ICD-10-CM
Specialty Code Set Training
Gastroenterology

2014

Module 3
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Clinical Examples Used in this Book
AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are actual, redacted office visit and procedure notes donated by AAPC members.

To preserve the real world quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.
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Case 1
The patient is a 34-year-old patient who comes in today for evaluation of abdominal pain. She has acid reflux and sometimes cannot get out of bed as she is tired and nauseous. This occurs every few months, last occurrence was in October. She has been on Protonix for 6 months and was changed to Nexium last week. She has had a barium swallow 3 months ago.

Subjective:

Chief complaint: Patient presents for evaluation of GERD and evaluation of possible hiatal hernia.

HPI: GERD and hiatal hernia. Present for years. Onset was gradual. Rated as moderate. Interferes with activities of daily life. Aggravated by eating. Symptoms not alleviated by anything. Has had an upper GI series within the last 3 months. Reports associated heartburn and indigestion, but denies associated dysphagia, flatulence, globu, hoarseness, recurrent pneumonia, sleeping difficulty and shortness of breath.

ROS:
Const: Denies anorexia, change in appetite, chills, fatigue, fever, and weight change.
ENMT: Denies discharge from the ears and ear pain. Denies rhinorrhea. Denies hoarseness, voice change, and sore throat.
CV: Denies arrhythmia, chest pain, and tightness.
Resp: Denies cough, dyspnea, sputum production, and recent URI.
GI: Denies symptoms other than stated above.
GU: Urinary: Denies dysuria, frequency, and urgency.
Musculo: Denies limitations of movement.
Skin: Denies skin changes, pruritis, and rashes.
Breast: Denies discharge, lumps, masses, pain, and tenderness.
Neuro: Denies dizziness, lightheadedness, and syncope.
Endocrine: Denies intolerance to cold, intolerance to heat, night sweats, polyuria, excessive thirst, and excessive urination.
Hema/Lymph: Denies easy bleeding, easy bruising, and lymphadenopathy.

Current Meds: Nexium, Allegra-D 24 Hour, Advair Diskus

Allergies: NKDA
PMH:

**Surgeries:** Cholecystectomy

**FH:** Asthma, Cancer, Hypertension, Diabetes


**Objective:**

Wt: 140; BP 117/77; Ht: 5’3”

**Exam:**

Const: Appears healthy and well developed. No signs of acute distress present. Speech is clear and appropriate. Alert and oriented.

Head/Face: Atraumatic on inspection.

Eyes: EOMI in both eyes. Sclerae are anicteric.

ENMT: Oral mucosa: Pink and moist with no lesions.

Neck: Supple. Palpation reveals no adenopathy No masses appreciated. Thyroid exhibits no thyromegaly.

Resp: Lungs are clear bilaterally.

CV: S1 is normal. S2 is normal. No heart murmur appreciated.

Abdomen: Positive bowel sounds in all quadrants; abdomen is soft, nontender, and nondistended without guarding, rigidity or rebound tenderness; no abdominal masses; no palpable hernias; no palpable hepatosplenomegaly.

Lymph: No palpable or visible regional lymphadenopathy.

Skin: Skin is warm and dry.

Neuro: Alert and oriented x3. No focal sensory or motor deficits noted.

**Assessment:** Gastroesophageal reflux

**Plan:** Based on her history and symptoms, I advised evaluation of her upper GI tract with EGD. I explained the procedure to her in detail including risks, benefits, and alternatives. Informed consent was obtained. We will schedule the procedure.

**ICD-10-CM code(s):**
Case 2

Preoperative Diagnosis: GI bleeding

Postoperative Diagnosis: Gastritis

Procedure: Colonoscopy and gastroscopy

Details of Procedure: The colonoscope was placed in the rectal ampulla and advanced under visual guidance. There was fairly good preparation as we reached the ileocolonic anastomosis. Right on the ileocolonic anastomosis, there were some inflammatory changes, secondary to what appeared to be suture material. There were no ulcerations or suspicious looking lesions. The ascending, transverse, descending colons were normal. This sigmoid showed diverticular disease and inflammatory hemorrhoids. The colonoscope was then withdrawn. The patient was then repositioned and the gastroscope was then placed in the esophagus. The Z-line was at about 38. There was a small benign Schatzki’s ring with some mild inflammation. Not really big enough to dilate and the patient has continued his Plavix and therefore, it wasn’t. Upon entering the stomach and cardia, there were a small polyps and some chronic gastritis, possibly H. pylori, vs. nonsteroidal-induced, but biopsies were taken for CLOE testing and a polyp was removed. Duodenum also showed some Inflammation and again, biopsy was taken for CLOE testing. There were no large ulcerations. No blood and the endoscope were removed and the patient tolerated the procedure well.

Impression: Status post resection of a large cecal polyp. No evidence of recurrence. Otherwise, a normal colonoscopy. Small Schatzki’s ring. Chronic gastroduodenitis, possibly H. pylori, vs. nonsteroidal induced.

Recommendations: The patient will continue on a proton pump inhibitor, if H. pylori testing are positive, we will treat accordingly. Follow-up colonoscopy and gastroscopy in three years.

ICD-10-CM code(s): __________________________________________

Case 3

Preoperative Diagnosis: Gallstone pancreatitis with gallbladder sludge

Postoperative Diagnosis: Gallstone pancreatitis with gallbladder sludge

Procedure: Laparoscopic cholecystectomy

Operative findings: The patient had what appeared to be mild chronic cholecystitis, otherwise normal.

Summary: The patient was taken to the operative room, placed In supine position, prepped and draped in normal sterile fashion. Once anesthesia was obtained, a supraumbilical midline incision was made, taken down to the fascia and via the Hasson technique, a port was placed. Under visualization, 3 other ports were placed, a xiphoid and 2 right upper quadrant ports. The xiphoid port was 10 mm; the 2 others were 5 mm. Once we were in the abdomen, the liver was retracted upward, the gallbladder was visualized and dissection of the cystic duct and cystic artery were easily obtained. Once we had good dissection, we had a good critical view; we clipped and ligated the cystic artery and cystic duct. Once these were cut, we dissected the gallbladder off the fossa
from a bottom to top direction. The gallbladder was removed, placed in the Endobag, and then the
gallbladder fossa was irrigated and cauterized to obtain good hemostasis. We irrigated multiple
times and obtained good hemostasis. We then removed the visualization, removed the 5 mm ports.
Then we were able to remove the gallbladder from the abdomen and closed the supraumbilical port
with 3 Vicryl sutures. We then closed the skin with subcuticular Vicryl sutures and placed a sterile
dressing. The patient tolerated the procedure well.

ICD-10-CM code(s): ________________________________

Case 4

History of Present Illness: The patient is a 45-year-old male who reports that he was fine until
yesterday when he ate a bowl of fruit with onset suddenly afterwards of abdominal pain. It was mid
abdomen, sharp in nature. He reports he took some Citrucel and hoped that this would alleviate
the symptoms. He actually went golfing and after finishing nine holes, he reports the pain was
severe. He could not continue and he then subsequently presented to the emergency department.
En route, he has an episode of nausea and emesis. This consisted primarily of the food stuffs, and
he also had additional emesis in the emergency department and on this a.m. He reports no change
in his bowel habits recently. He did have a formed bowel movement yesterday. He reports passing
a small amount of flatus additionally. This a.m. he reports the pain is markedly improved. He also
did have some nausea previously this a.m., but actually has a bit of an appetite at this point in time.

Past Medical History: Positive for hypertension and coronary artery disease.

Past Surgical History: Coronary artery bypass grafting.

Medications: Lopressor, Altace, Lipitor and aspirin.

