Medical Report: Patient 004-11678

1. Patient Information:

* **Patient Unit Stay ID:** 411036 * **Unique Patient ID:** 004-11678 * **Gender:** Female * **Age:** 54 * **Ethnicity:** African American * **Hospital Admission Time:** 2015-XX-XX 07:14:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 22:12:00 * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015-XX-XX 07:26:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 22:00:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 79.7 kg * **Admission Height:** 167.6 cm

2. History:

Admission history indicates the patient presented to the Emergency Department with Sepsis and a renal/UTI (including bladder) infection. The patient's history also reveals pre-existing conditions including hypertension, diabetes mellitus, multiple sclerosis, and myasthenia gravis. The onset of symptoms and their progression prior to admission are not detailed in the provided data. Further information is needed to complete a thorough history section. NULL

3. Diagnoses:

The patient received multiple diagnoses during her ICU stay. These include:

* **Primary Diagnoses:** * Signs and symptoms of sepsis (SIRS) (ICD-9: 995.90) * Change in mental status (ICD-9: 780.09, R41.82) * **Major Diagnoses:** * Lower urinary tract infection (ICD-9: 595.9, N30.9) * Multiple sclerosis (ICD-9: 340, G35) * Infection related fever (ICD-9: 780.6, R50.9) * Hypertension (ICD-9: 401.9, I10) * Diabetes Mellitus * Myasthenia gravis (ICD-9: 358.00, G70.0)

The diagnoses suggest a complex clinical picture involving infection, neurological issues, and metabolic and cardiovascular comorbidities. The temporal relationship between these diagnoses and their interplay requires further clinical context.

4. Treatments:

The patient received a wide range of treatments, including:

* **Antibiotics:** Piperacillin/tazobactam, Vancomycin * **Antihypertensives:** Calcium channel blockers * **Anticoagulants:** Low molecular weight heparin (LMWH), Coumadin * **Bronchodilators:** (Specific medication not specified) * **Electrolyte replacement:** Potassium * **Insulin:** Sliding scale administration * **Laxatives:** (Specific medication not specified) * **Intravenous fluids:** Normal saline * **Chest X-ray:**

The administration of multiple medications and therapies reflects the multi-system nature of her illness. The effectiveness and response to these treatments are not detailed in the data. Additional information is required for complete assessment.

5. Vital Trends: NULL

6. Lab Trends:

The available lab data includes:

* **Chemistry Panel (at 119 minutes):** Albumin (3.4 g/dL), Sodium (142 mmol/L), AST (39 Units/L), Creatinine (0.9 mg/dL), Chloride (111 mmol/L), Potassium (4 mmol/L), Total Bilirubin (0.4 mg/dL), BUN (13 mg/dL), FiO2 (21% at 119

minutes). * **Hematology Panel (at 423 minutes):** Hct (36.3%), Hgb (12.4 g/dL), WBC (6.5 K/mcL) * **Custom Lab (at 119 minutes):** Pro BNP (127.0000)

These results suggest potential issues such as hypoalbuminemia, although further values are needed to assess trends and clinical significance. The FiO2 level requires further data points and clinical context for proper interpretation.

7. Microbiology Tests: NULL

8. Physical Examination Results:

Physical examination data is available for two time points (149 and 3203 minutes post-admission). The exam includes vital signs (HR, RR, BP, O2 saturation) and a neurological assessment using the Glasgow Coma Scale (GCS). A complete physical exam was performed. At 149 minutes, HR was 86, RR was 16, systolic BP was 156, diastolic BP was 82, and O2 saturation was 100% on 28% FiO2. At 3203 minutes, HR ranged from 62 to 98, RR ranged from 0 to 21, systolic BP ranged from 131 to 144, diastolic BP ranged from 51 to 69, and O2 saturation ranged from 96 to 100%. The GCS scores are listed as 'scored' indicating the need for raw values to assess trends. The patient's weight (79.7 kg) was recorded at admission and respiratory mode was spontaneous for both time points. The lack of other physical exam findings limits the detail of this section.