Medical Report: Patient 007-10474

1. Patient Information

* **Patient Unit Stay ID:** 964285 * **Unique Patient ID:** 007-10474 * **Gender:** Female * **Age:** > 89 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015-XX-XX 08:48:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 22:20:00 * **Hospital Discharge Location:** Rehabilitation * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 09:15:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 23:53:00 * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Admission Weight:** 58.7 kg * **Discharge Weight:** 58.7 kg * **Admission Height:** 154.9 cm

2. History

Admission history indicates the patient was admitted from the Emergency Department with a primary diagnosis of GI bleeding of unknown location. The patient presented with symptoms consistent with gastrointestinal bleeding, and anemia, necessitating admission to the Med-Surg ICU. Further details regarding the patient's presenting symptoms, including duration, severity and associated complaints, are not available in the provided data. A complete medical history prior to this ICU admission is not included in this dataset. Information on past medical conditions, surgeries, allergies, and family history is lacking.

3. Diagnoses

The patient received multiple diagnoses during her ICU stay. These included:

* **Anemia:** This diagnosis was active upon discharge. The ICD-9 code is missing. * **GI Bleeding:** This diagnosis was active upon discharge. ICD-9 codes 578.9 and K92.2 were recorded. Note that there is a duplicate entry of this diagnosis, one recorded early in the stay, and one later, with the earlier entry marked as inactive upon discharge. This suggests the initial diagnosis may have been refined or superseded during the course of the patient's treatment.

All listed diagnoses were marked as 'Other' in terms of priority. The absence of a designated Primary diagnosis indicates the need for clarification in the full medical record.

4. Treatments

The patient received a variety of treatments during her stay, including:

* **Stress Ulcer Treatment (Medication):** This treatment was active at discharge and also recorded earlier in the stay as inactive, suggesting intermittent use or adjustment. * **Normal Saline Administration (IV fluids):** This was an active treatment upon discharge. The initiation of this treatment early in the stay is also recorded, but this early entry was marked inactive. This likely reflects the ongoing nature of IV fluid management. * **Blood Product Administration (IV fluids):** This treatment was also active upon discharge, alongside a prior inactive entry, indicating blood transfusion likely occurred during the stay. * **Gastroenterology Consultation:** This consult was active upon discharge, indicating a need for specialized gastroenterological assessment and management. * **Oxygen Therapy (<40%):** This treatment was active upon discharge, indicating supplemental oxygen was required, possibly due to respiratory compromise related to the bleeding or anemia.

The specific medications administered for stress ulcer prophylaxis and the volume and timing of fluid administration are not detailed within this report. This data is needed for a complete treatment summary.

5. Vital Trends NULL

6. Lab Trends

The provided data includes several laboratory results. Significant findings include:

* **Hemoglobin (Hgb):** Initial Hgb was low (7.1 g/dL), indicating anemia, and improved to 11.1 g/dL and 12.1 g/dL at later time points. This shows improvement in the patient's anemia during treatment. * **Hematocrit (Hct):** Similar to Hgb, initial Hct (21.7%) was low, improving to 32.7% and 35.8% later, reflecting the response to treatment for anemia. * **Blood Gas Values:** Available blood gas results (paO2, paCO2, HCO3, pH, O2 Sat, Base Excess, Carboxyhemoglobin, and O2 Content) show some deviation from expected ranges. More information is needed to interpret these and assess the severity. * **Other Chemistries:** Electrolyte levels (sodium, potassium, chloride, bicarbonate, glucose, BUN, creatinine, calcium, and ionized calcium) and other chemistry values (anion gap, total protein, albumin, direct bilirubin, and total bilirubin) are available at various time points, but without a clear time sequence or full set of results, comprehensive interpretation is not possible. A time series analysis is needed here. * **Complete Blood Count (CBC):** Additional CBC parameters (WBC, RBC, MCV, MCH, MCHC, RDW, platelets, -polys, -lymphs, -monos, -basos) show some abnormalities. A full interpretation requires more data and a contextual clinical assessment.

7. Microbiology Tests NULL

8. Physical Examination Results

The physical exam notes indicate the patient's total fluid intake was 350 ml, while total output was 0 ml. Net fluid balance was +350 ml. The Glasgow Coma Scale (GCS) was documented as 14 (Eyes 4, Verbal 4, Motor 6), suggesting intact neurological function. A detailed physical examination is missing.

Note: This report is limited by the incompleteness of the provided data. The absence of vital signs, a complete physical examination, and detailed treatment information precludes a thorough clinical assessment and interpretation. Additional data is required for a complete and accurate medical report. The inclusion of dates would also drastically improve this report.