## \*\*1. Patient Information\*\*

\* \*\*Patient Unit Stay ID:\*\* 257802 \* \*\*Unique Patient ID:\*\* 003-10264 \* \*\*Patient Health System Stay ID:\*\* 221378 \* 
\*\*Gender:\*\* Male \* \*\*Age:\*\* 70 \* \*\*Ethnicity:\*\* Caucasian \* \*\*Hospital ID:\*\* 79 \* \*\*Ward ID:\*\* 133 \* \*\*Unit Type:\*\* 
Med-Surg ICU \* \*\*Unit Admit Time:\*\* 2014-XX-XX 15:25:00 (Assuming a date is available elsewhere, which is not provided) \* \*\*Unit Admit Source:\*\* Operating Room \* \*\*Unit Discharge Time:\*\* 2014-XX-XX 18:00:00 (Assuming a date is available elsewhere, which is not provided) \* \*\*Unit Discharge Location:\*\* Floor \* \*\*Unit Discharge Status:\*\* Alive \* 
\*\*Hospital Admit Time:\*\* 2014-XX-XX 10:28:00 (Assuming a date is available elsewhere, which is not provided) \* 
\*\*Hospital Admit Source:\*\* Operating Room \* \*\*Hospital Discharge Time:\*\* 2014-XX-XX 17:30:00 (Assuming a date is available elsewhere, which is not provided) \* \*\*Hospital Discharge Location:\*\* Home \* \*\*Hospital Discharge Status:\*\* Alive \* 
\*\*Admission Weight:\*\* 73.5 kg \* \*\*Discharge Weight:\*\* 73.8 kg \* \*\*Admission Height:\*\* 180.3 cm (Assuming cm is the unit, which is not provided) \* \*\*APACHE Admission Dx:\*\* Transphenoidal surgery

## \*\*2. History\*\*

NULL (Insufficient information provided in the JSON to generate a detailed patient history. A comprehensive history would include details of presenting complaints, past medical history, family history, social history, and medication history.)

\*\*3. Diagnoses\*\*

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

\* \*\*Primary:\*\* s/p head and neck cancer surgery \* \*\*Major:\*\* Hypopituitarism due to CNS tumor (ICD-9 code: 253.2, E23.0) 
\* \*\*Major:\*\* Hypothyroidism (pituitary) (ICD-9 code: 244.8, E03.8) \* \*\*Major:\*\* Mild pain (recorded multiple times) \* 
\*\*Other:\*\* Hypertension (ICD-9 code: 401.9, I10)

Note: Several diagnoses were recorded both active and inactive at different times. This might suggest a fluctuating clinical picture or changes in the patient's condition.

\*\*4. Treatments\*\*

The patient received a variety of treatments during their ICU stay. Active treatments upon discharge included:

\* Bolus parenteral analgesics \* Nicardipine (antihypertensive) \* Chest x-ray \* Normal saline administration \* Parenteral glucocorticoid administration \* Ondansetron (antiemetic) \* Cefazolin (first generation cephalosporin) \* Compression stockings \* Nasal cannula oxygen therapy

Other treatments were administered during the stay but were not active at the time of discharge. These included various analgesics, VTE prophylaxis methods (compression boots), and hydralazine.

\*\*5. Vital Trends\*\*

NULL (No vital sign data was provided in the JSON. This section would typically include trends in heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation over time.)

\*\*6. Lab Trends\*\*

The provided lab data shows multiple blood tests performed at different times during the stay. Key lab values included:

\* Hemoglobin (Hgb): Initial value of 11.5 g/dL. \* White blood cell count (WBC): Initial value of 5.4 K/mcL. \* Platelets: Initial value of 181 K/mcL. \* Blood chemistry (BUN, creatinine, electrolytes, glucose) values were obtained at multiple time points, showing some variation. Specific numerical trends require a time series analysis (see visualization section). \* Complete blood count (CBC) with differential was performed, including values for MCV, MCH, MCHC, RDW, and various cell percentages. Specific trends require further analysis. \* Arterial blood gas (ABG) analysis was performed, including FiO2 and LPM O2 values. Further data is needed to interpret these values. \* Urine analysis (urinary osmolality, urinary sodium, urinary specific gravity) was performed at multiple time points, showing some variation. Specific numerical trends require a time series analysis (see visualization section).

\*\*7. Microbiology Tests\*\*

NULL (No microbiology test results were provided in the JSON.)

\*\*8. Physical Examination Results\*\*

The physical examination was performed and documented using structured data. Key findings at the time of examination included:

\* Glasgow Coma Scale (GCS) score: Scored as 13 (3+4+6) \* Heart rate (HR): Current rate of 72 bpm, with a range of 61-72 bpm. \* Blood pressure (BP): Current systolic of 158 mmHg, with a range of 139-155 mmHg; Current diastolic of 65 mmHg, with a range of 61-69 mmHg. \* Respiratory rate: Current rate of 14 breaths per minute, with a range of 11-19 breaths per minute. \* Oxygen saturation (SpO2): 96-100%. \* Weight: Admission weight 73.5 kg. \* Mental Status: Somnolent, partially oriented, calm/appropriate affect. \* Heart Rhythm: Sinus Rhythm \* Respiratory Mode: Spontaneous