Patient Information

Patient Unit Stay ID: 234934 Unique Patient ID: 002-10184 Gender: Female Age: 59 Ethnicity: Caucasian Hospital ID: 73 Ward ID: 114 Admission Diagnosis: Chest pain, unknown origin Admission Height: 175.3 cm Admission Weight: 109.9 kg Discharge Weight: 109.9 kg Hospital Admit Time: 2015-XX-XX 08:30:00 (Hospital Admit Offset: -46 minutes from unit admit) Hospital Admit Source: Emergency Department Hospital Discharge Year: 2015 Hospital Discharge Time: 2015-XX-XX 22:25:00 (Hospital Discharge Offset: 2229 minutes from unit admit) Hospital Discharge Location: Home Hospital Discharge Status: Alive Unit Type: CCU-CTICU Unit Admit Time: 2015-XX-XX 09:16:00 Unit Admit Source: Emergency Department Unit Visit Number: 1 Unit Stay Type: admit Unit Discharge Time: 2015-XX-XX 22:26:00 (Unit Discharge Offset: 2230 minutes from unit admit) Unit Discharge Location: Home Unit Discharge Status: Alive

Medical History

NULL (Insufficient data provided)

Diagnoses

Primary Diagnosis: Chest pain, unknown origin

Treatments

NULL (Insufficient data provided)

Vital Trends

NULL (Insufficient data provided)

Lab Trends

The provided lab data includes various blood tests conducted at different time points during the patient's stay. The data shows multiple sets of lab results, some taken before ICU admission (-201 minutes offset), some at 126 minutes, and others at 804, 1388 and 1907 minutes after ICU admission. There is evidence of repeated measurements of various parameters. Specific trends require further analysis and visualization, but we can observe initial and subsequent results for many labs, suggesting monitoring of the patient's condition. Some key lab values include:

* **Glucose:** Initial glucose levels were high (318 mg/dL), later decreasing to 213 mg/dL and then increasing again to 317 mg/dL. Further analysis is needed to understand the significance of these fluctuations. * **Troponin-I:** Elevated troponin levels were observed at multiple time points (0.78 ng/mL, 1.25 ng/mL, 1.41 ng/mL, 1.28 ng/mL), indicating possible myocardial injury. The trend needs further investigation to determine if the levels are improving or worsening. * **Hemoglobin (Hgb) and Hematocrit (Hct):** Initial hemoglobin and hematocrit values were within the normal range, but repeated testing is needed to monitor their levels. * **Electrolytes:** Sodium, potassium, chloride, bicarbonate, and anion gap were measured repeatedly to monitor electrolyte balance. * **Liver function tests:** ALT and AST were measured. * **Lipid panel:** Total cholesterol, LDL, and HDL were measured. * **Complete blood count (CBC):** WBC, RBC, platelets, MCV, MCH, MCHC, and RDW, and differential counts for neutrophils, lymphocytes, monocytes, and basophils were measured. The repeated CBC values allow for monitoring of the patient's blood counts. The initial white blood cell count was elevated (10.4 K/mcL). The differential shows a high percentage of polymorphonuclear leukocytes.

Microbiology Tests

NULL (Insufficient data provided)

Physical Examination Results

The physical exam indicates that a structured physical exam was performed at 6 minutes post unit admission. The patient's admission and current weight were both recorded as 109.9 kg, indicating no change in weight during the stay. A Glasgow Coma Scale (GCS) score of 15 (Eyes 4, Verbal 5, Motor 6) was documented, suggesting normal neurological function. Further details about other aspects of the physical exam are lacking.

The information provided is incomplete and requires additional data for a comprehensive medical report. The absence of vital sign trends and detailed treatment information limits the ability to provide a complete clinical picture. The date and time information in the patient data is missing and needs to be added to make the report more informative.