Medical Report: Patient 005-10003

1. Patient Information

* **Patient Unit Stay ID:** 426975 * **Unique Patient ID:** 005-10003 * **Gender:** Male * **Age:** 69 * **Ethnicity:** Hispanic * **Hospital Admission Time:** 2014-XX-XX 18:49:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2014-XX-XX 13:44:00 * **Hospital Discharge Status:** Expired * **Hospital Discharge Location:** Death * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2014-XX-XX 20:43:00 * **Unit Admission Source:** Other ICU * **Unit Discharge Time:** 2014-XX-XX 13:44:00 * **Unit Discharge Status:** Expired * **Unit Discharge Location:** Death * **Admission Height:** 177.8 cm * **Admission Weight:** 86.1 kg

2. History

Insufficient data provided to generate a detailed patient history. The available data only shows the time of admission and discharge, along with the admission source and location. A complete history would require additional information such as presenting complaints, duration of symptoms, relevant past medical history, family history, social history, and medication history. This information is crucial for understanding the context of the patient's ICU stay and subsequent diagnoses.

3. Diagnoses

The patient presented with multiple diagnoses, some active upon discharge and some not. The primary diagnosis upon unit discharge was pneumonia (ICD-9 codes 486, J18.9). Other major diagnoses included:

* **Chronic Obstructive Pulmonary Disease (COPD):** (ICD-9 codes 491.20, J44.9) * **Acute Respiratory Failure:** (ICD-9 codes 518.81, J96.00) * **Sepsis with single organ dysfunction (acute respiratory failure):** (ICD-9 codes 038.9, 518.81, R65.20, J96.0) * **Leukocytosis:** (ICD-9 codes 288.8, D72.829) * **Lower Urinary Tract Infection:** (ICD-9 codes 595.9, N30.9) * **Aortic/mitral valve repair >= 7 days:** * **Hypotension/pressor dependent:** * **Septic shock:** (ICD-9 codes 785.52, R65.21) * **Acute renal failure (due to sepsis and hypovolemia/decreased circulating volume):** (ICD-9 codes 584.9, N17.9) * **Encephalopathy:** (ICD-9 codes 348.30, G93.40) * **Anemia of critical illness:** (ICD-9 codes 285.9, D64.9)

Note: Some diagnoses lack ICD-9 codes, indicating incomplete data entry.

4. Treatments

The patient received various treatments throughout their ICU stay. Active treatments upon discharge included:

* **Nebulized bronchodilator therapy** * **Continuous parenteral analgesics** * **Subcutaneous conventional heparin therapy (VTE prophylaxis)** * **Oxygen therapy (40% to 60%)** * **Mechanical ventilation (assist-controlled, tidal volume 6-10 ml/kg)** * **Pulmonary/CCM consultation** * **Cardiology consultation**

Inactive treatments included consultations with Pulmonary medicine and Infectious Disease, along with various medications (antibacterials, antifungals, insulin, vasopressors, and stress ulcer prophylaxis). The specific medications administered and their dosages are not detailed in the provided data.

5. Vital Trends

NULL. Vital sign data (heart rate, blood pressure, respiratory rate, oxygen saturation) are available in the physical exam section, but time-series data are missing for trend analysis.

6. Lab Trends

NULL. Laboratory results are provided, but time-series data are required for a trend analysis of various blood parameters (e.g., electrolytes, renal function, complete blood count). The available data shows several lab tests conducted at different time points, but the exact times are not specified in a format that allows for a continuous trend analysis.

7. Microbiology Tests

NULL. No microbiology test results are included in the provided dataset.

8. Physical Examination Results

A physical exam was performed at 1365 minutes post-unit admission. The patient was critically ill-appearing and obese, but not in acute distress. They were intubated and ventilated, with decreased bowel sounds and 1+ edema. Additional findings included paced heart rhythm, non-icteric conjunctivae, and a foley catheter and NG tube in place. Vital signs recorded at this time were: Heart rate 70-91 bpm, systolic blood pressure 93-119 mmHg, diastolic blood pressure 39-54 mmHg, respiratory rate 13-26 breaths/min, and oxygen saturation 82%-100%. A subsequent physical exam was not performed (noted as ‘Not Performed’ at 2448 minutes post-unit admission).