Medical Report for Patient 004-10432

1. Patient Information

* **Patient Unit Stay ID:** 383124 * **Unique Patient ID:** 004-10432 * **Gender:** Female * **Age:** 22 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2014-XX-XX 20:59:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2014-XX-XX 18:20:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2014-XX-XX 21:21:00 * **Unit Admit Source:** Operating Room * **Unit Discharge Time:** 2014-XX-XX 21:50:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight (kg):** 59 * **Discharge Weight (kg):** NULL * **Admission Height (cm):** 172.7

2. History

Admission diagnosis was Obstruction-airway (i.e., acute epiglottitis, post-extubation edema, foreign body, etc). Further details regarding the patient's medical history prior to admission are not provided in the available data. The report lacks information on presenting symptoms, family history, or social history. This section requires additional information.

3. Diagnoses

* **Primary Diagnosis:** Cardiovascular | Ventricular disorders | Acute pulmonary edema (ICD-9 code: 428.1, I50.1) * **Major Diagnosis:** Cardiovascular | Vascular disorders | Swollen extremity, etiology unknown | r/o lymphedema (ICD-9 code: NULL)

Both diagnoses were active upon discharge from the unit. There were additional entries for both diagnoses that were not active upon discharge.

4. Treatments

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

* **Respiratory Support:** Oxygen therapy (< 40%) via nasal cannula, Non-invasive ventilation via face mask. * **Cardiovascular Management:** Narcotic and non-narcotic analgesics (acetaminophen), Normal saline administration, Oral analgesics. * **Gastrointestinal Management:** Ondansetron (antiemetic), Oral feeds. * **Endocrine Management:** Dexamethasone (glucocorticoid). * **Radiologic Procedures:** Chest X-ray. * **Consultations:** Pulmonary/CCM consultation.

Several treatments were initiated and subsequently discontinued during the stay. Specific dosages and durations are not available in the supplied data.

5. Vital Trends

The following vital signs were recorded:

* **Heart Rate (HR):** Current 94 bpm, Lowest 90 bpm, Highest 97 bpm * **Blood Pressure (BP):** Systolic Current 101 mmHg, Systolic Lowest 101 mmHg, Systolic Highest 114 mmHg; Diastolic Current 66 mmHg, Diastolic Lowest 66 mmHg, Diastolic Highest 83 mmHg * **Respiratory Rate (RR):** Current 19 breaths/min, Lowest 19 breaths/min, Highest 22 breaths/min * **Oxygen Saturation (SpO2):** Current 93%, Lowest 93%, Highest 96%

This data represents a single point in time and does not reflect trends over the course of the ICU stay. A time series of vital signs is needed to assess trends.

6. Lab Trends

Only two lab results are available:

* **O2 Sat (%):** 93% * **FiO2 (%):** 24%

These represent a single measurement at 71 minutes post-admission. Additional lab data is required to analyze trends.

7. Microbiology Tests

NULL. No microbiology test results are included in the provided data.

8. Physical Examination Results

Physical exam findings show a Glasgow Coma Scale (GCS) score of 15 (Eyes 4, Verbal 5, Motor 6) at 72 minutes post-admission. Weight at admission was 59 kg. Respiratory mode was spontaneous.

Additional details about the physical exam are missing. A more complete physical exam record is necessary for a comprehensive report.

Note: This report is limited by the incompleteness of the provided data. Many sections lack sufficient information to provide detailed analysis. Additional data is necessary to fully characterize the patient's ICU stay.