"PERIPHERAL PERFUSION INDEX- SHOCK INDEX- EMERGENCY SEVERITY INDEX IN PREDICTION OF OUTCOME OF PATIENT IN TERTIARY CARE HOSPITAL."

BY

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DISSERTATION SUBMITTED TO



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Under the Guidance of

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Dr. SHUBHAM DEORE.

ABSTRACT

INTRODUCTION:

The admissions in the Emergency Department are increasing day by day in recent years requiring the strong and effective triage systems. The goals of these triage systems are to differentiate the patients as high to low-risk patients and immediate attention to the high-risk patients. As increasing emergency care demand, it puts pressure on the ED hampering the patient care. Multiple systems are working on triaging of the patients worldwide. Emergency Severity Index is the most used system in western countries increasing the influence in other parts of the world also. It consists of five stage system. Certain indicators like peripheral perfusion index and shock index which can be easily obtained in triage can be added to the ESI grading to improve and to make the triage more effective and improving the patient care in the Emergency Department.

OBJECTIVES

To determine the combined effect of the Peripheral Perfusion Index and Shock Index with ESI to predict hospital outcomes in the form of need of ventilation and morbidity in acute critically ill patients coming to Emergency Department. To determine the individual effect of the Peripheral Perfusion Index, Shock Index and Emergency Severity Index.

TYPE OF STUDY: Cross sectional study.

STUDY PERIOD: Period of 21 months (August 2022 to April 2024).

STUDY POPULATION:

Patients coming to Emergency Department BLDE, Shri B.M Patil Medical College Hospital and Research Centre, Vijayapura from August 2022 to April 2024 consisting of patients aged older than 18 years who visited the Emergency Medicine department who met the inclusion Criteria.

METHODOLOGY:

A cross-sectional study was conducted by department of pediatrics at Shri BM Patil Medical College Hospital and Research Centre. The study included hospital-based patients coming in Emergency Department. Data was collected via triage examination of the patients and the in-hospital status of the patients. The triage included variables such as age, residence, sex, heart rate, systolic blood pressure, shock index, peripheral perfusion index and emergency severity index grading.

STATISTICAL ANALYSIS:

Statistical analyses were conducted using SPSS (Version 20). The Mann-Whitney U test was employed for non-normally distributed variables to compare medians accurately. Categorical variables were analyzed using the Chi-square test or Fisher's exact test to determine associations between different categorical outcomes and groups. For comparisons involving more than two groups, ANOVA was utilized for normally distributed variables, and the Kruskal-Wallis H test for non-normally distributed variables, ensuring appropriate analysis based on data distribution. The correlation between PPI, SI, and ESI was assessed using Pearson or Spearman correlation coefficients, depending on the normality of the data distribution. Logistic regression analysis was conducted to evaluate the association of PPI and SI measurements with hospital admission and mortality outcomes, providing insights into the predictive value of these indices. The prognostic value of PPI, SI, and ESI in predicting adverse outcomes was further assessed using receiver operating characteristic (ROC) curve analysis and the area under the curve (AUC).

RESULTS:

Among the 610 participants, Emergency Severity Index (ESI) score of less than 3, The PPI at admission shows a strong predictive accuracy with an AUC of 0.89 and a standard error of 0.01. At 12 hours, the PPI's AUC slightly decreased to 0.86, and at 24 hours, it modestly increased to 0.87, indicating consistent predictive performance over time. The SI at admission had an AUC of 0.82, with a standard error of 0.02, reflecting moderate predictive accuracy. The SI's predictive power improved significantly, with an AUC of 0.93 at 12 hours and 0.95 at 48 hours, demonstrating high predictive accuracy.

CONCLUSION:

Peripheral Perfusion Index and Shock Index significantly enhance the predictive power of Emergency Severity Index, leading to better identification of high-risk patients and more timely interventions. The study suggests that incorporating these objective indices can optimize resource allocation and improve patient care. Future research should validate these results across multiple centers and explore additional variables. In conclusion, integrating PPI and SI with ESI can enhance triage effectiveness, ensuring better patient outcomes and more efficient emergency department operations.

Keywords: Triage, Herat Rate, Systolic Blood Pressure, Peripheral Perfusion Index, Shock Index, Emergency Severity Index.

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INTRODUCTION

In recent years, emergency departments (EDs) globally have experienced a substantial increment in patient admissions, necessitating the implementation of efficient and effective triage systems. These systems are crucial for prioritizing patient care, facilitating quick decision-making, and managing the overwhelming influx of patients. The primary goal of triage systems is to identify high- or low-risk patients, guiding different care trajectories and risk identification for hospital complications.(1) Although many Indian systems still rely on conventional triage systems that categorize patients using color codes-green, yellow, and red-several evidence-based triage systems are using globally. Notable among these are the Emergency Severity Index (ESI), the Canadian Triage Acuity Scale, the Soterion Rapid Triage System.(2) Among all of these, the ESI has gained widespread acceptance, particularly in the United States, and is increasingly utilized in non-English-speaking countries.(3) The increasing demand for emergency care has placed immense pressure on EDs to efficiently manage patient flow and prioritize care.(4) Triage systems play a pivotal role in this process, enabling healthcare providers to quickly assess patient severity and make informed decisions regarding treatment priorities.(5) The ESI categorizes patients on the emergency of their clinical condition and the resources they require. However, its reliance on subjective assessments and the potential for normal vital signs to mask underlying conditions highlight the need for supplementary objective measures.

The Emergency Severity Index is a five-level triage tool that not only evaluates patients' vital signs but also considers their current resources and symptoms.(6) This comprehensive approach aims to provide a more nuanced assessment of patient severity. Despite its widespread use, the ESI has certain limitations. It involves subjective judgment, which can lead to variability in triage decisions.(7) Though, vital signs may remain within normal limits until physiologic compensatory mechanisms are overwhelmed, potentially leading to the misclassification of high-risk patients. So, there is a need of additional objective measurements to supplement the ESI, enhancing the accuracy of patient risk assessment and improving outcomes.

One such objective measurement is the PPI-Peripheral Perfusion Index, [a non-invasive numerical value reflecting real-time changes in peripheral blood flow]. Obtained from the photoelectric plethysmographic signal of pulse oximetry, PPI is recorded on the pulse-oximeter monitor and is fluctuating by the amount of blood flow at the monitoring site.(8) An increase in pulsatile flow, indicated by greater pulsation intensity, results in a higher PPI value. PPI serves as an at time recording of local blood flow changes, indicating tissue perfusion. Recent trails have demonstrated significant correlation between PPI with patient outcomes, suggesting its potential as a valuable prognostic tool in the ED setting.(9)

Another important measure of hemodynamic stability is the SI i.e, Shock Index, defined as the components like heart rate divided by systolic blood pressure. SI being useful outcome variable with various clinical conditions and is a key indicator of hemodynamic instability.(10,11) An elevated SI often signals reduced contractility and left ventricular output and acute circulatory damage, with a persistent increase indicates worsening with increased morbidity and

mortality.(12) Despite its clinical utility, SI has been studied in critically ill patients within intensive care settings, with limited research on its application in the ED.(13)

The study aims to evaluate the correlation between the PPI, SI, and ESI in patients presenting to the triage. It will help to assess whether PPI and SI measurements are associated with requirement of ventilation and condition of the patient at 48 hours outcome. Additionally, the study seeks to determine if any of these indicators play a significant role in predicting clinical results compared to the others. Understanding the relationships between these indices and hospital outcomes could provide valuable insights for enhancing triage accuracy and improving patient care in the ED. By incorporating objective measures such as PPI and SI alongside traditional triage tools like ESI, healthcare providers may better identify high-risk patients, ensure timely interventions, and in result improve clinical outcomes. The findings of this study could have significant effects for the development of more robust triage systems, resulting in the efficient allocation of resources and the delivery of high-quality emergency services. Despite the advantages of PPI with SI, their application in the ED setting remains underexplored. The limited research on the correlation between these indices and traditional triage tools like ESI underscores the need for any other investigation. The study aims to fill this gap by examining prognostic performance of PPI, SI, with ESI in predicting hospital outcomes. By evaluating the relationships between these indices and key clinical outcomes such as hospital admission and mortality, the study seeks to provide evidence for the integration of objective measures into existing triage systems.

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Aim:

The study aims to enhance understanding and effectiveness of triage systems at emergency department by investigating the relationships and prognostic value of the PPI, Shock Index (SI), and Emergency Severity Index (ESI) in predicting hospital outcomes such as admission rates and mortality.

Objectives:

Primary Objectives: (1) Evaluation of correlation between indices like PPI, SI, and ESI in patients who presents to the Emergency Dept; (2) Determine the association between PPI and SI measurement in need of the ventilation and 48 hours hospital outcome; (3) Evaluate the relative prognostic value of PPI, SI, and ESI in predicting adverse outcomes.

REVIEW OF LITERATURE

The Review of Literature is organized as follows:

I. A. Overview of Emergency Department (ED) Challenges

- Increasing patient admissions
- Importance of effective triage systems

B. Purpose of the Review

- To explore existing literature on PPI, SI, and Emergency Severity Index (ESI)
- To identify gaps and justify the need for the current study

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- Development of modern triage protocols

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A. Identified Gaps in Literature

- Limited research on combined use of PPI, SI, and ESI in ED settings
- Need for more comprehensive studies linking these indices to hospital outcomes

B. Justification for the Present Study

- Addressing the identified gaps
- Potential contributions to triage practices and patient care

I. A. Overview of Emergency Department (ED) Challenges

The global healthcare landscape has witnessed a significant surge in patient admissions to emergency departments (EDs) over recent years.(14) This trend is attributed to various factors, including population growth, increasing prevalence of chronic diseases, aging populations, and the rising incidence of acute medical conditions.(15) As a result, EDs are frequently overwhelmed, leading to prolonged waiting times, overcrowding, and strained healthcare resources. These challenges not only impede the delivery of timely and effective care but also contribute to increased patient morbidity and mortality.

One of the critical functions of EDs is the rapid and accurate assessment of patient acuity to ensure that those with the most urgent needs receive immediate attention. This process, known as triage, is essential for prioritizing patient care, managing limited resources, and optimizing patient outcomes.(16,17) Effective triage systems are vital in this context as they facilitate quick decision-making, help in reducing bottlenecks, and improve the overall efficiency of ED operations.(18) Traditional triage methods, which often rely on subjective clinical judgments and basic vital signs, may not always capture the true severity of a patient's condition, potentially leading to misclassification and suboptimal care. Therefore, enhancing triage accuracy through the integration of objective and reliable indices is paramount.

B. Purpose of the Review

Review is done to systematically explore the existing available literature on three key indices used in EM department: the Peripheral Perfusion Index (PPI), Shock Index (SI), and Emergency Severity Index (ESI). These indices have been studied individually for their potential to improve triage accuracy and predict patient outcomes, but their combined application and comparative effectiveness remain underexplored. By examining the current body of research, this column aims to identify the evidence on the prognostic performance of PPI, SI, and ESI, highlighting their respective strengths and limitations.

Additionally, this review seeks to identify gaps in the literature that justify the need for further investigation. Despite the advancements in triage methodologies, there is limited integration of objective measurements like PPI and SI with traditional tools such as ESI. Understanding the potential synergistic benefits of combining these indices could lead to more robust and reliable triage systems, ultimately enhancing patient care and outcomes in the EM settings. The results from this literature will provide a foundation for the present study, which aims to assess the interaction between PPI, SI, and ESI in predicting hospital outcomes, thereby contributing to the ongoing efforts to optimize emergency care practices.

II. Triage Systems in Emergency Medicine

A. Historical Context and Evolution

Early Triage Systems

The concept of triage, derived with French nomenclature "trier" meaning to sort, has its origins in military medicine.(19) The practice dates back to the Napoleonic Wars, where battlefield surgeons like Baron Dominique Jean Larrey developed early triage protocols to treat the soldiers on priority basis of the severity of the injuries and the chances of survival. This method aimed to make the most efficient use of medical resources available in high-casualty situations, ensuring that those with the greatest need and chance of recovery received immediate care. During World War I and II, triage systems became more structured and were widely adopted by military medical corps.(20) The primary goal was to sort casualties into categories: those who could be saved with immediate intervention, those who would benefit from delayed treatment, and those for whom treatment would be futile.(21) These early triage practices laid the groundwork for modern emergency medical systems by emphasizing the importance of prioritizing care based on clinical urgency.

Development of Modern Triage Protocols

The transition from military to civilian emergency medicine in the mid-20th century marked the development of modern triage protocols. The increasing frequency of large-scale emergencies, such as natural disasters and mass casualty incidents, underscored the need for efficient triage systems in civilian hospitals. In the 1960s and 1970s, various triage scales and methods were introduced in emergency departments (EDs) worldwide.

One of the significant advancements in triage was the development of the UK based Manchester Triage System (MTS) in 1990s. MTS introduced a structured approach to triage, categorizing patients into five levels of urgency based on clinical symptoms and presentation. This system aimed to standardize triage decisions, reduce variability, and improve patient outcomes.(22)

Similarly, in the United States, the ESI was developed in the late 1990s. (7) ESI is based on fivelevel triage system that not only assesses the severity of a patient's condition but also considers the resources needed for their treatment. The introduction of ESI represented a significant shift towards integrating resource utilization into triage decisions, thus optimizing ED workflow and resource allocation.(23)

B. Conventional Triage Systems

Description and Use in Various Countries

Conventional triage systems, often referred to as three-level triage systems, are widely used across the globe. These systems typically categorize patients among three levels, priority based on the immediate need of their medical condition. The most common designations are:

- Level 1 (Immediate): Patients with life-threatening conditions requiring immediate intervention.
- Level 2 (Urgent): Patients with serious but not immediately life-threatening conditions.
- Level 3 (Non-Urgent): Patients with minor injuries or illnesses who can safely wait for treatment.

Countries like Canada, Australia, and various European nations have implemented modified versions of these triage systems to suit their specific healthcare environments. For example, the Australasian Triage Scale (ATS), one more being the Canadian Triage and Acuity Scale (CTAS) are five-level systems that provide a more nuanced categorization, improving the precision of patient assessments and prioritization.

Advantages and Limitations

Advantages:

 Simplicity and Speed: Conventional triage systems are designed to be quick and easy to use, enabling rapid assessment and decision-making. This is crucial in busy EDs where time is of the essence.

- 2. **Standardization:** These systems provide a standardized approach to triage, reducing variability in patient assessment and ensuring that patients receive care based on objective criteria.
- 3. **Resource Allocation:** By categorizing patients based on urgency, triage systems help allocate medical resources more effectively, ensuring that those in greatest need receive timely intervention.

Limitations:

- Subjectivity: Despite efforts to standardize triage, the assessment can still be subjective, leading to variability in triage decisions. Different healthcare providers may interpret symptoms and urgency differently, affecting the consistency of care.
- 2. Limited Sensitivity: Conventional triage systems primarily rely on observable symptoms and basic vital signs, which may not always capture the true severity of a patient's condition. This can result in the under-triage of patients whose conditions may deteriorate rapidly.
- 3. **Resource Intensive:** Implementing and maintaining standardized triage protocols require significant training and resources. In resource-limited settings, it may be challenging to adhere strictly to these protocols, potentially impacting the quality of triage.

Overall, while conventional triage systems have been instrumental in improving emergency care, there remains a need for enhancements to address their limitations. Integrating more objective and sensitive measures, such as the PPI and SI, with the tools like the Emergency Severity Index (ESI), holds promise in advancing effectiveness at triage systems in emergency medicine.

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III. Emergency Severity Index (ESI)

A. Development and Adoption

Origins and Evolution

The ESI was developed in the late 1990s as a response to the need for a more efficient and standardized triage system in emergency departments (EDs). Its development was spearheaded by Dr. Richard Wuerz and colleagues, who recognized the limitations of existing triage systems that often failed to account for resource utilization and variability in patient acuity. The ESI was designed to address these gaps by incorporating a dual focus on the severity of the patient's clinical condition and the medical resources required in providing appropriate care.

Initially, the ESI was introduced in several pilot sites across the United States. These early implementations aimed to refine the triage tool based on real-world feedback and performance. Over time, the ESI underwent several iterations, each version incorporating lessons learned from clinical practice and emerging research. The continuous improvement process ensured that the ESI remained relevant and effective in a rapidly evolving healthcare environment.

Adoption in the United States and Globally

Following its initial development, the ESI quickly gained traction across the United States. Its structured approach and evidence-based design made it an attractive alternative to traditional triage systems. By the early 2000s, many EDs across the country had adopted the ESI, recognizing its potential to improve patient flow, resource allocation, and overall care quality.

The success of the ESI in the United States spurred interest in its adoption internationally. Countries with diverse healthcare systems began to evaluate the ESI's applicability within their own contexts. For instance, in Europe, several countries adapted the ESI to align with their national guidelines and clinical practices. Similarly, in Asia and the Middle East, the ESI was implemented in both public and private healthcare settings, demonstrating its versatility and global appeal.

The widespread adoption of the ESI can be attributed to several factors. Firstly, its ability to standardize triage processes across different healthcare settings reduced variability in patient assessment. Secondly, the ESI's focus on resource requirements helped EDs manage their capacities more effectively, especially during peak times. Lastly, the growing body of evidence supporting the ESI's effectiveness in improving patient outcomes reinforced its credibility and acceptance.

B. ESI Structure and Criteria

Five-Level Triage Tool

This Emergency Severity Inex is structured as a five-stage triage system, with levels ranging from the level 1 (most urgent) to level 5 (least urgent). This hierarchical framework allows for a nuanced categorization of patients based on the clinical severity of their conditions and immediacy of required interventions.

• Level 1 (Immediate): Patients who require immediate, life-saving interventions.

Examples include severe trauma, cardiac arrest, and respiratory failure.

- Level 2 (Emergent): Patients with conditions that pose a significant risk to life or limb if not promptly addressed. These patients are typically high-risk and require immediate attention but are not yet in a life-threatening situation.
- Level 3 (Urgent): Patients with conditions that necessitate prompt medical attention but are not immediately life-threatening. These patients may require several resources to diagnose and treat their condition.
- Level 4 (Semi-Urgent): With the less severe conditioned patients and managed with fewer resources. These patients are stable but still require medical evaluation and treatment.
- Level 5 (Non-Urgent): Patients with minor conditions that require minimal resources. These patients are stable and can safely wait for a longer period before receiving care.

Assessment Criteria and Resource Requirements

The ESI assessment involves a two-step process that considers both patient acuity and anticipated resource needs. The first step assesses the patient's condition to determine if they require immediate life-saving intervention (ESI Level 1). If not, the triage nurse proceeds to the second step, evaluating the patient's symptoms and clinical presentation to estimate the resources required.

