Medical Report for Patient 004-12627

1. Patient Information

* **Patient Unit Stay ID:** 404144 * **Unique Patient ID:** 004-12627 * **Gender:** Male * **Age:** 40 * **Ethnicity:** Caucasian * **Admission Weight:** 106.1 kg * **Hospital Admit Time:** 2015, 21:20:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2015, 20:00:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015, 23:29:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2015, 20:00:00 * **Unit Discharge Location:** Home * **Unit Discharge Status:** Alive * **Admission Diagnosis:** Diabetic ketoacidosis

2. History

NULL (Insufficient data provided to elaborate on the patient's medical history beyond the admission diagnosis.)

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. These included:

* **Primary Diagnosis (Active upon Discharge):** Diabetic Ketoacidosis (DKA) (ICD-9: 250.13, E10.1) * **Major Diagnoses (Active at some point):** Type I Diabetes Mellitus * **Other Diagnoses (Active at some point):** Nausea (ICD-9: 787.02, R11.0), Vomiting (ICD-9: 787.03, R11.10), Hypertension (ICD-9: 401.9, I10), Dehydration (ICD-9: 276.51, E86.0)

The temporal relationship between diagnoses is important. Nausea and vomiting were initially reported, followed by diagnoses of DKA and dehydration, suggesting a possible causal link. Hypertension was also a pre-existing condition.

4. Treatments

The patient received a range of treatments throughout their stay, including:

* **Fluid Management:** Multiple instances of normal saline administration, including fluid boluses. * **Insulin Therapy:** Continuous insulin infusion and sliding scale insulin administration were both used to manage the DKA. * **Antiemetic Medication:** Promethazine was administered to alleviate nausea and vomiting. * **Hypertension Management:** Hydralazine, a vasodilating agent, was administered intravenously to manage hypertension. * **Nutritional Support:** Oral feeds were initiated upon discharge from the unit.

The treatment plan evolved as the patient's condition changed, moving from aggressive fluid resuscitation and insulin management to maintenance therapy and nutritional support before discharge.

5. Vital Trends

NULL (No vital sign data provided)

6. Lab Trends

The following laboratory results were recorded:

* **Glucose:** 418 mg/dL (significantly elevated, consistent with DKA) * **Albumin:** 4.1 g/dL (within the normal range) * **Sodium:** 135 mEq/L (within normal range) * **Creatinine:** 1.4 mg/dL (slightly elevated, potentially reflecting dehydration or kidney stress) * **BUN:** 21 mg/dL (slightly elevated, potentially reflecting dehydration or kidney stress) * **Hematocrit (Hct):** 50% (slightly elevated, possibly due to dehydration) * **White Blood Cell Count (WBC):** 16.5 K/mcL

(elevated, indicating an inflammatory response or infection) * **FiO2:** 21% (room air, suggesting adequate oxygenation)

Further lab data is needed to fully assess the patient's response to treatment.

7. Microbiology Tests

NULL (No microbiology test data provided.)

8. Physical Examination Results

A structured physical exam was performed. The recorded values include:

* **Weight (kg):** 106.1 kg * **Respiration Mode:** Spontaneous * **Respiratory Rate:** 14 breaths per minute * **Heart Rate:** 114 bpm * **Blood Pressure:** 156/96 mmHg * **Oxygen Saturation:** 100% * **Glasgow Coma Scale (GCS):** 15 (4, 5, 6) - indicating normal neurological function

The physical examination findings support the patient's overall clinical presentation, showing normal neurological function despite the presence of DKA and other diagnoses.