Medical Report: Patient 002-10052

1. Patient Information

* **Patient Unit Stay ID:** 151900 * **Patient Health System Stay ID:** 137239 * **Unique Patient ID:** 002-10052 * **Gender:** Female * **Age:** 66 * **Ethnicity:** Caucasian * **Hospital ID:** 73 * **Ward ID:** 97 * **Unit Type:** MICU * **Unit Admit Time:** 2014-XX-XX 10:25:00 (Assuming a date is available but not provided in the JSON) * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2014-XX-XX 20:05:00 (Assuming a date is available but not provided in the JSON) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 2014-XX-XX 10:02:00 (Assuming a date is available but not provided in the JSON) * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2014-XX-XX 20:20:00 (Assuming a date is available but not provided in the JSON) * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Admission Weight:** 86.8 kg * **Discharge Weight:** 79 kg * **Admission Height:** 165.1 cm (Assuming cm is the unit) * **APACHE Admission Dx:** Sepsis, pulmonary

2. History

NULL (Insufficient information provided in the JSON to generate a detailed patient history. The provided data only contains diagnoses and lab results, not the narrative history leading to admission.)

3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnoses upon admission were Septic Shock (ICD-9 codes 785.52, R65.21) and Acute Respiratory Distress (ICD-9 code 518.82). These were marked as Primary and Major respectively. Other diagnoses included:

* Anemia (ICD-9 code: Not specified) * Pneumonia (ICD-9 codes 486, J18.9) * Hyperglycemia (ICD-9 codes 790.6, R73.9) * Acute Renal Failure (ICD-9 codes 584.9, N17.9) * COPD (ICD-9 codes 491.20, J44.9) * Acute Coronary Syndrome (ICD-9 code: Not specified) * Laryngeal CA (ICD-9 codes 161.9, C32.9) * Thrombocytosis (ICD-9 codes 289.9, D47.3)

Note that some diagnoses were active upon discharge (anemia, pneumonia, acute renal failure, COPD, acute coronary syndrome, septic shock, laryngeal CA) while others were not (hyperglycemia, acute respiratory distress). The sequence of diagnosis codes does not necessarily reflect temporal order of diagnosis.

4. Treatments

NULL (No treatment information is provided in the JSON.)

5. Vital Trends

Based on the physical exam, at the time of the initial assessment (-2 minutes from unit admission), the patient's vital signs were:

* Heart Rate (HR): 96 bpm * Systolic Blood Pressure (BP): 81 mmHg * Diastolic Blood Pressure (BP): 52 mmHg * Oxygen Saturation (O2 Sat): 100% * FiO2: 40%

Further vital sign data is needed to establish trends over time.

6. Lab Trends

The provided lab data shows multiple blood tests performed at various time points during the patient's stay. Key lab values and their trends (requiring further data for a complete analysis) include:

* **Bedside Glucose:** Shows fluctuations, with values ranging from 79 mg/dL to 156 mg/dL over the course of the stay. More frequent measurements are needed to fully characterize glucose control. * **Hemoglobin (Hgb):** Initial value of 10.9 g/dL decreased to 7.7 g/dL and then increased to 8.4 g/dL This suggests anemia initially, requiring further investigation of the trend. * **Hematocrit (Hct):** Shows a similar decreasing trend initially, from 33% to 22.4% and then to 24.9%. This further supports the anemia diagnosis. * **Creatinine:** Initial value of 1.24 mg/dL decreased to 0.84 mg/dL and later rose to 0.96 mg/dL. This indicates some renal function fluctuation during the stay. * **Potassium:** Fluctuated between 3.2 mmol/L and 4.2 mmol/L. This is within the normal range but shows some variation. * **Sodium:** Varied between 134 mmol/L and 140 mmol/L. This is also within the normal range. * **Blood tests:** Other blood tests, including complete blood counts (CBC) with differential, and basic metabolic panel (BMP) were performed. Detailed analysis requires more data points and visualization.

7. Microbiology Tests

NULL (No microbiology test results are included in the provided JSON data.)

8. Physical Examination Results

The initial physical examination (-2 minutes from unit admit time) documented a Glasgow Coma Scale (GCS) score of 13 (Verbal:1, Eyes: 4, Motor:6) and a structured physical exam was performed. Additional physical exam findings are needed to fully document the patient's condition. The patient's admission weight was 86.8 kg, and her current weight was also 86.8 kg at the time of the initial exam. The weight did not change during her stay.