Resource needs are categorized based on the number and type of interventions a patient might need, such as laboratory tests, imaging studies, specialist consultations, and therapeutic procedures. This dual focus on acuity and resources ensures that the ESI provides a comprehensive and practical approach to triage, facilitating effective prioritization and resource management.

C. ESI Performance and Limitations

Studies on ESI Effectiveness

Multiple studies evaluated the effectiveness of ESI in different clinical settings. Research has consistently shown that the ESI improves the accuracy of triage decisions, enhances patient flow, and optimizes resource utilization. For instance, a study by Gilboy et al. (2011) demonstrated that the ESI reliably stratifies patients by acuity, ensuring that those with the most urgent needs receive timely care. Another study by Wuerz et al. (2000) highlighted the ESI's role in reducing waiting times and overall length of stay in the ED, thereby improving patient satisfaction and outcomes.

Additionally, the ESI has been found to have high inter-rater reliability, meaning that different triage nurses tend to assign the same ESI level to similar cases, reducing variability and improving consistency in patient assessment. The ESI's predictive validity has also been supported by studies showing strong correlations between ESI levels and key outcomes such as hospital admission rates, need for intensive care, and mortality.

Limitations Due to Subjective Assessments

Despite its strengths, the ESI is not without limitations. One of the primary challenges is the potential for subjective bias in triage assessments. While the ESI provides a structured framework, the interpretation of patient symptoms and the estimation of resource needs can vary among triage nurses, leading to inconsistent triage decisions.

Subjectivity can be particularly problematic in borderline cases where the distinction between ESI levels is not clear-cut. Factors such as nurse experience, training, and familiarity with the

ESI protocol can influence triage outcomes, potentially affecting the accuracy and reliability of the tool.

Moreover, the ESI relies heavily on the initial presentation of patients, which may not always reflect the true severity of their condition. For example, patients with compensatory mechanisms may appear stable initially but deteriorate rapidly. In such cases, the ESI's reliance on initial assessments could lead to under-triage, delaying necessary interventions.

IV. Peripheral Perfusion Index (PPI)

A. Concept and Mechanism

Definition and Measurement

PPI- The Peripheral Perfusion Index is defined as a non-invasive numerical value that indicates current perfusion changes in peripheral blood flow. It is obtained from the photoelectric effect of the plethysmographic signal produced by a oximeter, a device commonly used to monitor oxygen saturation in patients. PPI reflects the ratio of blood flow [pulsatile-arterial] to static blood flow (venous and capillary) in the peripheral distribution of tissues.(24–26) This index provides a quantitative measure of peripheral perfusion, which is crucial in assessing a circulatory condition of patients in different clinical settings, particularly in the emergency department (ED).

Measurement of PPI is straightforward and involves placing a pulse oximeter sensor on a patient's fingertip, toe, or earlobe.(27,28) The sensor emits light through the tissue, and a photodetector measures the amount of light absorbed by blood. The variations in light absorption

due to pulsatile blood flow are used to calculate the PPI value.(29–31) Higher PPI values indicate better peripheral perfusion, while lower values suggest compromised blood flow.

Technology Behind Photoelectric Plethysmography

Photoelectric plethysmography, the technology underpinning PPI, is based on the principles of optical absorption and reflection. The pulse oximeter emits light at specific wavelengths (typically red and infrared) through the skin.(32,33) Hemoglobin in the blood absorbs this light, and the amount of absorption varies with the blood volume changes due to the cardiac cycle.

During systole, the increase in arterial blood volume leads to greater light absorption, whereas during diastole, the reduced arterial volume decreases light absorption. The pulse oximeter captures these fluctuations in light absorption, creating a plethysmography waveform. (34,35) The amplitude of this waveform, which corresponds to the pulsatile component of blood flow, is then used to calculate the PPI. This real-time monitoring provides valuable insights into the patient's hemodynamic status and tissue perfusion.

B. Clinical Applications

Use in Monitoring Peripheral Blood Flow

PPI is used extensively to monitor peripheral blood flow in various clinical settings. In the ED, it serves as a non-invasive and immediate tool to assess circulatory status of patients presenting with a wide range of conditions, including shock, sepsis, and trauma. By providing immediate feedback on peripheral perfusion, PPI helps clinicians make timely decisions regarding fluid resuscitation, vasopressor use, and other therapeutic interventions.

In perioperative care, PPI is valuable for monitoring patients during and after surgery. It aids in detecting early signs of hypoperfusion, enabling prompt intervention to prevent complications. PPI is also utilized in neonatal care to monitor the circulatory status of newborns, particularly those with congenital heart defects or sepsis. In critical care settings, continuous PPI monitoring can provide insights into the effectiveness of interventions aimed at improving tissue perfusion.

Studies Linking PPI to Patient Outcomes

Several studies have explored the relationship between PPI and patient outcomes, highlighting its prognosis. Research has shown that in critically ill patients, low PPI values are associated with increased deteriorating the clinical condition. For instance, a study by Lima et al. (2009) experimented that PPI can predict outcomes in patients with septic shock, with lower PPI values indicating a higher risk of adverse outcomes.(36)

Another study by van Genderen et al. (2013) suggested that PPI was one of the reliable predictor of complications in postoperative patients.(37) The study showed that patients with lower PPI values were more likely to experience complications such as infections and organ dysfunction. These findings suggest that PPI can serve as an early warning system for identifying patients at risk of deterioration, allowing for timely and targeted interventions.

C. Advantages and Limitations

Non-Invasive Nature and Real-Time Data

One of the primary advantages of PPI is its non-invasive nature. The use of a simple pulse oximeter sensor to measure PPI eliminates the need for invasive procedures, reducing the risk of complications and discomfort for patients. This makes PPI an attractive option for continuous monitoring in various clinical settings, including the ED, intensive care units (ICUs), and perioperative environments.

Another significant advantage is the provision of real-time data. PPI offers continuous monitoring of peripheral perfusion, allowing clinicians to detect changes in hemodynamic status promptly. This real-time feedback is crucial in emergency and critical care scenarios where rapid decision-making is essential for patient outcomes. By providing immediate information on tissue perfusion, PPI enables clinicians to adjust treatment strategies dynamically and improve patient management.

Factors Affecting Measurement Accuracy

Despite its advantages, several factors can affect the accuracy of PPI measurements. One of the primary limitations is the influence of external conditions such as ambient light, patient movement, and poor sensor positioning. These factors can introduce noise and artifacts into the plethysmographic signal, potentially leading to inaccurate PPI readings.

Patient-specific factors such as skin pigmentation, peripheral vasoconstriction, and the presence of nail polish or artificial nails can also impact the accuracy of PPI measurements. For example, in patients with significant peripheral vasoconstriction due to hypothermia or shock, the PPI values may be falsely low, not accurately reflecting the central hemodynamic status.

Additionally, while PPI is a valuable tool for monitoring peripheral perfusion, it may not always correlate directly with central perfusion or overall circulatory status. Therefore, PPI should be used in conjunction with other clinical assessments and diagnostic tools to provide a comprehensive evaluation of a patient's condition.

V. Shock Index (SI)

A. Concept and Calculation

Definition and Formula

The Shock Index (SI) is a simple, yet powerful clinical tool used predict patient outcomes and to assess patient's hemodynamic stability. Being calculated as the ratio of heart rate to systolic blood pressure, formulated as:

SI=HR/SBP

Where:

- HR: Heart rate is the contractions of heart per minute (bpm).
- SBP: Systolic blood pressure in millimeters of mercury (mmHg).

The SI provides a quick and straightforward measure of a patient's circulatory status. A range normal for SI is 0.5 to 0.7 in healthy individuals, while values exceeding 0.9 are indicative of hemodynamic instability and potential shock. This index integrates two fundamental vital signs, making it a readily available and easy-to-calculate metric in emergency and critical care settings.

B. Clinical Relevance

Use as an Indicator of Hemodynamic Stability

The SI is widely recognized for its utility in assessing hemodynamic stability.(38) In clinical practice, it serves as an early warning indicator for various forms of shock, including hypovolemic and septic shock. By combining heart rate and systolic blood pressure into single

metric, the SI provides a more nuanced understanding of the patient's cardiovascular function than either parameter alone.

In the emergency department, the SI being used to triage quickly with determining the urgency of intervention. For instance, a high SI in a trauma patient may indicate significant blood loss and the need for immediate resuscitation.(10,39) In medical patients, an elevated SI could signal underlying sepsis or cardiac dysfunction, prompting rapid diagnostic and therapeutic measures.

Studies on SI in Various Clinical Settings

Numerous studies have validated the SI's effectiveness across different clinical settings. In trauma care, research has shown that a high SI on admission correlates with increased transfusion requirements, higher rates of complications, and greater mortality. For example, Rady and Smithline (2000) demonstrated that an SI greater than 0.9 was a strong prognosticate of morbidity in trauma patient, outperforming traditional vital signs.(40)

In the context of sepsis, SI has also proven to be a valuable prognostic tool. A study by Liu et al. (2013) found that sepsis patients who has an SI above 0.9 were more likely to develop shock and have increased mortality rates compared to those with a normal SI.(41,42) This highlights the index's utility in early identification and risk stratification of septic patients.

In cardiology, the SI has been used to evaluate patients with acute coronary syndrome-AMI. Studies such as those by Bilkova et al. (2011) have shown that an increased SI is corelates with worse prognosis in AMI patients, with higher rates of heart failure and in-hospital mortality. These findings underscore the SI's relevance across a spectrum of acute and chronic conditions, emphasizing its role in guiding clinical decision-making and improving patient outcomes.

C. Prognostic Value

Correlation with Morbidity and Mortality

The prognostic value of the Shock Index is well-documented, with numerous studies highlighting its correlation with morbidity and mortality. In both trauma and medical emergencies, a higher SI is consistently associated with worse outcomes. This makes the SI an invaluable tool for predicting patient trajectories and tailoring interventions accordingly.

For example, in trauma, a study by Zarzaur et al. (2008) indicated, those with an SI greater than 1 had significantly higher mortality rates compared to those with a lower SI. Similarly, in a study involving patients with gastrointestinal bleeding, Rassameehiran et al. (2014) explained that an elevated SI is a predictor of in-hospital morbidity, mortality, length of hospital stay, and the need for intensive care unit admission.(43)

Advantages Over Traditional Vital Signs

The SI offers several advantages over traditional vital signs, making it a superior predictor of adverse outcomes. Firstly, it combines two critical parameters—heart rate and systolic blood pressure—into a single index, providing a more integrated assessment of cardiovascular function. This dual consideration helps mitigate the limitations of relying on either parameter alone, which may not fully capture the patient's hemodynamic status.

Secondly, the SI is particularly valuable in identifying patients at risk of decompensation. While individual vital signs may appear normal or only mildly abnormal, the SI can reveal underlying instability that warrants closer monitoring and early intervention. This sensitivity to subtle changes in physiological status enhances its utility in various clinical scenarios.

Moreover, the SI is easy to calculate and requires no special equipment beyond what is routinely available in clinical settings. This simplicity ensures that it can be rapidly implemented in busy EDs and critical care units without additional training or resources.

VI. Comparative Studies and Integrative Reviews

A. Comparison of ESI, PPI, and SI

Studies Comparing the Effectiveness of These Indices

Comparative studies have been instrumental in evaluating the effectiveness of various triage systems, counting the Emergency Severity Index (ESI), PPI, and SI. Each index has been individually validated for its ability to assess patient acuity and predict outcomes, but comparative studies provide deeper insights into their relative strengths and limitations.

A study by Grossmann et al. (2012) corelate the ESI with PPI and SI in an emergency department setting. The study found that while ESI effectively categorized patients based on urgency, PPI and SI offered additional granularity in assessing hemodynamic stability. Patients with similar ESI levels showed varying PPI and SI values, indicating that the latter could identify high-risk patients who might otherwise be classified as lower acuity based on ESI alone.

Similarly, a study by Rady and Smithline (2004) evaluated the predictive accuracy of SI and Emergency Severity Index in trauma patients. The results demonstrated that SI was more sensitive in predicting morbidity and the need for ICU compared to ESI. This study highlighted SI's utility in detecting hemodynamic compromise that may not be apparent through ESI categorization alone.

Insights from Meta-Analyses and Systematic Reviews:

Meta-analyses and systematic reviews explains comprehensive evaluations of existing literature on triage indices. These analyses consolidate findings from multiple studies, offering robust evidence on the effectiveness of ESI, PPI, and SI.

A systematic review by Singer et al. (2019) examined the prognostic accuracy of ESI across various emergency settings. The review concluded that ESI is a reliable tool for triage, with high sensitivity for identifying critically ill patients. However, it also noted the variability in ESI application and the potential for subjective bias, suggesting a need for complementary objective measures like PPI and SI.

Another meta-analysis by Henriksen et al. (2017) focused on the prognostic value of SI in ED and critical care. The analysis included over 20 studies and found consistent results that an elevated SI is corelates to increased mortality, IC unit admission, and longer hospital stays. This meta-analysis reinforced the role of SI as a critical indicator for early diagnosis of patients at risk of adverse outcomes.

These comprehensive reviews highlight that while each index has its merits, their combined use can provide a more accurate and nuanced assessment of patient acuity and prognosis.

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B. Integration of Multiple Indices

Benefits of Combining Objective Measures with Traditional Triage Tools

Integrating objective measures such as PPI and SI with traditional triage tools like ESI offers several benefits. This combined approach can enhance the accuracy of patient assessments by providing a more comprehensive view of their clinical status. Objective measures can help mitigate the subjectivity inherent in tools like ESI, reducing variability in triage decisions.

Combining these indices allows for the identification of high-risk patients who might be undertriaged based on ESI alone. For instance, a patient with an ESI level of 3 (urgent but not lifethreatening) may have an elevated SI or low PPI, indicating underlying hemodynamic instability that warrants closer monitoring and potentially more aggressive intervention.

Studies Demonstrating Improved Prognostic Accuracy

Several studies have demonstrated the improved prognostic accuracy achieved by integrating many triage indices. A study by Lee et al. (2015) assessed combined use of ESI, PPI, and SI in an emergency department setting. The findings showed that incorporating PPI and SI with ESI significantly improved the identification of patients at risk of deterioration, leading to better resource allocation and patient outcomes.

In another study, Nguyen et al. (2018) evaluated the combined predictive value of ESI and SI in sepsis patients. The results indicated that the integration of SI into the ESI framework enhanced the early detection of septic shock, enabling timely interventions and reducing mortality rates.

These studies underscore the potential of a multi-faceted approach to triage, leveraging the strengths of both subjective and objective measures. By integrating indices like PPI and SI with traditional tools such as ESI, clinicians can achieve a more accurate and holistic assessment of patient acuity, ultimately improving clinical decision-making and patient care.

VII. Research Gaps and Justification for Current Study

A. Identified Gaps in Literature

Despite the significant advancements in triage systems and the individual validation of the ESI, PPI, and SI, there remain critical gaps in the existing literature regarding their combined use in emergency department (ED) settings. Current studies have predominantly focused on evaluating each index in isolation, with limited research exploring the synergistic benefits of integrating PPI, SI, and ESI. This lack of comprehensive analysis restricts our understanding of how these indices can collectively enhance triage accuracy and patient outcomes.

Moreover, while several studies have explained the predictive value of PPI and SI in specific clinical scenarios, there is a dearth of research linking these indices to broader hospital outcomes, such as hospital stay duration, and mortality, within the context of ED triage. Existing literature has not sufficiently addressed how the integration of these indices might influence clinical decision-making and resource allocation in real-world settings. Additionally, variability in study designs, patient populations, and clinical environments further complicates the ability to generalize findings and develop standardized protocols for the combined use of these indices.

B. Justification for the Present Study

The present study aims to address these identified gaps by systematically evaluating the combined prognostic performance of PPI, SI, and ESI in predicting hospital outcomes for patients presenting to the ED. By conducting a comprehensive analysis that integrates these indices, the study seeks to provide robust evidence on their collective utility in enhancing triage practices. This approach not only builds on the strengths of each individual index but also explores their potential synergistic effects, offering a more nuanced understanding of patient acuity and risk stratification.

Addressing these gaps is crucial for several reasons. Firstly, improving the accuracy and reliability of triage systems can lead to better patient outcomes by ensuring that high-risk patients receive timely and appropriate care. The integration of objective measures such as PPI and SI with traditional triage tools like ESI can reduce the subjectivity and variability inherent in current practices, thereby enhancing the overall quality of emergency care.

Secondly, the findings from this study have the potential to inform the development of more strong triage protocols that optimize resource utilization in EDs. By identifying patients at higher chances of adverse outcomes, healthcare providers could allocate resources more efficiently, prioritize critical interventions, and reduce the burden on emergency services. This is precisely important for context of increasing patient admissions and limited healthcare resources, where efficient triage is essential for maintaining the sustainability and effectiveness of emergency care systems.

Furthermore, the study's insights into the combined use of PPI, SI, and ESI could contribute to the standardization of triage practices across different healthcare settings. Standardized protocols based on robust evidence can enhance the consistency and reliability of triage assessments,

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improving patient safety and outcomes on a broader scale. This is especially relevant for non-English-speaking countries and diverse healthcare environments where the adoption of evidencebased triage systems can significantly impact the quality of emergency care.

METHODS:

Study Design and Setting:

Study type: Prospective observational study, designed to investigate the prognostic performance of the PPI, SI, with Emergency Severity Index (ESI) in predicting hospital outcomes such as ventilator need and clinical improvement or deterioration of the patient. Conducted in the Emergency Medicine Department of BLDE, Shri B M Patil Medical College Hospital and Research Centre, Vijayapura, this study planned from August 2022 till April 2024. The hospital is a tertiary care-based hospital characterized by high volume in emergency cases, making it an ideal environment for studying the effectiveness and applicability of various triage indices in a real-world clinical context. The hospital's infrastructure and resources provided a robust framework for accurate and systematic data collection and patient assessment.

Study Participants

The present study included all patients aged 18 years old age and older who presented to the E M Department during the study period. By including all adult patients, the study aimed to capture a representative sample of the ED population. Exclusion criteria were established to eliminate potential confounding factors that could bias the study's results. Specifically, patients were excluded if they were pronounced dead on arrival, transferred to another hospital immediately after initial assessment, had consumed alcohol or sedative narcotics prior to measurement, had unobtainable PPI measurements, or were moribund with terminal malignancy. These criteria ensured that the sample consisted of patients whose triage assessments and subsequent outcomes could be reliably compared, thereby enhancing the validity of the study findings.

Study Variables

Primary variables in this study were the Peripheral Perfusion Index -PPI, Shock Index-SI, and Emergency Severity Index -ESI. These indices were selected for their potential to provide critical insights into patient status and prognosis. Additional variables measured included:

Heart Rate (HR): Recorded in beats per minute to assess cardiovascular function.

