Patient Medical Report

1. Patient Information:

* **Patient Unit Stay ID:** 910048 * **Patient Health System Stay ID:** 676556 * **Gender:** Male * **Age:** 67 * **Ethnicity:** Caucasian * **Hospital ID:** 157 * **Ward ID:** 369 * **Admission Height (cm):** 192 * **Admission Weight (kg):** 92.8 * **Discharge Weight (kg):** NULL * **Hospital Admit Time:** 2015-XX-XX 14:51:00 (Exact date missing from data) * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 2015-XX-XX 00:40:00 (Exact date missing from data) * **Hospital Discharge Location:** Rehabilitation * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 14:26:00 (Exact date missing from data) * **Unit Admit Source:** Step-Down Unit (SDU) * **Unit Visit Number:** 3 * **Unit Stay Type:** readmit * **Unit Discharge Time:** 2015-XX-XX 21:51:00 (Exact date missing from data) * **Unit Discharge Location:** Step-Down Unit (SDU) * **Unit Discharge Status:** Alive * **Unique Patient ID:** 006-101726

2. History:

The provided data does not include a detailed patient history. Further information is needed to complete this section. The admission diagnosis indicates uncontrolled hypertension, potentially leading to the ICU admission. The unit admit source being a Step-Down Unit suggests a prior hospitalization or treatment requiring less intensive care before transfer to the ICU. More information about the patient's symptoms, prior medical conditions, family history, and social history is crucial for a comprehensive history.

3. Diagnoses:

* **Diagnosis ID:** 10332076 * **Patient Unit Stay ID:** 910048 * **Active Upon Discharge:** False * **Diagnosis Offset (minutes):** 4 * **Diagnosis String:** cardiovascular|vascular disorders|hypertension|hypertensive emergency/urgency * **ICD-9 Code:** 401.0, I10 * **Diagnosis Priority:** Primary

The primary diagnosis was hypertensive emergency/urgency. The absence of other diagnoses in the dataset suggests that this was the main reason for the ICU admission. However, a complete picture necessitates additional diagnoses, if any, to be included in a full report.

4. Treatments:

* **Treatment ID:** 25005822 * **Patient Unit Stay ID:** 910048 * **Treatment Offset (minutes):** 4 * **Treatment String:** cardiovascular|ventricular dysfunction|vasodilator|nicardipine * **Active Upon Discharge:** False

The patient received nicardipine, a vasodilator, to manage potential ventricular dysfunction related to the hypertensive emergency. The treatment was discontinued upon discharge from the unit. A complete treatment plan would require additional information about medication dosages, routes of administration, and other interventions implemented during the ICU stay. The lack of other treatments listed might be due to data incompleteness and should be investigated.

5. Vital Trends:

NULL. The data does not contain time-series data on vital signs such as heart rate, blood pressure, respiratory rate, or oxygen saturation. This information is essential for tracking the patient's condition over time and should be included in a complete report.

6. Lab Trends:

The following lab results are available, all with a lab result offset of -61 minutes except for FiO2 (3 minutes), bedside glucose (43 minutes) and bedside glucose (294 minutes):

* **Glucose:** 112 mg/dL * **Phosphate:** 3.5 mg/dL * **Chloride:** 107 mmol/L * **Bicarbonate:** 18 mmol/L * **Potassium:** 3.5 mmol/L * **Sodium:** 138 mmol/L * **Creatinine:** 1.2 mg/dL * **BUN:** 28 mg/dL * **Anion Gap:** 13 * **FiO2:** 28 % * **Magnesium:** 1.9 mg/dL * **Calcium:** 9.1 mg/dL * **Bedside Glucose (43 minutes):** 121 mg/dL * **Bedside Glucose (294 minutes):** 124 mg/dL

Note that the provided data only shows single lab results for most analytes. Serial measurements are required to assess trends and their correlation with the patient's clinical course. The absence of time-series data prevents the creation of a meaningful lab trend analysis.

7. Microbiology Tests:

NULL. No microbiology test data is present in the provided dataset.

8. Physical Examination Results:

* **Physical Exam Performed:** Yes * **Heart Rate (Current):** 71 bpm * **Heart Rate (Lowest):** 59 bpm * **Heart Rate (Highest):** 91 bpm * **Blood Pressure (Systolic, Current):** 154 mmHg * **Blood Pressure (Systolic, Lowest):** 129 mmHg * **Blood Pressure (Systolic, Highest):** 193 mmHg * **Blood Pressure (Diastolic, Current):** 56 mmHg * **Blood Pressure (Diastolic, Lowest):** 54 mmHg * **Blood Pressure (Diastolic, Highest):** 92 mmHg * **Respiratory Rate (Current):** 17 breaths/min * **Respiratory Rate (Lowest):** 15 breaths/min * **Respiratory Rate (Highest):** 23 breaths/min * **Oxygen Saturation (Current):** 98% * **Oxygen Saturation (Lowest):** 91% * **Oxygen Saturation (Highest):** 98% * **Admission Weight:** 92.8 kg * **Urine Output:** 1600 ml * **Intake Total:** 1155 ml * **Output Total:** 1600 ml * **Dialysis Net:** 0 ml * **Total Net:** -445 ml * **Glasgow Coma Scale (GCS) - Total Score:** 15 (6 motor, 4 eyes, 5 verbal)

The physical exam shows that a structured physical exam was performed. Vital signs recorded are within ranges that may be considered normal or slightly elevated depending on the patient's baseline and context. However, the lack of serial measurements prevents a proper assessment of trends and the overall clinical picture. Further details about the physical examination findings beyond vital signs are needed for a complete evaluation.