Medical Report: Patient 006-100520

1. Patient Information

* **Patient Unit Stay ID:** 931649 * **Unique Patient ID:** 006-100520 * **Gender:** Male * **Age:** 74 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2014-XX-XX 08:19:00 (Hospital ID: 148, Ward ID: 384) * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2014-XX-XX 00:06:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **ICU Admission Time:** 2014-XX-XX 01:54:00 (Unit Type: CSICU) * **ICU Admission Source:** Emergency Department * **ICU Visit Number:** 1 * **ICU Stay Type:** Admit * **Admission Weight:** 90.8 kg * **Discharge Weight:** 87 kg * **ICU Discharge Time:** 2014-XX-XX 21:38:00 * **ICU Discharge Location:** Step-Down Unit (SDU) * **ICU Discharge Status:** Alive * **Admission Height:** 172 cm

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses, primarily related to cardiovascular and pulmonary issues. The diagnoses entered at various times during the ICU stay include:

* **Primary Diagnosis (Active upon discharge):** Acute Respiratory Failure (ICD-9: 518.81, J96.00) * **Major Diagnoses (Some active upon discharge):** * Acute Myocardial Infarction (No ST Elevation) (ICD-9: 410.71, I21.4) – Multiple entries at different times indicating ongoing assessment and management. * Ischemic Dilated Cardiomyopathy (ICD-9: 425.8, I25.5) – Active upon discharge, suggesting a significant ongoing condition. * Congestive Heart Failure (ICD-9: 428.0, I50.9) – Multiple entries. This was not active upon discharge but highlights the severity of the patient's cardiac status. * s/p PTCA (Percutaneous Transluminal Coronary Angioplasty) – This post-procedure diagnosis suggests prior intervention for coronary artery disease.

The temporal distribution of diagnoses suggests a complex clinical picture evolving throughout the ICU stay. The multiple entries for some diagnoses indicate ongoing monitoring and treatment adjustments. The presence of both acute and chronic conditions underscores the complexity of the patient's case.

4. Treatments

The patient received various treatments during their ICU stay. These included:

* **Mechanical Ventilation:** Administered multiple times across the ICU stay, indicating periods of respiratory support. The treatment was not active upon discharge. * **Norepinephrine > 0.1 micrograms/kg/min:** Administered to manage shock, indicating a critical cardiovascular event. * **Glycoprotein IIB/IIIA Inhibitor:** Administered to manage myocardial ischemia/infarction; a common treatment for acute coronary syndrome.

The use of mechanical ventilation and vasopressors highlights the severity of the patient's condition requiring intensive care. The discontinuation of these treatments upon discharge suggests improvement in the patient's respiratory and cardiovascular status.

5. Vital Trends

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6. Lab Trends

The patient underwent multiple laboratory tests during their ICU stay. The available data shows trends in several key parameters. Hematological data show fluctuations in several blood parameters. Bedside glucose levels were frequently monitored, showing variation throughout the stay. Chemistry panels, including electrolytes, creatinine, and liver function tests, were also conducted at multiple points, with some values showing abnormalities. - Hemoglobin (Hgb) and Hematocrit (Hct) levels show variability, suggesting potential for blood loss or changes in hydration status. Initial values were elevated, reflecting possible dehydration or hemoconcentration. These levels later decreased, potentially due to treatment or hemodynamic changes. - Platelet counts fluctuated. The initial count was high but decreased during the stay, which may be attributed to various factors such as consumption or dilution. - Bedside glucose levels exhibited significant fluctuations, highlighting the importance of glucose control in managing the patient's condition. Values were frequently elevated, indicating a need for ongoing management of hyperglycemia. - Chemistry tests revealed various abnormalities at various times. For example, creatinine, indicative of kidney function, was elevated at times, suggesting a potential for renal insufficiency. Electrolyte levels also showed variability. - Troponin-I levels were elevated initially, but decreased over time. This strongly suggests a myocardial injury (consistent with the MI diagnosis). - ABG analyses showed fluctuations in pH, paCO2, paO2, and bicarbonate levels. This suggests that the patient's respiratory status was unstable and required respiratory support, as evidenced by the use of mechanical ventilation and supplemental oxygen (FiO2).

7. Microbiology Tests

NULL (Insufficient information provided)

8. Physical Examination Results

Physical examinations were performed at multiple times during the patient's stay. The documented data primarily consists of vital signs and weight and fluid balance. The initial vitals at 48 minutes after ICU admission were: Heart rate (HR): 74 bpm, Blood pressure (BP): 160/69 mmHg, Respiratory rate: 22 breaths/min, O2 saturation (O2 Sat): 91%, FiO2: 100%, PEEP: 5 cm H2O, and ventilation rate: 22 breaths/min. Later vitals at 5105 minutes after ICU admission were: HR: 96 bpm, BP: 197/85 mmHg, Resp Rate: 28 breaths/min, O2 Sat: 91%, FiO2: 40%, PEEP: 5 cm H2O, and ventilation rate: 14 breaths/min. The patient's weight at ICU admission was 90.8 kg, decreasing to 87 kg at the time of the second exam. Fluid balance shows a net negative balance of -550 ml in the first exam and +275 ml in the second exam.

The physical exam findings suggest the patient was critically ill, with initial readings reflecting respiratory distress and hemodynamic instability. The later readings show some improvement in some parameters, but fluctuations remain.