Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 472360 * **Patient Health System Stay ID:** 400737 * **Gender:** Female * **Age:** 63 * **Ethnicity:** African American * **Hospital ID:** 144 * **Ward ID:** 267 * **Admission Diagnosis:** Anemia * **Admission Height:** 157.48 cm (Assuming cm) * **Hospital Admit Time:** 09:15:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 23:33:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 01:36:00 * **Unit Admit Source:** Floor * **Unit Visit Number:** 2 * **Unit Stay Type:** readmit * **Admission Weight:** NULL * **Discharge Weight:** 56.5 kg * **Unit Discharge Time:** 22:57:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Unique Patient ID:** 005-10903

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses upon admission to the Med-Surg ICU. These diagnoses, listed in order of priority, are:

* **Primary:** Acute blood loss anemia (285.1, D62) * **Major:** Sepsis with multi-organ dysfunction (995.92, R65.20) * **Major:** Diabetic ketoacidosis (DKA) (250.13, E10.1) * **Major:** Metabolic acidosis (normal anion gap) (276.2, E87.2) * **Major:** Severe sepsis (995.92, R65.2) * **Major:** Severe thrombocytopenia (287.5, D69.6) * **Major:** Urinary tract infection (599.0, N39.0) * **Major:** Acute renal failure (584.9, N17.9) * **Major:** Metabolic acidosis (uremic acidosis) (276.2, E87.2) * **Major:** Metabolic acidosis (ketoacidosis/diabetic) (276.2, E87.2) * **Major:** Hospital acquired pneumonia (486, J18.9) * **Major:** Obstructive uropathy (586, N19) * **Major:** Congestive heart failure (428.0, I50.9) * **Major:** Acute pyelonephritis (without renal calculi) (590.10, N10) * **Major:** Pressor-dependent hypotension * **Major:** Nutritional deficiency (263.9, E46) * **Major:** Coagulopathy (286.9, D68.9) * **Major:** Thrombocytopenia (etiology unknown) (287.5, D69.6) * **Other:** Leukocytosis (288.8, D72.829) * **Other:** Acute respiratory failure (518.81, J96.00) * **Other:** Hypoxemia (799.02, J96.91) * **Other:** Hypocalcemia (275.41, E83.51) * **Other:** Constipation (564.00, K59.00) * **Other:** Fever (780.6, R50.9)

The multiplicity of diagnoses suggests a complex clinical picture, likely indicative of a systemic inflammatory response. The presence of both sepsis and acute renal failure is particularly concerning. The metabolic acidosis is likely multifactorial, related to both DKA and renal dysfunction.

4. Treatments

The patient received a comprehensive range of treatments during her ICU stay, including:

* Non-invasive ventilation * Empiric antibacterial coverage * Blood cultures * Ondansetron (antiemetic) * Nephrology consultation * Continuous insulin infusion * Urology consultation * Transthoracic echocardiography * Norepinephrine (vasopressors) * Compression boots (VTE prophylaxis) * Cardiology consultation * Bolus and oral analgesics * Narcotic analgesics * Sodium bicarbonate (bicarbonate administration) * Intravenous electrolyte administration * Sliding scale insulin administration * Laxatives * Pantoprazole (stress ulcer prophylaxis) * Ceftriaxone (third-generation cephalosporin) * Vancomycin * Pulmonary/CCM consultation * Urine cultures * Hematology consultation * Calcium administration

The treatment plan reflects a multidisciplinary approach to managing the patient's complex medical condition. The use of vasopressors, along with the diagnoses of sepsis and hypotension, highlights the severity of the patient's cardiovascular compromise.

5. Vital Trends

NULL (Insufficient information provided)

6. Lab Trends

The provided lab data shows multiple blood tests over time. Significant trends include:

* **Elevated liver enzymes:** ALT and AST showed significant elevations (e.g., ALT up to 1004 U/L, AST up to 895 U/L), indicating liver injury that may be related to sepsis or medication side effects. This needs further investigation. * **Acute kidney injury:** Creatinine levels were initially elevated (up to 1.21 mg/dL), suggesting acute kidney injury. The subsequent decrease in creatinine levels (down to 0.56 mg/dL) indicates a response to treatment. * **Anemia:** Hemoglobin levels were low (as low as 4.8 g/dL), confirming the primary diagnosis of acute blood loss anemia. The subsequent improvement of hemoglobin levels (up to 8.5 g/dL) indicates a response to treatment such as blood transfusions. The MCV and MCHC indicate normocytic, normochromic anemia. * **Electrolyte imbalances:** The data shows fluctuations in serum electrolytes, including calcium (hypocalcemia) and potassium. * **Metabolic acidosis:** Bicarbonate levels were low (as low as 28 mmol/L), which is consistent with the diagnosis of metabolic acidosis. * **Elevated total and direct bilirubin:** Total and direct bilirubin levels were elevated (as high as 7.1 mg/dL and 2.5 mg/dL), suggesting cholestasis or liver dysfunction. * **High White Blood Cell Count:** WBC counts were significantly elevated (as high as 44.6 K/uL), consistent with leukocytosis and indicative of infection or inflammation. The differential white blood cell counts (-monos, -lymphs, -polys, -bands, -eos, -basos) would aid in determining the nature of the inflammatory response. Platelet counts were also low, consistent with thrombocytopenia, indicating a possible bleeding disorder.

7. Microbiology Tests

NULL (Insufficient information provided, only mentions blood and urine cultures were taken.)

8. Physical Examination Results

The physical exam documented a heart rate (HR) ranging from 95 to 109 bpm, with a regular sinus rhythm. Respiratory rate ranged from 15 to 26 breaths per minute with spontaneous respiration. Blood pressure (BP) varied, with systolic BP between 105 and 139 mmHg and diastolic BP between 71 and 88 mmHg. Oxygen saturation (O2 Sat%) fluctuated between 78% and 98%. The Glasgow Coma Scale (GCS) was scored, indicating neurological assessment. Weight was recorded, showing a decrease in weight from admission (41.3 kg) to discharge (56.5 kg). Fluid balance was also documented. The overall physical examination reflects a patient in a state of illness with multisystem involvement.