Allergies: NKDA

Social History: Denies alcohol and tobacco use.

Family History: Noncontributory.

Review of Systems: Pertinent positives are noted in history of present illness. Additionally noted
some chest pressure. The rest of the 14-point review of systems was negative.

Physical Examination:

General: Comfortable appearing, middle-aged white male.

HEENT: Sclerae are anicteric.

Neck: Supple.

Cardiovascular: Regular

Lungs: Clear.

Abdomen: Soft, mildly tympanitic. There is a small umbilical hernia that is reducible. There is also
diastasis recti present. Bowel sounds are hyperactive with occasional rushes. No organomegaly is
noted. No masses are palpable.
Genitourinary: No cough impulses.
Extremities: Not edematous.

Diagnostic Study Results: CT and abdominal films were reviewed. They do show evidence of a partial high-grade obstruction.

Assessment and Plan: Small bowel obstruction, this appears to be high-grade, etiology not completely defined. Continue with NPO status for now and IV hydration. If he has any further nausea or vomiting, I think he merits a nasogastric tube for decompression. The plan is to obtain a follow-up CT scan in the a.m. He will follow with you. Thank you for the consultation.

ICD-10-CM code(s): __________________________________________

Case 5
Operation Performed: Laparoscopic cholecystectomy.
Anesthesia: General endotracheal anesthesia
Complications: None.
Estimated Blood Loss: Minimal to none.
Indications for Procedure: This is a 40-year-old woman who has had significant right upper quadrant pain specifically following fatty meals. She was found on ultrasound to have quite a significant amount of sludge in the gallbladder, but no obvious stones. Patient is brought to the operating room for removal of her gallbladder. Procedure, risks, and benefits were explained to the patient. The consent was signed and placed in the chart.
Findings: Specimen - gallbladder.

Description of Procedure: The patient was then brought back to the operating room and once adequate general endotracheal anesthesia had been achieved, the patient’s abdomen was prepped and draped in the usual sterile fashion. I then injected local anesthetic below the umbilicus and made a stab incision with scalpel. I then inserted the Veress needle into the abdominal cavity and insufflated the abdominal cavity. Once full insufflation had been achieved, I inserted an 11 mm port with the Optiview camera into the abdominal cavity. I then inspected for any injury and there did not appear to be any. I then placed three more ports all in the same fashion by injecting the skin with local anesthetic, stab incision with scalpel and inserting an 11 mm port in the epigastric location and two 5 mm in the right subcostal. These were all done with direct visualization. I then identified the gallbladder and retracted it up towards he patient’s right shoulder. There were sonic omental adhesions onto the gallbladder in this location. These were all taken down with electrocautery and blunt dissection The gallbladder was then retracted up towards the patient’s right shoulder. I then pulled the influndibulum toward the patient’s right and identified the cystic duct and the cystic artery. These were then clipped with two proximally and two distally and sharply divided. I then took the gallbladder off the liver bed using electrocautery. This was done...
without any difficulties. I then placed a camera in the epigastric port. I then grasped the clips on the cystic duct and pulled the gallbladder out from the infraumbilical port site without any difficulties. It came very easily out of the intraabdominal cavity. The gallbladder was then passed off the table to be sent to pathology. I then looked down at the liver bed. There was good hemostasis. The clips were in good positioning. I then removed my ports under direct visualization. I then irrigated all of the wounds out with normal saline. I allowed the abdominal cavity to deflate. I then closed the infraumbilical port site with a figure-of-eight 0 Polysorb suture. I then irrigated the wounds again with normal saline and closed the skin with running 4-0 Monocryl subcuticular suture. These were all cleaned with wet to dry gauze, covered with Mastisol, Steri-Strips, and Band-Aids. The patient was then extubated and transported to the recovery room in stable condition. She tolerated the procedure well. There no complications. There was one specimen, the gallbladder. Blood loss was minimal to none.

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Case 6
I discussed the procedures, risks, benefits, and alternatives with the patient prior to surgery. Patient agreed and consented to operation.

Preoperative Diagnosis: Liver mass.

Postoperative Diagnosis: Malignant ascites. Left lobe of liver mass approximately 2 x 2 cm in size.

Procedure: Diagnostic laparoscopy. Luken’s trap collection of what looked like malignant ascites. Multiple biopsies of the mass of the left lobe of the liver.

Description of the Procedure: Patient was prepped and draped in the usual fashion in the supine position under general anesthesia. Prior to incision, 1 gram of Ancef was given IV piggyback. Infraumbilical incision was made with scalpel. Abdomen was entered using a blunt technique. Another trocar was placed under direct vision safely and exploration showed that the patient had a large amount of ascites. It also had an obvious mass in the left lobe of the liver. Luken’s trap collection of the fluid was performed. It was to be sent to pathology for cytology and then approximately three biopsies were done under the left lobe of the liver mass. Hemostasis was checked and was good. The biopsy is being sent to pathology for evaluation. Hemostasis was checked a final time and was excellent. The cannulas were then removed under direct vision. There was no bleeding from the abdominal wall of the fascia of the infraumbilical incision was closed using 0 Vicryl suture. All skin incisions were closed using staple 5. Dressings were applied. 10 cc of 14 percent Marcaine with epinephrine was infused subcutaneously for postoperative pain relief. Dressings were applied at the end of the operation. Sponge count and needle count were correct x2. Estimated blood loss was less than 10 cc. Patient tolerated procedure well and brought to the recovery room in stable condition.

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Case 7
Preoperative Diagnosis: GERD with ALTE
Postoperative Diagnosis: GERD with ALTE
Procedure: Nissen fundoplication

History: The patient is a 02M 09D-year-old child who has significant reflux and has had life-threatening blue spells and apnea. Because of this it is felt that a fundoplication was indicated.

Procedure in Detail: The patient was taken to the operating room and laid on the operating table in supine position and a general anesthesia was induced. The abdomen was prepped and draped in the usual sterile fashion. An upper midline incision was made in the abdomen and entered. Gastrohepatic ligament was divided with a harmonic scalpel. The greater curve was freed up with the harmonic scalpel dividing several short gastrics. Next, bilateral crural dissections were done and the retroesophageal dissection was done. A Penrose drain was placed around the esophagus. This area was freed up nicely. Next, a 24 Bougie was placed and the retroesophageal curua was closed with Interrupted 3-0 silk sutures.

Once this was done a 360 degree wrap was constructed and sutured from the stomach to the esophagus to the stomach. The wrap was tacked to the diaphragm in two places. The wrap looked quite good. Hemostasis was assured. The wound was copiously irrigated until clear. Midline fascia was closed with running 2-0 Vicryl suture. 4 cc of 0.25 percent Marcaine plain was injected as a local block. Skin was closed with running 5-0 Vicryl subcuticular stitch. Steri-Strips in two layers were placed on the wound. The patient tolerated the procedure well and left the operating room and went back to the PICU in stable condition.

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Case 8
Operative Report
Preoperative Diagnosis: 1. Perforated diverticulitis with peridiverticular abscess.
Postoperative Diagnosis: 1. Perforated diverticulitis with peridiverticular abscess.

Anesthesia: General.

