Patient Medical Report

1. Patient Information

* **PatientUnitStayID:** 384028 * **UniquePID:** 004-10063 * **Gender:** Female * **Age:** 69 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015, 20:45:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2015, 15:14:00 * **Hospital Discharge Status:** Alive * **Hospital Discharge Location:** Other * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 01:13:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 19:19:00 * **Unit Discharge Status:** Alive * **Unit Discharge Location:** Floor * **Admission Weight:** 74.8 kg * **Admission Height:** 162.6 cm

2. History

The patient was admitted to the hospital through the Emergency Department and subsequently transferred to the Med-Surg ICU. The admission diagnosis was bacterial pneumonia. The patient presented with a complex constellation of symptoms, including generalized abdominal pain and tenderness, which were reported as major diagnoses, and dehydration, also a major diagnosis. Hypoxemia was another significant finding, documented as a major diagnosis and requiring multiple interventions. Hypotension was noted and treated, also recorded as a major diagnosis. Nausea and vomiting were also present. The detailed timeline of symptom onset is unavailable in the provided data.

The patient's medical history prior to this ICU stay is not included in this dataset and therefore cannot be reported here. A more complete history would provide a more comprehensive understanding of the patient's condition and the context for their current presentation. Further information about social history, family history, and past medical treatments would enhance this section of the report. This would include details on any pre-existing conditions, allergies, and current medications outside of those administered during the ICU stay. Information about the patient's living situation and support system would also be relevant.

3. Diagnoses

Multiple diagnoses were recorded during the patient's ICU stay. The primary diagnosis was pneumonia (ICD-9 code: 486, J18.9). Major diagnoses included generalized abdominal pain/tenderness (ICD-9 code: 789.07, R10.84), dehydration (ICD-9 code: 276.51, E86.0), hypoxemia (ICD-9 code: 799.02, R09.02), and hypotension (ICD-9 code: 458.9, I95.9). Nausea with vomiting (ICD-9 code: 787.01, R11.2) was also listed as a major diagnosis. The diagnoses of dehydration and nausea with vomiting were still active upon the patient's discharge from the unit.

4. Treatments

A wide range of treatments were administered. These included medications for pain management (acetaminophen, oral and parenteral analgesics), bronchodilators, oxygen therapy (40%-60%), vasopressors (phenylephrine), antiarrhythmics (propafenone, diltiazem), and antiemetics (promethazine, serotonin antagonists). VTE prophylaxis was implemented using compression stockings and boots. Consultations were sought from cardiology, gastroenterology, and pulmonary/CCM. Additional interventions such as bronchoscopy, chest x-rays, and nasogastric tube insertion were also performed. The exact dosages and frequencies of medications are not specified within this dataset.

5. Vital Trends NULL. The provided data does not contain time-series vital sign data (heart rate, blood pressure, respiratory rate, oxygen saturation, etc.). To populate this section, additional data would need to be supplied.

6. Lab Trends

The laboratory data reveals fluctuating electrolyte levels, with potassium ranging from 3.4 to 4.3 mmol/L and calcium from 7.9 to 8.6 mg/dL. BUN levels increased from 12 to 38 mg/dL during the ICU stay. Chloride levels varied from 101.8 to 116 mmol/L. Glucose levels showed significant variation, ranging from 100 mg/dL to 197 mg/dL. Hematological tests showed elevated WBC counts and variable platelet counts. ABG results indicate fluctuating paO2 and paCO2 levels, with initial hypoxemia and acidosis (Base Deficit) improving during the course of treatment. The detailed time series of lab results

would be beneficial to determine trends and response to treatment. More specifically, a chronological ordering of the lab results would be helpful. Furthermore, knowing the timing of lab draws relative to treatments would allow for assessment of treatment efficacy.

7. Microbiology Tests NULL. The presence of stool cultures and C. difficile toxin testing is noted in the treatment section, but results are not provided. This section requires further data to generate a complete report.

8. Physical Examination Results

A structured physical exam was performed, recording the patient's vital signs. Heart rate varied from 105 to 125 bpm, systolic blood pressure from 87 to 100 mmHg, and diastolic blood pressure from 49 to 58 mmHg. Respiratory rate varied between 17 and 20 breaths per minute, and oxygen saturation was between 92% and 95%. The patient's weight was recorded as 74.8 kg upon admission. The neurologic examination indicated a GCS score of 15 (Eyes 4, Verbal 5, Motor 6). The respiratory mode was spontaneous.