Medical Report - Patient 009-10228

1. Patient Information

* **Patient Unit Stay ID:** 1059638 * **Patient Health System Stay ID:** 785865 * **Unique Patient ID:** 009-10228 * **Gender:** Male * **Age:** 74 * **Ethnicity:** African American * **Hospital ID:** 194 * **Ward ID:** 482 * **Unit Type:** MICU * **Unit Admit Source:** Emergency Department * **Unit Admit Time:** 09:04:00 * **Unit Discharge Time:** 02:55:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight (kg):** 100 * **Admission Height (cm):** 188 * **APACHE Admission Dx:** Pneumonia, bacterial

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis, active upon discharge, was acute respiratory failure (ICD-9 codes 518.81, J96.00). Other diagnoses included:

* Controlled hypertension (ICD-9 codes 401.9, I10): This diagnosis was present on admission but was inactive upon discharge. * Hyperlipidemia (ICD-9 codes 272.4, E78.5): This diagnosis was present on admission but was inactive upon discharge. * Thrombocytopenia (ICD-9 codes 287.5, D69.6): This diagnosis was present during the stay and was active upon discharge.

The timing of diagnosis entries is indicated by the `diagnosisoffset` field, showing the time elapsed in minutes from unit admission time. Note that some diagnoses were recorded multiple times. The `activeupondischarge` field indicates the status of each diagnosis at the time of unit discharge.

4. Treatments

The patient received various treatments during their ICU stay, some of which were active upon discharge. These included:

* **Infectious Diseases:** The patient received cultures for sputum, blood and urine. Treatment with piperacillin/tazobactam was administered. Blood and sputum cultures were not active upon discharge, but urine cultures remained active. * **Respiratory:** The patient was on mechanical ventilation (volume controlled and tidal volume <6 ml/kg). The volume controlled ventilation was active upon discharge. Tidal volume < 6 ml/kg was initially prescribed but not active upon discharge. * **Cardiovascular:** VTE prophylaxis with compression boots was administered and was active upon discharge. * **Gastrointestinal:** Stress ulcer prophylaxis with IV pantoprazole was given and was active upon discharge. * **Renal:** IV furosemide was used as an intravenous diuretic and was active upon discharge. * **Neurologic:** Propofol was used as a sedative agent and was active upon discharge.

The `treatmentoffset` field provides the time in minutes from unit admission when each treatment was initiated. The `activeupondischarge` field indicates the treatment's status at the time of unit discharge.

5. Vital Trends

NULL (Insufficient information provided)

6. Lab Trends

The provided lab data includes multiple blood tests performed at various times during the stay (indicated by `labresultoffset`). Key lab values and trends will be displayed graphically, as detailed in Section 2.

7. Microbiology Tests

NULL (Insufficient information provided. While cultures were performed, specific results are missing.)

8. Physical Examination Results

Physical examination results indicate that a structured physical exam was performed at 32 and 47 minutes post unit admission. Heart rate was recorded as 60 bpm (beats per minute). Respiratory rate was 20 breaths per minute. Oxygen saturation was 100%. The patient was sedated. Glasgow Coma Scale (GCS) was scored as 3 (1 for Eyes, 1 for Verbal, 1 for Motor).