Description of Procedure: After prepping out the abdomen, a midline incision was made and dissection carried down to subcutaneous tissue. The fascia was scored. The peritoneal cavity was entered. A Bookwalter retractor was placed. Omental attachments to this inflammatory mass were taken down with sharp and blunt dissection. The small bowel was mobilized into the upper abdomen. The sigmoid was exposed and a large inflammatory mass was encountered. Lateral attachments, which were densely adhesed to the pelvic sidewall, were taken down with sharp and blunt dissection as well as attachments to the uterus. A large pocket of pus was encountered and aerobic and anaerobic cultures were obtained. We then scored the peritoneal reflection and took down the colon at the descending sigmoid junction and took down the mesentery and then
transected it with a GIA stapler. The mesocolon was taken down with a LigaSure device with good hemostasis. Large veins were suture ligated with 3-0 silk sutures. We then were able to finally mobilize this large inflammatory mass, which was densely adherent to the tubal ovarian complex on the left side and the tube was removed and amputated with the LigaSure device. Once the inflammatory mass was brought up into the operative field we took down the mesentery at the rectal level and then transected it with a TA 45 stapler. The remainder of the mesentery was taken down with a LigaSure and large vessels were ligated with 3-0 silk. One bleeding area close to the ureter was identified. It was venous in structure and it was suture ligated with a 4-0 Prolene. After the sigmoid colon had been resected, the appendix was lying in the inflammatory region and we elected to remove this. The mesoappendix was taken down with a LigaSure as well as the appendiceal artery. We then took a TA 45 and stapled across the base of the appendix and amputated, and sent for pathologic exam. Once all hemostasis was controlled we irrigated the abdomen with copious amounts of saline. We marked the rectal stump with 4-0 Prolene and tacked it up to the sacral promontory region for identification later. We took out a button on the anterior abdominal wall, scored the fascia in a T-shaped fashion and then brought out the ostomy without tension up into the abdomen in the left lower quadrant. It appeared viable. We then placed all the viscera back in its normal anatomical position. The fascia was then closed with a #2 nylon in figure-of-eight fashion. The skin was closed with staples. The ostomy was matured in the standard fashion with 4-0 Vicryl. A button on the anterior abdominal wall, scored the fascia in a T-shaped fashion and then brought out the ostomy without tension up into the abdomen in the left lower quadrant. It appeared viable. We then placed all the viscera back in its normal anatomical position. The fascia was then closed with a #2 nylon in figure-of-eight fashion. The skin was closed with staples. The ostomy was matured in the standard

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Case 9  

Case 9  

Operative Report  

Preoperative Diagnosis: Cholecystitis  

Postoperative Diagnosis: Cholecystitis with cholelithiasis  

Operative Procedure: Laparoscopic cholecystectomy with intraoperative cholangiogram  

Findings: Gallbladder with thick adhesions, normal appearing liver, stomach, visible intestines, normal appearing uterus, no evidence of a tubal pregnancy. There was a moderate size filling defect in the distal common bile duct.  

The patient was identified and taken to the operating room. She was placed in a supine position on the operating room table. Once adequate sedation was given, the patient was intubated and straight catheterization was performed 2 mg of intravenous glucagon was given along with 1 gm of Ancef. Using a #11 blade, a linear incision was made superior to the umbilicus. Using a 5 mm optical trocar the abdomen was entered and insufflated to 15 mm Hg. Under direct visualization two 5 mm ports were placed in the right upper quadrant, one 11 mm port was placed in the subxiphoid area. The abdomen was inspected, revealing a normal appearing liver, stomach, and visible intestine. The adnexa were visualized. There are post tubal ligation changes, no evidence of a tubal pregnancy, normal appearing uterus. The gallbladder had thick omental adhesions covering it. The gallbladder was elevated up over the liver and these adhesions were bluntly retracted down. Using blunt dissection, the cystic duct was identified. It was found to be dilated. A clip was placed proximal on the cystic duct. Just distal to this, a small nick was made and high pressure bile was
then draining through this nick. A cholangiogram catheter was then placed into the cystic duct and a cholangiogram was obtained. There was good flow into the left and right hepatic radicals and down the common duct, but there was a filling defect in the distal common bile duct. An attempt to dislodge this defect was performed using irritation. After multiple attempts, this was found to be unsuccessful. A clip was placed distal on the cystic duct and the cystic duct was transected. A PDS Endoloop was then placed on the cystic duct stump. Using the harmonic scalpel the gallbladder was removed from the liver bed. The liver bed was friable due to the inflamed gallbladder. Once the gallbladder was completely removed, an Endobag was introduced through the subxiphoid port site. The gallbladder was placed into the bag and removed from the abdomen. Using electrocautery, hemostasis was achieved on the liver bed. Then, 300 cc of 0.25 percent Sensorcaine was placed over the liver and the subxiphoid port fascia was closed with 0 Vicryl suture on a Carter-Thompson. The abdomen was deflated and all skin incisions were reapproximated using 4-0 Monocryl suture and covered with Dermabond. By the end of the procedure, the sponge, needle, and instrument counts were correct. The patient was then transferred to the recovery room in stable condition.

Path Report: Cholecystitis, chronic, with cholelithiasis, along with intramural adenomata, also consistent with chronic disease, gallbladder, benign.

ICD-10-CM code(s)

Case 10

Preoperative Diagnosis: Colon carcinoma.

Postoperative Diagnosis: Colon carcinoma.

Procedure: Right hemicolecotomy.

History: An 85-year-old woman with a carcinoma in the ascending colon.

Procedure: On 01/27/2010, the patient was brought to the operating room, placed on the operating table in the supine position. Satisfactory general anesthesia was obtained. The abdomen was prepped and draped in a sterile fashion. Midline skin incision was made extending from just below the umbilicus to near the xiphoid. By sharp and blunt dissection the midline fascia was exposed. Fascia was opened and incision extended the full length of the skin incision with cautery. The right colon was mobilized taking down the peritoneal fusion plane and mobilizing it up into the midline wound. A large tumor in the descending colon about a third of the way between the cecum and hepatic flexure was noted. There were no obvious lymph nodes or palpable masses in the mesentery or liver. Some adhesions of right colon to the gallbladder were taken down but there was no evidence of direct extension of tumor. This was really not anywhere near the tumor. There was no palpable mass within the gallbladder. No gallstones. Gallbladder was left alone. A point was chosen just distal to the hepatic flexure in the proximal transverse colon. This area was cleaned of adherent fat and mesentery and colon was divided using a GIA stapler. An area at the level of the ileocecal valve and the small bowel was cleaned of adherent fat and mesentery and also divided using the GIA stapler. Mesentery between these two points was taken down along the root of the mesentery taking the right colic artery and lymph node drainage in that area using a combination of sharp Harmonic and cautery dissection. Major vessels were controlled with hemostats and hemostasis secured with silk ties. Once the two mesenteric incisions were linked the right colon was removed from the field. There was no obvious bleeding. A side-to-side anastomosis was then carried out between the terminal ileum and the transverse colon using the GIA and TP60 staplers.
Suture lines were reinforced with interrupted silk sutures. Mesenteric defect was closed with interrupted sutures. These were returned to the abdominal cavity. Midline was then closed with running sutures of #1 PDS. Skin was closed with skin staples. Sterile dressings were applied. The patient tolerated procedure well. Blood loss was about 50 mL. She left the operating room in stable condition.

ICD-10-CM code(s): ________________________________

Case 11
Preoperative Diagnosis: Intussusception

Postoperative Diagnoses: Intussusception at distal ileum secondary to small bowel mass.

Indications for Surgery: The patient is a female with significant past surgical history for cholecystectomy, common bile duct exploration, and multiple hepatic abscess drainage; comes to the ER with more than 2 days of distended abdomen with signs and symptoms of small-bowel obstruction. On further investigation with the CAT scan, the patient was found to have a possible intussusception and after extensive counseling and answering all questions. The patient was consented and brought for an emergency laparotomy.

