"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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IN PARTIAL FULFILLMENT FOR THE DEGREE OF

DOCTOR OF MEDICINE IN EMERGENCY MEDICINE,

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.

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

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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 five-level 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:

1. **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:

1. **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.

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.

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 under-triaged based on ESI alone. For instance, a patient with an ESI level of 3 (urgent but not life-threatening) 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, 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 evidence-based 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.

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

Factors	**Emergency Severity 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

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).

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

Factors	**48-hour outcome**		**p-value**
	Deteriorated	**Improved / 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)	
PI			
PI at admission	1.7 (0.9)	4.0 (1.9)	<0.001

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.

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

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	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

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 are significantly associated with the need for mechanical ventilation.

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

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

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 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 $p<0.001$).

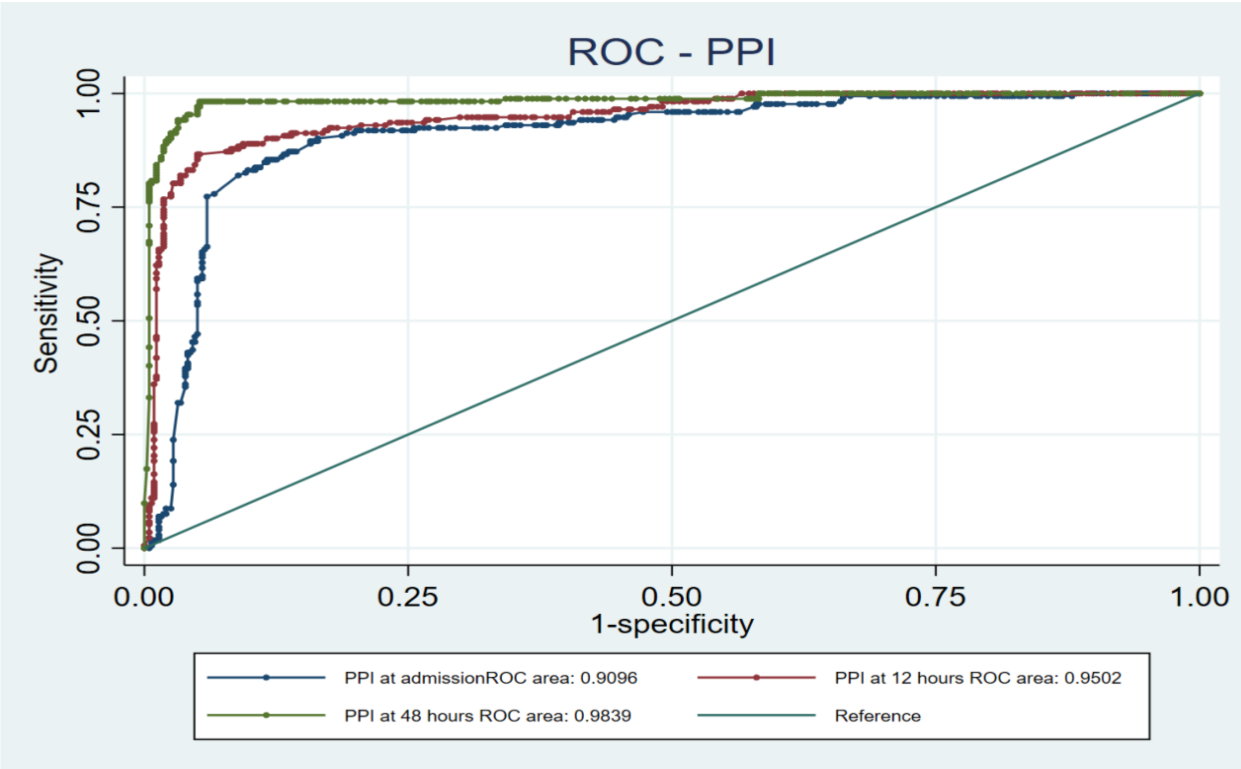
Table 7: Factors Associated with the Need for Ventilator Support

Variables	**Need for Ventilator**	
	OR (95%CI)	**p-value**
Age		
15 - 30	Ref	
31 - 45	2.18 (1.19 – 3.98)	0.011
46 - 60	3.3 (1.78 – 6.11)	<0.001
>60	3. 8 (2.15 – 6.73)	<0.001
Sex		
Female	Ref	
Male	1.24 (0.84 – 1.84)	0.268
Religion		
Hindu	Ref	
Muslim	2.10 (1.09 – 4.03)	0.025
PPI 0	0.36 (0.30 – 0.43)	<0.001
PPI12	0.31 (0.26 – 0.37)	<0.001
PPI48	0.46 (0.41 – 0.51)	<0.001
SI 0	1.07 (1.06 – 1.08)	<0.001
SI12	1.07 (1.06 – 1.08)	<0.001
SI48	1.05 (1.04 – 1.05)	<0.001

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).

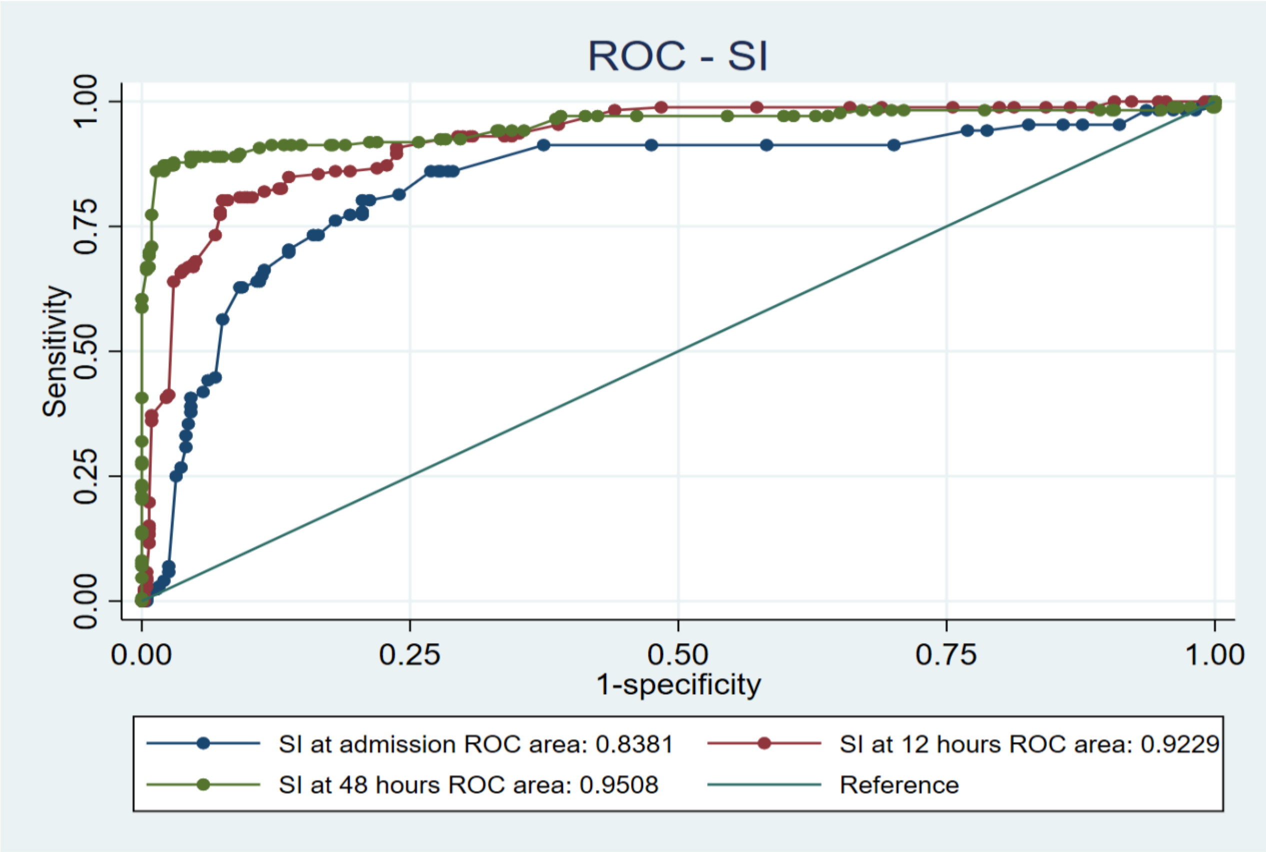


Graph 1: Indicates ROC PPI with sensitivity on X axis and (1-specificity) on Y axis.

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.



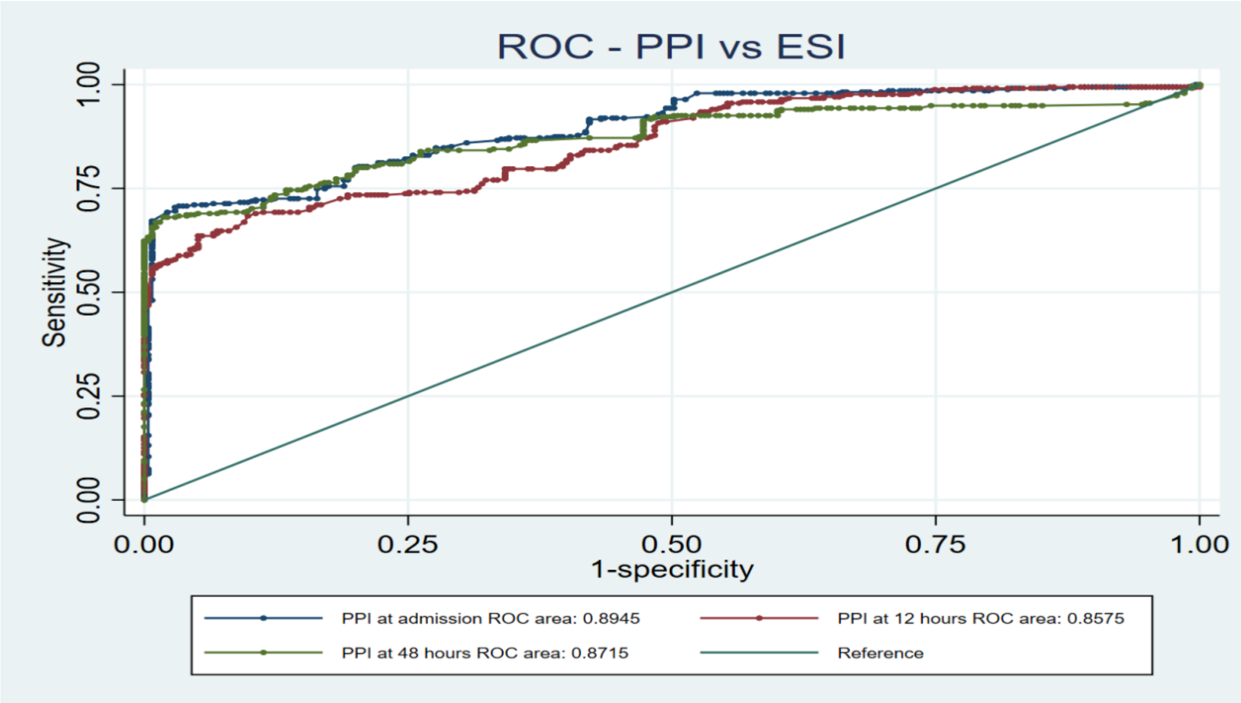
Graph 2: Indicates ROC-SI with sensitivity on X axis and (1-specificity) on Y axis.

Table 9: ROC Analysis Summary for SI (Outcome: Clinical deterioration)

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.

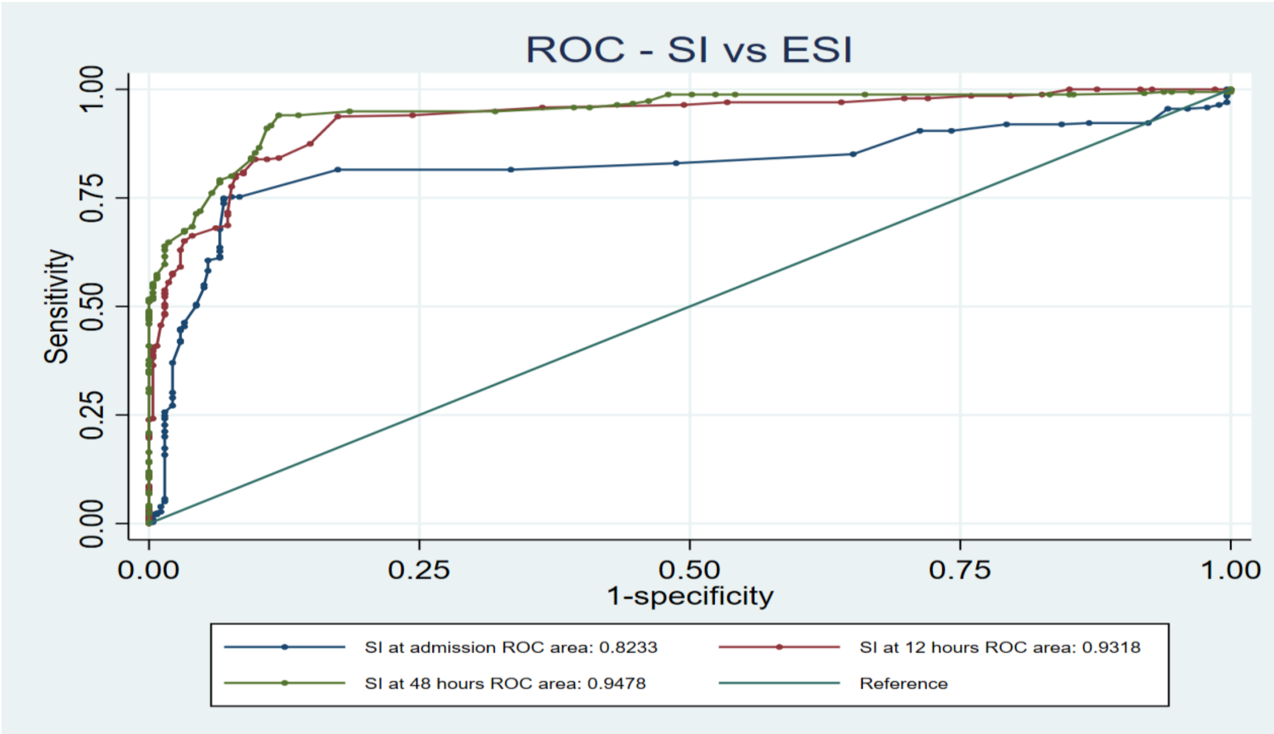


Graph 3: ROC- PPI vs ESI (ESI<3) On X axis sensitivity with Y axis (1-specificity)

Table 10: ROC Analysis Summary for PPI (Outcome: ESI score <3)

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 Summary for SI (Outcome: 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 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 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

Azadi Ka Amrit Mahotsav

BLDE
(DEEMED TO BE UNIVERSITY)
Declared as Deemed to be University u/s 3 of UGC Act, 1956
Accredited with 'A' Grade by NAAC (Cycle-2)
The Constituent College
SHRI B. M. PATIL MEDICAL COLLEGE, HOSPITAL & RESEARCH CENTRE, VIJAYAPURA

BLDE (DU)/IEC/ 703/2022-23 30/8/2022

INSTITUTIONAL ETHICAL CLEARANCE CERTIFICATE

The Ethical Committee of this University met on **Friday, 26th August, 2022 at 3.30 p.m. in the Department of Pharmacology** scrutinizes the Synopsis of Post Graduate Student of BLDE (DU)'s Shri B.M.Patil Medical College Hospital & Research Centre from ethical clearance point of view. After scrutiny, the following original/ corrected and revised version synopsis of the thesis/ research projects has been accorded ethical clearance.

