Medical Report for Patient 006-100070

1. Patient Information

* **Patient Unit Stay ID:** 887817 * **Patient Health System Stay ID:** 663199 * **Unique Patient ID:** 006-100070 * **Gender:** Female * **Age:** 80 * **Ethnicity:** Caucasian * **Hospital ID:** 176 * **Ward ID:** 391 * **Unit Type:** CSICU * **Unit Admit Time:** 05:38:00 (2014) * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 00:08:00 (2014) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 23:44:00 (2014) * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 20:40:00 (2014) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Weight:** 75 kg * **Discharge Weight:** 80.4 kg * **Admission Height:** 165.1 cm * **APACHE Admission Dx:** Renal bleeding

2. History

NULL (Insufficient data provided)

3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnosis was hemorrhage (hematology|bleeding and red blood cell disorders|hemorrhage), with major diagnoses including renal cell carcinoma affecting the right kidney (oncology|GU tumors|renal cell CA|right kidney) and hematuria (renal|abnormality of urine quantity or quality|hematuria). The hemorrhage diagnosis was active upon discharge, indicating ongoing concern. The ICD-9 codes provided were 189.0, C64.9 (for renal cell carcinoma), and 599.7, R31.9 (for hematuria). Note that ICD-9 codes were not provided for the hemorrhage diagnoses.

The diagnoses were entered at various time points relative to unit admission time. The renal cell carcinoma and hematuria diagnoses were initially recorded at approximately 1550 minutes and 36 minutes post-admission, respectively. Subsequent entries for these diagnoses were made at 344 minutes and 2078 minutes post-admission. The primary hemorrhage diagnosis was initially documented at 36 minutes, 344 minutes and 1550 minutes post-admission. The final hemorrhage diagnosis, also active on discharge, was entered at 2078 minutes post-admission.

4. Treatments

The patient received several treatments during her ICU stay. These included moderate volume resuscitation (150-250 mls/hr) of normal saline and transfusions of 1-2 units of packed red blood cells. The volume resuscitation was administered at both 344 and 1550 minutes post-admission. The blood transfusions were administered at 1550 minutes post-admission. None of these treatments were active upon discharge.

5. Vital Trends

NULL (Insufficient data provided. Vital signs were recorded in the physical exam, but not as a time series.)

6. Lab Trends

The provided lab data includes multiple blood tests taken at various times during the patient's stay. These included complete blood count (CBC) with differential, basic metabolic panel (BMP), and liver function tests (LFTs). The data shows fluctuations in several key parameters. Further analysis is needed to establish clear trends. Key lab values are presented in a separate summary table.

7. Microbiology Tests

NULL (Insufficient data provided.)

8. Physical Examination Results

The physical examination documented a Glasgow Coma Scale (GCS) score of 15 (scored), with individual scores of 4 for eye opening, 5 for verbal response, and 6 for motor response. Heart rate (HR) was recorded between 112 and 114 bpm. Systolic blood pressure (BP) ranged from 89 to 107 mmHg, and diastolic blood pressure ranged from 48 to 61 mmHg. Respiratory rate (RR) was between 15 and 16 breaths per minute. Oxygen saturation (O2 Sat) ranged from 92% to 99%. Admission weight was 75 kg.