Patient Information

Patient Unit Stay ID: 373392 Unique Patient ID: 004-12574 Gender: Male Age: 39 Ethnicity: Caucasian Hospital Admit Time: 2015-XX-XX 05:29:00 Hospital Admit Source: Emergency Department Hospital Discharge Time: 2015-XX-XX 17:47:00 Hospital Discharge Location: Home Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admit Time: 2015-XX-XX 07:36:00 Unit Admit Source: Emergency Department Unit Discharge Time: 2015-XX-XX 18:57:00 Unit Discharge Location: Floor Unit Discharge Status: Alive Admission Weight: 69 kg Discharge Weight: NULL Admission Height: 167.6 cm APACHE Admission Diagnosis: Sepsis, GI

History

NULL (Insufficient data provided)

Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis upon admission was abdominal pain/tenderness (ICD-9 codes: 789.00, R10.9). Other significant diagnoses included nausea (ICD-9 codes: 787.02, R11.0) and leukocytosis (ICD-9 codes: 288.8, D72.829). A surgical wound infection (ICD-9 code: 998.59) was also diagnosed and was active upon discharge. Several of these diagnoses were entered multiple times at various points during the stay, reflecting the ongoing assessment and evolution of the patient's condition. The temporal aspect of these diagnoses, as indicated by `diagnosisoffset` values, shows that some diagnoses were identified very early in the stay, while others were identified later, some becoming inactive over time. The `activeupondischarge` flag provides crucial information on the persistence of the diagnoses.

Treatments

The patient received a range of treatments during their ICU stay. These included: oral feeds, blood cultures, normal saline administration, chest x-rays, CT scans of the abdomen and pelvis, compression stockings for VTE prophylaxis, and medications such as piperacillin/tazobactam, vancomycin, and ondansetron. Many of these treatments were initiated early and continued until discharge. The `activeupondischarge` field clarifies which treatments were ongoing upon the patient's departure from the unit. The temporal progression of treatments, as indicated by the `treatmentoffset` field, allows for detailed analysis of the treatment strategy in relation to the evolving diagnoses.

Vital Trends

NULL (Insufficient data provided)

Lab Trends

The patient's laboratory results show some notable trends. Hematological tests reveal leukocytosis (elevated WBC count) of 11.2 K/mcL and 14.1 K/mcL at different times, and a low Hemoglobin (Hgb) level of 9.0 g/dL and 8.9 g/dL. The hematocrit (Hct) was also low, at 25.5% and 25.3%. Chemistry results showed elevated lipase levels (388 Units/L and 266 Units/L) and normal kidney function, with creatinine at 1.3 mg/dL. Electrolytes were within the normal range. The repeated measurements of several lab values over time allow for the monitoring of changes in the patient's condition.

Microbiology Tests

Blood cultures were performed (multiple times), suggesting a suspicion of bloodstream infection. The results of these cultures are not included in this report.

Physical Examination Results

A structured physical examination was performed. The systolic blood pressure was recorded between 129 and 130 mmHg, and the diastolic blood pressure was between 63 and 70 mmHg. A Glasgow Coma Scale (GCS) score of 15 (4+5+6) was recorded, indicating normal neurological function.