

## **\*\*Medical Report - Patient 005-10705\*\***

### **\*\*1. Patient Information\*\***

\* \*\*Patient Unit Stay ID:\*\* 468560 \* \*\*Patient Health System Stay ID:\*\* 397663 \* \*\*Unique Patient ID:\*\* 005-10705 \*  
\*\*Gender:\*\* Male \* \*\*Age:\*\* 29 years \* \*\*Ethnicity:\*\* Other/Unknown \* \*\*Hospital ID:\*\* 140 \* \*\*Ward ID:\*\* 261 \* \*\*Unit Type:\*\* Med-Surg ICU \* \*\*Unit Admit Time:\*\* 05:03:00 \* \*\*Unit Admit Source:\*\* Emergency Department \* \*\*Unit Discharge Time:\*\* 01:42:00 \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \* \*\*Hospital Admit Time:\*\* 02:18:00 \* \*\*Hospital Admit Source:\*\* NULL \* \*\*Hospital Discharge Year:\*\* 2015 \* \*\*Hospital Discharge Time:\*\* 22:44:00 \*  
\*\*Hospital Discharge Location:\*\* Home \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Admission Height:\*\* 182.9 cm \*  
\*\*Admission Weight:\*\* 122.4 kg \* \*\*Discharge Weight:\*\* NULL \* \*\*APACHE Admission Diagnosis:\*\* Acid-base/electrolyte disturbance

### **\*\*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 included:

\* \*\*Primary Diagnosis (Active upon Discharge):\*\* Diabetic Ketoacidosis (DKA) (ICD-9 codes: 250.13, E10.1) \* \*\*Major Diagnosis (Active upon Discharge):\*\* Acute Renal Failure due to hypovolemia/decreased circulating volume (ICD-9 codes: 584.9, N17.9); Diabetic Ketoacidosis (DKA) (ICD-9 codes: 250.13, E10.1) \* \*\*Other Diagnoses (Not Active upon Discharge):\*\* Septic Shock (ICD-9 codes: 785.52, R65.21); Hypovolemic Shock (ICD-9 codes: 785.59, R57.1); Hyperglycemia (ICD-9 codes: 790.6, R73.9); Diabetic Ketoacidosis (DKA) (ICD-9 codes: 250.13, E10.1); Metabolic Acidosis (Ketoacidosis/Diabetic) (ICD-9 codes: 276.2, E87.2); Hypovolemia (ICD-9 codes: 276.52, E86.1); Signs and symptoms of sepsis (SIRS) (ICD-9 code: 995.90); Type I uncontrolled diabetes mellitus (ICD-9 codes: 250.03, E10.65)

The temporal relationship between these diagnoses is important. All 'Other' priority diagnoses were recorded at 48 minutes post unit admission, suggesting a rapid initial assessment. The Major and Primary diagnoses, indicating more severe conditions, were recorded later at 903 minutes post unit admission, indicating a progression of the patient's condition. This suggests an initial presentation of shock and hyperglycemia, followed by the development of DKA and acute renal failure likely secondary to hypovolemia.

### **\*\*4. Treatments\*\***

The patient received a range of treatments during their ICU stay, including:

\* \*\*Cardiovascular:\*\* Normal saline administration (discontinued), fluid restriction (discontinued) \* \*\*Endocrine:\*\* Continuous insulin infusion (discontinued), subcutaneous dose of regular insulin (active upon discharge), subcutaneous dose of longer-acting insulin preparation (active upon discharge), sliding scale insulin administration (active upon discharge), administration of electrolytes (active upon discharge) \* \*\*Infectious Diseases:\*\* Therapeutic antibacterials (discontinued), Infectious Disease consultation (discontinued) \* \*\*Gastrointestinal:\*\* Pantoprazole (oral) for stress ulcer prophylaxis (active upon discharge) \* \*\*Pulmonary:\*\* Pulmonary/CCM consultation (active upon discharge)

The shift from intravenous fluid administration and continuous insulin infusion to subcutaneous insulin and oral medications indicates improvement and stabilization of the patient's condition towards the end of their ICU stay. The ongoing need for electrolyte correction and stress ulcer prophylaxis underscores the severity of the patient's condition.

### **\*\*5. Vital Trends\*\***

NULL (Insufficient information provided)

#### **\*\*6. Lab Trends\*\***

The lab results show fluctuations in various parameters. Initial blood glucose levels were extremely high (463 mg/dL), which significantly decreased with treatment. There was evidence of metabolic acidosis (low bicarbonate) and an elevated anion gap, consistent with DKA. Creatinine levels were elevated, indicating acute renal failure which improved (1.67 mg/dL to 1.33 mg/dL) over the course of the ICU stay. The patient also showed abnormalities in electrolytes (sodium, potassium, chloride). The complete blood count (CBC) indicated elevated white blood cell (WBC) count, consistent with infection or inflammation, which gradually reduced. The patient's PT and PTT were also slightly abnormal. The trend in bedside glucose levels showed a downward trend throughout the ICU stay, indicating effective treatment for DKA.

#### **\*\*7. Microbiology Tests\*\***

NULL (Insufficient information provided)

#### **\*\*8. Physical Examination Results\*\***

Initial physical examination revealed a somnolent patient with a heart rate of 112 bpm, respiratory rate of 24 bpm, and oxygen saturation of 100%. A later examination (at 899 minutes post-admission) showed improvement in the patient's condition with a heart rate of 91 bpm, respiratory rate of 19 bpm, and oxygen saturation of 100%. The patient was noted as obese and ill-appearing on admission but showed progress towards being "not in acute distress" by the later examination. The neurological examination was essentially normal at both time points. The cardiovascular, pulmonary, gastrointestinal, and other examinations showed no significant abnormalities. The initial and subsequent GCS scores were 15 and 15 respectively, indicating normal neurological function.