Medical Report: Patient 004-12030

1. Patient Information

* **Patient Unit Stay ID:** 384485 * **Patient Health System Stay ID:** 329249 * **Unique Patient ID:** 004-12030 * **Gender:** Female * **Age:** 82 years * **Ethnicity:** Caucasian * **Hospital ID:** 131 * **Ward ID:** 227 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2014-XX-XX 23:12:00 * **Unit Admit Source:** Direct Admit * **Unit Discharge Time:** 2014-XX-XX 16:16:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 2014-XX-XX 23:08:00 * **Hospital Admit Source:** Direct Admit * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 2014-XX-XX 22:17:00 * **Hospital Discharge Location:** Skilled Nursing Facility * **Hospital Discharge Status:** Alive * **Admission Weight:** 98.4 kg * **Admission Height:** 170.2 cm

2. History

NULL (Insufficient information provided in the JSON data to generate a detailed patient history.)

3. Diagnoses

The patient presented with multiple diagnoses during her ICU stay. The primary diagnosis was pulmonary respiratory failure and failure to wean. Major diagnoses included metabolic encephalopathy, coronary artery disease (both known and post-CABG), and chronic respiratory failure. Hypertension was also a significant contributing factor. All diagnoses except for coronary artery disease (known) and chronic respiratory failure were inactive upon discharge.

* **Primary Diagnosis:** Pulmonary respiratory failure / Failure to wean (ICD-9 code:) * **Major Diagnoses:** * Metabolic encephalopathy (ICD-9 code: 348.31, G93.41) * Coronary artery disease (known) (ICD-9 code: 414.00, I25.10) * Coronary artery disease (s/p CABG) (ICD-9 code: 414.00, I25.10) * Hypertension (ICD-9 code: 401.9, I10) * Chronic respiratory failure (ICD-9 code: 518.83, J96.10)

4. Treatments

The patient received a comprehensive range of treatments throughout her stay. These included medications such as metoprolol (beta-blocker for hypertension), aspirin (antiplatelet agent), cefepime (fourth-generation cephalosporin), and vancomycin (therapeutic antibacterial). Respiratory support consisted of oxygen therapy, ventilator weaning, and nebulized bronchodilators. Other treatments included insertion of a nasogastric tube, a Foley catheter, and the use of compression boots/stockings for VTE prophylaxis. Physical therapy was also consulted. Upon discharge, the patient was receiving aspirin, cefepime, and nebulized bronchodilators. A central venous catheter was placed during the stay but was discontinued before discharge. Several microbiology tests (sputum and urine cultures) were performed. An MRI of the head was performed during the stay.

5. Vital Trends

NULL (Insufficient data provided to generate vital sign trends.)

6. Lab Trends

The provided lab data shows multiple blood tests taken at various times during the patient's stay. These tests monitored various blood components, including complete blood counts (CBC) with differentials, blood chemistries, and arterial blood gases (ABGs). Bedside glucose measurements were also frequently performed. The trend in glucose levels appears to indicate periods of hyperglycemia. There is also available data on BNP levels indicating potential cardiac issues. Further analysis is needed to fully interpret these trends. There was also a CRP test performed.

7. Microbiology Tests

The patient underwent urine and sputum cultures. Results are not provided in the data.

8. Physical Examination Results

A structured physical examination was performed. Initial vital signs recorded included a heart rate of 90 bpm (with a low of 80 and high of 90), systolic blood pressure of 128 mmHg (with a low of 114 and high of 131), diastolic blood pressure of 80 mmHg (with a low of 74 and high of 89), and oxygen saturation of 100%. The Glasgow Coma Scale (GCS) was documented as 14/6/4 = 24, suggesting normal neurological function. The patient's weight was 98.38 kg upon admission. FiO2 was documented at 35%, and PEEP at 10 cm H2O.