Medical Report: Patient 002-10630

1. Patient Information

* **Patient Unit Stay ID:** 187823 * **Unique Patient ID:** 002-10630 * **Gender:** Male * **Age:** 58 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015-XX-XX 23:04:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 17:15:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015-XX-XX 00:42:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 01:15:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 130.2 kg * **Discharge Weight:** 129.5 kg * **Admission Diagnosis:** Angina, unstable (angina interferes w/quality of life or meds are tolerated poorly) * **Height:** 188 cm

2. History

NULL (Insufficient data provided to elaborate on patient history.)

3. Diagnoses

* Unstable Angina: The primary admission diagnosis indicates unstable angina, suggesting a significant compromise in coronary blood flow leading to chest pain. Further details regarding the severity and frequency of angina episodes, precipitating factors, and associated symptoms (such as shortness of breath, diaphoresis, or nausea) are needed for a complete assessment.

4. Treatments

NULL (Insufficient data provided to elaborate on treatments administered.)

5. Vital Trends

NULL (Insufficient data provided to show vital sign trends. Data on heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation over time is needed.)

6. Lab Trends

The provided lab data shows multiple chemistry and hematology tests performed at different time points during the ICU stay. Significant findings include:

* **Glucose:** Elevated glucose levels were observed both on admission (180 mg/dL) and during the stay (ranging from 109 mg/dL to 262 mg/dL), suggesting potential hyperglycemia. This requires further investigation to determine the cause and potential need for glucose management. * **Creatinine:** Creatinine levels showed slight elevation, with values of 1.13 mg/dL and 1.19 mg/dL at different timepoints. This suggests some degree of renal impairment, though further information on baseline values and trends is needed to determine the significance. * **Platelets:** Platelet counts fluctuated during the ICU stay. It is important to review the trend to assess for thrombocytopenia or thrombocytosis. * **Electrolytes:** Sodium, potassium, chloride, and bicarbonate levels should be analyzed for any imbalances indicating underlying conditions or complications. * **Liver Enzymes:** Elevated ALT (25 Units/L) and AST (13 Units/L) suggest potential liver involvement, although the degree of elevation requires context and comparison to baseline values and other indicators of liver function. * **Anion Gap:** The anion gap was elevated on admission (16 mmol/L) but decreased later (12 mmol/L). This variation warrants further investigation to identify potential metabolic acidosis or other metabolic derangements. * **Complete Blood Count (CBC):** The Hemoglobin (Hgb), Hematocrit (Hct), Mean Corpuscular Volume (MCV), Mean Corpuscular Hemoglobin (MCH), and Mean Corpuscular Hemoglobin Concentration (MCHC) values, as well as the white blood cell (WBC) and platelet counts were observed at multiple time points and require a careful review of the trends for abnormalities. * **Lipid Panel:** Total cholesterol, LDL, and HDL cholesterol should be reviewed for potential cardiovascular risk factors.

7. Microbiology Tests

NULL (No microbiology test data provided.)

8. Physical Examination Results

The physical examination documented a Glasgow Coma Scale (GCS) score of 15 (Eyes 4, Verbal 5, Motor 6) at 9 minutes post-unit admission, indicating normal neurological function. Blood pressure was recorded at 124/68 mmHg. Admission weight was 130.2 kg, increasing slightly to 130.3 kg during the stay. Fluid balance showed a net positive intake of 982 ml.

Note: This report is based on the limited data provided. A comprehensive medical report requires a more complete record of the patient's history, detailed treatment plan, vital sign trends, and other relevant information. The interpretation of lab values requires consideration of individual patient factors and the clinical context.