

## CONSULTATION REPORT

**PATIENT NAME :** James Washington

**ATTENDED BY :** K. P. Ganeshappa, M.D.

**PATIENT ID :** JamWas000

**REFERRED BY :** John Williams, M.D.

**DATE OF BIRTH :** 12/31/1958

**AGE:** 51

**SEX:** Male

**EXAM DATE:** 07/28/2009

**CHIEF COMPLAINT /PRESENT ILLNESS:**

50 y/o male with history of hypertension, heart disease. Referred for evaluation of Hepatitis C

LFTs normal

ELISA positive

HCV RNA undetectable

**MEDICATIONS:**

Ramipril-10 mg

Lipitor-20mg

Warafin-5 mg

Amlodipine-5 mg-1 tab daily

Carvedilol-6.25 mg-1 tab two times daily

**ALLERGIES:**

NKDA

**MEDICAL HISTORY:**

Hypertension - 401.9, HCV 070.54

**SOCIAL HISTORY:**

**SMOKING :** Patient denies smoking.

**ALCOHOL :** Patient denies drinking alcohol.

**CAFFEINE :** Coffee, tea, soda 4 cups per day, for 40 years.

**SLEEP :** Continuity disturbances

**IMMUNIZATIONS :** Current per pt.

**DRUGS :** Patient denies taking drugs.

**EDUCATIONAL NEEDS :** Patient denies barriers to learning.

**SYSTEMS REVIEW:**

**GENERAL:** Patient experiences no chills. Patient experiences no abnormal sweating. No history of fever or chills. No history of loss of appetite. No history of weakness. No history of weight gain or loss.

**CARDIAC/RESPIRATORY:** No history of pain in chest. No claudication. No history of cough. No dyspnea. No edema. No hemoptysis. No history of murmurs. No nocturia. No orthopnea. No palpitation. No pleuritic pain. No history of shortness of breath. No sputum. No wheezing.

**GASTROINTESTINAL:** No history of abdominal pain. No history of loss of appetite. No history of bloating. No history of blood in stools. No history of constipation. No history of diarrhea. No dysphagia. No history of heartburn or hemorrhoids. No history of jaundice. No history of nausea, regurgitation or vomiting.

**PHYSICAL EXAMINATION:**

**BP :** 164/89 **Pulse :** 56 **Resp :** 16 **Height :** 67 inches **Weight :** 183 lbs **BMI :** 28.7 **Temp :** 97.4 F

**GENERAL:** Well developed, well nourished patient. Alert and oriented.

**ABDOMEN:** Does not appear distended. No evidence of Ascites. Bowel sounds present. No evidence of inguinal hernia. Liver and spleen not palpable. No masses palpable. No surgical scars. No tenderness on palpation. The umbilicus appears normal in position.

**LUNGS:** Equal breath sounds. No evidence of any dullness or tenderness on the chest. No evidence of rales. Movements with respiration appear bilaterally symmetrical and normal. Trachea seems in midline. No wheezing.

**CARDIOVASCULAR :** S1 and S2 appear normal. No S3, S4 or murmur. JVP not increased. .

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## **IMPRESSIONS:**

1. Chronic Hepatitis C by antibody. This can represent one of 3 possibilities: 1) Chronic HCV 2) HCV resolved by the patients immune system (20% of the time our own immune response eliminates the virus) 3) False positive antibody. Will look for chronic disease by drawing HCV-RNA and genotype. If negative will get a RIBA to separate false positive from resolved infection. If has chronic disease will get the rest of the serologic evaluation to ensure no concurrent liver diseases and get a liver biopsy to evaluate severity of disease.

2. Immunity to HAV and HBV needs to be determined. Concurrent HAV or HBV with underlying liver disease can lead to increase risk to liver failure. Thus would vaccinate if not immune to HAV and HBV. Liver enzymes are normal so he does not have any chronic liver disease, these would be optional.

## **PLAN:**

Confirm HCV RNA negative

Check immunity to HAV and HBV

Call for results.

No f/u needed as no chronic liver disease and no chronic Hepatitis C

Signature

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K. P. Ganeshappa, M.D.