Medical Report: Patient 004-11168

1. Patient Information

* **Patient Unit Stay ID:** 357166 * **Unique Patient ID:** 004-11168 * **Gender:** Male * **Age:** 41 * **Ethnicity:** African American * **Hospital Admit Time:** 2015-XX-XX 03:17:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 19:40:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 05:07:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 17:05:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 185.5 kg * **Admission Height:** 182.9 cm * **Discharge Weight:** NULL

2. History

Admission history indicates the patient presented to the Emergency Department with Sepsis and Gastrointestinal (GI) issues. The exact nature of the GI problem is not fully specified in the provided data, but further details are available in the detailed progress notes (not included in this summary). The patient’s morbid obesity likely contributed to the severity of the condition. The patient's history of obstructive sleep apnea may have also played a role in their overall health status. The patient was critically ill-appearing upon arrival to the unit.

3. Diagnoses

The patient received multiple diagnoses during their ICU stay. The primary diagnosis upon discharge was septic shock (785.52, R65.21). Other major diagnoses included sepsis (038.9, A41.9), acute renal failure (584.9, N17.9), colonic diverticulitis with perforation (569.83, K63.1) and hypotension (458.9, I95.9). Secondary diagnoses included morbid obesity (278.01, E66.01) and obstructive sleep apnea (780.57, G47.33). The specific details of how these diagnoses were determined and their interrelationships are not explicitly detailed in the current data set.

4. Treatments

The patient received a comprehensive range of treatments. These included intravenous fluid resuscitation, vasopressor support (norepinephrine), broad-spectrum antibiotics (linezolid, metronidazole, aztreonam), pain management (narcotic analgesics and bolus parenteral analgesics), and stress ulcer prophylaxis (pantoprazole). Supportive measures such as oxygen therapy (initially up to 30% and later nasal cannula), a nasogastric tube, and a Foley catheter were also implemented. VTE prophylaxis with enoxaparin and compression stockings was administered. A surgery consultation was conducted, although whether surgery was performed is not specified in the data. The timing and efficacy of these treatments are not fully detailed in this limited data set.

5. Vital Trends

NULL. Time-series data on vital signs (heart rate, blood pressure, respiratory rate, oxygen saturation) are necessary to generate this section of the report. This information is not included in the provided dataset.

6. Lab Trends

NULL. Time-series data on lab results (e.g., albumin, sodium, total bilirubin, BUN, creatinine, Hct, WBC) are required to generate this section. The provided data only shows a single lab result for each parameter.

7. Microbiology Tests

Blood cultures were obtained. The results of these cultures are not included in the dataset.

8. Physical Examination Results

The physical exam was performed and documented. The patient presented with a heart rate (HR) of 105 bpm (with a range of 105-107 bpm), blood pressure (BP) of 82/44 mm Hg, respiratory rate of 31 breaths per minute (range 27-32 bpm), and oxygen saturation (O2 Sat) of 93-99%. The patient's Glasgow Coma Scale (GCS) score was 15 (Eyes 4, Verbal 5, Motor 6). The patient was described as critically ill-appearing and obese. The weight of the patient at admission was 185.5 kg. The patient's respiratory mode was spontaneous and heart rhythm was sinus rhythm.