Patient Information

Patient Unit Stay ID: 264901 Unique Patient ID: 003-11088 Gender: Male Age: 81 Ethnicity: Caucasian Hospital Admit Time: 2014-XX-XX 17:18:00 Hospital Discharge Time: 2014-XX-XX 16:35:00 Unit Admit Time: 2014-XX-XX 17:44:00 Unit Discharge Time: 2014-XX-XX 19:39:00 Admission Weight: 113.7 kg Discharge Weight: 115 kg Admission Height: 180.3 cm Hospital Admit Source: Floor Unit Admit Source: Direct Admit Hospital Discharge Status: Alive Unit Discharge Status: Alive Hospital Discharge Location: Home Unit Discharge Location: Floor

Medical History

Insufficient data provided to generate a detailed medical history. The provided data focuses on diagnoses, treatments, and lab results during the ICU stay, but lacks information on prior medical conditions, family history, social history, or other relevant details. A complete medical history would require additional information.

Diagnoses

The patient presented with multiple diagnoses during their ICU stay. These diagnoses were recorded at various times during the stay, indicated by the `diagnosisoffset` field. Note that `activeupondischarge` indicates whether the diagnosis was still active at the time of discharge from the ICU. The ICD-9 codes are provided for each diagnosis.

* **Atrial Fibrillation:** `427.31, I48.0` (Multiple entries, some active upon discharge) * **Acute COPD Exacerbation:** `491.21, J44.1` (Multiple entries, some active upon discharge) * **COPD:** `491.20, J44.9` (Multiple entries) * **Congestive Heart Failure:** `428.0, I50.9` (Multiple entries, some active upon discharge) * **Atrial Flutter (with hemodynamic compromise):** `427.32, I48.1` (Multiple entries, some active upon discharge) * **Atrial Flutter (1:2 conduction):** `427.32, I48.1` (Multiple entries)

The diagnosis priority for all listed diagnoses was marked as 'Other'. This suggests the presence of several co-morbidities influencing the patient’s condition.

Treatments

The patient received various treatments during their ICU stay. Similar to diagnoses, the `treatmentoffset` indicates the time of treatment initiation, and `activeupondischarge` indicates if the treatment continued at ICU discharge.

* **Cardiovascular Treatments:** Esmolol (Class II antiarrhythmic), Atorvastatin (HMG-CoA reductase inhibitor), Amiodarone (Class III antiarrhythmic), Calcium channel blocker, Digoxin. Multiple instances of electrical cardioversion were administered. * **Pulmonary Treatments:** Nebulized bronchodilators, Beta-agonist bronchodilators, Oxygen therapy via nasal cannula. * **Gastrointestinal Treatments:** Esomeprazole and Omeprazole (stress ulcer prophylaxis) * **Endocrine Treatments:** Insulin, D50, Methylprednisolone (systemic glucocorticoid) * **Renal Treatments:** Renal ultrasound.

Vital Trends

NULL. Vital sign data (Heart Rate, Blood Pressure, Respiratory Rate, Oxygen Saturation) are present in the Physical Exam section, but the data is not longitudinal; it only contains point-in-time measurements. Therefore, trends cannot be established without time-series data.

Lab Trends

Multiple lab tests were conducted during the patient's ICU stay. The timing of these tests is given by the `labresultoffset`. These include chemistry, hematology, and bedside glucose tests. Trends in specific parameters can be analyzed from the time series data:

* **Glucose:** Elevated glucose levels throughout the stay, requiring insulin treatment. * **Creatinine:** Shows some fluctuation but generally remains within a higher range. This may indicate renal impairment requiring monitoring and potentially medication adjustments. * **Potassium:** Some fluctuation, however, mostly remains within a normal range. * **Bedside Glucose:** Frequent monitoring demonstrates significant fluctuations in blood glucose levels. This highlights the need for continuous blood glucose management.

Microbiology Tests

NULL. No microbiology test data is provided.

Physical Examination Results

Physical examinations were performed at various times during the stay (indicated by `physicalexamoffset`). The examinations recorded vital signs, including heart rate, blood pressure, respiratory rate, and oxygen saturation. Weight and input/output were also recorded. Neurological assessments included a Glasgow Coma Scale (GCS) score, which was recorded as ‘scored’ without a specific numerical value. The Level of Consciousness was consistently documented as 'normal LOC'. The physical exam data is not longitudinal and thus trends cannot be determined.