated with gas buildup, such as chewing gum, drinking through a straw, or drinking carbonated beverages on a regular basis. He is aware of food triggers such as broccoli and caulifower. He does eat more red meat than he should, consistent with a typical Western

diet, and we discussed that high fat foods may also trigger his IBS symptoms. The CPAP is likely a significant contributing factor to this as it will make him swallow air, and C.E. is aware of this, but also understands the importance of continuing to use the CPAP nightly.

C.E. does show signs of depression, and has had mild symptoms in the past. I feel that it will be best to address the depression with a medication that also may help with his abdominal discomfort. While both SSRIs and TCAs have been used for pain in IBS, the SSRIs tend to increase the frequency of patient's stools, so I feel that a TCA will be more appropriate in this situation as it has some anti-cholinergic effect that can decrease the frequency of stools.

The rubbery masses felt on exam are likely to be lipomas. The patient's father and brother also have these. I do not find these to be concerning.

P:

1. LLE edema. Recommended that the patient wear his compression stockings and limit the amount of sodium in his diet. I will continue to watch this, and have advised the patient about symptoms suggestive of a pulmonary embolus. At this time, I do not feel that duplex US of the lower extremity is necessary, but I will consider this with any worsening of the edema, and if the patient develops signs or symptoms consistent with PE he will be admitted for evaluation.
2. IBS. I will start the patient on nortriptylene at dosing consistent with use for depression. My hope is that this will address both the IBS symptoms and the depression. We discussed dietary triggers extensively, and C.E. will continue to monitor and attempt to avoid triggers.
3. Depression. Patient will be started on nortriptylene as above.
4. Patient to follow up in 3 months for check of blood pressure and monitoring of his mood and IBS symptoms. He has been instructed to call the office if his mood worsens or he starts to have intrusive thoughts of self-harm. He will also call if the compression stockings are not improving his edema, or if he develops symptoms consistent with PE.

MEDICAL STUDENT, M3