Medical Report for Patient 004-12750

1. Patient Information:

* **Patient Unit Stay ID:** 351720 * **Unique Patient ID:** 004-12750 * **Gender:** Female * **Age:** 87 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015-XX-XX 02:40:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 16:35:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 06:34:00 * **Unit Admit Source:** Direct Admit * **Unit Discharge Time:** 2015-XX-XX 14:40:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 71.2 kg * **Admission Height:** 162.6 cm

2. History:

The patient was admitted to the hospital via the Emergency Department with a chief complaint of chest pain, epigastric. The detailed history is not provided in the given data. However, multiple diagnoses related to cardiovascular issues (hypertension, hyperlipidemia, acute myocardial infarction (NSTEMI), chest pain) and a urinary tract infection were recorded during the ICU stay. The exact timeline and circumstances surrounding the onset of symptoms remain unclear without further information. The patient's medical history prior to this admission is unknown based on the provided data. A more comprehensive review of past medical records would be necessary to gain a complete understanding of the patient's medical history. The duration of symptoms and any associated risk factors for the cardiovascular events are also missing from the current dataset.

3. Diagnoses:

The patient received multiple diagnoses during her ICU stay. The primary diagnosis upon discharge was acute myocardial infarction (NSTEMI) (ICD-9 code: 410.71, I21.4). Other significant diagnoses included hypertension (ICD-9 code: 401.9, I10), hyperlipidemia (ICD-9 code: 272.4, E78.5), and a urinary tract infection (ICD-9 code: 599.0, N39.0). Chest pain was also a recurring diagnostic consideration (ICD-9 codes: 786.50, R07.9). The diagnoses were recorded at varying times during the ICU stay, suggesting that the clinical picture evolved over time. The absence of details on the diagnostic process (e.g., results of ECG, cardiac enzymes, imaging studies) limits a thorough assessment of the diagnostic certainty.

4. Treatments:

The patient received a range of treatments, including medications for cardiovascular conditions (aspirin, enoxaparin, propranolol, simvastatin), antibiotics for the urinary tract infection, and supportive care (compression stockings, compression boots). Multiple cultures (urine, blood) were ordered. Chest X-rays were also performed. The specific dosages, administration routes, and durations of these treatments are not specified within this dataset. The effectiveness of these treatments cannot be fully evaluated without additional clinical information, such as the patient's response to therapy and any adverse events experienced.

5. Vital Trends: NULL

6. Lab Trends:

The available lab data includes a limited set of values from a single time point approximately 156 minutes post-unit admission. The data includes blood glucose (142 mg/dL), sodium (130 mEq/L), BUN (15 mg/dL), albumin (3.7 g/dL), creatinine (0.8 mg/dL), hematocrit (36.6%), and WBC count (7.7 K/mcL). Additionally, a FiO2 of 21% was recorded at approximately 326 minutes post-unit admission. A comprehensive analysis of lab trends requires more frequent measurements over the course of the ICU stay. Without a complete time series of lab results, it's impossible to assess the patient's overall response to therapy or to identify any significant fluctuations in her condition.

7. Microbiology Tests: NULL

8. Physical Examination Results:

The physical exam recorded a heart rate between 75 and 83 bpm, a systolic blood pressure between 96 and 110 mmHg, and a diastolic blood pressure between 46 and 55 mmHg. Respiratory rate was recorded between 14 and 25 breaths per minute, and oxygen saturation was between 95% and 96%. The Glasgow Coma Scale (GCS) was documented as 15 (Eyes: 4, Verbal: 5, Motor: 6). The patient's weight at admission was 71.2 kg. The patient's respiratory mode was spontaneous and a structured physical exam was performed. Further details regarding the physical exam findings, including specific observations about the patient's overall appearance and any other relevant findings, are not included in the provided data.