Medical Report for Patient 003-10535

1. Patient Information

* **Patient Unit Stay ID:** 264276 * **Patient Health System Stay ID:** 227184 * **Unique Patient ID:** 003-10535 * **Gender:** Male * **Age:** 37 years * **Ethnicity:** Native American * **Hospital ID:** 92 * **Ward ID:** 143 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2015-XX-XX 16:04:00 (Assuming a date is available but not provided in the JSON) * **Unit Admit Source:** Floor * **Unit Discharge Time:** 2015-XX-XX 06:26:00 (Assuming a date is available but not provided in the JSON) * **Unit Discharge Location:** Other Hospital * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 2015-XX-XX 03:18:00 (Assuming a date is available but not provided in the JSON, calculated from `hospitaladmitoffset`) * **Hospital Admit Source:** Floor * **Hospital Discharge Time:** 2015-XX-XX 06:20:00 (Assuming a date is available but not provided in the JSON) * **Hospital Discharge Location:** Other * **Hospital Discharge Status:** Alive * **Admission Weight:** 129.1 kg * **Discharge Weight:** 116.2 kg * **Admission Height:** 188 cm (Units assumed)

2. History

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

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis upon discharge was acute respiratory failure (518.81, J96.00). Other significant diagnoses included:

* Acute renal failure (584.9, N17.9) * Anemia of renal disease (285.21, D63.1) * Multifactorial anemia (285.9, D64.9) * Acute blood loss anemia (285.1, D62) * Aspiration pneumonia (507.0, J69.0) * Encephalopathy (348.30, G93.40) * Hypokalemia (276.8, E87.8) * Alcohol withdrawal (291.81, F10.239) * Lower GI bleeding (578.9, K92.2) * Hypotension (458.9, I95.9) * Transfusion reaction (999.8, T80.9) * ARDS (518.81, J80) * Hypovolemia (276.52, E86.1) * Cardiac arrest (427.5, I46.9) – witnessed, < 15 minutes CPR * Altered mental status/pain

Note that multiple entries for the same diagnosis likely reflect ongoing assessment and reassessment throughout the patient's stay. The `activeupondischarge` flag indicates whether the diagnosis was still considered active at the time of discharge.

4. Treatments

The patient received a wide range of treatments, many of which were related to their multiple diagnoses. These included:

* Mechanical ventilation * Oxygen therapy (various concentrations) * Vasopressors * Inotropic agents * Packed red blood cells transfusions (more than 2 units) * Octreotide (for varices) * Stress ulcer prophylaxis (omeprazole) * VTE prophylaxis (compression boots) * Sedative agents * Psychiatry consultation * Bronchoscopy * CPAP/PEEP therapy * Normal saline solution

Again, multiple entries for similar treatments might indicate adjustments in therapy over time. The `activeupondischarge` flag helps determine active treatments at the time of discharge. The specific medications used are not explicitly stated.

5. Vital Trends

NULL (Vital signs data not provided in JSON)

6. Lab Trends

The provided lab data shows trends in several key chemistries and blood gases. The data includes multiple time points for each lab test. Specific trends require further analysis, but initial observations suggest fluctuations in blood gases (pH, PaO2, PaCO2, HCO3, Base Excess), electrolytes (potassium, sodium, chloride, magnesium, phosphate), and liver function tests (ALT, AST, total protein, albumin, total bilirubin, direct bilirubin, prealbumin). The complete picture requires a time-series analysis. Hematology results (Hgb, Hct, RBC, MCV, MCH, MCHC, WBC, platelets, -bands, -lymphs, -monos, -polys, -eos, -basos) are also available, showing fluctuations in the various blood components.

7. Microbiology Tests

NULL (Microbiology data not provided in JSON)

8. Physical Examination Results

The physical exam was initially ‘Performed - Structured’ and later entries show it as ‘Not Performed’, indicating that a complete physical exam was conducted at the beginning of the stay but not consistently documented throughout the stay. The initial exam noted the patient as ‘ill-appearing’ but ‘well developed’ and ‘not in acute distress’. Vital signs included a heart rate of 74 bpm (current, highest, and lowest values were the same), systolic blood pressure of 72 mmHg (current and lowest), systolic blood pressure of 82 mmHg (highest), diastolic blood pressure of 37 mmHg (current), diastolic blood pressure of 36 mmHg (lowest), diastolic blood pressure of 41 mmHg (highest), respiratory rate of 23 bpm (current, highest, and lowest values were the same), O2 saturation of 96% (current, highest, and lowest values were the same), and weight of 111.584 kg (admission weight). The patient had a sinus rhythm. The Glasgow Coma Scale (GCS) was recorded as scored, with individual scores of Eyes: 1, Verbal: 2, and Motor: 4. The patient's mental status was described as obtunded and not oriented, with a depressed affect. The initial FiO2 was 100% and PEEP was 5 cm H2O.