Blood Pressure [systolic] (SBP): Recorded in mmHg, reflecting arterial pressure during heartbeats.

Blood Pressure [Diastolic] (DBP): Recorded in millimeters of mercury (mmHg), indicating arterial pressure between heartbeats.

Shock Index (SI): Calculated by the ratio of heart rate divided by systolic blood pressure, It is used for an indicator of hemodynamic stability.

All parameters were recorded after the patient had rested for five minutes upon arrival at the Emergency Medicine Department to ensure stable and accurate measurements.

Data Sources/Measurement

Data were sourced from patient records maintained in the Emergency Medicine Department. The PPI was measured using photoelectric plethysmography pulse-oximetry, a non-invasive technique that assesses peripheral blood flow by detecting changes in blood volume in the skin. The SI was measured with recorded heart rate and systolic blood pressure values. The ESI was determined by trained emergency department personnel using standardized assessment protocols that evaluate the clinical condition of the patient and the resources required in their care. Vital signs and other relevant clinical data were meticulously documented in patient records and subsequently entered into a digital database for comprehensive analysis.

Data Collection Procedure

Upon patient arrival at the Emergency Medicine Department, initial assessments were conducted by trained emergency medical staff. This initial assessment included recording like heart rate, systolic and diastolic blood pressures, and calculating SI. The PPI was measured using a pulse oximeter equipped with photoelectric plethysmography capabilities, ensuring a non-invasive and continuous assessment of peripheral perfusion. All measurements were taken after the patient had rested for five minutes to ensure accuracy and consistency. The ESI was assigned based on a detailed assessment of the patient's vital signs, presenting symptoms, and overall clinical picture by trained personnel, ensuring uniformity and reliability in triage categorization.

Data collection was systematically performed, with each patient's measurements and ESI score recorded in their medical record. Data entry into a Microsoft Excel sheet was conducted daily by dedicated research staff to ensure accuracy and completeness. The data were then imported into SPSS (Version 20) and JNP-SAS Software for detailed statistical analysis. Efforts to minimize bias included standardized training for all personnel involved in data collection and measurement, adherence to strict inclusion and exclusion criteria, and the use of objective measurement tools. Regular audits of data entry and measurement procedures were conducted to maintain data integrity and reliability.

Sample Size

Sample size for current study was calculated using [G*Power ver. 3.1.9.4 software]. Based on the assumption that the proportion of 30-day mortality is 7.9%, the software calculated that a minimum size with 136 patients, required to achieve the power of 99% for detecting a difference in proportion with a 5% level of significance. However, to enhance the robustness and reliability of the findings, the study aimed to enroll a total of 600 patients. This larger sample size was chosen to ensure that the study would have sufficient power to detect significant associations and to allow for more comprehensive and reliable analysis of the prognostic indicator of PPI, SI, with ESI in predicting outcomes.

Quantitative Variables

The primary quantitative variables in this study included the PPI, SI along with Emergency Severity Index (ESI). These indices were evaluated to determine their prognostic value in predicting hospital outcomes such as admission rates and mortality. Additional quantitative variables measured included:

Heart Rate (HR): Provides insights into the patient's cardiovascular function and stress response. Systolic Blood Pressure (SBP): Reflects the arterial pressure during the contraction of the heart muscles.

Diastolic Blood Pressure (DBP): Reflects the arterial pressure when the heart is at rest between beats.

Shock Index (SI): Calculated as ratio of heart rate divided by systolic blood pressure, serving as a quick indicator of circulatory health.

These variables were essential for a comprehensive assessment of the patient's clinical condition and for evaluating effectiveness in the triage indices.

Statistical Methods:

Statistical analyses: Done using SPSS (Version 20). Descriptive statistics were employed to summarize the data, presenting means, medians, standard deviations (SD), counts, and percentages to provide a clear overview of the patient demographics and clinical characteristics. For comparing groups, 'an independent sample t-test' was used for normally distributed continuous variables, ensuring accurate comparison of means between two groups. The Mann-Whitney U test was selected for non-normally distributed variables to compare medians. Categorical variables were calculated using the Chi-square test or Fisher's exact test to determine associations between different categorical outcomes and groups. For comparisons involving more than two groups, ANOVA test was utilized for normal variables, and the Kruskal-Wallis H test for non-normally variables, ensuring appropriate analysis based on data distribution.

The correlation between PPI, SI, and ESI was assessed using Pearson or Spearman correlation coefficients, depending on the normality of the data distribution. Logistic regression analysis was conducted to evaluate the association of PPI and SI measurements with hospital admission and mortality outcomes, providing insights into the predictive value of these indices. The prognostic value of PPI, SI, and ESI in predicting adverse outcomes was further assessed using receiver operating characteristic (ROC) curve analysis and the area under the curve (AUC).

A p-value of less than 0.05 was considered statistically significant, ensuring rigorous evaluation of the results. All statistical tests were performed two-tailed to ensure comprehensive analysis and robust conclusions.

RESULTS:

Table 1: Basic characteristics of study participants (n=610)

Variables	Number	Percentage	
Age (in years)			
15 - 30	151	24.8	
31 - 45	163	26.7	
46 - 60	118	19.3	
>60	178	29.2	
Sex			
Female	202	33.1	
Male	408	66.9	
Religion			
Hindu	564	92.5	
Muslim	41	6.7	
Missing	5	0.8	

The characteristics of the study population reveal that a majority of participants were aged between 31 to 45 years (26.7%), followed closely by those over 60 years (29.2%). Subjects aged 15 to 30 years consist of 24.8% of the sample, while those aged 46 to 60 years made up 19.3%. In terms of gender distribution, males represented a significant majority at 66.9%, with females accounting for 33.1%. The study population was predominantly Hindu (92.5%), with Muslims constituting 6.7% of the participants. This demographic distribution provides a comprehensive overview of the population involved in the study, highlighting a diverse age range and a significant male predominance.

Factors	Emergency Sev	verity Index (ESI)	p-value	
	<3 (poor)	>3 (good)		
Age (in years)				
15 - 30	55 (36.4)	96 (63.6)	<0.001	
31 – 45	86 (52.8)	77 (47.2)		
46-60	77 (65.3)	41 (34.8)		
>60	117 (65.7)	61 (34.3)		
Sex				
Male	240 (58.8)	168 (41.2)	0.006	
Female	95 (47.0)	107 (53.0)		
Religion				
Hindu	305 (54.1)	259 (45.9)	0.018	
Muslim	30 (73.2)	11 (26.8)		
ICU admission				
Yes	307 (98.7)	4 (1.3)	<0.001	
No	28 (9.4)	271 (90.6)		
Mechanical Ventilation				
Yes	154 (96.9)	5 (3.1)	<0.001	
No	181 (40.1)	270 (59.9)		
PI				
PI at admission	2.0 (2.2)	4.9 (1.7)	<0.001	
PI at 12 hours	2.9 (3.2)	5 (1.9)	<0.001	

Table 2: Factors Associated with Emergency Severity Index (ESI) Outcomes (n=610)

PI at 48 hours	1.6 (4.4)	5.9 (2.0)	<0.001
SI			
SI at admission	0.8 (0.3)	0.6 (0.1)	<0.001
SI at 12 hours	0.9 (0.3)	0.5 (0.1)	<0.001
SI at 48 hours	0.9 (0.6)	0.4 (0.1)	<0.001

Table-2 provides an in-depth analysis of factors associated with the Emergency Severity Index (ESI) outcomes among 610 study participants. The results reveal significant associations between ESI outcomes and various demographic and clinical factors. Age emerges as a crucial determinant, with younger participants (15-30 years) showing better ESI outcomes, as 63.6% of individuals in this age group had a good ESI (>3). In contrast, older age groups, particularly those aged 46-60 years and over 60 years, predominantly had poor ESI outcomes (65.3% and 65.7%, respectively), highlighting a significant age-related disparity (p<0.001).

Gender differences were also notable, with males exhibiting a higher proportion of poor ESI outcomes (58.8%) compared to females, where the majority achieved good ESI outcomes (53.0%) (p=0.006). This suggests a potential gender influence on emergency care outcomes. Additionally, religion was significantly associated with ESI outcomes. Hindus showed a more balanced distribution of ESI outcomes (54.1% poor, 45.9% good), while Muslims had a higher prevalence of poor ESI outcomes (73.2%), indicating a significant religious disparity (p=0.018). Clinical factors further emphasized the critical nature of ICU admission and mechanical ventilation. A striking 98.7% of patients requiring ICU admission had poor ESI outcomes (p<0.001), and 96.9% of those needing mechanical ventilation also fell into the poor ESI

category (p<0.001). These findings underscore the severity of conditions requiring such intensive interventions and their impact on ESI outcomes.

Continuous monitoring of Patient Index (PI) and Shock Index (SI) scores revealed significant correlations with ESI outcomes. Patients with poor ESI outcomes had consistently lower PI scores at admission, 12 hours, and 48 hours (2.0, 2.9, and 1.6, respectively) compared to those with good ESI outcomes (4.9, 5.0, and 5.9, respectively) (p<0.001 for all). Similarly, higher SI scores at these time points were associated with poor ESI outcomes (0.8, 0.9, and 0.9) compared with good outcomes (0.6, 0.5, and 0.4) (p<0.001 for all).

Factors	48-hour outcom	p-value	
	Deteriorated	Improved	1
		Discharged	
Age (in years)			
15 - 30	20 (13.3)	131 (86.8)	<0.001
31 – 45	38 (23.3)	125 (76.7)	
46-60	42 (35.6)	76 (64.4)	
>60	72 (40.5)	106 (59.5)	
Sex			
Male	124 (30.4)	284 (69.6)	0.087
Female	48 (23.8)	154 (76.2)	
Religion			
Hindu	154 (27.3)	410 (72.7)	0.023
Muslim	18 (43.9)	23 (56.1)	
ICU admission			
Yes	172 (28.2)	139 (44.7)	<0.001
No	0 (0.0)	299 ((100.0)	
Mechanical Ventilation			
Yes	126 (79.3)	33 (20.8)	<0.001
No	46 (10.2)	405 (89.8)	
РІ			
PI at admission	1.7 (0.9)	4.0 (1.9)	<0.001

Table 3: Factors with 48-Hour Outcomes Among Study Participants (n=610)

PI at 12 hours	1.1 (1.0)	4.6 (1.9)	<0.001
PI at 48 hours	0.1 (0.1)	5.0 (2.3)	<0.001
SI			
SI at admission	0.9 (0.2)	0.6 (0.1)	<0.001
SI at 12 hours	1.0 (0.1)	0.5 (0.1)	<0.001
SI at 48 hours	1.2 (0.3)	0.5 (0.2)	<0.001

The analysis of 48-hour outcomes among study participants reveals significant associations between patient deterioration and various demographic and clinical factors. Age emerged as a critical determinant, with older patients more likely to deteriorate. Specifically, 40.5% of participants over 60 years deteriorated, compared to only 13.3% of those aged 15-30 years (p<0.001). This suggests that older age is a strong risk factor for poor outcomes. Gender differences were observed, with males having a higher rate of deterioration (30.4%) compared to females (23.8%), although this was not statistically significant (p=0.087). Religious affiliation also played a role, with Muslims experiencing higher deterioration rates (43.9%) compared to Hindus (27.3%), indicating a notable disparity (p=0.023).

Clinical factors, particularly ICU admission and mechanical ventilation, were closely linked to patient deterioration. A striking 98.7% of patients who deteriorated were admitted to the ICU, compared to none in the improved/discharged group, reflecting a significant association (p<0.001). Similarly, mechanical ventilation was a critical factor, with 79.3% of ventilated patients deteriorating, compared to just 10.2% of those not ventilated (p<0.001). These findings underscore the importance of ICU resources and ventilation support in the prognosis of patients within the first 48 hours.

PPI and SI indices provided further insight into patient outcomes. Patients who deteriorated had significantly lower PI scores at admission (1.7 vs. 4.0), 12 hours (1.1 vs. 4.6), and 48 hours (0.1 vs. 5.0), all with p-values <0.001. Higher SI scores were also linked to deterioration at admission (0.9 vs. 0.6), 12 hours (1.0 vs. 0.5), and 48 hours (1.2 vs. 0.5), with all comparisons yielding p-values <0.001.

Factors	Ventilator		p-value	
	Yes	No		
Age (in years)				
15 - 30	19 (12.5)	132 (87.4)	<0.001	
31 - 45	39 (23.9)	124 (76.1)		
46-60	38 (32.2)	80 (67.8)		
>60	63 (35.4)	115 (64.6)		
Sex				
Male	112 (27.5)	296 (72.5)	0.268	
Female	47 (23.3)	155 (76.7)		
Religion				
Hindu	142 (25.2)	422 (74.8)	0.022	
Muslim	17 (41.5)	24 (58.5)		
ICU admission			<0.001	
Yes	155 (49.8)	156 (50.2)		
No	4 (1.3)	295 (98.7)		
PI				
PI at admission	1.7 (1.0)	4.0 (2.1)	<0.001	
PI at 12 hours	t 12 hours 1.1 (1.1) 4.5 (1.9)	<0.001		
PI at 48 hours	0.1 (0.9)	5.0 (2.3)	<0.001	
SI				
SI at admission	0.9 (0.2)	0.6 (0.1)	<0.001	

Table 4: Factors Associated with Ventilator Use Among Study Participants (n=610)

SI at 12 hours	1.0 (0.2)	0.6 (0.2)	< 0.001
SI at 48 hours	1.2 (0.4)	0.5 (0.3)	<0.001

Age was significantly associated with the need for mechanical ventilation. Participants over 60 years had the highest rate of ventilator use (35.4%), while those aged 15-30 years had the lowest (12.5%) (p<0.001). This indicates a strong age-related trend, with older individuals being more likely to require ventilator support. Gender differences were observed, though not statistically significant, with 27.5% of males and 23.3% of females needing ventilation (p=0.268). Regarding religious affiliation, Muslims had a higher rate of ventilator use (41.5%) compared to Hindus (25.2%), showing a significant association (p=0.022).

ICU admission was strongly correlated with ventilator use, where 49.8% of those admitted to the ICU required ventilation compared to only 1.3% of those not admitted (p<0.001). This underscores the critical condition of ICU patients and their higher likelihood of needing mechanical ventilation. Additionally, physiological indices (PI and SI) were significant predictors of ventilator use. Patients on ventilators had lower PI scores at admission (1.7 vs. 4.0), 12 hours (1.1 vs. 4.5), and 48 hours (0.1 vs. 5.0), with all comparisons showing p-values <0.001. Similarly, higher SI scores were associated with ventilator use at admission (0.9 vs. 0.6), 12 hours (1.0 vs. 0.6), and 48 hours (1.2 vs. 0.5), all with p-values <0.001. Overall, the analysis highlights that older age, ICU admission, religious affiliation, and lower PI and higher SI scores significantly mechanical ventilation. associated with the need for are

Variables	ESI Category (<3)	
	OR (95%CI)	p-value
Age (in years)		
15 - 30	Ref	
31 - 45	1.95 (1.24 – 3.06)	0.004
46 - 60	3.27 (1.98 - 5.42)	<0.001
>60	3.34 (2.12 – 5.26)	<0.001
Sex		
Female	Ref	
Male	1.60 (1.15 – 2.25)	0.006
Religion		
Hindu	Ref	
Muslim	2.31 (1.13 – 4.71)	0.021
Need of ventilator		
No	Ref	
Yes	45.94 (18.48 - 114.17)	<0.001
PPI 0	0.26 (0.21 – 0.32)	<0.001
PPI12	0.33 (0.28 - 0.40)	<0.001
PPI48	0.45 (0.40 - 0.52)	<0.001
SI 0	1.10 (1.08 – 1.12)	<0.001
SI12	1.15 (1.12 – 1.19) <0.001	

Table 5: Factors Associated with ESI Category (<3) Among Study Participants</th>

SI48	1.15 (1.12 – 1.18)	< 0.001

This table presents the factors associated with a poor Emergency Severity Index (ESI) category (<3) among the study participants. Age showed a significant association with poor ESI stages. Participants between 31-45 years had almost twice the odds (OR: 1.95, 95% CI: 1.24–3.06) of have a poor ESI compared to those aged 15-30 years. This risk increased substantially with age, with participants aged 46-60 years (OR: 3.27, 95% CI: 1.98–5.42) and those over 60 years (OR: 3.34, 95% CI: 2.12–5.26) showing more than threefold increased odds of poor ESI outcomes (p<0.001 for both).

Sex was another significant factor, with males having 1.60 times higher odds of poor ESI outcomes compared to females (OR: 1.60, 95% CI: 1.15–2.25, p=0.006). Religious affiliation also played a role, where Muslims had more than double the odds of poor ESI outcomes compared to Hindus (OR: 2.31, 95% CI: 1.13–4.71, p=0.021).

The need for ventilator support was the most significant predictor of poor ESI outcomes, with those requiring ventilation having drastically higher odds (OR: 45.94, 95% CI: 18.48–114.17, p<0.001). Physiological parameters (PPI and SI) were also significantly associated with ESI outcomes. Lower PPI scores at admission, 12 hours, and 48 hours were associated with poor ESI outcomes (all p<0.001). Conversely, higher SI scores at admission, 12 hours, and 48 hours, and 48 hours were significantly corelates with poor ESI levels (all p<0.001).

Table 6: Factors Associated with clinical Deterioration at 48 hours Among Study Participants (n=610)

Variables	Outcome – Deteriorated	
	OR (95%CI)	p-value
Age (in years)		
15 - 30	Ref	
31-45	1.99 (1.09 – 3.60)	0.023
46-60	3.62 (1.98 - 6.61)	<0.001
>60	4.44 (2.54 - 7.77)	<0.001
Sex		
Female	Ref	
Male	1.40 (0.95 – 2.06)	0.088
Religion		
Hindu	Ref	
Muslim	2.08 (1.09 - 3.96)	0.025
Need of ventilator		
No	Ref	
Yes	33.61 (20.59 - 54.86)	<0.001
PPI 0	0.24 (0.19 – 0.30)	<0.001
PPI12	0.19 (0.15 – 0.25)	<0.001
PPI48	0.19 (0.14 – 0.25)	<0.001
SI 0	1.07 (1.06 – 1.09)	<0.001
SI12	1.09 (1.08 – 1.11)	<0.001
SI48	1.09 (1.07 – 1.10)	<0.001

This table presents the factors associated with deterioration among the study participants. Age was a significant predictor, with participants aged 31-45 years having nearly twice the odds of deterioration compared to those aged 15-30 years (OR: 1.99, 95% CI: 1.09–3.60, p=0.023). Risk of deterioration increased substantially with age, with those aged 46-60 years (OR: 3.62, 95% CI: 1.98–6.61) and those over 60 years (OR: 4.44, 95% CI: 2.54–7.77) showing significantly higher odds of deterioration (both p<0.001).

