Patient Medical Report

1. Patient Information

* **PatientUnitStayID:** 939222 * **PatientHealthSystemStayID:** 693971 * **Gender:** Female * **Age:** 65 * **Ethnicity:** Caucasian * **HospitalID:** 154 * **WardID:** 394 * **APACHE Admission Dx:** Sepsis, pulmonary * **Admission Height:** 158 cm * **Hospital Admit Time:** 2015-MM-DD 20:22:00 (Hospital admit offset: -343 minutes from unit admit time) * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-MM-DD 07:09:00 (Hospital discharge offset: 1744 minutes from unit admit time) * **Hospital Discharge Location:** Death * **Hospital Discharge Status:** Expired * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-MM-DD 02:05:00 * **Unit Admit Source:** Emergency Department * **Unit Visit Number:** 1 * **Unit Stay Type:** admit * **Admission Weight:** 50 kg * **Discharge Weight:** 49.7 kg * **Unit Discharge Time:** 2015-MM-DD 07:09:00 (Unit discharge offset: 1744 minutes from unit admit time) * **Unit Discharge Location:** Death * **Unit Discharge Status:** Expired * **Unique PID:** 006-100030

2. History

NULL (Insufficient information provided in the JSON data.)

3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnosis upon admission, and remaining active upon discharge, was septic shock (ICD-9 codes: 785.52, R65.21). Other significant diagnoses included:

* **Acute respiratory failure:** (ICD-9 codes: 518.81, J96.00) - This diagnosis was present both upon admission and at various points during the stay, but was not active at the time of discharge. It was marked as 'Major' priority. * **Pneumonia:** (ICD-9 codes: 486, J18.9) - This diagnosis was also present at multiple times during the ICU stay, both as a major and potentially secondary diagnosis, but was not active upon discharge. * **Acute COPD exacerbation:** (ICD-9 codes: 491.21, J44.1) - Similar to the other diagnoses, this was a 'Major' priority diagnosis present during the stay, but not active upon discharge. * **Sepsis:** (ICD-9 codes: 038.9, A41.9) - This diagnosis, a primary diagnosis, was present at the beginning of the ICU stay but not active upon discharge.

The repeated diagnoses of respiratory failure, pneumonia, and acute COPD exacerbation suggest a complex and potentially interconnected disease process.

4. Treatments

The patient received several treatments during her ICU stay, including:

* **Non-invasive ventilation:** Initiated early in the stay (50 and 52 minutes post-admission) to manage respiratory failure, but later discontinued. * **Normal saline administration:** Administered as intravenous fluid at multiple points during the stay (50, 52, 809, 1918 minutes post-admission). * **Mechanical ventilation:** Required at two different times (812 and 2288 minutes post-admission) indicating periods of more severe respiratory distress. * **Norepinephrine > 0.1 micrograms/kg/min:** Administered as a vasopressor for shock management at multiple points during the stay (2288, 809, 1918 minutes post-admission). * **Packed red blood cells:** Administered (812 and 1918 minutes post-admission) indicating potential blood loss or anemia. * **Amiodarone:** Administered (1918 minutes post-admission) to manage arrhythmias.

The multiple interventions highlight the severity of the patient's condition and the multifaceted approach to her care.

5. Vital Trends

NULL (Insufficient data provided in JSON to generate vital signs trends.)

6. Lab Trends

The lab results show fluctuations in several key indicators. There is a record of elevated bedside glucose levels (240 mg/dL at 517 minutes and 206 mg/dL at 959 minutes) suggesting hyperglycemia which requires further investigation to determine the cause, and also shows a trend towards normalization. The initial lactate level was elevated (3.3 mmol/L), indicating possible tissue hypoxia. Later measurements of lactate also reveal elevated levels (3.4 mmol/L at 885 minutes), suggesting ongoing metabolic stress. The albumin levels were low (2.2 g/dL initially and 2.2 g/dL at 1940 minutes), indicative of hypoalbuminemia, a common finding in critically ill patients. There are multiple blood gas results. The initial blood gas showed an elevated PaCO2 (61.9 mmHg), low PaO2 (61.8 mmHg), and high Base Excess (13.5 mEq/L), consistent with respiratory acidosis. Later blood gases show improvement but suggest ongoing respiratory compromise. Hemoglobin values were initially low (8 g/dL) and showed some improvement, but remained low throughout the stay. The initial PT-INR of 1.2 suggests no significant clotting abnormality. BNP levels were significantly elevated at 6884 pg/mL, suggesting heart failure. The white blood cell count was initially elevated (19.8 K/mcL), indicating infection or inflammation. There is also evidence of electrolyte imbalances. Potassium levels were initially elevated (4.8 mmol/L). These lab results should be analyzed in a time series to better understand the disease progression.

7. Microbiology Tests

NULL (No microbiology test data provided.)

8. Physical Examination Results

The physical exam recorded at 42 minutes post-unit admit time indicated the following:

* **Heart Rate (HR):** Current HR was 107 bpm, with a lowest recorded HR of 107 bpm and highest of 114 bpm. * **Blood Pressure (BP):** Current systolic BP was 96 mmHg, with a lowest of 88 mmHg and highest of 96 mmHg. Current diastolic BP was 61 mmHg, with lowest and highest both at 61 mmHg. * **Respiratory Rate (RR):** Current RR was 22 breaths per minute, lowest was 22 breaths per minute and highest was 25 breaths per minute. * **Oxygen Saturation (O2 Sat):** Current O2 Sat was 97%, with a lowest of 96% and a highest of 97%. * **Weight:** Admission weight was 50 kg, current weight was 45.4 kg (a net loss of -4.6 kg). * **Glasgow Coma Scale (GCS):** Total score of 15 (Eyes: 4, Verbal: 5, Motor: 6), indicating normal neurological function.

The physical exam findings support the diagnoses of respiratory and cardiovascular compromise. The weight loss is a significant observation that needs further clinical context.