Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 313736 * **Unique Patient ID:** 004-12627 * **Gender:** Male * **Age:** 40 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015-XX-XX 16:36:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 15:02:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015-XX-XX 07:27:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 12:31:00 * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Admission Weight:** 94 kg * **Admission Height:** 198 cm * **Admission Diagnosis:** Diabetic ketoacidosis

2. History

The patient, a 40-year-old Caucasian male, was admitted to the hospital through the Emergency Department with a primary diagnosis of Diabetic Ketoacidosis (DKA). The patient's history includes uncontrolled Type I diabetes mellitus, hypertension, and gastrointestinal issues including esophagitis with regurgitation and nausea with vomiting. The patient presented with symptoms consistent with DKA, including dehydration and hypotension, requiring immediate intervention in the Med-Surg ICU.

The detailed timeline of diagnosis entries suggests an initial presentation with hypertention and DKA, followed by later diagnoses of dehydration and related gastrointestinal complications. The evolving nature of the diagnoses highlights the severity and complexity of the patient's condition upon arrival.

Further details regarding the patient's social history, family history, and past medical history are unavailable in the provided dataset. A more complete history would be beneficial for a comprehensive understanding of the patient's condition and risk factors.

3. Diagnoses

* **Primary:** * Diabetic Ketoacidosis (DKA) (ICD-9: 250.13, E10.1) * Uncontrolled Type I Diabetes Mellitus (ICD-9: 250.03, E10.65) * **Major:** * Hypertension (ICD-9: 401.9, I10) * Dehydration (ICD-9: 276.51, E86.0) * Esophagitis with Regurgitation (ICD-9: 530.11, K21.0) * Nausea with Vomiting (ICD-9: 787.01, R11.2) * **Other:** * Hypertension (ICD-9: 401.9, I10) * Dehydration (ICD-9: 276.51, E86.0) * Esophagitis with Regurgitation (ICD-9: 530.11, K21.0) * Nausea with Vomiting (ICD-9: 787.01, R11.2)

Multiple diagnoses indicate a complex clinical picture. The presence of both acute (DKA, dehydration) and chronic (diabetes, hypertension) conditions required a multi-faceted approach to treatment. The repetition of certain diagnoses reflects the ongoing assessment and management of the patient's condition.

4. Treatments

The patient received a comprehensive treatment plan addressing the multiple diagnoses. Treatments included:

* **Fluid Management:** Normal saline fluid boluses were administered. * **Insulin Therapy:** Continuous insulin infusion, subcutaneous regular insulin, subcutaneous longer-acting insulin, and sliding scale insulin were utilized to manage DKA. * **Gastrointestinal Management:** Stress ulcer prophylaxis (pantoprazole) and antiemetic medications (promethazine, ondansetron) were administered to manage nausea, vomiting, and prevent stress ulcers. * **Electrolyte Management:** Potassium and magnesium were administered intravenously to correct electrolyte imbalances frequently associated with DKA. * **VTE Prophylaxis:** Compression stockings were utilized to prevent venous thromboembolism. * **Imaging:** A chest X-ray was performed. * **Nutrition:** Oral feeding was initiated.

The combination of treatments reflects the urgency of the DKA and the need to stabilize the patient's hemodynamic status and glucose levels. The use of multiple insulin regimens highlights the complexity of managing blood glucose in this setting. The ongoing administration of some treatments upon discharge suggests the chronic nature of some of the patient's conditions.

5. Vital Trends NULL - Insufficient data provided.

6. Lab Trends NULL - Insufficient data provided.

7. Microbiology Tests NULL - Insufficient data provided.

8. Physical Examination Results

* **Weight (Admission):** 94 kg * **Heart Rate:** 132 bpm * **Blood Pressure (Systolic):** 155 mmHg * **Blood Pressure (Diastolic):** 68 mmHg * **Respiratory Rate:** 18 breaths/min * **Oxygen Saturation:** 99% * **FiO2:** 21% * **Glasgow Coma Scale (GCS):** 15 (Eyes: 4, Verbal: 5, Motor: 6)

The physical examination shows that the patient presented with tachycardia, elevated blood pressure, and normal oxygen saturation at admission. The GCS score of 15 indicates an alert and oriented patient. More frequent and detailed physical exam data would be beneficial for tracking the patient's physiological response to treatment.