Medical Report for Patient 005-11459

1. Patient Information

* **Patient Unit Stay ID:** 494366 * **Patient Health System Stay ID:** 418653 * **Unique Patient ID:** 005-11459 * **Gender:** Female * **Age:** 82 * **Ethnicity:** Hispanic * **Hospital ID:** 140 * **Ward ID:** 261 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 03:00:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 07:13:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 02:26:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 23:48:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Weight:** 68 kg * **Admission Height:** 152.4 cm * **APACHE Admission Diagnosis:** Sepsis, renal/UTI (including bladder)

2. History

NULL (Insufficient information provided in the JSON data to construct a detailed patient history.)

3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnosis upon discharge was septic shock (ICD-9 codes 785.52, R65.21). Other diagnoses included:

* **Renal Electrolyte Imbalance:** Hypomagnesemia (ICD-9 codes 275.2, E83.42) and moderate hypokalemia (ICD-9 codes 276.8, E87.6). * **Cardiovascular:** Hyperlipidemia and pressor-dependent hypotension. * **Hematology:** Thrombocytopenia (ICD-9 codes 287.5, D69.6). * **Gastrointestinal:** Lab-confirmed *C. difficile* colitis (ICD-9 codes 008.45, A04.7). * **Renal:** Lower urinary tract infection (ICD-9 codes 595.9, N30.9).

Several of these diagnoses were present both at admission and upon discharge, indicating ongoing issues. Note that the ICD-9 codes are not consistently provided for all diagnoses. The absence of an ICD-9 code does not necessarily indicate a lack of diagnosis confirmation, but it does hinder complete coding and record keeping.

4. Treatments

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

* **Cardiovascular:** Administration of normal saline and, at one point, colloid solutions. Use of vasopressors (norepinephrine > 0.1 micrograms/kg/min) was noted, though it appears this was discontinued before discharge. * **Infectious Disease:** Empiric and targeted antibacterial coverage (including aztreonam) was administered. Blood and urine cultures were obtained to guide treatment. Infectious Disease consultations were performed. * **Pulmonary:** Bronchodilator medication was administered, and chest x-rays were taken. * **Renal:** A Foley catheter was inserted; renal ultrasound was performed.

The timing of treatments is documented in minutes from unit admit time. The specific durations of intravenous fluids and other therapies are not detailed here. A more comprehensive treatment timeline would be beneficial for a complete understanding of the patient's care.

5. Vital Trends

NULL (Insufficient data provided in the JSON to generate vital sign trends.)

6. Lab Trends

The provided lab data shows several key trends:

* **Hematology:** The patient exhibited thrombocytopenia (low platelet count), with values ranging from 69 to 146 K/uL over the course of her stay. Her hemoglobin (Hgb) levels also fluctuated, ranging from 9.9 to 12.7 g/dL. WBC counts were elevated, ranging from 7.0 to 24.2 K/uL, suggesting an infection. MCV and MCHC levels indicated some variation in red blood cell characteristics. RDW was consistently elevated (15.1% to 15.5%), suggesting anisocytosis (variation in red blood cell size). * **Chemistry:** Potassium levels were initially low (2.9 mmol/L), but improved to 3.9 mmol/L by the end of her stay, indicating a response to treatment. Magnesium levels were low (1.4 to 1.9 mg/dL), again suggesting an electrolyte imbalance. BUN (Blood Urea Nitrogen) and creatinine levels showed variability, reflecting changes in renal function, initially elevated (1.79 mg/dL) then dropping and rising again (0.38 to 1.13 mg/dL), and anion gap fluctuated from 7-12 mmol/L. Bicarbonate levels also fluctuated (23 to 26 mmol/L) indicating metabolic changes. Glucose levels were elevated, with frequent bedside glucose measurements showing values between 66 and 255 mg/dL, reflecting the effect of sepsis and treatment.

More frequent lab data would be needed to fully characterize the dynamics of these trends. Note that the units of measurement for some lab results are missing or inconsistent.

7. Microbiology Tests

Blood and urine cultures were obtained. The results of these cultures are partially available: A positive result for *C. difficile* colitis is documented. The outcome of the blood cultures is described as ‘cultures pending’ at one point, suggesting that the results were not yet available at the time of discharge. The report requires further details about the microbiology test results.

8. Physical Examination Results

Physical examinations were performed at multiple time points during the ICU stay. The patient consistently appeared critically ill, though not in acute distress. Vital signs showed fluctuations in heart rate (64-98 bpm), blood pressure (72/41 to 146/90 mmHg), respiratory rate (20-27 breaths/min), and oxygen saturation (79%-99%). The patient had a Foley catheter in place. Neurological examination revealed a GCS of 15, with some agitation, normal pupils, and reduced hearing bilaterally. Lung auscultation revealed diffusely decreased breath sounds at times, but also periods of clear breath sounds. Cardiovascular examination revealed normal heart sounds and pulses. Gastrointestinal examination revealed normal bowel sounds and no masses or organomegaly. Extremities showed adequate perfusion with no edema.

The physical exam findings are consistent with the patient's diagnoses and treatment course. Additional physical exam details would improve the completeness of the report.