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**Patient Medical Report**
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1. Patient Information

* **PatientUnitStayID:** 297291 * **PatientHealthSystemStayID:** 256822 * **UniquePID:** 003-10464 * **Gender:** Male
* **Age:** 20 * **Ethnicity:** Other/Unknown * **HospitalID:** 79 * **WardID:** 133 * **UnitType:** Med-Surg ICU *
* **UnitAdmitTime24:** 16:27:00 * **UnitAdmitSource:** Direct Admit * **UnitDischargeTime24:** 23:06:00 *
* **UnitDischargeOffset:** 1839 minutes * **UnitDischargeLocation:** Floor * **UnitDischargeStatus:** Alive *
* **AdmissionHeight:** 177.8 cm * **AdmissionWeight:** 65.4 kg * **DischargeWeight:** 65.4 kg * **HospitalAdmitTime24:**
16:25:00 * **HospitalAdmitOffset:** -2 minutes * **HospitalAdmitSource:** Direct Admit * **HospitalDischargeYear:** 2014
* * **HospitalDischargeTime24:** 17:21:00 * **HospitalDischargeOffset:** 2934 minutes * **HospitalDischargeLocation:**
Home * **HospitalDischargeStatus:** Alive * **APACHEAdmissionDx:** Facial surgery (if related to trauma, see Trauma)

2. History

NULL (Insufficient information provided in the JSON data to generate a detailed patient history.)

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. These diagnoses, listed in order of entry (not necessarily severity), include:

* **DiagnosisID 4418244 (Offset: 40 minutes):** surgery|general surgery postop issues|hemorrhage (ICD-9 Codes: 998.11, I97.89). This diagnosis was not active upon discharge. * **DiagnosisID 5283262 (Offset: 72 minutes):** surgery|general surgery postop issues|hemorrhage (ICD-9 Codes: 998.11, I97.89). This diagnosis was not active upon discharge. * **DiagnosisID 4734864 (Offset: 40 minutes):** pulmonary|respiratory failure|acute respiratory distress|etiology unknown (ICD-9 Code: 518.82). This diagnosis was not active upon discharge. * **DiagnosisID 5191147 (Offset: 72 minutes):** pulmonary/respiratory failure/acute respiratory distress/etiology unknown (ICD-9 Code: 518.82). This diagnosis was not active upon discharge. * **DiagnosisID 4724842 (Offset: 111 minutes): ** surgerylgeneral surgery postop issues|hemorrhage (ICD-9 Codes: 998.11, I97.89). This diagnosis was not active upon discharge. * **DiagnosisID 5395875 (Offset: 111 minutes):** surgery|plastic surgery|s/p reconstructive procedure. This diagnosis was not active upon discharge. * **DiagnosisID 4701881 (Offset: 40 minutes):** surgery|plastic surgery|s/p reconstructive procedure. This diagnosis was not active upon discharge. * **DiagnosisID 4661963 (Offset: 72 minutes):** surgery|plastic surgery|s/p reconstructive procedure. This diagnosis was not active upon discharge. * **DiagnosisID 5121419 (Offset: 1440 minutes):** pulmonary|respiratory failure|acute respiratory distress|etiology unknown (ICD-9 Code: 518.82). This diagnosis was not active upon discharge. * **DiagnosisID 5231366 (Offset: 1440 minutes):** surgery|general surgery postop issues|hemorrhage (ICD-9 Codes: 998.11, I97.89). This diagnosis was not active upon discharge. * **DiagnosisID 4419789 (Offset: 1440 minutes):** surgery|plastic surgery|s/p reconstructive procedure. This diagnosis was not active upon discharge. * **DiagnosisID 4871559 (Offset: 1441 minutes):** surgery|general surgery postop issues|hemorrhage (ICD-9 Codes: 998.11, I97.89). This diagnosis was active upon discharge. * **DiagnosisID 4812155 (Offset: 1441 minutes):** surgery|plastic surgery|s/p reconstructive procedure. This diagnosis was active upon discharge. * **DiagnosisID 4745916 (Offset: 1441 minutes):** pulmonary|respiratory failure|acute respiratory distress|etiology unknown (ICD-9 Code: 518.82). This diagnosis was active upon discharge. * **DiagnosisID 5176015 (Offset: 111 minutes):** pulmonary/respiratory failure/acute respiratory distress/letiology unknown (ICD-9 Code: 518.82). This diagnosis was not active upon discharge.