TITLE: "PERIPHERAL PERFUSION INDEX- SHOCK INDEX- ESI IN PREDICTION OF OUTCOME OF PATIENT IN TERTIARY CARE HOSPITAL".

NAME OF THE STUDENT/PRINCIPAL INVESTIGATOR: Deore Shubham Bhausaheb

NAME OF THE GUIDE: Dr. Ravi Patil, Dept. of Emergency Medicine.

Dr. Santoshkumar Jeevangi
Chairperson
IEC, BLDE (DU),
VIJAYAPURA
Chairman,
Institutional Ethical Committee,
BLDE (Deemed to be University)
Vijayapura

Dr.Akram A. Naikwadi
Member Secretary
IEC, BLDE (DU),
VIJAYAPURA
MEMBER SECRETARY
Institutional Ethics Committee
BLDE (Deemed to be University)
Vijayapura-586103, Karnataka

Following documents were placed before Ethical Committee for Scrutinization.

- Copy of Synopsis/Research Projects
- Copy of inform consent form
- Any other relevant document

Smt. Bangaramma Sajjan Campus, B. M. Patil Road (Sholapur Road), Vijayapura - 586103, Karnataka, India.
BLDE (DU): Phone: +918352-262770, Fax: +918352-263303, Website: www.bldedu.ac.in, E-mail: office@bldedu.ac.in
College: Phone: +918352-262770, Fax: +918352-263019, E-mail: bmpmc.principal@bldedu.ac.in

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 Date

(Investigator)

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:

ESI criteria -

Diagnosis –

ICU admission – YES/NO

Need for Ventilation: Yes—if yes then, Non-invasive ventilation / Invasive Ventilation

No

48-hrs outcome: Improved/Deteriorated or Died

	At the time of arrival	At 12th hrs after admission	At the 48th hrs after admission
Peripheral Perfusion Index			
Shock Index (HR/SBP)			
Emergency Severity Index Grade		–	–

MASTER CHART:

1	NAME OF THE PA	AGE	SEX	DATE OF ADMIS	IP NUMBER	RELIGION	RESIDENCE	PROVISIONAL DIAG	ICU ADMISS	NEED OF VENTILA	IF ON VENTILA	48 HRS OUTC	EMERGENCY SEVERITY	PERIPHERAL PERFUSION	SHOCK IN	SHOCK INDEX	PERIPHERAL PERFUSION	PERIPHERAL PERFUSION	SHOCK IND
15	Shantabai Teli	63	Female	05-07-2023	133118	Hindu	Vijayapura	Cardiogenic pulmonary oedem	Yes	Yes	Non invasive ventilatio	Discharged	GRADE 2	0.8	0.8	1	2	1.2	0.7
16	Bhimchi pujari	61	Male	28-09-2023	240404	Hindu	Vijayapura	Pulmonary thromboembolism	Yes	Yes	Non invasive ventilatio	deteriorated	GRADE 2	0.6	0.9	1.2	0.07	0.01	1.5
17	Kasturibai hittanalli	62	Female	07-10-2023	318324	Hindu	Hipparagi Vijayapura	CVA with pontine hemorrhag	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	0.64	0.6	0.9	1.9	1	1.3
18	Dilip Handigunur	49	Male	13-03-2023	8715	Hindu	Hipparagi Vijayapura	Brachial plexus injury with rta	Yes	No		Improved	GRADE 3	5	0.8	0.6	4.5	5	0.6
19	Sidda Nutikar	38	Male	20-12-2023	198526	Hindu	Indi Vijayapura	Meningoencephalitis	Yes	No		Improved	GRADE 2	1.64	0.8	0.7	3	2.5	0.9
20	Sanvoco Mulla	28	Female	01-01-2024	477	Muslim	Vijayapura	Amitraz poisoning	Yes	No		Improved	GRADE 4	5	0.6	0.6	4	5	0.6
21	Basappa manager	20	Male	25-08-2023	271957	Hindu	Indi Vijayapura	Pyrethrin compound consump	Yes	No		Improved	GRADE 4	0.9	0.9	0.6	3	4	0.5
22	Bharat Agrawal	73	Male	06-03-2024	37719	Hindu	Indi	Acute coronary syndrome	Yes	Yes	Non invasive ventilatio	Improved	GRADE 2	3	0.6	1	2.1	2	1.1
23	Nashir chaudhari	53	Male	20-07-2023	233681	Hindu	Hipparagi Vijayapura	Posterior circulation stroke	Yes	No		Improved	GRADE 2	3	0.6	0.8	3	3.5	0.9
24	Parvati patil	40	Female	07-02-2024	42152	Hindu	Bablaleshwar	Anemia in failure	Yes	No		Discharged	GRADE 1	1.23	0.6	0.8	2	1	0.9
25	Laxman kaseer	58	Male	25-08-2023	231747	Hindu	Bablaleshwar vijayap	DCLD	Yes	No		Improved	GRADE 3	5	0.6	0.7	4.5	4	0.5
26	Shankar Navi	85	Male	02-01-2024	1175	Hindu	Maddebihal Vijayapu	Septic shock secondary to LF	Yes	Yes	Non invasive ventilatio	Improved	GRADE 2	0.01	1	0.9	0.02	0.01	1.2
27	Amar jamadar	40	Male	03-04-2023	110512	Muslim	Vijayapura	Hypovolemic shock secondar	Yes	No		Improved	GRADE 3	2	1.2	1	1	2.5	0.6
28	Vitthal Gogari	75	Male	03-05-2023	144349	Hindu	Maddebihal Vijayapu	Acute exacerbation of COPD	Yes	Yes	Non invasive ventilatio	Improved	GRADE 3	3	0.6	0.5	3.5	4	0.6
29	Nagappa kumbhar	42	Male	07-05-2024	155083	Hindu	Sindgi	Septic shock secondary to ri	Yes	No		Deteriorated	GRADE 1	1.98	0.8	1	1	0.8	1.4
30	Mayappa Wadad	45	Male	25-04-2023	134435	Hindu	Sindgi Vijayapura	Meningoencephalitis	Yes	No		Deteriorated	GRADE 1	1.65	0.6	1	2	1	1.4
31	Hanamantray Narayanpur	66	Male	30-10-2023	340573	Hindu	Sindgi Vijayapura	Septic shock secondary to LF	Yes	Yes	Non invasive ventilatio	Improved	GRADE 3	4	0.9	1	3	3.76	0.8
32	Sapna patil	22	Female	01-01-2024	18	Hindu	Vijayapura	Acute gastritis	No	No		Improved	GRADE 4	5	0.5	0.5	6	5	0.6
33	Basappa Manager	20	Male	25-08-2023	271957	Hindu	Bagewadi vijayapura	Unknown compound consump	Yes	No		Discharged	GRADE 3	3	0.5	0.8	2	2.5	0.7
34	Laxman melinmani	75	Male	13-03-2024	83306	Hindu	Jevaragi Gulbarga	Septic shock secondary to LF	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	1.06	0.5	1.2	1.24	0.01	1.4
35	Saddalingappa savati	60	Male	29-09-2023	310230	Hindu	Ingaleshwar Bagewadi	Septic shock secondary to ri	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	1.23	0.5	1.2	3	0.001	1.6
36	Babu kavalagi	57	Male	24-06-2023	206589	Hindu	Badigeri Vijayapura	Hemorrhagic stroke	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	1.65	0.7	0.9	0.8	0.02	1.4
37	Manjunath hadimani	24	Male	10-04-2024	130527	Hindu	Indi Vijayapura	Amitraz compound consumpt	Yes	No		Improved	GRADE 3	5	0.6	0.9	3	4.73	0.6
38	Dilip Handigunur	49	Male	13-03-2023	8715	Hindu	Vijayapura	Rta with multiple long bone fr	Yes	No		Discharged	GRADE 3	5	0.5	0.6	4	4	0.5
39	Shekappa pujari	45	Male	03-12-2023	379079	Hindu	Madbabhavi vijayapu	Acute coronary syndrome	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	0.8	0.8	1	0.08	0.01	1.2
40	Babu Kavalagi	57	Male	24-06-2023	206589	Hindu	Badigeri Vijayapura	Septic shock secondary to LF	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	1.06	0.6	0.9	0.9	0.001	1.3
41	Iqbal Saudagar	38	Male	16-11-2023	358892	Muslim	Ukali B Bagewadi vij	Pulmonary thromboembolism	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	1.54	0.6	1	0.09	0.001	1.4
42	Ajit patil	38	Male	20-05-2023	172284	Hindu	Kolhar Vijayapura	Acute pancreatitis	Yes	Yes	Invasive ventilation	deteriorated	GRADE 2	2.01	0.7	0.9	0.04	0.001	1.2
43	Imamsab Nadaf	87	Male	11-03-2023	85751	Muslim	Halerolli vijayapura	Congestive Cardiac Failure	Yes	No		deteriorated	GRADE 2	1.98	0.5	0.9	1.2	0.001	1.3
44	Hobai masalar	41	Male	26-04-2023	136361	Hindu	Jumanal vijayapura	Acute pancreatitis	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	1.06	0.6	1.2	1.7	0.002	1.5
45	Ningappa bhamansavar	64	Male	11-03-2024	81123	Hindu	Vijayapura	Septic shock secondary to LF	Yes	Yes	Invasive ventilation	deteriorated	GRADE 2	2.01	0.6	0.9	1.67	0.06	1.6
46	Roshanbee korabu	65	Female	09-01-2024	10302	Hindu	Bablaleshwar vijayap	Septic shock secondary to LF	Yes	No		deteriorated	GRADE 1	1.87	0.7	1.2	0.1	0.001	1.6
47	Bandeppa Nagareddi	58	Male	22-12-2023	401056	Hindu	Ganesh nagar Vijayap	Septic shock secondary to LF	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	0.98	1.2	0.9	1.68	2.89	0.89
48	Pushparaj Gaqual	41	Male	01-04-2023	242148	Hindu	Inamdar colony vijay	Septic shock secondary to sc	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	1.03	0.8	1.3	3.12	1.2	1.6
49	Rabanbee sinteer	71	Female	05-01-2023	6449	Muslim	Vijayapura	Acute coronary syndrome	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	2.01	1	0.8	2.4	0.02	0.6
50	Vijay koli	25	Male	01-12-2023	377312	Hindu	Gulbarga	Meningoencephalitis	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	1.03	0.8	1.2	0.8	0.25	1.5
51	Ningappa Bhamansavar	64	Male	11-03-2024	81123	Hindu	Vijayapura	Urosepsis	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	2.45	0.8	1	1.04	1.06	1.4
52	SACHIN MUTTAPPA NAC	25	Male	09-10-2023	320700	Hindu	Vijayapura	Non venomous snake bite	No	No		Improved	GRADE 3	7	0.68	0.7	11	14	0.72
53	Ningappa sallappa valikar	30	Male	25-04-2024	140285	Hindu	Vijayapura	Pyrethroid compound poison	No	No		Improved	GRADE 3	3	0.78	0.72	6	8	0.7
54	CHANNAPPA KALLAPPA	35	Male	22-02-2024	60893	Hindu	Alamel tq., Vijayapur	Alcoholic liver disease with m	No	No		Discharged	GRADE 4	5.45	0.62	0.72	5	8	0.8
55	RAVIGOUDA R HAMDAC	39	Male	29-01-2023	27352	Hindu	Talikoti, Vijayapura	Acute gastroenteritis	No	No		Improved	GRADE 4	4.65	0.6	0.68	5	11	0.72
56	Mosesab siddappa Badige	34	Male	24-03-2024	96385	Hindu	B. Bagewadi, Vijayap	Uncontrolled diabetes type 2	No	No		Improved	GRADE 3	3.23	0.89	0.8	3	8	0.76
57	DEVUBA Jane Mhasvar	40	Male	04-03-2024	73787	Hindu	ITTANHINGAL TQ., V	Alcohol intoxication	No	No		Improved	GRADE 3	2.6	0.84	0.75	6	6.8	0.7
58	SURESH SHRISHAIL PATI	25	Male	08-12-2022	434573	Hindu	Vijayapura	Drug induced hypersensitivity	No	No		Improved	GRADE 4	3	1.14	0.9	6	7	0.64
1	NAME OF THE PA	AGE	SEX	DATE OF ADMIS	IP NUMBER	RELIGION	RESIDENCE	PROVISIONAL DIAG	ICU ADMISS	NEED OF VENTILA	IF ON VENTILA	48 HRS OUTC	EMERGENCY SEVERITY	PERIPHERAL PERFUSION	SHOCK IN	SHOCK INDEX	PERIPHERAL PERFUSION	PERIPHERAL PERFUSION	SHOCK IND
58	SURESH SHRISHAIL PATI	25	Male	08-12-2022	434573	Hindu	Vijayapura	Drug induced hypersensitivity	No	No		Improved	GRADE 4	3	1.14	0.9	6	7	0.64
59	PADDU PRADAN CHAVA	58	Male	12-03-2023	86585	Hindu	Hanchinal tq, Vijayapu	Acute febrile illness	Yes	No		Discharged	GRADE 4	5	0.56	0.6	6	8	0.1
60	Madhappa basappa bagal	22	Male	02-03-2023	74269	Hindu	Kaladi district , Vij	Partial hanging with transient	No	No		Improved	GRADE 3	1	0.88	0.81	3	5	0.76
61	SHOBA TUKARAM PAW	43	Female	13-02-2023	55505	Hindu	Gacchin katti colony	RTA with soft tissue injury	Yes	No		Discharged	GRADE 1	1.23	0.8	0.77	5	8	0.65
62	Sangappa patanshetti	62	Male	17-04-2023	126360	Hindu	Vijayapura	Hypertensive urgency	No	No		Discharged	GRADE 4	3	0.3	0.4	4	7	0.58
63	Shankramma	43	Female	28-06-2023	211024	Hindu	Vijayapura	RT MCA infarct	Yes	No		Improved	GRADE 3	2	0.4 0.56		3.6	7	0.65
64	Dhansing R Chavan	62	Male	08-03-2024	77503	Hindu	Tikota district , Vijay	Hepatic encephalopathy with	No	No		Improved	GRADE 3	1	1.16	0.9	3	4	0.8
65	Sharanappa somappa	56	Male	08-01-2023	003929	Hindu	Vijayapura	Metabolic encephalopathy	No	No		Improved	GRADE 4	4	0.86	0.7	5	8	0.62
66	Channamma shaalu	41	Female	24-07-2023	197882	Hindu	Indi Vijayapura	Sepsis with shock	Yes	Yes	Invasive ventilation	deteriorated	GRADE 1	2.15	0.5	0.9	1.97	0.02	1.2
67	Totappa Talwar	39	Male	04-10-2023	316417	Hindu	Vijayapura	Acute pulmonary oedema	Yes	Yes	Non invasive ventilatio	Deteriorated	GRADE 2	3.75	0.6	0.76	4	1.78	1.25
68	Mahadev bandragotti	61	Male	17-08-2023	261747	Hindu	Maddebihal Vijayapu	Acute exacerbation of copd	Yes	Yes	Non invasive ventilatio	Deteriorated	GRADE 2	3.56	0.45	0.67	2.67	0.23	0.58
69	Basavraj Biradar	52	Male	08-08-2023	255446	Hindu	Bagewadi vijayapura	Acute ischemic stroke	Yes	No		Improved	GRADE 3	5.67	0.4	0.5	5.98	5.34	0.52
70	Ashok Katti	55	Male	06-10-2023	316728	Hindu	Vijay nagar Vijayapur	Deep venous thrombosis	Yes	No		Improved	GRADE 3	7.56	0.47	0.56	5.72	5.42	0.45
71	Deerasingh rathod	71	Male	26-07-2023	242248	Hindu	Solapur Maharashtra	DCLD	Yes	No		Deteriorated	GRADE 2	0.43	0.45	0.56	0.34	0.224	0.45
72	Iranna badiger	71	Male	14-07-2023	226598	Hindu	Vikas colony vijayap	Ddd	Yes	No		Improved	GRADE 2	1.54	0.56	0.6	2.77	2.45	0.55
73	Laxmibai walikar	66	Female	02-11-2023	343325	Hindu	Vijayapura	Ddd	Yes	No		Improved	GRADE 1	1.06	074	0.95	0.02 Lo		
74	Hanmantrai walikar	46	Male	09-10-2023	288439	Hindu	Sindgi bijapur	Acute ischemic stroke	Yes	Yes	Non invasive ventilatio	Deteriorated	GRADE 2	2.01	0.5	0.56	4.56	2.34	Indi vijayapura 0.56
75	Zamcela Momin	71	Female	30-01-2023	37224	Muslim	Indi Vijayapura	Septic shock under evaluation	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.56	0.4	0.89	0.13	0.01	0.6
76	Sarojadevi Patil	61	Female	10-12-2023	386405	Hindu	Maddebihal Vijayapu	Acute exacerbation of copd	Yes	Yes	Non invasive ventilatio	Improved	GRADE 2	0.02	0.8	0.65	2.67	3.45	0.5
77	Farida Masigar	46	Female	29-01-2023	37219	Muslim	Sindgi Vijayapura	Meningoencephalitis	Yes	No		Deteriorated	GRADE 2	1.68	0.78	0.67	4.46	4.67	0.64
78	Basamma nishodi	52	Female	12-10-2022	353119	Hindu	Vijayapura	Meningoencephalitis	Yes	No		Improved	GRADE 2	2.06	0.67	0.57	5.35	5.44	0.58
79	Govindappa Chatri	38	Male	11-01-2024	18932	Hindu	Sindgi Vijayapura	Unknown compound consump	Yes	No		Improved	GRADE 2	2.01	0.67	0.6	2.07	4.47	0.58
80	Mohammadsab Hallur	82	Male	11-01-2024	18932	Muslim	Vinay nagar Vijayapu	Sepsis with acute gs	Yes	No		Deteriorated	GRADE 1	1.68	0.67	0.56	3.46	2.36	0.6
81	Rukmini	17	Female	20-07-2023	245006	Hindu	Vishnu nagar Vijayap	Unknown compound consump	Yes	No		Improved	GRADE 2	2.01	0.56	0.65	5.46	4.09	0.52
82	Ninpad Muchandi	36	Male	10-09-2023	288927	Hindu	Chadchan Vijayapura	Snake bite neurotoxic	Yes	Yes	Invasive ventilation	Improved	GRADE 1	1.06	0.98	0.56	4.53	4.35	0.6
83	Chandbee sindagi	36	Female	03-11-2023	345003	Hindu	Sindgi Vijayapura	Acute in ckd	Yes	Yes	Non invasive ventilatio	Improved	GRADE 1	0.26	0.9	0.56	0.268	2.36	0.67
84	Siddagondappa biradar	60	Male	22-01-2023	28657	Hindu	Maddebihal Vijayapu	DKA	Yes	No		Improved	GRADE 2	2.01	0.67	0.56	2.76	3.68	0.58
85	Babu pawar	46	Male	11-01-2023	34768	Hindu	Sindgi Vijayapura	DKA	Yes	No		Improved	GRADE 2	2.03	0.56	0.53	4.46	3.46	0.52
86	Allabaksh chapparband	40	Male	10-11-2022	400536	Muslim	Sindgi Vijayapura	Type 1 rf sec to lrti	Yes	Yes	Non invasive ventilatio	Improved	GRADE 2	2.04	0.6	0.6	4.35	4.36	0.58
87	Kirti kankanwadi	24	Female	02-06-2022	416160	Hindu	Solapur	LRTI	Yes	No		Discharged	GRADE 2	2.01	0.67	0.45	3.67	4.68	0.61

