Patient Information

Patient Unit Stay ID: 312665 Unique Patient ID: 004-10008 Gender: Female Age: 54 Ethnicity: Caucasian Hospital Admit Time: 2014-01-14 01:14:00 Hospital Admit Source: Emergency Department Hospital Discharge Time: 2014-01-14 19:29:00 Hospital Discharge Location: Home Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admit Time: 02:45:00 Unit Admit Source: Emergency Department Unit Discharge Time: 20:13:00 Unit Discharge Location: Floor Unit Discharge Status: Alive Admission Diagnosis: Infarction, acute myocardial (MI)

Medical History

NULL (Insufficient data provided)

Diagnoses

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

* **Primary:** * Acute Myocardial Infarction (no ST elevation) (ICD-9: 410.71, I21.4) - Multiple entries, some active and some inactive upon discharge. * **Major:** * Acute Respiratory Distress (ICD-9: 518.82) - Multiple entries, some active and some inactive upon discharge. * Congestive Heart Failure (ICD-9: 428.0, I50.9) - Multiple entries, some active and some inactive upon discharge. * **Other:** * Atrial Fibrillation (ICD-9: 427.31, I48.0) - Multiple entries, some active and some inactive upon discharge.

The temporal relationship between diagnoses is noteworthy. Several diagnoses, particularly those related to cardiovascular issues and respiratory failure, were recorded around the same time. This suggests a potential interconnectedness of these conditions.

Treatments

The patient received a wide range of treatments during her ICU stay. Key treatments included:

* **Cardiovascular:** Enoxaparin (low molecular weight heparin), sublingual nitroglycerin, digoxin (inotropic agent), carvedilol (alpha/beta blocker), aspirin (antiplatelet agent), and amiodarone (class III antiarrhythmic). Many of these treatments were administered multiple times and some were active upon discharge. * **Pulmonary:** Albuterol (beta-agonist bronchodilator), and oxygen therapy via nasal cannula. Albuterol was administered multiple times, while oxygen therapy was active upon discharge. * **Gastrointestinal:** Ondansetron (serotonin antagonist antiemetic), and oral feeds. These treatments were given multiple times, but were not active upon discharge.

The comprehensive nature of the treatment regimen highlights the severity of the patient’s condition and the multi-system approach taken by the medical team.

Vital Trends

NULL (Insufficient data provided)

Lab Trends

The following lab results were recorded at approximately 76 minutes post unit admission:

* Troponin-I: 2.28 ng/mL * Glucose: 141 mg/dL * Creatinine: 1.2 mg/dL * BUN: 20 mg/dL * Sodium: 137 mEq/L * FiO2: 28 % * paO2: 69 mm Hg * paCO2: 40.3 mm Hg * pH: 7.41 * Hct: 47.9 % * WBC: 9.6 K/mcL * BNP: 2537 pg/mL

The elevated troponin-I level strongly suggests myocardial injury, consistent with the admission diagnosis of acute myocardial infarction. Other lab values provide a snapshot of the patient's overall metabolic and respiratory status at that time point. Further data is needed to assess trends.

Microbiology Tests

NULL (Insufficient data provided)

Physical Examination Results

A structured physical exam was performed at approximately 71 minutes post unit admission. Key findings included:

* Heart Rate (HR): Current 106 bpm, Lowest 106 bpm, Highest 107 bpm * Blood Pressure (BP): Systolic - Current 132 mmHg, Lowest 125 mmHg, Highest 134 mmHg; Diastolic - Current 108 mmHg, Lowest 88 mmHg, Highest 119 mmHg * Respiratory Rate (RR): Current 34 breaths/min, Lowest 17 breaths/min, Highest 34 breaths/min * Oxygen Saturation (O2 Sat): Current 96%, Lowest 96%, Highest 98% * FiO2: 28% * Glasgow Coma Scale (GCS): Total score of 15 (Eyes 4, Verbal 5, Motor 6)

The physical exam findings support the severity of the patient's cardiovascular and respiratory compromise. The GCS score indicates normal neurological function.