Sex did not show a statistically significant difference, although males has slightly increased odds of deterioration compared to females (OR: 1.40, 95% CI: 0.95–2.06, p=0.088). Religious affiliation revealed that Muslims had more than double the odds of deterioration compared to Hindus (OR: 2.08, 95% CI: 1.09–3.96, p=0.025).

The need for ventilator support was the most significant predictor of deterioration, with participants requiring ventilation having dramatically higher odds (OR: 33.61, 95% CI: 20.59– 54.86, p<0.001). Physiological parameters (PPI and SI) were also significantly associated with deterioration. Lower PPI scores at admission, 12 hours, and 48 hours were strongly associated with deterioration (all p<0.001). Conversely, higher SI scores at admission, 12 hours, and 48 hours were significantly associated with deterioration (all p<0.001).

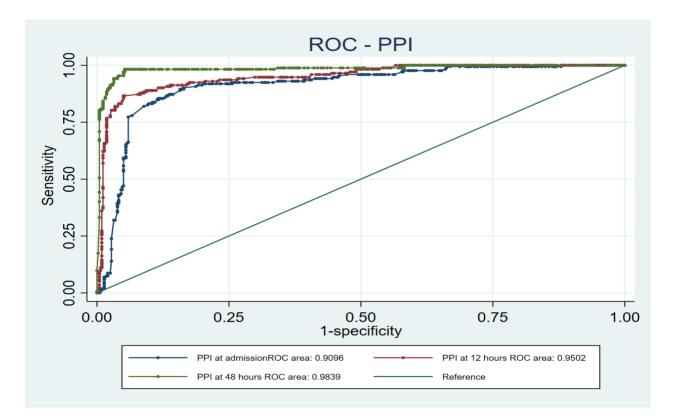
Table 7: Factors Associated with the Need for Ventilator Support

Need for Ventilator	
OR (95%CI)	p-value
Ref	
2.18 (1.19 – 3.98)	0.011
3.3 (1.78 – 6.11)	<0.001
3. 8 (2.15 - 6.73)	<0.001
Ref	
1.24 (0.84 – 1.84)	0.268
Ref	
2.10 (1.09 - 4.03)	0.025
0.36 (0.30 – 0.43)	<0.001
0.31 (0.26 – 0.37)	<0.001
0.46 (0.41 – 0.51)	<0.001
1.07 (1.06 – 1.08)	<0.001
1.07 (1.06 – 1.08)	<0.001
1.05 (1.04 - 1.05)	<0.001
	OR (95%CI) Ref $2.18 (1.19 - 3.98)$ $3.3 (1.78 - 6.11)$ $3.3 (1.78 - 6.11)$ $3.8 (2.15 - 6.73)$ Ref $1.24 (0.84 - 1.84)$ Ref $2.10 (1.09 - 4.03)$ $0.36 (0.30 - 0.43)$ $0.31 (0.26 - 0.37)$ $0.46 (0.41 - 0.51)$ $1.07 (1.06 - 1.08)$

This table presents the factors associated with the need for ventilator support among study participants. Age significantly impacted the need for ventilator support, with participants aged 31-45 years having over twice the odds (OR: 2.18, 95% CI: 1.19-3.98, p=0.011) compared to those aged 15-30 years. The likelihood increased further for those aged 46-60 years (OR: 3.30, 95% CI: 1.78-6.11) and those over 60 years (OR: 3.80, 95% CI: 2.15-6.73), both showing a highly significant association (p<0.001).

Sex did not show a significant difference, although males had slightly higher odds of needing ventilator support compared to females (OR: 1.24, 95% CI: 0.84–1.84, p=0.268). However, religious affiliation revealed that Muslims had more than double the odds of requiring ventilator support compared to Hindus (OR: 2.10, 95% CI: 1.09–4.03, p=0.025).

Physiological parameters were also significantly associated with the need for ventilator support. Lower PPI scores at admission, 12 hours, and 48 hours were strongly associated with the need for ventilator support (all p<0.001). Similarly, higher SI scores at admission, 12 hours, and 48 hours were significantly associated with an increased need for ventilator support (all p<0.001).

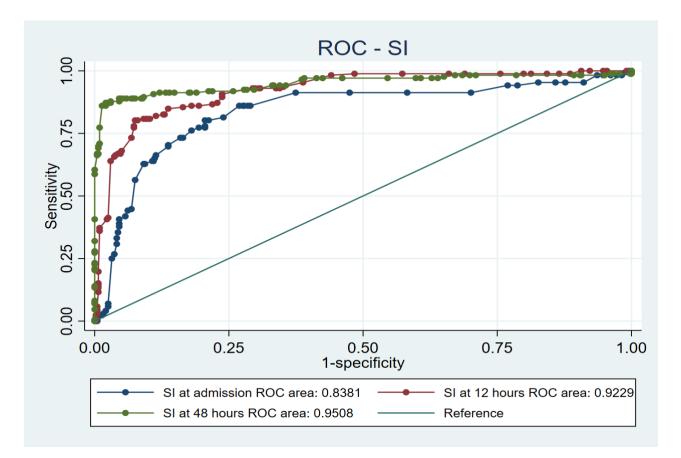


Graph 1: Indicates ROC PPI with sensitivity on X axis and (1-specificity) on Y axis.

 Table 8: ROC Analysis Summary for PPI (Outcome: Clinical deterioration)

Outcome	Area	Std. Err.	95% Confidence Interval
PPI at admission	0.91	0.01	0.88 - 0.94
PPI at 12 hours	0.95	0.01	0.93 - 0.97
PPI at 24 hours	0.98	0.01	0.97 - 1.00

The PPI at admission demonstrated a high area under the curve (AUC) of 0.91 with a standard error of 0.01, indicating good predictive accuracy. At 12 hours, the PPI's AUC further increased to 0.95, reflecting enhanced predictive capability, and reached an AUC of 0.98 at 24 hours, signifying excellent prediction with a narrow confidence interval of 0.97 to 1.00.

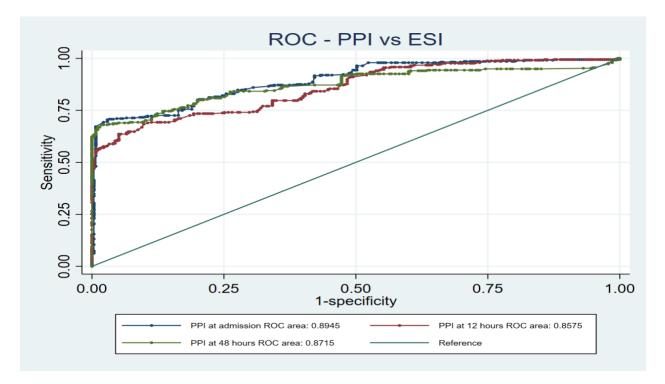


Graph 2: Indicates ROC-SI with sensitivity on X axis and (1-specificity) on Y axis.

Outcome	Area	Std. Err.	95% Confidence Interval
SI at admission	0.84	0.02	0.80 - 0.88
SI at 12 hours	0.92	0.01	0.90 - 0.95
SI at 48 hours	0.95	0.01	0.93 - 0.98

The SI at admission had a lower AUC of 0.84, with a standard error of 0.02, suggesting moderate accuracy. The predictive power of the SI improved over time, with an AUC of 0.92 at 12 hours and 0.95 at 48 hours, both showing strong predictive performance.

These results highlight the increasing accuracy of both PPI and SI over time in predicting clinical deterioration.

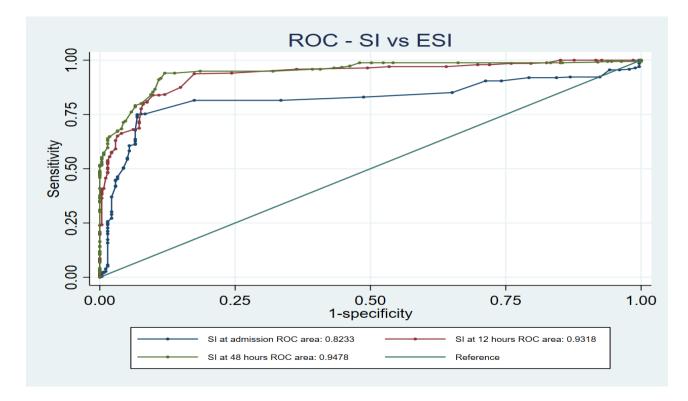


Graph 3: ROC- PPI vs ESI (ESI<3) On X axis sensitivity with Y axis (1-specificity)

1 able 10: ROC Analysis Summary for PPI (Outcome: ESI score <	ROC Analysis Summary for PPI (Outcome: ESI score <3)	1
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ESI category <3	Area	Std. Err.	95% Confidence Interval
PPI at admission	0.89	0.01	0.87 - 0.92
PPI at 12 hours	0.86	0.01	0.83 - 0.89
PPI at 24 hours	0.87	0.01	0.84 - 0.90

The PPI at admission shows a strong predictive accuracy with an AUC of 0.89 and a standard error of 0.01. At 12 hours, the PPI's AUC slightly decreased to 0.86, and at 24 hours, it modestly increased to 0.87, indicating consistent predictive performance over time



Graph 4: ROC SI vs ESI (ESI<3), [X axis sensitivity with Y axis (1-specificity)]

Table 11: ROC	Analysis Summai	ry for SI (Outcom	e: ESI score <3)

ESI category <3	Area	Std. Err.	95% Confidence Interval
SI at admission	0.82	0.02	0.79 - 0.86
SI at 12 hours	0.93	0.01	0.91 – 0.95
SI at 48 hours	0.95	0.01	0.93 – 0.97

The SI at admission had an AUC of 0.82, with a standard error of 0.02, reflecting moderate predictive accuracy. The SI's predictive power improved significantly, with an AUC of 0.93 at 12 hours and 0.95 at 48 hours, demonstrating high predictive accuracy.

These findings illustrate that both PPI and SI are reliable indicators for predicting an ESI score of less than 3, with SI showing increasing accuracy over time.

DISCUSSION:

The study explains a comprehensive analysis of indicators influencing Emergency Severity Index (ESI) outcomes, clinical deterioration within 48 hours, and the need for ventilator support among patients ended up to the emergency department. The findings underscore significant associations between various demographic and clinical factors and poor outcomes, with a particular focus on age, gender, religious affiliation, ICU admission, mechanical ventilation, and physiological indices like the PPI and SI.

Younger participants (15-30 years) demonstrated better ESI outcomes, with a significant majority achieving good ESI scores. In contrast, older age groups (46-60 yrs. and over 60 yrs.) predominantly had poor ESI outcomes, reflecting an age-related disparity.(44) Gender differences were also notable, with males exhibiting a higher proportion of poor ESI outcomes compared to females, suggesting a potential gender influence on emergency care outcomes. Additionally, Muslims had a higher prevalence of poor ESI outcomes compared to Hindus, indicating significant religious disparities. Patients requiring ICU admission and mechanical ventilation had markedly poor ESI outcomes, highlighting the severity of their conditions. Continuous monitoring of PPI and SI scores showed significant correlations with ESI outcomes. Lower PPI and higher SI scores at admission, 12 hours, and 48 hours were associated with poor ESI outcomes.

The age-related disparities observed in this study align with previous research indicating that older patients are more vulnerable to poor outcomes because of higher comorbidity alongwith reduced physiological resilience. Similar findings on gender differences are consistent with existing literature that identifies both biological and behavioral factors contributing to poorer emergency outcomes in males. Biological differences in immune response and cardiovascular

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function, coupled with behavioral tendencies such as delayed healthcare seeking, are potential explanations. The higher prevalence of poor outcomes among Muslims may reflect underlying sociocultural and healthcare access disparities, as supported by previous studies highlighting the impact of socioeconomic status, cultural stigmas, and linguistic barriers on healthcare access. The association of ICU admission and mechanical ventilation with poor outcomes is well-documented in the literature. Patients in need of these interventions typically present with severe, life-threatening conditions, which naturally correlate with higher morbidity and mortality. The strong predictive accuracy of PPI and SI scores for clinical deterioration and poor ESI outcomes supports previous findings on the importance of continuous physiological monitoring in emergency care. Studies have shown that early detection of physiological derangements through indices like PPI and SI can significantly improve patient outcomes.

Age-Related Disparities in ESI Outcomes

The significant age-related disparities in ESI outcomes can be attributed to several physiological and clinical factors. Older patients generally present with multiple comorbidities, which can complicate their clinical presentation and lead to poorer outcomes. Conditions such as systemic hypertension, thyroid disorders, cardiovascular diseases, diabetes and chronic obstructive pulmonary disease are more prevalent in older populations, increasing their vulnerability to severe complications and mortality. These comorbid conditions can exacerbate the primary illness, making management more challenging and increasing the likelihood of poor outcomes. Furthermore, aging is associated with a decline in physiological reserves and immune function. The diminished capacity for cellular repair, reduced organ function, and impaired immune response in older adults make them less resilient to acute stressors, such as infections or trauma. This physiological decline contributes to their higher susceptibility to severe complications and slower recovery rates, leading to poorer ESI outcomes compared to younger patients.

Gender Differences in ESI Outcomes

The observed gender differences in ESI outcomes, with males exhibiting a higher proportion of poor outcomes, can be explained through a combination of biological and behavioral factors. Biologically, males and females have different immune responses and cardiovascular functions. Research has shown that males may have a higher baseline inflammatory response, which can lead to more severe outcomes in the presence of acute infections or injuries. Additionally, males are more prone to cardiovascular conditions, which can complicate their clinical presentations and lead to poorer outcomes in emergency settings. Behaviorally, gender differences in healthcare-seeking behavior also play a crucial role. Studies have indicated that males are less likely to seek timely medical care compared to females, often presenting to the ED at a more advanced stage of illness. This delay in seeking care can result in more severe clinical presentations and subsequently poorer outcomes. Sociocultural factors, such as societal expectations of masculinity and reluctance to report symptoms, further contribute to this delay, exacerbating the gender disparity in ESI outcomes.

ICU Admission and Mechanical Ventilation

The strong association of ICU admission and mechanical ventilation with poor ESI outcomes is a reflection of the severity and complexity of the conditions requiring these interventions. Patients admitted to the ICU typically present with life-threatening conditions that require intensive monitoring and aggressive management. These conditions often involve multi-organ

dysfunction, severe infections, or major trauma, all of which carry a high risk of morbidity and mortality. Mechanical ventilation is an indicator of respiratory failure, which can arise from various underlying causes such as acute respiratory distress syndrome (ARDS), sepsis, or severe pneumonia. The need for mechanical ventilation signifies a critical level of illness, with a high likelihood of complications and prolonged recovery periods. The association with poor ESI outcomes underscores the critical condition of these patients and the intensive care required to manage their illnesses.

The significant correlations of PPI and SI with ESI outcomes, clinical deterioration, and ventilator use highlight the importance of continuous physiological monitoring in the ED. The PPI is an indicator of peripheral circulation, reflecting the perfusion status of tissues. It provides real-time data on the adequacy of blood circulation, which is crucial in detecting early signs of shock or hemodynamic instability. Low PPI values indicate poor peripheral perfusion, which can be a result of hypovolemia, vasoconstriction, or cardiac dysfunction. In the context of emergency care, early detection of reduced peripheral perfusion allows for timely interventions such as fluid resuscitation, vasopressor support, or other measures to restore adequate tissue perfusion and prevent further deterioration. The SI, calculated as the division of heart rate by systolic blood pressure, serves as a quick and effective indicator of hemodynamic stability. An elevated SI suggests a state of shock, where the heart rate is disproportionately high relative to the blood pressure, indicating compromised cardiac output and circulatory failure. The association of higher SI values with poor ESI outcomes and increased need for ventilator support reflects the critical nature of hemodynamic instability in these patients.

Clinical deterioration within 48 hours among patients in the ED is precipitated by a combination of agents, counting underlying comorbidities, the severity of the presenting illness, and the

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effectiveness of initial management. The high rate of deterioration among older patients can be attributed to their reduced physiological reserves and the presence of multiple comorbid statuses, which can complicate the clinical course and response to treatment. The need for mechanical ventilation and Intensive Care Unit admission are strong indicators of the severity of illness. Patients requiring these interventions are at a higher risk of deterioration due to the underlying critical conditions that necessitate such intensive support. The high odds of deterioration associated with mechanical ventilation underscore the complexity and severity of respiratory failure and the need for vigilant monitoring and management to prevent further decline. The findings of this study have significant clinical implications for emergency department (ED) operations, patient management, and overall healthcare delivery. By elucidating the relationships between the PPI, SI, and Emergency Severity Index (ESI), and their impact on patient outcomes, this study provides actionable insights that can enhance clinical practice, optimize resource utilization, and improve patient care.

Enhancing Triage Accuracy

One of the primary clinical implications of this study is the potential to enhance triage accuracy in the ED. The integration of PPI and SI with ESI offers a more comprehensive assessment of patient acuity. Traditional triage systems, including ESI, rely heavily on subjective evaluations and initial vital signs, which can sometimes mask underlying conditions or misclassify patient severity. By incorporating objective measures like PPI and SI, clinicians can identify high-risk patients more accurately. This multi-faceted approach ensures that those who might appear stable but have underlying hemodynamic instability are promptly recognized and treated, reducing the likelihood of adverse outcomes.

Optimizing Resource Utilization

Effective resource allocation is critical in the high-pressure environment of the ED. The findings of this study suggest that PPI and SI can serve as valuable tools for predicting patient deterioration and the need for intensive care interventions such as ICU admission and mechanical ventilation. By identifying patients at higher risk of poor outcomes early in their ED visit, healthcare providers can prioritize resources more efficiently. This targeted approach allows for better management of ICU beds, ventilators, and other critical resources, ensuring they

are reserved for patients most likely to benefit from them. It also helps in reducing unnecessary admissions and interventions, thereby optimizing the overall use of hospital resources.

Improving Patient Outcomes

The integration of PPI and SI into routine triage practice has the potential to significantly improve patient outcomes. Early identification of patients with poor perfusion or hemodynamic instability enables timely interventions that can prevent clinical deterioration. For example, patients with low PPI values or high SI ratios can be closely monitored and provided with aggressive fluid resuscitation, vasopressor support, or other necessary treatments to stabilize their condition. By intervening early, clinicians can reduce the risk of complications, shorten hospital stays, and improve survival rates.

Reducing Variability in Triage Decisions

Subjectivity and variability in triage decisions are ongoing challenges in emergency medicine. Different clinicians may interpret patient symptoms and urgency differently, leading to inconsistent triage outcomes. The use of objective measures such as PPI and SI can help standardize triage assessments, reducing variability and improving consistency across different practitioners and shifts. This standardization ensures that all patients are evaluated using the same criteria, leading to more reliable and equitable triage decisions.