172	Athup Sikandar	36	Male	09-03-2023	93641	Hindu	Tikota, Vijayapura	Unknown compound consump	No	No		Discharged	GRADE 3	5	0.5	0.6	7	8.6	0.64
173	Yallapa pirappa pujari	11	Male	29-05-2024	183954	Hindu	Nagtan nagar, Vijayapura	Snake bite	No	No		Improved	GRADE 3	3.45	0.64	0.65	4	9	0.6
174	Mudiappa burappa	22	Male	02-03-2023	74269	Hindu	Kakandi, Vijayapura	Traumatic hypoxic brain injury	No	No		Improved	GRADE 3	3.67	0.64	0.7	4.6	8.8	0.6
175	Nasirahmar Ram	42	Male	26-09-2023	307122	Hindu	Indi Vijayapura	Pyrethrin compound consump	Yes	No		Improved	GRADE 2	2.15	0.60	0.37	3.04	3.52	0.94
176	Dunibai Rathod	66	Female	04-06-2023	251876	Hindu	Vijayapura	Acute exacerbation of COPD	Yes	Yes	Non invasive ventilatio	Improved	GRADE 2	2.17	0.78	0.78	5.38	5.84	0.85
177	Vishwa Jayaram Nair	28	Male	31-01-2024	34793	Hindu	Bldc campus, Vijayapura	Acute Gastroenteritis	No	No		Improved	GRADE 5	5.96	0.78	0.7	6	11	0.68
178	Gurappa Dalawai	56	Male	24-06-2023	263729	Hindu	Sindagi Vijayapura	Pontine stroke	Yes	No		Improved	GRADE 2	2.56	0.86	0.78	4.30	3.93	0.76
179	Shobha Tukaram	43	Male	13-02-2023	33305	Hindu	Gandhi katti colony	RTA with soft tissue injury	No	No		Discharged	GRADE 5	6.48	0.6	0.72	5.2	8.9	0.65
180	Kashiputra pattar	66	Male	12-02-2023	31470	Hindu	Vinod nagar Vijayapura	Type 2 respiratory failure	Yes	Yes	Non invasive ventilatio	Improved	GRADE 2	2.45	0.76	0.96	4.92	4.92	0.64
181	Ibrahim Malla	42	Male	02-12-2023	378583	Muslim	Mudhol vijayapura	Sepsis sec to rt lower limb ce	Yes	No		Deteriorated	GRADE 1	1.31	0.91	0.96	2.92	0.83	1.3
182	Shankaramma v math	43	Male	20-06-2023	211024	Hindu	Basavan bagewadi	RT MCA infarct	No	No		Improved	GRADE 3	3.65	0.84	0.74	5.2	0.63	0.62
183	Sangappa shivappa patti	62	Male	17-04-2024	126960	Hindu	Mallikarjun nagar, Vijayapura	Hepatorenal organic	No	No		Discharged	GRADE 4	4.01	0.61	0.52	5.8	8.4	0.6
184	Shridevi G Betageri	58	Female	03-10-2022	340183	Hindu	KHB colony, Solapur	Urosepsis with AKI	No	No		Discharged	GRADE 3	3.45	0.65	0.78	6	6.3	0.77
185	Suresh ...	39	Male	12-02-2023	35476	Hindu	Vijayapura	Head injury with multiple facia	No	No		Improved	GRADE 3	3.1	0.57	0.6	5.2	8.2	0.72
186	Shubai Doddabe	34	Female	24-07-2023	236978	Hindu	Sindagi Vijayapura	Neurotoxic snake bite	Yes	No		Improved	GRADE 2	2.65	0.76	0.57	2.83	1.92	0.9
187	Kustani pujari	31	Female	17-09-2023	297505	Hindu	Mudhol vijayapura	Sepsis secondary to ugs	Yes	No		Improved	GRADE 3	4.92	0.78	1.2	3.84	3.34	0.94
188	Ravikumar pawduk	28	Male	12-03-2023	66643	Hindu	Chadchan, Vijayapura	Pyrethroid compound poisoni	No	No		Discharged	GRADE 3	3.69	0.4	0.52	5.3	8.4	0.62
189	Kashinath bhimaraya Adoni	60	Male	30-10-2023	341767	Hindu	Vijayapura	Dimethoate poisoning	No	No		Improved	GRADE 3	3	0.6	0.63	5.7	7.2	0.66
190	Mallikarjun Mattpati	29	Male	24-05-2023	168576	Hindu	sindagi	Anxiety disorder	Yes	No		Improved	GRADE 3	5.38	0.90	0.65	4.94	5.38	0.73
191	Budhaat ...	51	Male	09-02-2023	5109	Muslim	Vijayapura	COPD	Yes	Yes	Non invasive ventilatio	Improved	GRADE 2	2.93	0.67	0.75	3.84	4.92	0.65
192	Jattappa ...	33	Male	22-01-2024	24511	Hindu	Talikoti, Vijayapura	Unknown compound consump	No			Improved	GRADE 4	3	0.6	0.62	5.2	7	0.7
193	Basappa Teli	46	Male	04-05-2023	146095	Hindu	Itagi vijayapura	Rta with mild head injury	Yes	No		Improved	GRADE 3	4.82	0.84	0.75	5.38	4.39	0.58
194	Tarasi ...	24	Male	14-10-2023	326063	Hindu	Solapur Maharashtra	snakebite	Yes	No		Improved	GRADE 3	4.82	0.74	0.75	4.38	4.37	0.96
195	Basappa Hadpa	71	Male	08-11-2023	95535	Hindu	Indi Vijayapura	Acute ischemic stroke	Yes	No		Improved	GRADE 2	2.45	0.57	0.57	4.83	4.82	1.02
196	Ramappa Basappa	61	Male	26-12-2022	445243	Hindu	B BAGEWADI, Vijay	Hypovolemic shock	No	No		Improved	GRADE 3	3.6	0.64	1.3	4	5.7	0.9
197	Yamanur Somayya	73	Male	31-03-2023	109467	Hindu	Sindagi Vijayapura	Perforated bowel	Yes	No		Deteriorated	GRADE 1	1.05	0.68	1.2	1.94	0.82	1.3
198	Rugha marati ...	73	Male	26-02-2023	70114	Hindu	Arakeri ta, Vijayapura	Drug withdrawal seizures	No	No		Improved	GRADE 4	4	0.74	0.65	5.5	8.9	0.62
199	Kurappa ...	36	Male	06-04-2023	115264	Hindu	Indi Vijayapura	Sepsis secondary to LRTI	Yes	No		Improved	GRADE 3	3.02	0.78	0.78	3.82	4.20	0.74
200	Vinod Nikam	31	Male	31-01-2023	36797	Hindu	Muddebihal Vijayapura	Rta with head injury	Yes	No		Improved	GRADE 3	4.92	0.96	0.96	4.32	5.72	0.54
201	Bhimappa basappa ...	51	Male	30-05-2023	175552	Hindu	Babaleshwar, Vijayapura	Neurotoxic snake bite	No	No		Improved	GRADE 3	3.64	0.58	0.9	5.7	6.5	0.65
202	Sharanamma Basappa	61	Male	30-12-2023	401053	Hindu	Vinod nagar Vijayapura	LRTI	Yes	No		Improved	GRADE 3	3.48	0.75	0.65	4.82	4.74	0.57
203	Sharada Patil	51	Female	14-06-2023	192643	Hindu	Indi Vijayapura	Anemia in failure	Yes	No		Improved	GRADE 2	2.65	0.84	0.76	4.82	3.83	0.86
204	Mahaboobsab Makashi	53	Male	10-07-2022	223318	Muslim	Vijayanagar Vijayapura	Acute hemorrhagic stroke	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.45	0.95	0.76	1.83	0.01	0.76
205	Ramappa Shirasad	72	Male	12-06-2023	191243	Hindu	Civil hospital vijayapura	Acute ischemic stroke	Yes	No		Discharged	GRADE 2	2.15	0.86	0.83	4.29	1.82	0.73
206	Nasirahmar Ram	42	Male	26-10-2023	307198	Hindu	Mudhol vijayapura	Imidacloprid poisoning	Yes	No		Improved	GRADE 3	3.92	0.77	0.95	4.92	4.81	0.64
207	Savita Ambali	26	Female	12-03-2023	65101	Hindu	Ashram road vijayapur	LRTI	Yes	No		Improved	GRADE 2	2.01	0.81	0.74	4.31	3.82	0.78
208	Siddappa Awali	60	Male	05-04-2023	112727	Hindu	Indi Vijayapura	Acute ischemic stroke	Yes	No		Deteriorated	GRADE 1	1.02	0.95	0.75	1.83	0.82	1.2
209	Umar Adrani	43	Male	07-05-2023	143240	Hindu	Sindagi Vijayapura	Snakebite	Yes	No		Deteriorated	GRADE 1	1.98	0.93	0.56	1.02	0.03	1.02
210	Manjunath Basikal	31	Male	13-04-2023	123002	Hindu	Mudhol vijayapura	Lower limb cellulitis	Yes	No		Improved	GRADE 2	2.05	1.02	0.96	3.82	1.72	1.04
211	Bhimraj ...	73	Male	10-01-2023	13540	Hindu	Muddebihal Vijayapura	Acute ischemic stroke	Yes	No		Deteriorated	GRADE 1	1.05	0.98	0.99	2.01	0.001	1.02
212	Gopal ...	66	Male	13-06-2023	191414	Hindu	Chadchan	Rta with head injury	Yes	No		Improved	GRADE 4	4.82	0.67	0.56	4.82	4.97	0.76
213	Vinod Mahito	22	Male	13-12-2023	397008	Hindu	Sindagi Vijayapura	Pulmonary thromboembolism	Yes	Yes	Non invasive ventilatio	Improved	GRADE 3	4.33	0.75	0.46	4.27	4.13	0.67
214	Kustani ...	70	Female	07-06-2023	184050	Hindu	Vijayanagar Vijayapura	Rt lower limb cellulitis	Yes	No		Improved	GRADE 3	3.45	0.56	0.66	6.28	4.38	0.65
215	...	46	Male	05-12-2023	380482	Hindu	Chadchan Vijayapura	Acute hemorrhagic stroke	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.92	0.98	1.09	2.02	0.82	1.02
216	Rugha marati	72	Male	26-02-2023	70114	Hindu	Arakeri, Vijayapura	Seizure under evaluation	No	No		Improved	GRADE 5	7.65	0.8	0.76	5	8	0.65
217	Basavaraj ...	43	Male	17-12-2023	395003	Hindu	Talikoti, Vijayapura	CKD with Anemia	No	No		Improved	GRADE 3	3.6	0.8	0.72	5	8	0.7
218	Mukesh ...	35	Male	11-05-2024	158803	Hindu	B bagewadi, Vijayapura	Facial fracture	No	No		Improved	GRADE 4	4	0.5	0.61	6.1	8.9	0.7
219	Jagadish Shrishail ...	35	Male	26-03-2023	6431	Hindu	B bagewadi, Vijayapura	Seizures under valuation	No	No		Improved	GRADE 4	3.1	0.8	0.7	4.3	7.6	0.62
220	Laxmikanth B Bhajanar	30	Male	17-01-2023	22616	Hindu	Gulbarga	Status epilepticus	No	No		Improved	GRADE 4	4.25	1.45	0.99	3.2	5.7	0.68
221	Parumanand dumogoed	66	Male	13-04-2023	128139	Hindu	Itagi	sqe	No	No		Improved	GRADE 5	5.75	0.59	0.5	5.36	6.37	0.44
222	Burama Mane	27	Male	20-04-2023	129943	Hindu	Vijayapura	Rta with mild head inury	No	No		Improved	GRADE 5	5.59	0.57	0.53	6.31	6.95	0.41
223	Virupakshappa Gidaru	83	Male	21-04-2023	131544	Hindu	Indi	sqe	No	No		Improved	GRADE 4	5.01	0.53	0.52	4.98	5.01	0.4
224	Akash Nagathan	27	Male	10-04-2023	161900	Hindu	Itagi	uti	No	No		Discharged	GRADE 4	3.95	0.6	0.54	4.84	5.01	0.51
225	Basavashree chakadi	22	Female	21-04-2023	131821	Hindu	Mudhol	uti	No	No		Improved	GRADE 5	5.34	0.58	0.52	5.75	6.16	0.43
226	Sanjee rathod	39	Male	22-04-2023	131843	Hindu	Vijayapura	lrti	No	No		Improved	GRADE 4	4.19	0.57	0.51	4.78	5.07	0.4
227	Purushoram kambale	33	Male	17-05-2023	160664	Hindu	Vijayapura	organic compound poisoning	No	No		Discharged	GRADE 5	5.71	0.6	0.56	6.22	6.8	0.43
228	Shantabai Teli	63	Female	05-07-2023	133110	Hindu	Muddebihal	Non venomous snake bite	No	No		Improved	GRADE 5	6.15	0.52	0.48	6.74	7	0.41

