Medical Report: Patient 002-10922

1. Patient Information

* **Patient Unit Stay ID:** 162841 * **Unique Patient ID:** 002-10922 * **Gender:** Female * **Age:** 84 years * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2014, 22:09:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2014, 19:45:00 * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 15:42:00 * **Unit Admission Source:** Floor * **Unit Visit Number:** 2 * **Unit Stay Type:** Readmit * **Admission Weight:** 78.8 kg * **Discharge Weight:** 81.6 kg * **Unit Discharge Time:** 00:53:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Height:** 160 cm

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses upon admission to the Med-Surg ICU. The diagnoses, listed in order of priority, were:

* **Primary:** Sepsis (038.9, A41.9) * **Major:** Pneumonia (486, J18.9) * **Other:** Acute renal failure (584.9, N17.9) * **Other:** Atrial fibrillation (427.31, I48.0) * **Other:** Chronic kidney disease (585.9, N18.9) * **Other:** Bradycardia * **Other:** Acute hepatic dysfunction (573.9, K76.9) * **Other:** Asthma/Bronchospasm (493.90, J45)

The sepsis diagnosis was the primary concern, with pneumonia being a major contributing factor. The other diagnoses represent co-morbidities and complications associated with the patient's condition.

4. Treatments

NULL (Insufficient information provided)

5. Vital Trends

NULL (Insufficient information provided. Vital signs data is needed to generate this section.)

6. Lab Trends

The provided lab data includes multiple blood tests conducted at various time points during the patient's stay. Significant variations are noted in several key indicators:

* **Hemoglobin (Hgb):** Initial Hgb levels were low (around 10.4 g/dL), improved slightly (to approximately 11 g/dL) and then showed a slight decline again (to 10.1 g/dL) before final discharge. This suggests anemia, possibly related to the patient's underlying conditions. * **White Blood Cell Count (WBC):** WBC counts were consistently elevated (ranging from 17.3 K/mcL to 21.6 K/mcL), indicating an active inflammatory response consistent with the sepsis diagnosis. * **Creatinine:** Creatinine levels were initially high (1.94 mg/dL and 2.34 mg/dL), indicating renal dysfunction, and then decreased to 1.05 mg/dL upon discharge. This demonstrates some improvement in kidney function over the course of treatment. * **Albumin:** Albumin levels were low (2.1 g/dL and 2.2 g/dL initially) suggesting possible malnutrition or liver dysfunction, and later improved to 2.0 g/dL prior to discharge. * **Liver Enzymes (ALT, AST):** Markedly elevated liver enzymes (ALT: 806 Units/L and 1073 Units/L; AST: 156 Units/L and 493 Units/L) were present on initial tests consistent with hepatic dysfunction. These levels decreased significantly during the stay (ALT: 241 Units/L and 399 Units/L; AST: 48 Units/L and 53 Units/L). These changes suggest a response to treatment for the hepatic dysfunction. * **Other Blood

tests:** Additional blood tests, including electrolytes and other indicators (e.g. total bilirubin, total protein, PT, PTT, RDW, MCV, MCH), were also performed, but detailed analysis requires a trend analysis over time, which is not possible with the provided summary data. Further interpretation requires more context from the complete lab report.

7. Microbiology Tests

NULL (Insufficient information provided)

8. Physical Examination Results

The physical exam was performed, and the patient's Glasgow Coma Scale (GCS) score was recorded as 15 (Eyes: 4, Verbal: 5, Motor: 6). Admission weight was 78.8 kg. Intake was 2094 ml, output was 30 ml, resulting in a net positive fluid balance of 2064 ml. The physical exam notes also indicate that a structured physical exam was performed.

Note: This report is based on the limited data provided. A more comprehensive report would require additional medical history, treatment details, and complete vital signs and lab result trends. The interpretation of some lab values is limited due to the lack of longitudinal data.