Medical Report: Patient 006-100190

1. Patient Information

* **Patient Unit Stay ID:** 907256 * **Unique Patient ID:** 006-100190 * **Gender:** Female * **Age:** 65 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2014-XX-XX 21:01:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2014-XX-XX 01:24:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Neuro ICU * **Unit Admission Time:** 2014-XX-XX 23:13:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2014-XX-XX 18:55:00 * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Admission Weight:** 93 kg * **Discharge Weight:** 93 kg * **Admission Height:** 170 cm

2. History

Insufficient data provided to generate a detailed patient history. The available data only includes admission and discharge times and locations, along with the unit type and admission source. Further information regarding the patient's presenting complaint, relevant past medical history, family history, social history, and medication history is necessary for a comprehensive history section. The admission diagnosis mentions “Neoplasm, neurologic”, suggesting a neurological condition possibly related to a tumor, but details are lacking. A complete history would detail the onset, duration, and character of symptoms leading to admission.

3. Diagnoses

* **Diagnosis ID 10763397 (Primary):** Neurologic|Seizures|Seizures (ICD-9 code: 345.90, R56.9). Diagnosis entered 36 minutes after unit admission. Inactive upon discharge. * **Diagnosis ID 10434152 (Primary):** Neurologic|Seizures|Seizures (ICD-9 code: 345.90, R56.9). Diagnosis entered 181 minutes after unit admission. Inactive upon discharge.

The duplicated primary diagnoses of seizures suggest the patient experienced seizures during their ICU stay. However, the absence of details about seizure type, frequency, severity, and response to treatment limits the understanding of the patient’s condition. Additional information, such as EEG findings, would significantly enhance this section.

4. Treatments

* **Treatment ID 23661907:** Neurologic|Seizure therapy|Anticonvulsant. Treatment entered 181 minutes after unit admission. Inactive upon discharge.

The treatment record indicates the administration of anticonvulsant medication to manage seizures. The specific medication, dosage, route of administration, and response to treatment are missing and are critical for a complete assessment of the patient's care.

5. Vital Trends

Vital signs are partially available from the physical examination records. The data includes:

* **Heart Rate (HR):** Current: 85 bpm, Lowest: 72 bpm, Highest: 87 bpm (recorded at 179 minutes post-admission) * **Heart Rate (HR):** Current: 72 bpm, Lowest: 72 bpm, Highest: 72 bpm (recorded at 28 minutes post-admission) * **Blood Pressure (BP):** Systolic: Current: 126 mmHg, Lowest: 123 mmHg, Highest: 128 mmHg (recorded at 179 minutes post-admission) * **Blood Pressure (BP):** Systolic: Current: 116 mmHg, Lowest: 121 mmHg, Highest: 116 mmHg (recorded at 28 minutes post-admission) * **Blood Pressure (BP):** Diastolic: Current: 61 mmHg, Lowest: 59 mmHg, Highest: 111 mmHg (recorded at 179 minutes post-admission) * **Blood Pressure (BP):** Diastolic: Current: 71 mmHg, Lowest: 66 mmHg, Highest: 71 mmHg (recorded at 28 minutes post-admission) * **Respiratory Rate:** Current: 27 breaths/min, Lowest: 17 breaths/min, Highest: 29 breaths/min (recorded at 179 minutes post-admission) * **Respiratory

Rate:** Current: 17 breaths/min, Lowest: 17 breaths/min, Highest: 17 breaths/min (recorded at 28 minutes post-admission) * **Oxygen Saturation (O2 Sat):** Current: 98%, Lowest: 98%, Highest: 99% (recorded at 179 minutes post-admission) * **Oxygen Saturation (O2 Sat):** Current: 99%, Lowest: 99%, Highest: 99% (recorded at 28 minutes post-admission)

To create meaningful vital sign trends, continuous monitoring data is required. The provided data represents only snapshot values from physical examinations.

6. Lab Trends

The provided lab data shows results from a single time point (approximately 198 minutes pre-admission and another around admission). These include: BUN, chloride, albumin, sodium, AST, creatinine, potassium, total bilirubin, glucose, bicarbonate, total protein, anion gap, calcium, alkaline phosphatase, eosinophils, PTT, monocytes, bedside glucose, lymphocytes, hemoglobin, platelets, troponin-I, hematocrit, MCV, HDL, total cholesterol, and triglycerides. A time series of these values is needed to identify trends. The creatinine level appears to have increased from 0.71 mg/dL to 0.9 mg/dL between the two measurements.

7. Microbiology Tests

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

8. Physical Examination Results

Physical examination notes indicate a Glasgow Coma Scale (GCS) score was recorded at 179 minutes and 28 minutes post-admission. The provided data, however, only includes the individual components of the GCS (Eyes, Verbal, Motor) at 179 minutes post admission (1,1,4) and 28 minutes post-admission (4,1,1), but not the total GCS score. Additional details about other aspects of the physical exam, such as cardiovascular, respiratory, and abdominal examinations are missing. The weight remained consistent at 93 kg.