Medical Report: Patient 006-100602

1. Patient Information

* **Patient Unit Stay ID:** 851093 * **Unique Patient ID:** 006-100602 * **Gender:** Male * **Age:** 64 * **Ethnicity:** Caucasian * **Hospital Admission Time:** 2015-01-33 01:33:00 * **Hospital Admission Source:** NULL * **Hospital Discharge Time:** 2015-01-33 22:55:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2015-01-32 01:32:00 * **Unit Admission Source:** ICU * **Unit Visit Number:** 4 * **Unit Stay Type:** transfer * **Admission Weight:** 93.8 kg * **Discharge Weight:** NULL * **Unit Discharge Time:** 2015-01-33 20:53:00 * **Unit Discharge Location:** Acute Care/Floor * **Unit Discharge Status:** Alive * **Admission Height:** 169 cm

2. History

The provided data does not contain a detailed patient history. Further information is required to complete this section. The admission diagnosis for the ICU stay was ‘Obstruction-airway (i.e., acute epiglottitis, post-extubation edema, foreign body, etc)’ suggesting a respiratory issue as the primary reason for admission. The patient's history of atrial fibrillation, acute respiratory distress, and diabetes mellitus are also noted in the diagnoses section, but the chronology and details surrounding these conditions are missing. The lack of a structured history section makes it difficult to establish a complete timeline of events leading to this ICU admission. A comprehensive history including the onset and progression of symptoms, prior medical interventions, family history, and social history is necessary for a complete clinical picture. This information is critical for a thorough assessment of the patient's condition and the development of an appropriate treatment plan.

3. Diagnoses

The patient presented with multiple diagnoses:

* **Primary:** Obstruction of trachea / bronchus (ICD-9 codes: 786.00, R06.1) - Active upon discharge. * **Major:** Atrial fibrillation (ICD-9 codes: 427.31, I48.0) - Active upon discharge. * **Major:** Acute respiratory distress (ICD-9 code: 518.82) - Active upon discharge. * **Other:** Diabetes mellitus (ICD-9 code: NULL) - Active upon discharge.

It is important to note that multiple instances of each diagnosis exist, reflecting different times of recording during the stay. The absence of specific ICD-9 codes for some diagnoses limits the precision of the report. Further clarification is needed regarding the temporal relationship between these diagnoses. Were they all present on admission? Did some develop during the ICU stay? This information is crucial for understanding the patient's overall clinical trajectory. The severity of each diagnosis also requires further evaluation, as the priority flags are not entirely consistent across all entries.

4. Treatments

The patient received the following treatments:

* **Vasopressors:** Used to treat shock. Not active upon discharge. * **Diltiazem:** A Class IV antiarrhythmic used to manage atrial fibrillation. Active upon discharge.

The duration and response to these treatments are not specified in this dataset. The absence of dosage information and details regarding other interventions (e.g., oxygen therapy, mechanical ventilation) also limits the completeness of this section. A comprehensive treatment plan should include detailed information on all medications, including dosages, routes of administration, and frequency of administration. Similarly, details about other interventions and their efficacy are essential for evaluating the effectiveness of the overall treatment strategy. The lack of this information hinders the assessment of treatment effectiveness and potential areas for improvement.

5. Vital Trends

NULL. No vital sign data is provided. To complete this section, time-series data for heart rate (HR), blood pressure (BP), respiratory rate (RR), oxygen saturation (SpO2), temperature, and other relevant vital signs are required. These data would allow for the visualization of trends and identification of any significant fluctuations or patterns that could indicate deterioration or improvement in the patient's condition.

6. Lab Trends

The following lab results are available:

Several blood chemistry and hematology tests were performed. The data includes values for glucose (mg/dL), potassium (mmol/L), sodium (mmol/L), chloride (mmol/L), bicarbonate (mmol/L), creatinine (mg/dL), anion gap, albumin (g/dL), total protein (g/dL), total bilirubin (mg/dL), AST (SGOT) (IU/L), ALT (SGPT) (IU/L), alkaline phosphatase (IU/L), Hgb (g/dL), Hct (%), MCV (fL), MCH (pg), MCHC (g/dL), RDW (%), MPV (fL), platelets (K/mcL), and WBC (K/mcL). Time-series data for these parameters is needed for trend analysis. Multiple measurements of many parameters were taken at different time points, but without a clear time series, it is impossible to analyze the progression of the patient's condition from the lab results alone. The trend analysis would reveal whether the lab values are improving, worsening, or remaining stable over time, which is essential for assessing the patient's response to treatment and overall prognosis.

7. Microbiology Tests

NULL. No microbiology test results are provided.

8. Physical Examination Results

A structured physical exam was performed. The recorded values include: Heart Rate (Current: 106 bpm, Lowest: 92 bpm, Highest: 137 bpm), Blood Pressure (Systolic Current: 117 mmHg, Systolic Lowest: 112 mmHg, Systolic Highest: 166 mmHg, Diastolic Current: 76 mmHg, Diastolic Lowest: 52 mmHg, Diastolic Highest: 94 mmHg), Respiratory Rate (Current: 14 breaths/min, Lowest: 11 breaths/min, Highest: 24 breaths/min), Oxygen Saturation (Current: 97%, Lowest: 94%, Highest: 100%), Weight (Admission: 93.8 kg, Current: 95.1 kg, Delta: +1.3 kg), and Input/Output (Intake Total: 780 ml, Output Total: 2700 ml, Dialysis Net: 0 ml, Total Net: -1920 ml). Glasgow Coma Scale (GCS) was recorded as 15 (Eyes: 4, Verbal: 5, Motor: 6). The data suggest a relatively stable, albeit somewhat elevated, vital sign profile at the time of the physical examination. However, a longitudinal view of physical exam findings is necessary to ascertain the patient's overall progress during the ICU stay.