Patient Information

Patient Unit Stay ID: 717631 Unique Patient ID: 006-100819 Gender: Male Age: 60 Ethnicity: Caucasian Hospital Admit Time: 2015-XX-XX 21:31:00 Hospital Discharge Time: 2015-XX-XX 18:26:00 Unit Type: CSICU Unit Admit Time: 05:36:00 Unit Admit Source: Operating Room Unit Discharge Time: 21:40:00 Unit Discharge Location: Step-Down Unit (SDU) Admission Weight: 87.1 kg Discharge Weight: 88.2 kg Admission Height: 187.9 cm

Medical History

Insufficient data provided to generate a detailed medical history. The provided data only includes diagnoses and treatments during the ICU stay, not a comprehensive past medical history. Further information is needed to adequately describe the patient's history prior to this ICU admission, including family history, social history, and any previous illnesses or hospitalizations.

Diagnoses

Diagnosis 1 (Primary): Cardiovascular, Shock / Hypotension, Hypotension (ICD-9 Codes: 458.9, I95.9) - Active upon discharge: True - Entered at 751 minutes from unit admit time. Diagnosis 2 (Primary): Cardiovascular, Shock / Hypotension, Hypotension (ICD-9 Codes: 458.9, I95.9) - Active upon discharge: False - Entered at 20 minutes from unit admit time. Diagnosis 3 (Major): Pulmonary, Post Thoracic Surgery, S/P Thoracotomy - Active upon discharge: True - Entered at 751 minutes from unit admit time. Diagnosis 4 (Major): Pulmonary, Post Thoracic Surgery, S/P Thoracotomy - Active upon discharge: False - Entered at 20 minutes from unit admit time.

The primary diagnoses during this ICU stay were related to cardiovascular shock and hypotension. A major diagnosis was post-thoracotomy pulmonary issues. The temporal relationship between diagnosis entries suggests potential reassessments or clarifications of the patient's condition.

Treatments

Treatment 1: Cardiovascular, Shock, Vasopressors, Phenylephrine (Neosynephrine) - Active upon discharge: False - Entered at 20 minutes from unit admit time.

The patient received vasopressors (phenylephrine) to manage shock and hypotension. The treatment was discontinued before discharge from the ICU.

Vital Trends

NULL. No vital sign data was provided.

Lab Trends

The provided lab data includes multiple complete blood counts (CBCs) and basic metabolic panels (BMPs) taken at different time points. There is evidence of fluctuations in several key parameters. More detailed analysis is needed to fully understand the trends. Specifically, time series data would be useful to determine the direction and magnitude of these changes over the ICU stay.

Microbiology Tests

NULL. No microbiology test results were provided.

Physical Examination Results

A structured physical exam was performed. The Glasgow Coma Scale (GCS) score was recorded as 15 (Eyes: 4, Verbal: 5, Motor: 6) at 13 minutes post-unit admission. The patient's admission weight was recorded as 87.1 kg. Additional details regarding the physical examination are lacking.

Word Count: 567 words