Medical Report: Patient 006-100970

1. Patient Information

* **Patient Unit Stay ID:** 757201 * **Patient Health System Stay ID:** 584668 * **Unique Patient ID:** 006-100970 * **Gender:** Male * **Age:** > 89 * **Ethnicity:** Caucasian * **Hospital ID:** 148 * **Ward ID:** 347 * **Unit Type:** MICU * **Unit Admit Time:** 2014-XX-XX 20:35:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 2014-XX-XX 20:47:00 * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 2014-XX-XX 18:34:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 2014-XX-XX 19:13:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Weight:** 90 kg * **Discharge Weight:** 91 kg * **Admission Height:** 170 cm * **APACHE Admission Dx:** MI admitted > 24 hrs after onset of ischemia

2. History

NULL (Insufficient data provided)

3. Diagnoses

The patient presented with multiple diagnoses, primarily related to cardiovascular issues and uncontrolled hypertension. The diagnoses entered within 44 minutes of unit admission time included:

* **Primary:** Cardiovascular, Chest pain / ASHD, Acute Coronary Syndrome (Diagnosis ID: 11892914, 11922340, 12025711) * **Major:** Surgery, Acute Cardiac Problems, Uncontrolled Hypertension (Diagnosis IDs: 11755266, 11228473, 11741082) * **Major:** Cardiovascular, Chest pain / ASHD, Chest Pain (Diagnosis IDs: 11437448, 12248855)

Later diagnoses, made after approximately 1888 minutes (31.5 hours) in the unit, included:

* **Primary:** Cardiovascular, Chest pain / ASHD, Acute Coronary Syndrome, s/p PTCA (Diagnosis ID: 10728084) * **Primary:** Cardiovascular, Chest pain / ASHD, Acute Coronary Syndrome, Acute Myocardial Infarction (no ST elevation) (Diagnosis ID: 11505942) * **Major:** Cardiovascular, Chest pain / ASHD, Chest Pain (Diagnosis ID: 12402976)

The presence of both acute coronary syndrome and acute myocardial infarction (non-ST elevation) suggests a significant cardiac event. The multiple instances of chest pain diagnoses across different time points highlight the persistent nature of the patient's symptoms. The uncontrolled hypertension is a significant contributing factor. The ICD-9 codes provided are 401.9, I10, 786.50, and R07.9. Note that some diagnoses lack ICD-9 codes.

4. Treatments

NULL (Insufficient data provided)

5. Vital Trends

The physical examination recorded vital signs at multiple time points. Initial measurements (at 33 and 43 minutes post-admission) showed a heart rate of 60 bpm, respiratory rate of 29 breaths per minute, and oxygen saturation of 86%. A later exam (at 1884 minutes post-admission) indicated a heart rate of 60 bpm, respiratory rate of 27 breaths per minute, and oxygen saturation of 98%. Blood pressure readings varied significantly between the initial and later measurements. The initial systolic blood pressure was 163 mmHg and diastolic was 79 mmHg, while the later reading showed systolic blood pressure of 142 mmHg and diastolic of 68 mmHg. The patient's weight increased by 1 kg during the ICU stay.

6. Lab Trends

Laboratory results are available for multiple chemistry, hematology, and miscellaneous tests. There are two sets of complete blood counts (CBCs), one obtained before ICU admission (-210 minutes) and another at 955 minutes. Initial Troponin-I levels were elevated at 1.39 ng/mL and 1.62 ng/mL (-210 and 165 minutes respectively), indicating myocardial injury. A subsequent Troponin-I test at 610 minutes showed a level of 3.05 ng/mL, suggesting ongoing myocardial damage. Creatinine levels were initially elevated (1.14 mg/dL, -210 min) but improved upon later testing (1.03mg/dL, 955 minutes and 0.79 mg/dL, 2305 minutes). The initial bedside glucose was 93 mg/dL (-198 minutes) and later increased to 122 mg/dL (8 minutes) and 171 mg/dL (162 minutes). Other notable lab values include electrolytes, liver enzymes, and coagulation studies. The data suggests a complex picture of cardiac injury, renal function changes, and possibly metabolic disturbances.

7. Microbiology Tests

NULL (Insufficient data provided)

8. Physical Examination Results

Physical examinations were performed at multiple time points (33, 43, and 1884 minutes post-admission). The Glasgow Coma Scale (GCS) score was consistently recorded as 15 (Eyes 4, Verbal 5, Motor 6) at all times. The physical exam also documented vital signs (HR, RR, SpO2, BP), weight, and I&O.; The detailed information about changes in vital signs and weight is provided in the Vital Trends section above. The performed physical exams were marked as 'Performed - Structured'.