Enhancing Training and Education

The implementation of PPI and SI in routine triage practice requires adequate training and education for ED staff. The study's findings can be used to develop comprehensive training programs that educate clinicians on the importance of these indices, how to interpret their values, and the appropriate clinical responses to different levels of PPI and SI. By enhancing the knowledge and skills of ED staff, hospitals can ensure that these tools are effectively utilized to improve patient care.

Strengths and Limitations of the Findings

Strengths

- 1. **Comprehensive Assessment**: One of the key strengths of this study is its comprehensive approach in evaluating the prognostic performance of PPI, SI, and ESI. By incorporating multiple indices, the study provides a holistic view of patient assessment, enabling a more nuanced understanding of patient acuity and outcomes.
- 2. **Objective Measurements**: The study leverages objective, quantifiable measures (PPI and SI) alongside the more subjective ESI. This integration helps reduce variability and bias in triage assessments, leading to more consistent and reliable patient evaluations.
- 3. **Robust Sample Size**: With a sample size of 610 patients, the study has sufficient power to detect significant associations and draw meaningful conclusions. This large sample size enhances the reliability and generalizability of the findings.
- 4. **Real-World Setting**: Done in a busy tertiary care centre, study's findings are highly applicable to real-world emergency department settings. The diverse patient population and high volume of cases ensure that the results are relevant and can be readily implemented in similar clinical environments.
- 5. **Prospective Design**: The prospective observational design allows for real-time data collection and analysis, reducing the risk of recall bias and enhancing the accuracy of the findings. This design also enables the study to capture the dynamic changes in patient status over time.

Limitations

- 1. **Single-Center Study**: The study was done at a single tertiary care centre, which may limit the generalizability of the findings to other settings, especially those with different patient demographics, resources, or healthcare practices. Multi-center studies are needed to validate these findings across diverse environments.
- 2. Exclusion Criteria: Certain patient groups, such as those with terminal malignancy or those who were transferred immediately after assessment, were excluded. This might introduce selection bias, as the excluded patients could have different outcomes or triage characteristics.
- 3. **Potential for Measurement Error**: While PPI and SI are objective measures, they can still be affected by external factors such as sensor placement, patient movement, and environmental conditions. These potential sources of measurement error could impact the accuracy of the findings.
- 4. Short Follow-Up Period: The study primarily focused on immediate and 48-hour outcomes. While this is relevant for acute care settings, longer follow-up periods would provide more comprehensive insights into the long-term prognostic value of PPI, SI, and ESI.
- 5. Limited Scope of Variables: While the study included key indices and clinical parameters, other relevant factors such as comorbidities, medication use, and socioeconomic status were not considered. These variables could influence patient outcomes and should be included in future research.

CONCLUSION

The study evaluated the integration of the PPI-Peripheral Perfusion Index and SI-Shock Index with the ESI-Emergency Severity Index to improve triage accuracy in emergency departments. The findings indicated that PPI and SI significantly enhance the predictive power of ESI, leading to better identification of high-risk patients and more timely interventions. Age, gender, and religious affiliation were also identified as important factors influencing patient outcomes. The study suggests that incorporating these objective indices can optimize resource allocation and improve patient care. Future research should validate these results across multiple centers and explore additional variables. In conclusion, integrating PPI and SI with ESI can enhance triage effectiveness, ensuring better patient outcomes and more efficient emergency department operations.

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ANNEXURE – I

ETHICAL CLEARANCE CERTIFICATE

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ANNEXURE II

RESEARCH INFORMED CONSENT FORM

BLDE (Deemed to be University) Shri. B.M. PATIL Medical College, Hospital & Research Centre, VIJAYAPURA-586103

TITLE OF THE PROJECT: PERIPHERAL PERFUSION INDEX- SHOCK INDEX-EMERGENCY SEVERITY INDEX IN PREDICTION OF OUTCOME OF PATIENT IN TERTIARY CARE HOSPITAL.

GUIDE: Dr. RAVI B PATIL, MD

PROFESSOR AND HOD DEPARTMENT OF EMERGENCY MEDICINE

PG STUDENT: Dr SHUBHAM DEORE

PG DEPARTMENT OF EMERGENCY MEDICINE

PURPOSE OF RESEARCH:

I have been explained about the reason for doing this study and selecting me as a subject for this study. I have also been given free choice for either being included or not in this study.

PROCEDURE:

I am aware that in addition to routine care received, I will be asked a series of questions by the investigator. I have been asked to undergo the necessary investigations and treatment, which will help the investigator in this study.

RISK AND DISCOMFORTS:

I understand there is no risk involved and that the patient may experience some discomforts due to panic situation during the examination. This is mainly the observational study and no risk is involved in the study. All the data collected would be kept safe and private.

BENEFIT:

I do understand that my participation in this study will have no direct benefits to me, other than the potential benefit of the research and education.

CONFIDENTIALITY:

I understand that the medical information produced by this study will become a part of hospital records and will be subjected to confidentiality. Any information about sensitive, personal nature will not be a part of the medical record but will be stored in the investigations research file. If any of the data are used for publication in the medical literature or for teaching purpose, no name will be disclosed, and other identifiers such as photographs will be used only with special written permission taken priorly. I also understand that I may visualize the photograph before granting permission.

REQUEST FOR MORE INFORMATION:

I understand that I may ask questions about the study at any time; Dr. SHUBHAM DEORE at the department of Emergency Medicine is available to answer my questions or concerns. I understand that I will be informed of any significant new findings discovered during the course of the study, which might influence my continued participation. A copy of this consent form will be given to me to keep for careful reading.

REFUSAL FOR WITHDRAWAL OF PARTICIPATION:

I understand that my participation is voluntary and that I may refuse to participate or may withdraw consent and discontinue participation in the study at any time without prejudice. I also understand that Dr SHUBHAM DEORE may terminate my participation in the study after he has explained the reasons for doing so.

INJURY STATEMENT:

I understand that in the unlikely event of injury to me, resulting directly for participation in this study; if such injury were reported promptly, the appropriate treatment would be available to the patient. But no further compensation would be provided by the hospital. I understand that by my agreements to participate in this study and not waiving any of my legal rights.

I have been explained about the purpose of the research, the procedures required and the possible risks to the best of my ability.

Dr. SHUBHAM DEORE (Investigator) Date

STUDY SUBJECT CONSENT STATEMENT:

I confirm that DR SHUBHAM B. DEORE has explained to me the purpose of the research, the study procedures that I will undergo, and the possible risks and discomforts as well as benefits that I may experience in my own language. I have read the form and understand this consent. Therefore, I agree to give consent to participate as a subject in this research project.

Participant / Guardian

Date:

Witness to signature

Date:

B.L.D.E (DEEMED TO BE UNIVERSITY) SHRI B M PATIL MEDICAL COLLEGE, VIJAYAPURA, KARNATAKA SCHEME OF CASE TAKING

INFORMANT:

Name:	
Age:	IP NO:
Sex:	DOA:
Religion:	
Residence:	
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Diagnosis –	
ICU admission – YES/NO	
Need for Ventilation: Yes—if yes th	en, Non-invasive ventilation / Invasive
Ventilation	

No

48-hrs outcome: Improved/Deteriorated or Died

	At the time of arrival	At 12 th hrs after admission	At the 48 th hrs after admission
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06643 Hinde
241767 Hinde | Verypers
 | Head injury with makiple facia N | lo I | No | | ngcorod | GRADE 5
GRADE 2
 | 2 | | 0.57 | | 5.R I
80 1
 | 8.8 |
| uteri pajuri | 01 Funds

 | 17-09-2020 | 297505 Hindu | Model ripespara
 | Supple successfory to ups Y
Pyreferoid compound poicon N
Dismide poiconing N
Anniete dioorder Y | 142 | No | | nprovid
Nethergod | GRADE 3
GRADE 3
GRADE 3
GRADE 3
 | 4.1 | | 0.78 | 12 0 |
 | 0.94 |
| arikanar pandalik
Ishinath bhinaraya Adavi | 60 Male

 | 12-03-2023 | 241767 Hindu | Chadolan, Vesyspan
Vesyspana
 | Pyrethroid compound poison N
Clunide poisoning N | lo lo | No | | Rectarged
Agrored | GRADE 5
GRADE 5
 | | 2 | | 0.52 | 5.7
 | 7.2 |
| folikorjon Mothpoti
Ischoor kazi | 29 Male

 | 24-05-2023
09-02-2023 | 168576 Hindu
51103 Maclim
24531 Hindu | zindeji
 | Assists disordur Y
COPD Y | 100 | No | Nos invaciro vustilatio in | npeorod | GRADE 3
 | 53 | | 0.90 | 0.85 4 | 34 5.
 | 5.08 |
| Mippo cakerippo volko | 00 Male

 | 22-01-2024 | 24501 Hade | Talikoti , Vijayapura
 | Unknown compound consume N | lo I | No | | ngrored | GRADE 2
GRADE 4
 | | 3 | 0.0 | | 5.2
 | T |
| nsappa Teli
sesji thoks | 46 Male
24 Male

 | 04-05-2023
14-10-2023 | 145035 Hindu
325053 Hindu | Rogi vilograpiana
Solopur Makanashtra
 | Fits with mild bood iners Y
prokebits Y | (e)
(az | No
No | | ngrorod
ngrorod | GRADE 3
GRADE 3
 | 4. | #2
#2 | 0.84 | 0.75 5 | 30 4.
38 4.
 | 4.09
4.37 |
| arappa Harijan
arwitappa Dacappa | 71 Male

 | 08-11-2023 | 015535 Hindu
445243 Hindu | Indi Wijogopera
 | Acets lockanic stroks Y | Fez I | No | | aprovud | GRADE 2
GRADE 3
 | 2 | 45 | 0.57 | 0.57 4
1.0 | 4.
 | 5.7 |
| apartreo Serrace | 73 Male

 | 26-12-2022
31-03-2023 | 108407 Hinde
1084 Hinde | Sinda Visenbers
Arskulita, Vijayspa
 | Perforented bowed | 0 | No | 1 1 | Approved
Deteriorated | GRADE 1
GRADE 4
 | | | | |
 | 0.02 |
| isaha morati zhoadogo
ucapeza chikulaki | 73 Male
28 Male

 | 26-02-2023 | 10184 Hindu
115264 Hindu | Arskei to, Vilayapa
Indi Vilayapara
 | Drug withdrowski ciczens N
Supplic cocondary to LRTI Y | lo
Iec | No
No | | | GRADE 4
GRADE 3
 | | | | |
 | |
| urappa chikalaki
inod Nikum
himoppa bacappa chiqari | 01 Male
73 Male
73 Male
73 Male
34 Male
35 Male
31 Male
31 Fotole
31 Male
31 Male
31 Male
31 Male

 | 31-03-2023
26-04-2023
30-05-2023
30-05-2023
30-05-2023
30-05-2023
30-05-2023
30-05-2023 | 15254 Hade
38737 Hade | Meddobiled Viewape
 | Sepcia secondary to LRTI Y
Pite with lead injury Y
Neurotoxic production N
LRTI Y | 6 | No | | nproved
nproved | GRADE 3
GRADE 3
 | 3)
4) | 32 | | 0.76 3 | 32 5
 | 5.72 |
| himspos bacspos chiquri
harasonno Bacsqued | 51 Male
61 Male

 | 30-05-2023 | 403053 Hade | Vise sage Viseop
 | Neurofoxic znake bite N
LATI Y | le
fez | No
No | | nprovod
nprovod | GRADE S
GRADE S
 | 23 | 64
45 | 0.58 | 0.8 4 | 5.7
82 4
 | 8.5
4.74 |
| harananna Barageed
harada Patil
Nakabooboob Moksoki | 51 Female
53 Maile

 | 14-06-2023
10-07-2023 | 115552 Hinds
405053 Hinds
192643 Hinds
22338 Made | Indi Viloeopera
 | Azemia in failure Y
Acets homorrhogic stroks Y | Tes I | No | kanalar mellining - F | aproved
Octorionated | GRADE 2
GRADE 1
 | 2 | 45 | 0.85 | 0.76 4 | .0 00
 | 0.03 |
| amappa Sitimani | 72 Mals
42 Mals

 | 12-06-2023 | 191245 Hade
507100 Hade | Civil hospital nijagap
 | Acets lockanic stroks Y
Inidoclopride poiconing Y | fez | No | C | Discharged | GRADE 2
 | 2 | 16 | 0.86 | 0.83 4 | 25 1.
 | 1.82 |
| layaskanar Ran
anka Ambali | 42 Male
26 Female

 | 26-10-2023
12-03-2023 | 05/01 Hade | Mudhol vijsespers
Askran road vijvospi
 | Iniduclopride poisoning Y | les
les | No | | ngroved
ngroved | GRADE 5
GRADE 2
 | 3 | .01
101 | 0.81 | 0.95 4 | 32 4
.31 0.
 | |
| | 26 Formula
60 Maila

 | 05-04-2023
07-05-2023 | 05101 Hindu
112727 Himdu | Indi Vijsenpara
 | LATI Y
Acuts izeliumie ztroks Y | 62 | No | | | GRADE 1
GRADE 1
 | 1 | .01 | | 0.76 | .91 0.
 | 0.92 |
| heixeath Danikol | 01 Male

 | 10-04-2020 | \$85240 Hindu
\$25002 Hindu | Sindqi Vijsespara
Madhol vijsespara
 | Lower linb cellulitis Y | fes I | No | | Notoriorsted
Aproved | GRADE 2
 | 1. | .05 | | 0.56 | 02 0.
82 1
 | 172 |
| himraj zindaj
onal Businaldad | 73 Male

 | 10-01-2023 | 13540 Hindu | Meddobiled Yilisespe
Chedolon
Siledigi Yilisespen
 | Acute inchemic stroke Y | [92 | No. | | Atoriorated Atoriorated | GRADE 1
GRADE 5
 | 1. | 82 | 0.89 | 0.99 | .01 0.0
.02 4
 | .001
4.07 |
| load Mohite | 22 Mula

 | 15-12-2025 | 207008 Hade | Sindigi Vilitenpera
 | Pulmonary thromboundolism Y | fer l | Yes | Non invasivo vostilutio it | agrored | GRADE D
GRADE D
 | 4. | 33 | 0.76 | 0.46 | 27 4
 | 4.12 |
| iongapa Annu
Inakan Admai
Inakan Basikel
Alexa Bashadal
Iong Bashadal
Iong Mahas
anteri Alabadi
Inakan panen | 60 Mala
43 Mala
43 Mala
73 Mala
66 Mala
28 Mala
70 Femala
46 Mala
72 Mala
47 Mala
48 Mala
49 Mala

 | 10-04-2020
10-01-2020
10-01-2020
10-02-2020
10-10-2020
07-06-2020
05-12-2020
05-12-2020 | 123000 Hade
13540 Hade
131454 Hade
237000 Hade
104050 Hade
380462 Hade | Vieweiger Vieweiger
Chedolae Vieweiger
 | Pulmenary threehoenbolism Y
Rt lover limb cellulitis Y
Acuts howerhagic stroks Y
Solares under ovaluation N | 142 | No
Ysz | | ngeorod
Octoriorated | GRADE 1
 | | 45 | 0.50 | 0.06 6 | 20 4.
02 0.
 | 4.00
3.02 |
| hoha morati | T2 Mais

 | | T0154 Hade | Arskeri, Yibespera
 | Science under evaluation N | io I | No | | ngcorod | GRADE 1
GRADE 5
 | | 82
85 | 0.8 | 0.76 | 5
 | 8 |
| asovani hadapad
lakoh hozanai |

 | 17-12-2023
11-05-2024 | 158853 Hindu | B bageward , Visyng
 | Focial fractures N | io . | No | | ngrored | GRADE 3
GRADE 3
 | | 4 | 0.0 | | 5
6.1I
 | 0.9 |
| sgadich Shrichail duagi
annikaeth D Divijanar | 35 Male
50 Male

 | 26-03-2023
17-01-2023 | 6435 Hindu
22550 Hindu | B bagenadi , Vilayap
 | Delourez under valuation N
Distance opiliopticae N | lo | No | | nprovid
nprovid | GRADE 4
GRADE 4
 | 4 | 3.1 | 0.8 | |
 | 7.6 |
| urumasand damograid | 66 Mula
66 Mula
12 Mula

 | 17-01-2023
19-04-2023
20-04-2023 | 120120 Hade | based.
 | | io | No | | agrored | GRADE 5
GRADE 5
 | 4.
5.
5. | | | 0.5 5 | 96 6.
31 6.
 | 6.07
6.85 |
| | 21 Male
83 Male

 | 20-04-2023
21-04-2023
10-04-2023 | 125343 Hindu
131544 Hindu
161300 Hindu | Visyspers
 | Rts with mild bood inerg N
Rts Vith mild bood inerg N | lo
lo | No
No | | | GRADE 5
GRADE 4
GRADE 4
 | | | 0.53 | |
 | 6.95
5.01
5.04 |
| kopolicidoppo Gidove
Alch Nogethen
heyvather chakteli
sejag ratked | 21 Mais
23 Mais
24 Famils
33 Mais
33 Mais
33 Mais
54 Famils
54 Famils

 | 10-04-2023 | 151300 Hade | kogi
Modilol
Vijagapura
 | nti N | io I | No | | nprovid
Xisthergod | GRADE &
 | 5.
3. | | 0.50 | 0.52 4 |
 | |
| sejue rathod | 38 Male

 | 22-04-2023 | 131843 Hisdu | Visiopero
 | ei N | lo | No | | nproved
npreved | GRADE 4
 | 5. | .19 | 0.58 | |
 | 6.16
5.07 |
| aradaran kanbala
hawabai Teli | 50 Male
60 Female

 | 21-04-2023
22-04-2023
17-05-2023
05-07-2023 | 101921 Hindu
103843 Hindu
100654 Hindu
100768 Hindu | Vijayopara
Muddobikul
 | organic compound policoning N
Non-renemous snake bite N | lo I | No | | nprovod
Xischargod
nprovod | GRADES
GRADES
GRADES
GRADES
 | | | 0.0 | 0.56 6 |
 | 6.6 |
| |

 | | | lares 1
 | | | - | | |
 | | ~ | | | ar l
 | * |
| |

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 | | | | | |
 | | | | |
 | |
| |

 | | | | | |
 | | | | - | |
 | | | | |
 | _ |
| AME OF THE PA' AGE | - SEX -

 | DATE OF ADMIS - IP NU
05-07-2020 | TOTIO Hinda | Meddobikal
 | PROVISIONAL DIAG *
Non-venemous sauke bite | No No | NEED OF VENTILA | P ON VENTILA | 48 HRS OUTC | GRADE 5
 | ENCT SEVERITY PERIPHERAL PERFUSIC | 6.5 | 0.52 | 0.40 PERIPHERAL PERFUSH |
 | 7 |
| vannappa kegar
artozh indi | 56 Mak
56 Mak

