Medical Report: Patient 005-11459

1. Patient Information

* **Patient Unit Stay ID:** 494366 * **Patient Health System Stay ID:** 418653 * **Unique Patient ID:** 005-11459 * **Gender:** Female * **Age:** 82 * **Ethnicity:** Hispanic * **Hospital ID:** 140 * **Ward ID:** 261 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 03:00:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 07:13:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 02:26:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 23:48:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Height:** 152.4 cm * **Admission Weight:** 68 kg * **Discharge Weight:** NULL

2. History

Admission history indicates the patient presented to the Emergency Department with Sepsis and renal/UTI (including bladder) as primary diagnoses. Further details regarding the patient's medical history prior to this ICU admission are not available in the provided data. The onset and progression of the sepsis and UTI are not specified, requiring further investigation and review of the patient's complete medical records.

3. Diagnoses

The patient was diagnosed with multiple conditions during her ICU stay. The primary diagnosis upon admission and at discharge was septic shock (785.52, R65.21), with cultures pending. Other diagnoses included:

* Hypomagnesemia (275.2, E83.42): This was recorded as an active diagnosis upon discharge. * Moderate hypokalemia (287.5, D69.6): This was both active and inactive during the stay. * Hyperlipidemia (272.4, E78.5): This was both active and inactive during the stay. * Pressor-dependent hypotension: This was both active and inactive during the stay, with no ICD-9 code provided. * Thrombocytopenia (287.5, D69.6): This was an active diagnosis upon discharge. * Lab-confirmed C. difficile colitis (008.45, A04.7): This was an active diagnosis upon discharge. * Lower urinary tract infection (595.9, N30.9): This was an active diagnosis upon discharge.

The temporal relationships between these diagnoses are not fully elucidated in this data set, but the presence of multiple electrolyte imbalances suggests a complex clinical picture.

4. Treatments

The patient received a variety of treatments during her ICU stay. Treatments included:

* Normal saline administration (IV fluids): This treatment was not active upon discharge. * Chest x-ray: This treatment was active upon discharge. * Infectious Disease consultation: This treatment was active upon discharge. * Blood cultures: Both active and inactive during the stay. * Vasopressors (norepinephrine > 0.1 micrograms/kg/min): This treatment was not active upon discharge. * Foley catheter: This treatment was not active upon discharge. * Bronchodilator administration: This treatment was active upon discharge. * Urine cultures: This treatment was both active and inactive during the stay. * Empiric antibacterial coverage: Both active and inactive during the stay. * Colloid administration (IV fluids): This treatment was not active upon discharge. * Aztreonam administration: This treatment was active upon discharge. * Renal ultrasound: This treatment was both active and inactive during the stay.

The sequencing and duration of these treatments are not fully documented, necessitating a deeper review of the patient's complete medical record.

5. Vital Trends NULL. Vital sign data (Heart Rate, Blood Pressure, Respiratory Rate, Oxygen Saturation) are present in the physical exam, but insufficient for a trend analysis.

6. Lab Trends

The provided lab data shows multiple blood tests over time. Detailed trends require a time-series analysis not possible with the current data representation. However, some key values are presented below. Further analysis requires more complete time-series data.

7. Microbiology Tests

The patient underwent blood and urine cultures. The results of these cultures are pending or not included in the provided data. Further information is needed to assess the presence and type of infection.

8. Physical Examination Results

Physical exams were performed at multiple time points. The patient's initial presentation was as critically ill-appearing. Subsequent exams showed the patient was 'not in acute distress'. GCS scores, heart rate, blood pressure, respiratory rate, and oxygen saturation values were recorded at different times, but again, insufficient for a trend analysis. The data indicates the patient had a foley catheter, normal bowel sounds, and reduced hearing bilaterally. Additional details about the physical examination findings are not available in the provided data.