1	NAME OF THE PA	AGE	SEX	DATE OF ADMI	IP NUMBER	RELIGION	RESIDENCE	PROVISIONAL DIAG	ICU ADMISS	NEED OF VENTILA	IF ON VENTILA	48 HRS OUTC	EMERGENCY SEVERITY	PERIPHERAL PERFUSION	SHOCK INI	SHOCK INDEX	PERIPHERAL PERFUSION	PERIPHERAL PERFUSION	SHOCK IND
228	Shantabai Teli	63	Female	05-07-2023	133110	Hindu	Muddebihal	Non venomous snake bite	No	No		Improved	GRADE 5	6.15	0.52	0.48	6.74	7	0.41
229	Sivammappa kagur	56	Male	12-05-2023	155510	Hindu	Sindgi	Chest pain under evaluation	No	No		Improved	GRADE 4	4.01	0.59	0.51	4.15	5	0.4
230	Santosh indi	36	Male	03-09-2023	446996	Hindu	Vijayapura	abdominal pain under evaluati	No	No		Improved	GRADE 4	4.11	0.57	0.54	4.41	4.91	0.51
231	Rakshita Maganavar	17	Female	16-06-2023	195276	Hindu	Vijayapura	Acute febrile illness	No	No		Improved	GRADE 4	4.36	0.58	0.53	4.82	4.39	0.51
232	Gangabai wali	25	Female	07-04-2023	115307	Hindu	Indi	Acute gastritis	No	No		Improved	GRADE 5	5.81	0.58	0.41	6.41	6.81	0.38
233	Sunita Biradar	49	Female	15-06-2023	195015	Hindu	Vijayapura	lrti	No	No		Discharged	GRADE 4	4.01	0.6	0.54	4.97	5.01	0.51
234	Ningangouda biradar	41	Male	03-06-2024	186064	Hindu	Indi	Rta with mild head inury	No	No		Discharged	GRADE 4	4.23	0.57	0.55	4.72	4.83	0.41
235	Kalyanabai machyal	68	Female	08-04-2023	117001	Hindu	Vijayapura	bed sores	No	No		Improved	GRADE 5	5.11	0.53	0.51	5.89	6.04	0.44
236	Shrinath bagalgi	22	Male	09-06-2024	186840	Hindu	Itagi	sqe	No	No		Improved	GRADE 5	5.74	0.52	0.5	6.63	7	0.45
237	Gangawa madar	46	Female	08-06-2023	186827	Hindu	Vijayapura	cellulitis	No	No		Improved	GRADE 4	4.36	0.59	0.5	4.41	4.89	0.4
238	Umesh Biradar	34	Male	04-06-2023	181537	Hindu	Indi	Non venomous snake bite	No	No		Improved	GRADE 5	5.37	0.59	0.41	5.93	6.74	0.32
239	Pandit Rathod	62	Male	03-06-2023	180716	Hindu	Vijayapura	lrti	No	No		Improved	GRADE 5	5.53	0.6	0.56	6.31	6.97	0.41
240	Altaf Sindgi	43	Male	11-04-2023	120307	Muslim	Sindgi	Acute febrile illness	No	No		Improved	GRADE 4	4.01	0.6	0.53	4.83	5	0.52
241	Jashwanth sinq	41	Male	10-05-2023	153019	Hindu	Muddebihal	sqe	No	No		Improved	GRADE 4	4.25	0.54	0.51	4.32	4.54	0.4
242	Ambavva Gowdi	67	Female	26-04-2023	136245	Hindu	Mudhol	Chest pain under evaluation	No	No		Discharged	GRADE 5	5.12	0.51	0.48	6.31	7.01	0.36
243	Kutubudin Malla	61	Male	08-05-2023	150530	Muslim	Sindgi	COPD	No	No		Improved	GRADE 4	4.01	0.58	0.51	4.72	5	0.4
244	Shivaraj Yaranal	41	Female	27-04-2023	137567	Hindu	Indi	alcohol withdrawal	No	No		Improved	GRADE 4	3.72	0.59	0.57	4.64	4.92	0.51
245	Annapurna patil	21	Female	08-05-2023	150519	Hindu	Vijayapura	organic compound poisoning	No	No		Improved	GRADE 5	5.32	0.59	0.48	5.98	6.39	0.31
246	Ramasidda Madar	22	Male	07-05-2023	149284	Hindu	Mudhol	Non venomous snake bite	No	No		Improved	GRADE 5	5.85	0.53	0.41	6.91	7.01	0.3
247	Ajay charan	21	Male	04-05-2023	145356	Hindu	Indi	Chest pain under evaluation	No	No		Improved	GRADE 4	3.15	0.6	0.58	3.45	4.17	0.51
248	Vuthal madale	77	Male	02-11-2023	344968	Hindu	Chadchan	Sepsis secondary to LRTI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.05	0.87	1.02	1.73	0.012	1.3
249	Mariyappa chalawadi	46	Male	21-07-2023	234910	Hindu	Muddebihal Vijayapu	Snakebite	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.63	0.94	1.03	2.83	1.93	1.32
250	Shrikanth doddamani	56	Male	03-11-2023	346183	Hindu	Vijayapura	Rta with head injury	Yes	No		Improved	GRADE 3	3.56	0.58	0.65	4.58	4.81	0.64
251	Shivputra gaikwad	29	Male	17-12-2023	394679	Hindu	Mudhol vijayapura	RTA with chest trauma	Yes	No		Improved	GRADE 3	3.92	0.97	0.68	4.29	4.29	0.45
252	Shivputrappa kosamani	37	Male	25-11-2023	370490	Hindu	Chadchan Vijayapura	Partial hanging	Yes	No		Improved	GRADE 3	4.29	0.57	0.57	4.92	4.75	0.48
253	Siddaramappa bellibhavi	74	Male	09-06-2023	117231	Hindu	Sindgi Vijayapura	Sepsis secondary to LRTI	Yes	Yes	Non invasive ventilatio	Deteriorated	GRADE 1	1.06	0.99	1.02	1.73	0.27	1.25
254	Gangappa Kaladagi	80	Male	15-03-2023	89575	Hindu	Mudhol vijayapura	Acute ischemic stroke	Yes	No		Improved	GRADE 2	2.65	0.87	0.67	3.38	3.63	0.56
255	Nagappa Umbhavi	76	Male	14-04-2023	123618	Hindu	Chadchan Vijayapura	Intestinal obstruction	Yes	No		Improved	GRADE 3	4.28	0.57	0.57	4.84	4.92	0.58
256	Shesha Kulkarni	56	Male	19-05-2023	161931	Hindu	Vijayapura	Acute hemorrhagic stroke	Yes	No		Deteriorated	GRADE 1	1.98	0.96	0.97	2.02	0.37	1.89
257	Gyanappa kariyappa pujari	36	Male	18-04-2023	126965	Hindu	Sindgi Vijayapura	Meningoencephalitis	Yes	No		Improved	GRADE 3	4.82	0.78	0.74	3.93	4.83	0.85
258	Laxmi biradar	28	Female	22-02-2023	66388	Hindu	Muddebihal	Pyrethrin compound consump	Yes	No		Improved	GRADE 3	4.75	0.64	0.64	4.64	4.94	0.63
259	Ramappa chalawadi	43	Male	14-07-2023	228147	Hindu	indi vijayapura	Meningoencephalitis	Yes	No		Deteriorated	GRADE 2	2.65	0.81	0.97	3.94	1.36	0.99
260	Imaba majandar	81	Male	26-06-2023	208325	Muslim	Devarahipparagi vija	Acute on Ckd	Yes	Yes	Non invasive ventilatio	Deteriorated	GRADE 2	2.65	0.86	0.98	1.07	0.86	1.03
261	Mallikarjun hiremath	76	Male	04-09-2023	282173	Hindu	Talikoti Vijayapura	Acute ischemic stroke	Yes	No		Improved	GRADE 3	3.87	0.75	0.63	3.83	4.36	0.85
262	Motabai nayak	66	Female	24-06-2023	205229	Hindu	Talikoti Vijayapura	Acute pancreatitis	Yes	No		Improved	GRADE 3	3.45	0.63	0.48	5.28	6.28	0.94
263	Hanamanth Gaadhi	49	Male	20-05-2023	233494	Hindu	Indi Vijayapura	DCLD with ascitic	Yes	No		Deteriorated	GRADE 1	1.98	0.99	0.58	4.38	5.28	0.75
264	Basavraj Dalawai	33	Male	07-08-2023	255136	Hindu	Devarahipparagi vija	RTA with head injury	Yes	No		Improved	GRADE 3	3.56	0.75	0.52	4.94	6.27	0.48
265	Basanna Halagunki	66	Male	27-04-2023	138169	Hindu	Talikoti Vijayapura	Blunt abdominal trauma	Yes	No		Deteriorated	GRADE 1	1.23	0.75	0.91	4.82	5.28	1.25
266	Bailappa shakpur	89	Male	11-01-2023	14345	Hindu	Vijayanagar Vijayapur	Septic shock secondary to LF	Yes	Yes	Non invasive ventilatio	Deteriorated	GRADE 1	1.36	0.96	1.24	4.28	0.02	1.23
267	Nasasaheb dammale	46	Male	10-01-2023	12146	Hindu	Devar hipparagi Vija	Meningoencephalitis	Yes	No		Improved	GRADE 3	3.63	0.86	0.64	3.85	4.64	0.54
268	Jagadish Chavan	32	Male	27-10-2022	376037	Hindu	Vijayapura	Chest pain under evaluation	No	No		Improved	GRADE 4	4.82	0.58	0.53	4.18	4.87	0.4
269	Gollalappa malage	72	Male	15-04-2024	243312	Hindu	Itagi	bed sores	No	No		Improved	GRADE 5	5.72	0.58	0.45	6.19	7	0.41
270	Shrishail oddar	45	Male	14-04-2024	124627	Hindu	Vijayapura	abdominal pain under evaluati	No	No		Improved	GRADE 5	5.07	0.6	0.59	5.25	6.15	0.43
271	Sidda Totad	42	Male	07-11-2022	388343	Hindu	Itagi	Chest pain under evaluation	No	No		Improved	GRADE 5	6.02	0.51	0.47	6.97	7	0.33
272	Narayan sindagi	60	Male	21-03-2024	093270	Hindu	Vijayapura	uncontrolled DM	No	No		Improved	GRADE 4	3.38	0.59	0.53	4.15	5.01	0.41
273	Bhagirathi Walikar	72	Female	17-06-2023	391751	Hindu	Vijayapura	COPD	No	No		Improved	GRADE 5	5.07	0.55	0.41	5.73	6.08	0.35
274	Kurappa zaratti	44	Male	11-11-2022	393046	Hindu	Indi	sqe	No	No		Discharged	GRADE 5	5.37	0.54	0.44	6.83	6.93	0.31
275	Dharmanna kambale	58	Male	18-03-2024	305603	Hindu	Vijayapura	Neurotoxic snake bite	No	No		Discharged	GRADE 4	4.22	0.57	0.53	3.90	4.27	0.51
276	Sidamma kumbar	77	Male	16-11-2022	398411	Hindu	Indi	bedsore	No	No		Improved	GRADE 5	5.92	0.59	0.41	6.22	6.89	0.4
277	Santosh pujari	28	Male	02-03-2024	070658	Hindu	Mudhol	abdominal pain under evaluati	No	No		Improved	GRADE 5	5.86	0.58	0.49	5.92	6.93	0.31
278	Paravati Hiremath	77	Female	24-11-2022	407313	Hindu	Vijayapura	Chest pain under evaluation	No	No		Improved	GRADE 4	3.43	0.58	0.54	4.32	4.73	0.4
279	Yuvaraj Gabyad	18	Male	28-11-2022	411722	Hindu	Sindgi	rta with mild head injury	No	No		Improved	GRADE 4	3.51	0.53	0.51	4.13	4.88	0.4
280	Savita kadapad	34	Female	28-11-2022	411857	Hindu	Indi	Chest pain under evaluation	No	No		Improved	GRADE 4	4.75	0.59	0.57	4.08	4.89	0.52
281	Bhagyashree Mangyal	20	Female	12-01-2024	013726	Hindu	Muddebihal	organic compound poisoning	No	No		Improved	GRADE 5	5.70	0.59	0.51	5.99	6.32	0.49
282	Bazira malsandar	42	Male	06-01-2024	007376	Hindu	Vijayapura	abdominal pain under evaluati	No	No		Discharged	GRADE 5	5.18	0.51	0.46	5.73	6.76	0.41
283	Rukhma doddamani	36	Female	06-01-2024	007333	Hindu	Indi	sqe	No	No		Improved	GRADE 4	4.02	0.54	0.52	4.17	5	0.4
284	Gopal gubbi	66	Male	21-12-2023	400448	Hindu	Vijayapura	bed sores	No	No		Discharged	GRADE 4	4.36	0.57	0.54	3.93	4.07	0.51

