Patient Medical Report

1. Patient Information

* **PatientUnitStayID:** 249805 * **PatientHealthSystemStayID:** 214182 * **UniquePID:** 003-1579 * **Gender:** Female * **Age:** 29 * **Ethnicity:** Caucasian * **HospitalID:** 83 * **WardID:** 160 * **UnitType:** Med-Surg ICU * **UnitAdmitSource:** Emergency Department * **HospitalAdmitSource:** Emergency Department * **HospitalAdmitTime24:** 16:31:00 * **HospitalDischargeTime24:** 18:33:00 * **UnitAdmitTime24:** 23:17:00 * **UnitDischargeTime24:** 19:12:00 * **AdmissionWeight (kg):** 74.5 * **DischargeWeight (kg):** 78.1 * **AdmissionHeight (cm):** 172.72 * **APACHEAdmissionDx:** Diabetic ketoacidosis

2. History

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3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnosis upon admission and at discharge was Diabetic Ketoacidosis (DKA) (ICD-9 codes: 250.13, E10.1). Other diagnoses included:

* **Viral Hepatitis C:** (ICD-9 codes: 573.1, 070.51, B17.1) This diagnosis was recorded multiple times throughout the stay and was active upon discharge. * **Signs and Symptoms of Sepsis (SIRS):** (ICD-9 code: 995.90) This diagnosis was also recorded multiple times and was active upon discharge. * **Pancreatitis:** This diagnosis lacked an ICD-9 code and was recorded multiple times, being active upon discharge. * **C. difficile colitis:** (ICD-9 codes: 008.45, A04.7) This diagnosis was recorded multiple times, but not active upon discharge.

The multiplicity of diagnosis entries suggests a complex and evolving clinical picture during the patient's ICU stay. The lack of narrative history makes it difficult to determine the temporal relationships between these diagnoses and their relative contribution to the patient's overall condition.

4. Treatments

The patient received a wide range of treatments. These included:

* **Antibacterial therapies:** Multiple courses of empiric antibacterial coverage, vancomycin, metronidazole, piperacillin/tazobactam, and meropenem were administered at various points during the stay. The use of multiple antibiotics suggests a concern for polymicrobial infection or treatment changes based on culture results (which are not provided in the dataset). * **Pain and Agitation Management:** The patient received citalopram (Celexa), oral analgesics, and bolus parenteral analgesics for pain and agitation management. * **Fluid Management:** Aggressive volume resuscitation with normal saline was administered and was active on discharge. This implies significant fluid losses, potentially related to the sepsis or pancreatitis. * **Electrolyte Correction:** Intravenous administration of potassium and phosphate was given to correct electrolyte imbalances often associated with severe illness. * **Glucose Management:** Continuous insulin infusions and D50 were used to manage the patient's DKA. The repeated bedside glucose measurements indicate close monitoring of blood glucose levels. * **Stress Ulcer Prophylaxis:** Omeprazole was given to prevent stress ulcers, a common complication of critical illness. * **Antiemetic Therapy:** Promethazine and ondansetron were used to control nausea and vomiting.

The active treatments at discharge (aggressive volume resuscitation, vancomycin, and oral analgesics) highlight the ongoing management of the patient's conditions.

5. Vital Trends

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6. Lab Trends

The provided lab data shows multiple blood tests performed at different time points, both during and prior to the ICU admission. There is a significant number of bedside glucose measurements, which is consistent with the diagnosis of DKA. Trends in other labs like electrolytes (sodium, potassium, chloride, phosphate, bicarbonate), liver enzymes (AST, ALT, alkaline phosphatase), renal function (BUN, creatinine), and complete blood counts (WBC, Hgb, Hct, platelets, MCV, MCH, MCHC, differential counts) are available but require further analysis to identify trends. This analysis would necessitate plotting these values against time to visualize any patterns. The initial glucose is extremely elevated at 916 mg/dL, reflecting the acute DKA. The glucose levels fluctuate throughout the stay, suggesting ongoing challenges in managing hyperglycemia. The low albumin levels (2.6 g/dL) suggest some degree of malnutrition or liver dysfunction. The low bicarbonate levels (10-18 mmol/L) are consistent with the metabolic acidosis of DKA. The abnormal ABG results (pH 6.94 and Base Excess -27 at admission) further confirm the severity of the metabolic acidosis.

7. Microbiology Tests

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8. Physical Examination Results

Physical exam data is available at multiple time points. Weight measurements indicate a weight gain of +3.6 kg during the stay. The GCS scores indicate an initial neurologic impairment, suggesting the severity of the illness at presentation. Vital signs (HR, BP, RR, O2 saturation) are documented. The repeat vital signs and the evolution of the GCS score suggest an ongoing monitoring of the patient's condition. However, the lack of detailed descriptions in the physical examination fields limits the interpretation of the results.