Medical Report: Patient 003-10799

1. Patient Information

* **Patient Unit Stay ID:** 296926 * **Patient Health System Stay ID:** 256495 * **Unique Patient ID:** 003-10799 * **Gender:** Male * **Age:** 66 * **Ethnicity:** Caucasian * **Hospital ID:** 108 * **Ward ID:** 136 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 05:43:00 (2014) * **Unit Admit Source:** Operating Room * **Unit Discharge Time:** 15:56:00 (2014) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 01:21:00 (2014) * **Hospital Admit Source:** Operating Room * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 20:35:00 * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Admission Weight:** 101.6 kg * **Discharge Weight:** 108.3 kg * **Admission Height:** 182.9 cm * **APACHE Admission Dx:** GI perforation/rupture, surgery for

2. History

NULL (Insufficient data provided)

3. Diagnoses

The patient presented with multiple diagnoses, all ultimately deemed inactive upon discharge:

* **Primary Diagnosis:** Post-GI surgery, specifically s/p exploratory laparotomy (Diagnosis IDs: 5245677, 5275784, 4599936, 4876558) * **Secondary Diagnoses:** Gastrointestinal intestinal disease, viscus perforation, gastric (Diagnosis IDs: 5160718, 5246482, 4876558). Note that ICD-9 codes 537.9 and K31.9 are associated with the secondary diagnoses. The lack of ICD-9 codes for the primary diagnosis requires further investigation.

4. Treatments

The patient received a range of treatments during their ICU stay, all of which were inactive at discharge. These treatments encompassed various medical specialties:

* **Infectious Diseases:** Empiric antibacterial coverage, Metronidazole, Levofloxacin. * **Gastrointestinal:** Exploratory laparotomy, Esomeprazole (stress ulcer prophylaxis), Enteral feeds (tube feeding). * **Cardiovascular:** Transthoracic echocardiography, Nitroglycerin. * **Neurologic:** Neuraxial analgesics, Lorazepam (sedative agent). * **Pulmonary:** Nicotine patch, Beta-agonist (bronchodilator), Nebulized bronchodilator. * **Renal:** Lactated Ringer's administration, Normal saline administration, Intravenous electrolyte administration, Magnesium administration. * **Endocrine:** D50 (glucose), Insulin. * **General Support Services:** Physical therapy consult, Occupational therapy consult.

5. Vital Trends

NULL (Insufficient data to generate trends. Time-series data for heart rate, blood pressure, respiratory rate, and oxygen saturation is needed.)

6. Lab Trends

The patient underwent extensive laboratory testing. A detailed time-series analysis of the following lab values is required to identify trends:

* **Hematology:** Platelets, Hematocrit (Hct), Hemoglobin (Hgb), RBC, MCV, MCH, MCHC, RDW, WBC, Monocytes, Lymphocytes, Eosinophils, Basophils, Polymorphonuclear Leukocytes. * **Chemistry:** BUN, Creatinine, Chloride, Glucose, Anion Gap, Albumin, Total Protein, Total Bilirubin, Phosphate, Calcium, Lipase, CPK, CPK-MB, Troponin-T, Alkaline Phosphatase, AST (SGOT), ALT (SGPT), PT, PTT, PT-INR. * **Blood Gases:** FiO2, LPM O2

Note that multiple lab results are available at different time points. A temporal analysis is crucial for assessing changes in the patient's condition.

7. Microbiology Tests

NULL (No microbiology data is provided.)

8. Physical Examination Results

A physical examination was performed at 2 minutes post-unit admission and again at 2454 minutes post-unit admission, with results as follows:

* **Initial Physical Exam (2 minutes):** A structured physical exam was performed. Heart rate was 73 bpm. Blood pressure (systolic) was 107 mmHg (lowest 99 mmHg). Blood pressure (diastolic) was 66 mmHg (lowest 65 mmHg). Respiratory rate was 18 breaths per minute. Oxygen saturation was 97%. Weight was 101.6 kg. The Glasgow Coma Scale (GCS) was scored as follows: Eyes 4, Verbal 5, Motor 6; overall mental status was noted as normal LOC. The heart rhythm was noted as sinus, and respiratory mode as spontaneous. * **Subsequent Physical Exam (2454 minutes):** The physical exam was not performed.

This report highlights the need for additional data to fully characterize the patient's ICU stay. Specifically, vital signs, detailed lab trends and microbiology results are necessary for a complete assessment.