Patient Information

Patient Unit Stay ID: 312258 Patient Health System Stay ID: 269958 Gender: Male Age: 53 Ethnicity: Caucasian Hospital ID: 131 Ward ID: 227 Unique Patient ID: 004-1222 Admission Height: 172.7 cm Admission Weight: 104.3 kg APACHE Admission Dx: Weaning from mechanical ventilation (transfer from other unit or hospital only) Hospital Admit Time: 20:30:00 Hospital Discharge Year: 2014 Hospital Discharge Time: 19:50:00 Hospital Discharge Location: Rehabilitation Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admit Time: 21:01:00 Unit Admit Source: Direct Admit Unit Visit Number: 1 Unit Stay Type: admit Unit Discharge Time: 21:33:00 Unit Discharge Location: Floor Unit Discharge Status: Alive

Medical History

Insufficient data provided. NULL

Diagnoses

The patient presented with multiple diagnoses during their ICU stay. These diagnoses, listed in order of entry, include:

* **Morbid Obesity:** (ICD-9 codes: 278.01, E66.01) This was a Major diagnosis upon admission. * **Post-anoxic Encephalopathy:** (ICD-9 codes: 348.1, G93.1) This diagnosis was marked as ‘Other’ and was not active upon discharge. * **Sepsis:** (ICD-9 codes: 038.9, A41.9) This was a major diagnosis and was active upon discharge. * **Acute Respiratory Distress Syndrome:** (ICD-9 code: 518.82) This was a major diagnosis and was active upon discharge. * **Chronic Respiratory Failure:** (ICD-9 codes: 518.83, J96.10) This was a primary diagnosis and was active upon discharge. * **Hyperlipidemia:** (ICD-9 codes: 272.4, E78.5) This was an ‘Other’ diagnosis and was not active upon discharge. * **Hyperglycemia:** (ICD-9 codes: 790.6, R73.9) This diagnosis was a major diagnosis and was active upon discharge. * **Regurgitant Esophagitis:** (ICD-9 codes: 530.11, K21.0) This was an ‘Other’ diagnosis and was active upon discharge. * **Anemia:** (ICD-9 code:) This was a major diagnosis and was active upon discharge. No ICD-9 code was provided. * **Dysphagia:** (ICD-9 codes: 787.2, R13.10) This was an ‘Other’ diagnosis and was active upon discharge. * **Pneumonia:** (ICD-9 codes: 486, J18.9) This was a major diagnosis and was active upon discharge. * **Seizures:** (ICD-9 codes: 345.90, R56.9) This was an ‘Other’ diagnosis and was not active upon discharge. There were several entries for this diagnosis. * **Hypertension:** (ICD-9 codes: 401.9, I10) This was an ‘Other’ diagnosis and was not active upon discharge. There were several entries for this diagnosis. * **Polyneuropathy:** (ICD-9 codes: 357.9, G62.9) This was an ‘Other’ diagnosis and was active upon discharge. There were several entries for this diagnosis.

Many of these diagnoses appear multiple times in the record, suggesting ongoing monitoring and treatment of these conditions. The absence of a complete medical history prevents a more comprehensive assessment of the patient's overall health status prior to this ICU stay.

Treatments

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

* **Mechanical Ventilation:** (multiple entries, various modes including pressure support and synchronized intermittent mandatory ventilation (SIMV)) This treatment was not active upon discharge. * **Oxygen Therapy:** (multiple entries, various percentages) This treatment was active upon discharge. * **Medication Administration:** Including analgesics (bolus parenteral and narcotic), sedatives (midazolam), intravenous diuretics (furosemide), vancomycin, antifungal therapy, hydralazine, doxepin, and coumadin. The activity status of these varied. * **Enteral Nutrition:** (multiple entries, various methods including enteral formula, nutritional supplements, and nasogastric tube feeding) This treatment was active upon discharge. * **Foley Catheter:** This treatment was active upon discharge. * **Consultations:** Including Pulmonary/CCM and Neurology. * **Diagnostic Tests:** Including transthoracic echocardiography and non-invasive testing for DVT. These were performed at different times during the patient's stay. * **VTE Prophylaxis:** Using compression stockings and enoxaparin (low molecular weight heparin). This treatment was active upon discharge. * **Tracheostomy:** This was performed and was not active upon discharge.

The numerous treatments highlight the complexity of the patient's condition and the multi-system involvement. A more detailed understanding of the treatment rationale and response would require additional information.

Vital Trends

Insufficient data provided. NULL

Lab Trends

The provided laboratory data includes multiple measurements of blood glucose, which fluctuated significantly during the patient's stay. Other lab values show trends in Hematological parameters (Hemoglobin (Hgb), Hematocrit (Hct), RBC, MCV, MCH, MCHC, RDW, Platelets, PT, PT-INR, and WBC), and chemistry parameters (BUN, creatinine, sodium, chloride, bicarbonate, calcium, magnesium, total protein, albumin, total bilirubin, CRP, T3RU, T4, TSH, BNP, base excess, paO2, FiO2, and PEEP). Serial blood glucose measurements indicate significant hyperglycemia, requiring insulin management. Hematological data show fluctuations that might be attributable to the patient's underlying conditions. Analysis of the time-series data for these parameters is needed to ascertain the exact trends. Detailed time-series data is needed to fully characterize these trends.

Microbiology Tests

The patient underwent urine and sputum cultures. The results of these tests are not provided. NULL

Physical Examination Results

The physical examination documented vital signs at admission. Heart rate (HR) ranged from 94 to 100 bpm. Systolic blood pressure (BP) ranged from 103 to 116 mmHg and diastolic BP from 62 to 73 mmHg. Respiratory rate (RR) ranged from 20 to 22 breaths per minute. Oxygen saturation (O2 Sat) was 100%. The Glasgow Coma Scale (GCS) was estimated as 15 (E4V4M6) due to medication. A structured physical exam was performed.