

****Medical Report: Patient 005-10193****

****1. Patient Information****

* **Patient Unit Stay ID:** 498848 * **Patient Health System Stay ID:** 422331 * **Unique Patient ID:** 005-10193 *
Gender: Male * **Age:** 58 * **Ethnicity:** Hispanic * **Hospital ID:** 141 * **Ward ID:** 307 * **Unit Type:** Med-Surg
ICU * **Unit Admit Time:** 2014-XX-XX 14:54:00 (Assuming a date) * **Unit Admit Source:** Floor * **Unit Discharge
Time:** 2014-XX-XX 20:56:00 (Assuming a date) * **Unit Discharge Location:** Other ICU * **Unit Discharge Status:**
Alive * **Hospital Admit Time:** 2014-XX-XX 19:56:00 (Assuming a date, calculated from offset) * **Hospital Admit
Source:** NULL * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 2014-XX-XX 19:25:00 (Assuming a
date, calculated from offset) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission
Weight:** 122.1 kg * **Discharge Weight:** 116.1 kg * **Admission Height:** 180.3 cm * **APACHE Admission Dx:**
CABG alone, coronary artery bypass grafting

****2. History****

NULL (Insufficient information provided)

****3. Diagnoses****

The patient presented with multiple cardiovascular diagnoses. The primary diagnosis upon unit admission was cardiomyopathy (ICD-9 code not provided). Major diagnoses included AV block (ICD-9 codes: 426.10, I44.30) and congestive heart failure (ICD-9 codes: 428.0, I50.9). Another major diagnosis was post-CABG < 7 days, indicating a recent coronary artery bypass grafting surgery. A further major diagnosis of 'percutaneous cardiac intervention within recommended time period' suggests prior interventions. All diagnoses were inactive upon discharge from the unit.

****4. Treatments****

The patient received a range of treatments during their ICU stay. These included cardiac angiography (both right and left heart), CABG surgery, administration of antihyperlipidemic agents, intravenous fluid (normal saline), oxygen therapy (40% to 60%), and intravenous diuretics. Consultations were undertaken with cardiology, cardiac surgery, and pulmonary medicine/critical care medicine teams. Beta-blockers were also administered for hypertension.

****5. Vital Trends****

NULL (Insufficient information provided. Vital signs data would need to be included to populate this section.)

****6. Lab Trends****

The provided lab data shows multiple blood tests conducted over time. These included complete blood counts (CBC) with differentials, basic metabolic panels (BMP), and arterial blood gases (ABGs). Serial bedside glucose measurements were also taken. Note that precise timing of some lab draws is unclear due to negative offsets in labresultoffset. Trends need further analysis using time series visualization.

****7. Microbiology Tests****

NULL (Insufficient information provided)

****8. Physical Examination Results****

Physical exams were performed and documented using a structured format. The patient was described as ill-appearing. The vital signs recorded at one point included a heart rate (HR) between 79 and 102 bpm, blood pressure (BP) between

105/59 and 117/71 mmHg, respiratory rate (RR) between 9 and 32 breaths per minute, and oxygen saturation (SpO₂) between 78% and 100%. The patient was intubated and ventilated. Hemodynamic data indicated a CVP of 3 mmHg, PAOP of 13 mmHg, Systemic Vascular Resistance Index of 2508 dynes sec cm⁻⁵ m⁻², CO of 4.8 L/min, and SVR of 1049 dynes sec cm⁻⁵ m⁻². The patient's weight decreased from 122.1 kg to 116.1 kg during the stay. Fluid balance shows a net negative balance of -2332 ml.