

****Medical Report: Patient 006-103364****

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

*****Patient Unit Stay ID:** 958720 * **Patient Health System Stay ID:** 705670 * **Unique Patient ID:** 006-103364 *
Gender: Male * **Age:** 34 years * **Ethnicity:** Caucasian * **Hospital ID:** 157 * **Ward ID:** 369 * **Unit Type:**
Med-Surg ICU * **Unit Admit Time:** 00:14:00 * **Unit Admit Source:** Floor * **Unit Visit Number:** 3 * **Unit Stay
Type:** Readmit * **Admission Weight:** 126.3 kg * **Discharge Weight:** 108 kg * **Unit Discharge Time:** 04:50:00 *
Unit Discharge Location: Skilled Nursing Facility * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 22:09:00
* **Hospital Admit Source:** Step-Down Unit (SDU) * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:**
04:50:00 * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Admission
Height:** 185 cm * **APACHE Admission Dx:** Sepsis, unknown**

****2. History****

NULL (Insufficient data provided)

****3. Diagnoses****

The patient presented with multiple diagnoses, all marked as inactive upon discharge except for ESRD and septic shock. The primary diagnosis was septic shock (ICD-9 codes 785.52, R65.21), entered 12061 minutes and 9226 minutes after unit admission. Major diagnoses included Cardiomyopathy (cardiovascular|ventricular disorders|cardiomyopathy), Toxic Encephalopathy (neurologic|altered mental status / pain|encephalopathy|toxic) with ICD-9 codes 349.82, G92, and ESRD (end stage renal disease) (renal|disorder of kidney|ESRD (end stage renal disease)) with ICD-9 codes 585.6, N18.6. Pleural effusion (pulmonary|pleural disorders|pleural effusion) with ICD-9 codes 511.9, J91.8 and Lower GI bleeding (gastrointestinal|GI bleeding / PUD|lower GI bleeding) with ICD-9 codes 578.9, K92.2 were also listed as major diagnoses. The timing of diagnosis entries suggests a complex clinical picture evolving over the ICU stay. Note that multiple entries exist for the same diagnosis string, likely reflecting updates or refinements to the diagnosis over time. The absence of ICD-9 codes for some diagnoses may indicate incomplete documentation or reliance on alternative coding systems.

****4. Treatments****

The patient received various treatments during their ICU stay. These included hemodialysis (renal|dialysis|hemodialysis) for chronic renal failure, initiated at various times (911, 1044, 1042 minutes from unit admission) and continued until discharge (12859 minutes post-admission). Mechanical ventilation (pulmonary|ventilation and oxygenation|mechanical ventilation) and non-invasive ventilation (pulmonary|ventilation and oxygenation|non-invasive ventilation) were also administered, starting at different time points (1044, 911, 5454, 11415 minutes post admission). The use of vasopressors (cardiovascular|shock|vasopressors) , specifically norepinephrine (at doses both above and below 0.1 micrograms/kg/min), was employed to manage shock (cardiovascular|shock|vasopressors), beginning at different times (1044, 2876, 8855, 10223 minutes post admission). An esophagogastroduodenoscopy (gastrointestinal|endoscopy/gastric instrumentation|esophagogastroduodenoscopy) was also performed (6764 minutes post-admission). The temporal sequencing of these treatments reflects the dynamic management of the patient's multiple organ system failures.

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

NULL (Insufficient data provided)

****6. Lab Trends****

The provided lab data shows multiple measurements of blood glucose, complete blood count (CBC) with differential, and basic metabolic panel (BMP) over time. Bedside glucose levels fluctuated significantly, ranging from a low of 58 mg/dL to a high of 145 mg/dL. Hemoglobin (Hgb) and hematocrit (Hct) levels also varied, suggesting potential blood loss or fluid shifts. Electrolyte levels (sodium, potassium, chloride, bicarbonate) and renal function markers (BUN, creatinine) exhibited changes, possibly reflecting the patient's underlying renal failure and overall clinical status. The frequent bedside glucose

checks point to ongoing concern for glycemic control. The ABG data shows fluctuations in pH, PaO₂, PaCO₂, and Base Excess, indicating the dynamic nature of the patient's respiratory status. Further analysis is needed to establish precise trends and correlations with other clinical parameters. The multiple lab tests provide crucial insights into the patient's response to treatment and the progression of their illness. The incomplete nature of the data, however, limits the completeness of the trend analysis.

****7. Microbiology Tests****

NULL (Insufficient data provided)

****8. Physical Examination Results****

Initial physical exam documented at 0 minutes post-admission indicated a structured physical exam was performed. A subsequent exam at 8850 minutes post-admission revealed vital signs: heart rate (HR) ranging from 77 to 114 bpm, blood pressure (BP) systolic from 98 to 127 mmHg, and diastolic from 32 to 53 mmHg; respiratory rate (RR) from 14 to 32 breaths per minute and oxygen saturation (O₂ Sat) from 88% to 99%. The Glasgow Coma Scale (GCS) was initially estimated as 14 (Eyes 4, Verbal 5, Motor 6) due to medication effects and was later scored as 15 at 8850 minutes post admission. Admission weight of 126.3 kg was recorded, and further information about fluid balance (I&O;) is available including the total intake (1150 ml), the total output (301 ml) and dialysis net (-4000 ml), resulting in a total net of -3151 ml. These findings suggest a fluctuating condition with some improvement in neurological status over time. The limited nature of the physical exam data, however, prevents a comprehensive overview of the patient's physical state.