Patient Information

Patient Unit Stay ID: 297175 Unique Patient ID: 003-10109 Gender: Male Age: 61 Ethnicity: Caucasian Hospital Admit Time: 2015-XX-XX 01:21:00 Hospital Discharge Time: 2015-XX-XX 17:40:00 Unit Admit Time: 2015-XX-XX 01:21:00 Unit Discharge Time: 2015-XX-XX 16:56:00 Admission Weight: 47.5 kg Discharge Weight: 47.5 kg Admission Height: 170.2 cm Hospital Admit Source: Emergency Department Unit Admit Source: Direct Admit Hospital Discharge Location: Home Unit Discharge Location: Floor Hospital Discharge Status: Alive Unit Discharge Status: Alive APACHE Admission Diagnosis: Emphysema/bronchitis

Medical History

Insufficient data provided to generate a detailed medical history. The provided data only includes diagnoses, lab results, treatments, and physical exam findings during the ICU stay. A complete medical history would require information on prior illnesses, surgeries, hospitalizations, family history, social history (e.g., smoking, alcohol use), and medication history prior to this ICU admission. This would provide context for understanding the current episode of care.

Diagnoses

The patient presented with multiple pulmonary diagnoses during their ICU stay. These included:

* Acute respiratory failure due to increased CO2 production (ICD-9 codes: 518.81, J96.00) – This was an initial diagnosis, not active on discharge. * Severe COPD (ICD-9 codes: 491.20, J44.9) – Active on discharge. * Acute COPD exacerbation (ICD-9 codes: 491.21, J44.1) – Active on discharge. * Hypoxemia (ICD-9 codes: 799.02, J96.91) – Not active on discharge. * Respiratory acidosis (ICD-9 codes: 276.2, E87.2) – Active on discharge. * Hypercarbia (ICD-9 codes: 786.09, J96.92) – Active on discharge.

Note that multiple entries for the same diagnosis exist; this may reflect updates or refinements to the diagnosis over the course of the ICU stay. The clinical significance of each diagnosis and their interrelationship require further clinical interpretation. The priority of the diagnoses is not consistently recorded and marked as 'Other' in most cases. Further investigation is needed to determine the primary diagnosis.

Treatments

The patient received a variety of treatments during their ICU stay, including:

* Respiratory support (non-invasive ventilation) – Active on discharge. * Antibiotics (ceftriaxone, azithromycin, vancomycin) – Vancomycin active on discharge. * Bronchodilators (beta-agonists, nebulized bronchodilators) – Beta-agonist active on discharge. * Glucocorticoid administration – Active on discharge. * Analgesics (narcotic and non-narcotic, oral and IV) – Oral analgesics and narcotic analgesics active on discharge. * Stress ulcer prophylaxis (omeprazole) – Active on discharge. * Antiplatelet agent (aspirin) – Active on discharge. * VTE prophylaxis (enoxaparin) – Active on discharge. * Anticonvulsant (gabapentin) – Active on discharge.

The specific dosages and duration of each treatment are not specified in the provided data, preventing a complete assessment of the treatment regimen.

Vital Trends

NULL. Vital sign data (heart rate, blood pressure, respiratory rate, oxygen saturation) is available within the physical examination results but is insufficient to generate detailed trends without time stamps.

Lab Trends

The provided lab data includes multiple blood tests (hematology and chemistry panels) and arterial blood gases (ABGs) taken at different times during the ICU stay. However, without timestamps associated with the lab results, trends cannot be analyzed. The labs show some evidence of metabolic acidosis (low pH, low PaO2, high PaCO2, elevated Base Excess) and anemia (low Hemoglobin and Hematocrit), with some electrolyte abnormalities. The absence of timestamps prevents a clear picture of the progression or resolution of these abnormalities.

Microbiology Tests

The patient had sputum cultures performed, but the results are not included in the provided data.

Physical Examination Results

The physical examination documented the patient as ill-appearing and cachectic. Vital signs were recorded at multiple time points, but without timestamps, the trends of these measurements are not meaningful. The patient's heart rhythm was initially documented as sinus rhythm and later as regular. Respiratory rate was also documented at multiple time points, but without timestamps or additional context, trends cannot be reliably assessed. Oxygen saturation was recorded at various points, also lacking sufficient time information. The Glasgow Coma Scale (GCS) was recorded as 15 at two different time points, suggesting no significant neurological deterioration during the ICU stay. The patient's weight remained constant at 47.5 kg during the ICU stay. Urine output was 900 ml during the observation period.