Patient Information

Patient Unit Stay ID: 769546 Unique Patient ID: 006-100335 Gender: Male Age: 82 Ethnicity: Caucasian Hospital Admission Time: 2015-XX-XX 09:14:00 Hospital Admission Source: Emergency Department Hospital Discharge Time: 2015-XX-XX 19:26:00 Hospital Discharge Location: Home Hospital Discharge Status: Alive Unit Type: CSICU Unit Admission Time: 2015-XX-XX 10:49:00 Unit Admission Source: Emergency Department Unit Discharge Time: 2015-XX-XX 16:27:00 Unit Discharge Location: Step-Down Unit (SDU) Unit Discharge Status: Alive Admission Weight: 65.4 kg Discharge Weight: 64.5 kg

History

Insufficient data provided to generate a detailed patient history. The available data only shows the admission diagnosis of Emphysema/bronchitis, suggesting a history of respiratory issues. Further information, such as family history, social history, and past medical history, is needed to build a comprehensive history. The patient's age (82) indicates a potential for age-related comorbidities.

Diagnoses

The patient presented with multiple diagnoses:

* **Primary:** Acute COPD exacerbation (491.21, J44.1) - This was active upon discharge, indicating a persistent condition requiring ongoing management. * **Major:** Acute respiratory failure (518.81, J96.00) - This was active upon discharge, also suggesting a severe condition. * **Major:** Congestive heart failure (428.0, I50.9) - This was active upon discharge, indicating the presence of cardiovascular compromise.

The presence of both respiratory and cardiovascular issues suggests a complex clinical picture, and the need for comprehensive management of multiple organ systems. It is important to note that the time offsets for some diagnoses are the same (47 minutes and 562 minutes), suggesting potential diagnostic updates or clarifications over the course of the ICU stay.

Treatments

The patient received non-invasive ventilation. This treatment was not active upon discharge, suggesting that the patient's respiratory status improved during the ICU stay. The absence of other treatments listed may indicate the information is incomplete, or that the treatments were not recorded in this specific table. More comprehensive treatment information is needed for a complete report.

Vital Trends

NULL. Vital sign data (heart rate, blood pressure, respiratory rate, oxygen saturation) are missing from the provided dataset. A trend analysis is impossible without this information.

Lab Trends

The following lab results were available:

* **Sodium:** 134 mmol/L * **Albumin:** 3.3 g/dL * **Potassium:** 4.4 mmol/L * **Creatinine:** 0.88 mg/dL * **Bicarbonate:** 26 mmol/L * **WBC x 1000:** 11.3 K/mcL * **Calcium:** 8.5 mg/dL * **MCV:** 103 fL * **Total Bilirubin:** 0.4 mg/dL * **RDW:** 13.3 % * **Total Protein:** 8.3 g/dL * **Platelets x 1000:** 257 K/mcL * **ALT (SGPT):** 22 Units/L * **Hgb:** 11.5 g/dL * **AST (SGOT):** 25 Units/L * **MCH:** 33.5 pg * **Anion Gap:** 8 * **MPV:** 9.1 fL * **BUN:** 17 mg/dL * **Chloride:** 100 mmol/L * **FiO2:** 40 % * **Respiratory Rate:** 15 /min * **Hct:** 35.3 % * **Troponin-I:** <0.02 ng/mL (two measurements) * **Glucose:** 161 mg/dL * **Bedside Glucose:** 152 mg/dL * **Acetaminophen:** <2 mcg/mL * **Ethanol:** <10 mg/dL * **PT:** 13.5 sec * **PT-INR:** 1.0 ratio * **Alkaline Phos.:** 72 Units/L * **BNP:** 905 pg/mL

Without time-series data, trend analysis is impossible. Multiple lab results were obtained at the same time (-274 minutes offset), indicating a single blood draw. The elevated WBC count (11.3) suggests an inflammatory response. The high BNP (905) indicates heart strain consistent with congestive heart failure. Further analysis requires longitudinal data.

Microbiology Tests

NULL. No microbiology test results are included in the provided data.

Physical Examination Results

The physical exam was performed, and vital signs were recorded. Heart rate was between 75 and 77 bpm. Blood pressure was between 135/58 and 149/60 mmHg. Respiratory rate was 18 breaths per minute, and oxygen saturation was 100%. The Glasgow Coma Scale (GCS) was 15 (Eyes 4, Verbal 5, Motor 6). Admission weight was 65.4 kg, with a net fluid balance of +10 mL. The patient's respiratory mode was spontaneous and heart rhythm was paced. More detailed information is needed for a comprehensive physical exam assessment.