Medical Report: Patient 006-100520

1. Patient Information

* **Patient Unit Stay ID:** 931649 * **Unique Patient ID:** 006-100520 * **Gender:** Male * **Age:** 74 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2014-XX-XX 08:19:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2014-XX-XX 00:06:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **ICU Admission Time:** 2014-XX-XX 01:54:00 * **ICU Admission Source:** Emergency Department * **ICU Discharge Time:** 2014-XX-XX 21:38:00 * **ICU Discharge Location:** Step-Down Unit (SDU) * **ICU Discharge Status:** Alive * **Admission Weight:** 90.8 kg * **Discharge Weight:** 87 kg * **Admission Height:** 172 cm

2. History

Insufficient data provided to generate a detailed medical history. The available data only indicates the patient was admitted to the hospital through the Emergency Department and subsequently transferred to the CSICU. Further information about the events leading to admission, prior medical conditions, family history, and social history are needed to complete this section.

3. Diagnoses

The patient presented with multiple diagnoses, reflecting the complexity of their condition. The diagnoses included:

* **Primary Diagnosis (Active upon Discharge):** Acute Respiratory Failure (ICD-9: 518.81, J96.00) * **Major Diagnoses (Some Active upon Discharge):** * Acute Myocardial Infarction (Non-ST Elevation) (ICD-9: 410.71, I21.4) - Multiple entries suggest recurrent or persistent episodes. * Ischemic Dilated Cardiomyopathy (ICD-9: 425.8, I25.5) * Congestive Heart Failure (ICD-9: 428.0, I50.9) * S/P PTCA (Post-Percutaneous Transluminal Coronary Angioplasty) – This indicates a prior interventional procedure.

The temporal relationship between the diagnoses and their relative importance are partially indicated by the `diagnosisOffset` and `diagnosisPriority` fields. However, a complete timeline of events and clinical reasoning behind the diagnoses is missing. The multiple entries for Acute Myocardial Infarction (Non-ST Elevation) and Congestive Heart Failure suggest a chronic and progressive nature to these conditions.

4. Treatments

The patient received several treatments during their ICU stay, including:

* **Mechanical Ventilation:** Multiple entries suggest intermittent use of mechanical ventilation during the stay. * **Glycoprotein IIB/IIIA inhibitor:** This medication is used to treat acute coronary syndromes, indicating management of myocardial infarction. * **Norepinephrine > 0.1 micrograms/kg/min:** Administration of norepinephrine suggests treatment for shock, possibly related to cardiogenic shock given the other diagnoses.

The duration and effectiveness of these treatments are not detailed in the provided data. Additional information on medication dosages, response to therapy, and any adverse events would be crucial for a comprehensive treatment summary.

5. Vital Trends

NULL. No vital sign data is provided.

6. Lab Trends

The laboratory data shows multiple blood tests were conducted, including complete blood counts (CBCs) with differential, basic metabolic panels (BMPs), cardiac markers (troponin-I), and brain natriuretic peptide (BNP). There were fluctuations in several parameters, indicating the patient's condition was dynamic. Serial bedside glucose measurements show values ranging from 144 to 368 mg/dL, and a trend towards higher glucose levels would need further investigation.

7. Microbiology Tests

NULL. No microbiology test data is available.

8. Physical Examination Results

Two structured physical exams were performed, one early and one later in the ICU stay. The physical exam documented vital signs (heart rate, blood pressure, respiratory rate, and oxygen saturation), GCS score (at two different time points), and fluid balance (Intake, Output, Net). Heart rate, respiratory rate, and blood pressure values recorded varied over the course of the stay, reflecting the patient's unstable condition. Fluid balance indicated a significant net negative balance (-550ml at the first exam, +275ml at the second), suggesting fluid management was a key aspect of treatment. Additional details about the patient's physical condition, including findings from auscultation, palpation, and other assessments, are absent.

Note: This report is limited by the incompleteness of the provided data. A more thorough assessment requires access to a complete medical record, including vital signs, detailed nursing notes, imaging studies, and other clinical data.