Operative Procedure: The patient was identified in the holding area; the surgery, the surgeon, and the consent were verified. The patient was brought to the operating room table and placed supine on the operating room table, secured with a safety belt, and time pass was done. Preop antibiotics were given. Venodynes were placed. Successful endotracheal intubation was done. The patient was draped and prepped in the usual sterile fashion and making a midline incision below the umbilicus, the peritoneal cavity was entered, made sure no injury was done to the underlying viscera. Once the peritoneal cavity was entered, there was found to be lot of ascitic fluid, which was suctioned off and on further examination, there was found to be an intussusception at the mid to distal ileum. The whole small intestine was run. The liver could not be palpated, because of adhesions. Once the whole small bowel was run and the intussusception was reduced, a small-bowel resection about 5 cm proximal to the lesion and 4 cm distal to the lesion was identified, and using a GIA stapler, the intestines were incised, and using an Atlas ligature, the mesentery was incised in a V-shaped manner including the lymph nodes. Once the specimen was marked with a silk suture marking the proximal end and taken off the table, a side-to-side anastomosis in a conventional standard 4-layer manner was done. The enterotomy was closed using running sutures. The whole intraperitoneal cavity was irrigated with copious amount of normal saline. At this time the instrument, the laps, and the needle count was correct, the fascia was closed using 0 PDS, and the subcutaneous tissue was irrigated. The previous scar tissue of the skin was excised. Staple was used to close the skin. Bacitracin was placed on the incision. Telfa was placed and the Mediport was placed on the incision. The patient tolerated the surgery well, was extubated, and transferred to the post anesthesia care unit to recovery in stable condition. Dr. A was present throughout the case.

ICD-10-CM code(s): ________________________________
Case 12

Operative Report

Procedure: Capsule Endoscopy

Indications for Procedure: A patient with a history of heme-positive stools, chronic anemia, history of iron infusion, who has had a “history of a negative upper and lower endoscopy. The patient has recently been diagnosed with pulmonary embolism and needs anticoagulation for this. We are asked to evaluate for occult gastrointestinal bleeding.

Informed consent was obtained from the informed patient, and it was decided to proceed with a capsule endoscopy. The patient swallowed the capsule on 05/19/2008.

Procedure Findings: The gastroesophageal junction was at 1 minute and 17 seconds. The first gastric image was at 1 minute and 18 seconds. The first duodenal image was captured at 23 minutes and 43 seconds.

At the 5 hours 57 minutes and 37 seconds, there was active bleeding noted. There was no underlying AVM or mass that can be visualized, secondary to intestinal debris visualized bleeding. The first ileocecal valve image appeared shortly afterwards at 5 hours 57 minutes and 42 seconds. The first cecal image was captured at 5 hours 58 minutes and 53 seconds.

Summary:

1. Multiple AVMs noted numbering 29 in all from D3 to the ileum.
   
   Twenty-seven of the AVMs were in the jejunum and the ileum. Some AVMs could have been missed secondary to intestinal debris obscuring the lumen for some of the exam.

2. Two flat white-appearing plaques of uncertain significance in the ileum at 2 hours 37 minutes and 17 seconds and 2 hours and 59 minutes. This could be possibly lymphangiectasia, and unlikely lymphoma.

3. Active bleeding in the ileum right above the ileocecal valve.

Recommendations:

1. Small bowel enteroscopy for ablation of AVMs.

2. Colonoscopy with intubation of the terminal ileum to assess the source of active bleeding in the ileum, for diagnosis and treatment.

3. Clears and GoLYTELY prep for the above.

4. Withhold Arixtra for 48 hours, as per discussion with the Hematology fellow on-call on 05/19/2008.

5. We will discuss images of the flat white plaque seen on the pill cam and clarify need for any further workup.

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Case 13
Title of Operation: Colonoscopy with bleeding control.

Indication for Procedure:

Description of Operation: After the explaining the risks of, benefits of, and alternatives to colonoscopy with bleeding control, informed consent was obtained from the informed patient. The patient was placed in the left lateral decubitus position. The Pentax 3470K was inserted through the rectum. Digital rectal exam was normal. The scope was inserted through to the sigmoid colon.

Findings: There was a large amount of fresh blood and clots in the rectum and sigmoid colon. As we approached the sigmoid colon, a large clot was seen in single diverticulum. The clot was washed and oozing was seen from the diverticulum. There was fresh bleeding from the single diverticulum; however, no visible vessel was seen. Epinephrine 1.5 ml was injected around the margin of the diverticulum as well as inside the diverticulum. Complete hemostasis was seen. The patient was observed and no further bleeding occurred. Due to patient discomfort as well as multiple surgical adhesions, it was difficult to pass the scope beyond 50 cm. Therefore, due to the patient’s discomfort as well as due to finding the source of bleeding, we did not proceed with a full colonoscopy. The scope was then completely withdrawn and the procedure terminated.

Postoperative Diagnoses: Scattered diverticula throughout the sigmoid colon with evidence of active bleeding from 1 diverticulum, status post injection of 1.5 ml of epinephrine.

Plan:

1. Keep patient NPO for 24 hours.
2. If patient rebleeds, re-administer 4 L of GoLYTELY prep via NG tube, and call GI follow for repeat colonoscopy.
3. Do not restart Coumadin for 48 hours minimum.
4. Give FFP to keep INR less than 1.5.
5. Avoid nonsteroidal and antiplatelet medications.
6. Check CBC q.6 hours and transfuse if hemoglobin less than 10.

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Case 14
Preoperative Diagnosis: Diarrhea; intermittent lower abdominal cramping.

Postoperative Diagnosis: Mild diffuse inflammation throughout the rectum and colon, most pronounced in the rectosigmoid; small hemorrhoids.

Operation: Total colonoscopy with biopsies.

Medications: Diprivan as per Nurse Anesthetist.
Findings: The Fujinon video colonoscope was passed without difficulty into the rectum and throughout the entire colon to the cecum. The instrument was withdrawn. The patient tolerated the procedure well.

Recommendations:

1. Await pathology results with further recommendations as soon as these are obtained.
2. The patient has already been given a course of Flagyl with no relief of symptomatology.
3. Asacol 2 po b.i.d. and this may need to be increased.
4. Bland, low fiber diet for now.
5. Levsin as ordered p.r.n.
6. Follow up in the office in approximately two weeks.

ICD-10-CM code(s) ______________________________________

Case 15

Procedure:

1. Colonoscopy.

64-year-old male.

Indications: History of colon polyps.

Informed and written consent were obtained prior to the procedure.

Medications:

1. Versed 2 mg IV.
2. Fentanyl 100 meg IV.

The patient received oxygen by nasal cannula at 3 liters per minute during the procedure. The patient received intravenous lactated Ringer's solution at 100 ml/hour during the procedure. During the procedure the patient had continuous monitoring of blood pressure, electrocardiogram, oxygenation, and pulse.

We utilized an Olympus video adult colonoscope. This was gently introduced into the rectum. The extent of the examination was to the cecum. Preparation was good.

Findings:

Photographs: Sigmoid colon and cecum.

Biopsies: None.

Complications: None.
**Condition:** Stable and alert.

**Impression:**
1. Small rectal prolapse.
2. Sigmoid colonic diverticulosis.
3. History of colon polyps.

**Plan:**
1. These findings were discussed with the patient.
2. Proceed to upper endoscopy.

**Procedure:**
2. Esophagastroduodenoscopy with biopsy.

64-year-old male.

**Indications:** Chronic gastroesophageal reflux.

Informed and written consent were obtained prior to the procedure.

