Patient Information

* **Patient Unit Stay ID:** 198628 * **Unique Patient ID:** 002-12056 * **Gender:** Female * **Age:** 47 * **Ethnicity:** Caucasian * **Hospital ID:** 60 * **Ward ID:** 83 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 01:37:00 * **Unit Admit Source:** ICU to SDU * **Unit Discharge Time:** 03:41:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 04:24:38 * **Hospital Admit Source:** Floor * **Hospital Discharge Time:** 19:00:00 * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Admission Height (cm):** 167.6 * **Discharge Weight (kg):** 49.4

Medical History

NULL (Insufficient data provided)

Diagnoses

NULL (Insufficient data provided)

Treatments

NULL (Insufficient data provided)

Vital Trends

NULL (Insufficient data provided)

Lab Trends

The provided data contains a series of lab results obtained at different time points during the patient's ICU stay. The time offsets indicate the number of minutes from the unit admit time. Several key lab values show notable variations:

* **Complete Blood Count (CBC) parameters:** The white blood cell count (WBC) shows an elevated level at 15.6 K/mcL at 5723 minutes post-unit admission, indicating a potential infection or inflammatory response. This is in contrast to an earlier reading of 9.7 K/mcL at 483 minutes post-unit admission. Red blood cell count (RBC), Hemoglobin (Hgb), and Hematocrit (Hct) values also show some variation between the initial and later readings, possibly indicating anemia or blood loss. Mean Corpuscular Volume (MCV) and Mean Corpuscular Hemoglobin Concentration (MCHC) suggest a possible microcytic anemia. The platelet count is relatively low (294 K/mcL at 5723 minutes and 298 K/mcL at 483 minutes) compared to normal ranges, suggesting potential thrombocytopenia. Differential counts, including lymphocytes, monocytes, eosinophils, basophils, and polymorphonuclear leukocytes (neutrophils), indicate a shift toward a more inflammatory profile. Further investigation into the specific composition of the WBC is needed for proper diagnosis.

* **Chemistry panel:** The patient presented with elevated liver enzymes (AST and ALT) and alkaline phosphatase, which could indicate liver damage or dysfunction. Levels of total protein and albumin are low (6.4 g/dL and 2.3 g/dL respectively), suggesting possible protein deficiency or malnutrition. The anion gap is elevated (9 mmol/L initially, then 6 mmol/L later), a finding that warrants further investigation. Electrolyte levels (sodium, potassium, chloride, and bicarbonate) show some variability, though at times they fall within normal ranges. Blood glucose levels are mildly low (104 and 108 mg/dL), potentially indicating hypoglycemia, but more data is needed to confirm this.

* **Kidney function:** Creatinine and blood urea nitrogen (BUN) levels show variability, but values generally remain within acceptable limits. Further investigation is needed to fully assess kidney function.

* **Other:** The patient's initial magnesium level was 1.6 mg/dL, and phosphate was 2.7 mg/dL. These fall within normal ranges. The BNP level is elevated at 65 pg/mL. An arterial blood gas (ABG) analysis (at 5810 minutes) shows a paO2 of

84 mm Hg, a paCO2 of 69 mm Hg, a pH of 7.42, a bicarbonate (HCO3) of 44 mmol/L, and a base excess of 16 mEq/L, suggesting respiratory alkalosis and metabolic acidosis. The urinary specific gravity was 1.010. This indicates a concentrated urine, but further evaluation is needed to interpret the clinical significance.

Microbiology Tests

NULL (Insufficient data provided)

Physical Examination Results

NULL (Insufficient data provided)