

****Patient Medical Report****

****1. Patient Information:****

***PatientUnitStayID:** 608375 * **PatientHealthSystemStayID:** 495524 * **Gender:** Male * **Age:** 57 * **Ethnicity:** Caucasian * **HospitalID:** 155 * **WardID:** 362 * **Admission Diagnosis:** Sepsis, GI * **Admission Height:** 177.9 cm * **Hospital Admit Time:** 2015-XX-XX 00:00:00 * **Hospital Admit Source:** PACU * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 22:16:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 16:07:00 * **Unit Admit Source:** Acute Care/Floor * **Unit Visit Number:** 2 * **Unit Stay Type:** transfer * **Admission Weight:** 102.8 kg * **Discharge Weight:** 112.9 kg * **Unit Discharge Time:** 2015-XX-XX 20:34:00 * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Unique Patient ID:** 006-101785

****2. History:****

NULL (Insufficient data provided)

****3. Diagnoses:****

The patient presented with multiple diagnoses during their ICU stay. The primary diagnoses, both initially and upon discharge, were:

* **Gastrointestinal|Post-GI surgery|s/p exploratory laparotomy:** This diagnosis was entered 508 minutes and 1883 minutes after unit admission. It was not active upon discharge. * **Pulmonary|Respiratory failure|Hypoxemia (ICD-9 codes 799.02, J96.91):** This diagnosis was documented multiple times throughout the stay, both as primary and major diagnoses. It remained active upon discharge.

The timing of these diagnoses suggests a potential causal relationship, with respiratory failure possibly stemming from or exacerbated by the post-surgical condition.

****4. Treatments:****

The patient received the following treatments:

* **Gastrointestinal|Exploratory surgery|Exploratory laparotomy:** This treatment was administered at 508 minutes and 1883 minutes post unit admission. It was active upon discharge. * **Pulmonary|Ventilation and oxygenation|Mechanical ventilation:** This treatment was initiated at 747 and 763 minutes post unit admission. It was not active upon discharge. * **Pulmonary|Ventilation and oxygenation|Mechanical ventilation|Non-invasive ventilation:** This treatment was initiated 275 minutes post unit admission and was not active on discharge.

The administration of mechanical ventilation points to the severity of respiratory complications.

****5. Vital Trends:****

The following vital signs were recorded at different time points:

* **Heart Rate (HR):** Current: 76 bpm (at 502 minutes), 112 bpm (at 5 minutes), 153 bpm (at 274 minutes), 92 bpm (at 748 minutes); Lowest: 75 bpm (at 502 minutes), 87 bpm (at 5 minutes); Highest: 175 bpm (at 502 minutes and 274 minutes). * **Blood Pressure (BP):** Systolic Current: 146 mmHg (at 502 minutes), 103 mmHg (at 5 minutes), 103 mmHg (at 274 minutes), 109 mmHg (at 748 minutes); Systolic Lowest: 103 mmHg (at 502 minutes), 109 mmHg (at 5 minutes and 748 minutes); Systolic Highest: 146 mmHg (at 502 minutes and 748 minutes), 212 mmHg (at 5 minutes); Diastolic Current: 64 mmHg (at 502 minutes), 73 mmHg (at 5 minutes), 65 mmHg (at 274 minutes), 52 mmHg (at 748 minutes); Diastolic

