Medical Report - Patient 005-10807

1. Patient Information

* **Patient Unit Stay ID:** 453764 * **Patient Health System Stay ID:** 385770 * **Unique Patient ID:** 005-10807 * **Gender:** Female * **Age:** 58 years * **Ethnicity:** African American * **Hospital ID:** 140 * **Ward ID:** 261 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 21:44:00 (Assuming a date is available but missing from data) * **Unit Admit Source:** Recovery Room * **Unit Discharge Time:** 2015-XX-XX 22:47:00 (Assuming a date is available but missing from data) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 2015-XX-XX 14:40:00 (Assuming a date is available but missing from data) * **Hospital Admit Source:** Recovery Room * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 20:20:00 (Assuming a date is available but missing from data) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Height:** 157.5 cm * **Admission Weight:** 95.2 kg * **Discharge Weight:** NULL

2. History

Insufficient data provided to generate a detailed patient history. The APACHE admission diagnosis indicates a GI obstruction requiring surgery, but further details on the patient's presenting symptoms, prior medical history, and family history are needed. Information regarding the nature of the undiagnosed mass mentioned in the diagnoses is also crucial but absent. A complete history would include a chronological account of the patient's symptoms leading to admission, any prior hospitalizations, relevant family history (particularly related to gastrointestinal or endocrine conditions), and any significant social history (smoking, alcohol use, etc.) that may have contributed to the current condition.

3. Diagnoses

The patient presented with multiple diagnoses, some active upon discharge and some not. The primary diagnosis was s/p Whipple procedure (post-operative Whipple procedure) and s/p surgery for undiagnosed mass. Major diagnoses included s/p exploratory laparoscopy, s/p cholecystectomy, diabetes mellitus, and hypertension. Seizures were also diagnosed but were inactive upon discharge. It is important to note that the ICD-9 codes are missing from the data, which would be crucial for a complete clinical picture and coding purposes. A more complete diagnosis section would include a detailed description of each diagnosis, its severity, and its relationship to other diagnoses.

4. Treatments

The patient received various treatments during their ICU stay. Active treatments upon discharge included nasogastric tube, antiemetic, compression boots, prophylactic antibacterials, and a Pantoprazole (stress ulcer prophylaxis). Inactive treatments included metoclopramide (prokinetic agent), nasal cannula oxygen therapy, and bolus parenteral analgesics. The insulin and glucose management strategy is also indicated but specifics are missing. A complete treatment plan would detail medication dosages, routes of administration, and the duration of each treatment. It would also explain the rationale behind each treatment choice.

5. Vital Trends

NULL. The provided data lacks information on vital signs over time (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation) to generate trends.

6. Lab Trends

NULL. While lab results are included, the data lacks the temporal dimension (time points) to construct trends over the patient's stay. To generate informative trends, data on the time of collection for each lab test is needed.

7. Microbiology Tests

NULL. No microbiology test results are present in the data.

8. Physical Examination Results

Physical examination results are available for two different time points, indicating a general examination at admission and a follow-up exam at a later time (approximately 2354 minutes post admission). These exams revealed the patient to be ill-appearing but not in acute distress, with a sinus rhythm, and a well-developed body habitus. Specific measurements including heart and respiratory rates, blood pressure, and oxygen saturation were recorded, with some variation between time points. Bowel sounds were decreased and there was mild pain on palpation of the abdomen. The neurological exam showed normal level of consciousness and appropriate affect. Further details about the physical examination are needed for a more elaborate report, including a complete description of all findings and their interpretations.