

ICD-10-CM Specialty Code Set Training Urology

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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Coding Cases

Case 1

Preoperative Diagnosis: End-stage renal failure.

Postoperative Diagnosis: End-stage renal failure

Operation: Cadaveric kidney transplant.

Anesthesia: General endotracheal

Findings: See below.

Specimens: None. Prior to transporting the patient to the operating room, a history and physical was completed. Consent was obtained after full discussion of plans for kidney transplantation, cystoscopy, and potential complications including, but not limited to; technical loss of the organ, dysfunction following revascularization, rejection, infection, thromboembolism, medication reactions, mortality risk, protocols of care, and expected outcomes. The alternative of medical or dialysis management instead of transplantation was also reviewed. The suitability of the kidney for transplantation was addressed by backbench surgery and inspection separately documented. The patient's prior urological circumstances were discussed with Dr. Urology who performed cystoscopy following anesthesia induction, also separately documented. The cross-match was reported to be negative with read back and ABO, type of the donor organ, and recipient was confirmed. The appropriate prophylactic antibiotics were ordered to begin within 1 hour of the start of surgery and to end within 24 hours of completion of transplantation. The patient was taken to the operating room where a time-out was taken to confirm the patient identity, correct site of surgery, accuracy of and signature on the consent forms, agreement with all in the operating room on the procedures to be carried out, appropriate positioning, the need to administer antibiotic fluid for irrigation, a review of any precautions which may be based on past history or medication use, and donor organ labeling to insure the appropriate organ for this patient. Pre-anesthetic testing as well as operative plans was reviewed with the anesthesia service. After Dr. Urology had performed cystoscopy and advised us of the suitability of the urethra and the bladder, and after Dr. Anesthesia and staff had placed a right internal jugular line without noted problem, the patient was positioned appropriately and the abdomen was prepped and draped. A right lower quadrant curvilinear incision was carried out. Bovie cautery was used to control bleeding and to open the subcutaneous and musculofascial layers. Because the bladder had been quite small, I elected to extend the incision a little further medially than usual. Epigastric vessels were ligated in continuity and divided. Retractor blades were placed and there was excellent exposure to the entire iliac fossa. Dissection began by dividing tissues over the bladder dome. These tissues were quite vascular and were controlled in continuity with 3-0 silk ties prior to their division. This allowed a fairly large area of the rather small bladder dome to be exposed for later surgery. The external iliac artery and vein were dissected from surrounding structures without noted problem. The circumflex iliac vein was ligated in continuity before being divided. There was adequate length for these vessels. The kidney was brought from the back table. It was a right kidney with a single artery and vein and a duplicated collecting system. We had extended the vein with venous anastomosis and begun ureteric surgery as documented in a prior dictation. A partial occluding clamp was placed on the

external iliac vein and venotomy performed. The extended renal vein was sewn to the external iliac end-to-side using 5-0 Prolene suture, over-and-over technique. Clamps were then placed on the external iliac artery and arteriotomy performed and extended with a 5 mm punch. The trimmed renal artery was sewn end-to-side to the iliac using 5-0 Prolene suture, over-and-over technique. Bulldog clamps were placed on both renal vessels and clamp removed from the iliacs. There was no bleeding at the anastomosis. All clamps were removed and there was an immediate and even perfusion of the kidney. The ureter bled, tiny amounts of filtrate were made within a matter of minutes. The anastomotic time was 22 minutes. The kidney was found to have the best lie in a horizontal position, and 2 pexing sutures were placed to keep the kidney in that position after hemostasis was assured. The bladder was then opened between stay sutures and inspected. It was slightly hemorrhagic in the mucosa. The twin ureters were trimmed for length and a single suture was placed to approximate these structures. We then used each ending that double-arm suture to sew the heel of the ureteric complex to the bladder using over-and-over technique to the right and to the left, so that there was essentially a double orifice but single anastomosis. A single suture of 6-0 PDS was used to approximate the dome of the two ureters and only 2 bites of suture were required to do this. I was quite pleased with this anastomosis and we assured ureteric and Foley catheter patency prior to completing it. The ureteric complex and the bladder mucosa were then placed into a short tunnel created with a figure-of-eight suture of 3-0 Prolene, the ends of which were left long. Copious irrigation with antibacterial solution was undertaken, as it had been throughout the entire case. Bleeders were searched for and none were found. With retractor blades removed, inspection of all areas again was undertaken. There was no clamp damage to any vessels. The kidney appeared to have an excellent lie and good perfusion. The musculofascial layers were approximated using a running 0 PDS suture. Marcaine anesthesia was instilled in suprafascial layers for postoperative pain control. Subcutaneous tissues were approximated with 3-0 absorbable suture and the skin was closed with a running 4-0 Monocryl using a plastic technique. Dry sterile dressing was placed over antibacterial ointment. Sponge, needle, and instrument counts were reported to me as correct. The procedure recorded is kidney transplant with cystoscopy. Specimens were not obtained and there were essentially no equipment problems to be addressed. Key concerns for recovery and management were reviewed prior to leaving the operating room.

