Medical Report: Patient 007-10248

1. Patient Information:

* **Patient Unit Stay ID:** 968367 * **Patient Health System Stay ID:** 713315 * **Unique Patient ID:** 007-10248 * **Gender:** Female * **Age:** 86 years * **Ethnicity:** Caucasian * **Hospital ID:** 180 * **Ward ID:** 427 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 18:27:00 * **Unit Admit Source:** Recovery Room * **Unit Discharge Time:** 2015-XX-XX 03:51:00 * **Unit Discharge Location:** Telemetry * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 2015-XX-XX 06:19:00 (calculated from offset) * **Hospital Admit Source:** Recovery Room * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 22:20:00 (calculated from offset) * **Hospital Discharge Location:** Rehabilitation * **Hospital Discharge Status:** Alive * **Admission Weight:** 59.87 kg * **Discharge Weight:** 60 kg * **Admission Height:** 157.48 cm (assuming cm) * **APACHE Admission Dx:** GI obstruction, surgery for (including lysis of adhesions)

2. History:

NULL (Insufficient data provided)

3. Diagnoses:

The patient presented with multiple diagnoses during her ICU stay. These include:

* **Gastrointestinal|biliary disease|cholecystitis:** This diagnosis was active upon discharge. No ICD-9 code was provided. * **Gastrointestinal|intestinal disease|GI obstruction / ileus:** This diagnosis was initially present but not active upon discharge. No ICD-9 code was provided. This diagnosis was recorded multiple times throughout the stay. * **Cardiovascular|arrhythmias|atrial fibrillation|with controlled ventricular response:** This diagnosis was active upon discharge. ICD-9 codes 427.31 and I48.0 were recorded. This diagnosis was recorded multiple times throughout the stay. * **Cardiovascular|arrhythmias|atrial fibrillation|with rapid ventricular response:** This diagnosis was not active upon discharge. ICD-9 codes 427.31 and I48.0 were recorded.

The priority of diagnoses was not consistently documented, with most listed as 'Other'. Further information is needed to clarify the primary diagnosis and the temporal relationships between the diagnoses.

4. Treatments:

The patient received various treatments during her ICU stay, including:

* **Gastrointestinal medications (stress ulcer prophylaxis):** This treatment was active at some point but not on discharge. It was documented multiple times throughout the stay. * **Gastrointestinal intravenous fluid administration (normal saline):** This treatment was active at some point but not on discharge. It was documented multiple times throughout the stay. * **Surgery (exploratory laparotomy):** This treatment was performed. * **Surgery (analgesics/sedatives/NMBS):** Sedative and analgesic agents were administered. * **Surgery (nasogastric tube):** A nasogastric tube was placed. * **Pulmonary medications (antibacterials and anticoagulants):** Antibacterial and anticoagulant medications were administered, with some active on discharge. * **Endocrine treatments (insulin):** Insulin was administered, and this was active at discharge. * **Cardiovascular treatment (antiarrhythmics and beta-blockers and ACE inhibitor):** Antiarrhythmic, beta-blocker, and ACE inhibitor medications were administered. An intravenous diuretic was also administered.

The timing of treatments relative to the diagnoses and to each other is not detailed in the provided data. More information is necessary for a complete treatment timeline.

5. Vital Trends:

NULL (Insufficient data provided. Vital signs are mentioned in physical exam but not in a time series format.)

6. Lab Trends:

The patient underwent numerous laboratory tests during her stay. Multiple blood tests were performed including complete blood counts (CBC) with differentials, basic metabolic panels (BMP) and liver function tests (LFT). Serial measurements of blood glucose, bedside glucose, and bedside lactate were also obtained. Serial blood tests show fluctuations in various parameters, suggesting potential underlying issues. A BNP was measured at discharge. More detailed time-series data is needed to fully analyze lab trends.

7. Microbiology Tests:

NULL (Insufficient data provided)

8. Physical Examination Results:

Physical examinations were performed multiple times during the patient's stay. The recorded values include:

* **Initial (around 203 min post admit):** GCS: 15 (4,5,6), HR: 88 bpm, BP: 79/50 mmHg, Resp Rate: 16 breaths/min, O2 Sat: 98%, Weight: 59.87 kg. * **Subsequent (around 7177 min post admit):** GCS: 15 (scored), HR: 108 bpm (82-115 bpm range), BP: 165/87 mmHg (151-167/58-117 mmHg range), Resp Rate: 15 breaths/min (10-21 breaths/min range), O2 Sat: 98% (76-100% range), Weight: 68.2 kg (+8.33 kg change).

The data suggests that the patient's vital signs and weight fluctuated throughout her stay. A more comprehensive record of physical examination findings across the entire stay would be beneficial for a complete assessment. The meaning of 'scored' for GCS is unclear and needs clarification.