ADMITTING DIAGNOSIS: Sepsis {ICD10=A41.9; ICD9=995.91; SNOMED=91302008; PRIMARY}.

DISCHARGE DIAGNOSES: Septic shock {ICD10=R57.9; ICD9=785.52; SNOMED=76571007} with organ system dysfunction due to bacterial pneumonia {ICD10=J18.9; ICD9=482.9; SNOMED=53084003}. Acute renal failure {ICD10=N17.9; ICD9=584.9; SNOMED=14669001} secondary to above and acute tubular necrosis {ICD10=N17.0; ICD9=584.5; SNOMED=23697004}. Chronic obstructive pulmonary disease {ICD10=J44.9; ICD9=496; SNOMED=13645005}. Systemic lupus erythematosus {ICD10=M32.9; ICD9=710.0; SNOMED=55464009}.

CONSULTANTS: None.

PROCEDURES: Echocardiography {ICD10=B246ZZZ; ICD9=37.28; SNOMED=40701008; PRIMARY} showing an ejection fraction of 46% with normal valvular structure with the exception of the mitral valve which does show some mid anterior leaflet malformation, borderline elevation of serum Troponin's at .06. These abnormalities improve during the hospital stay.

HISTORY OF PRESENT ILLNESS: The patient presents to the ER due to worsening weakness {ICD10=R53.1; ICD9=780.79; SNOMED=13791008} and orthostatic dizziness {ICD10=R42; ICD9=780.4; SNOMED=404640003}. She began feeling ill 3 days prior to admission. It was felt she had pneumonia {ICD10=J18.9; ICD9=486; SNOMED=233604007} and was started on po antibiotics and sent home. She didn't get better and returned and because of her worsening condition, she was admitted and worked up with the presumptive diagnosis of failed outpatient therapy but because of her hypotension {ICD10=I95.9; ICD9=458.9; SNOMED=45007003}, it is felt this likely represents acute sepsis and she also showed acute renal failure and so this was felt to be related to the septic shock. She was admitted for treatment of these conditions. For specifics regarding this inpatient admission, please refer to the inpatient chart.

HOSPITAL COURSE: After admission, she was actually admitted to the ICU and had to be ventilated because of progressive respiratory failure {ICD10=J96.9; ICD9=518.81; SNOMED=409622000} {WARNING: Dig into more descriptive ICD10-CM code.}. She was placed on stress {ICD9=V62.89; SNOMED=73595000} dose of steroids as well as pressors {ICD10=4A133BC; ICD9=89.61; SNOMED=42826002}, bronchodilators, IV {RXNORM=1779; PRIMARY} antibiotics {ICD9=99.21; SNOMED=68322007} and we were able to wean the ventilator {ICD10=5A1935Z; ICD9=96.70; SNOMED=706172005} steadily and by the 3rd or 4th hospital day, she actually was off the ventilator completely. Subsequent to that, her renal function began to improve with hydration to the point,where it returned to basic normal function. She had no further episodes of relapse, made steady progress, she does require some supportive oxygen {RXNORM=7806} but she requires it at home as well and so by the last hospital day, her white count is essentially normal. She has no significant chest congestion. She is breathing comfortably and maintaining saturations above 95% on 2 liters nasal cannula and it is felt she has reached her maximum benefit of hospitalization and so she will be discharged home with continued po antibiotic therapy resumption and return to her normal home activity and medications. She did have to be medicated {RXNORM=1539837} with some Clonidine {RXNORM=2599} while here in the hospital due to hypertension {ICD10=I10; ICD9=401.9; SNOMED=38341003} and this will be continued as well. She will be discharged home with a completion course of her po antibiotics over the next 10 days. This will include Ceftin {RXNORM=215926} and Diflucan {RXNORM=202813}. She will continue her other home medications and will use some Albuterol {RXNORM=435} nebulized to help with shortness of breath {ICD10=R06.02; ICD9=786.05; SNOMED=267036007} and wheezing {ICD10=R06.2; ICD9=786.07; SNOMED=56018004}, steroid taper to get her back down to steroid dosing and have her follow up with her primary care physician for ongoing medical management.

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