ICD-10-CM Code: _____

Case 2

Subjective: The patient is a 26-year-old female who presents for follow up of left sided renal calculi. The patient was originally seen in the emergency room down state for left sided flank pain. She was found to have an obstructing renal calculi on CT stone protocol per the patient. We do not have those records available here. Again, the patient was seen here in the office by Dr.X. who did refill her Vicodin, Flomax, and a 14 days prescription of Cipro 500 mg to prevent pyelonephritis. A culture was also done at that time and grew beta hemolytic strep greater than 100,000 organisms. In the office today the patient continues to have colicky left sided flank pain, continued chills, nausea, and loss of appetite. She has no documented fevers and no vomiting. She has 1 day left of Flomax and 8 days left of Ciprofloxacin. The patient is out of Vicodin. The patient has been increasing her smoking use, she is up to 1/2 pack per day. She is waking up with chest discomfort, tightness, and shortness of breath. She has recently found herself smoking in front of one of her children and she has decided that she needs to quit smoking.

Objective: Blood pressure is 140/70, weight is 101.36 kilograms. Heart regular rate and rhythm, no murmurs. Lungs are clear to auscultation bilaterally. Abdomen has positive bowel sounds times 4 quadrants. There is CVA tenderness and left lower quadrant pain on palpation. There is no guarding and no rebound tenderness. Skin is clean without rashes, erythema, or jaundice.

Assessment: Left nephrolithiasis. Urinary tract infection with beta hemolytic strep. Tobacco abuse, uncontrolled

Plan: The patient will stop her Ciprofloxacin. A prescription for amoxicillin 850 mg p.o. b.i.d. times 7 days. Vicodin 5/500 1 to 2 p.o. every 4 hours p.r.n. pain, #60 were given with no refills. Chantix. The side effects were discussed with the patient, as well as instructions for taking this with food. The patient was also encouraged to take this medication after she passes her kidney stone. The patient was encouraged to continue to strain for her stone.

ICD-10-CM Code: _____

Case 3

Preoperative Diagnosis: Chordae without hypospadias.

Postoperative Diagnosis: Chordae without hypospadias.

Procedure Performed: Straightening of chordate. Transposition of foreskin with creation of mucosal collar. Simple scrotoplasty. Penile block

Anesthesia: General endotracheal, caudal block, and penile block.

Findings: Dense dysgenetic bands of dartos tethering the ventral corporal bodies.

Estimated Blood Loss: Negligible.

Indication for Operation: The patient is an 11-month-old male with congenital chordae without hypospadias who presents for surgical repair.

Procedure in Detail: After informed consent was obtained, the patient was brought to the operating suite and placed supine on the operating room table. General endotracheal anesthesia was induced. The patient was turned to the lateral position and a caudal block performed by Anesthesia. He was returned to the supine position. The patient was administered IV Cefazolin. The lower abdomen and penoscrotal region were sterilely prepped and draped in the usual manner. The dorsal foreskin was manually reduced from the glans. A glans retraction suture was placed. An incision was made ventrally on the penis transversally and similarly a mucosa incision was made proximal to the glans. This was carried circumferentially to create a mucosal collar. Retraction sutures were placed on either side of the ventral penile skin, which was severely deficient. Similarly retraction sutures were placed on the dorsal foreskin. The penis was then degloved circumferentially. Once the penile skin was released, there was still severe curvature of the ventral penis. This was due to dense dysgenetic bands of dartos. These were excised from the corporal bodies on either side to allow both lengthening and straightening of the penis. These dysgenetic bands were actually circumferential and they were released from the penis both dorsally and ventrally. Fixation of the penopubic and penoscrotal junctions were then performed with 5-0 clear Nylon placed through the dartos and Scarpa's fascia into the corporal bodies on both the dorsal

