Medical Report: Patient 005-10504

1. Patient Information

* **Patient Unit Stay ID:** 472969 * **Patient Health System Stay ID:** 401214 * **Unique Patient ID:** 005-10504 * **Gender:** Male * **Age:** 44 years * **Ethnicity:** Hispanic * **Hospital ID:** 141 * **Ward ID:** 307 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 22:49:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 06:07:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 16:37:00 * **Hospital Admit Offset (minutes from unit admit):** -372 * **Hospital Admit Source:** NULL * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 22:00:00 * **Hospital Discharge Offset (minutes from unit admit):** 15791 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Height:** 177.8 cm * **Admission Weight:** 80.7 kg * **Discharge Weight:** NULL * **APACHE Admission Dx:** Diabetic ketoacidosis

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis, active upon discharge, was Diabetic Ketoacidosis (DKA), with ICD-9 codes 250.13 and E10.1. This diagnosis was recorded at 2800 minutes from unit admission time. Another instance of DKA was recorded at 1433 minutes and 143 minutes from unit admission, however, these were not active upon discharge. Type II uncontrolled diabetes mellitus (ICD-9 codes 250.02 and E11.65) was also a major diagnosis, active upon discharge and recorded at 2800 minutes post-admission. Pneumonia (ICD-9 codes 486 and J18.9) was recorded as both a major and other diagnosis at various points during the stay, with some instances active upon discharge and others not. The multiple entries for each diagnosis might reflect updates or revisions to the patient's condition over time. The diagnosis priority field indicates the relative importance assigned to each diagnosis by the medical team.

4. Treatments

The patient received a variety of treatments throughout their ICU stay. Active treatments upon discharge included:

* Therapeutic antibacterials (infectious diseases) at 2800 minutes * Nebulized bronchodilators (pulmonary) at 2800 minutes * Oxygen therapy (<40%) via nasal cannula (pulmonary) at 2800 minutes * Chest x-ray (pulmonary) at 2800 minutes * Social work consult (general) at 2800 minutes * Continuous infusion of insulin (endocrine) at 2800 minutes * Normal saline administration (endocrine) at 2800 minutes * Magnesium administration (endocrine) at 2800 minutes

Other treatments administered during the stay but not active at discharge included VTE prophylaxis (pulmonary), potassium administration (endocrine) and cultures (infectious diseases). These were administered at various time points during the patient's stay. The multiple entries for some treatments may indicate repeated administrations or changes in treatment plans.

5. Vital Trends

NULL (Insufficient information provided)

6. Lab Trends

The provided data includes numerous laboratory tests performed at different times during the patient's stay. These tests primarily focus on complete blood count (CBC) parameters such as WBC, RBC, Hgb, Hct, MCV, MCH, MCHC, RDW, MPV, and platelet counts, as well as blood chemistry values (glucose, BUN, creatinine, anion gap, chloride, sodium, calcium, ionized calcium, phosphate, lactate, AST, ALT, total protein, total bilirubin, direct bilirubin, and albumin) and blood

gas values (pH, PaCO2, PaO2, O2 content, FiO2, and Base Excess). The data shows multiple measurements for several of these parameters at various intervals. A detailed trend analysis requires a time series representation of the data, which is not directly presented in this format. However, the presence of multiple bedside glucose measurements suggests close monitoring of the patient's blood sugar levels.

7. Microbiology Tests

The patient underwent cultures at different times during their stay, reflecting an ongoing assessment of potential infections.

8. Physical Examination Results

Physical examinations were performed at 97 minutes and 191 minutes and 2798 minutes post-unit admission. Consistent findings included: GCS score of 15, normal cranial nerves, equal and reactive pupils, normal heart sounds, normal pulses, no organomegaly, no masses, no edema, and no pain on palpation. The patient was consistently described as ill-appearing and not in acute distress. Respiratory findings included spontaneous respiration, with noted rales in the lower right lung field (both anterior and posterior) and prolonged exhalation. Vital signs are recorded (HR, BP, Resp Rate, O2 Sat) but trends are not directly available. The weight was recorded at admission as 80.7kg. Fluid balance is also documented (Urine, Intake, Output, Dialysis Net, Total Net). The repetition of the exam at multiple time points suggests ongoing monitoring of the patient's condition.