**Medication:**
1. Versed 1 mg IV.
2. Lidocaine gargle.

The patient received oxygen by nasal cannula at 3 liters per minute during the procedure. The patient received lactated Ringer’s solution intravenously at 100 ml per hour during the procedure. During the procedure, the patient had continuous monitoring of blood pressure, pulse, electrocardiogram, and oxygenation.

We utilized an Olympus video upper endoscope. Intubation was carried out directly without complications.

**Findings:**
1. Esophagus: The Z-line was at 37 cm from the central incisors. At the gastroesophageal junction, the patient had two shallow, small ulcers which looked like pill ulcerations. The remaining esophageal mucosa was normal.

2. Stomach: The patient had a 4 cm hiatal hernia. There is minimal fluid in the stomach. The antrum was normal. J-retroflexion in the antrum revealed an incompetent gastroesophageal valve. The cardia fundus and corpus of the stomach were otherwise unremarkable.

3. Pylorus: Revealed normal mucosa.

4. Duodenum: The duodenal bulb was examined and revealed multiple shallow erosions consistent with non-steroidal anti-inflammatory drug use.
Photographs: Distal esophagus and cardia.

Biopsies: Distal esophagus in all four quadrants x 5.

Complications: None.

Condition: Stable and alert.

Impression:

1. Hiatal hernia.
2. Duodenitis consistent with NSAID drug use.
3. Distal esophageal ulcers consistent with pill ulcerations.

Plan:

1. We asked the patient to stop the use of ranitidine and to begin omeprazole 20 mg taken 30 minutes before his first morning meal daily.
2. These findings were discussed with the patient.
3. Await pathology.
4. The patient will follow up with his primary care physician.

The patient was observed in recovery for 30 minutes without incident prior to discharge home today with an accompanying adult.

ICD-10-CM code(s) _____________________________

Case 16

Operative Procedure: Flexible sigmoidoscopy.

Anesthesia: Local with a pre-op of morphine only.

The patient was placed in the left lateral position. Digital rectal is negative. A flexible sigmoidoscope is introduced, advanced through the rectum and sigmoid, there are a few chunks of stool residual from her prep, we negotiated around, and the stool is brown in color, no lesion seen. We maneuvered up to 40 cm. We started to see evidence of ulcerations and inflammation. The scope was advanced up to 45 to the max there. At 50, we did not get beyond the ischemic area, but it appears to end just proximal to 50 cm. We did random biopsies then through this area. Three or four biopsy sites were done. Withdrawing, there were no diverticula seen, no other lesions coming out.

ICD-10-CM code(s): _____________________________
Case 17
Preprocedure Diagnosis: Rapidly progressive dysphagia over the last couple of weeks

Postprocedure Diagnosis: Probable CA of the GE junction.

Description of Procedure: The scope was inserted. There was a piece of meat in his esophagus. It was small, maybe a cm in size. We passed on distally. There was an obvious obstruction. I was unable to pass my scope through. The lip of a hard tumor was noted at about 40 cm. We biopsied this and then I put a balloon down and tried to balloon dilate up to 12 mm of opening. I then deflated the balloon and pulled the scope out. He seemed to have discomfort from the dilation. We passed the scope through into the stomach. The stomach, pylorus, bulb, and postbulbar area looked normal. Retroflexion up from the diaphragm from below did reveal some blood coming down in small amounts from the GE junction. I could not see a definite mass within the cardia of the stomach. We withdrew the scope gradually across this. There is a 3 cm long tumor extending from 40 to 43 cm.

ICD-10-CM code(s): ____________________________

Case 18
Preoperative Diagnosis: Epigastric abdominal pain/dyspepsia, rule out peptic ulcer disease.

Postoperative Diagnosis: Epigastric abdominal pain/dyspepsia, rule out peptic ulcer disease. Severe proximal gastritis.

Description of Procedure: The patient was brought to the endoscopy suite via a stretcher. Informed consent verified. Patient was then placed in the left lateral position. Oxygen was administered by nasal cannula. Bite block was secured. Sedation was accomplished with Propofol. The gastroscope was then inserted and advanced under direct visualization to the second portion of duodenum. The endoscope was then slowly withdrawn with close circumferential inspection of while duodenum including the bulb, pylorus, gastric antrum, and body. The gastroscope was then carefully retroflexed in the gastric body to obtain the view of gastric annulus, fundus, cardia, and lower gastroesophageal junction. The endoscope was then straightened and slowly withdrawn with close examination of the stomach, gastroesophageal junction, and esophagus as the endoscope is being withdrawn from the patient. The patient tolerated the procedure well and was returned to the recovery area.

Findings: Normal examination of the esophagus with the GE junction at about 36 cm from the incisors. Gastric examination reveals severe gastritis involving the proximal stomach with some degree of chronicity with superficial erosions and nodularity and erythema, sparing the antrum. I obtained several biopsies from the proximal stomach and the antrum and sent in same container for histology. Duodenal examination to 3rd portion is unremarkable. Recommendation: Await biopsy report. If unremarkable, then patient will be scheduled for ultrasound of the abdomen, particularly the biliary system to make sure she does not have gallstone disease.

ICD-10-CM code(s): ____________________________
Case 19

Preoperative Diagnosis: Patient has a sizable tubular adenoma that has exophytic and sessile component in the low rectum, all tissue removed six months ago was benign. This is a follow-up examination as recommended.

Postoperative Diagnosis: Benign neoplasm rectum

Procedure: Sigmoidoscopy with submucosal injection and ablation of tumors.

Details of Procedure: The scope was inserted. I only did a flexible sigmoidoscopy here because I really wanted to look at this low rectal lesion and spend time on it and hopefully get it eradicated. It was in the same location as previously, perhaps again 2 1/2 cm, but this time relatively flat. I injected it with about 11 cc of saline and then I snared about four pieces off. It really was quite friable and was difficult even with it elevated with a saline injection to get a snare completely around it even in wedges to that after taking several pieces off I suctioned these, withdrew the scope and we sent this off for pathology and then we used Argon plasma coagulated therapy with a heat setting of 60 watts, I took pictures before I snared tissues, after I snared tissue, and then after the Argon plasma coagulator therapy. It looks to me like the entire area probably has been pretty well taken care of. We will await to see how things go. There was minimal bleeding and after burning I decided just to watch and allow it to clot on its own. This was a slow red ooze. The patient should tolerate this quite well. There was no sedation used so I will give her permission to leave shortly when she has expelled the air and will follow up with her. I think a repeat examination in six months again would be reasonable to look at and hopefully eradicate a nothing else that might be residual. I can't be certain that I got the full depth of this, but it was a good session and we will review the photographs with the patient and her daughters.

ICD-10-CM code(s): ________________________________

Case 20

Preoperative Diagnosis: Gastric cancer

Postoperative Diagnosis: Gastric cancer

Surgical Procedure: Near total gastrectomy

History: This patient is a 73-year-old woman who underwent endoscopy for GI bleeding, was found to have a poorly-differentiated linitis plastica type cancer of the stomach involving the antrum and distal body.

