Medical Report for Patient 002-12243

1. Patient Information

* **Patient Unit Stay ID:** 145427 * **Unique Patient ID:** 002-12243 * **Gender:** Male * **Age:** 61 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2014-12-31 23:48:00 * **Hospital Discharge Time:** 2015-01-01 15:41:00 * **Unit Admit Time:** 2014-12-31 23:58:00 * **Unit Discharge Time:** 2015-01-01 22:47:00 * **Unit Type:** SICU * **Admission Weight:** 91.7 kg * **Discharge Weight:** 93.1 kg * **Admission Height:** 177.8 cm * **Hospital Admit Source:** Emergency Department * **Unit Admit Source:** Operating Room * **Hospital Discharge Location:** Home * **Unit Discharge Location:** Floor * **Hospital Discharge Status:** Alive * **Unit Discharge Status:** Alive

2. History

NULL (Insufficient information provided in the JSON data to generate a detailed patient history.)

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis, active upon discharge, was sepsis (ICD-9 codes: 038.9, A41.9). Other significant diagnoses included:

* **Sepsis:** `infectious diseases|systemic/other infections|sepsis` (038.9, A41.9) - Primary, Active upon discharge. * **Post-GI Surgery (Exploratory Laparotomy):** `gastrointestinal|post-GI surgery|s/p exploratory laparotomy` - Major, Not active upon discharge. * **Post-GI Surgery (Exploratory Laparoscopy):** `gastrointestinal|post-GI surgery|s/p exploratory laparoscopy` - Other, Active upon discharge. * **Diverticulitis of Colon:** `infectious diseases|GI infections|enteritis|diverticulitis of colon` (562.11, K57.32) - Major, Active and inactive upon discharge. * **Peritonitis due to Bowel Perforation:** `gastrointestinal|abdominal/ general|peritonitis|due to bowel perforation` (567.9, K65.0) - Other, Active upon discharge.

The temporal relationships between these diagnoses suggest a possible causal link between the bowel perforation/peritonitis and the subsequent sepsis. The exploratory laparotomy and laparoscopy likely relate to the initial surgical intervention for the perforation.

4. Treatments

NULL (Insufficient information provided in the JSON data to detail treatments administered.)

5. Vital Trends

NULL (No vital sign data was included in the JSON input.)

6. Lab Trends

The provided laboratory data includes multiple blood tests performed at different time points during the patient's stay. There are two sets of complete blood counts (CBCs) and comprehensive metabolic panels (CMPs), one from before admission and one from later in the hospital stay. Analysis of these trends is crucial for understanding the patient's response to treatment. Initial lab values showed elevated lipase (194 Units/L), suggesting possible pancreatitis. The initial CMP reveals an elevated anion gap (10 mmol/L), which can be indicative of metabolic acidosis often associated with sepsis. Initial hemoglobin (Hgb) was 15 g/dL and hematocrit (Hct) was 44.2%, while the later values were 13.3 g/dL and 40.4%, respectively. This decrease could reflect blood loss associated with the surgery or ongoing inflammatory process. The patient's creatinine levels show a slight decrease from 1.12 mg/dL to 1.05 mg/dL between the initial and later tests. Platelet counts also decreased slightly from 219 K/mcL to 196 K/mcL. Further analysis of the complete blood counts is required to assess the differential count and evaluate for other potential infections or inflammatory response. Serial monitoring of these labs is essential to assess the patient's response to therapy and identify potential complications. The

data suggests that the patient's condition improved over time, with a reduction in inflammation markers. The change in lab values is consistent with a response to treatment. However, the exact treatments are not available in the given data. A full hematological analysis is needed to assess the complete picture of the patient's blood profile changes.

7. Microbiology Tests

NULL (No microbiology test results were included in the JSON input.)

8. Physical Examination Results

A structured physical examination was performed. The recorded systolic blood pressure was 119 mmHg, and the diastolic blood pressure was 58 mmHg. The Glasgow Coma Scale (GCS) score was 15 (Eyes: 4, Verbal: 5, Motor: 6), indicating normal neurological function. Fluid balance showed an intake and output of 1000 ml each, with a net balance of 0 ml. This suggests adequate hydration. The physical exam is limited in detail.