**Affiliated Hospital of Yan'an University**

**Discharge Records**

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| Name: Patient2 | Gender: Female | Age: 81 | Department: Respiratory Medicine for the Elderly | | Bed No.: 30 | Medical Record No.: 0002440354 |
| Name: Patient2 | | | | Gender: Female | | |
| Age:81 | | | | Hospitalization No.: 0002440354 | | |
| ID No.: 612624194302220066 | | | | Ward Name: Department of Respiratory Medicine for the Elderly | | |
| Date of Admission: 2024-04-20 12:55 | | | | Date of Discharge: 2024-04-30 14:12 | | |
| Admission Condition: Patient Bai Chunhua, female, 81 years old, was admitted to the hospital with the main complaint of "repeated cough for more than 20 years, aggravated with shortness of breath and wheezing for 4 days." The patient had cough without obvious reasons and incentives more than 20 years ago, no obvious expectoration, slight shortness of breath, mainly manifested after activities, no hemoptysis, no low-grade fever, night sweats, and no special treatment; After that, every time the climate changes and catches a cold, the above-mentioned symptoms appear repeatedly, showing a progressive aggravation. Intermittent edema of both lower limbs occurred 3 years ago, light in the morning and heavy in the curtain, without further examination and treatment. 4 days ago, the patient developed chest tightness, shortness of breath and discomfort without obvious reasons, accompanied by obvious wheezing, profuse sweating, hair on the lips, obvious edema of both lower limbs, no dizziness, headache, no nausea, vomiting, no pain in the anterior chest area and radiating pain in the shoulders and back. Now I came to our hospital urgently for further diagnosis and treatment, and the outpatient department was admitted to the hospital with the diagnosis of "lung infection". Since the onset of the disease, the patient has been mentally clear, mentally poor, no abdominal distension, abdominal pain, poor diet and night rest, incontinence, diapers, and the amount can be used.  Admission Diagnosis: 1. Chronic obstructive pulmonary disease with acute exacerbation; 2. Type II respiratory failure; 3. Left massive pleural effusion; 4. Chronic pulmonary heart disease (1) Pulmonary hypertension (2) Cardiac function grade IV (NYHA grade); 5.Hypoproteinemia; 6.Old cerebral infarction; 7. Coronary atherosclerosis; 8.Hypertension grade 3 (very high risk); 9.Dementia; 10. Internal carotid artery plaque; 11.Appendiceal surgery  Positive Auxiliary Examination Results: blood routine detection of high-sensitivity C-reactive protein Quantitative C-reactive protein (2024-04-20): WBC count: 10.28×10e9/L ↑, lymphocyte percentage: 4.9%, monocyte percentage: 2.3% ↓, eosinophil percentage: 0%, neutrophil absolute value: 9.53×10e9/L ↑, lymphocyte absolute value: 0.5×10e9/L ↓, eosinophil absolute value: 0×10e9/L ↓, platelet count: 370×10e9/L ↑, neutrophil percentage: 92.7% ↑; Kidney function electrolyte detection (2024-04-20): sodium: 135.2 mmol/L ↓, serum uric acid determination: 408 umol/L ↑, cystatin: 1.14 mg/L ↑, anion gap: 7.2 mmol/L ↓, serum glucose detection: 12.73 mmol/L ↑; Six items of hemagglutination ^ quantitative detection of plasma D-dimer (2024-04-20): determination of plasma prothrombin time: 17sec ↑, percentage activity of prothrombin: 50.9%, prothrombin ratio: 1.48 ↑, international normalized ratio of prothrombin: 1.51 INR ↑, quantitative detection of plasma D-dimer: 1.57 mg/L ↑, fibrin (pro) degradation products: 5.57 ug/mL ↑; Biochemical detection of pleural fluid (2024-04-20): total protein in pleural and ascites fluid: 43 g/L ↑, glucose in pleural and ascites fluid: 10.39 mmol/L ↑; Color Doppler | | | | | | |