1	NAME OF THE PA	AGE	SEX	DATE OF ADMI	IP NUMBER	RELIGION	RESIDENCE	PROVISIONAL DIAG	ICU ADMISS	NEED OF VENTILA	IF ON VENTILA	48 HRS OUTC	EMERGENCY SEVERITY	PERIPHERAL PERFUSION	SHOCK INI	SHOCK INDEX	PERIPHERAL PERFUSION	PERIPHERAL PERFUSION	SHOCK IND
284	Gopal gubbi	66	Male	21-12-2023	400448	Hindu	Vijayapura	bed sores	No	No		Discharged	GRADE 4	4.36	0.57	0.54	3.93	4.07	0.51
285	Doddamma pujari	32	Female	25-12-2022	443352	Hindu	Indi	Non venomous snake bite	No	No		Discharged	GRADE 5	5.51	0.51	0.48	6.2	6.84	0.35
286	Kavita solanki	19	Female	13-12-2023	383525	Hindu	Vijayapura	Partial hanging	No	No		Improved	GRADE 4	4.65	0.56	0.54	3.85	4.16	0.52
287	Mallikarjun handi	57	Male	12-12-2023	388263	Hindu	Mudhol	Chest pain under evaluation	No	No		Improved	GRADE 5	5.08	0.53	0.43	5.29	6.24	0.31
288	Renuka singe	37	Female	10-12-2023	386938	Hindu	Mudhol	sqe	No	No		Improved	GRADE 5	6.17	0.59	0.41	6.38	7	0.32
289	Aravind Rathod	36	Male	10-12-2023	386401	Hindu	Indi	Anxiety disorder	No	No		Improved	GRADE 4	4.65	0.59	0.55	4.39	4.64	0.4
290	Savita jadhav	46	Female	08-12-2023	384046	Hindu	Sindgi	abdominal pain under evaluati	No	No		Discharged	GRADE 4	4.28	0.57	0.54	4.13	4.67	0.52
291	Madhu charan	18	Female	21-02-2024	053617	Hindu	Indi	organic compound poisoning	No	No		Improved	GRADE 4	4.98	0.59	0.51	4.07	4.89	0.4
292	Ranjana Rathod	25	Female	21-02-2024	053603	Hindu	Muddebihal	abdominal pain under evaluati	No	No		Improved	GRADE 5	5.32	0.6	0.54	5.31	6.37	0.46
293	Gouramma	63	Female	03-12-2022	417378	Hindu	Mudhol	COPD	No	No		Improved	GRADE 5	5.85	0.54	0.45	6.04	7	0.36
294	Janabee manavar	22	Male	05-12-2022	418755	Hindu	Muddebihal	pyrethrin poisoning	No	No		Discharged	GRADE 5	5.98	0.58	0.41	6.28	6.82	0.31
295	Rachayya hiremath	55	Male	19-02-2024	057189	Hindu	Vijayapura	bed sores	No	No		Improved	GRADE 4	4.98	0.57	0.54	4.01	4.76	0.4
296	Nazma malla	30	Female	17-02-2024	055191	Muslim	Indi	sqe	No	No		Improved	GRADE 4	4.15	0.58	0.53	4.13	5.01	0.51
297	Shankrappa huddar	72	Male	06-12-2022	421173	Hindu	Mudhol	COPD	No	No		Improved	GRADE 5	5.81	0.58	0.53	5.99	6.09	0.52
298	Laxman dinni	28	Male	08-12-2022	423790	Hindu	Vijayapura	rta with mild head injury	No	No		Improved	GRADE 5	5.18	0.56	0.43	5.43 5.88		0.32
299	Fakirappa korbar	76	Male	11-03-2023	84343	Hindu	Chadchan Vijayapura	Acute ischemic stroke	Yes	No		Improved	GRADE 3	3.65	0.58	0.65	4.93	4.85	0.65
300	Mahantesh jamakandi	25	Male	03-02-2024	038806	Hindu	Indi	sqe	No	No		Discharged	GRADE 4	4.16	0.57	0.55	3.87	4.22	0.51
301	Ameerhamja Malla	61	Male	23-04-2023	133135	Muslim	Sindgi Vijayapura	Acute hemorrhagic stroke	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.35	0.91	0.74	1.83	0.01	1.34
302	Anil kosamani	32	Male	30-01-2024	240250	Hindu	Itagi	pyrethrin poisoning	No	No		Improved	GRADE 4	4.63	0.6	0.58	4.31	4.86	0.56
303	Rajkumar hiremath	60	Male	13-10-2023	343019	Hindu	Muddebihal Vijayapu	Meningoencephalitis	Yes	No		Improved	GRADE 3	3.74	0.84	0.64	3.93	4.83	0.65
304	Savitri Biradar	54	Female	25-10-2022	378841	Hindu	Indi	uti	No	No		Improved	GRADE 4	4.98	0.57	0.53	4.42	4.91	0.51
305	Krishnabai Jadhav	62	Female	30-10-2022	379389	Hindu	Muddebihal	lrti	No	No		Improved	GRADE 5	5.75	0.59	0.44	6.01	7.01	0.4
306	Godavari Barudol	54	Female	11-04-2024	088037	Hindu	Sindgi	COPD	No	No		Improved	GRADE 5	5.08	0.6	0.53	5.43	5.87	0.51
307	Sultan malsandar	30	Male	07-04-2023	116013	Muslim	Talikoti Vijayapura	RTA with chest trauma	Yes	No		Improved	GRADE 3	4.73	0.67	0.64	5.82	5.57	0.74
308	Dalu Pawar	35	Male	10-04-2024	118425	Hindu	Mudhol	rta with head injury	No	No		Improved	GRADE 5	6.07	0.57	0.45	6.33	6.88	0.36
309	Yallappa	78	Male	08-07-2023	108435	Hindu	Chadchan Vijayapura	Acute ischemic stroke	Yes	No		Deteriorated	GRADE 2	2.65	0.73	0.55	3.73	1.02	0.91
310	Asha golasangi	20	Female	08-04-2024	116148	Hindu	Vijayapura	organic compound poisoning	No	No		Improved	GRADE 4	4.65	0.59	0.54	3.85	4.45	0.53
311	Renukha Desai	31	Female	21-03-2023	96714	Hindu	Kolar vijayapura	Pyrethrin compound consump	Yes	No		Improved	GRADE 3	3.36	0.52	0.53	5.28	4.83	0.74
312	Laxmi Kambale	21	Female	07-04-2024	115426	Hindu	Itagi	Non venomous snake bite	No	No		Discharged	GRADE 5	5.58	0.58	0.43	5.73	6.62	0.31
313	Yamanavva Pati	51	Female	04-08-2023	251123	Hindu	Chaddhan Vijayapura	Intestinal obstruction	Yes	No		Improved	GRADE 3	4.28	0.98	0.72	3.83	3.98	0.75
314	Deepa Dolli	35	Female	04-04-2024	112229	Hindu	Indi	sqe	No	No		Improved	GRADE 5	5.26	0.52	0.46	6.47	6.72	0.41
315	Netravati zalaki	30	Female	03-04-2024	109727	Hindu	Muddebihal	Anxiety disorder	No	No		Improved	GRADE 4	4.15	0.58	0.54	3.72	4.62	0.51
316	Shrishail patil	49	Male	11-01-2023	234913	Hindu	Muddebihal Vijayapu	RTA with head injury	Yes	No		Deteriorated	GRADE 2	2.15	0.65	0.76	3.46	1.82	1.33
317	Pratibha pujari	24	Female	25-03-2023	100073	Hindu	Sindagi vijayapura	Op compound consumption	Yes	No		Improved	GRADE 3	3.45	0.67	0.93	4.94	4.04	0.83
318	Rafiq majavar	45	Male	31-03-2024	106316	Muslim	Mudhol	COPD	No	No		Improved	GRADE 4	4.65	0.57	0.55	4.28	4.88	0.4
319	Manesh Badiger	20	Male	30-03-2024	103985	Hindu	Indi	organic compound poisoning	No	No		Improved	GRADE 4	4.15	0.56	0.53	3.72	4.26	0.5
320	Basavantrayagouda Patil	18	Male	04-12-2023	379227	Hindu	Muddebihal	Anxiety disorder	No	No		Improved	GRADE 5	5.56	0.51	0.49	6.53	6.81	0.41
321	Jyoti Rathod	33	Female	22-11-2023	365776	Hindu	Sindgi	partial hanging	No	No		Improved	GRADE 5	5.02	0.57	0.43	6.01	6.52	0.31
322	Ramasidda Patil	41	Male	21-11-2023	364442	Hindu	Muddebihal	lrti	No	No		Improved	GRADE 4	3.88	0.54	0.52	4.09	4.93	0.5
323	Saraswati Kamatar	30	Female	20-11-2023	364288	Hindu	Muddebihal	uti	No	No		Discharged	GRADE 4	4.65	0.57	0.55	4.61	4.71	0.4
324	Siddamma Hullur	16	Female	17-11-2023	308310	Hindu	Indi	Unknown compound consump	No	No		Improved	GRADE 5	5.57	0.56	0.5	5.61	6.26	0.48
325	Bhimanna Javoor	53	Male	13-11-2023	356744	Hindu	Vijayapura	COPD	No	No		Discharged	GRADE 5	5.85	0.58	0.51	6.61	7	0.44
326	Chidanand Mantoor	45	Male	12-11-2023	355365	Hindu	Vijayapura	uncontrolled DM	No	No		Improved	GRADE 5	5.54	0.53	0.45	5.73	6.26	0.41
327	Sangeeta Nagavar	19	Female	15-01-2023	019638	Hindu	Vijayapura	organic compound poisoning	No	No		Discharged	GRADE 4	4.15	0.59	0.56	3.37	4.21	0.51
328	Rizawana Doddamani	26	Female	11-11-2023	355338	Muslim	Mudhol	uti	No	No		Improved	GRADE 4	4.63	0.57	0.56	4.03	4.29	0.51
329	Kamalabai Mahindrakar	66	Female	17-01-2023	013123	Hindu	Vijayapura	sqe	No	No		Improved	GRADE 4	4.68	0.54	0.5	4.29	5.01	0.4
330	Pratibha Pujari	24	Female	25-03-2023	100079	Hindu	Chaddhan Vijayapura	Op compound consumption	Yes	No		Improved	GRADE 3	3.18	0.56	0.54	5.83	4.84	0.67
331	Altaf Mulavad	32	Male	14-11-2023	357013	Muslim	Muddebihal Vijayapu	RTA with head injury	Yes	No		Improved	GRADE 2	2.89	0.86	0.78	2.92	0.02	1.02
332	Pravin Khavekar	47	Male	23-02-2023	67810	Hindu	Chaddhan Vijayapura	RTA with head injury	Yes	No		Deteriorated	GRADE 2	2.46	0.86	0.92	3.31	2.81	1.23
333	Gourabai Natikar	76	Female	20-03-2023	103167	Hindu	Talikoti Vijayapura	Acute ischemic stroke	Yes	No		Improved	GRADE 3	4.82	0.67	0.75	3.84	4.45	0.67
334	Santosh Minchanal	33	Male	14-06-2023	193914	Hindu	Muddebihal Vijayapu	Hematotoxic snake bite	Yes	No		Deteriorated	GRADE 2	5.72	0.76	0.64	4.82	1.3	1.2
335	Bhagavva Pujari	20	Female	10-11-2023	354083	Hindu	Sindgi	organic compound poisoning	No	No		Improved	GRADE 4	3.81	0.54	0.53	4.16	4.87	0.4
336	Umesh Dhalur	17	Male	09-11-2023	351933	Hindu	Indi	Non venomous snake bite	No	No		Improved	GRADE 5	5.27	0.53	0.5	6.47	6.82	0.42
337	Kasimsab malsandar	67	Male	08-11-2023	351404	muslim	Mudhol	COPD	No	No		Discharged	GRADE 4	3.11	0.58	0.54	4.04	4.77	0.5
338	Sabanna kumbar	25	Male	06-11-2023	348268	hindu	Vijayapura	Anxiety disorder	No	No		Improved	GRADE 5	5.38	0.58	0.46	5.82	6.77	0.36
339	Mallappa Hittanalli	26	Male	04-11-2023	347372	hindu	Vijayapura	rta with mild head injury	No	No		Improved	GRADE 4	4.01	0.57	0.53	4.53	5.01	0.51
340	Sachin Biradar	24	Male	04-11-2023	343047	Hindu	Indi	Non venomous snake bite	No	No		Discharged	GRADE 5	5.5	0.57	0.41	6.01	7.01	0.38

