Patient Information

Patient Unit Stay ID: 514387 Patient Health System Stay ID: 434956 Gender: Female Age: 81 Ethnicity: Caucasian Hospital ID: 140 Ward ID: 261 Unique Patient ID: 005-12042 Admission Height: 157.5 cm Admission Weight: 58.8 kg Hospital Admit Time: 17:22:00 Hospital Admit Source: Emergency Department Hospital Discharge Year: 2014 Hospital Discharge Time: 22:10:00 Hospital Discharge Location: Home Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admit Time: 20:34:00 Unit Admit Source: Emergency Department Unit Visit Number: 1 Unit Stay Type: Admit Unit Discharge Time: 01:36:00 Unit Discharge Location: Floor Unit Discharge Status: Alive Admission Diagnosis: Bleeding, GI-location unknown

History

NULL (Insufficient data provided)

Diagnoses

The patient presented with multiple diagnoses during her ICU stay. These diagnoses, listed in order of entry, were:

* GI Bleeding (Primary): ICD-9 code 578.9, K92.2. This was initially diagnosed at 83 minutes post-unit admission and was also active upon discharge. * Hypertension (Major): ICD-9 code 401.9, I10. This was diagnosed at 83 minutes and 1308 minutes post-unit admission, and was active on discharge. * Hyperlipidemia (Major): ICD-9 code 286.9, E78.5. This diagnosis was recorded at 122 minutes and 1308 minutes post-unit admission. * Atrial Fibrillation (Major): ICD-9 code 427.31, I48.0. This diagnosis was recorded at 122 minutes and 1308 minutes post-unit admission. * Anemia (Major): Initially diagnosed at 83 minutes post-unit admission. * Acute Renal Failure due to Hypovolemia (Major): Diagnosed at 122 minutes and 1308 minutes post-unit admission, active upon discharge. * Coagulopathy/Coumadin Administration (Major): Diagnosed at 122 minutes and 1308 minutes post-unit admission, active upon discharge. * Acute Blood Loss Anemia (Major): Diagnosed at 1308 minutes post-unit admission, active upon discharge. * Hypothyroidism (Major): Diagnosed at 122 minutes and 1308 minutes post-unit admission, active upon discharge.

Note that some diagnoses were recorded multiple times, indicating ongoing relevance throughout the ICU stay. The `activeupondischarge` field signifies which conditions persisted at the time of unit discharge.

Treatments

The patient received a variety of treatments, including:

* Packed Red Blood Cells transfusion (1-2 units): Administered at 122 minutes post-unit admission. * Fresh Frozen Plasma: Administered at 122 minutes post-unit admission. * Oral Glucocorticoids: Administered at 122 minutes post-unit admission. * IV and Oral Pantoprazole (Stress Ulcer treatment/prophylaxis): Administered at 122 minutes and 1308 minutes post-unit admission. * Ondansetron (antiemetic): Administered at 122 minutes post-unit admission. * Vitamin K: Administered at 122 minutes post-unit admission. * Gastroenterology Consultation: Consulted at 83 minutes and 1308 minutes post-unit admission. * Pulmonary/CCM Consultation: Consulted at 1308 minutes post-unit admission. * Chest X-Ray: Ordered at 83 minutes post-unit admission. * Nuclear Biliary Scan: Ordered at 83 minutes post-unit admission. * Levothyroxine (T4) (Thyroid Hormone): Administered at 1308 minutes post-unit admission and active on discharge. * Lisinopril (ACE inhibitor) : Administered at 1308 minutes post-unit admission and active on discharge. * Verapamil (Calcium Channel Blocker): Administered at 1308 minutes post-unit admission and active on discharge. * Spironolactone (Oral Diuretic): Administered at 1308 minutes post-unit admission and active on discharge.

Vital Trends

NULL (Insufficient data provided)

Lab Trends

The provided lab data includes multiple blood tests performed at different time points. Key trends include:

* Hematology: The patient exhibited low Hemoglobin (Hgb) and Hematocrit (Hct) levels initially, consistent with acute blood loss anemia. These levels improved somewhat throughout the stay. Platelet counts fluctuated, and other blood counts, such as WBC, MCV, MCH, MCHC, RDW and differential counts, were recorded but show no clear trends. * Chemistry: Initial values for sodium, potassium, chloride, bicarbonate, creatinine, BUN, anion gap, glucose, total protein, albumin, total bilirubin, direct bilirubin, ALT (SGPT) and AST (SGOT) were obtained. These were repeated later in the stay. Some values indicate electrolyte imbalances and renal dysfunction. There are multiple measurements for many labs, but insufficient data to establish meaningful trends. * Coagulation: PT and PTT were recorded, showing prolonged times initially, consistent with coagulopathy. PT-INR was also measured, showing elevated levels which improved over time.

Microbiology Tests

NULL (Insufficient data provided)

Physical Examination Results

Physical exams were performed at multiple time points. Initial exams (17 minutes and 107 minutes post-unit admission) indicated the patient was ill-appearing, but alert and oriented. Vitals indicated some cardiovascular instability (irregular, narrow complex rhythm; low systolic blood pressure). There were later recordings of vitals, but these were limited to a single timepoint.