Medical Report for Patient 007-10086

1. Patient Information

* **Patient Unit Stay ID:** 965562 * **Unique Patient ID:** 007-10086 * **Gender:** Male * **Age:** 83 years * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015-02-08 02:08:00 * **Hospital Discharge Time:** 2015-02-08 18:21:00 * **Hospital Discharge Status:** Expired * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** (Assuming this is relative to Hospital Admit Time) * **Unit Admission Source:** Floor * **Unit Discharge Time:** 2015-02-08 18:21:00 * **Unit Discharge Status:** Expired * **Admission Weight:** 82.32 kg * **Discharge Weight:** 92.6 kg * **Admission Height:** 175.26 cm

2. History

The provided data does not contain a detailed patient history. Further information is needed to complete this section. This section would typically include information about presenting symptoms, duration of illness, relevant past medical history (including previous hospitalizations, surgeries, and significant illnesses), family history, social history (including smoking, alcohol use, and drug use), and medication history. NULL

3. Diagnoses

* **Diagnosis ID 12780791:** cardiovascular|ventricular disorders|congestive heart failure (ICD-9 code: 428.0, I50.9). Active upon discharge: False. Entered 45 minutes after unit admit time. Priority: Other. * **Diagnosis ID 12781350:** cardiovascular|ventricular disorders|congestive heart failure (ICD-9 code: 428.0, I50.9). Active upon discharge: True. Entered 1104 minutes after unit admit time. Priority: Other. The primary admission diagnosis was congestive heart failure (CHF). The persistence of this diagnosis until discharge suggests it was a significant contributing factor to the patient's death.

4. Treatments

The patient received a variety of treatments during their ICU stay. These included:

* **Oxygen therapy:** Nasal cannula (initially, but not at discharge). * **Inotropic agents:** Used to support ventricular function (ongoing at discharge). * **Stress ulcer prophylaxis:** Medications to prevent stress ulcers (ongoing at discharge). * **Antiarrhythmics:** Amiodarone (ongoing at discharge). * **Antiplatelet agents:** Medications to prevent blood clots (ongoing at discharge). * **Vasopressors:** Phenylephrine (Neosynephrine) (ongoing at discharge). * **Inotropic agent:** Dobutamine (ongoing at discharge). * **SSRI administration:** Selective Serotonin Reuptake Inhibitor (for pain/agitation/altered mentation, ongoing at discharge). * **Antiemetic:** (Initially, but not at discharge). * **Palliative care consultation:** (ongoing at discharge). * **Social work consult:** (Initially, but not at discharge).

The continuation of multiple cardiovascular support treatments until discharge suggests the severity of the patient's condition.

5. Vital Trends

The provided data includes some vital signs (Heart Rate, Blood Pressure, Respiratory Rate, and Oxygen Saturation) from a physical exam performed 34 minutes after unit admission. However, a trend analysis requires serial measurements over time. NULL

6. Lab Trends

The lab data shows multiple blood tests performed at various times during the patient's stay. Analysis of trends requires time-series data, which is not fully represented here. However, some observations can be made: * **Elevated Liver Enzymes:** ALT (SGPT) and AST (SGOT) were significantly elevated at multiple time points, indicating liver damage. The

values suggest a possible cause of liver injury, which needs further investigation. * **Electrolyte Imbalances:** There were fluctuations in potassium and calcium levels, potentially indicating underlying metabolic issues. The time-series is needed to evaluate if treatment was successful. * **Renal Function:** Creatinine levels were elevated in multiple samples, suggesting impaired renal function. The trend over time would be crucial in assessing kidney function deterioration. * **Hematological Values:** Hemoglobin (Hgb), hematocrit (Hct), MCV, MCH, MCHC, and platelet counts show variations, suggesting possible anemia and potentially other hematological abnormalities. A complete blood count (CBC) trend is necessary for a complete assessment. More detailed analysis requires a time series. NULL

7. Microbiology Tests

NULL. No microbiology test data is available.

8. Physical Examination Results

The physical exam shows that a structured physical exam was performed 34 minutes post unit admission. The following vital signs were recorded: * **Heart Rate:** 90 bpm (current, lowest, and highest) * **Blood Pressure (systolic):** 73 mmHg (current), 70 mmHg (lowest), 73 mmHg (highest) * **Blood Pressure (diastolic):** 52 mmHg (current), 51 mmHg (lowest), 52 mmHg (highest) * **Respiratory Rate:** 24 breaths/min (current and lowest), 25 breaths/min (highest) * **Oxygen Saturation:** 96% (current and lowest), 97% (highest) * **Weight:** 82.32 kg (admission and current), 0 kg (delta) * **I&O; (ml):** 300 ml Urine, 350 ml Intake, 350 ml pRBC's, 301 ml Output, 0 ml Dialysis, +49 ml Total Net * **Glasgow Coma Scale (GCS):** Scored 15 (Eyes 4, Verbal 5, Motor 6)

The vital signs and physical exam findings suggest a patient in critical condition, requiring further investigation through a time series analysis.