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Medical Report

Mdm Sigma Huda
DOB: 10.10.1945
YD 0143526

Mdm. Huda was diagnosed to have *type 2 diabetes mellitus* in 1992. She has been treated at various hospitals and clinics with oral hypoglycaemic agents, with good glycaemic control. She was first seen by the endocrinologists at the National University Hospital (NUH), Singapore in January 2006 when she was admitted for an elective cholecystectomy. Her diabetic control was noted to be excellent, with the glycated haemoglobin value (HbA1C) at 6.5%. She was on Glimepiride 6 mg once daily, Rosiglitazone 4 mg once daily, and Metformin 1.5 gm twice daily. She was reviewed by the dietitian and diabetic nurse educator, and received adequate education with regards to the importance of proper dietary intake, the techniques of self monitoring of blood glucose, the importance of regular intake of anti-diabetic medications, and the various micro- and macrovascular complications of diabetes mellitus. She was advised to continue on the three anti-diabetic medications. When reviewed in the clinic 5 months later (May 2006), her HbA1c was noted to be excellent at 6.3%. She was instructed to reduce the dose of Glimepiride should home blood glucose monitoring values get to be persistently below 4–5 mmol/L. She apparently had an episode of severe hypoglycaemia on 23.6.06. Her anti-diabetic medications were stopped for a few days. She was then advised to recommence Metformin 500 mg twice daily in early July 2006, and Rosiglitazone 2 mg once daily in early August 2006. Glimepiride was stopped. As a result of this reduction in anti-diabetic medications, her HbA1c value, measured on 30.8.06, was elevated at 8%, depicting poor glycaemic control. The dose of Rosiglitazone was increased to 4 mg once daily. She was advised to continue on Metformin 500 mg twice daily. She was advised to do home blood glucose monitoring, with a view to further adjusting the dose of her anti-diabetic medications should home blood glucose monitoring values be persistently elevated. She was due for follow-up in the endocrine clinic on 1.12.06.

She was reviewed by Dr. J K Gangadhara Sundar, Consultant Ophthalmologist, on 1.9.06. There was *no evidence of diabetic retinopathy.* She was found to have *early cataracts* in both eyes, and severe bilateral punctual stenosis causing tearing. She was due for follow-up on 29.11.06.

She has *diabetic nephropathy with renal impairment*. She was reviewed by Dr. Rajat Tagore, Consultant Nephrologist, on 31.8.06. Serum creatinine was elevated at 103 umol/L (normal 50-90), with an estimated MDRD GFR of 47 mL/1.73 m^2. Earlier serum creatinine values were 92 umol/L (24.1.06), 78 umol/L (31.1.06) and 89 umol/L (2.5.06). Urine albumin:creatinine ratio was normal [25 mg/gm (N < 30)] on 2.5.06. Dr. Tagore felt that the decline in renal function was most likely due to underlying diabetic nephropathy. However, renal vascular disease needed exclusion, and she was advised to have a MR renal angiogram at her next follow-up visit in November 2006, together with renal function tests. She was advised to continue on Burinex K (Bumetanide, a diuretic).

She is a known *hypertensive*, and is on Bisoprolol 5 mg once daily and Ramipril 2.5 mg once daily. Her blood pressure was 110/70 mmHg when last checked in the cardiology clinic on 31.8.06.

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Mdm. Huda is known to have *hyperlipidaemia*. She was prescribed Atorvastatin 40 mg once daily when last reviewed on 31.8.06. Her total and LDL cholesterol, when measured on 30.8.06, were 3.40 and 2.13 mmol/L respectively. Serum triglyceride was normal (1.36 mmol/L) but serum HDL cholesterol was low at 0.65 mmol/L. A repeat fasting lipid profile was planned during her follow-up visit in November 2006, with a view to further adjust the dose of lipid lowering medication, if necessary.

She was detected to have *ischaemic heart disease (IHD) with double-vessel disease* in January 2006, when she was admitted under Mr. Stephen Chang, Consultant Hepatobiliary Surgeon, for cholecystectomy. Routine pre-operative assessment revealed ventricular ectopics. Cholecystectomy was postponed. Instead, she was seen by A/Prof. Lim Yean Teng, Senior Consultant Cardiologist. MIBI scan revealed reversible defects, consistent with ischemia in the left anterior descending artery territory. Coronary angiogram was performed on 27.1.06. It revealed double vessel coronary artery disease with totally occluded high mid right coronary artery. A 90% stenosis was noted shortly after the origin of the first diagonal branch of left anterior descending artery. In addition, left anterior descending artery also had an intermediate lesion at the proximal LAD, and a 65% lesion in the mid part of the artery. She underwent PTCA. However, intervention attempts at the chronic totally occluded mid right coronary artery lesion were unsuccessful. Coronary stenting was performed to the proximal and mid left anterior descending artery lesions, and balloon angioplasty was performed to the first diagonal branch of left anterior descending artery. When reviewed in May 2006, she complained of occasional episodes of chest discomfort. A repeat coronary angiogram performed on 3.5.06 revealed no re-stenosis in the intervened left anterior descending and first diagonal artery. The right coronary artery remained unchanged. Her occasional chest discomfort was attributed to the chronically occluded right coronary artery. Medical therapy was advised. Repeat angioplasty should be considered should her symptoms of chest discomfort become worse despite full anti-anginal therapy. When last reviewed on 31.8.06, she was advised to take Clopidogrel 75 mg once daily and Trimetazidine MR 35 mg twice daily, together with Bisoprolol 5 mg once daily. She was due for follow-up in the cardiology clinic on 30.11.06.

She underwent *laparoscopic cholecystectomy* on 11.5.06 following stabilization of her cardiac status. She has had an appendicectomy in 1965. In addition, there is past medical history of spondylolisthesis of the spine, and pre-pyloric gastritis.

In summary, Mdm. Huda has type 2 diabetes mellitus for 15 years, with diabetic nephropathy and renal impairment. Her glycaemic control was poor when last reviewed in August 06. The doses of her anti-diabetic medications were adjusted. She was detected to have renal impairment in August 2006 [estimated MDRD GFR of 47 mL/1.73 m^2]. She was advised closer monitoring of her renal function, and further investigations to exclude renovascular disease. She was detected to have IHD in January 2006 with a totally occluded right coronary artery (which could not be stented despite extensive efforts), and high grade stenosis in the left anterior descending artery (stented with 2 cypher stents) and a small diagonal branch (treated with balloon angioplasty). Her blood pressure and serum lipids are well controlled. She does have low HDL values. She was advised follow-up with her Cardiologist, Renal Physician and Endocrinologist in late November 2006; however, she failed to keep these appointments.

Yours sincerely,

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