Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 162502 * **Patient Health System Stay ID:** 145386 * **Gender:** Male * **Age:** 83 * **Ethnicity:** Caucasian * **Hospital ID:** 69 * **Ward ID:** 98 * **Admission Diagnosis:** CHF, congestive heart failure * **Admission Height:** 180.3 cm (Assuming cm, as units are not specified) * **Hospital Admit Time:** 2015-XX-XX 22:16:00 (Date unspecified) * **Hospital Admit Source:** Direct Admit * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 19:41:00 (Date unspecified) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 22:18:00 (Date unspecified) * **Unit Admit Source:** Direct Admit * **Unit Visit Number:** 1 * **Unit Stay Type:** admit * **Admission Weight:** 104.3 kg * **Discharge Weight:** 99.7 kg * **Unit Discharge Time:** 2015-XX-XX 22:53:00 (Date unspecified) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Unique Patient ID:** 002-11232

2. History

NULL (Insufficient information provided in the JSON data to elaborate on the patient's medical history.)

3. Diagnoses

* **Diagnosis ID:** 3840201 * **Patient Unit Stay ID:** 162502 * **Active Upon Discharge:** True * **Diagnosis Offset (minutes from unit admit):** 628 * **Diagnosis String:** cardiovascular|valvular disease|valvular insufficiency|with CHF * **ICD-9 Code:** NULL (Not provided) * **Diagnosis Priority:** Primary

The primary diagnosis upon admission to the Med-Surg ICU was valvular insufficiency with congestive heart failure (CHF), a condition affecting the heart's ability to pump blood effectively. The diagnosis was established 628 minutes after the patient's admission to the ICU. The cardiovascular system is clearly the focus of concern. Further details about the patient's history leading to this diagnosis are lacking. The absence of an ICD-9 code prevents a more precise categorization and further analysis of the diagnosis within the broader context of medical coding systems.

4. Treatments

NULL (Insufficient information provided in the JSON data to elaborate on the treatments administered.)

5. Vital Trends

The provided physical exam data includes multiple entries, indicating that vital signs were monitored during the ICU stay. However, there is no time series information, so trends cannot be determined from the data. To assess vital sign trends, additional data would be needed to show how heart rate (HR), blood pressure (BP), respiratory rate (Resp), and oxygen saturation (O2 Sat%) changed over time. The available data shows the current, highest, and lowest values for some vitals during one point in time, but not their evolution. For instance, at one point, the patient's HR was recorded at 86 bpm, with a lowest reading of 86 and a highest of 104 bpm. Similarly, systolic BP was 119 mmHg, with a lowest and highest of 134 mmHg. The respiratory rate was 29 breaths per minute, with a lowest and highest of 19 and 37 breaths per minute respectively. Oxygen saturation was 91%, with a low of 85% and a high of 98%. These snapshots are insufficient to determine any trends without additional data points.

6. Lab Trends

The provided lab data includes multiple blood tests performed at different times (offsets from unit admit time). However, without timestamps associated with each lab result, trends cannot be determined. Data exists for glucose, BUN, chloride, calcium, RDW, platelets, RBC, lymphocytes, eosinophils, and basophils. Some tests were performed multiple times, suggesting serial monitoring of the patient's condition. For example, glucose levels were measured at 94 mg/dL and 100 mg/dL, BUN at 34 mg/dL and 42 mg/dL, and creatinine at 1.34 mg/dL and 1.37 mg/dL. To track trends, we need to

organize these results chronologically to see how these values changed over time. The lack of time series data makes it difficult to make meaningful observations about the patient's response to treatment or the progression of their illness.

7. Microbiology Tests

NULL (No microbiology test data is included in the JSON.)

8. Physical Examination Results

The physical exam section shows that a structured physical exam was performed at 626 minutes and -143 minutes post-unit admission. This indicates that the examination was conducted both shortly after admission and potentially before admission to the ICU. The exam recorded vital signs (HR, BP, Resp, O2 Sat%), weight, and fluid balance. The GCS (Glasgow Coma Scale) was also assessed, with scores of 15 (4+5+6). Again, without a clear time sequence, it's impossible to determine how the patient's condition evolved based on the physical exam findings.