Medical Report: Patient 005-10903

1. Patient Information

* **Patient Unit Stay ID:** 472359 * **Patient Health System Stay ID:** 400737 * **Unique Patient ID:** 005-10903 * **Gender:** Female * **Age:** 63 years * **Ethnicity:** African American * **Hospital ID:** 144 * **Ward ID:** 267 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 00:12:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 20:47:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 09:15:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 23:33:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Height:** 157.48 cm * **Admission Weight:** 41.3 kg * **Discharge Weight:** 50.2 kg * **Admission Diagnosis:** Sepsis, renal/UTI (including bladder)

2. History

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3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. These diagnoses, listed in the order they were recorded, include:

* **Sepsis** (Primary Diagnosis, ICD-9 code: 995.92, R65.2): This was the primary diagnosis upon admission and suggests a severe systemic infection. * **Acute Renal Failure** (Major Diagnosis, ICD-9 code: 584.9, N17.9): This indicates impaired kidney function, a critical complication often associated with sepsis. * **Diabetic Ketoacidosis (DKA)** (Major Diagnosis, ICD-9 code: 250.13, E10.1): This metabolic disorder, common in diabetics, contributes to the patient's overall instability. * **Acute Pyelonephritis** (Major Diagnosis, ICD-9 code: 590.10, N10): This kidney infection further complicates the patient's renal status. * **Urinary Tract Infection (UTI)** (Major Diagnosis, ICD-9 code: 599.0, N39.0): A urinary tract infection that likely contributed to the pyelonephritis and sepsis. * **Congestive Heart Failure** (Major Diagnosis, ICD-9 code: 428.0, I50.9): Heart failure adds another layer of complexity to the patient's condition. * **Thrombocytopenia (Etiology Unknown)** (Major Diagnosis, ICD-9 code: 287.5, D69.6): Low platelet count, potentially contributing to bleeding risks. * **Metabolic Acidosis (various types)** (Multiple diagnoses, ICD-9 code: 276.2, E87.2): This electrolyte imbalance is a common finding in critically ill patients, particularly those with sepsis and DKA. * **Anemia** (Other Diagnosis): Reduced red blood cell count, another frequent complication in septic patients. * **Leukocytosis** (Other Diagnosis, ICD-9 code: 288.8, D72.829): Elevated white blood cell count indicating the body's response to infection. * **Constipation** (Other Diagnosis, ICD-9 code: 564.00, K59.00): A common problem in hospitalized patients, potentially affecting overall well-being. * **Nutritional Deficiency** (Major Diagnosis, ICD-9 code: 263.9, E46): Malnutrition, often seen in severely ill patients. * **Hypoxemia** (Other Diagnosis, ICD-9 code: 799.02, J96.91): Low oxygen levels in the blood, a common manifestation of respiratory failure. * **Acute Respiratory Failure** (Other Diagnosis, ICD-9 code: 518.81, J96.00): This is a serious condition characterized by impaired gas exchange in the lungs. * **Hypotension/Pressor Dependent** (Major Diagnosis): This indicates low blood pressure requiring medication to maintain adequate circulation. * **Diabetes Mellitus** (Major Diagnosis): Underlying condition that contributes to DKA. * **Coagulopathy** (Other Diagnosis, ICD-9 code: 286.9, D68.9): An abnormality in blood clotting processes.

4. Treatments

The patient received a variety of treatments during her ICU stay. These included:

* **Electrolyte Correction:** Intravenous administration of electrolytes to address imbalances. * **Insulin Management:** Continuous infusion and sliding scale administration of insulin to manage DKA. * **Non-Invasive Ventilation:** To support respiratory function. * **Empiric Antibacterial Coverage:** Broad-spectrum antibiotics to combat infection. * **VTE Prophylaxis:** Low molecular weight heparin (enoxaparin) and compression boots to prevent blood clots. * **ACE Inhibitor (Lisinopril):** To manage hypertension. * **Narcotic and Oral Analgesics:** Pain management. * **Antiemetic (Ondansetron):** To prevent nausea and vomiting. * **Stress Ulcer Prophylaxis (Pantoprazole):** To protect against stomach ulcers. * **Consultations:** Cardiology, Nephrology, Infectious Disease, Hematology, and Urology consultations.

