Medical Report - Patient 002-10462

1. Patient Information

* **Patient Unit Stay ID:** 179269 * **Unique Patient ID:** 002-10462 * **Gender:** Female * **Age:** 82 years * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015, 19:33:42 * **Hospital Admission Source:** Floor * **Hospital Discharge Time:** 2015, 19:30:00 * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 02:03:00 * **Unit Admission Source:** Floor * **Unit Discharge Time:** 14:58:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 72.5 kg * **Discharge Weight:** 63.5 kg * **Admission Diagnosis:** Sepsis, pulmonary * **Admission Height:** 154.9 cm

2. History

NULL. The provided data does not contain a patient history. A complete medical report requires detailed information about the patient's presenting complaint, relevant past medical history (including surgeries, hospitalizations, and chronic conditions), family history, social history (including smoking, alcohol use, and drug use), and medication history. This section is crucial for understanding the context of the ICU stay and the patient's overall health status.

3. Diagnoses

The primary admission diagnosis was Sepsis, pulmonary. Further diagnostic information is needed to provide a comprehensive list of diagnoses. Additional data points such as discharge summaries, progress notes, and imaging reports would be required to complete this section. The presence of sepsis indicates a serious infection, which warrants investigation into the specific pathogen and the organs affected. The pulmonary component suggests a lung infection or complication. More details are needed.

4. Treatments

NULL. The provided data does not include details on the treatments administered during the ICU stay. This section should detail all medications administered (dosages, routes, times), intravenous fluids, respiratory support (type and settings of ventilation, oxygen therapy), other interventions (e.g., surgery, dialysis, blood transfusions), and any complications encountered during treatment. Without this information, a complete picture of the patient's management cannot be provided.

5. Vital Trends

The physical exam data provides some vital sign information at a single point in time:

* **Heart Rate (HR):** Current 102 bpm, Lowest 96 bpm, Highest 102 bpm. * **Blood Pressure (BP):** Systolic Current 93 mmHg, Systolic Lowest 71 mmHg, Systolic Highest 94 mmHg; Diastolic Current 47 mmHg, Diastolic Lowest 41 mmHg, Diastolic Highest 50 mmHg. * **Respiratory Rate (RR):** Current 23 breaths/min, Lowest 21 breaths/min, Highest 23 breaths/min. * **Oxygen Saturation (SpO2):** Current 93%, Lowest 90%, Highest 95% * **Central Venous Pressure (CVP):** 12 mmHg

These values represent only a snapshot of the patient's condition. Time-series data showing vital signs over the course of the ICU stay is needed to understand trends and responses to interventions. This might show worsening or improvement in the patient's condition, indicating the effectiveness of treatments.

6. Lab Trends

The provided lab data includes a variety of tests performed at multiple time points during the ICU stay, including complete blood count (CBC) with differential, coagulation studies (PT, PTT, INR), basic metabolic panel (BMP), and cardiac markers

(troponin-I). A complete analysis requires visualizing these data to identify trends over time. For example, a decrease in hemoglobin (Hgb) and hematocrit (Hct) could suggest ongoing bleeding or anemia. Changes in creatinine and BUN could indicate kidney function changes. Trends in electrolytes (sodium, potassium, chloride, bicarbonate) and anion gap are crucial to assess fluid and electrolyte balance.

7. Microbiology Tests

NULL. No microbiology data (culture results) is present in the provided dataset. This is a significant omission in a patient with sepsis, as identifying the causative organism is essential for targeted antibiotic therapy.

8. Physical Examination Results

The physical exam was performed. A full physical exam needs detailed descriptions of findings in all body systems in addition to vital signs to be complete. The limited data suggests a structured physical exam was completed and the Glasgow Coma Scale (GCS) was scored, indicating a neurological assessment. Additional physical exam findings are needed to fully document the patient’s condition.