Medical Report for Patient 006-100338

1. Patient Information

* **Patient Unit Stay ID:** 758325 * **Patient Health System Stay ID:** 585352 * **Unique Patient ID:** 006-100338 * **Gender:** Male * **Age:** 64 * **Ethnicity:** Other/Unknown * **Hospital ID:** 148 * **Ward ID:** 347 * **Unit Type:** MICU * **Unit Admit Time:** 2014-XX-XX 16:29:00 (Assuming a date) * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2014-XX-XX 20:21:00 (Assuming a date) * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 2014-XX-XX 14:15:00 (Assuming a date, 134 minutes before unit admit) * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 2014-XX-XX 22:34:00 (Assuming a date) * **Hospital Discharge Location:** Other External * **Hospital Discharge Status:** Alive * **Admission Weight:** 63 kg * **Discharge Weight:** 58.6 kg * **Admission Height:** 183 cm * **Admission Diagnosis:** Pneumonia, aspiration

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The primary diagnoses upon admission were severe sepsis (ICD-9 codes: 995.92, R65.2) and pulmonary aspiration (ICD-9 codes: 507.0, J69.0). Secondary diagnoses included severe sepsis (995.92, R65.2), aspiration pneumonia (507.0, J69.0), hypoxemia (799.02, J96.91), acute respiratory failure (518.81, J96.00), acute respiratory distress (518.82), and hypotension (458.9, I95.9). Septic shock (785.52, R65.21) was also diagnosed.

Note that multiple entries for the same diagnosis string and ICD-9 codes exist, suggesting potential repeated entries or evolving severity of the conditions over the course of the stay. The `diagnosisOffset` field indicates the time elapsed since unit admission when each diagnosis was recorded. This temporal aspect is crucial for understanding the progression of the patient's illness. The `activeUpondischarge` field indicates that none of the diagnoses were active at the time of unit discharge.

4. Treatments

The patient received several treatments during their ICU stay. These included mechanical ventilation (both invasive and non-invasive), albumin administration as a colloid, and norepinephrine administration for shock management. The duration of these treatments is not explicitly stated but can be inferred from the `treatmentOffset` and `activeUpondischarge` fields. The `activeUpondischarge` field shows that all listed treatments were discontinued before unit discharge.

5. Vital Trends

NULL (Insufficient data; only single points in time for some vital signs are available from Physical Exam)

6. Lab Trends

The provided lab data includes multiple blood tests (hematology and chemistry) and bedside glucose measurements taken at various times during the patient's stay. Key lab values such as Hemoglobin (Hgb), Hematocrit (Hct), White Blood Cell count (WBC), Platelet count, and various electrolytes (sodium, potassium, chloride, bicarbonate, anion gap, calcium) were monitored. The data also includes ABG results (pH, PaO2, PaCO2, Base Excess), liver function tests (ALT, AST), and other markers (BUN, creatinine, albumin, transferrin, Ferritin, Vitamin B12, Folate). The values show fluctuations in various parameters over time. A detailed analysis requires plotting these values against time to observe trends. There are also multiple measurements of bedside glucose, suggesting frequent monitoring of the patient's blood sugar.

7. Microbiology Tests

NULL (No microbiology test results are included)

8. Physical Examination Results

The physical exam records show the patient's weight at admission (63 kg) and at a later point (59.9kg), indicating a weight loss of 3.1kg. A Glasgow Coma Scale (GCS) score was recorded (initially 13, later 14). Heart rate (HR) measurements ranged between 54 and 77 bpm. Systolic blood pressure (BP) ranged from 88 to 180 mmHg, and diastolic BP ranged from 49 to 82 mmHg. Respiratory rate varied from 15 to 39 breaths per minute and the patient was ventilated. Oxygen saturation (O2 Sat) was consistently high (99-100%). Central venous pressure (CVP) was measured at 3 cm H2O, and later at 0. PEEP was recorded at 5 cm H2O, and later at 8 cm H2O. The physical exam was performed using structured data entry. The temporal progression of these findings is not clear without additional data points.