Patient Information

Patient Unit Stay ID: 302668 Unique Patient ID: 003-16144 Gender: Male Age: 80 Ethnicity: Caucasian Hospital Admission Time: 2014, 21:55:00 Hospital Discharge Time: 2014, 04:30:00 Hospital Discharge Status: Expired Unit Type: Med-Surg ICU Unit Admission Time: 16:30:00 Unit Admission Source: Floor Unit Discharge Time: 20:22:00 Unit Discharge Status: Alive Admission Weight: 103.37 kg Discharge Weight: 103.3 kg Admission Height: 177.8 cm

Medical History

NULL (Insufficient data provided)

Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The diagnoses, listed in order of priority and time of entry, were:

* **Primary:** Pleural effusion due to heart failure (diagnosis entered at 1133 minutes from unit admit time; ICD-9 code: 511.9, J91.8) * **Major:** Congestive heart failure (diagnosis entered at 2646 and 4604925 minutes from unit admit time; ICD-9 code: 428.0, I50.9) * **Major:** Acute coronary syndrome (diagnosis entered at 86, 1133, 2315, 2646, 3022, and 3641 minutes from unit admit time; ICD-9 code: (missing for several entries)) * **Major:** Type II diabetes mellitus (diagnosis entered at 225, 940, 1133, 2315, 2646, 3022, and 3670 minutes from unit admit time; ICD-9 code: (missing for all entries)) * **Major:** Acute respiratory distress (diagnosis entered at 86, 942, 1133, 2315, 2646, 3022, and 3641 minutes from unit admit time; ICD-9 code: 518.82) * **Major:** Acute respiratory failure (diagnosis entered at 88, 1133, 2315, 2646, 3022, and 3641 minutes from unit admit time; ICD-9 code: 518.81, J96.00) * **Major:** Atrial fibrillation with controlled ventricular response (diagnosis entered at 88, 942, 1133, 2315, 2646, 3022, and 3670 minutes from unit admit time; ICD-9 code: 427.31, I48.0) * **Major:** Hypertension (diagnosis entered at 86, 940, 1133, 2315, 2646, 3022, and 3670 minutes from unit admit time; ICD-9 code: 401.9, I10) * **Major:** Coagulopathy due to Coumadin administration (diagnosis entered at 86, 940, 1133, 2315, 2646, 3022, and 3670 minutes from unit admit time; ICD-9 code: 286.9, D68.32) * **Primary:** Right pleural effusion (diagnosis entered at 88, 940, 1133, 2315, 2646, 3022, and 3670 minutes from unit admit time; ICD-9 code: 511.9, J91.8)

Note the repetition of diagnoses reflects multiple entries over the course of the ICU stay. The `activeupondischarge` field indicates that hypertension and Type II diabetes mellitus, and pleural effusion and acute respiratory failure were still active at the time of unit discharge.

Treatments

The patient received extensive treatment during their ICU stay. Treatments included but were not limited to:

* Medications: Ondansetron, IV furosemide, piperacillin/tazobactam, diltiazem, carvedilol, metoprolol, lisinopril, famotidine, and aspirin were among the medications administered. * Procedures: Thoracentesis, head CT scan (without contrast), and transthoracic echocardiography were performed. * Respiratory support: The patient received mechanical ventilation, CPAP/PEEP therapy, and oxygen therapy (at varying concentrations). * Fluid management: The patient received normal saline administration. * VTE prophylaxis: Compression stockings were used.

Many treatments were administered multiple times, indicating ongoing management of the patient's conditions. At the time of discharge, the patient was still receiving Ondansetron, IV furosemide, and a CT scan with contrast, along with metoprolol and a Foley catheter.

Vital Trends

NULL (Insufficient data provided)

Lab Trends

The provided lab data includes several blood tests performed at various time points during the patient's stay. The tests included complete blood count (CBC) with differential (WBC, RBC, Hgb, Hct, MCV, MCH, MCHC, RDW, platelets, -monos, -bands, -lymphs, -polys, -eos, -basos), basic metabolic panel (BMP) (glucose, BUN, creatinine, calcium, chloride, sodium, bicarbonate, total protein, albumin, alkaline phos, AST, ALT, phosphate, and LDH), and arterial blood gas (ABG) (pH, paO2, paCO2, O2 Sat, Total CO2, Base Excess).

Significant variations in lab values are observed over time. For example, creatinine levels showed a notable increase from 1.7 mg/dL to 3.3 mg/dL between the initial test and the final test, indicating potential renal dysfunction. Similarly, BUN levels increased significantly. The patient's hemoglobin also showed some variation, suggesting the need for close monitoring of their blood count. Serial ABGs document the fluctuations in acid-base balance and oxygenation status.

Further analysis is needed to correlate these lab trends with the patient's clinical course and treatment response.

Microbiology Tests

NULL (Insufficient data provided)

Physical Examination Results

Physical exam findings were documented at multiple time points. Initial examination (at 32 minutes post unit admission) revealed a heart rate of 67 bpm (range 67-68 bpm), blood pressure of 132 mmHg systolic (range 132-137 mmHg), respiratory rate of 24 breaths per minute (range 24-26 breaths per minute), and oxygen saturation of 99%. The patient's GCS was 15 (Eyes 4, Verbal 5, Motor 6), with normal level of consciousness, calm and appropriate affect, and oriented to person, place, and time. Respiratory effort was described as labored. The patient's admission weight was recorded as 103.37 kg. The heart rhythm was noted as irregular, with a narrow complex. Subsequent physical exams (at 941, 1130, 221, 2640, and 3668 minutes post admission) were not performed.