Medical Report for Patient 004-10432

1. Patient Information

* **Patient Unit Stay ID:** 383124 * **Unique Patient ID:** 004-10432 * **Gender:** Female * **Age:** 22 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2014-XX-XX 20:59:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2014-XX-XX 18:20:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2014-XX-XX 21:21:00 * **Unit Admission Source:** Operating Room * **Unit Discharge Time:** 2014-XX-XX 21:50:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 59 kg * **Admission Height:** 172.7 cm

2. History

Admission diagnosis: Obstruction-airway (i.e., acute epiglottitis, post-extubation edema, foreign body, etc.). The patient presented to the Emergency Department and was subsequently admitted to the Med-Surg ICU following surgery in the operating room. Further details regarding the reason for the initial airway obstruction and the nature of the surgery are not available in this data set.

3. Diagnoses

The patient received multiple diagnoses during their ICU stay. The primary diagnosis was acute pulmonary edema (ICD-9 codes: 428.1, I50.1). A major diagnosis was swollen extremity, etiology unknown, rule out lymphedema. Both diagnoses were active upon discharge. Additional entries show that these diagnoses were initially recorded at 91 minutes after unit admit time, with earlier entries at 69 minutes, though these latter entries were not active upon discharge. This suggests a change in the patient's condition and the subsequent reassessment of their primary and secondary diagnoses. The lack of ICD-9 codes for the lymphedema diagnosis indicates that the diagnostic clarity was not as precise for this condition, possibly due to incomplete information or ongoing diagnostic assessment.

4. Treatments

The patient received a range of treatments during their stay. These include oxygen therapy via nasal cannula, narcotic and non-narcotic analgesics (acetaminophen), normal saline administration, ondansetron (a serotonin antagonist antiemetic), dexamethasone (glucocorticoid), and oral feeds. A pulmonary/CCM consultation was also conducted. The administration of oxygen therapy, analgesics, intravenous fluids, ondansetron, dexamethasone, and oral feeds continued until discharge. Chest X-rays were also administered. The use of both narcotic and non-narcotic analgesics suggests management of moderate to severe pain, while ondansetron points to nausea management. Dexamethasone use may indicate management of inflammatory conditions. The data shows that several treatments, including nasal cannula oxygen therapy, were initiated early in the ICU stay and later transitioned to other therapies, such as non-invasive ventilation via face mask. This suggests a dynamic adjustment to the patient’s clinical needs.

5. Vital Trends

NULL (Insufficient data to generate vital sign trends. While some vital signs are present in the physical exam section, they lack temporal information preventing the creation of a trend.)

6. Lab Trends

The available lab data includes only two entries, both obtained 71 minutes after unit admission. One shows O2 saturation at 93%, and the other shows FiO2 (fraction of inspired oxygen) at 24%. Insufficient data exists to generate trends.

7. Microbiology Tests

NULL (No microbiology data provided.)

8. Physical Examination Results

The physical exam recorded at 72 minutes post-unit admission revealed the following: GCS (Glasgow Coma Scale) score of 15 (Eyes 4, Verbal 5, Motor 6), heart rate ranging from 90 to 97 bpm, blood pressure (systolic) ranging from 101 to 114 mmHg, blood pressure (diastolic) ranging from 66 to 83 mmHg, respiratory rate ranging from 19 to 22 breaths per minute, and O2 saturation ranging from 93% to 96%. The patient's respiratory mode was spontaneous. Admission weight was recorded as 59 kg. The limited number of physical exam entries does not allow for the establishment of trends.

Additional Notes: The data set provides a limited view of the patient's complete medical history. The lack of temporal information for many variables (vital signs, lab results) restricts a comprehensive analysis. More detailed information would be required to provide a more complete and nuanced medical report.