and ventral aspects. After recreation of the penopubic and penoscrotal angles, and straightening of the penis, attention was turned to redistribution of the foreskin due to deficiency of the penile skin. The foreskin was divided in midline until the penile skin approximated the mucosal collar. It was then approximated with interrupted 7-0 Vicryl suture dorsally. The resultant flaps were brought around ventrally. Due to the extensive dissection ventrally, the incision had been carried down to the scrotum. The flaps were trimmed in midline and then the scrotal raphe and penile raphe were recreated with 7-0 Vicryl suture after several deep 7-0 Vicryl sutures had been placed. The mucosal collar was trimmed in midline and then reapproximated with running 7-0 Vicryl suture. The penile skin was approximated to the mucosal collar ventrally with interrupted 7-0 Vicryl. The excess foreskin was trimmed on either side and then approximated the mucosal collar with 7-0 Vicryl in an interrupted fashion. A complex penile dressing was placed. This was comprised of Owens gauze soaked in Benzoin and wrapped around the penis, followed by Coban wrapped around the penis, secured in place with Trans-Pore tape. The patient's bladder was drained with a #8 French sugar Firlit catheter. While the bladder was draining, a penile block was performed with 1/2 percent Marcaine injected under the pubic arch. The catheter was removed. The patient was awakened from general anesthesia. He was transferred to the post anesthetic care unit in stable condition.

ICD-10-CM Code: _____

Case 4

Preoperative Diagnosis: Prostate carcinoma.

Postoperative Diagnosis: Prostate carcinoma.

Procedure: Robotic-assisted radical prostatectomy

Anesthesia: General.

Complications: None

Drains: A 20 French Foley catheter and a 1 cm Jackson-Pratt drain in the pelvis.

Condition: Patient to recovery room in stable condition.

Indications for the Procedure: The patient is a 67-year-old white male with prostate carcinoma now admitted for robotic prostatectomy. The patient understands all the risks of the procedure including bleeding, infection, bowel, vessel, bladder injury, urinary incontinence, urinary retention, erectile dysfunction and is now brought for surgery. Patient also has a umbilical hernia. We will repair this at the same time.

Procedure in Detail: Patient brought to the operating room, prepped and draped in the usual sterile fashion in the dorsal lithotomy position. A small supraumbilical incision was made. This was carried down through the skin and subcutaneous tissue. The fascia was opened. There was a large amount of omentum that was into his umbilical hernia. This was transected. The remaining part of the omentum was removed from the umbilical hernia. There was no bowel in the umbilical hernia. Camera trocar was inserted. Da Vinci ports and working ports were placed in their standard position. Retroperitoneal space was entered by taking down the bladder flap anteriorly. Prostate was identified. The endopelvic fascia on either side of the prostate was incised. The puboprostatic ligaments were left intact. Dorsal venous complex was secured with a #1 Vicryl in a figure-of-eight

fashion and tied anteriorly to help with postoperative continence. The anterior bladder neck was then transected. Foley catheter balloon was deflated and brought into field using retractor of the 4th arm. Posterior bladder neck was transected. Both ureteral orifices were set back. Seminal vesicles were dissected out to their tips and transected. Vas were cauterized and transected. Lateral pedicles of the bladder neck were taken down with clips and sharp dissection. Prostate was dissected off the rectum. The dorsal venous complex was transected. The urethra was transected, and the specimen was placed into a lap bag. Bladder neck urethral anastomosis was undertaken using a running 2-0 Monocryl after the bladder neck had been closed with a 2-0 Monocryl. JP drain was placed in the pelvis. The anastomosis was watertight. All port sites were removed under direct vision. There was no bleeding seen. The umbilical hernia site was closed with #1 Vicryl as well as the remaining part of the fascia after the lap bag was removed. Clips were placed on the skin, a sterile dressing was applied. Patient was taken to recovery room in stable condition.

