Medical Report: Patient 006-108754

1. Patient Information

* **Patient Unit Stay ID:** 624150 * **Unique Patient ID:** 006-108754 * **Gender:** Female * **Age:** 54 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015, 21:39:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015, 16:22:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015, 23:43:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2015, 16:22:00 * **Unit Discharge Location:** Home * **Unit Discharge Status:** Alive * **Admission Weight:** 55 kg * **Discharge Weight:** 58.6 kg * **Admission Height:** 159 cm * **APACHE Admission Dx:** Diabetic ketoacidosis

2. History

NULL (Insufficient information provided in the JSON data to elaborate on the patient's medical history before ICU admission.)

3. Diagnoses

The patient presented with Diabetic Ketoacidosis (DKA), as indicated by the primary diagnoses entered at 20 minutes and 51 minutes post-unit admission. The ICD-9 codes listed are 250.13 and E10.1, consistent with DKA. A third diagnosis of DKA was recorded at 872 minutes post-unit admission and remained active upon discharge. This suggests that, while initially managed, the DKA may have persisted or recurred during the ICU stay, warranting further investigation and treatment. The persistence of DKA as an active diagnosis at discharge indicates the condition was not fully resolved during the ICU admission. Further details regarding the management of the DKA and response to treatment would be beneficial for a comprehensive understanding of the patient's progress.

4. Treatments

The patient received aggressive volume resuscitation with normal saline, administered intravenously as indicated by treatments recorded at 20 and 51 minutes post-unit admission. Both treatments ceased to be active upon discharge, suggesting a successful response to fluid resuscitation. More detail on the administered fluid volumes, the patient's fluid balance, and any other treatments (e.g., insulin therapy) given for DKA is needed for a complete treatment record.

5. Vital Trends

NULL (No vital sign data is available in the provided JSON data. Data points such as heart rate, blood pressure, respiratory rate, and oxygen saturation are necessary to generate this section.)

6. Lab Trends

The lab results show fluctuations in several key parameters. Glucose levels were initially very high (326 mg/dL at 31 minutes post-admission and 329 mg/dL at admission), reflecting the DKA. Later measurements showed improved glucose control (121 mg/dL at 977 minutes and 99 mg/dL at 2152 minutes). Electrolyte imbalances were also present, with initial potassium levels of 3.5 mmol/L rising to 4.1 mmol/L, then to 4.2 mmol/L and 4.3 mmol/L at later timepoints. Bicarbonate levels showed some improvement, increasing from 17 mmol/L to 20 mmol/L to 22 mmol/L to 24 mmol/L and 25 mmol/L. The initial sodium level of 138 mmol/L fluctuated, indicating potential fluid shifts associated with the DKA treatment. The complete blood count (CBC) revealed initially elevated white blood cells (WBC) (24.5 K/mcL), which decreased to 7.2 K/mcL, suggesting an inflammatory response. The patient's Creatinine levels were initially below the detection limit and remained so throughout the stay, suggesting normal renal function. A visual representation of these trends over time would better illustrate the patient's response to treatment.

7. Microbiology Tests

NULL (No microbiology test results are included in the JSON data.)

8. Physical Examination Results

A structured physical exam was performed at 22 minutes post-unit admission. The Glasgow Coma Scale (GCS) score was 15 (Eyes 4, Verbal 5, Motor 6), indicating normal neurological function. The heart rate varied between 109 and 113 bpm, with a current rate of 112 bpm. Blood pressure was recorded at 138/57 mmHg. Respiratory rate was 20-21 breaths per minute. Oxygen saturation was 95-96%. The patient's weight upon admission was 55 kg, dropping to 53.5 kg during the stay, representing a decrease of 1.5 kg. The patient's total fluid intake was 5270 ml, and no output is recorded. A more detailed physical examination would provide a more comprehensive assessment of the patient's condition.