1	NAME OF THE PAT	AGE	SEX	DATE OF ADMIS	IP NUMBER	RELIGION	RESIDENCE	PROVISIONAL DIAG	ICU ADMISS	NEED OF VENTILA	IF ON VENTILA	48 HRS OUTCO	EMERGENCY SEVERITY	PERIPHERAL PERFUSION	SHOCK IN	SHOCK INDEX	PERIPHERAL PERFUSION	PERIPHERAL PERFUSION	SHOCK IND
341	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.75	0.55	0.47	6.1	6.73	0.41
342	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.73	0.59	0.59	4.21	4.92	0.4
343	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	4.10	0.50	0.54	4.17	4.72	0.4
344	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	4.07	0.57	0.53	3.96	4.21	0.51
345	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	4.00	0.6	0.59	4.43	4.09	0.4
346	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.01	0.6	0.53	5.46	5.07	0.41
347	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 4	3.16	0.54	0.54	3.01	4.07	0.5
348	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.75	0.57	0.51	6.54	7	0.47
349	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.46	0.57	0.51	4.73	4.91	0.5
350	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.57	0.56	0.41	6.23	6.07	0.36
351	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.17	0.51	0.4	5.09	6.15	0.36
352	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.32	0.5	0.49	5.77	6.53	0.41
353	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.32	0.59	0.54	3.09	4.69	0.52
354	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 4	3.73	0.57	0.52	4.43	4.06	0.51
355	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 3	4.23	0.47	0.35	4.02	4.29	0.36
356	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Deteriorated	GRADE 2	1.02	0.90	0.97	1.09	0.00	1.24
357	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.53	0.49	0.41	5.60	6.01	0.36
358	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	6.07	0.57	0.51	6.50	7	0.40
359	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.16	0.50	0.53	3.74	4.29	0.57
360	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.26	0.47	0.41	5.07	6.03	0.39
361	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.69	0.57	0.55	3.90	4.56	0.53
362	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Invasive ventilation	Deteriorated	GRADE 1	1.92	0.95	0.90	1.09	0.03	1.23
363	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 4	3.96	0.59	0.59	4.23	4.01	0.51
364	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.32	0.52	0.40	6.37	6.00	0.41
365	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Invasive ventilation	Deteriorated	GRADE 1	1.20	0.90	0.90	1.06	0.02	1.24
366	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 4	3.95	0.6	0.54	4.46	5	0.4
367	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Non invasive ventilatio	Deteriorated	GRADE 1	1.06	0.92	0.90	1.02	0.01	1.23
368	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.30	0.54	0.52	5.03	6.13	0.40
369	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Non invasive ventilatio	Deteriorated	GRADE 2	3.03	0.06	0.90	1.92	0.05	1.23
370	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.37	0.59	0.55	4.01	4.05	0.4
371	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Invasive ventilation	Deteriorated	GRADE 1	1.65	0.07	0.90	1.02	0.03	1.23
372	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Invasive ventilation	Deteriorated	GRADE 2	2.96	0.06	0.90	1.07	0.05	1.24
373	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 5	5.15	0.54	0.47	5.72	6.03	0.41
374	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 5	5.96	0.46	0.42	5.00	6.44	0.37
375	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	6.13	0.55	0.5	6.27	6.70	0.46
376	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 4	3.15	0.50	0.76	3.72	4.03	0.5
377	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 4	4.16	0.59	0.57	4.71	4.00	0.51
378	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.01	0.53	0.51	3.47	4.44	0.4
379	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.49	0.59	0.51	6.69	7	0.43
380	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.92	0.57	0.52	6.03	6.09	0.41
381	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.92	0.59	0.52	4.03	4.09	0.52
382	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.03	0.59	0.54	4.10	4.09	0.51
383	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	4.51	0.50	0.54	3.07	4.54	0.5
384	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.02	0.57	0.52	4.13	4.01	0.4
385	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 4	4.17	0.54	0.52	4.44	5.01	0.5
386	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.37	0.51	0.43	6.14	6.03	0.36
387	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 5	5.06	0.59	0.47	5.47	5.90	0.41
388	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	6.03	0.57	0.41	6.04	7	0.33
389	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	4.1	0.54	0.57	4.47	4.15	0.54
390	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 5	5.31	0.40	0.42	5.07	6.11	0.4
391	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.32	0.56	0.53	3.00	4.11	0.51
392	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 5	6.10	0.56	0.44	6.34	6.51	0.41
393	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.46	0.59	0.53	3.93	4.97	0.51
394	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.79	0.50	0.40	6.10	6.57	0.31
395	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 4	3.41	0.50	0.54	3.02	4.15	0.52
396	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.03	0.57	0.55	4.41	4.97	0.5
397	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	6.07	0.57	0.43	6.23	6.62	0.41
398	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 5	5.16	0.56	0.47	6.13	6.03	0.41
399	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.34	0.59	0.54	4.13	4.73	0.52
400	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Discharged	GRADE 4	3.73	0.57	0.53	4.43	5.01	0.5
401	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.73	0.59	0.51	6.43	6.77	0.49
402	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 5	5.22	0.46	0.43	5.67	6.23	0.36
403	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Improved	GRADE 4	3.05	0.55	0.51	4.21	4.64	0.4
1	NAME OF THE PAT	AGE	SEX	DATE OF ADMIS	IP NUMBER	RELIGION	RESIDENCE	PROVISIONAL DIAG	ICU ADMISS	NEED OF VENTILA	IF ON VENTILA	48 HRS OUTCO	EMERGENCY SEVERITY	PERIPHERAL PERFUSION	SHOCK IN	SHOCK INDEX	PERIPHERAL PERFUSION	PERIPHERAL PERFUSION	SHOCK IND
404	Ningaragouda Biradar	23	Male	26-04-2023	318962	Hindu	Vijayapura	chest pain under evaluation	No	No		Improved	GRADE 5	5.86	0.5	0.47	6.73	7	0.43
405	Sundrabai Olekar	54	Female	24-04-2023	314799	Hindu	Indi	abdominal pain under evaluat	No	No		Discharged	GRADE 4	4.03	0.56	0.55	4.61	5	0.5
406	Mahadevi kumar	49	Female	01-07-2023	212435	Hindu	vijayapur	Acute hemorrhagic stroke	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	3.93	0.06	0.90	1.03	0.06	0.02
407	bhavana Gani	55	Female	30-12-2023	498221	Hindu	Sindagi vijayapura	Acute pancreatitis	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.93	0.94	0.98	1.07	0.03	1.23
408	Malamma Tated	71	Female	21-07-2023	234909	Hindu	Muddebihal Vijayapura	Acute ischemic stroke	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	2.28	0.79	0.98	1.07	0.13	1.23
409	Mamatas Hanmatagi	41	Female	02-04-2023	200029	Hindu	Talikoti Vijayapura	RTA with chest trauma	Yes	Yes	Non invasive ventilatio	Deteriorated	GRADE 2	3.97	0.06	0.90	1.02	0.03	1.24
410	Mallappa markal	71	Male	20-03-2023	31522	Hindu	Vijayanagar Vijayapura	Acute ischemic stroke	Yes	No		Improved	GRADE 3	3.82	0.54	0.97	3.94	3.92	0.86
411	Salumsheikh	69	Male	04-03-2023	77019	Muslim	Khwaja Galli Vijayapura	Snake bite	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	4.92	0.93	0.76	1.02	0.02	1.23
412	Mahiboobsab Walikar	54	Male	24-02-2023	8249	Muslim	Sindagi Vijayapura	Op consumption poisoning	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	3.81	0.94	0.90	1.02	0.06	1.02
413	Jayashree siddashmath	40	Female	06-03-2023	74204	Hindu	Sindagi Vijayapura	acute pancreatitis	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.29	0.96	0.98	1.92	0.02	1.24
414	Vasha Rathod	61	Male	08-01-2023	282260	Hindu	Muddebihal Vijayapura	Type 2 respiratory failure	Yes	Yes	Non invasive ventilatio	Deteriorated	GRADE 2	3.02	0.78	0.87	2.02	0.06	1.02
415	Pravaya Kumar	40	Male	24-02-2023	6701	Hindu	Mudhol vijayapura	LRTI	Yes	No		Improved	GRADE 3	4.73	0.76	0.75	4.92	4.02	0.87
416	Pooja Rathod	18	Female	14-05-2023	187222	Hindu	Mudhol vijayapura	Pyrethrin consumption poisoning	Yes	No		Improved	GRADE 3	5.83	0.83	0.65	4.97	6.33	0.54
417	Rukma Shek	41	Female	20-05-2023	172000	Muslim	Indi Vijayapura	Sepsis secondary to AGE	Yes	No		Deteriorated	GRADE 2	4.93	0.82	0.88	2.83	0.26	1.24
418	Mamad Rodnavadi	26	Male	02-12-2023	371592	Muslim	Indi Vijayapura	COPD	Yes	Yes	Non invasive ventilatio	Improved	GRADE 3	3.85	0.58	0.54	4.25	5.26	0.74
419	Sabhana Kadchi	44	Female	17-04-2023	197329	Muslim	Sindagi Vijayapura	Sepsis secondary to [illegible]	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	4.28	0.65	0.66	3.86	0.03	1.24
420	[illegible]	63	Male	16-04-2023	194634	Hindu	Devarahipparagi vijayapura	Acute hemorrhagic stroke	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	4.20	0.06	0.90	0.00	0.002	1.25
421	Dundavva Surjapur	42	Female	04-07-2023	217902	Hindu	Indi Vijayapura	Neurotoxic snake bite	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	4.95	0.76	0.98	1.00	0.05	1.24
422	Akkamma bakryal	74	Female	09-01-2023	254557	Hindu	Athani sangli	Septic shock secondary to LF	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	4.33	0.90	1.02	1.06	0.04	1.24
423	Hanmaraddi talikoti	74	Male	30-03-2023	187909	Hindu	Talikoti Vijayapura	Acute ischemic stroke	Yes	No		Improved	GRADE 3	3.92	0.78	0.97	4.23	4.16	0.65
424	Chandrashekhar kumar	24	Male	01-10-2023	312127	Hindu	Indi Vijayapura	RTA with left tibia fracture	Yes	No		Improved	GRADE 3	4.35	0.75	0.65	3.04	4.29	0.54
425	Kartavi Basadal	53	Male	09-09-2023	284477	Hindu	Sindhi colony vijayapura	LRTI	Yes	Yes	Non invasive ventilatio	Improved	GRADE 3	4.18	0.36	0.64	3.19	4.26	0.57
426	Hiraapa bhairadagi	74	Male	29-07-2023	251254	Hindu	Indi Vijayapura	Acute ischemic stroke	Yes	No		Deteriorated	GRADE 1	3.20	0.76	1.02	1.03	0.02	1.2
427	Hanappa nasta	74	Male	29-04-2023	120761	Hindu	Babaleshwar vijayapura	Acute hemorrhagic stroke	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	0.67	1.24	1.32	0.02	0.06	1.25
428	Iranna Gatti	25	Male	20-05-2023	164276	Hindu	Indi Vijayapura	Snake bite	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	0.02	1.03	1.02	0.02	0.00	0.03
429	Shankrayya yadavmath	34	Male	29-05-2023	174206	Hindu	Indi Vijayapura	LRTI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	0.20	0.90	1.02	0.02	0.06	1.21
430	Tapu Rathod	61	Male	09-12-2023	306276	Hindu	Indi Vijayapura	Acute GE with shock	Yes	No		Deteriorated	GRADE 2	0.72	0.90	1.09	0.064	0.002	1.24
431	Kamlabai ingeti	61	Female	30-04-2023	211761	Hindu	Indi Vijayapura	Acute ge with shock	Yes	No		Deteriorated	GRADE 2	0.09	1.02	1.24	0.04	0.02	1.32
432	Bhagyashree Talwar	18	Female	23-09-2023	304024	Hindu	Vijayapura	oop	Yes	No		Improved	GRADE 5	5.59	0.50	0.5	6.46	6.62	0.41
433	rukmini sudikar	20	Female	24-10-2023	335622	hindu	sindgi vijayapura	acute anxiety	Yes	No		Improved	GRADE 3	3.94	0.96	0.65	3.09	3.05	0.67
434	Girija Biradar	18	Female	16-09-2023	298734	hindu	Indi	psychiatic illness	No	No		Discharged	GRADE 5	5.99	0.49	0.41	6.3	6.71	0.32
435	yaradarahatti	65	Male	11-01-2023	12590	hindu	indi	acute ischemic stroke	Yes	No		Deteriorated	GRADE 2	1.05	0.95	1.00	0.96	0.05	1.25
436	chantabai kadger	71	Female	18-04-2023	196800	hindu	sindgi	acute ge with shock	Yes	No		Improved	GRADE 3	4.25	1.05	0.65	3.85	3.15	0.36
437	Channappa Karla	18	Male	14-09-2023	294917	hindu	Muddebihal	[illegible]	Yes	No		Improved	GRADE 4	3.22	0.59	0.53	3.61	3.97	0.5
438	shivaraj sindagi	66	Male	04-07-2023	217818	hindu	indi	ACUTE HEMORRHAGIC STRK	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.02	0.90	1.21	0.30	0.002	1.24
439	SHRIMANTH KOLURGI	69	Male	19-04-2023	244253	HINDU	DEVARHIPPARAGI	SNAKEBITE	Yes	No		Improved	GRADE 3	3.45	0.58	0.98	3.68	3.09	1.2
440	Gurulingappa Biradar	71	Male	19-09-2023	298501	Hindu	Mudhol	non venomous snake bite	Yes	No		Improved	GRADE 5	5.47	0.57	0.5	5.71	5.91	0.45
441	Shekarayya Hiremath	63	Male	08-04-2023	217700	Hindu	Sindgi	COPD	Yes	No		Discharged	GRADE 5	5.94	0.54	0.40	5.59	6.14	0.41
442	LAXMI VIBHUTI	24	Female	30-06-2023	241696	HINDU	TALIKOTI	ECTOPIC PREGNANCY	Yes	No		Improved	GRADE 3	3.56	0.90	1.02	3.65	3.90	1
443	KAVERI KENGANAL	21	Female	24-04-2023	123369	HINDU	INDI	ANEMIA IN FAILURE	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.05	0.90	1.09	0.90	0.06	1.23
444	BASAYYA JAKKALAKI	31	Male	17-05-2023	123369	HINDU	MUDDEBIHAL	RTA WITH MILD HEAD INJURY	Yes	No		Improved	GRADE 3	4.23	0.65	0.65	4.65	4.65	0.6
445	Lingesh Hirur	53	Male	02-09-2023	298754	Hindu	Indi	abdominal pain under evaluat	No	No		Improved	GRADE 4	3.76	0.53	0.51	4.24	4.64	0.4
446	Rekha Shegaav	27	Female	02-09-2023	344099	Hindu	Vijayapura	non venomous snake bite	Yes	No		Improved	GRADE 5	5.50	0.56	0.51	6.47	6.74	0.47
447	RIYANA NADAF	24	Female	17-05-2023	74254	MUSLIM	KAUGALLI VIJAYAPU	LRTI	Yes	No		Improved	GRADE 3	3.45	0.65	0.65	3.46	3.90	0.65
448	DASHARATH SURYAVAN	62	Male	17-10-2023	321900	HINDU	INDI	RTA WITH HEAD INJURY	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.26	0.90	1.02	0.90	0.09	1.2
449	AMBUJAT SURYAVANSHI	32	Male	16-01-2023	232325	HINDU	DEVAR HIPPARAGI	PARTIAL HANGING	Yes	No		Improved	GRADE 3	4.02	0.65	0.65	4.15	4.31	0.54
450	SUNITA SHIRAMGOND	19	Female	24-10-2023	349519	HINDU	SINDGI	PYRETHROID CONSUMPTION	Yes	No		Improved	GRADE 3	4.06	0.65	0.75	4.012	4.23	0.54
451	SHIVRAM JADHAV	29	Male	23-02-2023	67461	HINDU	SOLAPUR	CVT	Yes	No		Improved	GRADE 3	3.15	0.54	0.75	3.36	3.06	0.54
452	BASAYYA JAHIREKUREBAI	26	Male	19/11/2023	67611	HINDU	INDI	DIMETHOATE POISONING	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.02	0.56	1.02	0.23	0.05	1.02
453	KOMU RATHOD	57	Male	16-10-2023	324759	HINDU	JATH SANGLI	RTA WITH HEAD INJURY	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.03	0.90	1.02	0.09	0.02	1.23
454	RAJESHRI RATHOD	41	Female	24-04-2023	304892	HINDU	JATH SANGLI	LRTI	Yes	Yes	Non invasive ventilatio	Deteriorated	GRADE 2	1.02	0.82	0.90	1	0.02	1.02
455	HARASAMMA KUMBHAR	74	Female	26-11-2023	371267	HINDU	INDI	SEPSIS SEC TO UTI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	0.90	0.93	1.02	0.36	0.03	1.23
456	SHAMALAMMA GAVARI	MUDHOL	Female	06-07-2023	213161	HINDU	INDI	UTI	Yes	No		Improved	GRADE 3	3.02	0.75	0.65	3.68	3.69	0.65
457	MAHANTGAUDA BADARA	44	Male	04-11-2023	346230	HINDU	INDI	SNAKEBITE	Yes	No		Improved	GRADE 3	4.25	0.65	0.65	4.13	5.12	0.45
458	SAVITA PUJARI	31	Female	03-04-2023	247604	HINDU	MUDDEBIHAL	LRTI	Yes	No		Improved	GRADE 3	3.02	0.56	0.54	3.56	3.65	0.56
459	DURGASING HAJERI	73	Male	03-04-2023	67754	HINDU	MUDDEBIHAL	SEPSIS WITH UTI	Yes	No		Improved	GRADE 3	3.49	0.65	0.65	3.90	3.87	0.65
460	VEERBHADRA HONAGAUDA	34	Male	01-04-2023	274800	HINDU	SINDGI	RTA WITH HEAD INJURY	Yes	No		Improved	GRADE 3	3.65	0.07	0.54	3.90	3.90	0.64
461	SARASWATI BAGALI	26	Female	05-11-2023	213526	HINDU	MUDHOL	SEPSIS WITH LRTI	Yes	Yes	Non invasive ventilatio	Deteriorated	GRADE 2	1.03	0.07	0.45	1.06	0.9	1.02
462	Laxmibai Bantanur	56	Female	02-04-2023	279701	Hindu	Vijayapura	chest pain under evaluation	Yes	No		Improved	GRADE 4	3.23	0.59	0.54	4.21	4.62	0.51
463	DODAPPA CHITTAPUR	58	Male	29-04-2023	291707	HINDU	SINDGI	ACUTE ISCHEMIC STROKE	Yes	No		Deteriorated	GRADE 1	0.65	0.07	1.02	0.23	0.03	1.03
464	SHANTA HATGAR	61	Female	12-08-2023	251450	HINDU	INDI	ACUTE HEMORRHAGIC STRK	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.65	0.65	1.02	0.56	0.02	1.32
465	Akash Makari	29	Male	31-01-2023	271426	Hindu	Mudhol	tablet consumption poisoning	No	No		Discharged	GRADE 5	5.63	0.51	0.4	5.87	6.7	0.32
466	PRAVEEN TALAWALI	19	Male	20-03-2023	48563	HINDU	INDI	SNAKEBITE	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.65	0.07	1.02	0.65	0.05	1.02