 | 12-05-2023 | 155510 Hinda
446536 Hinda | Sindgi
Vijagapara
 | Chart pain under ersteution
schominal pain under ersteution | No | No | | Ingrored | GRADE 4
 | | 4.01 | 0.59 | 0.51 | 4.15
 | 5 |
| takshita Magamanar | of Male
17 Female

 | 03-03-2023
%-06-2023 | 446.536 Hada
135276 Hada | Vibespers
Vibespera
 | sbidominal pais undur erstesti
Acute febrile ilkess | No
No | No No | | Ingroved
Ingroved | GRADE 4
GRADE 4
 | | | | 0.54 |
 | 4.01 |
| ikov iedenez | 17 Female
25 Female

 | 16-06-2023
07-04-2023 | 195276 Hinda
115307 Hinda | ledi .
 | Acute quatritia | No | No | | | GRADE 4
GRADE 5
 | | 4.36
5.81 | 0.50 | 0.53 | 4.02
6.41
 | 4.30
6.81 |
| avits Birsdor
ingangouda biradur | 45 Feasle
41 Male
68 Feasle
22 Male

 | 15-06-2023
03-06-2024
08-04-2023
03-06-2024 | 135015 Havda
106064 Hinda | Vijagovra
Indi
 | lati
Atta with mild bood inerg | No | No | | Discharged
Discharged | GRADE 4
GRADE 4
 | | 4.01 | 0.0
57 | 0.54
0.55
0.51 | 4.72
 | 4.00 |
| ingangonda biradar
olyanabai mazhyal
hrianth byalyal | 68 Female
22 Male

 | 08-04-2023 | 106040 Minda
106040 Minda | Yijsepans
Itsai
 | bed zorez | No | No
No | | Ingeored
Ingeored | GRADE 5
GRADE 5
 | | 5.11
5.74 | 0.53 | 0.51 | 5.83
6.60
 | 6.04 |
| hrisoth bester
Inngsver medler
Inngsk Birsolar | 46 Female
34 Male

 | 08-06-2024
08-06-2023
04-06-2023 | 186927 Hinda
186927 Hinda | Viseosrs
Indi
 | inian
collection | No | No | | Ingrared
Ingrared
Ingrared | GRADE 4
 | | 5.74
4.06
5.07 | 0.59 | 0.5
0.5
0.41 | 4.41
 | 4.00 |
| nors birydyr
ardit Riyhod | o4 Male
62 Male

 | 04-06-2023
03-06-2023 | 18/837 Hoda
180716 Hoda | Vibespers
 | Non-venumour ranke bits
[14] | No
No | neo
Neo | | | GRADE 5
GRADE 5
 | | 5.51 | 0.53 | 0.41 | 5.53
 | 6.14 |
| andit Rivited
Inal Dividaj
Alexandra de a | 62 Male
43 Male

 | 03-06-2023
11-04-2023 | 100716 Hinds
120307 Micriss | Vilianders
Sindgi
Meddobikul
 | Acute fabrile illease | No | No | | Ingrored
Ingrored | GRADE 4
GRADE 4
 | | 5.52
4.01 | 0.6 | 0.55 | 6.01
4.80
 | 5 |
| advaath dag
advaath Gosadi | 41 Male
67 Female

 | 10-05-2023
26-04-2023 | 153019 Hinda
126245 Hinda | Madhel
 | Sign
Check pain under erstaution | No | No | | Discharged | GRADES
 | | 4.25 | 0.54 | 0.51
0.40 | 4.52
6.01
 | 4.54 |
| Astrodia Mella
Neoral Yaraad | 61 Mulc
41 Funale

 | 08-05-2023
27-04-2023 | 100500 Minutian
101567 Minuta | Dindaj
Indi
 | COPO
sloskol withdrawal | No | No
No | | Ingeored
Ingeored | GRADE 4
GRADE 4
 | | 4.01 | 0.58 | 0.51 | 4.72
 | 5 |
| Mobedin Mella
Neseral Yasaad
Angerana patil
Kenasidida Madar | 21 Female
22 Male

 | 07-05-2023 | 151567 Hinda
150519 Hinda
143284 Hinda | Mittenpera
Medici
 | stockel withdrawsl
ergunic compound policening
Non venumour rashe bits | No | No | | Ingeored | GRADE 5
GRADE 5
GRADE 5
 | | 5.02
5.85 | 0.59 | 0.57
0.40
0.41 | 6.64
5.00
6.91
 | 4.32
6.39
7.01 |
| cranatida Mixdar
lay charan | 22 Mak
21 Mak

 | 07-05-2023
04-05-2023 | 143284 Hinds
145356 Hinds |
 | Non vesumour realso bits
Chect pain under orsketting | No | No
No | | Inproved | GRADES
GRADEA
 | | 5.85 | | 0.41 |
 | 7.01 |
| loy charan
othal module | 21 Male
77 Male

 | 02-11-2023 | 145356 Hinda
344368 Hinda | Indi
Chudchan
 | Chect pain under evaluation
Sepois secondary to LRTI | Yes | Yes | Invacive ventilation | Ingroved
Deteriorated | GRADE 4
GRADE 1
 | | 3.15 | 0.67 | 0.58 | 3.45
\$73
 | 0.012 |
| lsrigspps choksosli
krikseth doddansei | 46 Mak
56 Mak

 | 21-07-2023
00-11-2023 | 234910 Hinda
346503 Minda | Meddobikal Vijoyape
Vijoyapera
 | Saskebite
Rts with lead injury | Tes | No | Invacive ventilation | Deteriorsted
Ingeored | GRADE 1
GRADE 3
 | 1 | 1.63 | 0.54 | 1.03
0.85 | 2.83
4.50
 | 1.93 |
| kingetre guikmed | 29 Mek
37 Mek

 | 17-12-2020
25-11-2020 | 334673 Hinda | Madkel väyrepura
 | Rits with bood lightly
RITA with chest trooms
Partial languing
Sepcis secondary to LRTI
Acote ischemic stroke
Intertiaal obstruction
Acote hemorrikagis stroke
Maniseisorendadisi | Yes | No
No | | Ingrared | GRADE 3
GRADE 3
 | | 3.82 | 0.97 | 0.68 | 4.29
 | 4,29 |
| iddaramagea belbhavi | 31 Male
74 Male
80 Male

 | 25-11-2023
00-06-2023
15-00-2023 | 117231 Havda | Sindqi Viliyopura
 | Sepcis secondary to LRT1 | Yes | Yes | Nos invasive vestikatio | Deteriorated | GRADE 3
GRADE 1
GRADE 2
 | | 4.25
1.05
2.65 | 0.99 | 0.57
1.02
0.67 | 4.82
 | 4.15
0.27
3.63 |
| ddaranag op belbhari
ingspon Koledeop
ingspon Unabhari
ester Koliserei | od Mak
76 Mak

 | 15-03-2023
M-04-2023 | 117231 Hinda
83575 Hinda
123618 Hinda
161331 Hinda | Methol response
Chadchas Vijaysours
 | nexts inclusion atroks
Intertiani obstruction | Tez | No
No | | Inprovid | GRADE 3
 | | 2.65 | 0.00
0.87
0.57
0.06 | | 3.38
4.54
 | 3.63 |
| eska Kulsumi | 76 Mak
56 Mak

 | 19-05-2023
19-05-2023 | 161031 Hinda | Visespera
 | Acute honomkagic stroke | Yes | No | | Deteriorated | GRADE 3
GRADE 1
ORADE 1
 | | 1.30 | 0.96 | 0.57 | 2.02
 | 4.52 |
| coni biradar | 25 Female

 | 22-02-2023 | 66388 Node | Meddobibal
 | Pyrethria compound concemp | | No | | Inproved | GRADE 3
 | | 4.82 | 0.75 | 0.14
0.64 | 3.83
 | 4.83 |
| amappa chalawadi
Isha mujumdar | 43 Male
81 Male

 | 14-07-2023
26-06-2023 | 220147 Hinds
208325 Murlim | indi viisespera
 | Mexingioscephabtic | Yes
Yes | No | Non-instantion and in- | Deteriorated | GRADE 2
GRADE 2
 | | 2.65
2.65 | 0.01
0.86 | 0.97 | 3.34
1.07
 | 1.36
0.86 |
| silikorjan hiremath | 76 Mak
66 Female

 | 04-03-2023 | 202173 Hoda
202273 Hoda | Doranakippanogi vija
Talikoti Vijopapana
Talikoti Vijopapana
Iodi Vijopapana
 | Acute is chanic stroke | Yes | No | | Ingrored | GRADE 3
 | | 3.67
3.45 | 0.75 | 0.63 | 5.80
 | 4.08 |
| otobni nasak
nomosth Goedhi | 65 Female
43 Misle

 | 24-06-2023
20-05-2023 | 205220 Hinda
203434 Hinda | Talikoti Yijasapara
Indi Vijasapara
 | Acute payoroutitis
DCLD with social | Tel
Yel | No
No | | Ingroved
Deteriorstud | GRADE 3
GRADE 1
 | | | | 0.48 |
 | 6.28
5.28 |
| activital Dalawagi | 49 Mak
03 Mak

 | 20-05-2023
07-00-2023
23-04-2023 | 233434 Hinds
255136 Hinds
138169 Hinds
14945 Hinds | Devarahipparagi vija
 | DCLD with socials
RTA with head leavy
Blast shdomiani troums
Supplic abook awardury to LS | Yes | No | | Ingrored | GRADE 1
GRADE 3
 | | 1.55 | 0.55 | 0.52 | 4.38
 | 5.28 |
| ananasti Gandhi
asavrai Dalavasi
seansi Halaquahi
ulhapa shukpur | 66 Mulc
83 Mulc

 | 27-04-2023
15-01-2023 | 14345 Hinda | Talikoti Yijugapara
Vijugaugar Vijugapara
 | Suptic shock succedury to LF | Yez | Teo Teo | Nos invarios vestilatio | Dotoriorated | GRADE 1
GRADE 1
 | | 1.20 | 0.75 | 0.91 | 4.82
4.28
 | 5.26 |
| sessible demoste
reselich Churce | 46 Male
02 Male

 | 10-01-2023
27-10-2022 | 12146 Hinda
316037 Hinda | Dever hipported Vila
 | Mexile gioscephalitic
Chest pain under evaluation | Yes | No. | | Ingeored
Ingeored | GRADE 3
GRADE 4
 | | 0.60
4.82 | 0.06 | 0.64 | 0.05
4.39
 | 4.64 4.87 |
| olisisps malage | 72 Male
45 Male

 | 27-90-2022
15-04-2024
54-04-2024 | 243312 Hinda
124527 Hinda | Vijespera
Rogi
Vijespera
 | Check pain under erstaution
bad cores
shidominal pain under erstauti | No | No | | Ingrored
Ingrored | GRADE 5
 | | 6.82
5.72
5.07 | 0.58 | 0.55
0.45
0.59 | 4.35
6.13
5.25
 | 7 |
| wishail oddar | 45 Male
42 Male

 | 14-04-2024
07-11-2022 | 124527 Hoda
088343 Hoda | Yikespera
Itopi
 | shdominal pain under erabatti
Chart pain under contextion | No | No
No | | | GRADES
 | | 5.07 | 0.6 | 0.55 |
 | 6.15 |
| dda Totsd
ursen diadsol | 42 Mult
60 Mult

 | 07-11-2022
21-03-2024 05321 | 088343 Hinda
O Ninda | Hogi
Vilixespera
 | Chart psin under erstastion
uncentralled DM | No | No | | Ingrarod | GRADE 5
GRADE 4
 | | 6.02 | 0.51 | 0.47 | 6.97
4.13
 | 5.01 |
| kasirutki Walikar
sespipa esoutti
karmaana kambale | 72 Female
44 Male

 | 17-06-2020
11-11-2022 | 391751 Hoda
393046 Hoda | Vitenpen
Indi
 | COPO | No | No | | Ingroved
Discharged
Discharged | GRADES
GRADES
 | | 5.07
5.31 | 0.55 | 0.41 | 5.rJ
6.83
 | 6.93 |
| harmaana kambale | 50 Male
77 Male

 | 10-03-2024
16-11-2022 | 001751 Hinda
030046 Hinda
005603 Hinda
030411 Hinda | Yisesees
 | Neurotoxic make bite | No | No | | Discharged | GRADE 4
GRADE 5
 | | 4.22 | 0.55
0.54
0.57
0.59 | 0.53 | 5.55
5.53
6.22
 | 4.27 |
| arkozh pejuri | 28 Male

 | 16-11-2022
02-03-2024 07065 | 338411 Hinda
8 Hinda | Indi
Madhol
 | bedrore
sbdominslipsis under ersløsti | No
No | nio
No | | Ingeored
Ingeored | GRADE 5
 | | 5.82
5.86 | 0.59 | 0.45 | 6.ad
5.82
 | 6.89 |
| arovati Minemath | 28 Male
17 Female

 | 02-03-2024 07065
24-11-2022 | 8 Hode
407313 Hode | Vijagapera
 | Chest pain under evolution | No | No | | Inproved | GRADE 4
 | | 5.86 | 0.58 | 0.45 | 5.52
 | 6.93 |
| owni Gubwod
svita kadapad | 18 Mais
34 Female

 | 28-11-2022
28-11-2022 | 411722 Hinda
411857 Hinda | Sindgi
Indi
 | rts with mild hood injury
Chect pain under evaluation | No | No | | Inproved | GRADE 4
GRADE 4
 | | 0.51
4.75 | 0.53 | 0.51
0.57 | 4.13
4.08
 | 4,88 |
| hagyashree Mangyal | 20 Female
42 Malo

 | 12-01-2024 01072 | 6 Minda
6 Minda | Meddobikal
Yiisespera
 | orquic compound policosing
abidominal pain under evaluati | No | No
No | | Ingrared
Discharged | GRADES
GRADES
 | | 5.70
5.18 | 0.59 | 0.51
0.46 | 5.00
5.73
 | 6.32 |
| scheno dodanosi
osal osbli | 42 mile
36 Penale
66 Male

 | 06-01-2024 00133
06-01-2024 00133
21-12-2023 | o nexte
3 Nexte
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 | spoonnes pon inder crision
sen
bed sires | No | No | | Inproved
Discharged | GRADE 4
GRADE 4
 | | 4.02 | 0.54 | 0.52 | 4.17
9.80
 | 5 4.07 |
| AME OF THE DA | 66 Male

 | | 400440 Hinds | Visielgen
 | | No
CU ADMISI * | NEED OF HEREE | IF ON VENTILA | Lischarged | GRADE 4
 | NCY SEVERITY PERIPHERAL PERFUSION | 4.35 | 0.57 | |
 | 4.07 |
| IAME OF THE PA' AGE | 66 Mole

 | DATE OF ADMIS * IP NU
25-12-2023 | 400448 Hindu | Visuapara
 | bod sores / | No | No. | | Discharged | GRADE 4
 | | 4.36 | 0.57 | 0.54 | 3.93
 | 4.07 |
| oddamma pojari
uvita polaski | 32 Fonsio
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 | 25-12-2022
13-12-2023 | 443952 Hindu
303525 Hindu |
 | Non vesamour zaske bite
Partial kanging | no
No | No | | Discharged
Ingresed | GRADE 5
GRADE 4
 | | 4.65 | 0.51 | 0.48 | 0.65
 | 6.84 |
| laliharjun handi
caulca cinga | 57 Mala
37 Femala

 | 12-12-2023 | 388263 Hindu
386938 Hindu |
 | Chest pain under evaluation | No | No
No | | Ingrared | GRADES
GRADES
 | | 5.08
6.17 | 0.53 | 0.43
0.41 |
 | 6.24
T |
| cours ango
ranka Rathod
wito jadhar | 36 Male
46 Female

 | 10-12-2023 | 386401 Hindu | ledi
Sindoj
 | Assists disorder 1
Assists disorder 1
abdominal pain under erakent i | No | No | | Ingroved
Ingroved
Discharged | GRADE 4
GRADE 4
 | | 4.65 | 0.53 | 0.55 | 4.00
 | 4.64 |
| ntojadhar
odlu choran | 46 Female
18 Female

 | 08-12-2023 21-02-2024 05561 | 384046 Hindu
Hindu | Sindoi
Indi
 | abdominal pain under eraberti f
orqueix composed poloosied f | No
No | No
No | | | GRADE 4
GRADE 4
 | | 4.2/8 | | 0.54 |
 | |
| odiu dono
aliano Rathed
Internet | 25 Fonale
63 Fonale

 | 21-02-2024 05360 | A 17378 Mindu | Meddebilai
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shidominal pain under veskuti f
COPO | No | No
No | | Ingraved
Ingraved | GRADE 4
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GRADE 5
 | | 5.02 | 0.5 | 0.54 | 4.01
5.31
6.04
 | 4.85
6.37
7 |
| zvranno
nabio: manorar
ichago: kiromatk
izma molia | 18 Fonsis
25 Fonsis
63 Fonsis
22 Mais

 | 21-02-2024 05361
21-02-2024 05360
03-12-2022
05-12-2022 | 417978 Hindu
418755 Hindu | ledi
Meddubikul
Medkol
Meddubikul
 | COPO perethria poizoaliq perethria perethria poizoaliq perethria p | No | No | | Ingrared
Discharged | GRADES
GRADES
 | | 4.58
5.02
5.85
5.58 | 0.54 | 0.45
0.41 | | 6.82
 |
| advance block and | 55 Male
30 Female

 | 13-02-2024 057101
17-02-2024 055131 | Hindu
Meslim | Vijugsus
 | bed pares | No | No
No | | Ingrored
Ingrered | GRADE 4
GRADE 4
 | | 4.55
4.15 | 0.57 | 0.54 | 4.01
4.13
 | 4.76
5.01 |
| sens nots | T2 Mole
25 Mole

 | 06-12-2022 | 421173 Hindu
423750 Hindu | Methol
 | C0P0 1 | No | No | | Ingrored
Ingrored | GRADE 5
 | | 5.81 | 0.58 | | 5.89
5.43 5.00
 | 6.09 |
| izna mala
nakroppa kuddar |

 | | 423750 Hisdu | Vibespera
Chuddee Vijesipera
 | rta with mild head injury . A
Acute ischenic stroke | Neo
Yes | No
No | | | GRADE 5
GRADE 3
 | | 3.45
3.65 | | 0.65 | 4.33
 | 4.65 |
| neeropponoder
mon diesi | 26 Mule
76 Mule

 | 08-12-2022
11-03-2023 | 04943 Hindu |
 | ngs I
Acuto honorritogic stroka | No | No | larative vestilation | Ingroved
Discharged
Datasisrated | GRADE 4
 | | 3.65
4.95
1.35 | 0.50 | 0.65 |
 | |
| seeroppo kodou
onse diesi
kiroppe korber
ohsetsch jamaksedi | 25 Mala

 | 11-03-2023
03-02-2024 03880 | 04943 Hindu
6 Hindu | ladi
Sindal Viturnar
 | Contraction of the owners | No | No | | Deteriorated
Ingrored | GRADE 1
GRADE 4
 | | 1.35 | 0.51 | 0.74 | 4.01
 | 4.05 |
| nami pipo indobu
unun disal
Akrope konter
skentun konter
skentun ja Mallo | 76 Mule
25 Mule
61 Mule

 | 11-03-2023
03-02-2024 03880
23-04-2023
30-01-2024 | 04343 Hindu
6 Hindu
130135 Media | ladi
Sindal Viloyopara
Itagi
 | perethrin poisoniq | 162 | 190 | | mprovod | GRADE 5
GRADE 6
 | | 0.14
4.55 | 0.64 | 0.54 | 0.93
4.42
 | 4.83 |
| nami pipo indobu
unun disal
Akrope konter
skentun konter
skentun ja Mallo | 76 Mule
25 Mule
61 Mule

