Medical Report for Patient 007-10459

1. Patient Information

* **Patient Unit Stay ID:** 963136 * **Unique Patient ID:** 007-10459 * **Gender:** Female * **Age:** 65 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015, 03:50:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2015, 20:30:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015, 05:11:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2015, 21:15:00 * **Unit Discharge Location:** Telemetry * **Unit Discharge Status:** Alive * **Admission Weight:** 59.33 kg * **Discharge Weight:** 59.78 kg * **Admission Height:** 157.48 cm

2. History

NULL (Insufficient information provided in the JSON data to reconstruct a detailed patient history. The provided data focuses on diagnoses, treatments, and lab results, but lacks narrative clinical history.)

3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnosis upon admission and at discharge was acute respiratory failure (ICD-9 codes: 518.81, J96.00). Other significant diagnoses included:

* **Acute Respiratory Failure (Primary):** Recorded at 36 minutes and 1255 minutes post-unit admission. The diagnosis was active upon discharge. * **Aspiration Pneumonia (Major):** Recorded at 1255 minutes and 1816 minutes post-unit admission. The diagnosis was active upon discharge. * **Altered Mental Status/Obtundation (Other):** Recorded multiple times (36, 1255, 1816, and 2094 minutes post unit admission). The diagnosis was active upon discharge. * **Sepsis with Organ Dysfunction (Other):** Recorded at 1255 minutes and 1816 minutes post-unit admission. The diagnosis was active upon discharge.

The temporal relationships between these diagnoses are noteworthy. The respiratory failure was an early diagnosis, suggesting a possible link to the subsequent sepsis and altered mental status. The aspiration pneumonia may have contributed to the respiratory failure.

4. Treatments

The patient received various treatments during her ICU stay. These included:

* **Mechanical Ventilation (Pressure Controlled):** Administered between 1255 and 1816 minutes post-unit admission. * **Sputum Cultures:** Ordered at 36 and 1255 minutes post-unit admission. * **Urine Cultures:** Ordered at 36 and 1255 minutes post-unit admission. * **Blood Cultures:** Ordered at 36 and 1255 minutes post-unit admission. * **Oxygen Therapy (<40%):** Active upon discharge (2094 minutes post-unit admission). * **Analgesics:** Administered at 2094 minutes post-unit admission and continued upon discharge. * **Antibacterials:** Administered at 2094 minutes post-unit admission and continued upon discharge. * **Sedatives:** Administered at 1816 minutes post-unit admission.

The initiation of mechanical ventilation and various cultures suggests an aggressive approach to managing the respiratory failure and suspected infection. The continued oxygen therapy and antibacterials upon discharge indicate ongoing respiratory and infectious concerns.

5. Vital Trends

NULL (Insufficient data to generate vital sign trends. While some vital signs are present in the Physical Exam section, these are single point measurements, not time series data.)

6. Lab Trends

The lab results show multiple blood tests over time, including complete blood counts (CBCs) with differential and basic metabolic panels (BMPs). There is evidence of elevated WBC counts (14, 18.2, 12.7 K/mcL) and elevated creatinine (1.4, 1.79, 1.36, 1.07 mg/dL) at various time points, suggesting an ongoing inflammatory process and possible renal dysfunction. There are also multiple bedside glucose measurements indicating fluctuating glucose levels (ranging from 57 to 420 mg/dL). ABG results show fluctuating pH, PaO2, PaCO2, and Base Excess, indicative of respiratory distress and acid-base imbalance. The trend of Troponin-I levels (0.03, 0.401, 1.14, 1.22 ng/mL) needs to be analyzed for potential cardiac involvement. The serial hemodynamic data is incomplete, limiting the ability to fully assess the patient's overall cardiovascular status. More data is needed to establish conclusive trends.

7. Microbiology Tests

The patient underwent sputum, urine, and blood cultures, indicating a workup for infection. The results of these cultures are not included in the provided data. Further information is needed to assess the presence and nature of any infection.

8. Physical Examination Results

The physical exam documented a GCS score of 5 (Eyes 1, Verbal 1, Motor 4) and a heart rate of 79 bpm at 4 minutes post-unit admission. Blood pressure was 97/50 mmHg. Respiratory rate was 15 breaths per minute. Oxygen saturation was 99%. Admission weight was 59.33 kg. The exam was performed and recorded in a structured format. More comprehensive physical exam data is needed for a complete assessment.