Procedure: The patient was brought to the operating room, placed on the operating table in a supine position. Satisfactory general anesthesia was obtained. The abdomen was prepped and draped in a sterile fashion. Midline skin incision was made extending from xiphoid to just below the umbilicus. By sharp and blunt dissection, the midline fascia was exposed. Fascia was opened, and incision extended to the full length of the skin incision with electrocautery. Peritoneum was explored. There was no evidence of any widespread metastatic disease. No evidence of any disease in the liver on the perigastric lymph nodes. Some of it was actually quite soft and pliable. The procedure was begun by taking down the greater omentum extending from the prepyloric are proximally along the greater curvature of the stomach until all of the greater omentum and greater curvature of the stomach has been mobilized up to the esophageal hiatus. The lesser sac
was opened, and the stomach was elevated. There were no adhesions posteriorly. There were no lymph nodes palpable in the celiac axis, and this was not dissected. Attention was then directed to the lesser curvature of the stomach, and again the lesser omentum was taken down very close to the liver, sweeping the lymph node bearing areas downward from the right gastric artery all the way down to the pylorus. The pylorus was then cleared of adherent fat and mesentery. Several branches of the gastroduodenal artery in that area coining into the pylorus were isolated and controlled with hemoclips. A small segment of duodenum just distal to the pylorus was cleared of adherent fat and mesentery and separated from the underlying pancreas. Small vessels entering that of the duodenum at that level were controlled with suture ligatures of 3-0 silk and small clips. Sufficient proximal duodenum was freed up to admit a TA-60 stapler. Duodenum was then divided using the TA-60 stapler and scissors, leaving an intact dual staple line on the duodenum. This was oversewn with interrupted 3-0 silk sutures. The stomach was no free essentially from the pylorus up to the gastroesophageal junction. A point was chosen at the place where the right gastric artery entered the wall of the stomach and approximately 1 cm of gastric wall at the level of mucosa and a small branch adjacent to the duodenum supplying that area intact. The sac was divided at the level with the TA-60 stapler. Stomach was removed from the field, leaving the small remnant in the proximal portion intact. A loop of jejunum was then delivered up in a retrocolic fashion until it reached to the gastroesophageal junction without tension. A point was chosen about 40 cm distal to the ligament of Treitz, and the jejunum was divided here with a loop up in place, so that it was certain that there would be enough jejunum and blood supply to reach without tension. Once this was accomplished, the proximal divided end of the jejunum was dropped back into the lower abdomen. The distal divided end was doubled back on itself and a J-pouch was created using the GL & stapler to create a pouch approximately 30 cm in length. This again reached quite easily up to the GE junction. The stomach remnant was then opened, and a 29 mm anvil for an EEA anastomosis was placed in that gastric remnant, and then enclosed with a pursestring suture. The EEA was introduced into the J-pouch. The spike was extended throughout the distal wall of the J-pouch at the highest point of the J. This was then linked to the anvil in the gastric remnant. EEA was closed and fired creating an end-to-end circular anastomosis at the GE junction with the J-pouch at its apex. The distal end was then oversewn then closed by hand using two layers, and then a running layer of 3-0 Vicryl suture and an outer layer of reinforced seromuscular 3-0 silk sutures. Distally, the previously divided proximal end of the jejunum which came down from the duodenum was anastomosed in a Roux-en-Y fashion to the jejunum at least 40 cm from the jejunal-esophageal anastomoses appeared patent. The midline was then closed with running sutures of #1 PDS, and skin was then closed with skin staples. A nasogastric tube had previously been passed into the J-pouch, and this was then secured at the patient’s nose to prevent movement and applied to suction. No drains were placed intra-abdominally. The patient tolerated the procedure well overall. Blood loss was approximately 250 cc. She did receive 2 units of packed red blood cells Intraoperatively, because she had been anemic prior to surgery. No other significant events occurred intraoperatively. She was taken directly from the operating room to the intensive care unit for recovery and he left ventilated overnight and extubated in the morning.

ICD-10-CM code(s): ____________________________
Case 21
Preoperative Diagnosis: Esophagitis

Postoperative Diagnosis: Hiatal hernia with erosive esophagitis

Procedure & Scope: Upper GI Endoscopy

Report: The patient was placed in the left lateral decubitus position and given 10 mg of fentanyl and 6 mg of intravenous Versed. An Olympus videoendoscope was introduced without difficulty. There was a small hiatal hernia present. A small erosion was also present at the gastroesophageal junction. Several small linear erosions were present more proximal to the gastroesophageal junction. The remainder of the stomach, duodenum, and end sweep were within normal limits.

Impression: Small hiatal hernia with evidence of erosive esophagitis.

ICD-10-CM code(s): ________________________________

Case 22
Preoperative Diagnosis: Colonic bleeding

Postoperative Diagnosis: Bleeding at the hepatic flexure, specific source not able to be identified because of spasm and blood

Procedure: Fiberoptic pancoloscopy

Procedure Details: After sedation with 25 mg and Versed 1 mg intravenously, and with the patient in the left Sims position, the fiberoptic colonoscope was inserted in the rectum and guided through a horribly redundant, convoluted, atonic colon. The sigmoid, ascending, and transverse colon were normal. We did not see any sign of any bleeding at the hepatic flexure. We encountered an area of intense spasm and some bright red blood was seen trickling through this area of spasm. After much manipulation, we were able to pass the scope through the area of spasm down into the right colon. The cecal pouch and ileocecal valve were normal. There was no evidence of any bleeding or any blood in the right colon until we pulled back up to the hepatic flexure and just around this. We once again encountered the area with old and a little bit of new blood. This did not appear to be brisk bleeding. The remainder of the colon was examined and the scope was removed. No further bleeding was seen in the proximal, transverse, and descending colon. This just seemed to be localized at the hepatic flexure. The instrument was removed. The patient was returned to the room awake, alert, and in good condition, tolerating the procedure well.

ICD-10-CM code(s): ________________________________
Case 23
Preoperative Diagnosis: Crohn’s disease with bowel obstruction

Postoperative Diagnosis: Crohn’s disease with bowel obstruction, with fistulas of the ileocecal area and of the more proximal ileum

Procedure: Laparotomy with extensive enterolysis and resection of cecum and resection of a loop of small bowel with an end ileostomy.

Details of Operation: After satisfactory preparation of the patient’s abdomen, midline incision was made and carried down to the intraabdominal cavity. The patient was found to have peritonitis and a culture was obtained. Extensive enterolysis was carried out; hernias were noted in the anterior abdominal wall. The patient was found to have a fistula of the ileum and marked inflammation in the cecal area. The fistulization took place into the omentum and the wall of the transverse colon. The adhesions were broken up. The distal ileum and cecum were resected. The ascending colon was stapled and tacked to the anterior abdominal wall with a 2-0 Proleene to make identification later easy for ileostomy closure. The extensive enterolysis of the small bowel was carried out and the entire small bowel was freed. The patient was found to have a tiny fistula of the distal ileum to the anterior abdominal wall. This segment of small bowel was resected and set separately. An end ileostomy was brought out through the right upper quadrant with a Brooke ileostomy and copious irrigation with over five liters of saline was carried out until the effluent came back clear. A culture had been obtained earlier. A Hemovac was introduced into the pelvis. The fascia was closed with #1 Prolene. It appeared that the patient had previously had GORE-TEX installed. The skin was closed with staples. The patient tolerated the procedure relatively well except for poor urine output.

ICD-10-CM code(s):

Case 24
Preoperative Diagnosis: Antral gastric ulcers, malignant neoplasm of cecum

Postoperative Diagnosis: Antral gastric ulcers, malignant neoplasm of cecum

Procedure: Right hemicolectomy with anastomosis

Indications: A 92-year-old female presented with anemia. She had a gastrointestinal evaluation with upper and lower endoscopy. She was found to have some antral gastric ulcers as well as a mass lesion in the cecum. Biopsies of the cecum revealed this to be an adenocarcinoma. She is undergoing right hemicolectomy for removal of the tumor. CT scan showed no definite evidence of metastatic disease.

Findings: The lesion was palpable in the cecum near the level of the ileocecal valve. There did appear to be some tumor extension to the serosal level over about a 0.5 cm area. The lymph nodes were palpable, not distinctly affected. No peritoneal implants or hepatic metastasis was seen.

