Patient Information

Patient Unit Stay ID: 301185 Patient Health System Stay ID: 260300 Gender: Female Age: 87 Ethnicity: NULL Hospital ID: 93 Ward ID: 170 Admission Diagnosis: Sepsis, pulmonary Admission Height (cm): 157.4 Admission Weight (kg): 59 Discharge Weight (kg): 60.8 Hospital Admit Time: 2015-XX-XX 19:56:00 Hospital Discharge Time: 2015-XX-XX 18:40:00 Hospital Discharge Location: Skilled Nursing Facility Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admit Time: 04:52:00 Unit Admit Source: Direct Admit Unit Visit Number: 1 Unit Stay Type: admit Unit Discharge Time: 06:43:00 Unit Discharge Location: Floor Unit Discharge Status: Alive Unique Patient ID: 003-16257

Medical History

NULL (Insufficient information provided)

Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnoses upon admission were sepsis (ICD-9 codes: 038.9, A41.9) and pulmonary issues (Unspecified in the provided data, requiring further investigation from the original record). Other significant diagnoses included:

* Community-acquired pneumonia (ICD-9 codes: 486, J18.9) - Marked as Major Diagnosis. * Hypotension (ICD-9 codes: 458.9, I95.9) - Marked as Major Diagnosis. * Acute respiratory distress (ICD-9 code: 518.82) * Atrial fibrillation with controlled ventricular response (ICD-9 codes: 427.31, I48.0) * Metabolic acidosis, lactic acidosis (ICD-9 codes: 276.2, E87.2) * Leukocytosis (ICD-9 codes: 288.8, D72.829) * Fever (ICD-9 codes: 780.6, R50.9) * Change in mental status (ICD-9 codes: 780.09, R41.82) * Sinus tachycardia (ICD-9 codes: 785.0, R00.0)

The diagnoses listed as 'Other' indicate that they were secondary or contributing factors, and not the primary reason for admission. Note that multiple instances of the same diagnosis appear; this might reflect the evolution of the patient's condition, or multiple entries by different clinicians. Further clarification is needed.

Treatments

The patient received a range of treatments during her ICU stay. Treatments active upon discharge included:

* Non-invasive ventilation * Therapeutic antibacterials * IV furosemide (loop diuretic) * Aggressive volume resuscitation (>250 mls/hr) with normal saline * Diltiazem (calcium channel blocker) * Transthoracic echocardiography * CPAP/PEEP therapy * Oxygen therapy (<40%)

Additional treatments administered but not active at discharge included aggressive volume resuscitation with normal saline and cultures.

Vital Trends

NULL (Insufficient information provided in JSON. Requires time series data on heart rate, blood pressure, respiratory rate, oxygen saturation, etc.)

Lab Trends

The provided lab data includes several chemistry panels and blood gas analysis. Key lab values are shown below, but lack time series information to show trends. Additional data is required to fully assess lab trends:

* Potassium: Initial value of 4.2 mmol/L; later value of 3.0 mmol/L * Creatinine: Initial value of 1.09 mg/dL; later value of 1.14 mg/dL * Anion Gap: 9.9 mmol/L * Sodium: 137 mmol/L (initial); 138 mmol/L (later) * Bicarbonate: 24 mmol/L (initial);

23 mmol/L (later) * Albumin: 2.6 g/dL * Total Protein: 5.3 g/dL * Total Bilirubin: 0.2 mg/dL * BUN: 34 mg/dL (initial); 31 mg/dL (later) * Alkaline Phosphatase: 66 Units/L * ALT (SGPT): 23 Units/L * AST (SGOT): 26 Units/L * Glucose: 146 mg/dL (initial); 145 mg/dL (later) * Platelets: 147 K/mcL * MCHC: 30.8 g/dL * MCV: 100 fL * Hgb: 9.8 g/dL * WBC: 13.1 K/mcL * RDW: 15.8% * Calcium: 7.5 mg/dL (initial), 7.8 mg/dL (later) * Troponin-I: 0.139 ng/mL (initial), 0.104 ng/mL (later), 0.091 ng/mL (later), 0.307 ng/mL (earlier) * Lactate: 0.7 mmol/L (initial), 0.5 mmol/L (earlier) * Chloride: 107 mmol/L (initial); 105 mmol/L (later) * CPK: 65 Units/L * CPK-MB: 1.72 ng/mL * BNP: 226 pg/mL * ABG Results: paO2: 67 mm Hg, paCO2: 43 mm Hg, pH: 7.36, HCO3: 24.3 mmol/L, FiO2: 25%, Base Excess: -1.1 mEq/L (initial values) PaO2: 88 mm Hg, paCO2: 41 mm Hg, pH: 7.38, HCO3: 24.3 mmol/L, FiO2: 28%, Base Excess: -0.8 mEq/L (earlier values) * Influenza A and B: Negative * Vitamin B12: >1000 * Globulin: 2.7 g/dL

Microbiology Tests

The patient underwent cultures as part of her treatment for sepsis, but results are not available in the provided data. Further information is needed.

Physical Examination Results

A structured physical exam was performed. Vital signs recorded at the time of the exam included:

* Heart Rate (Current): 84 bpm * Heart Rate (Lowest): 84 bpm * Heart Rate (Highest): 94 bpm * Blood Pressure (Systolic, Current): 97 mmHg * Blood Pressure (Systolic, Lowest): 90 mmHg * Blood Pressure (Systolic, Highest): 117 mmHg * Blood Pressure (Diastolic, Current): 47 mmHg * Blood Pressure (Diastolic, Lowest): 43 mmHg * Blood Pressure (Diastolic, Highest): 47 mmHg * Respiratory Rate (Current): 28 breaths/min * Respiratory Rate (Lowest): 28 breaths/min * Respiratory Rate (Highest): 31 breaths/min * Oxygen Saturation (Current): 95% * Oxygen Saturation (Lowest): 93% * Oxygen Saturation (Highest): 95% * Glasgow Coma Scale (GCS): 14 (Eyes 4, Verbal 4, Motor 6)