Medical Report - Patient 004-11117

1. Patient Information

* **PatientUnitStayID:** 350551 * **PatientHealthSystemStayID:** 301365 * **UniquePID:** 004-11117 * **Gender:** Female * **Age:** 65 * **Ethnicity:** Caucasian * **HospitalID:** 131 * **WardID:** 227 * **Unit Type:** Med-Surg ICU * **Admission Date & Time:** (Hospital admit time needs to be specified) * **Discharge Date & Time:** (requires hospital admit date and time for calculation) * **Admission Weight:** 128.6 kg * **Discharge Weight:** NULL * **Admission Height:** 157.5 cm * **Hospital Admit Source:** Direct Admit * **Hospital Discharge Year:** 2015 * **Hospital Discharge Location:** Rehabilitation * **Hospital Discharge Status:** Alive * **Unit Admit Source:** Direct Admit * **Unit Visit Number:** 1 * **Unit Stay Type:** admit * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive

2. History

The provided data does not contain a detailed patient history. This section requires additional information from the patient's chart, including presenting complaints, relevant past medical history (e.g., prior hospitalizations, surgeries, allergies), family history, social history (e.g., smoking, alcohol use, drug use), and medication history. NULL

3. Diagnoses

The patient was admitted with multiple diagnoses. The primary diagnosis was respiratory failure (failure to wean and acute respiratory distress). Major diagnoses included chronic myelogenous leukemia, hypertension, and pulmonary hypertension. Diabetes mellitus was also listed as a major diagnosis. The diagnoses active upon discharge were chronic myelogenous leukemia and hypertension. Specific details regarding the severity and progression of each diagnosis during the ICU stay are needed for a complete assessment.

* **Primary Diagnosis:** Pulmonary|Respiratory failure|failure to wean (ICD-9 code missing) * **Major Diagnoses:** * Cardiovascular|Vascular disorders|hypertension (ICD-9 code: 401.9, I10) * Oncology|Hematologic malignancy|Leukemia|Chronic myelogenous (ICD-9 code: 205.10, C92.10) * Pulmonary|Respiratory failure|Acute respiratory distress (ICD-9 code: 518.82) * Pulmonary|Disorders of vasculature|Pulmonary hypertension (ICD-9 code missing) * Endocrine|Glucose metabolism|Diabetes mellitus (ICD-9 code missing) * **Diagnoses Active Upon Discharge:** * Oncology|Hematologic malignancy|Leukemia|Chronic myelogenous * Cardiovascular|Vascular disorders|hypertension

4. Treatments

The patient received a variety of treatments during her ICU stay. These included: mechanical ventilation, oxygen therapy, tracheal suctioning, VTE prophylaxis (compression boots and stockings), enteral feeding, stress ulcer prophylaxis (famotidine), analgesics, sedative agents, intravenous furosemide. Upon discharge, the patient continued treatment with analgesics, tube feeding, and VTE prophylaxis (compression stockings). A cardiac surgery consultation and a pulmonary/CCM consultation were also noted. The specific dosages, routes, and duration of each treatment require further detail.

5. Vital Trends

NULL. Vital signs data (heart rate, blood pressure, respiratory rate, oxygen saturation, temperature) are needed to create a trend analysis.

6. Lab Trends

The laboratory results reveal trends in several key parameters:

* **Glucose:** Fluctuated between 94 mg/dL and 169 mg/dL, indicating issues with glucose control. * **BUN:** Ranged from 11 mg/dL to 61 mg/dL, suggesting potential renal function issues or dehydration. * **Creatinine:** Varied from 0.7

mg/dL to 1.16 mg/dL, consistent with fluctuating renal function. * **Electrolytes (Sodium, Potassium, Chloride, Bicarbonate, Calcium):** Showed some variability, requiring a more comprehensive analysis to assess the degree of electrolyte imbalance. Additional context is needed to interpret these shifts. * **Complete Blood Count (Hemoglobin, Hematocrit, MCV, MCH, MCHC, Platelets, WBC):** Provides information about the patient's blood cell counts. A more detailed analysis is needed to assess any potential hematological abnormalities given the leukemia diagnosis. * **Other Labs (ALT (SGPT), AST (SGOT), Alkaline Phosphatase, Total Protein, Albumin, BNP, TSH, CRP, PT, PT-INR, Bedside Glucose, ABG data (pH, PaO2, PaCO2, Base Excess), Ventilator parameters (FiO2, PEEP, TV, Respiratory Rate, Pressure Support, LPM O2)):** A complete interpretation requires a comprehensive review of all lab results, their trends, and their correlation with the patient's clinical picture. Further detailed analysis is necessary.

7. Microbiology Tests

NULL. Information on microbiology tests (blood cultures, urine cultures, etc.) is missing.

8. Physical Examination Results

The physical exam was performed and documented. A GCS score of 15 (4, 5, 6) was recorded at one point. Heart rate was recorded as 76 bpm (consistent throughout the recording). Systolic blood pressure fluctuated between 75 mmHg and 108 mmHg. Oxygen saturation was 95% (consistent). FiO2 was 40%, PEEP was 5 cm H2O, and ventilator rate was 14 breaths/min. The complete physical examination findings are needed to provide a comprehensive report.