Medical Report: Patient 004-10577

1. Patient Information

* **Patient Unit Stay ID:** 405340 * **Patient Health System Stay ID:** 346335 * **Gender:** Male * **Age:** 58 * **Ethnicity:** Caucasian * **Hospital ID:** 133 * **Ward ID:** 176 * **Admission Diagnosis:** Pneumonia, bacterial * **Admission Height:** 180.3 cm * **Admission Weight:** 71.7 kg * **Hospital Admit Time:** 2014-XX-XX 06:00:00 (Note: Day and Month are missing from the data) * **Hospital Admit Source:** NULL * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 2014-XX-XX 14:49:00 (Note: Day and Month are missing from the data) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2014-XX-XX 00:04:00 (Note: Day and Month are missing from the data) * **Unit Admit Source:** Emergency Department * **Unit Visit Number:** 1 * **Unit Stay Type:** Admit * **Unit Discharge Time:** 2014-XX-XX 15:40:00 (Note: Day and Month are missing from the data) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Unique Patient ID:** 004-10577

2. History

Insufficient data provided to detail the patient's medical history. The admission diagnosis indicates bacterial pneumonia. Further details regarding prior medical conditions, family history, or social history are not available in the provided dataset.

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis upon admission was community-acquired pneumonia (ICD-9 code: 486, J18.9). Other significant diagnoses included:

* Congestive heart failure (ICD-9 code: 428.0, I50.9) – Active upon discharge. * Acute COPD exacerbation (ICD-9 code: 491.21, J44.1) – Active upon discharge. * Altered mental status/pain, with contributing factors of bipolar disorder and depression (ICD-9 codes: 296.80, F31.9, 311, F32.9). The presence of these diagnoses suggests a complex clinical picture requiring multi-system management.

4. Treatments

The patient received a comprehensive treatment regimen addressing their various diagnoses. Treatments included:

* **Respiratory Support:** Oxygen therapy (nasal cannula and 25-30%), bronchodilators (ipratropium, albuterol), and nebulized treatments. * **Antibiotic Therapy:** Levofloxacin (a quinolone antibiotic) was administered to combat the bacterial pneumonia. * **Cardiovascular Management:** Diltiazem (a calcium channel blocker) was used to manage potential arrhythmias associated with congestive heart failure. * **Gastrointestinal Management:** Pantoprazole (for stress ulcer prophylaxis) and oral feeds were administered. * **Pain Management:** Ketorolac (a non-narcotic analgesic) and citalopram (an SSRI) were used to manage pain and altered mental status. * **VTE Prophylaxis:** Compression boots and stockings were used to prevent venous thromboembolism.

5. Vital Trends

NULL: No vital sign data was provided.

6. Lab Trends

The following laboratory results were obtained:

* **Hematology:** WBC: 13.2 K/mcL; Hgb: 13 g/dL; Hct: 40.4%; Platelets: 303 K/mcL; RDW: 15% * **Chemistry:** BUN: 10 mg/dL; Chloride: 104 mmol/L; Glucose: 110 mg/dL; Creatinine: 0.9 mg/dL; Potassium: 4.2 mmol/L; Sodium: 139

mmol/L; Albumin: 2.8 g/dL * **Arterial Blood Gas (ABG):** FiO2: 28%

Detailed trends over time are not available from the provided data.

7. Microbiology Tests

NULL: No microbiology test results were included in the provided data.

8. Physical Examination Results

The physical examination was performed. The Glasgow Coma Scale (GCS) score at admission was 15 (Eyes 4, Verbal 5, Motor 6). The patient's admission weight was documented as 71.7 kg.

Note: Several data points, such as specific dates and times for hospital and unit admission and discharge, are missing from the input data. This limits the completeness of this report. Additional data would allow for a more comprehensive assessment of the patient's condition and care.