Patient Medical Report

1. Patient Information

* **Patient Unit Stay ID:** 263279 * **Patient Health System Stay ID:** 226281 * **Unique Patient ID:** 003-1599 * **Gender:** Male * **Age:** 83 * **Ethnicity:** NULL * **Hospital ID:** 93 * **Ward ID:** 170 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2014-XX-XX 13:01:00 (assuming date is available but missing in JSON) * **Unit Admit Source:** Floor * **Unit Discharge Time:** 2014-XX-XX 15:35:00 (assuming date is available but missing in JSON) * **Unit Discharge Location:** Death * **Unit Discharge Status:** Expired * **Hospital Admit Time:** 2014-XX-XX 15:39:00 (assuming date is available but missing in JSON) * **Hospital Admit Source:** Floor * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 2014-XX-XX 15:35:00 (assuming date is available but missing in JSON) * **Hospital Discharge Location:** Death * **Hospital Discharge Status:** Expired * **Admission Weight:** 78.7 kg * **Discharge Weight:** 78.7 kg * **Admission Height:** 175.3 cm

2. History

The patient's history is not explicitly provided in the JSON data. This section would ideally contain details of the patient's presenting complaint, relevant past medical history (including any previous hospitalizations or surgeries), family history, social history (e.g., smoking, alcohol use), and medication history. Further investigation beyond the provided data is required to populate this section fully. The admission diagnosis indicates a cardiac arrest. Additional information is needed to understand the circumstances surrounding the arrest and the patient's condition leading up to it. NULL

3. Diagnoses

The patient received multiple diagnoses, all marked as 'Other' priority. These include:

* Anemia * Fever * Septic shock * Thrombocytopenia * Chronic renal insufficiency * Primary lung cancer * Cardiac arrest (witnessed, <15 minutes CPR) * Cardiac arrest (initial rhythm: pulseless electrical activity) * Leukocytosis

ICD-9 codes were not consistently provided for all diagnoses. 780.6, R50.9 and 785.59, R65.21 are noted in the Fever and Septic Shock diagnoses respectively. 287.5, D69.6 is noted for Thrombocytopenia, and 585.9, N18.9 for Chronic Renal Insufficiency. 162.9, C34.90 is noted for Primary Lung Cancer. 427.5, I46.9 is noted for both cardiac arrest diagnoses, and 288.8, D72.829 is noted for Leukocytosis. The absence of ICD-9 codes for some diagnoses suggests incomplete documentation or a reliance on alternative coding systems.

4. Treatments

The patient received the following treatments:

* Vancomycin (antibacterial) * Phenylephrine (vasopressor) * Epinephrine (inotropic agent, >0.1 mcg/kg/min) * Sodium bicarbonate * Packed red blood cells * Piperacillin/tazobactam (antibacterial) * Norepinephrine (inotropic agent, >0.1 mcg/kg/min) * Pantoprazole (stress ulcer treatment) * Potassium (electrolyte) * Urine culture * Blood culture * Fluconazole (antifungal) * Platelet concentrate * Magnesium (electrolyte) * TPN (total parenteral nutrition)

The administration of multiple antibiotics and inotropic agents suggests a severe and complex clinical picture. The provision of TPN indicates a need for nutritional support.

5. Vital Trends

NULL. Vital sign data (heart rate, blood pressure, respiratory rate, oxygen saturation) is available in the physical exam section, but trends require a time-series analysis not provided in the JSON.

6. Lab Trends

NULL. Hematological lab results (Hemoglobin, Hematocrit, MCV, MCH, MCHC, Platelets, RBC, WBC, RDW, PT, PTT, INR) are provided, however, trends over time require a time-series analysis not present in the JSON. Two sets of labs are recorded, one at -121 minutes and another at 34 minutes. Further information is required to determine if these are the only lab results or if additional labs were performed during the ICU stay.

7. Microbiology Tests

Urine and blood cultures were ordered. Results are not available in the provided data. NULL

8. Physical Examination Results

The physical exam notes indicate that the patient was ill-appearing, comatose, and unable to assess orientation. Vital signs upon initial exam (at 9 minutes): HR 95 (lowest 75, highest 95); BP (systolic) 64 (lowest 69, highest 150); BP (diastolic) 29 (lowest 19, highest 60); Respiration rate 47 (lowest 32, highest 47); SpO2 82 (lowest 77, highest 82). A later exam (at 138 minutes) recorded: HR 82 (lowest 75, highest 95); BP (systolic) 30 (lowest 30, highest 30); BP (diastolic) 2 (lowest 2, highest 2); Respiration rate 36 (lowest 32, highest 47); SpO2 66 (lowest 66, highest 82). The patient was ventilated and had an irregular heart rhythm. Weight was recorded at 78.7 kg on admission and at the time of the exam. The patient was on a ventilator.