Medical Report: Patient 003-10799

1. Patient Information

* **Patient Unit Stay ID:** 296926 * **Patient Health System Stay ID:** 256495 * **Unique Patient ID:** 003-10799 * **Gender:** Male * **Age:** 66 * **Ethnicity:** Caucasian * **Hospital ID:** 108 * **Ward ID:** 136 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 05:43:00 (2014) * **Unit Admit Source:** Operating Room * **Unit Discharge Time:** 15:56:00 (2014) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 01:21:00 (2014) * **Hospital Admit Source:** Operating Room * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 20:35:00 (2014) * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Admission Weight:** 101.6 kg * **Discharge Weight:** 108.3 kg * **Admission Height:** 182.9 cm * **Admission Diagnosis:** GI perforation/rupture, surgery for

2. History

NULL (Insufficient data provided)

3. Diagnoses

The patient presented with multiple diagnoses, primarily related to the gastrointestinal system and post-surgical complications. The primary diagnosis upon admission was post-exploratory laparotomy, indicating prior abdominal surgery. Secondary diagnoses included gastric viscus perforation and intestinal disease. The diagnoses of gastric viscus perforation and intestinal disease were each recorded twice at different times during the ICU stay; the first instance at 30 minutes post-unit admission, the second at 725 minutes and 2460 minutes post-unit admission. This suggests either evolving understanding of the patient's condition or the need for further evaluation and clarification of the specific pathology. The ICD-9 codes 537.9 and K31.9 were associated with the intestinal disease and gastric perforation diagnoses. The discrepancies in the timing and number of diagnoses highlight the complexity of the patient's case.

4. Treatments

The patient received a wide range of treatments during their ICU stay, reflecting the multiple diagnoses. These treatments included empiric antibacterial coverage, metronidazole, and levofloxacin (a quinolone antibiotic), suggesting treatment of a suspected infection. Neuraxial analgesics and lorazepam were administered for pain and sedation management, typical for post-operative care. The administration of D50 and insulin indicates management of glucose levels, potentially due to stress or underlying conditions. Other treatments included stress ulcer prophylaxis (esomeprazole), bronchodilator (beta-agonist) and nebulized bronchodilator treatments, and Lactated Ringer's and normal saline administration for intravenous fluid management. Consultations with physical therapy and occupational therapy were also documented, signifying a plan for rehabilitation. The diversity of treatments emphasizes a multi-system approach to managing the patient's condition.

5. Vital Trends

NULL (Insufficient data provided)

6. Lab Trends

The patient underwent extensive laboratory testing during their ICU stay. Multiple blood tests were taken at various intervals, including complete blood counts (CBC), metabolic panels, and cardiac enzyme tests. The time-series data from these tests would be critical in assessing the patient's response to treatment and the progression of their condition. Specific lab values include multiple bedside glucose measurements that varied from 134 to 303 mg/dL, BUN that varied from 18 to 38 mg/dL, Creatinine that varied from 0.85 to 1.74 mg/dL, and Troponin-T levels that were elevated initially but trended downward. Analysis of these trends would reveal insights into the patient's metabolic state, renal function, and cardiac status. Multiple hemogram results reflect the patient's evolving hematologic profile. Further detailed analysis is required to interpret the significance of these fluctuations.

7. Microbiology Tests

NULL (Insufficient data provided)

8. Physical Examination Results

A structured physical exam was performed at 2 minutes post-unit admission. The Glasgow Coma Scale (GCS) was documented as scored with individual subscores of 4 (eyes), 5 (verbal), and 6 (motor), indicating a good level of consciousness. Heart rate (HR) was measured at 73 bpm. Systolic blood pressure (BP) was 107 mmHg, and diastolic BP was 66 mmHg. Respiratory rate was 18 breaths per minute. Oxygen saturation (O2 Sat) was 97%. The patient's admission weight was 101.6 kg. The patient's heart rhythm was documented as sinus, and respiratory mode as spontaneous. A subsequent physical exam was not performed (noted at 2454 minutes post-unit admission).