Medical Report - Patient 006-102774

1. Patient Information

* **Patient Unit Stay ID:** 694055 * **Unique Patient ID:** 006-102774 * **Gender:** Male * **Age:** 79 * **Ethnicity:** Caucasian * **Hospital ID:** 155 * **Ward ID:** 362 * **Unit Type:** Med-Surg ICU * **Admission Date & Time (Hospital):** 2014 (Year), 15:24:00 (24-hour time) * **Admission Source (Hospital):** Operating Room * **Discharge Date & Time (Hospital):** 2014 (Year), 00:36:00 (24-hour time) * **Discharge Location (Hospital):** Home * **Discharge Status (Hospital):** Alive * **Admission Date & Time (Unit):** (Date not provided), 15:45:00 (24-hour time) * **Admission Source (Unit):** Operating Room * **Discharge Date & Time (Unit):** (Date not provided), 04:55:00 (24-hour time) * **Discharge Location (Unit):** Step-Down Unit (SDU) * **Discharge Status (Unit):** Alive * **Admission Weight:** 85 kg * **Discharge Weight:** 85 kg * **Admission Height:** 170 cm * **APACHE Admission Diagnosis:** Tracheostomy

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses, primarily related to pulmonary issues. The diagnoses were recorded at various times throughout the ICU stay, as indicated by the `diagnosisoffset` field. The diagnoses include:

* **Primary Diagnosis:** Pulmonary disorders of the airways; obstruction of trachea/bronchus (ICD-9 codes: 786.00, R06.1). This diagnosis was active upon discharge from the unit. * **Major Diagnoses:** Pulmonary respiratory failure; acute respiratory failure (ICD-9 codes: 518.81, J96.00). This diagnosis was active upon discharge from the unit. Multiple entries for this diagnosis exist, suggesting either updates to the diagnosis or multiple instances of the condition.

4. Treatments

The patient received several treatments during their ICU stay:

* **Mechanical Ventilation:** This treatment was initiated early in the stay (40 minutes and 47 minutes post-admission) but was not active upon discharge. * **Tracheostomy:** This treatment was performed later in the stay (359 minutes post-admission) and remained active at the time of unit discharge. Multiple entries indicate the tracheostomy was likely a significant part of the treatment plan, potentially related to the airway obstruction.

5. Vital Trends

NULL (Insufficient data to generate vital sign trends. Data on Heart Rate, Blood Pressure, Respiratory Rate, and Oxygen Saturation are available at specific points, but not as a continuous time series).

6. Lab Trends

Several lab tests were performed on the patient during their ICU stay. The `labresultoffset` indicates the time elapsed from unit admission when the lab values were drawn. Trends require a longitudinal perspective, and thus cannot be fully characterized from the data. However, some key findings are notable:

* **Hemoglobin (Hgb):** There appears to be a decrease in Hgb levels over time, with initial values around 11.7 g/dL and later values around 8.6 g/dL. This may indicate anemia or blood loss. Further investigation into the temporal dynamics is needed. * **Glucose:** Glucose values show fluctuations, with an initial high of 205 mg/dL, followed by values ranging between 93 mg/dL and 129 mg/dL. This needs further analysis to ascertain whether these changes represent true trends or just random variation. * **Blood Chemistry:** Multiple blood chemistry tests (e.g., electrolytes, creatinine, BUN, liver

enzymes) were performed. However, without the temporal information, it is difficult to infer trends from these isolated lab results.

7. Microbiology Tests

NULL (No microbiology test data provided)

8. Physical Examination Results

Physical exams were performed at 31 and 46 minutes post-unit admission. The data suggests a structured physical exam was conducted, with recordings of vital signs like heart rate (HR), blood pressure (BP), respiratory rate (RR), and oxygen saturation (O2 Sat). Note that the HR, BP, and RR values are consistent across both recorded times. The O2 saturation was 96% initially and 97% later. A Glasgow Coma Scale (GCS) score was also recorded, indicating a low score (1) at 46 minutes after admission. This is indicative of severely impaired consciousness and requires contextual information (e.g., neurological exam findings) for a complete interpretation.

Note: This report is based on the limited data provided. A more comprehensive report would require additional information such as detailed medical history, medication records, and continuous vital sign monitoring data.