Medical Report: Patient 006-101426

1. Patient Information

* **Patient Unit Stay ID:** 896028 * **Patient Health System Stay ID:** 668199 * **Unique Patient ID:** 006-101426 * **Gender:** Male * **Age:** 64 * **Ethnicity:** Caucasian * **Hospital ID:** 155 * **Ward ID:** 362 * **Unit Type:** Med-Surg ICU * **Unit Admit Source:** Emergency Department * **Unit Admit Time:** 21:47:00 * **Unit Discharge Time:** 20:30:00 * **Unit Discharge Status:** Expired * **Hospital Admit Time:** 20:31:00 * **Hospital Discharge Time:** 20:30:00 * **Hospital Discharge Status:** Alive * **Hospital Discharge Location:** Home * **Admission Weight:** 56.3 kg * **Discharge Weight:** 61.5 kg * **Admission Height:** 175 cm * **APACHE Admission Dx:** Cardiac arrest (with or without respiratory arrest; for respiratory arrest see Respiratory System)

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses, some active upon discharge and others not. The diagnoses, prioritized by severity, are as follows:

* **Primary Diagnosis (Active upon Discharge):** Respiratory failure/arrest (ICD-9 code: 799.1, R09.2). This was the primary diagnosis at the time of admission. * **Major Diagnosis (Active upon Discharge):** Post-anoxic encephalopathy (ICD-9 code: 348.1, G93.1). This indicates brain damage due to oxygen deprivation. * **Major Diagnosis (Active upon Discharge):** Cardiac arrest (ICD-9 code: 427.5, I46.9). This is a critical event where the heart stops functioning. * **Major Diagnosis (Not Active upon Discharge):** Encephalopathy (ICD-9 code: 348.30, G93.40). This is another form of encephalopathy, possibly related to the post-anoxic diagnosis, but not actively contributing to the condition at discharge. * **Major Diagnosis (Not Active upon Discharge):** Cardiac arrest (ICD-9 code: 427.5, I46.9). A second instance of cardiac arrest is recorded, but was resolved prior to discharge. * **Major Diagnosis (Not Active upon Discharge):** Pulmonary respiratory failure/arrest (ICD-9 code: 799.1, R09.2). This is a second record of respiratory failure/arrest that was resolved.

The temporal relationships between these diagnoses are crucial. Note that several diagnoses were recorded at 3303 minutes and others at 53 minutes post-unit admit. This suggests a critical event occurred around the 53-minute mark followed by further complications and diagnoses later in the ICU stay.

4. Treatments

The patient received mechanical ventilation. The treatment was initially documented at 53 minutes post-unit admission and was continued until discharge (3303 minutes). This suggests the patient required respiratory support throughout a significant portion of their ICU stay.

5. Vital Trends

NULL (Insufficient information provided)

6. Lab Trends

The provided lab data shows multiple blood gas analyses (ABG) at various time points during the patient's ICU stay, indicating ongoing monitoring of respiratory and metabolic status. There were also chemistry and hematology tests performed. Specific trends and interpretations require more complete data and visual representation.

7. Microbiology Tests

NULL (Insufficient information provided)

8. Physical Examination Results

A structured physical exam was performed at 46 minutes post-unit admission. The recorded vital signs include a heart rate (HR) ranging from 54 to 57 bpm, a systolic blood pressure (BP) ranging from 109 to 118 mmHg, a diastolic BP of 55 mmHg, and a respiratory rate (RR) of approximately 20 breaths per minute. Oxygen saturation (O2 Sat) was 100%, with a PEEP of 5 cm H2O and a vent rate of 20 breaths per minute. A Glasgow Coma Scale (GCS) score was recorded as 15 (4, 5, 6). This suggests a relatively stable initial state, but more data is needed to assess the progression of the patient's status.