Medical Report: Patient 006-102318

1. Patient Information

* **PatientUnitStayID:** 899746 * **PatientHealthSystemStayID:** 670404 * **Gender:** Male * **Age:** 69 * **Ethnicity:** Caucasian * **HospitalID:** 146 * **WardID:** 374 * **APACHE Admission Dx:** Spinal/multiple trauma * **Admission Height:** 177.8 cm * **Hospital Admit Time:** 2014-XX-XX 20:51:00 (Hospital Admit Offset: -294 minutes) * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 2014-XX-XX 18:56:00 (Hospital Discharge Offset: 9671 minutes) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2014-XX-XX 01:45:00 * **Unit Admit Source:** Emergency Department * **Unit Visit Number:** 1 * **Unit Stay Type:** Admit * **Admission Weight:** 80.9 kg * **Discharge Weight:** 83.6 kg * **Unit Discharge Time:** 2014-XX-XX 21:48:00 (Unit Discharge Offset: 5523 minutes) * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **UniquePID:** 006-102318

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses, some active upon discharge and others not. The primary diagnosis upon discharge was acute respiratory distress syndrome (ARDS) (ICD-9 code 518.82). Other significant diagnoses included chronic lymphocytic leukemia (ICD-9 codes 204.10, C91.10), trauma to the chest with pleural effusion and hemothorax (ICD-9 code 860.2), thoracic spinal cord injury (ICD-9 code S24.1), cervical spinal cord injury (ICD-9 code S14.1), and altered mental status/pain (ICD-9 codes 780.09, R41.82). It's important to note that multiple entries for the same diagnosis exist, possibly reflecting different times of assessment or documentation throughout the ICU stay. The temporal aspect of diagnosis entry (diagnosisoffset) suggests a possible chronological evolution of the patient's condition.

4. Treatments

The patient received several treatments during their ICU stay. Treatments included intravenous fluid administration with normal saline boluses (250-1000mls), and a transfusion of 1-2 units of packed red blood cells. The administration of normal saline boluses was not active upon discharge, while blood product administration was still active at the time of discharge. Again, the `treatmentoffset` field indicates the timing of treatment initiation.

5. Vital Trends

NULL (Insufficient information provided. Vital signs data would need to be included to populate this section.)

6. Lab Trends

The provided lab data show multiple blood tests performed at various times during the hospital stay. Hematological data reveals fluctuations in Hemoglobin (Hgb), Hematocrit (Hct), Platelets, Mean Corpuscular Volume (MCV), Mean Corpuscular Hemoglobin (MCH), and Mean Corpuscular Hemoglobin Concentration (MCHC). Chemistry panels show changes in blood urea nitrogen (BUN), creatinine, albumin, total protein, ALT (SGPT), AST (SGOT), bicarbonate, chloride, calcium, anion gap, phosphate, and magnesium. Additionally, arterial blood gas (ABG) measurements including pH, PaO2, PaCO2, and Base Excess were recorded. These values need to be graphed to reveal trends and patterns. Note that some values were recorded before the unit admit time, indicating pre-admission testing.

7. Microbiology Tests

NULL (Insufficient information provided.)

8. Physical Examination Results

The physical exam documented a Glasgow Coma Scale (GCS) score of 15 (Eyes 4, Verbal 5, Motor 6) at 32 minutes post-unit admission. Heart rate (HR) was recorded as 72 bpm (both current and lowest), with a highest rate of 73 bpm. Blood pressure (BP) was 120/49 mmHg. Respiratory rate was 16 breaths per minute (both current and lowest), with a highest rate of 18 breaths per minute. The patient's admission weight was 80.9 kg. Fluid balance records indicate a net negative balance of 150 ml, suggesting possible dehydration. This section demonstrates a structured format for recording physical exam parameters.