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23-04-2020
00-01-2024 | 04343 Hindu
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130135 Media | Real
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vti | No | No | | Ingroved |
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 | 7.04 |
| nami pipo indobu
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Akrope konter
skentun konter
skentun ja Mallo | 76 Mule
25 Mule
61 Mule

 | 11-03-2020
03-02-2024
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6 Hindu
130135 Media | Real
Meddubihol Vijwyspo
 | peretkria poisoaiq //
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copeo | No
No | No
No | | Ingroved
Ingroved | GRADES
 | | 5.75 | 0.59 | 0.53 | 6.01
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141
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rta with locid injary
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| 241 Galasva Bajastri

 |

 | 20-1 | 11-2022 | 411054 hindu
 | Hadhal | bodenese | Na | Na
 | | Ingraned | | |
 | | 0.51 |
 | 7 9. | 1.47 |
| 349 SharanappaQudday
399 Soutakalanadi

 | 20 Famile

 | 19-1 | 14-2423 1 | 136795 Hindu
393299 Hindu
 | Maddabili of
Registration | rtsuithis of injury
partialities and | No. | Na
Na
 | | Ingraved | 084011 | | 5.57
 | .57 | 0.41 | 6.23 6
 | 4.91 0.
1.87 0. | 9.5 |
| 281 Sharadha Hiramath
282 Maruti Sanadi

 | 51 Male
45 Male

 | 20-1 | 19-2023 3
16-2024 090400 | 142625 Hisdu
Hisdu
 | Phaddabikal | Chart pain under archestion | Na | Ne
 | | Improved | GRADES | | 6.17 I
 | 1.51
1.5 I | 8.4 | 6.04 6
6.72 6
 | 6.16 0.
i.52 0. | 9.36
9.41
9.52
9.51 |
| 252 Street ab Malla

 | 54 Male
26 Male

 | 17-5 | 12-2423 3 | 2146/21 Hulin
215255 Histo
 | h-di | ab damin algoin and ar available
Chart poin under availabilitien | No. | Ha
Ha
 | | Ingrand
Dircherard | GRADE 4
GRADE 4 | |
 | 1.59 0 | 1.54 |
 | LES 0. | 0.52 |
| 354 Bhiropa Pulori

 | 26 Male

 | 26-1 | 19-2423 3 | JTS255 Hindu
 | TE-cy-sp-are | Chort pain under an abastian I
RTA VITH CHEST TRAUMA | He | Ha
 | | | | | 3.72
 | 1.57 4 | 152 | 60 6
 | LIE 0. | 0.51 |
| 255 Revenziddekekiketti Bekkelerhourv
255 MotteppeArackeekar

 | itya Male
23 Male

 | 26-66 | 16-2422 1 | 170755 Hindu
 | Maddabibal Vijey ap u | LRTI | Yes | Ne
 | | Deteriorated | GRADE2 | | 1.62
 | 1.97 0
1.98 0 | 1.07 | 1.09 0
 | 1.24 0.
1.69 1. | 1.24 |
| 257 Roparingh Pasan
251 Shokamma Bireder

 | 55 Male
65 Female

 | 23-65 | 12-2924 061650
19-2923 2 | Hindu
296913 Hindu
 | Hedbal | lesi : | Ma . | Ha
 | | Ingrared | GRADES
GRADES | | 5.50
 | 1.49 | 0.41 | 5.69 6
 | 6.01 0. | 9.24 |
| 351 Shokawa Birater
351 Irenos Bajas

 | 28 Male

 | 31-6 | 19-2423 2 | 277318
 | Türyəpəre
Sindəji | uti lini | No. | Ha
Ha
 | | Ingraved | | |
 | | 181 | 0.71 4
 | 1 0. | 0.97 |
| 259 Ironos Kajan
260 Kanganganda Biradar
261 Pinkina Dahad

 | 60 Male

 | | |
 | Til ny ngrar a | badenese | Na | Na
 | | Ingraned | GRADES | | 5.26
 | 1.50 0
1.47 0 | 0.41 |
 | 1.29 0.
1.89 0. | 9.97 |
| 251 Piskibal Robert
252 History of Parketkor

 | 20 Female
23 Male

 | 14-0 | 15-2+24 1 | 962642 Hindu
170755 Hindu
 | Türyəyərə
Həddəbihal Müryəyə | Man vona mararanaka bita
n MTA uith ek demin eftreven e | Na | Ma
Tor
 | In particular south Pattern | Ingraned
Deteriorated | GRADE4
GRADE1 | | 2.60 0
 | 1.57 e | 1.55 | 2.99 4
 | 1.56 0.
3.63 L | 9.52 |
| 363 Niresels Vieli
264 Generationa Paiari

 | 68 Female
11 Female

 | 26-5 | 12-2+23 3 | 3996.04 His du
 | h-di | shouth all the stingery | Na | Ha
 | | Direkerged
Ingeneral | GRADES | | 5.52
 | 1.59 0
1.52 0 | 1.89 | 633 6
 | 4.91 0.
1.89 0. | 0.51
0.41
1.24
9.4 |
| 264 Georgebeiningerver

 | 11 Female
11 Female

 | 26-5 | 12-2#23 3
12-2#23 4 | 277224 Hindu
407642 Hindu
 | Türyapara
Talihati Vijayapara | Acete is shemisetening | Na | Na
Tar
 | Inverire continuing | | GRADES
GRADE1 | | 5.32 F
 | 1.92 0 | 1.92 | 6.37 6
 | | 3.41 |
| 255 TavalaLeased

 | 11 Familie
10 Familie

 | 11-0- | 14-2424 | 407619 Hindu
120577 Hindu
 | Phodhad | Acuta is chamicatenha
Chart poin under conhesting | Na | Ma
 | | Datasianata-d
Direkorga-d | GRADE4 | |
 | | 1.54 | 6.45
 | | 9.4 |
| 357 Section Rothard

 | 24 Mate
20 Female

 | 19-6- | | 298637 Hindu
398464 Hindu
 | Sindai Wayapara
Maddabihal | Acuto penero stitie
Acuto fabrile ilbuser | Yest | Tor
 | Non-invertice ventilietie | Dutorigrated | GRADES | | 6.20
 | N92 9 | 1.45 | 1.42 6
 | 6.01 E. | 1.23 |
| 269 Serverh Heckeded
274 Servery offer offer

 | 22 Made

 | 45-1 | 11-2422 2 |
 | | LATI | Yes | Ter
 | Nonice oping continuing | Deteriorated | GRADE2 | |
 | | 1.00
9.55 |
 | . 45 1.
L 15 4 | 1.22 |
| 274 Severy a Harolikar
271 Chardrak with a Haron and

 | 17 Formale

 | 05-0 | 13-2824 974944 | Hindu
370708 Hindu
 | Photos Winners | ab damin of pain and or evaluat | Ma | Ha
Tot
 | | Ingraved
Determented | GRADE4 | | 3.37
 | 59 4 | 1.55 |
 | L15 1 | 9.4 |
| 371 What was also

 | TT Male

 | 62-1 | 11-2+22 2 | 268962 Hindu
 | Sindai fijayapara | Fostischeck committery tall | Yar | Tar
 | Inverire ventiletion
Inverire ventiletion | Datariarated
Datariarated | GRADE1
GRADE2 | | 2.46
 | N87 9 | 1.91 | 1.07 0
 | 1.45 1. | 1.23 |
| 272 Savitei Hiramath
274 Rodha Modaa ed

 | 42 Famile
20 Famile

 | 20-8 | 19-2024 021944
12-2022 2 | Hindu
220793 Hindu
 | Maddabilial | argenic campandpairaning | Na | Na
 | | Direkerged
Direkerged | GRADES
GRADES | | 5.15
 | 1.54 9
1.46 8 | 147 | 6.72 6
5.00 6
 | 1.60 0.
1.66 0. | 0.41 |
| 375 Jahosofra Javasker
375 Baranyos Birader

 | 73 Famale

 | 26-8 | 81-2824 024117 | Mindu
 | b-di | Inglesse campacity adverses | - | Ha
Ha
 | | Ingrand
Direkarand | GRADES
GRADES | | 6.13
 | N99
N99 | | 6.27 6
0.72 6
 | | 3.45 |
| 374 Baranona Biradar
277 Shubin Maškar

 | 11 Famile
22 Famile

 | 03-6 | 4-2423 | 119933 Hindu
179224
 | TEay apare
Meddebikel | uti
eta uitk wild ha ad injury | Na | Na
 | | Direkerard | GRADE 4
GRADE 4 | | 3.15
 | .51 | | 5.72
 | 1.43 4 | 9.46
9.5
9.51
9.4 |
| 278 Divagrani Pojeri

 | 20 Female

 | 04-04 | 14-2924 1 | 193555 Hindu
 | Indi | agate ary chatic libear | No. | Ma
 | | Direkerged
Ingewood | GRADE4 | | d. 56 0
 | | 0.51 | 4.71 6
0.47 6
 | 6.99 O.
644 O | 9.4 |
| 379 Gentefisited
388 Gentefisited

 | 20 Familie
26 Familie

 | 9-5 | 12-2922 4 | 420209 Mindu
120971 Mindu
 | TEay-spare
TEay-spare | Chort pain under confortion | The later | Ma
 | | Ingraved | GRADES | | 5.49
 | N99 0 | 0.91 | 6,69
 | 7 9. | 9.43 |
| 211 SustaMaxiaanar

 | 24 Famala

 | 29-6 | 2-2+24 05+545 |
 | | ab daminal pair under avaluat | No. | Ma
Ma
 | | Ingrand . | GRADE 4 | |
 | .54 4 | 1.52 |
 | 1.14 0. | 0.52 |
| 212 HallappaWeded
213 SurandaKachenar

 | 22 Male
28 Female

 | 01-0 | 14-2422 2 | 270524 Hindu
 | | rtauith aildha ad isjury
Acuta fabrila ilhaar | Na | Na
 | | Ingrared | GRADE4 | | 2.42
 | | 1.54 | 4.11 4
 | L19 0.
L19 0. | 0.52 |
| 314 Bhimman e Manda well

 | T1 Male

 | 94-6 | 12-2923 045104
90-2923 3 | Hindu
124297 Hindu
 | Pladial | nons febrils lines | Ne | Na
 | | Ingrand | ORADE 4 | | 4.91 0
 | 1.54 4
1.57 4 | 1.51 | 4.13
 | 1.94 0
4.81 0 | 9.5
9.4
9.5
9.24 |
| 225 Jyahi mathaai

 | 26 Famile

 | 02-5 | 90-2#23 3 | 299976 Hindu
 | Pladdabili.el | tesi t | Na | Na
 | | Direkarged
Ingenered | GRADE 4 | |
 | 1.54 0
1.51 0 | 1.92 | 6.44 5
 | 6.01 (| ** |
| 225 Shinasharan Yamana
227 Shantakai Diradar

 | 21 Male
23 Female

 | 05-9 | |
 | | Charty-sin under or abortian | No. | Ha
 | | Dircherard | GRADES
GRADES | | 5.64
 | .59 | 1.47 | 5,47 5
 | 1.62 0.
1.90 0. | 0.41 |
| 333 Recoke Sanka el

 | 29 Famile

 | 04-9 | 90-2#23 3 | 319349 Hindu
319349 Hindu
 | Pladdabiliel | IN | No | Ma
 | | Dircherged
Improved | GRADES | | 5.66 6.83
 | .59 0 | | 6.84
 | 7 0. | 9.33 |
| 229 Arbah Rathad
200 Subhar Dhaj

 | S1 Male
S6 Male

 | 02-9 | 90-2#23 1 | 214199 Hindu
212117 Hindu
 | Sindaj
Indi | Inti Inti Internetta Indone | Ne | Ma .
 | | Dirakarged | GRADE 4
GRADE 5 | | 4.1 I
5.21 I
 | 1,54 d | 142 | 4.47 6
5.97 6
 | 6.95 0.
6.95 0 | 9.4 |
| 221 Harter Prochest Hits of E

 | 20 Mala
91 Mala

 | 29-0- | 19-2422 3 |
 | | han rossing of the bits | Na | Ma
 | | Ingraved
Direkerged | GRADE4 | | 3.32
 | .56 4 | | 2,00
 | 4.11 0. | 0.51 |
| 392 Adirecep-sDedamoni
293 Guranei dosseli

 | 91 Male

 | 29-04 | 19-2923 3
16-2924 1 | 109223 Hindu
126992 Hindu
 | Paddabilited | bodenese at the second | Ne | Ma
Na |
 | | GRADES
GRADE4 | |
 | .54 0 | 1.44 | 6.34 6 | 6.51 0.
1.97 0.
 | 0.81 |
| 293 Geraraj Angadi
294 Lucei Rabai

 | 24 Male
24 Female

 | 02-9 | 90-2022 3 | 249346 Hindu
 | tësyspara | ali dansinal pais us dar avaluat
Chart pais under avaluation | Na | Na
 | | Improved
Improved | GRADE 4
GRADE 5 | |
 | 1,54 4
1,51 6 | |
 | 1.57 0.
1.57 0. | 0.51 |
| 295 Soviel Direder
295 Tavalo Potil

 | 65 Formale
20 Formale

 | 04-9 | 90-2422 3
18-2424 1 | 240163 Hisdu
967097 Hisdu
 | Holial | Chartpoin under or allostion | Na | Ma
 | | Direkerged
Ingeneral | GRADE4 | | 3.45 e
 | 1,50 0
1,57 0 | 1.54
1.55 | 0.02 4
4.41 4
 | 4.15 0.
1.97 0 | 9.52 |
| 397 Peranti haskeeri

 | 19 Famale

 | | |
 | TEayapare
Meddebikel | Cheety on under contestion
bodewore
downe fabrile illneer | Ne | Na
 | | Ingeneed
Ingeneed
Direkseyed | GRADES | |
 | 1,57 0
1,57 0
1,55 0 | |
 | .42 0 | 9.5
0.41
0.41 |
| 291 Vehaniseth Kurur

 | 62 Male
26 Male

 | 16-61 | 10-2022 3
15-2024 001715
10-2022 3 | Hindu
154295 Hindu
 | hái
Tionna - | dersta fakrika ilmaar
nan renamary en sha bita | Na | Ne
 | | | GRADES
GRADE4 | |
 | | |
 | L42 0.
L92 0.
L72 9. | 3.41 |
| 299 LukkeppeHektenerer
499 SenikoPel

 | 26 Male
27 Female

 | 15-02 | 10-2022 3 | 965949 Hindu
 | lodi . | argenic compound paironing | ne - | Na
 | | Dircherged | GRADE4 | | 3.73
 | 1.59 e | 1.53 | 4.0 4
60 5
 | 5.01 0 | 9.52 |
| 491 Heleppe Begewedi

 | 39 Male
40 Male

 | 02-6 | 19-2024 1
14-2024 1 | 149541 Hisdu
569247 Hisdu
 | Tiley apare | rteuithbeedinjury 1 | Ne | Ne
 | | Ingrand Ingrand | GRADES | | 5.73 F
 | 1.59 | 0.91 | 60 6
 | | 0.29 |
| 412 Smann a Walder
412 Shiverina kadabhavi

 | 29 Male

 | 27-6 | 19-2922 3 | 207942 Hindu
 | h-fi | Aceta fabrila ilbour | Ne | Ne
 | | Ingraned | GRADE 4 | | 2.15
 | .55 | 0.51 |
 | 14 | 9.4 |
| 1 HAME OF THE PAT * AGE

 | * SEE

 | DATE OF ADM | IS IP NUMBER | R . RELIGION .
 | RESIDENCE * | PROFISIONAL DIAG * | ICU ADHIST * | NEED OF PENTILA
 | IF ON TENTILA | 41 HRS OUTO | EMERGENCT SEVERITT I | PERIPHERAL PERFUSIO | . SHOCK IN
 | · SHOCK INDES | * PERIPHERAL PERFUSION | * PERIPHERAL PERFUSION
 | * SHOCK IND | |
| 414 NisgenogradeBirader

 | 23 Male

 | 26-19 | |
 | | chartpain under evaluation | | Ne
 | | Improved | GRADES | | 5.84
 | 0.5 0 | ur i | .73
 | 7 0. | .43 |
| 415 Sundrabai Olekar

 | 56 Formale

 | | | 384799 Hindu
 | h-á | eb-daminelp-ain-un-dor orrelout | Na | Ne
 | | | GRADE 4 | |
 | | | 4.61
 | | 0.5 |
| 435 Makedovikunvar

 | 49 Famile

 | | |
 | | Acuta hamarchogicztraka | | Ter
 | Invariou contilution | | GRADE2 | |
 | | |
 | | 0.62 |
| 497 leharanya Gani

 | 55 Fomalo

 | 30-15 | | 419221 Hindu
 | Sindogi eğayapura | Acutopenerostitiz | | Ter
 | inveriro rostilation | Deterioretad | GRADE1 | |
 | | |
 | .00 10 | 123 |
| 411 Melanova Tated

 | 71 Formale

 | | | 234909 Hindu
 | Moddobilhal filjeyapa | | 14 | Ter
 | loogioo restilation | | GRADE2 | |
 | | |
 | | 123 |
| 409 Menistes Hervytegi
410 Melloppaniarhyel

