Patient Information

Patient Unit Stay ID: 386342 Unique Patient ID: 004-16286 Gender: Male Age: 68 Ethnicity: Caucasian Hospital Admit Time: 2015-XX-XX 20:40:00 Hospital Admit Source: Emergency Department Hospital Discharge Year: 2015 Hospital Discharge Time: 2015-XX-XX 20:01:00 Hospital Discharge Location: Other Hospital Hospital Discharge Status: Alive Unit Type: Med-Surg ICU Unit Admit Time: 2015-XX-XX 22:08:00 Unit Admit Source: Emergency Department Unit Discharge Time: 2015-XX-XX 20:43:00 Unit Discharge Location: Step-Down Unit (SDU) Unit Discharge Status: Alive Admission Height: 170.1 cm Admission Weight: 83.9 kg

History

NULL (Insufficient information provided)

Diagnoses

The patient presented with multiple diagnoses, reflecting a complex clinical picture. The diagnoses include, but are not limited to:

* **Primary Diagnoses:** * Pleural Effusion (large, left): 511.9, J91.8 (ICD-9 codes) * Acute Respiratory Distress: 518.82 (ICD-9 code) * **Major Diagnoses:** * Hypertension: 401.9, I10 (ICD-9 codes) * Diabetes Mellitus * Coronary Artery Disease (s/p CABG, known): 414.00, I25.10 (ICD-9 codes) * COPD: 491.20, J44.9 (ICD-9 codes)

Note: Some diagnoses lack ICD-9 codes, indicating potential incomplete data entry.

Treatments

The patient received a wide range of treatments during their ICU stay. These included:

* **Cardiovascular:** Multiple medications were administered to manage hypertension (metoprolol, lisinopril, hydralazine), coronary artery disease (atorvastatin, aspirin), and ventricular dysfunction (IV furosemide). A transthoracic echocardiography was performed. * **Pulmonary:** Treatment focused on managing COPD and acute respiratory distress. This involved oxygen therapy (30-40%, nasal cannula), bronchodilator (albuterol), and antibiotic therapy (piperacillin/tazobactam, levofloxacin). Therapeutic and diagnostic thoracentesis were also performed, and chest x-rays were taken. * **Neurologic:** Diazepam and various analgesics (oral, bolus parenteral, and narcotic) were used for pain and agitation management. * **Gastrointestinal:** Ondansetron was administered for antiemetic support, and oral feeding was initiated. * **Infectious Disease:** Blood cultures were obtained, and peripheral venous catheter placement was performed.

Note: The timing of treatments is indicated by the 'treatmentoffset' variable, showing when treatments were initiated relative to unit admission time. The 'activeupondischarge' variable indicates whether the treatment was ongoing at discharge. The specific dosages and routes of administration are not detailed in this report.

Vital Trends

NULL (Insufficient data provided)

Lab Trends

The following lab results were recorded at approximately 44 minutes post-unit admission:

* Sodium: 144 mEq/L * Glucose: 197 mg/dL * PaO2: 78 mm Hg * BUN: 17 mg/dL * PaCO2: 46 mm Hg * Total Bilirubin: 0.8 mg/dL * HCO3: 27.2 mmol/L * Hct: 43.5 % * FiO2: 36 % * Albumin: 2.9 g/dL * WBC x 1000: 12.6 K/mcL * O2 Sat (%): 95 %

* Creatinine: 0.6 mg/dL * pH: 7.38

NULL (Insufficient data for trends over time)

Microbiology Tests

Blood cultures were obtained. Results are not available in this dataset.

Physical Examination Results

The physical examination at 46 minutes post-unit admission noted the patient as ill-appearing but not in acute distress. The patient was well-developed, with a GCS score of 15 (Eyes 4, Verbal 5, Motor 6), heart rate of 108 bpm (paced), respiratory rate of 22 breaths/min (spontaneous), blood pressure of 155/92 mmHg, and O2 saturation of 95% on 36% FiO2. The admission weight was 83.9 kg.