Patient Information

Patient Unit Stay ID: 312665 Unique Patient ID: 004-10008 Gender: Female Age: 54 Ethnicity: Caucasian Hospital Admit Time: 2014-01-14 01:14:00 Hospital Admit Source: Emergency Department Hospital Discharge Time: 2014-01-14 19:29:00 Hospital Discharge Location: Home Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admit Time: 02:45:00 Unit Admit Source: Emergency Department Unit Discharge Time: 20:13:00 Unit Discharge Location: Floor Unit Discharge Status: Alive Admission Diagnosis: Infarction, acute myocardial (MI)

Medical History

NULL (Insufficient data provided in the JSON to elaborate on the patient's full medical history beyond the admission diagnosis and diagnoses during the ICU stay.)

Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The diagnoses, their priority, and active status upon discharge are detailed below:

* **Primary Diagnosis:** Acute Myocardial Infarction (no ST elevation) (ICD-9: 410.71, I21.4) - Active upon discharge (diagnosisid: 5482301, 5804827, 7733439) * **Major Diagnoses:** * Acute Respiratory Distress (ICD-9: 518.82) - Not active upon discharge (diagnosisid: 5686818, 5816394, 6391875, 6943644, 7770333) * Congestive Heart Failure (ICD-9: 428.0, I50.9) - Active upon discharge (diagnosisid: 6221511, 6776670, 7782269, 5913129, 7432001) * **Other Diagnosis:** Atrial Fibrillation (ICD-9: 427.31, I48.0) - Active upon discharge (diagnosisid: 6214970, 6965714)

The temporal relationship between diagnoses is notable. Congestive heart failure and acute respiratory distress were diagnosed relatively early in the ICU stay, while the acute myocardial infarction was diagnosed later. The persistence of some diagnoses, such as congestive heart failure and atrial fibrillation until discharge, suggests ongoing challenges in managing these conditions.

Treatments

The patient received a comprehensive range of treatments during her ICU stay. These included medications targeting various aspects of her condition. Specific treatments and their active status upon discharge are as follows:

* **Cardiovascular:** * Anticoagulant administration (Enoxaparin): Administered, not active upon discharge (treatmentid: 17615306, 11550759, 12922202, 14824185) * Nitroglycerin (sublingual): Administered, active upon discharge (treatmentid: 15560041, 17910407, 18508774, 18035684) * Digoxin: Administered, not active upon discharge (treatmentid: 10684521, 11137294, 13779825, 13310510) * Carvedilol: Administered, active upon discharge (treatmentid: 16991694, 12881090, 15090509, 17716597) * IV Furosemide: Administered, active upon discharge (treatmentid: 17214803, 12063639, 14073180, 13968333) * Aspirin: Administered, active upon discharge (treatmentid: 12156239, 13292473, 15275720, 11134325, 13280246) * Amiodarone: Administered, active upon discharge (treatmentid: 11938102, 11630627) * **Pulmonary:** * Albuterol: Administered, active upon discharge (treatmentid: 16423193, 16152795, 15438830, 18148818, 17606256) * Oxygen therapy (nasal cannula): Administered, active upon discharge (treatmentid: 15245336) * **Gastrointestinal:** * Ondansetron: Administered, active upon discharge (treatmentid: 14704390, 17386657, 12967430, 18316066, 12278469) * Oral Feeds: Administered, active upon discharge (treatmentid: 11232168, 17755190, 13921995)

The extensive medication regimen reflects the complexity of the patient's conditions. The continued use of certain medications at discharge suggests that these treatments are deemed necessary for ongoing management of her heart and lung function.

Vital Trends

NULL (No vital sign data is available in the provided JSON.)

Lab Trends

The following lab results were recorded at 76 minutes post-unit admission:

* Troponin-I: 2.28 ng/mL * Glucose: 141 mg/dL * Creatinine: 1.2 mg/dL * BUN: 20 mg/dL * Sodium: 137 mEq/L * Hct: 47.9% * WBC: 9.6 K/mcL * BNP: 2537 pg/mL * Arterial Blood Gas (ABG): * FiO2: 28% * PaO2: 69 mmHg * PaCO2: 40.3 mmHg * pH: 7.41

The elevated BNP level is particularly noteworthy, strongly suggesting significant cardiac stress consistent with the diagnoses of congestive heart failure and acute myocardial infarction. The troponin-I level, although not drastically high, further supports the myocardial infarction diagnosis. The other lab values provide a baseline picture of the patient's overall metabolic and hematological status.

Microbiology Tests

NULL (No microbiology test data is available in the provided JSON.)

Physical Examination Results

A structured physical exam was performed at 71 minutes post-unit admission. Key findings include:

* Heart Rate (HR): Current 106 bpm; Lowest 106 bpm; Highest 107 bpm * Blood Pressure (BP): Systolic - Current 132 mmHg; Lowest 125 mmHg; Highest 134 mmHg; Diastolic - Current 108 mmHg; Lowest 88 mmHg; Highest 119 mmHg * Respiratory Rate (RR): Current 34 breaths/min; Lowest 17 breaths/min; Highest 34 breaths/min * Oxygen Saturation (O2 Sat): Current 96%; Lowest 96%; Highest 98% * FiO2: 28% * Glasgow Coma Scale (GCS): Total Score = 15 (Eyes 4, Verbal 5, Motor 6)

The elevated heart rate and respiratory rate suggest the patient was experiencing significant distress. The GCS score of 15 indicates normal neurological function. The blood pressure readings show some variability but remain within a clinically acceptable range given the patient’s other conditions. The high respiratory rate and need for supplemental oxygen (FiO2 28%) are consistent with the respiratory failure diagnosis.