ICD-10-CM Code: _____

Case 5

Preoperative Diagnosis: Urinary retention and urinary frequency

Postoperative Diagnosis: Urinary retention, urinary frequency, abdominal mass

Name of Operation: Cystoscopy, hydrodistension of bladder, Gravity cystogram

Indications: The patient is a 20-year-old female with a history of episodes of urinary retention. She also has urinary frequency and is undergoing evaluation.

Description of Procedure: After the appropriate permits were signed the patient was taken to the operative suite. After the successful induction of monitored anesthesia care using sedation with IV meds, the patient was placed in the lithotomy position. The perineum was prepped and draped the patient was placed in the lithotomy position. The perineum was prepped and draped in the normal sterile fashion with Betadine scrub and prep. The cystoscope was introduced per urethra. She had normal anatomic configuration. Upon entry into the bladder there was a mild trabeculation and mild hyper-erythematous vascularity but no discrete lesions or ulcers. Both ureteral orifices were in their normal anatomic position. They had a slight stadium appearance, but did not have any obvious reflex characteristics to them. There were no mucosal lesions to suggest neoplasia. There were no bladder diverticula. The bladder was hydrodistended but easily tolerated 600 cc and had not reached capacity. The bladder was then drained. There was no terminal hematuria and no punctuate lesions were visible. A Foley catheter was introduced back into the bladder, and with gravity filling, contract material was instilled into the bladder up to 600 cc to its natural capacity. Under fluoroscopic imaging, there was no obvious reflux. The bladder has normal contour. There did not appear to be a soft-tissue mass extending in the midline up along the left paracolic side which deviated all the bowel contents to the right upper quadrant and right side of the abdomen. On palpation, there did seem to be a soft tissue mass in the abdomen; however it had no pulsatile nature. With the bladder completely drained, the soft tissue density on fluoroscopy was still present and has been present even before administration of any contract material. This was felt to represent the soft tissue mass and will need further evaluation with CT scan. The bladder was drained through the Foley and the Foley was then removed. There was no bleeding. The patient tolerated the procedure without difficulty.

ICD-10-CM Code(s): _____

Case 6

Preoperative Diagnosis: End-stage renal disease, need for hemodialysis access long term.

Postoperative Diagnosis: End-stage renal disease, need for hemodialysis access long term.

Indication for Procedure: End-stage renal disease, need for hemodialysis access long term.

Procedure: Left radiocephalic AV fistula creation.

Description of Procedure: Under IV sedation, the patient's left arm was prepped and draped in the usual sterile fashion. A longitudinal sigmoid incision on the distal left wrist was made. Dissection was taken through subcutaneous tissues. The cephalic vein at the wrist was a good quality. Medial to this, the radial artery was exposed and encircled with vessel loops and 3,000 units of IV heparin was given. The cephalic vein was ligated distally with 3-0 silk tie, and the vein was transected, and it immediately identified some fresh thrombus. Thrombus was removed, and we got some weak back bleeding. The patient had an IV in this cephalic vein slightly proximal in the arm, about 2 inches above the level of the incision. I passed a #2 Fogarty, withdrew just a tiny bit of fresh thrombus, and got some back bleeding. I flushed it copiously with heparin saline irrigation. Because the vein was of such good quality, it was decided to go ahead and use it and that the arterialization of this would occur and probably keep it open without problems. The vein was spatulated and sewn to the radial artery, after making a longitudinal radial arteriotomy. This was sewn with a running 7-0 Prolene suture. Vascular control was released. The fistula had a nice thrill. The anastomotic line was hemostatic. The wound was closed with 3-0 Vicryl suture and 4-0 nylon vertical mattress suture. Dressing was applied. The patient tolerated the procedure well.

ICD-10-CM Code(s): _____

Case 7

Preoperative Diagnosis: Metastatic left testicle cancer.

Postoperative Diagnosis: Metastatic left testicle cancer.

Operation Performed: Insertion of port catheter by Dr. Jones radical left orchiectomy by Dr. Lloyd-Smith.