* **Chest X-ray:** To assess lung status. * **Transthoracic Echocardiography:** To evaluate heart function. * **Sodium Bicarbonate:** To correct metabolic acidosis. * **Calcium Administration:** To correct hypocalcemia. * **Vasopressors (Norepinephrine):** To support blood pressure.

5. Vital Trends

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6. Lab Trends

The provided lab data shows several key trends:

* **Bedside Glucose:** Fluctuated significantly throughout the stay, indicating challenges in glucose control, consistent with the DKA diagnosis. Levels ranged from lows of 52 mg/dL to highs exceeding 600 mg/dL. * **Creatinine:** Elevated (1.7-2.14 mg/dL at various points), indicating acute kidney injury, consistent with the acute renal failure diagnosis. Creatinine levels improved to 1.3 mg/dL upon discharge. * **Bicarbonate:** Initially low (12-17 mmol/L), reflecting the metabolic acidosis, and subsequently improved (23-27 mmol/L) with treatment. * **Anion Gap:** Elevated (13-22), further supporting the metabolic acidosis diagnosis. * **Total Bilirubin:** Elevated (3.0-10.6 mg/dL), suggesting liver dysfunction, a potential complication of sepsis. * **Albumin:** Low (1.7-2.8 g/dL), reflecting either malnutrition or liver dysfunction. Values improved to 2.2 g/dL by the end of the stay. * **Electrolytes:** Potassium levels fluctuated, with some elevated values (4.7-5.9 mmol/L), while sodium remained relatively stable (138-146 mmol/L) indicating electrolyte imbalance that was addressed through treatments. * **Complete Blood Count (CBC):** Significant variations in Hemoglobin (Hgb), Hematocrit (Hct), White Blood Cell count (WBC), Platelets, Mean Corpuscular Volume (MCV), Mean Corpuscular Hemoglobin (MCH), and Mean Corpuscular Hemoglobin Concentration (MCHC). These variations reflect the anemia, leukocytosis, and thrombocytopenia diagnoses. The data does not allow for analysis of the exact trends over time. The variation in differential WBC counts (-bands, -lymphs, -monos, -polys) also shows changes in the inflammatory response over time. * **Cardiac Enzymes:** Troponin I levels were elevated (0.23-0.31 ng/mL) indicating cardiac stress potentially related to sepsis. * **Coagulation:** PT and PTT were elevated, indicating impaired coagulation, consistent with the coagulopathy diagnosis.

7. Microbiology Tests

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8. Physical Examination Results

The physical exam documented the following:

* **Heart Rate (HR):** Lowest recorded HR was 131 bpm and the highest was 133 bpm. * **Blood Pressure (BP):** Lowest systolic BP was 123 mmHg, highest was 165 mmHg. Lowest diastolic BP was 58 mmHg, highest was 118 mmHg. * **Respiratory Rate (Resp):** Lowest was 25 breaths per minute, highest was 28 breaths per minute. * **Oxygen Saturation (O2 Sat):** Lowest and highest O2 Sat were both 100%, this is likely an error in data entry. * **Weight:** Admission weight was 41.3 kg, current weight 40.9 kg. This suggests a weight loss of -0.4 kg. * **Neurological Exam:** The patient's Glasgow Coma Scale (GCS) score was 15 (Eye 4, Verbal 5, Motor 6), indicating normal neurological function. The patient’s level of consciousness was documented as normal. * **Cardiac Rhythm:** Sinus rhythm was observed. * **Respiratory Mode:** Spontaneous respirations.