Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 468560 * **Patient Health System Stay ID:** 397663 * **Gender:** Male * **Age:** 29 * **Ethnicity:** Other/Unknown * **Hospital ID:** 140 * **Ward ID:** 261 * **APACHE Admission Dx:** Acid-base/electrolyte disturbance * **Admission Height:** 182.9 cm * **Hospital Admit Time:** 02:18:00 * **Hospital Admit Offset (minutes from unit admit):** -165 * **Hospital Admit Source:** NULL * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 22:44:00 * **Hospital Discharge Offset (minutes from unit admit):** 3941 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 05:03:00 * **Unit Admit Source:** Emergency Department * **Unit Visit Number:** 1 * **Unit Stay Type:** admit * **Admission Weight:** 122.4 kg * **Discharge Weight:** NULL * **Unit Discharge Time:** 01:42:00 * **Unit Discharge Offset (minutes from unit admit):** 1239 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Unique Patient ID:** 005-10705

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses, some active upon discharge and others resolved during the ICU stay. The diagnoses, listed in order of priority and with ICD-9 codes, were:

* **Primary:** Endocrine | Glucose Metabolism | DKA (250.13, E10.1) - Active upon discharge. * **Major:** Renal | Disorder of Kidney | Acute Renal Failure | Due to hypovolemia/decreased circulating volume (584.9, N17.9) - Active upon discharge. * **Major:** Renal | Disorder of Acid Base | Metabolic Acidosis | Ketoacidosis/Diabetic (276.2, E87.2) - Active upon discharge. * **Other:** Cardiovascular | Shock / Hypotension | Septic Shock (785.52, R65.21) - Resolved during stay. * **Other:** Cardiovascular | Shock / Hypotension | Hypovolemic Shock (785.59, R57.1) - Resolved during stay. * **Other:** Endocrine | Glucose Metabolism | Hyperglycemia (790.6, R73.9) - Resolved during stay. * **Other:** Endocrine | Glucose Metabolism | DKA (250.13, E10.1) - Resolved during stay. * **Other:** Endocrine | Glucose Metabolism | Diabetes Mellitus | Type I | Uncontrolled (250.03, E10.65) - Active upon discharge * **Other:** Renal | Disorder of Acid Base | Metabolic Acidosis | Ketoacidosis/Diabetic (276.2, E87.2) - Resolved during stay. * **Other:** Cardiovascular | Shock / Hypotension | Hypovolemia (276.52, E86.1) - Resolved during stay. * **Other:** Infectious Diseases | Systemic/Other Infections | Signs and Symptoms of Sepsis (SIRS) (995.90) - Resolved during stay.

The presence of both septic and hypovolemic shock, along with DKA and acute renal failure, suggests a complex clinical picture likely related to poorly controlled Type I diabetes. The metabolic acidosis is consistent with DKA. The acute renal failure is likely a consequence of hypovolemia associated with the shock states.

4. Treatments

The patient received a range of treatments, some continued upon discharge and others discontinued. Key treatments included:

* **Cardiovascular:** Intravenous fluid (normal saline administration) - Discontinued upon discharge * **Endocrine:** Insulin (continuous infusion) - Discontinued upon discharge * **Endocrine:** Insulin (subcutaneous dose of regular insulin) - Active upon discharge * **Endocrine:** Insulin (subcutaneous dose of longer-acting insulin preparation) - Active upon discharge * **Endocrine:** Electrolyte correction (administration of electrolytes) - Active upon discharge * **Infectious Diseases:** Therapeutic antibacterials - Discontinued upon discharge * **Endocrine:** Insulin (sliding scale administration) - Active upon discharge * **Infectious Diseases:** Infectious Disease consultation - Discontinued upon discharge * **Endocrine:** Electrolyte correction (administration of electrolytes) - Discontinued upon discharge * **Cardiovascular:** Intravenous fluid (fluid restriction) - Discontinued upon discharge * **Pulmonary:** Pulmonary/CCM consultation - Active upon discharge * **Gastrointestinal:** Medications (stress ulcer prophylaxis, pantoprazole, oral) - Active upon discharge

The treatment regimen focused on managing the patient's shock, correcting electrolyte imbalances, controlling blood glucose levels with various insulin administration strategies, and addressing potential infections with antibiotics. Stress ulcer prophylaxis was implemented to prevent complications.

5. Vital Trends

* **Heart Rate (HR):** Current 112, Lowest 111, Highest 112 (at 32 minutes from unit admit); Current 91, Lowest 88, Highest 116 (at 899 minutes from unit admit). * **Respiratory Rate (Resp):** Current 24, Lowest 22, Highest 24 (at 32 minutes from unit admit); Current 19, Lowest 14, Highest 27 (at 899 minutes from unit admit). * **Oxygen Saturation (O2 Sat):** Current 100, Lowest 100, Highest 100 (at 32 minutes from unit admit); Current 100, Lowest 91, Highest 100 (at 899 minutes from unit admit). * **Blood Pressure (BP):** Systolic: Current 103, Lowest 82, Highest 122; Diastolic: Current 59, Lowest 34, Highest 101 (at 899 minutes from unit admit).

6. Lab Trends

The provided lab data shows multiple blood tests performed at various time points. A detailed analysis requires time-series plotting to visualize trends. Key lab values initially show elevated glucose (463 mg/dL at 55 minutes), BUN (19 mg/dL at 55 minutes), creatinine (1.67 mg/dL at 55 minutes), anion gap (18 at 55 minutes), potassium (5 mmol/L at 55 minutes), and chloride (104 mmol/L at 55 minutes). Later values (3196 minutes) show a significant improvement in glucose (123 mg/dL), but creatinine remains elevated (0.81 mg/dL).

7. Microbiology Tests

NULL (Insufficient information provided)

8. Physical Examination Results

Physical examination findings at 32 and 899 minutes post unit admission reveal the patient to be initially somnolent, obese, and ill-appearing. Cardiovascular, respiratory, and neurological examinations were largely normal, with clear lung sounds, normal heart sounds, and a GCS of 15 (at 899 minutes). No masses or organomegaly were detected on abdominal palpation. Further information is required to fully interpret the physical examination findings.