Medical Report: Patient 004-14861

1. Patient Information

* **Patient Unit Stay ID:** 383358 * **Unique Patient ID:** 004-14861 * **Gender:** Female * **Age:** 84 years * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015, 23:16:00 * **Hospital Discharge Time:** 2015, 08:00:00 * **Hospital Discharge Status:** Expired * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 00:50:00 * **Unit Discharge Time:** 06:14:00 * **Unit Discharge Status:** Expired * **Admission Weight:** 65.9 kg * **Admission Height:** 165.1 cm

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses, all marked as Major except for two primary diagnoses of respiratory failure (failure to wean). The diagnoses included:

* **Primary:** * Pulmonary Respiratory Failure (Failure to Wean) * **Major:** * Pulmonary Respiratory Failure (ARDS) * Neurologic Altered Mental Status/Pain (Dementia, Alzheimer's Disease) * Cardiovascular Arrhythmias (Atrial Fibrillation) * Endocrine Glucose Metabolism (Diabetes Mellitus) * Pulmonary Disorders of Vasculature (Pulmonary Hypertension) * Pulmonary Pulmonary Infections (Pneumonia - Hospital Acquired, not ventilator-associated)

Note: Multiple entries for the same diagnosis indicate that the diagnosis was reevaluated and/or updated over the course of the ICU stay. ICD-9 codes were provided for some, but not all, diagnoses. The absence of an ICD-9 code does not necessarily indicate an error in data entry, but rather a limitation of the available information.

4. Treatments

The patient received a wide range of treatments during their ICU stay. These included:

* **Respiratory Support:** Mechanical ventilation (with pressure support), oxygen therapy (with FiO2 adjustments), CPAP/PEEP therapy, tracheal suctioning. * **Cardiovascular Management:** Amiodarone (Class III antiarrhythmic), aspirin (antiplatelet agent), Coumadin (anticoagulant), IV furosemide (intravenous diuretic), magnesium electrolyte administration. * **Endocrine Management:** Subcutaneous dose of longer-acting insulin preparations. * **Gastrointestinal Management:** Pantoprazole (stress ulcer prophylaxis), sucralfate (stress ulcer treatment), tube feeding (enteral feeds). * **Neurological Management:** Haloperidol (sedative agent). * **Other:** Compression boots (VTE prophylaxis), Pulmonary/CCM consultation, Cardiology consultation, Psychiatry consultation, and cultures.

Several treatments were active upon discharge, indicating ongoing management needs. The specific details of dosage and response to treatment are unavailable in this data set.

5. Vital Trends

NULL (Insufficient information provided)

6. Lab Trends

The provided lab data includes various blood chemistry, blood gas analysis, and bedside glucose measurements taken over the patient's ICU stay. Specific trends cannot be determined without time-series data (timestamps for each lab result). The available lab results include values for:

* **Blood Chemistry:** Chloride (mmol/L), AST (SGOT) (Units/L), BUN (mg/dL), total protein (g/dL), sodium (mmol/L), bicarbonate (mmol/L), phosphate (mg/dL), albumin (g/dL), calcium (mg/dL), creatinine (mg/dL), total bilirubin (mg/dL), prealbumin (mg/dL), and urinary specific gravity. * **Blood Gas Analysis:** pH, PaO2 (mm Hg), PaCO2 (mm Hg), HCO3 (mmol/L), Base Excess (mEq/L), FiO2 (%), PEEP (cm H2O), Pressure Support (cm H2O), and TV (mls). * **Hematology:** Platelets x 1000 (K/mcL), MCH (pg), MCHC (g/dL), MCV (fL), RBC (M/mcL), WBC x 1000 (K/mcL), RDW (%), -eos (%), -polys (%), -lymphs (%), -monos (%), and -basos (%).

CRP (C-reactive protein) levels were also measured. Many of the hematology values are represented as percentages.

7. Microbiology Tests

NULL (Insufficient information provided, although cultures were performed)

8. Physical Examination Results

The initial physical examination recorded a Glasgow Coma Scale (GCS) score of 15 (Eyes 4, Verbal 5, Motor 6), heart rate (HR) of 61 bpm, systolic blood pressure (BP) of 148 mmHg, and oxygen saturation (O2 Sat) of 92%. The lowest recorded systolic blood pressure was 138 mmHg, while the highest was 148 mmHg. The diastolic blood pressure was recorded as 104 mmHg at the time of the exam, with a lowest reading of 72 mmHg and a highest reading of 104 mmHg. The FiO2 was 40% and the PEEP was 5 cm H2O. Respiratory rate was 29 breaths per minute.