History: This 27-year-old gentleman presents with metastatic testicle cancer. There are pulmonary and retroperitoneal metastases. Dr. Jones & Dr. Smith are aware of the patient's preoperative presentation. Dr. Jones placed a port catheter at the start of this operation, and he will be dictating a separate operative report.

Procedure: Under general anesthesia, the patient's left inguinal region was prepped and draped. The scrotum was also prepped and draped into the field. There was a very large tumor occupying the left scrotum. A transverse incision was made in the left inguinal region. Subcutaneous tissue was divided. External oblique fascia was opened, and the ilioinguinal nerve was preserved. The cord for the left testicle was identified, and a 1/4-inch Penrose drain was placed in an occlusive manner around the left cord to the testis. The left testicle was then mobilized out of the left scrotum and with mild difficulty, eventually it was delivered into the wound. The testis was so huge that this made delivering the testicle somewhat difficult. The wound was thoroughly irrigated with antibiotic irrigation. The left cord was identified and 2 transfixation sutures with #1 chromic suture were

placed at the level of the internal inguinal ring. The cord was then divided. The testicle was then sent to pathology for immediate processing. The wound and fascia were injected with 0.25 percent plain Marcaine. The external oblique fascia was closed with running 2-0 PDS suture. The wound was re-irrigated, and subcutaneous tissues were reapproximated with three 4-0 Vicryl sutures. Skin was closed with running subcuticular 4-0 Monocryl suture. Steri-Strips were applied. A light dressing was applied. The patient tolerated the procedure well and left the operating room in good condition. The patient will be seen in follow-up through our clinic in 1 week.

ICD-10-CM Code(s): _____

Case 8

Chief Complaint: STD Exposure.

History of Present Illness: 33-year-old male patient presents with dysuria and also mild burning without urination. The onset was 2 days ago. The course/duration of symptoms is constant. Radiating pain in the lower back and superpubic “a little crank”. The character of symptoms is dull. Associated symptoms are urethral discharge. I did not see discharge, but wetness in pants with urination. Denies fever, denies chills and denies rash. Additional history: sexual history unprotected intercourse and patient’s partner here to be tested also.

Review of Systems: CONSTITUTIONAL: No fever, no chills, no sweats ENMT: No ear pain, no sore throat, no nasal congestion Gastrointestinal symptoms: No nausea, no vomiting. Additional review of 14 systems information: All other systems reviewed and otherwise negative.

Allergies: No known allergies

Medications: None

Immunizations: Tetanus up to date, 2months

Past Medical/Family/Social History: Medical History: Genitourinary sexually transmitted disease, gonorrhea. Patient denies any other past medical history. **SURGICAL HISTORY:** Patient denies any surgical procedures. **FAMILY HISTORY:** Diabetes mellitus. **SOCIAL HISTORY:** Alcohol use: occasional. Tobacco use: 2 cigarettes per day. Drug use: occasional. Occupation: Employed.

Examination: VITAL SIGNS: 5/30/2010 13:25 BP 132/65, HR 66 bpm, R 16, O₂ Sat 100 percent Room Air, Temp 36.4C **GENERAL:** Alert, no acute distress. **SKIN:** Warm, dry. **HEAD:** Normocephalic, atraumatic. **NECK:** Supple, no tenderness. **EYE:** Pupils are equal, round and reactive to light, normal conjunctiva. **EARS, NOSE, MOUTH AND THROAT:** Oral mucosa moist. **CARDIOVASCULAR:** Regular rate and rhythm, no murmur. **RESPIRATORY:** Lungs are clear to auscultation, respirations are non-labored. **GENITOURINARY:** Penis very moist penile head with stickiness, no swelling, no erythema. **LYMPHATIC:** Groin Left, inguinal, lymphadenopathy. **MUSCULOSKELETAL:** Normal ROM, normal strength, no tenderness. **PSYCHIATRIC:** Cooperative. Alert and oriented to person, place, time, and situation.

