Patient Information

* **Patient Unit Stay ID:** 160762 * **Unique Patient ID:** 002-11734 * **Gender:** Male * **Age:** 71 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015-XX-XX 12:56:24 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 15:35:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015-XX-XX 18:33:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 15:14:00 * **Unit Discharge Location:** Home * **Unit Discharge Status:** Alive * **Admission Weight:** 111.1 kg * **Discharge Weight:** 111.1 kg * **Admission Diagnosis:** Chest pain, unknown origin * **Admission Height:** 170.2 cm

Medical History

NULL (Insufficient data provided)

Diagnoses

NULL (Insufficient data provided)

Treatments

NULL (Insufficient data provided)

Vital Trends

NULL (Insufficient data provided)

Laboratory Trends

The provided data includes several hematology and chemistry lab results taken at two time points during the patient's ICU stay. The first set of tests was performed approximately 318 minutes before unit admission, and a second set was done at approximately 792 minutes post-unit admission. Key observations include:

* **Hemoglobin (Hgb):** Decreased from 11.3 g/dL at the initial measurement to 10.4 g/dL at the second. This suggests potential anemia or ongoing blood loss. * **Mean Corpuscular Volume (MCV):** Slightly decreased from 87 fL to 86.7 fL, which, in conjunction with the Hgb drop, might indicate microcytic anemia, although further investigation is needed. * **White Blood Cell Count (WBC):** Elevated at 11.4 K/mcL initially, then slightly lower at 10.8 K/mcL later. This could indicate an inflammatory response or infection. * **Creatinine:** Elevated at 1.9 mg/dL initially, increased to 1.7 mg/dL at the second measurement. This could signify renal impairment, requiring monitoring and further assessment. * **Troponin-I:** Undetectable (<0.02 ng/mL) at two different time points, suggesting no significant myocardial injury or acute coronary syndrome. * **Bedside Glucose:** Initially elevated at 160 mg/dL, then decreased to 87 mg/dL. This may indicate hyperglycemia that responded to treatment or reflects fluctuating blood glucose levels. * **Brain Natriuretic Peptide (BNP):** Elevated at 242 pg/mL. This could suggest heart failure or other cardiac issues.

Additional Chemistry tests (ALT, albumin, total protein, potassium, alkaline phosphatase, total bilirubin, calcium, chloride, BUN, sodium, anion gap) and coagulation tests (PT, PTT, PT-INR) were also performed, with some showing values outside of the normal range. A detailed interpretation of these values requires access to the reference ranges.

Microbiology Tests

NULL (Insufficient data provided)

Physical Examination Results

The physical exam recorded the patient's weight at admission (111.1 kg) and current weight (111.1 kg), indicating no weight change during the ICU stay. A Glasgow Coma Scale (GCS) was performed, with scores of 4 for Eyes, 5 for Verbal, and 6 for Motor, resulting in a total GCS score of 15, suggesting normal neurological function.

The physical exam was documented as ‘Performed - Structured’, suggesting a standardized approach to data collection.