Patient Information

Patient ID: 006-100338 Patient Unit Stay ID: 758327 Gender: Male Age: 64 Ethnicity: Other/Unknown Hospital Admit Time: 2014-XX-XX 14:15:00 Hospital Admit Source: Emergency Department Hospital Discharge Time: 2014-XX-XX 22:34:00 Hospital Discharge Location: Other External Hospital Discharge Status: Alive Unit Type: MICU Unit Admit Time: 2014-XX-XX 15:27:00 Unit Admit Source: Floor Unit Visit Number: 3 Unit Stay Type: readmit Admission Weight: 63 kg Discharge Weight: 73.3 kg Unit Discharge Time: 2014-XX-XX 22:34:00 Unit Discharge Location: Other External Unit Discharge Status: Alive

Medical History

Insufficient data provided. NULL

Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis, identified as 'cardiovascular|shock / hypotension|septic shock' (ICD-9 codes: 785.52, R65.21), was recorded multiple times throughout the stay, both early and late, indicating the persistence of this condition. A major diagnosis, 'pulmonary|respiratory failure|hypoxemia' (ICD-9 codes: 799.02, J96.91), was also documented at various intervals, signifying respiratory compromise. Furthermore, aspiration pneumonia ('pulmonary|pulmonary infections|pneumonia|aspiration', ICD-9 codes: 507.0, J69.0) was also a major diagnosis, suggesting a possible etiology for the respiratory failure. The diagnoses of septic shock and respiratory failure were both active upon discharge from the unit.

Treatments

The patient received several treatments during their ICU stay. 'Aggressive volume resuscitation (>250 mls/hr)' with normal saline was administered intravenously, indicating management of hypovolemia, possibly related to the septic shock. This treatment was active upon discharge. Vasopressor support with norepinephrine was used to manage hypotension, a key component of septic shock, but this treatment was discontinued before discharge. The patient also underwent an esophagogastroduodenoscopy, possibly to evaluate and/or treat the aspiration pneumonia. This procedure was also active at the time of discharge from the unit.

Vital Trends

Insufficient data provided. NULL

Lab Trends

The provided lab data shows multiple measurements taken at different time points during the patient's stay. Significant trends include elevated BUN and creatinine, indicating potential renal dysfunction. The patient's glucose levels fluctuated significantly, ranging from a low of 88 mg/dL to a high of 255 mg/dL, suggesting challenges in maintaining glycemic control. Electrolyte imbalances were also observed, with potassium levels ranging from 3.2 mmol/L to 4.8 mmol/L and sodium levels varying from 129 mmol/L to 153 mmol/L, highlighting the severity of the patient's condition. Hematological data shows the patient’s complete blood count (CBC) with differential which showed significant fluctuations in the white blood cell (WBC), hematocrit (Hct), hemoglobin (Hgb), and platelet counts, further indicating the severity of the sepsis and the body's inflammatory response. The anion gap was elevated which is consistent with the diagnosis of lactic acidosis secondary to sepsis. The patient's blood gas results showed a low PaO2 and elevated PaCO2, reflecting the respiratory failure. The PT and INR were elevated which is consistent with abnormal coagulation that is often seen in sepsis. The patient also had low albumin levels suggesting nutritional deficiencies. Finally, multiple bedside glucose measurements were taken, which ranged from 80 mg/dL to 219 mg/dL.

Microbiology Tests

Insufficient data provided. NULL

Physical Examination Results

Physical exam data recorded at 2002 and 176 minutes post unit admission. The patient's initial GCS score was recorded as 'scored' and later a more complete assessment gave a score of 14 (Eyes: 4, Verbal: 4, Motor: 6), suggesting neurological function was initially scored and later determined to be normal. Heart rate was recorded at 99 bpm (current), 95 bpm (lowest), and 113 bpm (highest), representing sinus rhythm. Blood pressure was recorded at 120/60 mmHg (current), with a low of 116/53 mmHg and a high of 173/68 mmHg. Respiratory rate was 21 breaths per minute (current), with a low of 18 and a high of 25 breaths per minute. Oxygen saturation was 91% (current and lowest), and 98% (highest). Admission weight was 63 kg. Fluid balance indicated a negative net balance of -5885 ml. The patient was ventilated.