Patient Information

Patient Unit Stay ID: 531662 Unique Patient ID: 005-10043 Gender: Male Age: 62 Ethnicity: Hispanic Hospital Admission Time: 2014 (Year), 18:00:00 (24-hour format) Hospital Admission Source: Operating Room Hospital Discharge Time: 2014 (Year), 18:23:00 (24-hour format) Hospital Discharge Location: Home Hospital Discharge Status: Alive Unit Type: CTICU Unit Admission Time: 17:00:00 (24-hour format) Unit Admission Source: Operating Room Unit Discharge Time: 16:26:00 (24-hour format) Unit Discharge Location: Floor Unit Discharge Status: Alive Admission Weight: 91.6 kg Discharge Weight: 91.1 kg Admission Height: 170.2 cm APACHE Admission Dx: CABG alone, coronary artery bypass grafting

Medical History

Insufficient data provided to elaborate on the patient's detailed medical history beyond the diagnoses and treatments listed below. Further information, such as prior hospitalizations, family history, social history, and medication history, would be needed for a complete medical history section.

Diagnoses

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

* **Primary Diagnosis:** Post-CABG < 7 days with CPB (cardiovascular|cardiac surgery|s/p CABG < 7 days|with CPB) (Diagnosis ID: 10238904, Active upon discharge: True) * **Major Diagnosis:** Respiratory failure, ventilatory failure, drug-related (surgery|respiratory failure|ventilatory failure|drug related) (Diagnosis IDs: 7967055, 7966991, 8299807; Active upon discharge: False, True, False respectively) * **Other Diagnoses:** * Acute blood loss anemia (hematology|bleeding and red blood cell disorders|anemia|acute blood loss anemia) (Diagnosis IDs: 8011860, 8224077, 9390112; Active upon discharge: False, False, True respectively) * Hyperglycemia (endocrine|glucose metabolism|hyperglycemia) (Diagnosis IDs: 9774523, 8120450, 8896665; Active upon discharge: False, False, True respectively) * Hypertension (cardiovascular|vascular disorders|hypertension) (Diagnosis IDs: 8428083, 9079923, 9082458; Active upon discharge: False, False, True respectively)

ICD-9 Codes associated with the diagnoses: 518.81, J96.00, 285.1, D62, 790.6, R73.9, 401.9, I10. Note that some diagnoses lacked associated ICD-9 codes in the provided data.

Treatments

The patient received a variety of treatments during their ICU stay. These treatments, and whether they were active upon discharge, include:

* Stress ulcer prophylaxis (GI therapies) (Treatment ID: 18987812, Active upon discharge: True) * Medicine consultation (consultations) (Treatment ID: 20818498, Active upon discharge: False) * Nasogastric tube (tubes and catheters) (Treatment IDs: 21145334, 20390884; Active upon discharge: True, False respectively) * Routine CABG (cardiovascular|cardiac surgery|CABG|routine) (Treatment IDs: 20984897, 21596011; Active upon discharge: True, False respectively) * Analgesics (analgesics /sedatives/ nmbs) (Treatment IDs: 23458145, 20888079; Active upon discharge: True, False respectively) * Cardiac surgery consultation (consultations) (Treatment IDs: 20449573, 22122338, 20318373; Active upon discharge: True, False, False respectively) * Pulmonary/CCM consultation (consultations) (Treatment IDs: 22426787, 20087417; Active upon discharge: True, False respectively) * Insulin (glucose control) (Treatment IDs: 21114183, 19651167; Active upon discharge: False, False respectively) * Oxygen therapy (< 40%) via nasal cannula (pulmonary|ventilation and oxygenation|oxygen therapy (< 40%)|nasal cannula) (Treatment ID: 22303841, Active upon discharge: True) * Prophylactic antibacterials for surgery (infection) (Treatment IDs: 23130399, 19782139, 23147942; Active upon discharge: True, False, False respectively) * Sedatives (medications) (Treatment IDs: 21300992, 19573141; Active upon discharge: False, False respectively) * Chest tube (tubes and catheters) (Treatment IDs: 21059368, 22591403; Active upon discharge: False, False respectively) * CPAP/PEEP therapy (pulmonary|ventilation and oxygenation|CPAP/PEEP therapy) (Treatment IDs: 22786800, 23165557; Active upon discharge: False, False respectively) * Mechanical ventilation (pulmonary|ventilation and oxygenation|mechanical ventilation) (Treatment IDs: 19318891, 22854099; Active upon discharge: False, False respectively) * VTE prophylaxis (vascular disorders) (Treatment ID: 22766834, Active upon discharge: False) * Foley catheter (tubes and catheters) (Treatment IDs: 22897122,

20338153, 22255111; Active upon discharge: True, False, False respectively)

Vital Trends

NULL. No vital sign data was provided. To include this section, data such as heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation over time would be needed.

Lab Trends

The provided data includes numerous lab results, but lacks timestamps to create trends. A time-series analysis showing changes in blood counts (e.g., Hemoglobin, Hematocrit, WBC), electrolytes (e.g., sodium, potassium), and other relevant markers (e.g., glucose, creatinine, lactate, PT, PTT, INR) over time would be informative, but cannot be generated without time data.

Microbiology Tests

NULL. No microbiology test data was provided.

Physical Examination Results

Two sets of physical examination results were recorded, at 132 minutes and 345 minutes after unit admission. Both examinations showed the patient to be ill-appearing but not in acute distress, with normal neurological findings (GCS 15, normal sensation and motor function, oriented x3, calm/appropriate affect), clear lung sounds, normal pulses, decreased bowel sounds, and no edema. Vital signs (HR, BP, RR, SpO2) were recorded, but only highest, lowest, and current values were available. Specific values are listed in the data. The patient had a foley catheter, pacing wires, mediastinal tubes, and chest tubes in place. The respiratory mode was spontaneous at the first exam and ventilated at the second exam.