Medical Report for Patient 003-11313

1. Patient Information:

* **Patient Unit Stay ID:** 301780 * **Unique Patient ID:** 003-11313 * **Gender:** Male * **Age:** 76 * **Ethnicity:** NULL * **Hospital Admit Time:** 2015, 05:00:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2015, 15:07:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 22:27:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 01:00:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 99.3 kg * **Discharge Weight:** 100.2 kg * **Admission Height:** 177.8 cm * **APACHE Admission Diagnosis:** Head/chest trauma

2. History:

NULL (Insufficient information provided in the JSON data to elaborate on the patient's medical history beyond the admission diagnosis.)

3. Diagnoses:

The patient presented with the following diagnoses during their ICU stay:

* **Chest Wall Trauma (ICD-9: 807.4):** This diagnosis was active upon discharge from the unit and marked as 'Other' priority. The diagnosis was recorded 77 minutes after unit admission time. The full pathstring is 'burns/trauma|trauma - chest|chest wall trauma'. This suggests significant trauma to the chest region. Further details regarding the mechanism of injury and extent of the trauma are lacking. * **Atrial Fibrillation (ICD-9: 427.31, I48.0):** This diagnosis was recorded 70 minutes after unit admission time. This was initially recorded as active and was later marked as inactive upon discharge, suggesting that the condition may have been resolved or controlled during the ICU stay. The diagnosis was also marked as 'Other' priority. The exact nature and severity of the atrial fibrillation, along with any treatment interventions, need further clarification.

4. Treatments:

The patient received the following treatments:

* **VTE Prophylaxis:** This treatment was initiated 70 minutes after unit admission and was not active upon discharge. The specific type of prophylaxis (e.g., compression stockings, anticoagulants) is not specified. The reason for discontinuation of the treatment requires further information. * **VTE Prophylaxis:** This treatment was initiated 77 minutes after unit admission and was active upon discharge. This indicates a continued need for venous thromboembolism prophylaxis, potentially due to the patient's immobility or other risk factors. The type of prophylaxis administered should be detailed in a complete medical record.

5. Vital Trends:

NULL (No vital sign data is included in the provided JSON.)

6. Lab Trends:

Laboratory results are available for two separate time points: one at approximately 713 minutes after unit admission and another at approximately -442 minutes before unit admission. Key laboratory findings at 713 minutes post-admission include:

* **Hemoglobin (Hgb):** 12.4 g/dL * **Hematocrit (Hct):** 36.5 % * **Mean Corpuscular Hemoglobin Concentration (MCHC):** 34 g/dL * **Mean Corpuscular Volume (MCV):** 91 fL * **Mean Platelet Volume (MPV):** 11.1 fL * **Platelets:**

82 K/mcL * **White Blood Cells (WBC):** 3.9 K/mcL * **Glucose:** 115 mg/dL * **Blood Urea Nitrogen (BUN):** 24 mg/dL * **Creatinine:** 1.27 mg/dL * **Chloride:** 104 mmol/L * **Potassium:** 4.5 mmol/L * **Sodium:** 140 mmol/L * **Calcium:** 8.9 mg/dL * **Albumin:** 3.8 g/dL * **Total Bilirubin:** 0.4 mg/dL * **Direct Bilirubin:** 0 mg/dL * **Alanine Aminotransferase (ALT):** 28 Units/L * **Aspartate Aminotransferase (AST):** 25 Units/L * **Bicarbonate:** 29 mmol/L * **Anion Gap:** 16 mmol/L * **Prothrombin Time (PT):** 25.3 sec * **Prothrombin Time - International Normalized Ratio (PT-INR):** 2.4 ratio * **Lymphocytes:** 18.5 % * **Eosinophils:** 0.03 % * **Basophils:** 0 % * **Monocytes:** 0.8 % * **Red Cell Distribution Width (RDW):** 14 %

The earlier set of lab results (-442 minutes pre-admission) show similar patterns but with some variations in values, indicating a potential change in the patient's condition over time. A detailed comparison between the two sets is needed for a complete interpretation.

7. Microbiology Tests:

NULL (No microbiology test data is available in the JSON data.)

8. Physical Examination Results:

Physical examination findings include:

* **Glasgow Coma Scale (GCS):** A GCS score was recorded twice, at 33 minutes and 11 minutes after unit admission. The initial GCS score was 15 (Eyes 4, Verbal 5, Motor 6), indicating a normal level of consciousness. The later GCS was also 15. The fact that a GCS was performed twice suggests neurological status was of particular interest and should be examined in the context of the patient's head trauma. * **Heart Rate (HR):** HR was recorded as 70 (Current), with a range of 65 (Lowest) to 71 (Highest). The rhythm was noted as irregular. * **Blood Pressure (BP):** BP (Systolic) was recorded as 114 (Current), with a range of 109 (Highest) to 114 (Lowest). BP (Diastolic) was 73 (Current), with a range of 73 (Lowest) to 80 (Highest). * **Respiratory Rate:** Respiratory rate was recorded as 16 (Current), with a range of 15 (Lowest) to 16 (Highest). The respiratory mode was spontaneous. * **Oxygen Saturation (O2 Sat):** O2 saturation was 97% (Current), with a range of 97% (Lowest) to 100% (Highest). * **Weight:** Admission weight was 99.3 kg.

The physical exam was documented as 'Performed - Structured' indicating standardized methods were used for the assessment. Further details on the patient's physical condition beyond these vital signs are absent from the provided data.