Medical Report for Patient 002-1012

1. Patient Information

* **Patient Unit Stay ID:** 184757 * **Patient Health System Stay ID:** 162659 * **Unique Patient ID:** 002-1012 * **Gender:** Female * **Age:** 81 years * **Ethnicity:** Caucasian * **Hospital ID:** 73 * **Ward ID:** 97 * **Unit Type:** MICU * **Unit Admit Source:** Operating Room * **Unit Admit Time:** 23:48:00 * **Unit Discharge Time:** 22:22:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Source:** Emergency Department * **Hospital Admit Time:** 19:19:00 * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 00:16:00 * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Admission Weight:** 54.6 kg * **Discharge Weight:** 52.2 kg * **Admission Height:** 162.6 cm

2. History

Insufficient information provided to generate a detailed patient history. The available data only indicates the diagnoses and their priorities, but lacks information about the patient's presenting symptoms, past medical history, family history, social history, or medication history. A comprehensive history is crucial for understanding the context of the patient's ICU stay and should include details such as onset of symptoms, duration, severity, and any relevant past illnesses or surgeries. This section requires further data.

3. Diagnoses

The patient presented with multiple diagnoses, some active upon discharge and others not. The diagnoses are listed below in order of priority (Primary, Major, Other), as provided, though the priority field was not consistently populated.

* **Primary:** s/p exploratory laparotomy (recorded twice, once active upon discharge) * **Major:** Small bowel obstruction, incarcerated hernia (recorded twice, once active upon discharge), Adhesions (recorded twice, once active upon discharge), Enteric Fistula (recorded twice, once active upon discharge) * **Other:** Hypertension (recorded twice, once active upon discharge), Pleural effusion (active upon discharge), Atrial fibrillation (active upon discharge), Anemia (recorded twice, once active upon discharge)

The multiplicity of diagnoses suggests a complex clinical picture. The presence of multiple gastrointestinal diagnoses, including small bowel obstruction, incarcerated hernia, and enteric fistula, points towards a significant abdominal pathology potentially requiring surgical intervention. The presence of pleural effusion suggests a possible complication related to the abdominal issue or a separate respiratory issue. The recorded cardiovascular diagnoses of hypertension and atrial fibrillation highlight co-morbidities that could influence the patient's overall prognosis and management. Further investigation is needed to clarify the interrelationships between the various diagnoses and establish a definitive etiological pathway.

4. Treatments

NULL. No treatment information is available in the provided data. This section should include a detailed account of all medical interventions administered during the ICU stay. This includes medications, surgical procedures, respiratory support, and other therapies.

5. Vital Trends

NULL. No vital sign data (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation) is available. This section requires further data to be populated. A graphical representation of these trends over time is essential for assessing the patient's hemodynamic stability and overall clinical course.

6. Lab Trends

The patient had numerous lab tests performed throughout their stay. Several tests were repeated across multiple time points. This necessitates the creation of a time series to assess trends. The data reveals fluctuations in various parameters, including electrolytes (sodium, potassium, chloride, bicarbonate), renal function (BUN, creatinine), liver function (ALT, AST), and complete blood count (hemoglobin, hematocrit, MCV, MCH, MCHC, RDW, WBC, platelets, -monos, -lymphs, -polys, -eos, -basos). The significance of these fluctuations requires further analysis and correlation with clinical events. Note, multiple glucose measurements are present, both from chemistry and bedside glucose testing. This requires further investigation to ensure accuracy and consistency.

7. Microbiology Tests

NULL. No microbiology test results are provided. This section should include any cultures taken and their results, crucial for identifying and treating infections.

8. Physical Examination Results

The physical examination documented a Glasgow Coma Scale (GCS) score of 15 (Eyes 4, Verbal 5, Motor 6) at 3 minutes post-unit admission. Blood pressure was recorded at 155/96 mmHg. Weight was recorded at 54.6 kg on admission and 54.7 kg shortly after. The total net fluid balance was +22 mL. A structured physical exam was performed. This limited information suggests a relatively stable initial neurological status, but more comprehensive data is needed for a full interpretation of the patient's physical condition. Further physical examination findings are required to complete this section.