Medical Report: Patient 004-11117

1. Patient Information

* **Patient Unit Stay ID:** 350551 * **Unique Patient ID:** 004-11117 * **Gender:** Female * **Age:** 65 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015, 21:31:00 * **Hospital Discharge Time:** 2015, 19:27:00 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015, 21:31:00 * **Unit Discharge Time:** 00:00:00 * **Admission Height:** 157.5 cm * **Admission Weight:** 128.6 kg * **Hospital Admit Source:** Direct Admit * **Hospital Discharge Location:** Rehabilitation * **Hospital Discharge Status:** Alive * **Unit Admit Source:** Direct Admit * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive

2. History

NULL (Insufficient information provided in the JSON data.)

3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnosis upon admission was respiratory failure (failure to wean). Other significant diagnoses included:

* **Major:** Chronic myelogenous leukemia (ICD-9 codes: 205.10, C92.10) * **Major:** Hypertension (ICD-9 codes: 401.9, I10) * **Major:** Pulmonary hypertension * **Major:** Diabetes Mellitus * **Major:** Acute respiratory distress syndrome (ICD-9 code: 518.82)

Multiple entries for the same diagnosis indicate repeated assessments and reevaluation of the patient's condition throughout her stay. The `activeupondischarge` field shows that chronic myelogenous leukemia and hypertension remained active diagnoses at the time of unit discharge. The time offsets indicate when each diagnosis was recorded relative to the unit admission time.

4. Treatments

The patient received a range of treatments throughout her ICU stay. Key treatments included:

* **Mechanical ventilation:** This was an initial treatment, but was discontinued at some point during the stay as indicated by `activeupondischarge` being `False`. * **Oxygen therapy (40% to 60%):** Also an early intervention, later discontinued. * **Tracheal suctioning:** Administered early and again later, indicating ongoing respiratory management needs. * **Stress ulcer prophylaxis (famotidine):** Administered early and again later, suggesting a consistent need for gastrointestinal protection. * **Enteral feeds (tube feeding):** Administered during the stay, and continued upon discharge, addressing nutritional needs. * **VTE prophylaxis (compression stockings and boots):** Implemented to prevent venous thromboembolism. * **Analgesics and sedative agents:** Prescribed for pain and agitation management, with the sedative use continuing at discharge. * **IV furosemide:** Used as an intravenous diuretic, continued upon discharge, suggesting ongoing renal management. * **Aspirin:** Prescribed as an antiplatelet agent, continued at discharge, suggesting ongoing cardiovascular management. * **Pulmonary/CCM and Cardiac surgery consultations:** Suggesting complex care coordination involving multiple specialties.

The `activeupondischarge` flag indicates which treatments were still active at the time the patient left the unit. The `treatmentoffset` values allow for chronological tracking of treatment initiation.

5. Vital Trends

NULL (Insufficient information provided in the JSON data.)

6. Lab Trends

The lab results show numerous blood chemistry and hematology tests conducted at various time points during the patient's stay. Glucose levels fluctuated between 94 mg/dL and 169 mg/dL, reflecting the diabetic condition. BUN (blood urea nitrogen) levels also varied, ranging from 11 mg/dL to 61 mg/dL, indicating changes in renal function. Creatinine levels varied from 0.7 mg/dL to 1.16 mg/dL, also indicative of fluctuating renal function. Electrolytes, such as sodium, potassium, chloride, and bicarbonate, also showed some variation, reflecting the complexity of the patient's medical condition. Hematology results, including WBC, RBC, Hgb, Hct, MCV, MCH, MCHC, and platelet counts, were also obtained and showed some variation which may reflect the patient’s leukemia. Bedside glucose measurements were frequently taken and reflected the patient’s diabetes and response to treatment.

7. Microbiology Tests

NULL (Insufficient information provided in the JSON data.)

8. Physical Examination Results

A structured physical exam was performed, with documented vital signs at the time of the first physical exam: Heart rate (HR) of 76 bpm, systolic blood pressure (BP) of 108 mmHg, diastolic BP of 52 mmHg, and O2 saturation of 95%. The Glasgow Coma Scale (GCS) was scored, with motor score of 6, verbal score of 5, and eyes score of 4, indicative of neurological status. The patient was ventilated at the time of the first physical exam.