Medical Report for Patient 006-100497

1. Patient Information

* **Patient Unit Stay ID:** 820642 * **Patient Health System Stay ID:** 622889 * **Unique Patient ID:** 006-100497 * **Gender:** Male * **Age:** 28 * **Ethnicity:** Caucasian * **Hospital ID:** 146 * **Ward ID:** 374 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 00:28:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 14:53:00 * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 22:11:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 01:30:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Height:** 172.3 cm * **Admission Weight:** 75 kg * **Discharge Weight:** 75 kg * **APACHE Admission Diagnosis:** Diabetic ketoacidosis

2. History

NULL (Insufficient information provided in the JSON data to reconstruct the patient's medical history.)

3. Diagnoses

* **Diagnosis ID:** 11054513, 10530348 * **Patient Unit Stay ID:** 820642 * **Diagnosis String:** endocrine|glucose metabolism|DKA * **ICD-9 Code:** 250.13, E10.1 * **Diagnosis Priority:** Primary * **Active Upon Discharge:** True (for Diagnosis ID 11054513), False (for Diagnosis ID 10530348) * **Diagnosis Offset:** 852 minutes (for Diagnosis ID 11054513), 24 minutes (for Diagnosis ID 10530348)

The patient presented with Diabetic Ketoacidosis (DKA), which was the primary diagnosis upon admission and remained active upon discharge from the unit. A second entry for DKA exists, but was marked as inactive upon discharge. The timing difference suggests a potential reassessment or modification of the initial diagnosis. Further details are needed to understand the context of the two entries.

4. Treatments

* **Treatment ID:** 24189809, 27158177 * **Patient Unit Stay ID:** 820642 * **Treatment String:** endocrine|intravenous fluid administration|normal saline administration|fluid bolus (250-1000mls) (Treatment ID 24189809), endocrine|intravenous fluid administration|normal saline administration|aggressive volume resuscitation (>250 mls/hr) (Treatment ID 27158177) * **Active Upon Discharge:** False (for both Treatment IDs) * **Treatment Offset:** 24 minutes (for both Treatment IDs)

The patient received intravenous fluid administration with normal saline, including both fluid boluses and aggressive volume resuscitation. Both treatments were discontinued before the patient's discharge from the ICU.

5. Vital Trends

NULL (No vital signs data is included in the provided JSON data.)

6. Lab Trends

The provided data includes multiple lab results for various blood tests, taken at different times during the patient's stay. The lab results include complete blood count (CBC) with differential, basic metabolic panel (BMP), and other chemistry panels. There are two sets of Hematology labs, suggesting before and after treatment. Key lab values, such as glucose levels, show significant fluctuation, potentially reflecting the DKA diagnosis and subsequent treatment. Further analysis is needed to determine exact trends.

7. Microbiology Tests

NULL (No microbiology test data is present in the JSON data.)

8. Physical Examination Results

The physical examination was performed and documented as “Performed - Structured”. Specific findings are partially documented. Heart rate was recorded as 91 bpm (current, lowest, and highest values indicating no significant variation during the recorded time). Oxygen saturation was 98% (current, lowest, and highest values again showing no recorded variation). The Glasgow Coma Scale (GCS) was scored at 15 (Eyes 4, Verbal 5, Motor 6), indicating normal neurological function. The patient's weight was 75 kg at both admission and discharge, showing no weight change during the stay. More detailed physical exam findings are needed for a comprehensive assessment.