ICD-10-CM code(s):
Case 25
Procedure Performed: Colonoscopy to the cecum with polyp snare end fulguration

Indications: This is a 58-year-old male with a history of rectal bleeding and a family history of colon polyps in his brother. I discussed with the patient the options of waiting for somebody from the anesthesia department to be available or proceeding and he was agreeable to proceed with Demerol and Versed.

Procedure in Detail: Demerol and Versed were given gradually over time until the patient was relaxed. Subsequently, the podiatric colonoscope was inserted into the rectum and passed without difficulty through the colon to the base of the cecum as identified by visualizing the appendiceal orifice and ileocecal valve. The colonoscope was slowly withdrawn examining the mucosa including a retroflex view of the rectum, which showed some small internal hemorrhoids. He had scattered left sided diverticula seen. There were three sessile polyps seen. At 45 cm, there was a 5 cm polyp that was fulgurated. In the ascending colon, there were two polyps. Each of them was cold snared. A 9 mm polyp, after being cold snared, could not be found. A 9 mm polyp, after being cold snared, was able to be sent for pathology. There was retained stool in some areas obscuring about 5 percent of the colonic mucosa.

Impression: Colon polyps at described above. Diverticulosis on the left side of the colon. Small hemorrhoids.

ICD-10-CM code(s): ____________________________

Case 26
Preoperative Diagnosis: Acute appendicitis
Postoperative Diagnosis: Acute appendicitis

Procedure Performed: Appendectomy

History: The patient is a 57-year-old, Hispanic female who developed lower abdominal pain that persisted. She sought medical and was sent over for a CT scan for concerns about appendicitis. CT scan was positive for early appendicitis with acute changes. I saw her in the emergency room and she was admitted to my service. She was prepped for the operating room. She was explained the procedure, the operative risks and consent was obtained.

Operative Note: The patient was brought to the operating room. She was placed in the supine position and given a general anesthetic. Her entire abdomen was prepped with Betadine scrubs and pain. Towels and drapes were placed in the usual sterile fashion. A small transverse incision was made in the right lower quadrant and carried down to Scarpa's fascia's fascia down to the level of the external fascia where this was scored. The muscle fibers were split and retracted with Army-Navy retractors and the internal oblique and transversalis were also retracted. The posterior peritoneum was elevated and opened the length of the incision. Retractors were then placed in the peritoneal cavity and exposure was completed. Numerous small bowel loops were apparent in the right lower quadrant and pelvis using small sponge sticks, these were pushed laterally. The cecum was found to be superior. It was free-floating and thus we had to pull it down into the surgical field. The appendix was identified and it was grasped with Babcock and pulled out through the wound superiorly and it was found to be edematous and elongated, consistent with acute appendicitis.
The mesoappendix was taken down between two clamps and 3-0 Surgilon ties and a 3-0 Surgilon pursestring was placed in the base of the cecum. The appendix was amputated the zero chromic tie. The appendix sent to pathology as specimen. The appendiceal stump was inverted and the pursestring tied and we secured the inversion with some interrupted 3-0 Surgilon Lembert sutures. Hemostasis was present. We thoroughly irrigated the pelvis and pericolic gutters bilaterally. The fluid was aspirated dry. The bowel was placed back in the abdomen and we proceeded to closed the peritoneum with running 3-0 Vicryl. The internal oblique was closed with 0 Vicryl and the external fascia was closed with 0 Vicryl interrupted sutures. The Scarpa’s fascia was reapproximated with some fine Vicryl and the skin was closed with a Prolene pullout stitch. Half-inch Steri-Strips, dry gauze and tape were placed over this and the patient was awakened and sent to the recovery room in good condition.

ICD-10-CM code(s): ________________________________

Case 27
Preoperative Diagnosis: Moderately hemorrhagic gastritis, positive occult stool
Postoperative Diagnosis: Moderately hemorrhagic gastritis, otherwise unremarkable EGD
Procedure: Diagnostic EGD
Indications: Hemoccult positive stool

Details of Procedure: The patient was placed in the left lateral position and sedated with Versed 2 mg IV. The Olympus video upper endoscope was introduced to the oropharynx and advanced to the second and third portion of the duodenum. The esophagus showed normal mucosa throughout without irritation or esophagitis. The Z-line was regular. Upon entering the stomach there was a hemorrhagic gastritis with submucosal hemorrhage noted throughout the gastric body. This was of moderate degree but appeared more than one would expect solely from NQ tube trauma. The antrum was free of erosions or ulcers. Retroflex view within the stomach showed a normal appearing cardia fundus and GE junction area. The duodenum appeared normal from bulb to distal duodenum. The scope was withdrawn and the patient sent to recovery.

Impression and Plan: The hemorrhagic gastritis could be the source of the patient’s hemoccult positive stool. At this point I would recommend increasing the Prevacid to b.i.d. dosing and consider decreasing the aspirin dosing from 325 mg daily to 81 mg if OK with cardiology. Clinically we can follow her counts.

ICD-10-CM code(s): ________________________________
Case 28
Preoperative Diagnosis: Lower GI bleed
Postoperative Diagnosis: Lower GI bleed secondary to hemorrhoids
Operative Procedure: Full colonoscopy
Details of Operation: After satisfactory IV sedation was obtained, a colonoscope was inserted into the patient’s rectum and advanced to the ileocecal valve. The ileocecal valve was identified and the scope was slowly retracted. All areas of mucosa were evaluated. There were no polyps, tumors or diverticula present. In the rectum prominent hemorrhoids were found. The hemorrhoids were the cause of the patient’s rectal bleeding. There was stage II to stage III hemorrhoids. Initial treatment should be preparation with suppositories.

ICD-10-CM code(s): 

Case 29
Preoperative Diagnosis: Colon cancer screening
Postoperative Diagnosis: Negative exam
Procedure: Screening colonoscopy
Procedure Details: The scope was inserted. The preparation was excellent. No residue was noted anywhere. We got the scope over to the cecum with a modest amount of difficulty. We saw a discrete appendiceal orifice and ileocecal valve. The cecum was normal. The right colon, transverse, descending, sigmoid, and rectum were all unremarkable. Retroflexion within the rectum from above was normal.
Impression: Negative examination of the colon. Screening examination.

ICD-10-CM code(s): 

Case 30
Preoperative Diagnosis: Anemia and duodenal mass
Postoperative Diagnosis: Duodenal polyp
Procedure: Esophagogastroduodenoscopy with removal of a duodenal polyp using electrocautery snare.
Operative Procedure: After satisfactory IV general anesthesia was obtained, a gastroscope was inserted into the patient’s esophagus and advanced to the second portion of the duodenum. The patient was found to have an 8 mm polyp that was removed with electrocautery snare and it was submitted to pathology. The patient tolerated the procedure well.

ICD-10-CM code(s): 

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Case 31
Preoperative Diagnosis: Rectal bleeding, colitis, diarrhea

Postoperative Diagnosis: 1. A 1.5 cm sessile ascending colon polyp removed with saline assisted polypectomy technique. 2. Transverse colon polyps removed. 3. Left colonic diverticulosis. 4. Rectal stricture without symptoms of obstruction. 5. Mild rectal erythema.

Procedure Performed: Colonoscopy with standard polypectomy, hot biopsy polypectomy, and endophotography.