Lowest: 55 mmHg (at 502 minutes), 73 mmHg (at 5 minutes); Diastolic Highest: 64 mmHg (at 502 minutes), 65 mmHg (at 274 minutes), 93 mmHg (at 5 minutes). * **Respiratory Rate:** Current: 17 breaths/min (at 502 minutes), 26 breaths/min (at 274 minutes), 17 breaths/min (at 748 minutes); Lowest: 8 breaths/min (at 502 minutes and 748 minutes), 18 breaths/min (at 274 minutes); Highest: 26 breaths/min (at 502 minutes and 274 minutes). * **Oxygen Saturation (O2 Sat):** Current: 98% (at 502 minutes), 91% (at 5 minutes), 96% (at 274 minutes), 97% (at 748 minutes); Lowest: 85% (at 502 minutes and 274 minutes), 85% (at 5 minutes); Highest: 98% (at 502 minutes), 97% (at 274 minutes), 98% (at 748 minutes). * **FiO2:** 75% (at 274 minutes), 80% (at 748 minutes) * **PEEP:** 8 cmH2O (at 748 minutes) * **Vent Rate:** 4 breaths/min (at 274 minutes), 18 breaths/min (at 748 minutes) * **Weight:** Admission: 102.8 kg (at 502 minutes, 5 minutes, 274 minutes, 748 minutes); Current: 112.9 kg (at 502 minutes, 5 minutes, 274 minutes, 748 minutes); Delta: +10.1 kg (at 502 minutes, 5 minutes, 274 minutes, 748 minutes). * **I&O:** Urine: 0 ml (at 502 minutes, 5 minutes, 274 minutes), 165 ml (at 748 minutes); Intake Total: 4400 ml (at 502 minutes, 5 minutes, 274 minutes), 1880 ml (at 748 minutes); Output Total: 825 ml (at 502 minutes, 5 minutes, 274 minutes), 725 ml (at 748 minutes); Dialysis Net: 0 ml (at 502 minutes, 5 minutes, 274 minutes, 748 minutes); Total Net: +3575 ml (at 502 minutes, 5 minutes, 274 minutes), +1155 ml (at 748 minutes). * **Glasgow Coma Scale (GCS):** Score: scored (at 502 minutes and 748 minutes), Eyes: 4, Verbal: 5, Motor: 6 (at 502 minutes and 748 minutes).

6. Lab Trends:

Several lab tests were conducted. Noteworthy trends include:

* **Blood gases:** Initial blood gas analysis showed a low bicarbonate (22.3 mmol/L), low paO2 (72.3 mmHg), and a negative base excess (-2.4 mEq/L), indicating respiratory acidosis. Later blood gas showed a slightly improved pH (7.306) but still indicated respiratory acidosis with low bicarbonate (21.5 mmol/L), reduced paO2 (91.9 mmHg), and a more negative base excess (-3.5 mmol/L) at 520 minutes post admission. The FiO2 was initially 45% and increased to 80% and 100% at different time points. These findings are consistent with the patient's respiratory failure. * **Electrolytes:** The patient's sodium (141 mmol/L), potassium (4.4 mmol/L), and chloride (108 mmol/L) levels were within normal ranges at 978 minutes post admission. * **Liver function:** AST (15 Units/L) and ALT (22 Units/L) were mildly elevated, suggesting possible liver involvement. Alkaline phosphatase (44 Units/L) was also elevated. * **Renal function:** Creatinine (0.64 mg/dL) was within normal limits. * **Complete blood count:** Hemoglobin (11.5 g/dL) and hematocrit (33.7%) were slightly low, potentially indicating anemia. White blood cell count (9.8 K/mcL) was slightly elevated, suggesting an inflammatory response. Platelets (244 K/mcL) were within normal ranges. MPV was 11fL and MCHC was 34.1 g/dL and MCH was 28.1 pg. MCV was 82 fL and RDW was 14.8%. * **Other:** Blood glucose levels were elevated at multiple time points (105 mg/dL, 107 mg/dL, 111 mg/dL, 116 mg/dL, 122 mg/dL), and albumin was low (2.4 g/dL) indicating nutritional deficiencies. Total bilirubin (1.3 mg/dL) was slightly elevated. Total protein (5.3 g/dL) and calcium (8 mg/dL) were within normal ranges. Anion gap was 6. Triglycerides were elevated (121 mg/dL). Lactate was elevated at two different time points (2.1 mmol/L, 2.6 mmol/L).

7. Microbiology Tests:

NULL (Insufficient data provided)

8. Physical Examination Results:

Physical exams were performed at 5, 274, 502, and 748 minutes post unit admission. The exams documented vital signs (HR, BP, RR, O2 Sat) and weight, I&O, and GCS scores. These recorded values are listed in the vital signs section above. All physical exams were marked as 'Performed - Structured'.