Medical Report for Patient 005-10834

1. Patient Information

* **Patient Unit Stay ID:** 430845 * **Patient Health System Stay ID:** 367098 * **Unique Patient ID:** 005-10834 * **Gender:** Male * **Age:** 63 * **Ethnicity:** Hispanic * **Hospital ID:** 140 * **Ward ID:** 261 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2014-XX-XX 06:06:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2014-XX-XX 22:03:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 2014-XX-XX 23:29:00 (calculated from offset) * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 2014-XX-XX 20:57:00 (calculated from offset) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Height:** 182.9 cm * **Admission Weight:** 78.9 kg * **Discharge Weight:** NULL

2. History

The patient was admitted to the Emergency Department and subsequently transferred to the Med-Surg ICU with a primary diagnosis of chest pain of unknown origin. The patient presented with a complex history including gastrointestinal symptoms (abdominal pain and tenderness, ascites), cardiovascular issues (chest pain, coronary artery disease - both known and with no previous CABG, hypotension, acute coronary syndrome, acute myocardial infarction (no ST elevation), and hyperlipidemia), renal complications (acute renal failure, hyponatremia, hyperkalemia, metabolic acidosis, lactic acidosis), hematological effects (leukocytosis), and endocrine disturbances (hyperglycemia and Type II diabetes mellitus - uncontrolled). The exact timeline of symptom onset is not provided in the available data, but multiple diagnoses were recorded within the first few hours of ICU admission. The severity of the condition is reflected in the multiple major diagnoses listed. The patient's overall presentation at admission was noted as ill-appearing.

3. Diagnoses

The patient received multiple diagnoses during their ICU stay, many of which were marked as major:

* **Primary (Upon Discharge):** Chest pain, unlikely cardiac in origin (786.50, R07.9) * **Major:** Coronary artery disease (no previous CABG) (414.01, I25.10) * **Major:** Acute coronary syndrome (acute myocardial infarction (no ST elevation)) (410.71, I21.4) * **Major:** Abdominal pain / tenderness (789.00, R10.9) * **Major:** Acute renal failure (584.9, N17.9) * **Major:** Hyponatremia (moderate) (E87.1) * **Major:** Hyperkalemia (moderate) (276.7, E87.5) * **Major:** Hypotension (458.9, I95.9) * **Major:** Abdominal carcinomatosis (197.6, C78.6) * **Major:** Leukocytosis (288.8, D72.829) * **Major:** Diabetes Mellitus Type II (uncontrolled) (250.02, E11.65) * **Major:** Ascites (789.5, R18.8) * **Other:** Hyperlipidemia (272.4, E78.5) * **Other:** Hyperglycemia (790.6, R73.9) * **Other:** Hematological effect of infection (leukocytosis) (288.8, D72.829) * **Other:** Metabolic acidosis (lactic acidosis) (276.2, E87.2) * **Other:** Dehydration (276.51, E86.0)

4. Treatments

The patient received various treatments, including:

* Multiple consultations (Pulmonary/CCM, Oncology, Gastroenterology) * Imaging studies (CT scans, chest x-rays) * VTE prophylaxis (compression boots) * Stress ulcer prophylaxis (famotidine) * Electrolyte correction * Glucose management (insulin - sliding scale and subcutaneous regular insulin) * Oxygen therapy (nasal cannula) * Antiemetic therapy (ondansetron) * Therapeutic antibacterials (levofloxacin) * Analgesics (acetaminophen) * Cultures * Pneumococcal vaccine (quality measure) Several treatments were active upon discharge, indicating ongoing management of the patient's conditions.

5. Vital Trends

NULL - Vital sign data is not included in the provided JSON.

6. Lab Trends

The provided lab data shows several important trends indicative of the patient's multiple diagnoses. There is evidence of renal impairment (elevated creatinine and BUN), electrolyte imbalances (hyponatremia and hyperkalemia), and metabolic acidosis (elevated anion gap and lactate). Hematological findings demonstrate leukocytosis. Glucose levels were markedly elevated at several points, consistent with the patient's uncontrolled type II diabetes. Troponin-I levels were elevated, suggesting myocardial injury. Liver function tests (ALT, AST, alkaline phosphatase, total bilirubin, direct bilirubin) showed some abnormalities, suggesting possible liver involvement. The Complete Blood Count (CBC) showed leukocytosis with elevated WBC, and low platelets. The patient's blood oxygen saturation was generally acceptable, although some low values were recorded. These lab results indicate a serious and multi-systemic illness.

7. Microbiology Tests

NULL - Microbiology test results are not included in the provided JSON.

8. Physical Examination Results

Physical examinations were performed at multiple time points. At 300 and 436 minutes post-unit admission, the patient was described as ill-appearing, but not in acute distress. The patient's neurological examination showed normal cranial nerves, motor function, and mental status, with the Glasgow Coma Scale (GCS) score consistently at 15 (4,6,5). The cardiovascular exam revealed normal heart sounds and pulses. Respiratory exam was consistent with spontaneous breathing and clear lung sounds. The gastrointestinal exam revealed no pain on palpation. The patient's weight was recorded as 78.9 kg on admission. Fluid balance shows a positive net fluid balance (+350 ml). JVD was absent.