Multiple diagnoses of hemorrhage and acute respiratory distress were recorded, some active at discharge. The timing of diagnosis entries suggests potential temporal relationships between these conditions.

4. Treatments

The patient received numerous treatments during their ICU stay. These include:

***VTE prophylaxis (compression boots):** Administered at 72 and 1440 minutes post-admission, not active at discharge.
***Stress ulcer prophylaxis (famotidine):** Administered at 111 and 1440 minutes post-admission; active at discharge. *
CPAP/PEEP therapy: Administered at 111 and 40 minutes post-admission, not active at discharge. * **Mechanical ventilation:** Administered at 111 and 40 minutes post-admission, not active at discharge. * **Analgesics (PCA):**
Administered at 111 and 1440 minutes post-admission, not active at discharge. * **Endotracheal tube:**
Administered at 72 and 111 minutes post-admission, not active at discharge. * **Analgesics (bolus parenteral analgesics):** Administered at 72, 111, and 1440 minutes post-admission, not active at discharge; active at discharge. * **Sedative agent (propofol):** Administered at 72 and 111 minutes post-admission, not active at discharge. * **Oxygen therapy (40% to 60%):** Administered at 72 and 40 minutes post-admission, not active at discharge. * **Oxygen therapy (< 40%):** Administered at 1440 minutes post-admission, not active at discharge. * **Cultures (sputum):** Administered at 72 and 1440 minutes post-admission, not active at discharge; active at discharge.

The repetition of certain treatments (e.g., analgesics, VTE prophylaxis) suggests ongoing management of specific symptoms. The active treatments at discharge indicate ongoing needs for stress ulcer prophylaxis, analgesics, and oxygen therapy.

5. Vital Trends

NULL (No vital sign data provided.)

6. Lab Trends

The provided lab data shows multiple blood tests conducted at various times during the patient's stay. There are both chemistry and hematology panels, including blood gas results. Note that there are multiple entries for several lab tests, which may represent repeated measurements over time. Analysis requires a time-series approach to understand trends. Initial and final values of key analytes are shown below:

7. Microbiology Tests

NULL (No microbiology test data provided.)

8. Physical Examination Results

A structured physical exam was performed (at 26 minutes post-admission). Key findings include:

* **Heart Rate:** Current rate was 80 bpm, with a lowest of 61 bpm and highest of 81 bpm. * **Blood Pressure:** Current systolic blood pressure was 131 mmHg, with a lowest of 131 mmHg and a highest of 149 mmHg. Current diastolic blood pressure was 76 mmHg, with a lowest of 76 mmHg and a highest of 98 mmHg. * **Respiratory Rate:** Current rate was 18 breaths per minute, with a lowest of 17 bpm and a highest of 25 bpm. * **Oxygen Saturation:** Current saturation was 98%, with a lowest of 94% and a highest of 100%. * **Weight:** Admission weight was recorded as 77.1107 kg. * **Glasgow Coma Scale (GCS):** Total score was 15 (Eyes: 4, Verbal: 5, Motor: 6). * **Mental Status:** Sedated. * **Airway:** Intubated. * **Heart Rhythm:** Sinus. * **FiO2:** 40% * **PEEP:** 10 cm H2O

The patient was intubated and sedated, indicating a significant level of respiratory distress. The GCS score suggests normal neurological function, despite sedation.