1	NAME OF THE PAT	AGE	SEX	DATE OF ADMIS	IP NUMBER	RELIGION	RESIDENCE	PROVISIONAL DIAG	ICU ADMISS	NEED OF VENTILA	IF ON VENTILA	48 HRS OUTC	EMERGENCY SEVERITY I	PERIPHERAL PERFUSION	SHOCK IN	SHOCK INDEX	PERIPHERAL PERFUSION	PERIPHERAL PERFUSION	SHOCK IND
467	SUHASINI WALIKAR	20	Female	24-10-2023	335622	HINDU	SINDGI	ACUTE ANXIETY	Yes	No		Improved	GRADE 3	3.65	0.65	0.67	3.79	4.65	0.67
468	Hanamant Bajantri	28	Male	30-08-2023	276162	Hindu	Muddebihal	chest pain under evaluation	No	No		Improved	GRADE 4	3.17	0.57	0.53	3.99	4.18	0.5
469	Vittal Naykodi	33	Male	27-08-2023	273790	Hindu	Vijayapura	abdominal pain under evaluat	No	No		Improved	GRADE 4	3.49	0.50	0.53	4.21	4.09	0.5
470	Laxmibai Sahukegand	71	Female	19-08-2023	265204	Hindu	Indi	bedsores	No	No		Improved	GRADE 5	5.14	0.51	0.40	5.35	5.7	0.42
471	GURABASU HITTI	65	Male	11-01-2023	13590	HINDU	MUDHOL	ACUTE ISCHEMIC STROKE	Yes	No		Deteriorated	GRADE 1	1.03	0.87	1.02	0.06	0.06	1.23
472	Shrishail Ramanahalli	31	Male	17-08-2023	261760		Vijayapura	non venomous snake bite	No	No		Improved	GRADE 4	3.37	0.55	0.51	3.02	4.37	0.4
473	Parashuram Kattimani	29	Male	14-08-2023	259948	Hindu	Indi	organic compound poisoning	No	No		Improved	GRADE 5	6.18	0.58	0.51	6.47	6.93	0.48
474	SHANTABAI BADIGER	71	Female	12-06-2023	190400	HINDU	INDI	ACUTE ISCHEMIC STROKE	Yes	No		Deteriorated	GRADE 2	1.02	0.54	0.65	0.07	0.06	1.23
475	Shabbir Badekhan	56	Male	13-08-2023	258400	Muslim	Vijayapura	chest pain under evaluation	No	No		Improved	GRADE 4	3.82	0.57	0.53	4.21	5	0.5
476	Vijayalaxmi Rathod	20	Female	12-08-2023	258409	Hindu	Indi	abdominal pain under evaluat	No	No		Improved	GRADE 5	6.04	0.57	0.49	6.28	7	0.4
477	Jyotsi Mahta	20	Male	12-08-2023	257700	Hindu	Indi	uti	No	No		Improved	GRADE 5	5.03	0.51	0.4	5.73	6.09	0.34
478	Murarid Ansari	28	Male	11-08-2023	257661	Muslim	Vijayapura	lrti	No	No		Improved	GRADE 4	4.01	0.58	0.54	4.73	4.09	0.53
479	Kalpana Hiremath	23	Female	09-08-2023	256606	Hindu	Vijayapura	uti	No	No		Improved	GRADE 4	4.00	0.6	0.50	4.91	5.01	0.54
480	Shantabai Tambe	61	Female	08-08-2023	255430	Hindu	Mudhal	bedsores	No	No		Improved	GRADE 5	5.05	0.58	0.5	5.36	6.12	0.44
481	Anjali Navi	22	Female	06-08-2023	254079	Hindu	Vijayapura	chest pain under evaluation	No	No		Improved	GRADE 5	5.75	0.49	0.45	6.21	6.33	0.4
482	Geeta Jadhav	24	Female	03-08-2023	250421	Hindu	Muddebihal	abdominal pain under evaluat	No	No		Improved	GRADE 5	5.17	0.59	0.47	5.59	6.13	0.4
483	Shanabai Naik	29	Female	31-07-2023	247449	Hindu	Mudhal	uti	No	No		Improved	GRADE 4	3.97	0.57	0.53	3.83	4.17	0.5
484	Basanna Biradar	36	Male	29-07-2023	245094	Hindu	Indi	chest pain under evaluation	No	No		Discharged	GRADE 4	3.10	0.50	0.54	3.95	4.07	0.5
485	Yallamma Biradar	21	Female	26-07-2023	242603	Hindu	Vijayapura	abdominal pain under evaluat	No	No		Improved	GRADE 5	5.66	0.40	0.45	5.80	6.07	0.4
486	Mahadevi Biradar	46	Female	26-07-2023	242604	Hindu	Vijayapura	Acute febrile illness	No	No		Improved	GRADE 4	3.41	0.57	0.53	4.18	4.61	0.4
487	Devraj Hala	32	Male	20-07-2023	234905	Hindu	Indi	non venomous snake bite	No	No		Discharged	GRADE 5	5.04	0.51	0.43	6.10	6.73	0.4
488	Hanamant Jivajigal	29	Male	14-10-2022	360407	Hindu	Ilagi	organic compound poisoning	No	No		Improved	GRADE 5	5.71	0.54	0.48	6.34	6.81	0.45
489	Savita Jadhav	61	Female	29-04-2024	145001	Hindu	Indi	bedsores	No	No		Improved	GRADE 4	3.64	0.56	0.53	4.23	4.02	0.5
490	Chidanand Balagavi	32	Male	19-10-2022	362696	Hindu	Ilagi	chest pain under evaluation	No	No		Improved	GRADE 5	5.71	0.57	0.47	6.05	6.37	0.34
491	Shivashankaragoud Patil	59	Male	15-10-2022	361639	Hindu	Sindgi	lrti	No	No		Improved	GRADE 5	5.63	0.58	0.41	6.13	6.04	0.34
492	Vithabai Kali	70	Female	29-04-2024	144240	Hindu	Sindgi	uti	No	No		Improved	GRADE 5	6.01	0.50	0.51	6.99	7	0.48
493	Indubai Mavaar	37	Female	17-10-2022	363572	Hindu	Vijayapura	uti	No	No		Improved	GRADE 4	3.34	0.59	0.57	3.86	4.27	0.5
494	Bhimanna Hadimani	75	Male	20-04-2024	133790	Hindu	Indi	COPD	No	No		Improved	GRADE 4	4.22	0.52	0.5	4.67	5.01	0.4
495	Mallikarjun Kudari	61	Male	23-10-2023	334976	Hindu	Vijayapura	lrti	No	No		Improved	GRADE 4	3.01	0.57	0.55	3.01	4.23	0.5
496	Anita Baragagar	33	Female	21-10-2023	333631	Hindu	Vijayapura	non venomous snake bite	No	No		Improved	GRADE 5	5.07	0.58	0.47	6.25	6.57	0.34
497	Ravindra Biradar	31	Male	13-10-2023	325296	Hindu	Vijayapura	organic compound poisoning	No	No		Improved	GRADE 4	4.05	0.57	0.53	4.27	4.74	0.5
498	RAJARAM PALASKAR	71	Male	23-01-2023	20665	HINDU	INDI	ACUTE PANCREATITIS	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.02	0.98	0.98	0.65	0.02	1.34
499	SANTOSH CHAVAN	27	Male	10-09-2023	290224	HINDU	SINDGI	RTA WITH HEAD INJURY	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.23	0.90	1.03	0.90	0.02	1.42
500	LAXMAN KAMMUR	59	Male	25-08-2023	231747	HINDU	SINDGI	ACUTE GE WITH SHOCK	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.23	0.09	1.23	0.56	0.03	1.34
501	SHIVAPPA SURYAVANSH	76	Male	25-11-2023	370637	HINDU	MUDHOL	SEPSIS SEC TO LRTI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.56	0.04	0.98	0.63	0.02	1.23
502	NASHIR CHAUDHARI	54	Male	20-07-2023	233601	HINDU	MUDDEBIHAL	ACUTE ISCHEMIC STROKE	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.23	0.90	0.90	0.90	0.02	1.3
503	HANAMANTRAY NARAYAI	67	Male	30-10-2023	340573	HINDU	MUDHOL	ACUTE ISCHEMIC STROKE	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.23	0.09	0.73	0.56	0.06	1.23
504	CHANDRASHEKHAR TELI	61	Male	24-08-2023	270410	HINDU	TALIKOTI	ACUTE HEMORRHAGIC STR	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.09	0.91	1.03	0.09	0.09	1.24
505	KAMALABAI JADHAV	66	Female	26-04-2023	135767	HINDU	MUDHOL	SEPSIS WITH LRTI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.34	0.07	1.02	0.65	0.07	1.2
506	SIDDHU NATIKAR	39	Male	20-12-2023	190526	HINDU	MUDHOL	ACUTE GE WITH HYPOVOLUM	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.06	0.09	1.03	0.98	0.06	1.24
507	BASAVRAJ KOLI	26	Male	11-02-2023	54017	HINDU	MUDHOL	PARTIAL HANGING	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.90	0.65	0.57	1.00	0.06	1.05
508	CHANDSAB MAYR	36	Male	07-07-2023	219998	HINDU	INDI	CVT	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.98	0.03	0.98	1.09	0.06	1.2
509	BABU KAVALAGI	50	Male	13-10-2023	206509	HINDU	DEVARHIPPARAGI	LRTI WITH SEPTIC SHOCK	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.60	0.70	0.09	0.90	0.02	1.13
510	RAMGONDA PATIL	41	Male	24-06-2023	206591	HINDU	BAGALKOT	SEPSIS SEC TO LRTI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.25	0.98	1.02	0.09	0.06	1.23
511	ANASUYA ROOTI	56	Female	27-03-2023	103002	HINDU	SINDGI	LRTI WITH SEPSIS	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.26	0.73	1.01	0.90	0.02	1.24
512	KALLAPPA TELI	66	Male	04-05-2023	145949	HINDU	MUDHOL	MENINGOENCEPHALITIS	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.09	0.07	1.02	1.06	0.06	1.2
513	SALMA MOKASHI	37	Female	15-06-2023	195244	MUSLIM	VINAYNAGAR	SEPTIS WITH PURPURA	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.64	0.98	1.01	0.98	0.05	1.2
514	SOMANINGAPPA NARASI	71	Male	01-01-2023	601	HINDU	BAGALKOT	ACUTE ISCHEMIC STROKE	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.65	0.92	0.90	0.90	0.02	1.23
515	Shankargouda Chikkand	67	Male	13-11-2023	355039	Hindu	Vijayapura	LRTI	No	No		Improved	GRADE 4	3.07	0.59	0.53	4.17	4.76	0.5
516	AJIT PATIL	39	Male	23-05-2023	172204	HINDU	BAGALKOT	RTA WITH HEAD INJURY	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.65	0.96	1.02	0.98	0.09	1.03
517	BANDEPPA NAGAREDDI	50	Male	22-12-2023	401056	HINDU	SINDGI	MENINGOENCEPHALITIS	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.90	0.07	0.90	1.06	0.06	1.02
518	Huranappa Halagani	76	Male	19-08-2023	265418	Hindu	Indi	LRTI	No	No		Discharged	GRADE 4	4.51	0.57	0.54	4.81	4.98	0.5
519	Vahva achael	25	Male	20-04-2024	140044	Hindu	Indi	NON venomous snake bite	No	No		Improved	GRADE 5	5.07	0.50	0.41	5.05	6.16	0.34
520	JB Halagi	55	Male	21-11-2023	423060	Hindu	Mudhal	LRTI	No	No		Discharged	GRADE 5	5.83	0.51	0.40	6.43	6.01	0.4
521	Ishan Nair	25	Male	25-04-2024	097202	Hindu	Muddebihal	organic compound poisoning	No	No		Improved	GRADE 4	3.43	0.56	0.54	3.87	4.11	0.4
522	Mehaboob Chalagid	56	Male	16-03-2024	006109	HINDU	Vijayapura	LRTI	No	No		Improved	GRADE 4	3.70	0.6	0.55	4.16	4.43	0.5
523	Merappa Waddar	60	Male	25-02-2024	064349	Hindu	Sindgi	bedsores	No	No		Improved	GRADE 4	4.07	0.58	0.54	4.57	5	0.53
524	Barappa Chittl	46	Male	10-05-2024	212407	Hindu	Ilagi	LRTI	No	No		Discharged	GRADE 5	5.50	0.59	0.51	5.95	6.52	0.48
525	Sumitra Satihal	27	Female	26-02-2024	064352	Hindu	Indi	UTI	No	No		Improved	GRADE 5	5.01	0.48	0.43	6.19	6.01	0.4
526	Shankaramma Kamatagi	66	Female	05-08-2023	253474	Hindu	Vijayapura	Acute febrile illness	No	No		Improved	GRADE 5	5.56	0.49	0.44	5.69	6.37	0.34
527	Ningappa Walikar	30	Male	25-04-2024	140205	Hindu	Ilagi	chest pain under evaluation	No	No		Improved	GRADE 4	3.51	0.56	0.53	3.69	4.37	0.5
528	Sachin Hadaginmani	26	Male	09-10-2023	320700	Hindu	Mudhal	chest pain under evaluation	No	No		Improved	GRADE 5	5.21	0.57	0.5	5.41	6.13	0.48
529	Bhaeranna Shirahad	70	Male	16-05-2024	165970	Hindu	Indi	abdominal pain under evaluat	No	No		Improved	GRADE 4	3.21	0.55	0.52	3.46	4.17	0.5

