Medical Report for Patient 003-17645

1. Patient Information

* **Patient Unit Stay ID:** 260468 * **Unique Patient ID:** 003-17645 * **Gender:** Female * **Age:** 87 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015, 22:38:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015, 21:30:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 01:01:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 14:56:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 51.2 kg * **Discharge Weight:** 52.5 kg * **Admission Height:** 157.5 cm * **APACHE Admission Dx:** Effusions, pleural

2. History

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3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnoses, all related to pulmonary and pleural issues, were:

* **Acute Respiratory Distress (ICD-9: 518.82):** This diagnosis was recorded multiple times throughout the stay, indicating the ongoing severity of respiratory compromise. It was listed as both a Major and Primary diagnosis at different times. * **Right Pleural Effusion (ICD-9: 511.9, J91.8):** This was also a primary diagnosis, recorded multiple times, signifying the presence of fluid in the right pleural space. The recurrence of this diagnosis suggests ongoing fluid accumulation or incomplete resolution. * **Left Pleural Effusion (ICD-9: 511.9, J91.8):** Similar to the right pleural effusion, this diagnosis was recorded multiple times, suggesting bilateral involvement. * **Acute Respiratory Failure due to Volume Overload without CHF (ICD-9: 518.81, J96.00):** This Major diagnosis indicates respiratory failure secondary to fluid overload. This suggests a possible link between the pleural effusions and the respiratory distress. The absence of CHF (Congestive Heart Failure) is specifically noted. * **Hypoxemia (ICD-9: 799.02, J96.91):** This diagnosis was recorded multiple times and points to low oxygen levels in the blood, a common finding in respiratory failure and pleural effusions.

Secondary diagnoses included:

* **Hypotension (ICD-9: 458.9, I95.9):** This diagnosis, marked as 'Other', suggests low blood pressure, which may have contributed to the overall clinical picture or resulted from the underlying conditions. It was active upon discharge.

The temporal relationship between these diagnoses (indicated by `diagnosisoffset`) may provide further insight into the progression of the patient's illness, although more detailed clinical notes would be necessary for a complete assessment.

4. Treatments

The patient received a range of treatments throughout her ICU stay. These include:

* **Respiratory Support:** CPAP/PEEP therapy and Non-invasive ventilation were administered to address the acute respiratory distress and hypoxemia. The use of both modalities suggests a need for varying levels of respiratory support. * **Cardiovascular Management:** The patient received treatment for hypotension, including intravenous fluids (colloid administration of albumin). Furthermore, the use of losartan (ARB) and carvedilol (alpha/beta blocker) indicates management of hypertension. Simvastatin (HMG-CoA reductase inhibitor) and Aspirin were used to manage potential cardiovascular issues. * **Renal Management:** IV furosemide (intravenous diuretic) was administered, potentially to manage fluid overload contributing to the respiratory issues. This treatment continued to be active upon discharge. * **Thromboprophylaxis:** Enoxaparin (low molecular weight heparin) was used for VTE (Venous Thromboembolism) prophylaxis. * **Gastrointestinal prophylaxis:** Omeprazole was administered for stress ulcer prophylaxis.

The timing of these treatments and their effectiveness would need to be evaluated using more detailed data. The active treatments at discharge suggest ongoing management of hypertension, fluid balance and VTE prophylaxis.

5. Vital Trends

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6. Lab Trends

The laboratory results show several key trends:

* **Electrolytes:** Initial potassium levels were slightly low (3.7 mmol/L) but increased to 4.2 mmol/L later. Sodium levels ranged from 130-135 mmol/L, and bicarbonate levels ranged from 24-27 mmol/L. These fluctuations likely reflect the treatment for volume overload and overall physiological instability. * **Renal Function:** BUN (Blood Urea Nitrogen) levels showed a marked increase over the course of the stay (from 16 to 33 mg/dL) reflecting the patient's evolving renal function. * **Cardiac Markers:** Troponin-I levels, although initially elevated (0.03 ng/mL), decreased to 0.01 ng/mL, suggesting possible myocardial injury, but resolution with treatment. CPK (Creatine Phosphokinase) and CPK-MB levels suggest a degree of cardiac stress. * **Liver Function:** AST (Aspartate Aminotransferase) and ALT (Alanine Aminotransferase) showed mild elevations, suggesting possible liver involvement. * **Hematology:** Hemoglobin and hematocrit levels show some variation, indicating a possible anemia. The platelet count decreased over time, possibly due to the use of heparin. * **Other:** CRP (C-reactive protein) indicates an inflammatory response. BNP (B-type Natriuretic Peptide) levels were elevated, indicating cardiac stress.

7. Microbiology Tests

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8. Physical Examination Results

The physical examination recorded a GCS (Glasgow Coma Scale) score of 15, suggesting normal neurological function. Heart rate was between 80 and 81 bpm, blood pressure between 125/62 and 147/78 mmHg, and respiratory rate was 19 breaths per minute. Oxygen saturation was consistently 99%, suggesting adequate oxygenation despite her respiratory diagnoses. Admission weight was 51.2 kg.