Medical Report for Patient 006-101872

1. Patient Information

* **Patient Unit Stay ID:** 796205 * **Unique Patient ID:** 006-101872 * **Patient Health System Stay ID:** 608184 * **Gender:** Male * **Age:** 56 * **Ethnicity:** Caucasian * **Hospital ID:** 175 * **Ward ID:** 417 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 05:54:00 * **Unit Admit Source:** Operating Room * **Unit Discharge Time:** 15:29:00 * **Unit Discharge Location:** Acute Care/Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 02:43:00 * **Hospital Admit Source:** Operating Room * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 01:55:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Weight (kg):** 76 * **Discharge Weight (kg):** 72

2. History

The patient was admitted to the Med-Surg ICU from the Operating Room following exploratory laparoscopy. The admission diagnosis was 'GI perforation/rupture, surgery for'. A primary diagnosis of 'gastrointestinal|post-GI surgery|s/p exploratory laparoscopy' was recorded 12 minutes after unit admission. Further details regarding the patient's medical history prior to this ICU admission are not provided in the available data. The length of stay in the ICU is approximately 2015 minutes, about 33.6 hours. Pre-admission lab values are available and will be discussed in the Lab Trends section. A detailed surgical report would be necessary to complete this section and provide a comprehensive understanding of the pre-operative and intra-operative details. Information regarding the nature and extent of the GI perforation/rupture is also needed to complete this section. The patient's overall medical history beyond this specific ICU stay is also missing.

3. Diagnoses

* **Primary Diagnosis:** gastrointestinal|post-GI surgery|s/p exploratory laparoscopy (Entered 12 minutes post-admission) * **ICD-9 Code:** NULL (not provided)

4. Treatments

The patient received treatment related to gastrointestinal issues and exploratory surgery, specifically exploratory laparoscopy. The treatment was active upon discharge. More specific details about the treatments administered during the ICU stay are missing from the provided data. This would include specific medications, intravenous fluids, surgical interventions, and any other supportive care provided.

5. Vital Trends

NULL (No vital signs data provided).

6. Lab Trends

The provided lab data shows multiple chemistry and hematology tests performed at various times during the patient's ICU stay, including both initial and follow-up lab tests. The data illustrates fluctuations in several key parameters. There are two sets of lab results; one at approximately 326 minutes and another at approximately 1761 minutes after admission. There was also a pre-admission lab result set. There are notable changes that require further clinical context to interpret fully. For example, albumin levels were initially 3.8 g/dL and dropped to 2.3 g/dL and then improved to 2.2 g/dL and 4.9 g/dL. Similarly, total protein levels initially measured at 7 g/dL decreased to 4.8 g/dL and then increased to 4.9 g/dL. Potassium levels showed a decrease from 4.5 mmol/L to 3.4 mmol/L. Sodium showed a slight increase from 133 mmol/L to 136 mmol/L. BUN levels decreased from 16 mg/dL to 6 mg/dL. The hematology results show some fluctuations in WBC count from 18.6 K/mcL to 10.3 K/mcL, with RBC count changing from 5.37 M/mcL to 4.36 M/mcL and Hgb changing from 14.9 g/dL to 12 g/dL. Further analysis is needed to correlate these changes with the patient's clinical course and to determine their significance.

7. Microbiology Tests

NULL (No microbiology data provided).

8. Physical Examination Results

A structured physical exam was performed. The recorded Glasgow Coma Scale (GCS) total score was 15 (Eyes: 4, Verbal: 5, Motor: 6). Blood pressure (BP) readings were recorded, with systolic BP ranging from 84 to 89 mmHg and diastolic BP ranging from 55 to 56 mmHg. Admission weight was 76kg, and the current weight was 72kg (a 4kg decrease). Fluid intake was 0 ml and output was 500 ml with a net fluid balance of -500 ml.

Note: This report relies solely on the provided data. Missing information prevents a complete and comprehensive assessment of the patient's condition. Additional data such as complete vital signs, detailed treatment records, and microbiology results are necessary for a thorough evaluation. Correlation with the patient’s clinical notes is essential for accurate interpretation of the lab results.