Medical Report for Patient 004-16896

1. Patient Information

* **Patient Unit Stay ID:** 365652 * **Unique Patient ID:** 004-16896 * **Gender:** Male * **Age:** 26 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2014, 20:14:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2014, 14:46:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 23:25:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 00:29:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 58.96 kg * **Admission Height:** 170.2 cm

2. History

The patient was admitted to the hospital through the Emergency Department with a primary diagnosis of Diabetic Ketoacidosis (DKA) and a secondary diagnosis of Type I diabetes mellitus. The patient presented with symptoms consistent with DKA (details not provided in the given data). The patient was transferred to the Med-Surg ICU for further management.

3. Diagnoses

* **Primary Diagnosis:** endocrine|glucose metabolism|DKA (ICD-9 codes: 250.13, E10.1) * **Secondary Diagnosis:** endocrine|glucose metabolism|diabetes mellitus|Type I

4. Treatments

The patient received the following treatments during their ICU stay:

* Subcutaneous dose of regular insulin * Acetaminophen (non-narcotic analgesic) for pain management * Fluoxetine (Prozac) (SSRI) for pain/agitation/altered mentation * Moderate volume resuscitation (150-250 mls/hr) of normal saline * Ondansetron (serotonin antagonist) for nausea and vomiting * Potassium electrolyte administration * Enoxaparin (low molecular weight heparin) for VTE prophylaxis * Sliding scale insulin administration * Continuous insulin infusion

The specific dosages and durations of these treatments are not provided in the available data. Further information would be needed to complete a thorough treatment summary.

5. Vital Trends

NULL. Vital sign data (heart rate, blood pressure, respiratory rate, oxygen saturation) is not included in the provided dataset. A complete vital trends section requires this information.

6. Lab Trends

The following lab results are available:

* **Hematology:** Blood tests were conducted revealing the following values at different time points. Precise time points and trends are difficult to determine without a time-series analysis. The data includes WBC, RBC, Hgb, Hct, MCV, MCH, MCHC, RDW, Platelets, Lymphocytes, Monocytes, Eosinophils, Basophils, and Polymorphonuclear neutrophils (polys) The results exhibit variability in some values over time, warranting further investigation. The lack of consistent units across different lab tests makes direct comparison challenging. The available data does not provide enough detail to establish clear trends across time.

* **Blood Gases:** ABG values, including pH, pCO2, pO2, Oxyhemoglobin, Methemoglobin, Carboxyhemoglobin, and Base Deficit, were also recorded. These values are crucial for assessing the patient's respiratory and acid-base balance. However, without a timeline, it is impossible to chart the trends of these values. An initial ABG indicated significant acidosis (pH 7.042) and a large base deficit (24.9 mEq/L). A later ABG showed improvement (values not provided).

* **Chemistry:** Chemistry panels were performed, including BUN, Creatinine, Glucose, Sodium, Potassium, Chloride, Bicarbonate, Total Bilirubin, Albumin, Total Protein, ALT (SGOT), AST (SGPT), and Alkaline Phosphatase. These values show significant variation throughout the patient's stay. The patient initially presented with elevated glucose levels (502 mg/dL), reflecting the DKA. Subsequent glucose values show substantial fluctuation but overall demonstrate a downward trend following treatment. Electrolyte levels (Sodium, Potassium, Chloride, and Bicarbonate) also show variation, requiring further analysis to understand the trends and their clinical significance.

7. Microbiology Tests

NULL. No microbiology test results are present in the provided data.

8. Physical Examination Results

The patient underwent a structured physical exam. A Glasgow Coma Scale (GCS) score of 15 (4+6+5) was recorded. Admission weight was 58.96 kg. Urine output was 525 ml. Initial vital signs recorded were: Heart rate 91 bpm, systolic blood pressure 116 mmHg, diastolic blood pressure 75 mmHg, respiratory rate 20 breaths/min, and oxygen saturation 100% on 21% FiO2.

Note: This report is based on the limited data provided. Additional information is needed to complete all sections fully and provide a more comprehensive assessment of the patient's condition and care.