Medical Report for Patient 003-10438

1. Patient Information

* **Patient Unit Stay ID:** 261520 * **Patient Health System Stay ID:** 224700 * **Unique Patient ID:** 003-10438 * **Gender:** Male * **Age:** 78 * **Ethnicity:** Caucasian * **Hospital ID:** 92 * **Ward ID:** 143 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 19:20:00 * **Unit Admit Source:** Emergency Department * **Hospital Admit Time:** 18:17:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 01:42:00 * **Hospital Discharge Location:** Death * **Hospital Discharge Status:** Expired * **Unit Discharge Time:** 01:42:00 * **Unit Discharge Location:** Death * **Unit Discharge Status:** Expired * **Admission Weight:** 103.1 kg * **Discharge Weight:** 103.1 kg * **Admission Height:** 165.1 cm

2. History

The patient was admitted to the Med-Surg ICU from the Emergency Department following a cardiac arrest (with or without respiratory arrest). The exact circumstances surrounding the cardiac arrest are not detailed in the provided data. Further information is needed to fully elucidate the patient's medical history prior to ICU admission. The available data suggests a complex clinical picture involving cardiovascular and pulmonary issues. The timeline of events leading up to the cardiac arrest is unknown, as is any prior history of cardiovascular disease, respiratory illness, or other relevant conditions. A more complete history, including family history and social history, is required for a comprehensive assessment.

3. Diagnoses

Multiple diagnoses were recorded during the patient's ICU stay. These include:

* **Primary:** Cardiovascular|cardiac arrest|cardiac arrest (427.5, I46.9) – This was the primary diagnosis upon admission and remained active upon discharge, indicating the severity of the condition. * **Other:** Cardiovascular|ventricular disorders|cardiomyopathy * **Other:** Cardiovascular|arrhythmias|AV block|complete heart block (426.0, I44.2) – This diagnosis was recorded multiple times throughout the stay, both active and inactive upon discharge. * **Other:** Pulmonary|respiratory failure|acute respiratory failure (518.81, J96.00) * **Other:** Endocrine|glucose metabolism|hyperglycemia (790.6, R73.9) * **Other:** Cardiovascular|arrhythmias|AV block|pacemaker in place, pacing and capturing

The multiplicity of cardiovascular and pulmonary diagnoses suggests a complex and potentially interconnected disease process. The presence of hyperglycemia points towards potential metabolic disturbances that may have contributed to the patient's condition. The absence of ICD-9 codes for some diagnoses necessitates further investigation to ensure complete and accurate coding.

4. Treatments

The patient received a variety of treatments during their ICU stay. These included:

* **Mechanical ventilation:** Initiated and subsequently discontinued. The reasons for initiation and discontinuation are not available in this data set. * **Oxygen therapy (>60%):** Administered at different points in the ICU stay, both active and inactive upon discharge. * **Temporary pacemaker implantation:** A temporary pacemaker was placed and later removed. The reason for the placement and removal are not detailed. * **Conventional intravenous heparin therapy:** Used as an anticoagulant, active upon discharge. This indicates a continued need for anticoagulation management. * **Hypothermia therapy:** Used for controlling cerebral perfusion pressure, active upon discharge. This suggests the patient experienced neurological consequences from the cardiac arrest. * **Analgesics and sedative agents (midazolam):** Administered for pain and agitation management, with midazolam being a specific sedative used. * **Neuromuscular blocking agent (vecuronium):** Used in conjunction with other therapies to manage cerebral perfusion pressure, with vecuronium being a specific neuromuscular blocker used. * **Class III antiarrhythmic (amiodarone):** Administered to manage arrhythmias, active upon discharge. This highlights ongoing arrhythmia management needs. * **Beta-blocker (metoprolol):** Used to manage arrhythmias, inactive upon discharge. This indicates that the need for metoprolol was not ongoing. * **Continuous

insulin infusion:** Used to manage hyperglycemia, inactive upon discharge. * **Blood and urine cultures:** Collected for infectious disease workup. * **Head CT scan and EEG:** Neurological imaging and electroencephalogram were conducted during the stay. * **Cardiac angiography:** Performed to evaluate the cardiovascular system. * **Physical restraints:** Used at various points during the ICU stay. This necessitates a review of the reasons for restraint use.

The variety of treatments underscores the complexity of the patient's condition, indicating a multi-system approach was necessary. The active treatments upon discharge highlight ongoing management requirements.

5. Vital Trends NULL. Vital signs data is not provided.

6. Lab Trends NULL. Time series data of lab results is not provided.

7. Microbiology Tests NULL. Microbiology test results are not provided.

8. Physical Examination Results

Initial physical exam at 3 minutes post-unit admission showed the patient weighing 101.6 kg. A subsequent exam (2781 minutes post-admission) indicated that a structured physical exam was not performed. However, at 18 minutes post-admission, a structured exam was conducted, noting: HR 68 (lowest 67, highest 68), systolic BP 122 (lowest 122, highest 149), diastolic BP 60 (lowest 60, highest 83), respiratory rate 28 (lowest 28, highest 33), O2 saturation 94% (lowest 90%, highest 94%), and the patient was ventilated and paced, appearing ill. The patient was comatose, and orientation was unable to be assessed. A later physical exam at 1260 minutes post-admission showed a GCS score of 5 (eyes 1, verbal 3, motor 1), HR of 67 (lowest 67, highest 75), systolic BP of 36 (lowest 16, highest 202), diastolic BP of 28 (lowest 9, highest 88), respiratory rate 13 (lowest 13, highest 46), O2 saturation 93% (lowest 90%, highest 98), and CVP of 31. The patient was again noted to be ventilated and ill-appearing, well developed, and not in acute distress. Weight at this time was recorded as 106 kg (a +4.4 kg change from admission), with 3150 ml of urine output.

The physical examination findings demonstrate the patient's critical condition, indicating severe respiratory and neurological compromise. The fluctuating vital signs and weight changes further highlight the severity of the illness.