Patient Medical Report

1. Patient Information

* **PatientUnitStayID:** 289502 * **UniquePID:** 003-10003 * **Gender:** Female * **Age:** 62 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015 (Year), 14:12:00 (24-hour format) * **Hospital Discharge Time:** 2015 (Year), 17:45:00 (24-hour format) * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 16:47:00 (24-hour format) * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 22:09:00 (24-hour format) * **Unit Discharge Location:** Floor * **Admission Weight:** 95.5 kg * **Discharge Weight:** 95.5 kg * **Admission Height:** 160 cm

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses, some active upon discharge and others not. The primary diagnosis upon discharge was Atrial Fibrillation (ICD-9 code: 427.31, I48.0). Other diagnoses included obesity (ICD-9 code: 278.00, E66.9), chest pain/ASHD (ICD-9 code: 786.50, R07.9), and diabetes mellitus. It is important to note that the obesity diagnosis was listed as both active and inactive upon discharge, suggesting either a recording error or a complex clinical picture where the obesity played a role in multiple aspects of care. The chest pain/ASHD diagnosis was also recorded as both active and inactive, potentially reflecting fluctuating symptoms.

4. Treatments

The patient received Diltiazem, a Class IV antiarrhythmic, to manage her Atrial Fibrillation. This treatment was active upon discharge. The treatment was also recorded as being administered earlier in the stay but subsequently discontinued. This suggests that the Atrial Fibrillation was successfully managed or that the medication proved ineffective, requiring alternative treatment strategies.

5. Vital Trends

The physical exam provided limited vital signs data at two separate time points. At the initial assessment (physicalexamoffset: 4 minutes), the patient's heart rate (HR) was 107 bpm (range 106-107 bpm), blood pressure (BP) 116/103 mmHg (systolic lowest 121, systolic highest 116, diastolic lowest 88, diastolic highest 103 mmHg), respiratory rate (RR) was 18 breaths per minute (range 17-21 breaths per minute), and oxygen saturation (O2 Sat) was 97% (range 97-97%). A later physical exam (physicalexamoffset: 2195 minutes) showed HR: 99 bpm (range 80-117 bpm), BP 130/72 mmHg (systolic lowest 71, systolic highest 147 mmHg, diastolic lowest 32, diastolic highest 101 mmHg), RR 20 breaths per minute (range 12-22 breaths per minute), and O2 Sat 97% (range 92-99%). More frequent monitoring of vital signs would be necessary to establish clear trends and assess the patient's response to treatment.

6. Lab Trends

The patient underwent multiple lab tests, including blood chemistry and hematology panels. Bedside glucose levels were frequently monitored, ranging from 131 mg/dL to 339 mg/dL throughout the ICU stay. The high glucose levels suggest the need for improved glycemic control. Other lab values varied throughout the stay, showing changes in electrolytes (sodium and potassium), creatinine, and blood components (Hgb, Hct, RBC, WBC, platelets). A trend analysis of these values over time is needed to detect any significant deviations from normal ranges and determine the effectiveness of treatment strategies.

7. Microbiology Tests

NULL (Insufficient information provided)

8. Physical Examination Results

The physical exam indicated that the patient was ill-appearing and obese. Her heart rhythm was irregular and narrow-complex. A GCS score of 15 was documented, which indicates normal neurological function. The patient was noted to be alert and oriented x3, with a calm and appropriate affect. The patient's weight remained stable at 95.5 kg throughout the ICU stay. Fluid balance showed a net negative balance of -925 ml, primarily due to urine output. The exam findings support the diagnoses of obesity and Atrial Fibrillation.