Medical Report for Patient 004-17087

1. Patient Information

* **Patient Unit Stay ID:** 351717 * **Patient Health System Stay ID:** 302316 * **Gender:** Female * **Age:** 61 * **Ethnicity:** NULL * **Hospital ID:** 123 * **Ward ID:** 175 * **Admission Diagnosis:** Encephalopathies (excluding hepatic) * **Admission Height:** 175.3 cm * **Hospital Admission Time:** 00:40:00 * **Hospital Admission Offset (minutes from unit admit):** -126 * **Hospital Admission Source:** NULL * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 05:10:00 * **Hospital Discharge Offset (minutes from unit admit):** 1584 * **Hospital Discharge Location:** Death * **Hospital Discharge Status:** Expired * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 02:46:00 * **Unit Admission Source:** Emergency Department * **Unit Visit Number:** 1 * **Unit Stay Type:** admit * **Admission Weight:** 82.7 kg * **Discharge Weight:** NULL * **Unit Discharge Time:** 05:10:00 * **Unit Discharge Offset (minutes from unit admit):** 1584 * **Unit Discharge Location:** Death * **Unit Discharge Status:** Expired * **Unique Patient ID:** 004-17087

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses, indicating a complex clinical picture. The primary diagnosis upon admission was hepatic encephalopathy (ICD-9 code: 572.2). Other major diagnoses included severe hypokalemia (276.8, E87.6), depression (311, F32.9), hypotension (458.9, I95.9), lactic acidosis (276.2, E87.2), change in mental status (780.09, R41.82), hypothermia (780.99, R68.0), alcohol withdrawal syndrome (291.81, F10.239), and hypoglycemia (251.1, E16.2). Hypertension (401.9, I10) was also noted as a secondary diagnosis. Anemia was suspected, although no ICD-9 code was recorded. All diagnoses were active upon discharge.

4. Treatments

The patient received a comprehensive range of treatments during their ICU stay. These included medications for stress ulcer prophylaxis (pantoprazole IV), electrolyte correction (potassium and magnesium), and antiemetics (ondansetron). Fluid management involved the administration of hypotonic fluids (D5 half-normal saline) and fluid bolus with normal saline. Blood product administration (packed red blood cells) was also given. Respiratory support consisted of oxygen therapy via nasal cannula (25-30%). Enteral feeding (oral feeds) was initiated. The patient also underwent a head CT scan. Active external rewarming with a warming blanket was utilized to manage hypothermia. Treatment for metabolic acidosis included sodium bicarbonate. Lactulose was administered, likely for hepatic encephalopathy management. Drug levels were monitored.

5. Vital Trends

NULL (Insufficient information provided)

6. Lab Trends

Initial laboratory results revealed hypoalbuminemia (albumin 2.5 g/dL), hyperglycemia (glucose 107 mg/dL), elevated BUN (11 mg/dL), elevated creatinine (1.8 mg/dL), elevated total bilirubin (4.4 mg/dL), elevated ammonia (121 mcg/dL), low hematocrit (Hct 24.5%), and a white blood cell count of 10.8 K/mcL. Sodium was 140 mEq/L. A later arterial blood gas (ABG) showed a FiO2 of 28%.

7. Microbiology Tests

NULL (Insufficient information provided)

8. Physical Examination Results

The physical examination noted that the patient appeared critically ill. The initial vital signs on admission recorded a heart rate of 77 bpm, blood pressure of 88/57 mmHg, and respiratory rate of 24 breaths per minute. A Glasgow Coma Scale (GCS) of 11 (Eyes 4, Verbal 2, Motor 5) was documented. The physical exam was performed and documented in a structured format.

Note: This report is based on the limited data provided. A more complete medical history, vital signs, and microbiology results would allow for a more thorough and comprehensive report. The absence of certain data points is explicitly stated as NULL.