Patient Information

Patient Unit Stay ID: 701925 Unique Patient ID: 006-100175 Gender: Female Age: 78 Ethnicity: Caucasian Hospital Admit Time: 2014-XX-XX 18:29:00 Hospital Admit Source: Emergency Department Hospital Discharge Time: 2014-XX-XX 20:26:00 Hospital Discharge Location: Skilled Nursing Facility Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admit Time: 2014-XX-XX 19:47:00 Unit Admit Source: Emergency Department Unit Discharge Time: 2014-XX-XX 17:08:00 Unit Discharge Location: Step-Down Unit (SDU) Unit Discharge Status: Alive Admission Weight: 59 kg Discharge Weight: 66.7 kg Admission Height: 165.1 cm

Medical History

NULL (Insufficient information provided)

Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnosis was sepsis, with secondary diagnoses including acute respiratory failure and pulmonary aspiration. Sepsis was an active diagnosis upon discharge from the unit. The diagnoses were recorded at various times throughout the patient's stay, with some being entered within minutes of admission, indicating their immediate clinical relevance. The ICD-9 codes associated with the diagnoses provide further detail for classification and coding purposes. Specific details regarding the progression and interplay of these conditions are not available in the provided data.

Diagnosis 1 (Primary, Active upon discharge): cardiovascular|shock / hypotension|sepsis (ICD-9: 038.9, A41.9) Diagnosis 2 (Major): pulmonary|respiratory failure|acute respiratory failure (ICD-9: 518.81, J96.00) Diagnosis 3 (Major): pulmonary|respiratory failure|pulmonary aspiration (ICD-9: 507.0, J69.0)

Multiple entries for the same diagnosis string with different diagnosis IDs and slightly varying timestamps suggest either multiple instances of the same diagnosis being recorded or potential data entry redundancies, requiring further investigation. The diagnosis priority field indicates the relative severity of the diagnoses reported, with 'Primary' indicating the most significant condition.

Treatments

The patient received several treatments during her ICU stay. These included mechanical ventilation, initially implemented early in the stay, and vasopressors (norepinephrine) to manage shock associated with sepsis. The treatment data lacks specific duration and dosage information for a comprehensive evaluation. The treatment administration times relative to admission also indicate the urgency of treatment interventions.

Treatment 1: pulmonary|ventilation and oxygenation|mechanical ventilation Treatment 2: cardiovascular|shock|vasopressors|norepinephrine > 0.1 micrograms/kg/min

Vital Trends

NULL (Insufficient information provided. Vital signs would typically be included in a time-series format.)

Lab Trends

The provided lab data includes a variety of chemistry, hematology, and blood gas results obtained at multiple time points during the patient's stay. Trends in these values, however, cannot be determined without temporal information associated with each lab result. The lab data shows a range of values for various parameters (e.g., glucose, electrolytes, blood gases, and hematologic markers). These require further analysis to identify trends and correlations with the patient's clinical course. The presence of both 'bedside glucose' and 'glucose' suggests the use of point-of-care testing in addition to central laboratory testing.

Microbiology Tests

NULL (Insufficient information provided)

Physical Examination Results

Physical exam data is available, but limited to vital signs and weight measurements at multiple timepoints. The lack of detailed descriptions and the presence of 'scored' entries suggest that a more complete physical exam was likely performed but not fully captured in the provided structured data. The data includes multiple entries of vital signs, indicating repeated measurements, but without timestamps, trend analysis is impossible. The weight measurements show a weight gain of 7.7 kg during the hospital stay.

Physical Exam 1 (Timepoint 1): HR 76, BP (systolic) 106, BP (diastolic) 64, Resp Rate 14, O2 Sat 97, CVP 18, Weight 59 kg Physical Exam 2 (Timepoint 2): HR 84, BP (systolic) 117, BP (diastolic) 66, Resp Rate 14, O2 Sat 98, CVP 4, Weight 66.7 kg

The discrepancies in the recorded vital signs at different time points may reflect changes in the patient's condition or measurement errors and would require further context for interpretation.