Medical Report for Patient 004-10113

1. Patient Information

* **Patient Unit Stay ID:** 417578 * **Patient Health System Stay ID:** 356310 * **Gender:** Female * **Age:** 53 * **Ethnicity:** Caucasian * **Hospital ID:** 122 * **Ward ID:** 181 * **APACHE Admission Dx:** Cardiomyopathy * **Admission Height:** 167.6 cm * **Hospital Admit Time:** 2015-XX-XX 18:26:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 15:59:00 * **Hospital Discharge Location:** Rehabilitation * **Hospital Discharge Status:** Alive * **Unit Type:** CTICU * **Unit Admit Time:** 2015-XX-XX 05:33:00 * **Unit Admit Source:** Other ICU * **Unit Visit Number:** 3 * **Unit Stay Type:** Transfer * **Admission Weight:** 59.7 kg * **Discharge Weight:** NULL * **Unit Discharge Time:** 2015-XX-XX 20:54:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Unique Patient ID:** 004-10113

2. History

NULL (Insufficient data provided)

3. Diagnoses

The patient presented with multiple diagnoses, many of which were active upon admission but not upon discharge. The primary diagnosis on admission was rule out aortic dissection (ICD-9 code missing). Major diagnoses included:

* **Cardiovascular:** Shock/hypotension (458.9, I95.9), Chest pain/ASHD/acute coronary syndrome/myocardial ischemia (411.89, I24.8), ventricular disorders/hypertension (401.9, I10), Congestive heart failure (428.0, I50.9), Acute coronary syndrome/acute myocardial infarction (no ST elevation) (410.71, I21.4), Chest pain/r/o aortic dissection (ICD-9 code missing) * **Neurologic:** Seizures (345.90, R56.9), Altered mental status/pain/depression (311, F32.9), Disorders of vasculature/stroke/ischemic stroke (434.91, I63.50), Altered mental status/pain/bipolar disorder (296.80, F31.9) * **Hematology:** White blood cell disorders/leukocytosis (288.8, D72.829) * **Infectious Diseases:** Systemic/other infections/sepsis (038.9, A41.9)

Upon discharge, the active diagnoses included leukocytosis (288.8, D72.829), moderate depression (311, F32.9), Ischemic stroke (434.91, I63.50), hypotension (458.9, I95.9), Chest pain/r/o aortic dissection (ICD-9 code missing),hypertension (401.9, I10), and acute myocardial infarction (no ST elevation) (410.71, I21.4), and idiopathic dilated cardiomyopathy (425.4, I42.8), hyperlipidemia (272.4, E78.5), and SVT (427.0, I47.1).

4. Treatments

The patient received a wide range of treatments during her ICU stay. Many were discontinued before discharge, while others were continued. Noteworthy treatments included:

* **Cardiovascular:** Anticoagulant administration (low molecular weight heparin, enoxaparin), antiplatelet agent (aspirin), ACE inhibitor (lisinopril), vasodilating agent (nicardipine), intravenous nitroglycerin, electrolyte administration (potassium), Cardiac surgery consultation, Cardiology consultation, VTE prophylaxis (compression stockings, compression boots), and cardiac angiography (left heart). * **Neurologic:** Anticonvulsant (lamotrigine), analgesics (bolus parenteral, oral), Neurology consultation, head CT scan (without contrast), MRI - head. * **Gastrointestinal:** Antiemetics (diphenhydramine, promethazine, ondansetron), stress ulcer prophylaxis (pantoprazole IV), enteral feeds (oral feeds). * **Infectious Diseases:** Therapeutic antibacterials (piperacillin/tazobactam, vancomycin), Cultures (urine, blood). * **Pulmonary:** Pulmonary/CCM consultation, chest x-ray, nicotine patch. * **General Support Services:** Discharge planning consult, physical therapy consult, occupational therapy consult, smoking cessation counseling.

5. Vital Trends

NULL (Insufficient data provided)

6. Lab Trends

The provided lab data includes values for several blood tests taken at different time points. These include complete blood counts (WBC, RBC, Hgb, Hct, MCV, MCH, MCHC, RDW, platelets), blood chemistries (BUN, creatinine, glucose, sodium, potassium, chloride, calcium, bicarbonate) and coagulation studies (PT, PT-INR). There appear to be two sets of blood tests, one around 207 minutes post-admission and the second around 1667 minutes post-admission. A third set of tests, including PT and PT-INR was performed at 3077 and 5919 minutes post-admission. Further analysis is needed to assess trends and clinical significance.

7. Microbiology Tests

NULL (Insufficient data provided)

8. Physical Examination Results

A structured physical examination was performed. Vital signs recorded at the time of the exam included: Heart rate (70-78 bpm), Blood pressure (99/67 mmHg), Respiratory rate (20-23 breaths/min), and Oxygen saturation (97-100%). The Glasgow Coma Scale (GCS) score was 14 (Eyes 3, Verbal 5, Motor 6). The patient's weight was 59.69kg, respiratory mode was spontaneous and FiO2 was 28%. Further details about the physical examination are not available in the provided data.