Medical Report for Patient 007-10412

1. Patient Information

* **Patient Unit Stay ID:** 967840 * **Unique Patient ID:** 007-10412 * **Gender:** Female * **Age:** > 89 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015-XX-XX 22:01:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 23:15:00 * **Hospital Discharge Location:** Other External * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015-XX-XX 02:44:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 18:15:00 * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Admission Weight:** 95.5 kg * **Discharge Weight:** 99.2 kg

2. History

Admission history indicates the patient was admitted through the Emergency Department with a primary diagnosis of Diverticular disease. Further details regarding the patient's medical history prior to admission are unavailable in the provided data. The patient presented with abdominal pain and tenderness. The timeline of symptom onset is not specified.

3. Diagnoses

* **Diagnosis ID:** 12749107 * **Patient Unit Stay ID:** 967840 * **Active Upon Discharge:** True * **Diagnosis Offset (minutes from unit admit):** 123 * **Diagnosis String:** gastrointestinal|abdominal/ general|abdominal pain / tenderness * **ICD-9 Code:** 789.00, R10.9 * **Diagnosis Priority:** Major

The primary diagnosis upon ICU admission was abdominal pain and tenderness, classified as a Major diagnosis. Secondary diagnoses are not listed but the ICD-9 codes suggest a possible nonspecific abdominal complaint (789.00) and unspecified abdominal pain (R10.9). The lack of a primary diagnosis in the patient's history suggests that the abdominal pain and tenderness were the presenting symptoms that led to the admission.

4. Treatments

The patient received the following treatments during their ICU stay:

* **Treatment ID:** 28098496 * **Treatment String:** gastrointestinal|medications|antibiotics * **Active Upon Discharge:** True * **Treatment ID:** 27955388 * **Treatment String:** gastrointestinal|intravenous fluid administration|normal saline administration * **Active Upon Discharge:** True * **Treatment ID:** 28041880 * **Treatment String:** gastrointestinal|consultations|Surgery consultation * **Active Upon Discharge:** True

The patient received intravenous fluids (normal saline), antibiotics, and a surgical consultation. The specific antibiotics administered are not detailed in the provided dataset. The outcome of the surgical consultation is unknown. The treatment plan appears to address the gastrointestinal issues indicated by the primary diagnosis. The absence of other treatments suggests that the patient's condition was managed effectively with the given interventions.

5. Vital Trends

* **Heart Rate (HR):** Current: 100 bpm, Lowest: 98 bpm, Highest: 101 bpm * **Respiratory Rate (Resp):** Current: 27 breaths/min, Lowest: 21 breaths/min, Highest: 27 breaths/min * **Oxygen Saturation (O2 Sat%):** Current: 96%, Lowest: 96%, Highest: 96%

The vital signs show a relatively stable heart rate and respiratory rate within a narrow range. Oxygen saturation was consistently at 96%. More detailed time-series data would be necessary to assess trends over time. The available data only presents a snapshot of the patient's vital signs at a single point in time. More frequent measurements would provide a more comprehensive picture of the patient's hemodynamic stability.

6. Lab Trends

The provided lab data represents a single time point, approximately 539 minutes prior to unit admission. Trends cannot be determined from this data alone. The lab results are listed below. Repeated measurements over time are needed to track trends and assess the patient's response to treatments.

(Detailed Lab results listed below in section 7)

7. Microbiology Tests NULL

8. Physical Examination Results

The physical exam was performed and documented. Specific findings beyond vital signs are not detailed, though weight measurements are available: Admission weight 95.45 kg, Current weight 99.2 kg, indicating a weight gain of 3.75 kg. A GCS score of 15 (Eyes 4, Verbal 5, Motor 6) is documented, suggesting normal neurological function at the time of the exam. Urine output was 1650 ml with zero intake. Further details of the physical exam are missing. A more complete physical exam would include detailed descriptions of the patient's appearance, neurological status, cardiovascular status, respiratory status and abdominal examination. This would allow for more complete clinical assessment.

Lab Results:

* Anion gap: 13 * Hgb: 13.1 g/dL * Creatinine: 0.7 mg/dL * MCV: 88.7 fL * Alkaline phos.: 110 IU/L * -eos: 0 % * Sodium: 129 mmol/L * RDW: 14.4 % * ALT (SGPT): 32 IU/L * WBC x 1000: 19.7 th/uL * Potassium: 3.6 mmol/L * MCH: 29.7 pg * Total bilirubin: 2.3 mg/dL * Hct: 39.3 % * Chloride: 94 mmol/L * RBC: 4.43 mill/uL * Direct bilirubin: 1.3 mg/dL * -basos: 0.2 % * Glucose: 128 mg/dL * MCHC: 33.5 g/dL * Albumin: 2.6 g/dL * -lymphs: 3.1 % * Troponin - I: <0.015 ng/mL * MPV: 8.1 fL * Lipase: 49 IU/L * -polys: 88.9 % * Bicarbonate: 22 mmol/L * Urinary specific gravity: 1.015 (two measurements) * AST (SGOT): 49 IU/L * -monos: 7.8 % * Calcium: 7.8 mg/dL * Platelets x 1000: 284 th/uL * BUN: 13 mg/dL