Medical Report for Patient 004-11168

1. Patient Information

* **Patient Unit Stay ID:** 357166 * **Unique Patient ID:** 004-11168 * **Gender:** Male * **Age:** 41 * **Ethnicity:** African American * **Hospital Admission Time:** 2015-XX-XX 03:17:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 19:40:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015-XX-XX 05:07:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 17:05:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 185.5 kg * **Admission Height:** 182.9 cm

2. History

Admission history indicates the patient presented to the Emergency Department with Sepsis and Gastrointestinal issues. The exact nature of the gastrointestinal problems is not specified in the provided data, though the diagnoses suggest a possible colonic diverticulitis with perforation. The patient's morbid obesity was also a significant contributing factor. The patient exhibited septic shock and hypotension upon admission to the ICU. Obstructive sleep apnea was also noted as a pre-existing condition, which may have played a role in the patient's overall health status. Further details regarding the patient's medical history prior to this admission are unavailable in this dataset.

3. Diagnoses

The patient received multiple diagnoses during their ICU stay. The primary diagnosis upon discharge was septic shock (ICD-9 codes 785.52, R65.21). Major diagnoses active upon discharge also included acute renal failure (ICD-9 codes 584.9, N17.9), colonic diverticulitis (ICD-9 codes 569.83, K63.1), and enteritis and diverticulitis of the colon (ICD-9 codes 562.11, K57). Other major diagnoses included sepsis (ICD-9 codes 038.9, A41.9), and hypotension (ICD-9 codes 458.9, I95.9). Additional diagnoses not active upon discharge included morbid obesity (ICD-9 codes 278.01, E66.01) and obstructive sleep apnea (ICD-9 codes 780.57, G47.33). The diagnosis of hypertension (ICD-9 codes 401.9, I10) was listed as other. The sequencing of diagnoses does not necessarily reflect the severity or order of appearance.

4. Treatments

The patient received a comprehensive range of treatments, including:

* **Antibiotics:** Metronidazole, Linezolid, Aztreonam * **Vasopressors:** Norepinephrine * **Analgesics:** Narcotic analgesics, Bolus parenteral analgesics * **Gastrointestinal Management:** Nasogastric tube insertion and suction. * **Fluid Resuscitation:** Moderate volume normal saline administration. * **Stress Ulcer Prophylaxis:** IV Pantoprazole. * **Antiemetic:** Ondansetron * **VTE Prophylaxis:** Enoxaparin (low molecular weight heparin) and compression stockings. * **Oxygen Therapy:** Nasal cannula and 25-30% oxygen. * **Foley Catheter** Placement. * **Surgery Consultation**

Several of these treatments were ongoing at the time of discharge.

5. Vital Trends

NULL: The provided data does not contain time-series data for vital signs.

6. Lab Trends

NULL: The provided data contains only a snapshot of lab results at a single time point, not a trend over time.

7. Microbiology Tests

NULL: The data mentions blood cultures were taken, but results are not included.

8. Physical Examination Results

The physical exam recorded at 58 minutes post-unit admission notes the patient as critically ill-appearing and obese. Vital signs recorded included a heart rate (HR) between 105 and 107 bpm, a blood pressure (BP) of 82/44 mmHg, and a respiratory rate (RR) between 27 and 32 breaths per minute. Oxygen saturation (O2 Sat) ranged from 93% to 99%. The Glasgow Coma Scale (GCS) score was 15 (Eyes 4, Verbal 5, Motor 6), indicating no neurological impairment. The patient's heart rhythm was noted as sinus and respiratory mode as spontaneous.