Medical Report for Patient 003-10109

1. Patient Information

* **Patient Unit Stay ID:** 246997 * **Unique Patient ID:** 003-10109 * **Gender:** Male * **Age:** 62 * **Ethnicity:** Caucasian * **Hospital Admit Time:** 2015-XX-XX 02:02:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 2015-XX-XX 17:50:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 02:11:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2015-XX-XX 17:28:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 50.1 kg * **Discharge Weight:** 50.1 kg * **Admission Height:** 172.7 cm

2. History

Admission diagnosis was Emphysema/bronchitis. The patient presented to the Emergency Department and was subsequently admitted to the Med-Surg ICU. The specifics of the patient's medical history prior to admission are not provided in the available data. Further information is needed to complete this section of the report. NULL

3. Diagnoses

The following diagnoses were recorded during the ICU stay:

* **Primary:** Acute respiratory failure (ICD-9 codes: 518.81, J96.00) * **Major:** Acute COPD exacerbation (ICD-9 codes: 491.21, J44.1) - This diagnosis was recorded at 717 minutes and 2240 minutes post unit admission. The discrepancy in timing requires further investigation. * **Major:** Acute COPD exacerbation (ICD-9 codes: 491.21, J44.1) - This diagnosis was recorded at 717 minutes and 2240 minutes post unit admission. The discrepancy in timing requires further investigation. * **Other:** Hypercarbia (ICD-9 codes: 786.09, J96.92) - This diagnosis was recorded at 717 minutes and 2240 minutes post unit admission. The discrepancy in timing requires further investigation. * **Other:** Metabolic alkalosis (ICD-9 codes: 276.3, E87.3) - This diagnosis was recorded at 116 minutes and 2240 minutes post unit admission. The discrepancy in timing requires further investigation. * **Other:** COPD (ICD-9 codes: 491.20, J44.9) * **Other:** Acute respiratory distress (ICD-9 code: 518.82)

Note: Multiple entries for the same diagnosis with differing activeupondischarge status and diagnosis offset suggest potential data entry inconsistencies requiring clarification. The provided data does not specify the exact dates of diagnosis. Further information would improve the accuracy and completeness of this section.

4. Treatments

The following treatments were administered during the ICU stay:

* **Non-invasive ventilation:** Active upon discharge. This suggests the patient required respiratory support throughout a significant portion of their stay. * **Endotracheal tube:** This treatment was initiated and later removed. The exact duration of endotracheal intubation is not specified in the provided data. * **Oxygen therapy (40% to 60%):** This treatment was initiated and later removed. The exact duration of oxygen therapy is not specified in the provided data. * **Stress ulcer prophylaxis:** This treatment was initiated and later removed. The exact duration of stress ulcer prophylaxis is not specified in the provided data. * **VTE prophylaxis:** This treatment was initiated and later removed. The exact duration of VTE prophylaxis is not specified in the provided data. * **CPAP/PEEP therapy:** This treatment was initiated and later removed. The exact duration of CPAP/PEEP therapy is not specified in the provided data. * **Sedative agent:** This treatment was initiated and later removed. The exact duration of sedative agent administration is not specified in the provided data. * **Endotracheal tube removal:** This suggests successful weaning from mechanical ventilation.

The provided data lacks specific details regarding dosages, routes of administration, and the precise timing of treatment initiation and cessation. More comprehensive data would enhance this section.

5. Vital Trends

Based on the physical exam, the patient's heart rate was consistently 91 bpm, systolic blood pressure was 120 mmHg, and diastolic blood pressure was 68 mmHg. Respiratory rate was 22 breaths per minute, and oxygen saturation was 90%. These values represent a single point in time and lack the temporal information to show trends. NULL

6. Lab Trends

The provided lab data includes multiple blood gas analyses (ABGs), complete blood counts (CBCs), and basic metabolic panels (BMPs) performed at various time points during the ICU stay. However, without the precise timestamps associated with each lab result, it is impossible to generate a comprehensive analysis of lab trends over time. NULL

7. Microbiology Tests

No microbiology test results are included in the provided data. NULL

8. Physical Examination Results

The physical exam documented the patient as critically ill-appearing but not in acute distress. The patient was sedated and intubated, and their orientation could not be assessed. Other findings include a sinus rhythm, and ventilated respiratory mode. The weight at admission was recorded as 68.0388 kg. The data provides a snapshot at a single timepoint and is insufficient to characterize the evolution of physical findings. Further information is needed. NULL