Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 332253 * **Unique Patient ID:** 004-10249 * **Gender:** Male * **Age:** 45 * **Ethnicity:** Caucasian * **Hospital ID:** 110 * **Ward ID:** 185 * **Unit Type:** CCU-CTICU * **Unit Admit Time:** 08:26:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 16:43:00 * **Unit Discharge Location:** Floor * **Hospital Admit Time:** 05:21:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Time:** 16:13:00 * **Hospital Discharge Location:** Home * **Admission Weight (kg):** 111.7 * **Discharge Weight (kg):** NULL * **Admission Height (cm):** 182.9 * **APACHE Admission Diagnosis:** Bleeding, GI-location unknown

2. History

NULL (Insufficient data provided to reconstruct a detailed patient history.)

3. Diagnoses

The patient presented with the following diagnoses during their ICU stay:

* **Primary Diagnosis:** Upper GI bleeding (ICD-9 codes: 578.9, K92.2). This diagnosis was active upon discharge. Multiple entries for this diagnosis exist, indicating a persistent issue throughout the stay. * **Major Diagnosis:** Hypertension (ICD-9 codes: 401.9, I10). This diagnosis was active upon discharge. Similar to the GI bleed, multiple entries highlight its ongoing significance.

4. Treatments

The patient received various treatments, including:

* **Gastrointestinal Treatments:** Aggressive volume resuscitation, Ondansetron (serotonin antagonist), Promethazine (antiemetic), Diphenhydramine (anticholinergic), Pantoprazole (stress ulcer prophylaxis – IV), Bisacodyl (laxative). Many of these treatments were administered at multiple points during the stay, potentially reflecting ongoing symptom management. * **Neurological Treatments:** Narcotic analgesics, Ketorolac (non-narcotic analgesic), Acetaminophen (non-narcotic analgesic), Oral analgesics, Bolus parenteral analgesics. The use of both narcotic and non-narcotic analgesics suggests a multimodal approach to pain management. * **Cardiovascular Treatments:** Labetalol (vasodilating agent – IV), Diltiazem (calcium channel blocker), Transthoracic echocardiography. The use of multiple treatments suggests management of underlying cardiovascular issues. * **Pulmonary Treatment:** Nicotine patch. This indicates an attempt to address smoking cessation or nicotine addiction. * **Consultations:** Gastroenterology consultation. This highlights the complexity of the patient's case and the need for specialized input.

Note that the `activeupondischarge` status indicates which treatments were still ongoing at the time of unit discharge. The multiple entries for certain treatments likely reflect adjustments in dosage or administration method over time.

5. Vital Trends

NULL (Insufficient data to generate vital sign trends. While some vital signs are recorded in the physical exam, there is no time-series information.)

6. Lab Trends

The following lab results were recorded:

* **Hematology:** The patient showed an initial elevated WBC count (18.6 K/mcL) which decreased to 15.8 K/mcL. Hemoglobin levels were initially 16.3 g/dL, dropping to 10.4 g/dL by the end of the stay, with intermediate values indicating a declining trend. Hematocrit followed a similar decreasing pattern. Platelet counts also demonstrated a slightly downward trend. Other hematological parameters like MCV, MCH, MCHC, RDW, and differential counts (-monos, -lymphs, -eos, -polys, -basos) were also recorded, but without sufficient temporal resolution to establish conclusive trends. * **Chemistry:** Electrolytes (sodium, potassium, chloride, bicarbonate), liver function tests (AST, ALT, total bilirubin, direct bilirubin, alkaline phosphatase), and renal function tests (BUN, creatinine) were measured, with only a single time point available for many tests. A glucose level of 159 mg/dL was recorded on one occasion. A TSH level of 0.659 mcU/ml was also observed.

The limited number of time points for many lab tests restricts the analysis of trends. Further lab results are needed for a comprehensive evaluation.

7. Microbiology Tests

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

8. Physical Examination Results

The physical examination documented the following:

* A structured physical exam was performed. * Heart rate (HR) was recorded at 74 bpm (current), with a range of 74-85 bpm. This suggests a relatively stable heart rate during the observation period. * Blood pressure (BP) showed a systolic reading of 107 mmHg (current), with a range of 105-116 mmHg, and a diastolic reading of 65 mmHg (current), ranging from 56-81 mmHg. These values suggest some fluctuation in blood pressure. * Oxygen saturation (O2 Sat) was 98% (current), with a consistent value across highest and lowest readings. This suggests adequate oxygenation. * Respiratory rate (Resp) was 22 breaths per minute. * Weight was recorded at 111.7 kg (admission weight). * Intake and output (I&O;) showed 150 ml of urine output and 0 ml of intake, resulting in a negative net balance of -150 ml. This suggests dehydration. * Glasgow Coma Scale (GCS) was scored as 15 (4+5+6), indicating normal neurological function. * FiO2% was recorded at 28%. This is a measure of the fraction of inspired oxygen.

The physical exam findings provide a snapshot of the patient's condition at a single time point, limiting the ability to assess changes over time.