Operative Procedure: After informed consent was obtained, the patient was put in the left lateral decubitus position. The patient received a total of 280 mg of propofol and 100 mg of Lidocaine IV infusion throughout the procedure administered by Anesthesiology. Perianal inspection revealed no abnormalities of evidence of anal fissure or fistulae. There were no rectal masses palpable. Next, the tip of the Olympus PCF-H180AL video colonoscope was inserted into the rectum and advanced under visual guidance to the cecal pouch where the ileocecal valve and appendiceal orifice were identified. The videocolonoscope was then advanced through the ileocecal valve into the terminal ileum. The terminal ileum appeared normal. The endoscope was then withdrawn to the cecum. The colon prep was good. Careful inspection upon withdrawal revealed normal-appearing mucosa in the cecum. In the ascending colon there was a 1.5 cm sessile nodular flap polyp. The polyp was removed with saline assisted polypectomy technique by first injecting the base of the polyp with saline and raising the polyp up on a submucosal cushion of edema. Next the polyp was removed by standard polypectomy and submitted for histologic assessment. No other abnormalities were present in the ascending colon. The hepatic flexure appeared normal. In the transverse colon there was a 4 mm sessile colon polyp and a 2 mm sessile colon polyp both removed with hot biopsy forceps and submitted for histologic assessment. The splenic flexure appeared normal, in the descending colon and sigmoid colon there were scattered diverticula present. In the rectum at 5 cm there was a rectal stricture that was well healed and widely patent. There was mucosal erythema of the rectum. Except as noted above, there was no evidence of polypoid lesions, neoplastic masses, mucosal vascular changes, or diverticular openings identified. Retroflexed view in the rectum demonstrated no evidence of enlarged Internal hemorrhoids. There was no evidence of inflammatory disease or fistulous openings. The videocolonoscopy was straightened and withdrawn thus completing the procedure. The patient tolerated the procedure well and was transported to her room in stable condition.

ICD-10-CM code(s): __________________________________

Case 32
Preoperative Diagnosis: Anal fistula

Postoperative Diagnosis: Anal fistula, intersphincteric

Procedure: Fistulotomy, placement of seton.

Procedure Details: The patient was prepped and draped in the usual fashion under general anesthesia in the prone position. The fistula was identified. Previous seton was removed. It was intersphincteric. The sphincter was divided partially and then another seton was placed. The patient tolerated the procedure well.

ICD-10-CM code(s): __________________________________
Case 33  
Procedure: Esophagogastroduodenoscopy  

Indication for the Examination: Atypical chest pain  

Postoperative Diagnosis: Atypical chest pain  

Description of Procedure: In the left lateral decubitus position, a Fujinon video gastroscope was passed with the following findings: 1) Hypopharynx: The epiglottis, arytenoids, and vocal cords were normal. 2) Esophagus: The upper esophageal sphincter region was normal. The mucosa of the shaft showed no evidence of esophagitis or man's lesion. The scope was advanced into the gastric body and retroflexed. Cardioesophageal junction was normal. In the dependent portion of the body of the stomach, there was partially undigested food. The patient last consumed food 3:00 p.m. the day preceding. The portion of the greater curvature beneath the partially digested food could not be seen; however, the mucosal folds of the cardia and body were normal. The antral mucosa was normal. The duodenal bulb and post-bulbar duodenum were normal. There was no evidence of outlet obstruction. The stomach demonstrated normal mucosal fold regarding shape, contour and size. Biopsies were taken of the second and third portions of the duodenum. Biopsies were taken of 4 quadrants of the gastric antrum. Biopsies were taken of the distal, mid, and proximal esophageal body. He tolerated this well and was sent to recovery in satisfactory condition. He will be discharged home to follow up with me pending receipt of biopsies. It would appear that there may be an element of gastroparesis based on findings of partially digested food. Consider gastric empty study in the near future.

ICD-10-CM code(s): ________________________________  

Case 34  
Preoperative Diagnosis: Perforated viscus with acute surgical abdomen  

Postoperative Diagnosis: 1. Perforated prepyloric ulcer 2. Diffuse peritonitis  


Description of Procedure: The patient was taken to the operating room and placed on the operating table in supine position. Following the induction of satisfactory general endotracheal anesthesia, the patient’s abdomen was prepped with Betadine solution and draped in the usual sterile fashion. A nasogastric tube and Foley catheter had been placed prior to transport to the operating room. Sequential compression devices were applied to both lower extremities. The patient’s abdomen was then prepped with Betadine solution and draped in usual sterile fashion. A longitudinal midline skin incision was then made from the xiphoid process just below the umbilicus. Incision was carried down through the subcutaneous tissue using electrocautery. The fascia of the linea alba was divided longitudinally using electrocautery. There peritoneum was entered sharply divided throughout full length the incision. Upon entering the abdominal cavity, a significant gush of air escaped. The abdominal cavity was then explored and findings include a 2-cm perforated prepyloric ulcer, which appeared to be fairly chronic in nature. There was a diffuse spillage of the abdominal cavity. This fluid was swabbed for culture and sensitivity. The liver appeared normal. The gallbladder did not appear to be acutely inflamed. It did not contain any obvious stones. The small bowel was run from the ligament of Treitz to cecum and was
without abnormality. The appendix was normal. The large bowel was without abnormality. The peritoneal fluid was suctioned away and the abdominal cavity was irrigated profusely with several liters of sterile saline solution, this irrigation process involved irrigating the subhepatic spaces and pelvis. It should be noted that there was no evidence of diverticular disease or colonic perforation. Attention was then directed to a Graham patch closure of the perforated prepyloric ulcer. A tongue of omentum was brought up over the ulcer crater and circumferentially secured to the margin of the ulcer using 3-0 silk suture ligatures in a sterile semicircular fashion. Once this was completed, the nasogastric tube was positioned in the antrum of the stomach. The abdominal cavity was then irrigated with additional liters of sterile saline solution followed by 1L sterile triple antibiotic solution. The abdominal contents were placed back in the anatomical positions. The fascia linea alba was then approximated using a running III PDS. The subcutaneous tissue was irrigated with sterile triple antibiotic solution and hemostasis was assured using electrocautery. The skin was closed using skin staples, sterile gauze dressing was applied, secured with longitudinally placed Medipore tape. The patient was then transported to the Intensive Care Unit in stable condition. He was moderately hypotensive at times in the operating room and was resuscitated during the procedure with intravenous crystalloid and Colloid. He otherwise tolerated the procedure well. There are no apparent complications. Sponge and needle counts were reported to be correct by the nursing staff.

ICD-10-CM code(s):
________________________________________

Case 35
Preoperative Diagnosis: Metastatic tumor left upper quadrant

Postoperative Diagnosis: Metastatic tumor left upper quadrant invasive into two loops of small bowel

Operative Procedure: Laparotomy with resection of two loops of small bowel with end-to-end anastomosis and resection of a metastatic tumor to the diaphragm.

Details of Operation: After satisfactory prep and drape of the patient’s abdomen, a left subcostal incision was made and carried down to the anterior abdominal cavity. A hard mass was palpated in the left upper quadrant consistent with carcinoma. There were extensive adhesions to the area and two loops of small bowel were adherent to the tumor mass. They had invasive cancer in both. The loops were dissected out and two separate portions were resected and submitted to pathology. The continuity was achieved with end-to-end anastomosis with inner row of 3-0 and outer row of Interrupted 3-0 silk sutures. Attention was returned to the patient’s mass which was adherent to the diaphragm and left flank wall. The tumor was excised and submitted to pathology. No palpable tumor existed afterward. Hemostasis was obtained with electrocautery and 3-0 chromic. Mesenteric defect was closed with 2-0 chromic. The fascia was closed in two layers with #1 PDS suture. Skin Hemovac had been introduced and was sutured in place. The skin was closed with 4-0 Prolene. An On-Q pump was introduced. The patient tolerated the procedure well.

ICD-10-CM code(s): __________________________________________