Medical Report for Patient 003-10552

1. Patient Information

* **Patient Unit Stay ID:** 260961 * **Unique Patient ID:** 003-10552 * **Gender:** Male * **Age:** 71 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015, 20:55:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015, 21:40:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 20:56:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 23:43:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 90.7 kg * **Discharge Weight:** 90.5 kg * **Admission Height:** 172.7 cm

2. History

The patient was admitted to the hospital through the Emergency Department with a primary diagnosis of GI bleeding (ICD-9 codes: 578.9, K92.2) at 20:55:00. The patient also presented with coagulopathy related to Coumadin administration (ICD-9 codes: 286.9, D68.32). Further details regarding the patient's medical history prior to admission are not provided in the available data. The initial diagnosis of GI bleeding was recorded 43 minutes after unit admission, and a secondary diagnosis of coagulopathy was entered concurrently. Subsequent entries within the diagnosis table indicate that the GI bleeding diagnosis was revisited and updated at 1617 and 1832 minutes post unit admission, with the latter entry indicating the diagnosis remained active at discharge. The coagulopathy diagnosis was similarly revisited at 1617 minutes post unit admission. The lack of narrative history makes it challenging to fully reconstruct the patient's clinical progression. More information would be needed to establish a detailed timeline of events. This omission limits the ability to effectively correlate clinical events with laboratory and treatment data. The timeline of symptoms and their severity remains unclear.

3. Diagnoses

* **Primary Diagnosis:** GI bleeding / PUD (578.9, K92.2) * **Secondary Diagnoses:** Coagulopathy (286.9, D68.32), GI bleeding (578.9, K92.2)

4. Treatments

The patient received various treatments during their ICU stay, including:

* Oxygen therapy (< 40%) * IV Pantoprazole (stress ulcer prophylaxis) * Transfusion of 1-2 units of packed red blood cells * Fresh frozen plasma * Prednisone * Vitamin K * Surgery consultation

5. Vital Trends NULL – No vital sign data is available.

6. Lab Trends

The provided laboratory data includes hematology, chemistry, and other miscellaneous tests performed at various time points during the hospital stay. There is a notable trend of abnormal hematologic values. Hemoglobin (Hgb) levels fluctuated, showing initial values around 8.7 g/dL and improving to 10 g/dL by the end of the stay, indicating ongoing blood loss and subsequent response to blood product administration. Hematocrit (Hct) followed a similar trend, and the patient had elevated white blood cell (WBC) counts (up to 17.9 K/mcL), suggesting an inflammatory process. The platelet count was around 409 K/mcL, possibly indicating a response to treatment. Chemistry panels showed some abnormalities. Initial values for Potassium were elevated (5.7 mmol/L), indicating potential electrolyte imbalance, which appeared to improve with time. The initial sodium level was 130 mmol/L which also showed improvement. The PT-INR values show significant variability, with initial values above 1 and decreasing to near 1 by the end of the stay, suggesting the coagulopathy responded to treatment. A complete analysis requires a visualization of these trends over time. The precise timing of lab draws is crucial to understand the dynamics of the patient’s condition. The data includes both initial and follow-up lab results, allowing for assessment of the efficacy of treatment.

7. Microbiology Tests NULL – No microbiology test results are available.

8. Physical Examination Results

The physical exam, performed 30 minutes post-admission, indicated a heart rate (HR) of 85 bpm, with a regular sinus rhythm, respiratory rate of 17 breaths per minute, blood pressure (BP) of 96/54 mmHg (current), and an O2 saturation (SpO2) of 99%. The patient was described as ill-appearing but well-developed and not in acute distress. A GCS score of 15 (4/5/6) was recorded. The patient's orientation could not be assessed. The weight at admission was recorded as 90.7 kg. A subsequent note at 1613 minutes indicates that a physical exam was not performed. These observations suggest an initial assessment of a stable yet concerning state.