Medical Report: Patient 002-10278

1. Patient Information

* **Patient Unit Stay ID:** 175243 * **Patient Health System Stay ID:** 155275 * **Unique Patient ID:** 002-10278 * **Gender:** Male * **Age:** 67 * **Ethnicity:** Asian * **Hospital ID:** 58 * **Ward ID:** 108 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 05:22:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 15:55:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 05:20:00 * **Hospital Discharge Time:** 16:20:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Weight:** 47.7 kg * **Discharge Weight:** 47.6 kg * **Admission Height:** 167.6 cm * **APACHE Admission Dx:** Bleeding, GI-location unknown

2. History

NULL (Insufficient data provided to describe the patient's medical history. The provided data only contains diagnoses and lab results, not a narrative history.)

3. Diagnoses

The patient presented with several diagnoses, listed in order of priority where applicable:

* **Primary:** gastrointestinal|GI bleeding / PUD|GI bleeding (ICD-9 code: 578.9, K92.2) * **Major:** neurologic|altered mental status / pain|pain * **Major:** hematology|bleeding and red blood cell disorders|anemia * **Other:** cardiovascular|arrhythmias|syncope (ICD-9 code: 780.2, R55) * **Other:** gastrointestinal|GI bleeding / PUD|upper GI bleeding (ICD-9 code: 578.9, K92.2)

Note that some diagnoses were active upon discharge ('True'), while others were not ('False'). The time of diagnosis entry (diagnosisoffset) is consistent for many diagnoses, suggesting they were documented around the same time.

4. Treatments

NULL (No treatment information is available in the provided data.)

5. Vital Trends

Based on the physical exam, the following vital signs were recorded:

* **Heart Rate (HR):** Current 70 bpm, Lowest 65 bpm, Highest 70 bpm * **Blood Pressure (BP):** Systolic Current 99 mmHg, Systolic Lowest 115 mmHg, Systolic Highest 99 mmHg; Diastolic Current 62 mmHg, Diastolic Lowest 67 mmHg, Diastolic Highest 62 mmHg * **Oxygen Saturation (O2 Sat):** Current 96%, Lowest 96%, Highest 100%

6. Lab Trends

The following laboratory values were recorded at two different time points (offsets -52 and 333 minutes from unit admit time, indicating likely pre- and post-treatment measurements):

* **Chemistry Panel:** Chloride, Bicarbonate, Total Protein, AST (SGOT), ALT (SGPT), Anion Gap, Sodium, Potassium, Calcium, Creatinine, Glucose, BUN, and Albumin levels were measured. There are notable changes from the initial to the follow-up measurements, for example, the total protein level increased from 4.2 g/dL to 4.5 g/dL and the anion gap increased from 8 to 9 mmol/L. Further analysis is needed to determine the significance of these changes within the context of the patient's clinical presentation. * **Hematology Panel:** Platelets, Hemoglobin (Hgb), Hematocrit (Hct), Mean Corpuscular Volume (MCV), Mean Corpuscular Hemoglobin Concentration (MCHC), Mean Corpuscular Hemoglobin

(MCH), Red Blood Cell Distribution Width (RDW), and differential white blood cell counts (%polymorphonuclear leukocytes, %lymphocytes, %monocytes, %eosinophils, %basophils) were also measured at different time points. There are also significant changes in many of these values, such as Hgb increasing from 3.8 g/dL to 10.1 g/dL and Hct increasing from 12.5% to 30.7%. These changes suggest a response to treatment or a natural course of the illness. A detailed analysis of these trends is necessary for a complete interpretation.

7. Microbiology Tests

NULL (No microbiology test results are included in the given data.)

8. Physical Examination Results

The physical exam was performed and documented. The Glasgow Coma Scale (GCS) was scored as 15 (Eyes 4, Verbal 5, Motor 6). The patient’s weight was recorded at 47.7 kg upon admission and remained unchanged during the ICU stay. Intake and output values were recorded as zero. A complete interpretation of these values requires additional clinical context.