

## **\*\*Medical Report: Patient 002-1007\*\***

### **\*\*1. Patient Information\*\***

**\*\*Patient Unit Stay ID:\*\*** 204935 **\*\*Patient Health System Stay ID:\*\*** 178462 **\*\*Unique Patient ID:\*\*** 002-1007 **\***  
**\*\*Gender:\*\*** Female **\*\*Age:\*\*** 83 **\*\*Ethnicity:\*\*** Caucasian **\*\*Hospital ID:\*\*** 71 **\*\*Ward ID:\*\*** 87 **\*\*Unit Type:\*\***  
Med-Surg ICU **\*\*Unit Admit Time:\*\*** 20:37:00 (2014) **\*\*Unit Admit Source:\*\*** Floor **\*\*Unit Discharge Time:\*\*** 08:40:00  
(2014) **\*\*Unit Discharge Location:\*\*** Floor **\*\*Unit Discharge Status:\*\*** Alive **\*\*Hospital Admit Time:\*\*** 08:41:00 (2014) **\***  
**\*\*Hospital Admit Offset (minutes from unit admit):\*\*** -2156 **\*\*Hospital Admit Source:\*\*** Floor **\*\*Hospital Discharge Year:\*\***  
2014 **\*\*Hospital Discharge Time:\*\*** 23:10:00 (2014) **\*\*Hospital Discharge Offset (minutes from unit admit):\*\*** 1593 **\***  
**\*\*Hospital Discharge Location:\*\*** Death **\*\*Hospital Discharge Status:\*\*** Expired **\*\*Admission Height (cm):\*\*** 162.6 **\***  
**\*\*Admission Weight (kg):\*\*** NULL **\*\*Discharge Weight (kg):\*\*** 86.5

### **\*\*2. History\*\***

NULL (Insufficient data provided to generate a detailed patient history.)

### **\*\*3. Diagnoses\*\***

The patient presented with multiple diagnoses, all active upon discharge from the unit. These include:

**\*\*Primary:\*\*** Congestive Heart Failure (CHF) (ICD-9 code: 428.0, I50.9) **\*\*Other:\*\*** Coronary Artery Disease (CAD)  
(diagnosis string: cardiovascular|chest pain / ASHD|coronary artery disease) **\*\*Other:\*\*** Chronic Renal Insufficiency  
(ICD-9 code: 585.9, N18.9) **\*\*Other:\*\*** Diabetes Mellitus (diagnosis string: endocrine|glucose metabolism|diabetes  
mellitus)

The congestive heart failure was identified as the primary diagnosis upon admission. The other listed diagnoses represent co-morbidities that likely contributed to the patient's overall condition and required comprehensive management during the ICU stay.

### **\*\*4. Treatments\*\***

NULL (Insufficient data provided to generate a detailed treatment plan.)

### **\*\*5. Vital Trends\*\***

NULL (Insufficient vital signs data provided.)

### **\*\*6. Lab Trends\*\***

The provided lab data shows multiple blood tests performed at various time points before and during the ICU stay. Significant findings include:

**\*\*Elevated Creatinine:\*\*** Multiple creatinine measurements reveal consistently elevated levels (around 4.4-4.5 mg/dL), indicating impaired kidney function, consistent with the chronic renal insufficiency diagnosis. **\*\*Elevated Potassium:\*\*** Similarly, potassium levels were consistently high (5.1-6.1 mmol/L), presenting a significant risk of cardiac arrhythmias. **\***  
**\*\*Low Hemoglobin:\*\*** Hemoglobin levels were low (9.1-9.4 g/dL), indicating anemia. **\*\*Elevated BUN:\*\*** Blood urea nitrogen (BUN) levels were elevated (87-89 mg/dL), reflecting decreased renal function. **\*\*Elevated BNP:\*\*** Brain natriuretic peptide (BNP) levels were significantly elevated (916-1694 pg/mL), strongly suggesting the presence of heart failure. This supports the primary diagnosis of congestive heart failure. **\*\*Hypoalbuminemia:\*\*** Albumin levels were low (2.6 g/dL), which may indicate malnourishment or other underlying medical conditions.

The fluctuation in glucose levels (bedside and lab) indicates the need for careful glycemic control given the diabetes mellitus diagnosis. Further analysis of the time series data is needed to understand the treatment response and possible trends over time.

#### **\*\*7. Microbiology Tests\*\***

NULL (No microbiology test results were provided.)

#### **\*\*8. Physical Examination Results\*\***

The physical examination documented a GCS (Glasgow Coma Scale) score of 10 (Eyes: 2, Verbal: 4, Motor: 4) at 7 minutes post-unit admission. Weight was recorded at 84.1 kg, with a net fluid balance of +50 ml (220 ml intake and 170 ml output) during the initial period.

The "Performed - Structured" entry suggests a complete physical exam was conducted. However, only a limited number of specific findings are included in the report. Additional information would be necessary for a more comprehensive physical exam summary.