Medical Report for Patient 006-102318

1. Patient Information

* **Patient Unit Stay ID:** 899746 * **Unique Patient ID:** 006-102318 * **Patient Health System Stay ID:** 670404 * **Gender:** Male * **Age:** 69 * **Ethnicity:** Caucasian * **Hospital ID:** 146 * **Ward ID:** 374 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 01:45:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 21:48:00 * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Admission Weight:** 80.9 kg * **Discharge Weight:** 83.6 kg * **Hospital Admit Time:** 20:51:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 18:56:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Height:** 177.8 cm * **APACHE Admission Dx:** Spinal/multiple trauma

2. History

NULL (Insufficient data provided)

3. Diagnoses

The patient presented with multiple diagnoses, some active upon discharge and others not. The primary diagnosis upon discharge was acute respiratory distress (ICD-9 code 518.82). Other significant diagnoses included:

* **Chronic Lymphocytic Leukemia:** (ICD-9 codes 204.10, C91.10) - This was a major diagnosis, but not active upon discharge. * **Acute Respiratory Distress:** (ICD-9 code 518.82) - This was a primary diagnosis, active upon discharge. * **Lung Trauma with Pleural Effusion/Hemothorax:** (ICD-9 code 860.2) - A major diagnosis, active upon discharge. * **Thoracic Spinal Cord Injury:** (ICD-9 code S24.1) - A major diagnosis, active upon discharge. * **Cervical Spinal Cord Injury:** (ICD-9 code S14.1) - A major diagnosis, active upon discharge. * **Change in Mental Status:** (ICD-9 codes 780.09, R41.82) - A major diagnosis, active upon discharge. * **Bilateral Blunt Injury to the Neck:** (ICD-9 code S10.8) - A major diagnosis, active upon discharge. * **Chest Wall Trauma:** (ICD-9 code 807.4) - A major diagnosis, active upon discharge.

The temporal relationships between these diagnoses are not fully clear from the data, as the `diagnosisOffset` values sometimes show multiple diagnoses entered simultaneously. Further investigation into the patient's chart would be necessary to fully understand the chronology of these conditions.

4. Treatments

The patient received several treatments during their ICU stay. The treatments included:

* **Fluid bolus (250-1000mls) of Normal Saline:** (Renal, intravenous fluid) - This was administered, but not active upon discharge. * **Transfusion of 1-2 units PRBCs:** (Cardiovascular, intravenous fluid, blood product administration) - This treatment was active upon discharge.

Again, the precise timing and sequencing of these treatments requires further data.

5. Vital Trends

NULL (Insufficient data provided)

6. Lab Trends

The lab data shows multiple blood tests performed at different times. Key trends include:

* **Hemoglobin (Hgb):** Fluctuated throughout the stay, starting at 12.6 g/dL, dropping to as low as 6.9 g/dL, and recovering to 8.4 g/dL by discharge. This suggests blood loss and subsequent transfusion was successful. * **Hematocrit (Hct):** Similar trend to Hgb showing a decrease and subsequent recovery. * **Platelets:** Showed variability, starting at 106 K/mcL, dropping to 71 K/mcL, and recovering to 90 K/mcL. This might be related to the trauma. * **PT and INR:** The Prothrombin Time (PT) and International Normalized Ratio (INR) suggest a coagulation issue. The INR varied from 2.1 to 1.5. This requires further clinical context. * **Blood Glucose:** Showed elevated levels, indicating potential hyperglycemia. Further information is needed to determine the cause. * **Other Chemistries:** BUN, creatinine, electrolytes (sodium, potassium, chloride, bicarbonate, magnesium, calcium, phosphate, ALT, AST, alkaline phosphatase, total protein, anion gap, lipase) were also measured. A complete interpretation requires a more comprehensive analysis of these values and their trends over time in relation to the patient's other clinical parameters.

7. Microbiology Tests

NULL (Insufficient data provided)

8. Physical Examination Results

A structured physical exam was performed. The Glasgow Coma Scale (GCS) at the time of the exam was 15 (Eyes 4, Verbal 5, Motor 6). Heart rate was 72 bpm, blood pressure was 120/49 mmHg, and respiratory rate was 16 breaths per minute. Admission weight was 80.9 kg. Fluid balance showed a net output of -150 ml.

Note: This report is based solely on the provided data. A complete and accurate assessment requires access to the full patient medical record, including narrative notes, imaging studies, and other relevant information. The temporal relationships between events are not fully clear from the data.