Medical Report for Patient 004-17719

1. Patient Information

* **Patient Unit Stay ID:** 394057 * **Unique Patient ID:** 004-17719 * **Gender:** Male * **Age:** 48 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2014, 23:28:00 * **Hospital Discharge Time:** 2014, 15:15:00 * **Unit Admission Time:** 01:58:00 * **Unit Discharge Time:** 15:15:00 * **Unit Type:** Med-Surg ICU * **Admission Weight:** 64.6 kg * **Admission Height:** 182.9 cm

2. History

The provided data does not contain a detailed patient history. Further information is needed to complete this section. The admission diagnosis was Diabetic Ketoacidosis (DKA), suggesting a history of diabetes mellitus, potentially type 1 given the presentation with DKA. However, the specifics of the patient's diabetes management prior to admission, duration of illness, and any other relevant medical history are absent from the current dataset. Information regarding family history, social history (smoking, alcohol, drug use), and any previous hospitalizations would also be beneficial for a complete history. The patient was admitted from the floor, indicating a prior inpatient stay at this hospital or transfer from another facility. This prior hospitalization should be explored in order to provide a more complete history. Note that the absence of a comprehensive history limits the interpretation of the current data. The timeline of events around admission and the patient's presentation should be further investigated to provide a more robust clinical narrative. The mechanism of the diabetic ketoacidosis onset is unknown from the dataset, and that information would contribute to the history section.

3. Diagnoses

* **Primary Diagnosis:** Diabetic Ketoacidosis (DKA) (ICD-9 codes: 250.13, E10.1) * **Major Diagnosis:** Hypertension (ICD-9 codes: 401.9, I10) This diagnosis was active both upon admission and discharge, indicating a pre-existing condition.

4. Treatments

The patient received several treatments during their ICU stay. These included:

* **Insulin Therapy:** Both continuous infusion (initially) and sliding scale administration (later) were utilized for management of DKA. The initial use of continuous insulin infusion is a common approach to manage severe DKA. The transition to sliding scale insulin administration is typical once the patient's condition has stabilized. More information about the exact insulin dosage regimens, blood glucose targets, and response to therapy is needed for a comprehensive treatment summary. * **Intravenous Fluid Administration:** The patient received normal saline, initially as a fluid bolus and later as moderate volume resuscitation. The specific amounts of fluids administered and the clinical rationale for these fluid regimens are not detailed in the provided data. Fluid resuscitation is a crucial aspect of DKA management, correcting the dehydration associated with the condition. The exact fluid balance and the patient's response to fluid replacement should be thoroughly documented. * **Stress Ulcer Prophylaxis:** Pantoprazole was administered to prevent stress ulcers, a common complication of critical illness. The duration of pantoprazole administration and the patient's tolerance of the medication are missing from the data. * **Antiemetic Therapy:** Promethazine was used to manage nausea and vomiting. Again, the dosage, frequency, and efficacy of this treatment are not specified in the dataset. Nausea and vomiting can be associated with DKA and other complications, and their management should be fully addressed in a complete report.

5. Vital Trends

NULL. Vital sign data (heart rate, blood pressure, respiratory rate, oxygen saturation) are missing from the dataset. These are crucial for assessing the patient's hemodynamic stability and respiratory status, particularly during an ICU stay. Trends in these parameters are essential for understanding the patient's response to treatment and overall clinical course.

6. Lab Trends

The provided lab data includes multiple blood tests and bedside glucose measurements. However, a temporal trend analysis requires additional data points and a clear timestamp for each lab result. There is a clear need for a detailed list of lab values with corresponding timestamps to assess trends across time. The available data shows both initial and subsequent lab values for several parameters (sodium, potassium, bicarbonate, chloride, creatinine, BUN, glucose), but lacks the context to generate a coherent trend analysis without additional data. Complete blood count (CBC) parameters (e.g., Hemoglobin, Hematocrit, White Blood Cell count, Platelets) are also available but only at one time point in the dataset. More frequent monitoring is expected in DKA management, and this should be addressed in a complete report. The arterial blood gas (ABG) results (pH, PaCO2, PaO2, Base Deficit, FiO2) are available at one timepoint, but this is insufficient to assess trends. The significant number of missing values should also be investigated. A more complete lab dataset will allow for the generation of meaningful trends.

7. Microbiology Tests

NULL. No microbiology test results are included in the provided data. This information would be crucial in ruling out or identifying infectious complications associated with DKA or other concurrent conditions.

8. Physical Examination Results

The physical exam documented a Glasgow Coma Scale (GCS) score of 15 (Eyes 4, Verbal 5, Motor 6) at 17 minutes post-unit admission, indicating normal neurological function. The patient's admission weight was 64.6 kg, and heart rate, respiratory rate, and blood pressure were recorded as 105 bpm, 9 breaths/minute, 181/98 mmHg, and 97% SpO2, respectively, at 17 minutes post-unit admission. These vital signs are not sufficient to establish trends due to the lack of additional measurements over time. A comprehensive physical examination would include a detailed assessment of all body systems, and the current data provides only a limited view.