Medical Decision Making:

LABS: POCT Blood Glucose, **URINE:** COLOR YELLOW, CLARITY CLEAR Specific Gravity Urine 1.028 Hip Urine Random 6.5Protein Urine Qualitative TRACE mg/dL ABN Glucose

Urine Qualitative NEGATIVE mg/dL Ketone Urine Qualitative NEGATIVE mg/dL Blood
 Urine Qualitative NEGATIVE Urobilinogen Urine Qualitative 2.0 mg/dLNitrate Urine
 Qualitative NEGATIVELeukocyte Esterase Urine Qual NEGATIVEBilirubin Urine Qualitative
 NEGATIVEUWBC <1 RBC - 2 /HPFMUCOUS - 3+ ABN PHARMACY: Rocephin 125 mg, IM,
 injection, Once, Routine, Azithromycin 1 gm, PO, tablet, Once, Routine

Impression: Urethritis

Plan: Will treat empirically due to lymph node enlargement and penile moisture. Patient was given the following educational materials: URETHRITIS, Male (Infec. vs. Inflam.), Adult. Follow up with: Follow up with primary care provider as needed. Call for test results on Monday night. If positive, you have already been treated, but need to discuss with partner negative pons chemical or other cause. Need to see your PCP for continued care and evaluation of symptoms. Counseled: Patient regarding diagnosis, diagnostic results, and treatment plan. Patient indicated understanding of instructions. STD prophylaxis: Accepted. Notes: Pt verbalized understanding of discharge instructions and was discharged via ambulation.

ICD-10-CM Code(s): _____

Case 9

Chief Complaint: Dysuria.

History of Present Illness: The patient is a 24-year-old female who presents with a complaint of abdominal pain and dysuria for 2 days. The exacerbating factor is exertion. The mitigating factor is rest. LMP date: 5-18-2010. No nausea, vomiting, or diarrhea.

Past Medical/Family/Social History: MEDICAL HISTORY: Reviewed as documented in chart. Cardiac: no hypertension, Diabetes: no diabetes mellitus type 2. SURGICAL HISTORY: Reviewed as documented in chart FAMILY HISTORY: Reviewed as documented in chart SOCIAL HISTORY: Reviewed as documented in chart, Alcohol: Denies alcohol use, Tobacco: Denies tobacco use, Drugs: Denies IVDU, Family/social situation no abuse concerns.

Review of Systems: CONSTITUTIONAL SYMPTOMS: General weakness, no fever, no chills. CARDIOVASCULAR SYMPTOMS: No chest pain. RESPIRATORY SYMPTOMS: No shortness of breath, no stridor. GASTROINTESTINAL SYMPTOMS: No nausea no hematemesis, no hematochezia. GENITOURINARY SYMPTOMS: Dysuria, no Hematuria. EYE SYMPTOMS: No recent vision problems, no icterus, no discharge. ENT: No sore throat. MUSCULOSKELETAL SYMPTOMS: Muscle pain. NEUROLOGIC SYMPTOMS: No speech problems. ALLERGY/ IMMUNOLOGIC SYMPTOMS: Allergies as noted> PSYCHIATRIC SYMPTOMS: No anxiety, no hallucinations, not homicidal. ENDOCRINE SYMPTOMS: Polyuria, no cushingoid, no galactorrhea

Other significant Review of Systems: All other systems reviewed and otherwise negative.

Allergies: No known allergies.

Immunizations: Per nurse's notes.

Examination: VITAL SIGNS: Temp 36.1C, BP 104/61, HR 79, RR 16, O₂ Sat 100 percent Room Air. GENERAL APPEARANCE: Moderate distress. SKIN: No rash. FACIAL: No bony stepoffs, no bruises. SCALP: No deformity. NECK: Supple, trachea midline, no tenderness. EYE: Pupils equal, round, and reactive to light, extraocular movements intact. EARS, NOSE, MOUTH AND THROAT: Tympanic membranes clear. Oral mucosa moist. No pharyngeal erythema or exudate. HEART: Regular rate and rhythm, no extra heart sounds, no murmurs. Perfusion: Within normal limits. RESPIRATORY: Occasional rhonchi. ABDOMINAL: Soft nontender. Normal bowel sounds. RECTAL: Deferred. EXTERNAL GENITALIA: Deferred. BACK: Nontender Normal alignment. EXTREMITY: No swelling. NEUROLOGICAL: No focal neuro deficits. PSYCH: Alert and oriented times 3.

