Patient Information

Patient Unit Stay ID: 378120 Unique Patient ID: 004-10117 Gender: Female Age: 51 Ethnicity: African American Hospital ID: 122 Ward ID: 212 Unit Type: Cardiac ICU Unit Admit Time: 05:44:00 Unit Admit Source: Floor Unit Discharge Time: 00:39:00 Unit Discharge Location: Floor Unit Discharge Status: Alive Hospital Admit Time: 14:47:00 Hospital Admit Source: Floor Hospital Discharge Year: 2015 Hospital Discharge Time: 21:45:00 Hospital Discharge Location: Home Hospital Discharge Status: Alive Admission Height: 157.5 cm Admission Weight: 88.81 kg Discharge Weight: NULL APACHE Admission Diagnosis: Hemorrhage (for gastrointestinal bleeding GI-see GI system) (for trauma see Trauma)

Medical History

Insufficient data provided to generate detailed medical history. The provided data focuses on diagnoses, treatments, labs, and physical exam findings during the ICU stay, not on the patient's broader medical history prior to admission.

Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The diagnoses, their priority, and active status upon discharge are detailed below:

* **Primary Diagnosis (Active upon Discharge):** Hemorrhage (diagnosisid: 7063529, diagnosisoffset: 2870 minutes) * **Major Diagnosis (Not Active upon Discharge):** Altered mental status / pain (diagnosisid: 6579183, diagnosisoffset: 2868 minutes) * **Major Diagnosis (Not Active upon Discharge):** Acute blood loss anemia (diagnosisid: 7718173, diagnosisoffset: 2868 minutes, ICD-9 code: 285.1, D62) * **Major Diagnosis (Active upon Discharge):** Left lower extremity DVT (diagnosisid: 6451910, diagnosisoffset: 2870 minutes, ICD-9 code: 451.2, I80.3) * **Major Diagnosis (Active upon Discharge):** Acute blood loss anemia (diagnosisid: 7741323, diagnosisoffset: 2870 minutes, ICD-9 code: 285.1, D62) * **Major Diagnosis (Not Active upon Discharge):** Left lower extremity DVT (diagnosisid: 6511450, diagnosisoffset: 2868 minutes, ICD-9 code: 451.2, I80.3) * **Major Diagnosis (Not Active upon Discharge):** Acute blood loss anemia (diagnosisid: 6429678, diagnosisoffset: 25 minutes, ICD-9 code: 285.1, D62) * **Major Diagnosis (Active upon Discharge):** Altered mental status / pain (diagnosisid: 7227210, diagnosisoffset: 2870 minutes) * **Major Diagnosis (Not Active upon Discharge):** Altered mental status / pain (diagnosisid: 6539800, diagnosisoffset: 25 minutes) * **Major Diagnosis (Not Active upon Discharge):** Hypotension (diagnosisid: 6974097, diagnosisoffset: 25 minutes, ICD-9 code: 458.9, I95.9) * **Primary Diagnosis (Not Active upon Discharge):** Hemorrhage (diagnosisid: 6530121, diagnosisoffset: 25 minutes) * **Primary Diagnosis (Not Active upon Discharge):** Hemorrhage (diagnosisid: 5586439, diagnosisoffset: 2868 minutes)

Note the multiple entries for some diagnoses; this may reflect updates or clarifications over the course of the stay. The ICD-9 codes are missing for several diagnoses.

Treatments

The patient received a variety of treatments during her ICU stay. The treatments, their active status upon discharge, and timing are detailed below:

* Ondansetron (antiemetic): (treatmentid: 10941490, treatmentoffset: 2868 minutes, Active upon discharge: False) * Non-cardiac angiography: (treatmentid: 11600734, treatmentoffset: 2868 minutes, Active upon discharge: False) * Central venous catheter placement: (treatmentid: 18350184, treatmentoffset: 2870 minutes, Active upon discharge: True) * CT scan (abdomen): (treatmentid: 12039609, treatmentoffset: 2868 minutes, Active upon discharge: False) * Acetaminophen (non-narcotic analgesic): (treatmentid: 10487808, treatmentoffset: 25 minutes, Active upon discharge: False) * CT scan (pelvis): (treatmentid: 17985388, treatmentoffset: 2868 minutes, Active upon discharge: False) * Foley catheter: (treatmentid: 17464896, treatmentoffset: 2870 minutes, Active upon discharge: True) * Non-invasive testing for DVT: (treatmentid: 18293501, treatmentoffset: 2870 minutes, Active upon discharge: True) * Non-invasive testing for DVT: (treatmentid: 12282445, treatmentoffset: 2868 minutes, Active upon discharge: False) * Urology consultation: (treatmentid: 12645137, treatmentoffset: 2 minutes, Active upon discharge: False) * Normal saline administration (fluid bolus): (treatmentid: 17617341, treatmentoffset: 2870 minutes, Active upon discharge: True) * Oral feeds (enteral feeds): (treatmentid: 18268483, treatmentoffset: 2870 minutes, Active upon discharge: True) * Bolus parenteral analgesics:

(treatmentid: 12281401, treatmentoffset: 2868 minutes, Active upon discharge: False) * Packed red blood cells (blood product administration): (treatmentid: 11324516, treatmentoffset: 2868 minutes, Active upon discharge: False) * IVC filter: (treatmentid: 14466229, treatmentoffset: 2870 minutes, Active upon discharge: True) * Urology consultation: (treatmentid: 12738508, treatmentoffset: 2868 minutes, Active upon discharge: False) * Non-cardiac angiography: (treatmentid: 13634513, treatmentoffset: 2870 minutes, Active upon discharge: True) * Packed red blood cells (transfusion of 1-2 units prbc's): (treatmentid: 15634188, treatmentoffset: 25 minutes, Active upon discharge: False) * Bolus parenteral analgesics: (treatmentid: 18150413, treatmentoffset: 2870 minutes, Active upon discharge: True) * Narcotic analgesic: (treatmentid: 14515792, treatmentoffset: 2868 minutes, Active upon discharge: False) * Urology consultation: (treatmentid: 14776027, treatmentoffset: 25 minutes, Active upon discharge: False) * Orthopedics consultation: (treatmentid: 11295090, treatmentoffset: 2868 minutes, Active upon discharge: False) * CT scan (abdomen): (treatmentid: 13600728, treatmentoffset: 2870 minutes, Active upon discharge: True) * Ondansetron (antiemetic): (treatmentid: 16610460, treatmentoffset: 25 minutes, Active upon discharge: False) * CT scan (pelvis): (treatmentid: 11383669, treatmentoffset: 2870 minutes, Active upon discharge: True) * Urology consultation: (treatmentid: 14337381, treatmentoffset: 2870 minutes, Active upon discharge: True) * Oral feeds (enteral feeds): (treatmentid: 11185727, treatmentoffset: 2868 minutes, Active upon discharge: False) * Compression stockings (VTE prophylaxis): (treatmentid: 13496479, treatmentoffset: 2870 minutes, Active upon discharge: True) * Normal saline administration (fluid bolus): (treatmentid: 11223108, treatmentoffset: 25 minutes, Active upon discharge: False) * Physical therapy consult: (treatmentid: 14682208, treatmentoffset: 2868 minutes, Active upon discharge: False) * Oral analgesics: (treatmentid: 15451308, treatmentoffset: 2868 minutes, Active upon discharge: False) * Packed red blood cells (blood product administration): (treatmentid: 17182034, treatmentoffset: 2870 minutes, Active upon discharge: True) * IVC filter: (treatmentid: 12965294, treatmentoffset: 2868 minutes, Active upon discharge: False) * Narcotic analgesic: (treatmentid: 17204496, treatmentoffset: 2870 minutes, Active upon discharge: True) * Compression stockings (VTE prophylaxis): (treatmentid: 13236483, treatmentoffset: 2868 minutes, Active upon discharge: False) * Foley catheter: (treatmentid: 15506364, treatmentoffset: 2868 minutes, Active upon discharge: False) * Oral analgesics: (treatmentid: 15973737, treatmentoffset: 2870 minutes, Active upon discharge: True) * Acetaminophen (antipyretics): (treatmentid: 13165457, treatmentoffset: 2870 minutes, Active upon discharge: True) * Central venous catheter placement: (treatmentid: 15480729, treatmentoffset: 2868 minutes, Active upon discharge: False) * Physical therapy consult: (treatmentid: 16312070, treatmentoffset: 2870 minutes, Active upon discharge: True) * Ondansetron (antiemetic): (treatmentid: 13088766, treatmentoffset: 2870 minutes, Active upon discharge: True) * Acetaminophen (antipyretics): (treatmentid: 15499241, treatmentoffset: 2868 minutes, Active upon discharge: False)

Note the multiple entries for some treatments; this may reflect updates or clarifications over the course of the stay. The descriptions are somewhat abbreviated.

Vital Trends

NULL. No vital sign data is provided.

Lab Trends

The patient underwent extensive blood work during her ICU stay. Key lab results and trends are shown below. Note that multiple measurements were taken at different times. A more complete time series would be necessary for a thorough trend analysis.

* **Hemoglobin (Hgb):** Initial values were low (6.0 g/dL and 6.6 g/dL), indicating anemia. Subsequent values showed improvement (7.2 g/dL, 7.4 g/dL, 7.5 g/dL, 7.8 g/dL, 7.7 g/dL, 7.8 g/dL, 8.0 g/dL). This suggests a response to treatment. * **Hematocrit (Hct):** Similarly, initial hematocrit was low (21.7%, 21.8%), consistent with anemia. Values increased over time (22.0%, 22.6%, 22.7%, 22.8%, 23.2%, 23.3%, 23.4%, 23.9%, 24.1%, 25.3%). * **Platelets:** Showed a decrease from 425 K/mcL to 356 K/mcL initially and then to 312 K/mcL, 202 K/mcL, 171 K/mcL indicating thrombocytopenia (low platelet count). Further evaluation is needed to determine the cause. * **White Blood Cell Count (WBC):** Elevated initially (9.5 K/mcL and 6.4 K/mcL) and then increased further (14.1 K/mcL, 15.4 K/mcL, 12.2 K/mcL) suggesting infection or inflammation. * **Other Labs:** Other chemistry and blood tests (BUN, Creatinine, Glucose, Electrolytes) were obtained, but without a clear time series, trend analysis is limited. Initial troponin-I was 0 ng/mL. There were also several differential blood counts (-polys, -lymphs, -monos, -eos, -basos) with varying percentages reported. PT and INR were measured during the stay; one measurement was a PT of 10.2 sec and an INR of 1.0. Another PT was 10.3 sec and INR of 1.0. These tests could indicate a coagulation disorder.

Microbiology Tests

NULL. No microbiology test data is provided.

Physical Examination Results

The physical exam documented a Glasgow Coma Scale (GCS) score of 15 (Eyes: 4, Verbal: 5, Motor: 6). Blood pressure readings were recorded as 99/66 mmHg. Heart rate was 80 bpm, respiratory rate was 18 breaths/min, and oxygen saturation was 100% on 21% FiO2. The patient's admission weight was 88.81 kg. A structured physical exam was performed.