Medical Report: Patient 002-10009

1. Patient Information

* **Patient Unit Stay ID:** 224606 * **Patient Health System Stay ID:** 193705 * **Gender:** Female * **Age:** 76 * **Ethnicity:** Caucasian * **Hospital ID:** 71 * **Ward ID:** 87 * **Admission Height (cm):** 160 * **Admission Weight (kg):** NULL * **Discharge Weight (kg):** 56.9 * **Hospital Admit Time:** 00:44:00 * **Hospital Admit Source:** Operating Room * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 20:06:00 * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 03:43:00 * **Unit Admit Source:** Operating Room * **Unit Visit Number:** 1 * **Unit Stay Type:** admit * **Unit Discharge Time:** 01:29:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Unique Patient ID:** 002-10009 * **Admission Diagnosis:** GI perforation/rupture, surgery for

2. History

NULL (Insufficient data provided)

3. Diagnoses

* **Primary Diagnosis:** Cardiovascular|shock / hypotension|septic shock (ICD-9: 785.52, R65.21) * **Major Diagnoses:** * gastrointestinal|abdominal/ general|peritonitis (ICD-9: 567.9, K65.0) * oncology|hematologic malignancy|leukemia|chronic myelogenous (ICD-9: 205.10, C92.10) * gastrointestinal|post-GI surgery|s/p exploratory laparotomy (ICD-9:) * gastrointestinal|intestinal disease|viscus perforation (ICD-9:) * hematology|platelet disorders|thrombocytopenia (ICD-9: 287.5, D69.6)

4. Treatments

NULL (Insufficient data provided)

5. Vital Trends

* **Heart Rate (HR):** Current, Lowest, and Highest readings all recorded as 110 at the initial physical exam (6 minutes post-unit admit). Further monitoring data is needed to establish trends. * **Blood Pressure (BP):** Systolic BP recorded as 64 (lowest) and 66 (highest) at the initial physical exam. Diastolic BP recorded as 38 at the initial physical exam. Further data required for trend analysis. * **Oxygen Saturation (O2 Sat%):** Current reading of 91%, with a highest recorded value of 92% at the initial physical exam. Additional data needed to assess trends. * **Weight:** Initial weight recorded as 47.6 kg (6 minutes post-unit admit). Discharge weight of 56.9 kg. This suggests a weight gain during the hospital stay, but more frequent measurements are needed to understand the trend better. * **Intake and Output:** Initial fluid intake total was 0 ml, and output total was 55 ml (6 minutes post-unit admit). Dialysis net and total net values were 0 and -55 ml respectively. Additional data is needed for a comprehensive assessment of fluid balance.

6. Lab Trends

The provided lab data includes multiple measurements at different time points. To fully analyze trends, a time-series analysis with graphical representation is necessary. Key lab values to track include:

* **Electrolytes:** Sodium, Potassium, Chloride, Bicarbonate, Calcium, Magnesium, Phosphate, Anion Gap * **Complete Blood Count (CBC):** Hemoglobin, Hematocrit, White Blood Cell count (WBC), Platelet count, Mean Corpuscular Volume (MCV), Mean Corpuscular Hemoglobin (MCH), Mean Corpuscular Hemoglobin Concentration (MCHC), Red Cell Distribution Width (RDW), Lymphocytes, Monocytes, Polymorphs, Bands, Eosinophils, Basophils * **Blood Gases:** pH, PaO2, PaCO2, Base Deficit * **Other:** Glucose, Lactate, Total Protein, Albumin, Troponin I, Fibrinogen, PT, PTT, PT-INR, Urinary Specific Gravity

7. Microbiology Tests

NULL (Insufficient data provided)

8. Physical Examination Results

* **Initial Physical Exam (6 minutes post-unit admission):** A structured physical exam was performed. Vital signs included: HR 110, Systolic BP 64-66, Diastolic BP 38, O2 Sat 91-92%. Weight was recorded as 47.6 kg. Neurological assessment using the Glasgow Coma Scale (GCS) resulted in a score of 14 (Eyes 3, Verbal 5, Motor 6). Intake and output were 0 ml and 55 ml, respectively. Additional physical exam findings are needed.