Patient Medical Report

1. Patient Information

* **PatientUnitStayID:** 503222 * **PatientHealthSystemStayID:** 425880 * **Gender:** Male * **Age:** 82 * **Ethnicity:** Hispanic * **HospitalID:** 140 * **WardID:** 261 * **APACHEAdmissionDx:** Pneumonia, bacterial * **Admission Height:** 165.1 cm * **Hospital Admit Time:** 09:25:00 (Hospital Admit Offset: -45 minutes from unit admit) * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 10:25:00 (Hospital Discharge Offset: 1455 minutes from unit admit) * **Hospital Discharge Location:** Death * **Hospital Discharge Status:** Expired * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 10:10:00 * **Unit Admit Source:** Emergency Department * **Unit Visit Number:** 1 * **Unit Stay Type:** admit * **Admission Weight:** 45.8 kg * **Discharge Weight:** NULL * **Unit Discharge Time:** 01:48:00 (Unit Discharge Offset: 938 minutes from unit admit) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **UniquePID:** 005-10383

2. History

NULL (Insufficient information provided)

3. Diagnoses

The patient presented with multiple diagnoses, with varying priorities and activity statuses upon discharge. The primary diagnosis was sepsis with single organ dysfunction – acute respiratory failure (ICD-9 codes: 038.9, 518.81, R65.20, J96.0), which was active upon discharge. Other active diagnoses included hypoxemia and acute respiratory failure (ICD-9 codes: 799.02, J96.91, 518.81, J96.00). Major diagnoses included aspiration pneumonia (ICD-9 codes: 507.0, J69.0). Inactive diagnoses upon discharge included Alzheimer's disease and dementia (ICD-9 codes: 294.10, 331.0, F02.8, G30.9). The time offsets indicate when each diagnosis was recorded relative to the unit admission time. The multiplicity of diagnoses suggests a complex clinical picture involving multiple organ systems.

4. Treatments

The patient received a range of treatments throughout their ICU stay. Treatments active upon discharge included insulin and glucose management for glucose metabolism, social work consult, chest x-ray, pulmonary/CCM consultation, piperacillin/tazobactam, levofloxacin, and continuous parenteral analgesics and sedative agents for pain/agitation management. Oxygen therapy (>60%) was also administered. Inactive treatments included oxygen therapy (<40%) via nasal cannula, and cultures. The timing of these interventions, indicated by the treatment offsets, is crucial in understanding the treatment strategy employed.

5. Vital Trends

NULL (Insufficient information provided. Vital signs would typically include heart rate, blood pressure, respiratory rate, temperature, and oxygen saturation over time.)

6. Lab Trends

The provided lab data includes a comprehensive hematology panel, blood gas analysis, and several chemistry tests. There are multiple glucose measurements showing fluctuation, with values ranging from 35 mg/dL to 126 mg/dL. The blood gas analysis reveals a low PaO2 (48.5 mm Hg), elevated PaCO2 (41 mm Hg), and a low bicarbonate (22 mmol/L) indicating respiratory acidosis with hypoxemia. The Base Excess (-3.4 mEq/L) further supports this finding. Liver function tests reveal significantly elevated AST (2272 U/L) and ALT (732 U/L) suggesting significant liver injury. Other lab results are listed, but require further analysis to interpret trends. More data points over time are needed for a comprehensive trend analysis.

7. Microbiology Tests

NULL (While cultures were performed, the results are not included.)

8. Physical Examination Results

Two physical examinations were documented during the patient's ICU stay (at 37 minutes and 672 minutes post unit admission). The patient was critically ill-appearing, cachectic, and somnolent, with a Glasgow Coma Scale (GCS) score of 12 (4,4,4) indicating an altered mental status. The patient exhibited scattered rhonchi on lung auscultation. Heart sounds were normal, with no murmurs or pericardial rubs. Pulses were normal. The abdomen was benign. The patient had a Foley catheter in place. The patient's vital signs were recorded in the physical exam, and showed an elevated blood pressure (highest systolic 175 mm Hg, diastolic 151 mm Hg) and a heart rate between 62 and 92 bpm. Further analysis of physical examination findings requires more complete data and correlations with other clinical data.