Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 246997 * **Patient Health System Stay ID:** 211654 * **Unique Patient ID:** 003-10109 * **Gender:** Male * **Age:** 62 * **Ethnicity:** Caucasian * **Hospital ID:** 92 * **Ward ID:** 143 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 02:11:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 17:28:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 02:02:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 17:50:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Weight:** 50.1 kg * **Discharge Weight:** 50.1 kg * **Admission Height:** 172.7 cm * **APACHE Admission Dx:** Emphysema/bronchitis

2. History

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3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis upon discharge was acute respiratory failure (ICD-9 codes: 518.81, J96.00). A major diagnosis, active upon admission but not upon discharge, was acute COPD exacerbation (ICD-9 codes: 491.21, J44.1). This diagnosis was recorded multiple times throughout the stay with varying active statuses, suggesting fluctuations in the patient's condition. Other diagnoses included hypercarbia (ICD-9 codes: 786.09, J96.92), also with multiple entries and fluctuating active statuses, and metabolic alkalosis (ICD-9 codes: 276.3, E87.3). The presence of COPD, acute respiratory distress, and acute respiratory failure points towards a complex respiratory picture. The metabolic alkalosis suggests a possible electrolyte imbalance that may be related to the respiratory issues or treatment received. The multiple entries for some diagnoses likely reflect the evolution of the patient's condition and the ongoing assessment and reassessment by the medical team.

4. Treatments

The patient received various treatments during their ICU stay. These included non-invasive ventilation (active upon discharge), which suggests a need for respiratory support. The patient also underwent endotracheal intubation (initially), but had the tube removed later (active upon discharge). Oxygen therapy (40%-60%) was administered, indicating the severity of the respiratory compromise. CPAP/PEEP therapy was also employed, further highlighting respiratory support. Stress ulcer prophylaxis and VTE prophylaxis were also initiated, signifying preventative measures for potential complications from prolonged ICU stay. The use of sedative agents points to the need for managing pain or agitation, potentially related to the patient's critical condition. The timing of treatments, as indicated by the `treatmentoffset`, suggests a dynamic approach to managing the patient's evolving clinical picture.

5. Vital Trends

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6. Lab Trends

The laboratory data reveals several key trends. Serial blood gas analyses showed an initial low pH (7.262) and high paCO2 (87.4 mm Hg) indicating respiratory acidosis, which improved over time to a pH of 7.464 and paCO2 of 48.6 mm Hg. The Base Excess also showed improvement, from 7.5 mEq/L to 8.2 mEq/L, suggesting a resolution of the metabolic acidosis. PaO2 values were consistently low, ranging from 61.9 mm Hg to 115 mm Hg, indicating hypoxemia. Complete blood count (CBC) results showed elevated white blood cell (WBC) count (12.2 K/mcL initially), which decreased to 7.7 K/mcL upon discharge. Electrolyte levels (sodium, potassium, chloride, bicarbonate, calcium) were also monitored, with some variations throughout the stay. The lactate levels were elevated initially (1.7 mmol/L) but decreased to 1.5 mmol/L. These lab results corroborate the respiratory diagnoses, and show a generally positive trend in the patient's condition over time, although oxygenation remained suboptimal.

7. Microbiology Tests

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8. Physical Examination Results

The initial physical examination documented the patient as critically ill-appearing but not in acute distress. The patient's mental status was initially sedated and unassessable for orientation. Initial vital signs recorded included a heart rate of 91 bpm, a systolic blood pressure of 120 mmHg, a diastolic blood pressure of 68 mmHg, and a respiratory rate of 22 breaths per minute. The patient was noted to be ventilated with a sinus rhythm and an oxygen saturation of 90%. The patient's weight was recorded as 68.0388 kg upon admission. These findings are consistent with the patient's diagnoses and the treatments provided during their ICU stay. The assessment of the patient as critically ill-appearing confirms the severity of the situation.