Medical Report for Patient 002-10163

1. Patient Information:

* **Patient Unit Stay ID:** 177689 * **Unique Patient ID:** 002-10163 * **Gender:** Female * **Age:** 63 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2014-10-30 10:30:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2014-10-31 16:42:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2014-10-30 10:04:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2014-10-31 20:00:00 * **Unit Discharge Location:** Telemetry * **Unit Discharge Status:** Alive * **Admission Weight:** NULL * **Discharge Weight:** 76.8 kg

2. History:

Admission diagnosis from the Emergency Department 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. A more complete history would include information on previous illnesses, surgeries, allergies, current medications, and family history.

3. Diagnoses:

* **Primary Diagnosis:** Pulmonary disorders of the airways; upper respiratory obstruction due to angioedema (ICD-9: 478.8, J39.3) * **Secondary Diagnoses:** * Endocrine, thyroid, hypothyroidism (ICD-9: 244.9, E03.9) * Cardiovascular, vascular disorders, hypertension (ICD-9: 401.9, I10)

The diagnoses suggest a complex clinical picture involving respiratory compromise (likely related to angioedema), thyroid dysfunction, and hypertension. The temporal relationship between these diagnoses and their influence on each other requires further clarification.

4. Treatments:

NULL. The provided dataset does not contain information about the treatments administered during the ICU stay. This section would ideally include a detailed list of medications, procedures, and therapies provided to the patient.

5. Vital Trends:

NULL. The dataset lacks information on vital signs (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation) over time. This is essential for understanding the patient's physiological response to the illness and treatment.

6. Lab Trends:

The available lab data shows complete blood count (CBC) results at two time points: one shortly before admission and another approximately 24 hours later. The data includes:

* **Hemoglobin (Hgb):** 13.9 g/dL (initial), 13.7 g/dL (24 hours later) * **Hematocrit (Hct):** 41.5% (initial), 41.4% (24 hours later) * **Mean Corpuscular Volume (MCV):** 92.6 fL (initial), 92.4 fL (24 hours later) * **Mean Corpuscular Hemoglobin (MCH):** 31 pg (initial), 30.6 pg (24 hours later) * **Mean Corpuscular Hemoglobin Concentration (MCHC):** 33.5 g/dL (initial), 33.1 g/dL (24 hours later) * **Red Blood Cell Count (RBC):** 4.48 M/mcL (initial), 4.48 M/mcL (24 hours later) * **White Blood Cell Count (WBC):** 17.2 K/mcL (initial), 16.4 K/mcL (24 hours later) * **Platelets:** 484 K/mcL (initial), 465 K/mcL (24 hours later) * **Red cell distribution width (RDW):** 13.7% (initial), 13.6% (24 hours later) * **-monos:** 7% (initial), 4% (24 hours later) * **-lymphs:** 38% (initial), 34% (24 hours later) * **-polys:** 55% (initial), 62% (24 hours later) * **-eos:** 0% (initial) * **-basos:** 0% (initial)

Chemistry results show glucose (93 mg/dL), bicarbonate (26 mmol/L), anion gap (12 mmol/L), sodium (138 mmol/L), potassium (4.1 mmol/L), chloride (104 mmol/L), creatinine (0.69 mg/dL initial, 0.71 mg/dL 24 hours later), calcium (9.7 mg/dL), BUN (23 mg/dL), and CRP (0.4 mg/dL at approximately 24 hours). The significance of these values requires consideration in the context of the patient's clinical presentation and other data. More frequent lab results would provide a richer picture of the patient's response to treatment. The meaning of the values for -monos, -lymphs, -polys, -eos, and -basos requires further clarification as they are not standard lab values.

7. Microbiology Tests:

NULL. No microbiology test results are available in the provided data. This section would include culture reports (blood, urine, etc.) if available.

8. Physical Examination Results:

* **GCS Score:** 15 (Eyes: 4, Verbal: 5, Motor: 6) * **Weight:** 78.3 kg * **Intake & Output:** Both Intake and Output were recorded as 0 ml. This may reflect incomplete documentation rather than the absence of intake and output. Dialysis and total net fluid balance were also recorded as 0. * **Physical Exam Performed:** Performed as a structured exam.

The GCS score of 15 indicates normal neurological function at the time of the exam. The weight is significantly higher than the discharge weight, which needs to be investigated further. The reported 0 ml for both intake and output requires further investigation and clarification. A detailed physical exam would provide a more thorough assessment of the patient's condition.