 | 41 Female
71 Male

 | | | 210039 Hinda
34533 Hinda
 | Tablats Teay apare | RTA with chart treams
Acuto inchanicatraka | Ter | Ter
 | Nasianarine vestilatie | Improved | GRADE2 | |
 | | |
 | | 124 |
| 410 Freiappanianyei
411 Selvenzheith

 | 69 Male

 | | | 77119 Halin
 | Khas Gall Nijeyapare | Sudukite | Ter . | ne
Tor
 | kogin-ustilation | Expressoo
Exteriorated | GRADE1 | |
 | | |
 | | 123 |
| 412 Mahibasharah Walikar

 | 59 Male

 | | |
 | Sinda Tinzara | Op concernation pairwain-g | Ter | Ter
 | Invariou contilation | | GRADE1 | |
 | | |
 | | 1.02 |
| 413 Jayartees uddarhmeth

 | 40 Formale

 | | |
 | Sindaj fijeyapure | | Ter | Ter
 | logio ostilation | | GRADE1 | |
 | | |
 | | 124 |
| 414 VachsRatked

 | 61 Male

 | 05-41 | | 252360 Hindu
 | Moddobilt al Tijayapa | a Type Zeorginatary feilure | Ter | Ter
 | Nasio-arise costiletic | Deterioreted | GRADE2 | | 3.82 6
 | .78 0 | 1871 | 1.02 0.
 | .06 1.) | 1.62 |
| 415 Presses Kanvar

 | 40 Male

 | | 12-2023 |
 | Mudhalvijeyapara | | | Ne
 | | | GRADET | | 4.72 0
 | | .75 | 1.92 4.
 | .02 0.1 | 2.47 |
| 416 PeojeRethod

 | 18 Formale

 | | 15-2023 1 | 157222 Hindu
 | Muthalinijayapura | Pyrothein concumption pairs | | Ne
 | | | GRADE3 | |
 | | | 1.97 6.
 | .33 0.5 | 0.54 |
| 417 Rashma Shak

 | 41 Female

 | | |
 | ladi Vişey opur e | Seprinzo candery ta AGE | Ter | Ne
 | | | GRADE2 | |
 | | |
 | | 124 |
| 411 Manual Rudrawadi
419 Sabhasa Kudohi

 | 26 Mela
44 Formala

 | 02-15 | 12-2923 3
16-2923 1 |
 | Indi Tijayopura | | Ter | Ter
 | Nasinopire vestilatia
Inopire vestilatian | | GRADET
GRADET | |
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 | |).74
124 |
| 419 Seminarausth

 | 63 Male

 | 11-10 | 16-2023 1 |
 | Six og Yesyspara | Seprizzo canóory talk uppor l
a Acuto homan hogicztrako | Ter . | Ter
 | Invarios vestilation | | GRADE1 | |
 | | | 1.01 8.0
 | | 125 |
| 421 Dundauwa Surjapar

 | 42 Formale

 | | |
 | | | | Ter
 | Invariou contilation | | GRADE1 | |
 | | |
 | | 124 |
| 422 Aldenmekatyal

 | 16 Formale

 | 08-41 | 4-2023 2 |
 | Attaizadi | Septiczkackze candery taLF | | Ter
 | | Duturianeta-d | GRADE1 | | 433 0
 | .98 1 | 1.02 | 1.05 0.
 | .04 1.3 | 124 |
| 423 Harawab talikati

 | T6 Male

 | 30-40 | 0-2023 | 197509 Hinda
 | Talikati fijeyopara | Acutairchamicstraka | Ter | Ne .
 | | | | |
 | | .97 | 1.23
 | 0.16 0.1 | 3.65 |
| 424 Chavdrarhokker devar

 | 26 Male

 | | |
 | | | F | Ne .
 | | Ingraved | GRADED | |
 | | |
 | | 0.54 |
| 425 Karturi Basedal

 | 53 Male

 | 61-16 | 10-2023 3 | 312127 Hinda
 | In di Tijayopura | RTA uith laft tible frectura | |
 | | Impraved | GRADET | | 435 0
 | | .45 1 | .14 4.
 | 129 0.5 | |
| 426 Ningeppakairadagi

 |

 | 09-81 | 14-2023 2 | 286477 Hindu
 | Sin dhi calany vijey og | RTA uith laft tible frectura
g LRTI | Ter | Ter
 | Nasionarino vostilutia | Ingraved
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GRADED | | 4.55 0
 | .75 e
.36 e | 04 | 1.04 4.
0.19 4.
 | 126 0.5 | 5.57 |
|

 | T6 Male

 | 09-84 | 14-2023 2
17-2023 2 | 286477 Hindu
291296 Hindu
 | Sindhi calaxy vijey op
Indi Tijey op ur e | g LRTI
Acuta inchanicatraka | Tar
Tar | Tee
Ne
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 | (75 0
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(76 1 | 0.64 | 1.04 4.
0.19 4.
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 | 02 1 | 12 |
| 427 Nenapasaute

 | T6 Male

 | 09-47
25-47
21-44 | 14-2923 2
17-2923 2
14-2923 9 | 286477 Hinda
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 | Sin dhi calany vijey op
In di Hijey op ur e
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a Acuto homarrhogicatraka | Ter
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(36 0
(76 1
124 1 | 1.64
1.02
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3.19 4.
1.03 6.
 | 126 0.3
(82 1
(86 1) | 12 |
| 421 IrenvaGarti

 | 76 Male
25 Male

 | 09-44
25-4
21-6
20-40 | 14-2023 2
17-2023 2
14-2023 1
16-2023 1 | 286477 Hinda
281256 Hinda
101761 Hinda
164236 Hinda
 | Sindhi calany vijey op
Indi Fijey op ur s
Bobh sloch u sr vijey s
Indi Fijey op ur s | g LAM
Acuto inchemicotrako
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 | Nas invarios vostilotia
Invarios vostilotian
Invarios vostilotian | Impraved
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Deterioreted | 69A0E3
69A0E3
69A0E1
69A0E1
69A0E1 | | 4.55 6
3.20 6
0.67 1
0.62 1
 | 175 0
136 0
176 1
124 1
180 1 | 1.64
1.02
1.02
1.02 | 1.04 4.
3.19 4.
1.03 6.
1.02 6.
1.02 6.
 | 126 0.3
102 1
106 1.3
108 0.4 | 12
125
0.63 |
| 421 IrenvaGarti
423 Shankrayyayaduadmath

 | 76 Mala
25 Mala
39 Mala

 | 09-4/
25-4/
21-4/
20-4/
29-4/
29-4/ | IF-2023 2
IT-2023 2
IF-2023 1
IF-2023 1
IF-2023 1 | 2864777 Hinda
281256 Hinda
101761 Hinda
164256 Hinda
174006 Hinda
 | Sindhi calany vijeyog
Indi Fijeyogura
Bahhalarhuar vijeya
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Acoto inchomicatrako
a Acoto homantegicatrako
Secko bito
LRTI | Ter
Ter
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 | Nasionarino nustilatio
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Deterioreted | 69A0E3
69A0E3
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0.20 0
 | (75 0
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(76 1
(24 1
(80 1 | 144
102
132
102
102 | 1.04 4.
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1.03 0.
1.03 0.
1.04 0.
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1.0 | 126 0.3
182 1
186 1
189 0.0
186 1
 | 12
125
0.60
1.21 |
| 421 Ironna Garti
429 Shankeeyya yadaadmatk
429 Taya Ratked

 | 76 Male
25 Male

 | 09-41
25-41
20-45
20-45
29-45
09-15 | 14-2023 2
17-2023 2
14-2023 1
14-2023 1
14-2023 1
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 | Sindhi calany vijeyop
Indi Vijeyopure
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Acuto ischomicstrako
a Acuto homarrhogicstrako
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Acuto GEwithshack | Ter
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 | Maximorino vustilatio
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venerid Anvenri 2 Algenes Hirementh 2 ventek ol Tembe	3 Plato D Female	19-98-2023 69-98-2023 60-98-2023	255406 Hinda 255406 Hinda 255400 Hinda	Tiayapara Tiayapara Mudhal	irti Ma uti Ma	No.		Ingraved Ingraved	GRADE 4 GRADE 4 GRADE 5		4.00	0.6	0.54 0.5	4.73 4.41 5.34	6.91 6.12
avtekai Tembo	1 Female	66-88-2023	255400 Hinds		bodzeror He	No.			GRADES		5.05				6.12
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Henviso Diredor	ti Female	26-97-2023	242603 Hinda	Tilayapara Tilayapara	ab dansio al pais un dar avaltari Ma Acesta fabrila Almarr Na	No.		Ingraved	GRADES		3.87 2.89 5.64 2.41 5.64 5.64 5.71		0.45	4.11	
dvadovi Biradar d vraj Mala 3	19 Female 12 Male 19 Male	26-97-2023 20-97-2023 14-18-2022	242603 Hinda 242604 Hinda 234905 Hinda 360407 Hinda		Acuta fabrila ilisaar Na nas rasa masa raska bita Na aroonia campasun faairaning Na	No.		Improved Improved Dircharged Improved	GRADES GRADES GRADES		2.41 5.04	0.51	0.45 0.52 0.42		6,61
in an order the size of the means	9 Malo	14-18-2022 29-94-2024	360407 Hisda 145001 Hisda	budi Regi	argonic campaso-Apairaning. Na	No		Ingraved	GRADES		5.71	0.54	0.48		6.81
Taxita Jadhav Nidenand Balogavi 2	H Famala 2 Halo	15-18-2022	TETERS Minda	Regi	chartpain under aveluetian. Ma	Ne		Ingraved	GRADES		2.64 5.71	5.56	0.52	4.05	6.92 1.37
NiverNesker a good Patil	9 Hele	19-18-2022 29-94-2024	265629 Hisda	Sindaj Sindaj	lei Ne	No.		Ingraved	GRADES		5.68 6.01 3.34 4.22	1.50 1.50	6,41 6,51 6,57	4.0	
idebal Masver 3	7 Femela	17-18-2022	343572 Hinda	7ijayapare	uti Na	N-		Ingraved	GRADE4		3.34	1.59	0.57	5.99 3.84 4.57	127
Anderson in Banagari Manakan kara sayar Pakil Shuka si Kali Ada ata Hadimani Hanana Hadimani Haiwana Hadimani Haikariya Kodori Irita Baranagar	9 Hala 9 Fanala 7 Fanala 8 Hala 11 Hala 3 Fanala	17-18-2022 20-84-2024 23-18-2023 21-18-2023	265529 Hinda 166240 Hinda 363572 Hinda 122790 Hinda 324976 Hinda 223621 Hinda	Pileyapare Indi Tileyapare Pileyapare	COPD Na	Na Na		Ingraved	GRADE 4 GRADE 5 GRADE 5 GRADE 5 GRADE 4 GRADE 4 GRADE 4 GRADE 5		4.22 3.61 5.17	0.52 0.57			
leitaBararogov 3	3 Female	21-18-2023	333631 Hisda	Pijey apare	nen renemeneren eksekite Na	х.		Ingraved	GRADES					5.01 6.25	
ovindra Dirodar AJARAH PALASKAR	H Halo	12-18-2023 23-01-2023	225296 His-44 22665 HINDU	Tijayapara INDI	arquic canyaondyabaning Ma ACUTE PANCREATINS Tar	Ha	longine metileties	Deteriorated	CRADE 4 GRADE 1 GRADE 2 GRADE 1 GRADE 1 GRADE 1 GRADE 1 GRADE 2 GRADE 2 GRA		4.05	1.57	0.50	427	1.74).92
ANTOSH CHAWAN 2	17 Mala 19 Mala	10-09-2023 25-99-2023	244224 HINDU 231747 HINDU		RTAVITHINEAD INJURY Tar ACUTE OF WITH SHOCK Tar	Ter	bergine restilation	Duturianatud Duturianatud	GRADE2		122	1.00	5.60 5.23	9.92 9.56	0.02 0.03
HITAPPA SURTAVANSE	N Male	25-11-2023	370637 HINDU	MUDHOL	ACUTE DE VITH SHOCK Tar SCUTE DE VITH SHOCK Tar SEP-SIS SECTOLETI Tar ACUTE ISCHEHEC STROKE Tar ACUTE ISCHEHEC STROKE Tar ACUTE ISCHEHEC STROKE Tar ACUTE ISCHEHE STROKE Tar	Ter	lorgine restilation lorgine restilation	Dotoniaratud Dotoniaratud Dotoniaratud	GRADE2		15	1.94 1.94	6.40	9.55	.42
ASHIR CHAUDHARI S	5 Hele 14 Hele 7 Hele 14 Hele 6 Fonde 19 Hele	25-11-2023 20-97-2023 34-18-2023 24-98-2023	210627 HINDU 200677 HINDU 246973 HINDU 271499 HINDU 105767 HINDU 165555 HINDU	MUCHOL MUCCEBINAL	ACUTEISONEMIC STROKE TH	Tar Tar			GRADE2		154	0.04	0.90	9.62 9.99	
AJARAH PALASKAR ANTOSH CAMVAN ASPAH KAMPAN HI ASPA SURTAMANSI ASHR CHAODHAR MARI SHITKA NARAYA HANDRA SHEKHAR TELI	i1 Mala	24-91-2023	278499 HINDU	TALIKOTI	ACUTE HEHORRHAGIC STRI Tar	Ter	houring contilation	Duturianated Duturianated	GRADE 1		123 1.19 1.34 1.06	0.81	6.76 5.62 5.62 5.62	0.55	
AMALABAI JADHAT O	4 Female N Male	26-94-2023	135767 HINDU 191525 HINDU	MUDHOL MUDHOL	SEPSIS WITH LATI Tar ACUTE GE WITH HTP OTOLUP Tar	Ter	Incurics contilation	Duturianated Duturianated	GRADE2 GRADE2		134	8.87 8.89	142	9.45	0.07 0.06
	16 Mala 16 Mala	11-92-2023 07-97-2023	54017 HINDU 219993 HINDU	MUDHICE.	PARTIAL HANGING Tax	Ter	Invariou contilution	Dotorianated Dotorianated	GRADE 2		1.90	. KS	0.57	1.00	2.42 2.43 2.42 2.44 2.44 2.44 2.44 2.44
A 24 M RAY 2001 22 A 24 M RAY 2001 22 A 24 U SAVAKA AG A 24 GONDA P A 11 A 24 GONDA P A 11 A 24 A 4 90 A 24 H O 4 A A 190 A 24 H O 4 A A 190 A 24 H O 4 A 3 H 24 H O 4 A 3 H 24 A 24 H O 4 A 3 H 24 H O 4 A 4 A 3 H	0 Male	12-18-2023	206509 HINDU	DETARHEPARAGI	LATI WITHSEPTIC SHOCK TH	Ter	borgeine mentiletion	Duturiarated	GRADE2 GRADE2 GRADE2 GRADE2 GRADE2			1.79	0.84	0.02	
ANGONDAPATIL	H Halo	12-18-2023 24-95-2023 27-83-2023	244509 HINDU 284591 HINDU 182692 HINDU	DETARHEPARAGI BAGALKOT SINDGI	LATI WITHSEPTIC SHOCK Top SEPSIS SECTOLATI Top LATI WITH SEPSIS Top	Ter Ter	Invaries contilation	Deteriorated Deteriorated Deteriorated	GRADE2			5.70 5.66 5.70	0.04 5.42 5.42 5.42 5.42 5.44	8.89	0.02 0.06
ALLAPPATELI	4 Malo	64-95-2023	145949 HINDU	SINDGI HRUDHIGE	HENRINGOENOEPHALITIS Tor	Ter	borgeing mantiletion	Deteriorated Deteriorated Deteriorated Deteriorated	GRADE 2 GRADE 2		1.09	5.79 5.87	142	1.05	x.ee
ALMAMOKASHI 1	9 Hala 8 Hala 6 Fornala 4 Hala 7 Fornala 11 Hala	27-93-2023 64-95-2023 15-96-2023 91-91-2022	145149 HINDU 145149 HINDU 195244 HUSUH 601 HINDU	PAGALKOT	MENHIGOENCEPHALITIS Tar SEPTIS MTHPURPURA Tar ACUTEISCHEMIC STROKE Tar	Ter	Invariou contilation	Deteriorated Deteriorated	GRADE2 GRADE2 GRADE1		1.65	1.46 1.42	1.91	9.99 9.99	
Next Inger III (Next Start	7 Helo 9 Helo	13-11-2023 28-95-2023	355039 His-44 172294 HINDU	TExyopare BAGALKOT	RTAVITHHEAD PUURY Tar	No.		Ingraved Deteriorated	GRADE 4 GRADE 1		3.07	.59	5.92		L.76
AT PATA. 3 ANDER FA HAGAREDOI S WANAGE Halegari	re mala 10 Mala	22-12-2023	493054 HINDU	BAGALKOT SHOGP Indi	RTAVITHIEAD INJURY Tar MENINGOEHOEPHALITIS Tar URTI Na	Tar	bergeine vontillation bergeine vontillation	Dutariarated Dutariarated	GRADE 2		1.60				
waxaya Halagani 1	10 Malu 16 Malu	22-12-2023 19-88-2023	491005 HENDU 255413 Hisda	b-li		No.		Deteriorated Dircharged	GRADE 2 GRADE 4		4.51	1.87	0.54	4.81	1.41
B Halogi S	S Hala S Hala S Hala 8 Hala 9 Hala 8 Hala	20-94-2024 21-91-2023 25-94-2024 047282 86-83-2024 046188 25-92-2024 044345 90-85-2024	160946 Hisda 423068 Hisda	bodi Modikal Moddobikal	NON vanamararan dia bita Na URTI Na			Dircharged	GRADES		\$.07 \$.83	0.51	6.41 0.88 0.55 0.55 0.54	6.0	6.81
has Nair 2	5 Helo	25-94-2024 097292	Hisda MINDA	Maddabilited	argonic company dynicaning Ma UNTI Ma	N.		Improved	GRADE 4		2.42	0.64	0.54	3.87	4.11
han naga a Malagan Dan Naga a Malaga B Malagi Nan Niki Tababase O Katigid Recoge Walder Walder Walder	0 Halo	25-92-2024 064345	Hindu Hindu 212407 Hindu	Sindaj	LATI Na bedrerer Na LATI Na	8.		Ingraved Ingraved Discharged	GRADE4 GRADE4 GRADE4 GRADE5		2.42 3.70 4.07 5.50	.58	0.54	4.87	
harappa Ohinti Samitra Satihal	K Hala 7 Female	90-95-2024 26-92-2024 0643982	212407 Hinda Hinda	haqi Indi	URTI Ne	No.		Direkarged Interpret	GRADES		5.50),50),59),40	0.51		1.52 6.81
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			EI RELIGION		PROVISIONAL DI LICH ADD		IF OR TERTI	48 BRS 081					PERIPHERAL PERFE		SHOCK IN
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