Medical Report for Patient 009-10008

1. Patient Information:

* **Patient Unit Stay ID:** 1057910 * **Patient Health System Stay ID:** 784330 * **Unique Patient ID:** 009-10008 * **Gender:** Female * **Age:** 51 * **Ethnicity:** Asian * **Hospital ID:** 197 * **Ward ID:** 477 * **Unit Type:** Cardiac ICU * **Unit Admit Time:** 05:25:00 * **Unit Admit Source:** Emergency Department * **Hospital Admit Time:** 03:04:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 20:47:00 * **Hospital Discharge Location:** Death * **Hospital Discharge Status:** Expired * **Unit Discharge Time:** 20:47:00 * **Unit Discharge Location:** Death * **Unit Discharge Status:** Expired * **Admission Height (cm):** 157.5 * **Admission Weight (kg):** 59.1 * **Discharge Weight (kg):** NULL

2. History:

The provided data does not contain a detailed patient history. Further information is needed to complete this section. This section would typically include information such as presenting complaints, relevant past medical history (including surgeries, allergies, and chronic conditions), family history, social history (smoking, alcohol, drug use), and medication history. The admission diagnosis indicates cardiac arrest as the primary reason for admission. However, the specifics of the event, including the circumstances surrounding the arrest and any prior symptoms, are missing.

3. Diagnoses:

* **Primary Diagnosis (ICD-9 code 427.5, I46.9):** Cardiovascular | Cardiac arrest | Cardiac arrest | Witnessed, < 15 minutes CPR. This diagnosis remained active upon discharge from the unit. * **Major Diagnosis (ICD-9 code 518.82):** Pulmonary | Respiratory failure | Acute respiratory distress. This diagnosis was not active upon discharge from the unit.

The presence of both cardiac arrest and acute respiratory distress suggests a severe and potentially life-threatening clinical scenario. The temporal relationship between these diagnoses needs further clarification. Were these simultaneous events, or did one precede the other? Further information on the progression of the patient's condition is needed to fully understand the diagnostic picture.

4. Treatments:

* **Pulmonary: Ventilation and Oxygenation: Mechanical ventilation:** This treatment was active upon unit discharge. The specific parameters of mechanical ventilation (e.g., tidal volume, respiratory rate, FiO2) are missing from the data and are crucial for a comprehensive treatment assessment. * **Cardiovascular: Shock: Vasopressors: Norepinephrine <= 0.1 micrograms/kg/min:** This treatment was also active upon unit discharge. Details regarding the dosage adjustments, response to treatment, and any other supportive cardiovascular therapies (e.g., inotropes, fluids) are absent.

Without additional details, it is difficult to ascertain the effectiveness of the treatments received.

5. Vital Trends:

NULL. The provided data does not include time-series data on vital signs (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation). This information is essential for tracking the patient's condition over time and assessing the effectiveness of interventions.

6. Lab Trends:

The lab data includes a substantial number of blood tests taken at different time points. However, without the timestamps, it’s impossible to create a comprehensive lab trend analysis. The tests cover a range of chemistries and hematological markers, including electrolytes, liver function tests, kidney function tests, and blood gases. Further analysis requires more detailed information.

7. Microbiology Tests:

NULL. No microbiology test results are included in the provided data.

8. Physical Examination Results:

Two sets of structured physical exam results were recorded, one at 69 minutes and another at 2252 minutes post-unit admission. Both exams included vital signs (heart rate, blood pressure, respiratory rate, and oxygen saturation). The Glasgow Coma Scale (GCS) was scored at both time points, but the individual component scores (eyes, verbal, motor) were only recorded at the earlier time point. The initial GCS was 3, indicating severe neurological impairment. Weight was recorded as 59.1kg on admission, and urinary output was 2350ml at the second exam. Fluid intake is reported as zero at the second exam. A more detailed physical examination would typically include a more comprehensive assessment of various body systems, such as cardiac, respiratory, and abdominal systems. The lack of detailed information limits the interpretation of these findings.