1	NAME OF THE	AGE	SEX	DATE OF ADM	IP NUMBER	RELIGION	RESIDENCE	PROVISIONAL DI	ICU ADMI	NEED OF VENT	IF ON VENTI	48 HRS OUT	EMERGENCY SEVE	PERIPHERAL PERFU	SHOCK I	SHOCK IND	PERIPHERAL PERFU	PERIPHERAL PERFU	SHOCK IN
525	Sumitra Satihal	27	Female	26-02-2024	064352	Hindu	Indi	UTI	No	No		Improved	GRADE 5	5.01	0.40	0.49	6.15	6.01	0.4
526	Shankaramma Kamatagi	66	Female	05-08-2023	253474	Hindu	Vijayapura	Acute febrile illness	No	No		Improved	GRADE 5	5.56	0.49	0.44	5.69	6.97	0.36
527	Ningappa Walikar	30	Male	25-04-2024	140205	Hindu	Ilagi	chest pain under evaluatio	No	No		Improved	GRADE 4	3.51	0.56	0.59	3.69	4.97	0.51
528	Sachin Hadaginmani	26	Male	09-10-2023	320700	Hindu	Mudhal	chest pain under evaluatio	No	No		Improved	GRADE 5	5.21	0.57	0.5	5.41	6.19	0.40
529	Bheeranna Shirahad	70	Male	16-05-2024	165970	Hindu	Indi	abdominal pain under eval	No	No		Improved	GRADE 4	3.21	0.55	0.52	3.46	4.17	0.51
530	Suresh Bidari	55	Male	14-05-2024	164060	Hindu	Muddebihal	chest pain under evaluatio	No	No		Improved	GRADE 4	3.19	0.54	0.51	3.59	3.04	0.4
531	Khandanna Pujari	56	Male	22-12-2023	401662	Hindu	Mudhal	LRTI	No	No		Improved	GRADE 5	5.21	0.49	0.45	6.19	7	0.4
532	Manishkumar Ram	20	Male	29-01-2024	032464	Hindu	Vijayapura	RTA WITH MILD HEAD IN	No	No		Improved	GRADE 5	5.59	0.59	0.59	6.57	6.97	0.49
533	Annasab Pinari	36	Male	12-12-2022	420255	Hindu	Indi	NON venomous snake bite	No	No		Improved	GRADE 4	3.41	0.59	0.57	3.09	3.99	0.55
534	Bhalalsidda Pujari	66	Male	11-09-2023	004944	Hindu	Indi	LRTI	No	No		Discharged	GRADE 5	5.49	0.51	0.5	6.51	6.79	0.45
535	Sabban Chavan	46	Male	20-01-2023	056464	Hindu	Muddebihal	RTA WITH SOFT TISSUE	No	No		Improved	GRADE 4	3.41	0.57	0.56	4.49	4.70	0.59
536	Baba Devamma Pujari	6	Female	21-11-2023	365692	Hindu	Mudhal	LRTI	No	No		Discharged	GRADE 5	5.69	0.59	0.40	6.21	6.09	0.42
537	Sanjeev Allani	40	Male	20-05-2024	109051	Hindu	Vijayapura	organic compound poisoni	No	No		Improved	GRADE 4	3.09	0.50	0.54	3.31	4.10	0.52
538	Sharanananda Biradar	46	Male	09-08-2023	251106	Hindu	Indi	chest pain under evaluatio	No	No		Improved	GRADE 4	3.11	0.56	0.59	3.76	4.41	0.51
539	Sanju Rajakale	35	Male	05-07-2023	247040	Hindu	Muddebihal	abdominal pain under eval	No	No		Improved	GRADE 4	3.51	0.6	0.54	3.04	4.27	0.4
540	Kumar Rathod	41	Male	22-10-2023	334221	Hindu	Vijayapura	alcohol withdrawal	No	No		Improved	GRADE 5	5.57	0.40	0.46	5.01	6.40	0.41
541	Sharananna Reddi	79	Male	09-10-2023	319924	Hindu	Vijayapura	bed sores	No	No		Improved	GRADE 5	5.49	0.59	0.47	6.42	6.79	0.42
542	Eharam Jakkar	72	Male	06-11-2022	387009	Hindu	Ilagi	GENERALISED WEAKNE	No	No		Discharged	GRADE 5	5.01	0.59	0.49	5.27	5.09	0.35
543	Suresh Patil	26	Male	10-12-2022	494579	Hindu	Indi	NON venomous snake bite	No	No		Improved	GRADE 4	3.10	0.59	0.57	3.44	4.19	0.59
544	Deepika Mamanar	40	Male	05-09-2024	079707	Hindu	Sindgi	Acute febrile illness	No	No		Improved	GRADE 4	3.51	0.50	0.59	4.45	4.09	0.4
545	Ravinanda Hamadani	39	Male	24-01-2023	027952	Hindu	Ilagi	chest pain under evaluatio	No	No		Improved	GRADE 5	5.11	0.54	0.5	5.74	6.29	0.46
546	Channanna Shrinivi	35	Male	22-02-2024	060099	Hindu	Vijayapura	abdominal pain under eval	No	No		Discharged	GRADE 5	5.10	0.51	0.44	5.64	6.01	0.41
547	Devraj Hala	32	Male	20-07-2023	234985	Hindu	Vijayapura	LRTI	No	No		Improved	GRADE 4	3.10	0.57	0.59	3.47	4.22	0.5
548	Siddamma Girinavar	61	Female	20-07-2023	234981	Hindu	Indi	UTI	No	No		Discharged	GRADE 4	3.00	0.59	0.54	4.41	4.31	0.51
549	Renamma Naikodi	51	Female	20-07-2023	234133	Hindu	Mudhal	RTA WITH HEAD INJURY	No	No		Improved	GRADE 5	5.71	0.47	0.46	6.09	6.69	0.36
550	Chandaram Manavali	76	Male	19-07-2023	233403	Hindu	Muddebihal	Acute febrile illness	No	No		Discharged	GRADE 5	6.10	0.50	0.51	6.67	6.00	0.47
551	Shanbrama Madenar	53	Male	17-07-2023	231204	Hindu	Vijayapura	acute encephalic illness	No	No		Improved	GRADE 5	5.47	0.57	0.55	5.20	5.02	0.42
552	Mahadevi Devaranavada	57	Female	19-07-2023	226364	Hindu	Indi	AGE	No	No		Discharged	GRADE 4	4.21	0.6	0.55	4.70	4.32	0.4
553	Gururaj Gudimani	43	Male	19-07-2023	225044	Hindu	Ilagi	RTA WITH HEAD INJURY	No	No		Discharged	GRADE 4	3.27	0.57	0.54	3.31	4.19	0.51
554	Sharananna Madar	25	Male	12-07-2023	224600	Hindu	Vijayapura	NON venomous snake bite	No	No		Improved	GRADE 4	3.97	0.55	0.59	4.06	4.49	0.4
555	Ashwini Malkanali	23	Female	09-07-2023	222000	Hindu	Ilagi	organic compound poisoni	No	No		Discharged	GRADE 5	5.91	0.59	0.56	6.27	6.74	0.46
556	Chandrashekhar Gulak	22	Male	08-07-2023	221555	Hindu	Muddebihal	chest pain under evaluatio	No	No		Improved	GRADE 5	5.96	0.40	0.46	6.07	6.71	0.42
557	Shanina Kariani	63	Female	07-09-2024	077106		Vijayapura	abdominal pain under eval	No	No		Discharged	GRADE 4	3.96	0.50	0.54	4.11	4.39	0.52
558	Vaishali Wanamde	20	Female	02-10-2023	319100	Hindu	Indi	acute encephalic illness	No	No		Improved	GRADE 4	3.97	0.59	0.57	4.24	4.66	0.59
559	Dinamila Maisnar	41	Female	25-11-2023	356942		Muddebihal	RTA WITH SOFT TISSUE	No	No		Improved	GRADE 5	5.21	0.52	0.46	5.64	5.95	0.41
560	Rabananda Patil	31	Male	16-04-2024	166095	Hindu	Mudhal	LRTI	No	No		Discharged	GRADE 5	5.97	0.47	0.44	6.47	6.79	0.35
561	Dalanna Manari	45	Male	19-05-2024	115900	Hindu	Vijayapura	chest pain under evaluatio	No	No		Improved	GRADE 4	3.16	0.6	0.54	3.96	3.02	0.4
562	Sharada Vikas Patil	33	Female	21-07-2021	116769	Hindu	Vijayapura	Anemia under evaluation	No	No		Improved	GRADE 5	5	0.74	0.7	5	7	0.66
563	RANGAPPA PUJARI	45	Male	15-06-2023	116025	hindu	mudhal	lrti	No	No		Improved	GRADE 4	4.60	0.65	0.74	4.06	4.09	0.45
564	Poornima malipatil	21	Female	17-10-2022	363507	Hindu	Vijayapura	Seizures under evaluation	No	No		Discharged	GRADE 4	4.29	0.70	0.7	3.9	0	0.67
565	Dalanna manari	44	Male	07-04-2023	115900	Hindu	Vijayapura	IVC THROMBOSIS	No	No		Improved	GRADE 3	1.0	0.00	0.01	3	4.5	0.76
566	Samanjun siddanna mad	66	Male	02-01-2024	002266	Hindu	Bableshwar, Vija	Empyema thoracis PTB	No	No		Improved	GRADE 3	2.4	0.70	0.7	4	6.0	0.66
567	Karunnia Dharenna	20	Male	25-09-2024	030747	Hindu	Jhamakhandi ta, Vij	Acute pancreatitis	No	No		Improved	GRADE 3	1.0	0.70	0.72	3	0	0.60
568	Shivanna Ramanna Kona	45	Male	25-05-2024	176002	Hindu	Bableshwar, vijay	Snake bite	No	No		Improved	GRADE 3	1.5	0.56	0.6	3.1	4.3	0.62
569	AJAYSING NAIK	34	Male	02-01-2023	2006	HINDU	SINDGI	SNAKEBITE	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	106	0.90	1.02	0.90	0.02	1.29
570	RAJSHEKHAR TAMAV	39	Male	16-09-2024	06052	HINDU	MUDHOL	RTA WITH HEAD INJURY	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.65	0.90	0.90	1.02	0.02	1.29
571	SANJEEV PAWAR	46	Male	05-12-2023	300462	HINDU	MUDDEBIHAL	MENINGOENCEPHALITI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.63	0.01	0.07	0.09	0.02	1.09
572	SHAKUNTALA DEVAK	20	Male	14-10-2023	284613	HINDU	SOLAPUR	OP POISONING	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.63	0.76	0.90	1.09	0.06	1.29
573	KASTURI CHIKKODI	70	Female	07-06-2023	104050	HINDU	INDI	MENINGOENEPHALITIS	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.09	0.90	1.34	0.06	0.09	1.24
574	SHIVANGAUDA BIRAD	52	Male	12-08-2023	257609	HINDU	SINDGI	RTA WITH HEMOTHORA	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.09	0.90	0.66	1.35	0.06	1.29
575	NEELAMMA YATGIRI	54	Male	19-01-2024	20205	HINDU	INDI	ACUTE HEMORRHAGIC	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.06	0.90	0.90	1.09	0.05	1.29
576	GURUBASAYYA MATH	41	Female	09-02-2023	52050	HINDU	YATGIR	PERFORATION PERITOI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.90	0.97	0.90	1.06	0.06	1.02
577	NAGAWWA ATHANUR	81	Female	26-06-2023	200522	HINDU	INDI	ACUTE ISCHEMIC STRO	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.90	0.0	0.90	1.06	0.00	1.29
578	NOORJAN MULLA	22	Male	20-10-2023	340003	MUSLIM	VINAY NAGAR	SEPSIS SEC TO UTI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.90	0.06	1.02	0.34	0.04	1.24
579	REVANSIDDA PUJARI	63	Male	14-01-2023	17950	HINDU	INDI	ACUTE PANCETITIS	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.90	0.65	0.09	0.90	0.06	1.09
580	BASAWRAJ DALAWAY	32	Male	07-08-2023	255156	HINDU	SINDGI	RTA WITH HEAD INJURY	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.65	0.90	0.09	1.06	0.00	1.34
581	SHARANAPPA GODEK	65	Male	19-05-2024	267249	HINDU	INDI	ASSAULT WITH HEAD IN	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.09	0.65	0.90	1.01	0.06	1.09
582	LAXMIBAI AMBEGAR	75	Female	21-05-2024	172999	HINDU	SINDGI	ACUTE ISCEMIC STROK	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.06	1.02	1.21	1.56	0.09	1.02
583	BHIMANNA CHOUDHA	73	Male	21-05-2024	173741	HINDU	MUDHOL	SEPSIS WITH LRTI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.06	0.90	1.09	0.65	0.05	1.06
584	GADEMMA WADERA	40	Female	22-05-2024	174997	HINDU	MUDDEBIHAL	LRTI	Yes	Yes	Non invasive ventil.	Deteriorated	GRADE 2	1.65	0.07	0.07	1.29	0.65	1.29
585	MALINGRAY YALADA	32	Male	23-05-2024	175292	HINDU	MUDHOL	ACUTE PANCREATITIS	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.69	0.99	0.90	1.06	0.06	1.2
586	MALANNA MADARAK	56	Male	25-05-2024	179904	HINDU	MUDDEBIHAL	ACUTE CHOLECYSTITIS	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.69	0.94	0.90	1.06	0.02	1.02
587	RAMAVVA WADDAR	56	Female	26-05-2023	179911	HINDU	INDI	UTI WITH SEPTIC SHOC	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.69	0.04	0.90	1.29	0.09	1.34
588	SANGEETH KOODIGAL	15	Female	26-05-2023	179914	HINDU	MUDHOL	ACUTE ANXIETY	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.90	0.97	0.90	1.06	0.06	1.02
589	CHANNAMMA SHANKI	41	Female	24-07-2023	197002	HINDU	INDI	MENINGITIS	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	2.04	0.06	0.90	1.06	0.06	1.25
590	TOTAPPA TALAWAR	33	Male	04-10-2023	314417	HINDU	SINDGI	RTA WITH HEAD INJURY	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.69	0.96	1.09	0.90	0.05	1.96
591	MAHADEV BANDRAG	61	Male	17-08-2023	261747	HINDU	BAGALKOT	SEPSIS WITH LRTI	Yes	Yes	Non invasive ventil.	Deteriorated	GRADE 2	2.01	0.06	0.60	1.69	0.09	1.06
592	BASAVRAJ BIRADAR	53	Male	08-08-2023	255446	HINDU	VINAY NAGAR	ACUTE PANCREATITIS	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.06	0.96	1.36	0.07	0.04	1.29
593	ASHOK KATTI	55	Male	06-10-2023	36720	HINDU	TALIKOTI	ALCOHOLIC INTOXICAT	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.67	0.90	0.90	1.69	0.07	1.09
594	DHEERSING RATHOD	71	Male	26-07-2023	242240	HINDU	BAGALKOT	PERFORATION PERITOI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.90	0.90	1.06	0.90	0.00	1.09
595	PUNPAWATI KORI	66	Female	07-02-2023	40962	HINDU	SINDGI	UTI WITH SEPTIC SHOC	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.90	0.90	1.09	1.06	0.09	1.06
596	IRANNA BADIGER	71	Male	14-07-2023	226990	HINDU	INDI	LRTI	Yes	Yes	Non invasive ventil.	Deteriorated	GRADE 2	2.01	0.07	1.00	1.06	0.06	1.29
597	LAXMIBAI WALIKAR	66	Female	02-11-2023	349325	HINDU	INDI	SEPSIS WITH UTI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.90	0.90	1.02	0.60	0.09	1.34
598	HANAMANTHRAIWAL	46	Male	09-09-2023	200455	HINDU	TALIKOTI	ACUTE PANCREATITIS	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	2.09	0.07	1.02	1.06	0.00	1.09
599	GAGADHAR UPPIN	54	Male	19-02-2023	56604	HINDU	SINDGI	ALCOHOL WITHDRAWAL	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	2.60	0.90	1.02	1.09	0.09	1.34
600	SHRAVIL BUSANUR	16	Male	07-09-2023	00249	HINDU	SINDGI	OP POISIONING	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.90	0.07	1.02	1.06	0.06	1.29
601	RAMESH ATHANI	23	Male	16-05-2023	159465	HINDU	ATHANI JATH	SNAKEBITE	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.06	0.07	1.09	0.65	0.06	1.29
602	LAXMI SHINDE	21	Female	15-05-2023	150275	HINDU	MUDHOL	PARTIAL HANGING	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.90	0.06	1.02	0.90	0.06	1.29
603	ROOPWATI HIREMAT	35	Female	20-11-2023	372615	HINDU	SINDGI	SEPSIS WITH UTI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.35	0.09	0.90	1.09	0.05	1.34
604	RAVUTAPPA TADLAG	77	Male	25-12-2022	449946	HINDU	INDI	ACUTE HEMORRHAGIC	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	1.37	0.90	1.02	1.09	0.04	1.06
605	SHANTAWWA BIRADA	63	Female	17-06-2023	196695	HINDU	MUDHOL	ACUTE ISCHEMIC STRO	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.07	0.07	0.90	1.06	0.04	1.2
606	ARUN SUVARNA	67	Female	09-12-2022	424046	HINDU	MUDHOL	ACUTE EXACERBATION	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	2.01	0.07	1.02	0.07	0.16	1.34
607	AISHWARYA MUJAWA	19	Female	30-09-2023	105775	HINDU	MUDDEBIHAL	OP POISONING	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 2	2.09	0.07	0.90	1.07	0.04	1.29
608	NAGAMMA KAMBLE	49	Female	19-10-2023	324960	HINDU	JATH	SEPSIS WITH UTI	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.07	0.07	0.90	1.06	0.04	1.29
609	SUDHEENDRA KULKA	49	Male	12-02-2024	47779	HINDU	BABHLESHWAR	ACUTE ISCHEMIC STRO	Yes	Yes	Invasive ventilation	Deteriorated	GRADE 1	1.90	0.07	1.02	1.02	0.09	1.34
610	Govindappa Talinarri	41	Male	09-02-2024	45919	Hindu	Sindagi district,	Head injury secondary to	No	No		Improved	GRADE 3	2.1	0.56	0.62	5	0	0.72
611	Shrishail Gadenna	52	Male	07-05-2024	155061	Hindu	Indi dist., Vijayap	Acute gastroenteritis in a	No	No		Improved	GRADE 4	4	0.6	0.64	5	0.4	0.2