\*\*Medical Report: Patient 006-100497\*\*

### \*\*1. Patient Information\*\*

\* \*\*Patient Unit Stay ID:\*\* 958499 \* \*\*Unique Patient ID:\*\* 006-100497 \* \*\*Gender:\*\* Male \* \*\*Age:\*\* 28 \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital Admission Time:\*\* 2014, 21:28:00 \* \*\*Hospital Discharge Time:\*\* 2014, 17:31:00 \* \*\*Unit Admission Time:\*\* 09:40:00 \* \*\*Unit Discharge Time:\*\* 16:13:00 \* \*\*Unit Type:\*\* Med-Surg ICU \* \*\*Admission Weight:\*\* 54.1 kg \* \*\*Discharge Weight:\*\* 54.1 kg \* \*\*Admission Height:\*\* 177 cm \* \*\*Hospital Admission Source:\*\* NULL \* \*\*Hospital Discharge Location:\*\* Home \* \*\*Hospital Discharge Status:\*\* Alive \* \*\*Unit Admission Source:\*\* Emergency Department \* \*\*Unit Discharge Location:\*\* Step-Down Unit (SDU) \* \*\*Unit Discharge Status:\*\* Alive

## \*\*2. History\*\*

Insufficient data provided to generate a detailed patient history. The provided data only includes admission and discharge times and locations, along with diagnoses and lab results. A comprehensive history would require additional information such as presenting symptoms, family history, past medical history, social history, and medication history. This section is therefore left as NULL.

# \*\*3. Diagnoses\*\*

\* \*\*Primary Diagnosis 1:\*\* Diabetic Ketoacidosis (DKA) (ICD-9 codes: 250.13, E10.1) \* Entered 9 minutes after unit admission. \* Not active upon discharge. \* \*\*Primary Diagnosis 2:\*\* Severe Sepsis (ICD-9 codes: 995.92, R65.2) \* Entered 39 minutes after unit admission. \* Active upon discharge. \* \*\*Major Diagnosis:\*\* Diabetic Ketoacidosis (DKA) (ICD-9 codes: 250.13, E10.1) \* Entered 39 minutes after unit admission. \* Active upon discharge.

The patient presented with multiple primary diagnoses, suggesting a complex clinical picture requiring urgent and multifaceted interventions. The persistence of sepsis and DKA upon discharge highlights the significance of these conditions and the need for continued management.

# \*\*4. Treatments\*\*

\* \*\*Aggressive Volume Resuscitation:\*\* Administration of normal saline intravenously at a rate exceeding 250 mls/hr. \* Initiated 39 minutes after unit admission. \* Active upon discharge. \* \*\*Aggressive Volume Resuscitation:\*\* Administration of normal saline intravenously at a rate exceeding 250 mls/hr. \* Initiated 9 minutes after unit admission. \* Not active upon discharge.

The aggressive volume resuscitation treatment underscores the severity of the patient's septic shock. The continuation of this treatment post-discharge indicates the ongoing need for fluid management.

### \*\*5. Vital Trends\*\*

The following vital signs were recorded at 30 minutes post unit admission: \* \*\*Heart Rate (HR):\*\* 112 bpm \* \*\*Blood Pressure (BP) Systolic:\*\* 126 mmHg \* \*\*Blood Pressure (BP) Diastolic:\*\* 72 mmHg \* \*\*Respiratory Rate:\*\* 22 breaths/min \* \*\*Oxygen Saturation (O2 Sat):\*\* 96%

## \*\*6. Lab Trends\*\*

The following lab results were recorded at approximately 95 minutes post unit admission, with additional results available from earlier time points. Detailed time series analysis would require more granular data. \* \*\*Glucose:\*\* 218 mg/dL \* \*\*Anion Gap:\*\* 11 \* \*\*Creatinine:\*\* 1.3 mg/dL \* \*\*Bicarbonate:\*\* 14 mmol/L \* \*\*Potassium:\*\* 4.4 mmol/L \* \*\*Chloride:\*\* 112 mmol/L \* \*\*BUN:\*\* 25 mg/dL \* \*\*Calcium:\*\* 7.3 mg/dL \* \*\*MPV:\*\* 9.8 fL \* \*\*RBC:\*\* 4.59 M/mcL \* \*\*Hgb:\*\* 15.3 g/dL \* \*\*Hct:\*\* 41.2 % \* \*\*RDW:\*\* 12.8 % \* \*\*MCH:\*\* 33.3 pg \* \*\*Platelets x 1000:\*\* 272 K/mcL \* \*\*PT:\*\* 14.1 sec \* \*\*PT-INR:\*\* 1.1 ratio \* \*\*MCHC:\*\* 37 g/dL \* \*\*WBC x 1000:\*\* 13.8 K/mcL \* \*\*Bedside glucose (multiple time points):\*\* Values ranging

from 94 to >600 mg/dL. \* \*\*Lactate (multiple time points):\*\* Values ranging from 2.8 to 6.8 mmol/L. \* \*\*Phosphate:\*\* 7.5 mg/dL (prior to admission) \* \*\*Magnesium:\*\* 1.8 mg/dL (prior to admission) \* \*\*CPK:\*\* 271 Units/L (prior to admission) \* \*\*CPK-MB:\*\* 4.5 ng/mL (prior to admission) \* \*\*CPK-MB INDEX:\*\* 1.7 % (prior to admission)

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

NULL. No microbiology test data is provided.

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

A structured physical exam was performed at 30 minutes and 4 minutes post unit admission. The Glasgow Coma Scale (GCS) was scored; specific values were not documented. Weight was 54.1 kg at admission and remained unchanged during the ICU stay. Intake was 250 ml and output was 1415 ml, resulting in a net negative fluid balance of -1165 ml. Additional physical exam data is not available.