Medical Report: Patient 002-10228

1. Patient Information:

* **Patient Unit Stay ID:** 197921 * **Patient Health System Stay ID:** 172981 * **Unique Patient ID:** 002-10228 * **Gender:** Female * **Age:** 67 * **Ethnicity:** Caucasian * **Hospital ID:** 67 * **Ward ID:** 109 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 01:10:00 (2014) * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 20:56:00 (2014) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 00:43:00 (2014) * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 19:39:00 (2014) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Weight:** 85 kg * **Discharge Weight:** 87.2 kg * **Admission Height:** 157 cm * **APACHE Admission Dx:** Sepsis, pulmonary

2. History: NULL (Insufficient data provided)

3. Diagnoses:

* **Primary Diagnosis:** Cardiovascular shock/hypotension, sepsis (ICD-9 codes: 038.9, A41.9) * **Other Diagnosis:** Pulmonary respiratory failure, acute respiratory distress syndrome (ICD-9 code: 518.82)

The primary diagnosis indicates a severe condition involving the cardiovascular system, characterized by shock and hypotension, complicated by sepsis. The secondary diagnosis of acute respiratory distress adds to the severity of the patient's condition, indicating significant respiratory compromise. The temporal relationship between the diagnoses is unknown; however, both were active upon discharge. The diagnosis of sepsis was entered 56 minutes after the patient's unit admission. The other diagnosis was also entered at the same time.

4. Treatments: NULL (Insufficient data provided)

5. Vital Trends:

The following vital signs were recorded at the time of the initial physical examination (39 minutes post unit admission):

* **Heart Rate (Current):** 85 bpm * **Heart Rate (Lowest):** 83 bpm * **Heart Rate (Highest):** 85 bpm * **Respiratory Rate (Current):** 27 breaths/min * **Respiratory Rate (Lowest):** 24 breaths/min * **Respiratory Rate (Highest):** 27 breaths/min * **Oxygen Saturation (Current):** 94% * **Oxygen Saturation (Lowest):** 94% * **Oxygen Saturation (Highest):** 94%

Further vital sign data would need to be provided to generate more detailed trends. The initial physical exam suggests a slightly elevated respiratory rate, within the range of 24-27 breaths per minute, which is elevated for a resting state. The heart rate appears to be within a normal range, although more data is needed to confirm this. Oxygen saturation is at a normal level.

6. Lab Trends:

The available lab data shows multiple blood tests performed at different time points during the patient's stay. Initial chemistry panel (drawn approximately 289 minutes before unit admit) indicated:

* **Chloride:** 99 mmol/L * **BUN:** 25 mg/dL * **Total Bilirubin:** 1.5 mg/dL * **Glucose:** 151 mg/dL * **Bicarbonate:** 22 mmol/L * **Total Protein:** 8.7 g/dL * **Calcium:** 9.2 mg/dL * **Albumin:** 3.3 g/dL * **Anion Gap:** 20 mmol/L * **AST (SGOT):** 15 Units/L * **ALT (SGPT):** 17 Units/L * **Potassium:** 3.7 mmol/L * **Sodium:** 137 mmol/L * **Creatinine:** 1.3 mg/dL

Later Hematology Panels (around 1895, 3898, 4741, 6178, 7925 minutes post unit admit) show:

* **WBC x 1000:** Values ranging from 13.8 to 20.9 K/mcL, indicating leukocytosis (high white blood cell count) throughout the stay. * **Hct:** Values ranging from 34.8% to 42.6%, indicating fluctuations in hematocrit. * **Hgb:** Values ranging from 11.3% to 13.9 g/dL, showing fluctuations in hemoglobin. * **RDW:** Values ranging from 13.7% to 14.7%, indicating variation in red blood cell size. * **MCV:** Values ranging from 85.4 to 86.6 fL, representing slight fluctuations in mean corpuscular volume. * **MCHC:** Values ranging from 32.3 to 32.8 g/dL, indicating fluctuations in mean corpuscular hemoglobin concentration. * **Platelets x 1000:** Values ranging from 226 to 333 K/mcL, showing fluctuations in platelet count. * **-Polys:** Values ranging from 78% to 92%, indicating the percentage of polymorphonuclear leukocytes. * **-Lymphs:** Values ranging from 6% to 10%, showing the percentage of lymphocytes. * **-Monos:** Values ranging from 6% to 9%, indicating the percentage of monocytes. * **-Eos:** Values ranging from 0% to 2%, showing the percentage of eosinophils. * **-Basos:** Values ranging from 0% to 1%, showing the percentage of basophils.

Serial bedside glucose measurements show elevated blood glucose levels. An ABG from approximately 200 minutes prior to unit admission showed: pH 7.42, pO2 81 mmHg, pCO2 34 mmHg, HCO3 22 mmol/L, and a base deficit of 2 mEq/L. Later ABGs taken around 2850 minutes post-unit admission reveal pH 7.44, pO2 90 mmHg, pCO2 33 mmHg, HCO3 22 mmol/L, and a base deficit of 1 mEq/L. A base excess of 0 mEq/L was measured around 3420 minutes post-unit admission. Additional FiO2 values were 40% and 60%.

Several lab values, such as glucose, BUN, creatinine, and liver enzymes (AST, ALT), show some degree of abnormality. The significant changes in several hematological parameters warrant further investigation. The serial glucose measurements and ABG results suggest a need for monitoring and possible management of glucose and acid-base balance.

7. Microbiology Tests: NULL (Insufficient data provided)

8. Physical Examination Results:

A structured physical examination was performed. The Glasgow Coma Scale (GCS) score was 15 (Eyes: 4, Verbal: 5, Motor: 6), indicating normal neurological function. The patient's weight was 85 kg on admission and 85.9 kg at the time of the exam. Intake and output were zero at the time of the exam.