Patient Information

Patient Unit Stay ID: 706954 Unique Patient ID: 006-100823 Gender: Male Age: 61 Ethnicity: Caucasian Hospital Admission Time: 23:16:00 Hospital Admission Source: Acute Care/Floor Hospital Discharge Year: 2015 Hospital Discharge Time: 19:30:00 Hospital Discharge Location: Home Hospital Discharge Status: Alive Unit Type: CSICU Unit Admission Time: 23:46:00 Unit Admission Source: Operating Room Unit Discharge Time: 16:11:00 Unit Discharge Location: Step-Down Unit (SDU) Unit Discharge Status: Alive Admission Weight: 99.2 kg Discharge Weight: 101.5 kg Admission Height: 178 cm Admission Diagnosis: CABG alone, coronary artery bypass grafting

Medical History

Insufficient data provided to elaborate on the patient's detailed medical history beyond the admission diagnosis. Further information is needed regarding past illnesses, surgeries, allergies, family history, and social history to complete this section. The available data only indicates that the patient underwent a CABG procedure.

Diagnoses

The patient's primary diagnosis upon admission and throughout the ICU stay was 'cardiovascular|cardiac surgery|s/p CABG < 7 days'. This diagnosis was active upon discharge from the unit. There were two additional instances where this same diagnosis was recorded. The ICD-9 code is missing from the record for all three instances of this diagnosis.

Treatments

The following treatments were documented during the patient's ICU stay:

* Mechanical ventilation (pulmonary|ventilation and oxygenation|mechanical ventilation). This treatment was not active upon discharge. * Norepinephrine <= 0.1 micrograms/kg/min (cardiovascular|shock|vasopressors|norepinephrine <= 0.1 micrograms/kg/min). This treatment was not active upon discharge. * Nicardipine (cardiovascular|ventricular dysfunction|vasodilator|nicardipine). This treatment was not active upon discharge.

Vital Trends

NULL. No vital sign data was provided in the input JSON.

Lab Trends

The provided lab data includes a comprehensive hematology panel, blood gas analysis, and basic metabolic panel. Several tests were performed multiple times during the patient's stay, allowing for the observation of trends over time. Specifically, there is evidence of hyperglycemia (elevated glucose levels), with values ranging from 87 mg/dL to 164 mg/dL across multiple time points. Complete Blood Count (CBC) results show fluctuations in several parameters, including Hemoglobin, Hematocrit, White Blood Cells, and Platelets. The initial Hemoglobin level was 15 g/dL, dropping to 9.4 g/dL by the final measurement. Hematocrit followed a similar trend. Electrolyte levels (potassium, sodium, chloride, bicarbonate) also show some variation. More detailed analysis is needed to determine the clinical significance of these changes.

Microbiology Tests

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

Physical Examination Results

A structured physical exam was performed. The recorded vital signs at the time of the exam were: Heart rate (HR) 71 bpm, Blood pressure (BP) 123/56 mmHg, Respiratory rate (RR) 14 breaths/min, and Oxygen saturation (O2 Sat) 100%. Hemodynamic data included Central Venous Pressure (CVP) of 4 mmHg, Pulmonary Artery Occlusion Pressure (PAOP) of 8 mmHg, Systemic Vascular Resistance Index (SVRI) of 2977 dynes sec cm-5 m-2, Cardiac output (CO) of 4 L/min, and Systemic Vascular Resistance (SVR) of 1359 dynes sec cm-5. The patient's Glasgow Coma Scale (GCS) score was 15 (Eyes 4, Verbal 5, Motor 6). Admission weight was 99.2 kg, which remained unchanged during the initial observation period.