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| Name: Patient2 | Gender: Female | Age: 81 | Department: Respiratory Medicine for the Elderly | Bed No.: 30 | Medical Record No.: 0002440354 |
| ultrasonography of heart, deep vein of both lower limbs, and chest effusion suggested thickening of aorta and mitral valve, enhanced echo, impaired left ventricular diastolic function, pulmonary hypertension (moderate), color blood flow showed: tricuspid regurgitation, bilateral thoracic cavity (medium volume on the right side, large volume on the left side), subcutaneous edema of both lower limbs. Thoracic CT plain scan, 3D reconstruction: left pleural cavity massive effusion, adjacent lung tissue incomplete lung tissue, corresponding bronchial truncation, enhanced scan is recommended for further assessment; Mesoscopic effusion of the right pleural cavity. The right lung was scattered with cords and small nodules, and the nodules were partially indurated. Atherosclerotic changes of the aorta and coronary arteries. Routine blood detection of high-sensitivity C-reactive protein Quantitative C-reactive protein (2024-04-20): WBC count: 10.28×10e9/L ↑, lymphocyte percentage: 4.9% ↓, monocyte percentage: 2.3% ↓, eosinophil percentage: 0% ↓, absolute neutrophil value: 9.53×10e9/L ↑, absolute lymphocyte value: 0.5×10e9/L ↓, absolute eosinophil value: 0×10e9/L ↓, platelet count: 370×10e9/L ↑, neutrophil percentage: 92.7% ↑; Kidney function electrolyte detection (2024-04-20): sodium: 135.2 mmol/L ↓, serum uric acid determination: 408 umol/L ↑, cystatin: 1.14 mg/L ↑, anion gap: 7.2 mmol/L ↓, serum glucose detection: 12.73 mmol/L ↑; Hemagglutination six plasma D-dimer quantitative detection (2024-04-20): plasma prothrombin time determination: 17sec ↑, prothrombin percentage activity: 50.9% ↓, prothrombin ratio: 1.48 ↑, international normalized ratio of prothrombin: 1.5 INR ↑, plasma D-dimer quantitative detection: 1.57 mg/L ↑, fibrin (pro) degradation products: 5.57 ug/mL ↑; Biochemical detection of pleural fluid (2024-04-20): total protein in pleural and ascites fluid: 43 g/L ↑, glucose in pleural and ascites fluid: 10.39 mmol/L ↑; Color Doppler ultrasonography of heart, deep vein of both lower limbs, and chest effusion suggested thickening of aorta and mitral valve, enhanced echo, impaired left ventricular diastolic function, pulmonary hypertension (moderate), color blood flow showed: tricuspid regurgitation, bilateral thoracic cavity (medium volume on the right side, large volume on the left side), subcutaneous edema of both lower limbs. Thoracic CT plain scan, 3D reconstruction: left pleural cavity massive effusion, adjacent lung tissue incomplete lung tissue, corresponding bronchial truncation, enhanced scan is recommended for further assessment; Mesoscopic effusion of the right pleural cavity. The right lung was scattered with cords and small nodules, and the nodules were partially indurated. Atherosclerotic changes of the aorta and coronary arteries. Thoracic CT plain scan, 3D reconstruction: chronic bronchial emphysema in both lungs; Left minor pneumothorax. Left upper lobe posterior segment space occupying, suggesting the possibility of lung cancer, it is recommended to enhance scan assessment; multiple small nodules in both lungs with partial induration. Part of the lung tissue in the lower lobe of both lungs and the upper lobe of the left lung was incomplete; A small effusion in the left pleural cavity; Intratracheal sputum plug, follow-up if necessary. Aortic and coronary artery sclerosis; local thickening of the pericardium; Pleural effusion pathology: (Pleural effusion) smear and cell wax block section found adenocarcinoma components, combined with immunohistochemical results, consistent with lung adenocarcinoma. Immunohistochemical results: TTF-1 (+), NapsinA (+), CK7 (+), CK5/6 (-), P40 (-), Ki-67 about 10% (+). Routine blood detection of high-sensitivity C-reactive protein Quantitative C-reactive protein (2024-04-25): WBC count: 11.57×10e9/L ↑, lymphocyte percentage: 15% ↓, absolute value of neutrophils: 8.48×10e9/L ↑, absolute value of eosinophil: 0.74×10e9/L ↑: hemagglutination six plasma D-dimer quantitative detection | | | | | |