Medical Report for Patient 005-10106

1. Patient Information

* **Patient Unit Stay ID:** 483209 * **Patient Health System Stay ID:** 409491 * **Unique Patient ID:** 005-10106 * **Gender:** Male * **Age:** 72 years * **Ethnicity:** Hispanic * **Hospital ID:** 142 * **Ward ID:** 290 * **Unit Type:** Med-Surg ICU * **Admission Height:** 172.7 cm * **Admission Weight:** 58.9 kg * **Hospital Admit Time:** 2015-XX-XX 22:56:00 (Hospital Admit Offset: -19151 minutes from unit admit) * **Hospital Admit Source:** Floor * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 21:33:00 (Hospital Discharge Offset: 19646 minutes from unit admit) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Admit Time:** 2015-XX-XX 06:07:00 * **Unit Admit Source:** Floor * **Unit Visit Number:** 1 * **Unit Stay Type:** Admit * **Unit Discharge Time:** 2015-XX-XX 03:32:00 (Unit Discharge Offset: 2725 minutes from unit admit) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **APACHE Admission Dx:** Pneumonia, other

2. History

NULL (Insufficient information provided in the JSON data.)

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The diagnoses entered, along with their priority and active status upon discharge, are detailed below:

* **Diagnosis 1 (Primary):** cardiovascular|shock / hypotension|septic shock (ICD-9 code: 785.52, R65.21) – entered at 275 minutes post-unit admit, inactive on discharge. * **Diagnosis 2 (Major):** cardiovascular|shock / hypotension|hypotension (ICD-9 code: 458.9, I95.9) – entered at 53 and 2424 minutes post-unit admit, active on discharge. * **Diagnosis 3 (Major):** pulmonary|pulmonary infections|pneumonia|aspiration (ICD-9 code: 507.0, J69.0) – entered at 275 and 2424 minutes post-unit admit, active on discharge. * **Diagnosis 4 (Major):** neurologic|seizures|seizures (ICD-9 code: 345.90, R56.9) – entered at 53 and 2424 minutes post-unit admit, active on discharge. * **Diagnosis 5 (Major):** neurologic|altered mental status / pain|dementia|Alzheimer's disease (ICD-9 code: 294.10, 331.0, F02.8, G30.9) – entered at 53 and 2424 minutes post-unit admit, active on discharge.

Note that multiple entries for the same diagnosis string exist, suggesting either re-evaluation or ongoing monitoring of these conditions.

4. Treatments

The patient received various treatments during their ICU stay. The treatments administered, along with their active status upon discharge, are listed below:

* **Treatment 1:** infectious diseases|consultations|Infectious Disease consultation – entered at 2424 minutes post-unit admit, active on discharge. * **Treatment 2:** neurologic|ICH/ cerebral infarct|antiplatelet agents|clopidogrel – entered at 275 and 2424 minutes post-unit admit, active on discharge. * **Treatment 3:** pulmonary|consultations|Pulmonary medicine consultation – entered at 53 and 2424 minutes post-unit admit, active on discharge. * **Treatment 4:** endocrine|glucose metabolism|insulin|subcutaneous dose of regular insulin – entered at 2424 minutes post-unit admit, active on discharge. * **Additional Treatments:** The patient also received various other consultations, medications (penicillins, valproate), and intravenous fluids (normal saline, fluid bolus, D5W) at different time points during their stay. Some treatments, like stress ulcer prophylaxis (famotidine), were discontinued before discharge. Cultures were also taken at different time points.

5. Physical Examination Results

The patient's physical examinations revealed the following:

* **Initial Physical Exam (8 minutes post-unit admit):** GCS Score estimated at 9 due to medications, HR 87 bpm (lowest and highest also recorded as 87), BP 95 mmHg systolic (lowest and highest also recorded), BP 47 mmHg diastolic (lowest and highest also recorded), respiratory rate 23 breaths per minute (lowest and highest also recorded), O2 saturation 100% (lowest and highest also recorded), Weight 58.9kg. The patient was critically ill-appearing and cachectic but not in acute distress. Bowel sounds were decreased, pulses were normal, heart sounds were normal (S1 and S2), and JVD was absent. Scattered rhonchi were noted on auscultation. The patient had a foley catheter in place. * **Subsequent Physical Exam (2232 minutes post-unit admit):** GCS score 11, HR 90 bpm (lowest 71, highest 97), BP 110 mmHg systolic (lowest 72, highest 128), BP 72 mmHg diastolic (lowest 42, highest 85), respiratory rate 18 breaths per minute (lowest and highest 18), O2 saturation 100% (lowest 99, highest 100), Weight 58.9kg. The patient was critically ill-appearing and cachectic but not in acute distress. Bowel sounds were decreased, pulses were normal, heart sounds were normal (S1 and S2), JVD was absent. Scattered rhonchi were noted on auscultation. The patient had a foley catheter in place.

6. Vital Trends NULL (Insufficient information provided in the JSON data.)

7. Lab Trends NULL (Insufficient information provided in the JSON data. While numerous lab results are present, there's no information on when these results were obtained relative to each other in order to establish trends.)

8. Microbiology Tests NULL (Insufficient information provided in the JSON data.)