Medical Decision Making:

Differential Diagnosis: Abdominal pain Clinical work-up/Interpretation Nursing orders:

Medications: Levofloxacin (Levaquin) (Levofloxacin 500 mg tab), 500 mg = 1 tab(s), PO, tablet, Once, Routine. Documentation reviewed: Emergency department nurses' notes emergency department records, prior records.

Impression and Plan:

Diagnoses: UTI

Condition: Improved, Stable Medication Orders Prescriptions: Levofloxacin (Levaquin) 250 mg PO q24hr #10 day(s) 0 Refill(s) 0 Tot Refills) Space 2 hrs. apart from antacids, dairy, sucralfate, and iron. Patient was given the following educational materials: BLADDER INFECTION, Female (Adult) Follow up: Follow up with primary care provider within 2 to 3 days. Counseled: Patient, Family, Friend, Regarding diagnosis and treatment plan.

ICD-10-CM Code(s): _____

Case 10

Preoperative Diagnosis: Mixed incontinence and pelvic relaxation.

Postoperative Diagnosis: Mixed incontinence and pelvic relaxation.

Procedure Performed: Monarc and cystoscopy.

Anesthesia: General.

Estimated Blood Loss: Less than 25 mL.

Complications: None.

Description of Procedure: After informed consent had been obtained, the patient was brought to the OR, placed supine and general anesthetic was induced without problems. She was then carefully padded and then shaved, prepped and draped in sterile fashion after she was moved to the dorsal lithotomy position. ALPS were placed prior to induction of therapy and she received IV antibiotics. A Foley catheter was placed in her bladder and the bladder was completely drained. 0.2 5 percent Marcaine with epinephrine was used for local anesthetic. Two small stab incisions were made along the inner thigh just at the medial border of the obturator foramen and below the abductor

tendon. This was at the level of the clitoris bilaterally. A midline incision was made centered over the urethra from the bladder neck with the scalpel and vaginal flaps were dissected. Care was taken to make sure the flaps were of sufficient thickness, but that we did not dissect too close to the urethra. The Monarc trocar was then carefully passed through the inner thigh incisions and then finger guided out the vaginal incision. Care was taken to make sure that the trocars did not button hole the vaginal flaps and that they were in good position. The Monarc with its protective sleeve was then snapped into position and brought out laterally. Copious amounts of antibiotic irrigation were used throughout. The Foley catheter was removed and a 21 French rigid cystoscope placed into the bladder. The bladder was carefully examined using both the 30 and 70 degree lens, as was the urethra. There was no evidence of any trauma to the urethra or the bladder and the sling appeared to be in good position. The protective sleeves were then removed. Care was taken to make sure that the Monarc provided good support, and that there was no undue tension. The excess sling was trimmed. The vaginal incision was closed with 2-0 Vicryl and a few interrupted sutures and the inner thigh incisions closed with chromic. Dr. X then proceeded with the rest of the procedure, which will be dictated separately. All needle and sponge counts were correct, and there were no apparent complications during the first portion of the procedure.

ICD-10-CM Code(s): _____

Case 11

Preoperative Diagnosis: Stress urinary incontinence.

Postoperative Diagnosis: Stress urinary incontinence.

Procedure Performed: 1. Pubourethral sling (Lynx). 2. Cystoscopy.

Anesthesia: General endotracheal anesthesia.

Estimated Blood Loss: Less than 50 mL.

Indications: The patient is a 65-year-old multiparous white female who has had a previous hysterectomy. She has worsening stress urinary incontinence. She had a cystometrogram revealing low postvoid residuals and leak-point pressures that were consistent with stress urinary incontinence. She wished to have a definitive procedure. She was aware of the risks including bleeding, infection, damage to surrounding organs, including bowel, bladder, and ureters. The risk of recurrence despite adequate technique, persistence in urinary leakage as well as the possibility of graft erosion.

Description of Procedure: The patient was taken to the operating room and underwent satisfactory general anesthesia. She was prepped and draped in the usual sterile fashion in the dorsal lithotomy position. A Foley was placed to gravity. After appropriate anesthesia had been assessed, a “pause for the cause” was met. A weighted speculum was placed in the posterior vaginal vault and the anterior portion of the vagina was infiltrated with 1 percent lidocaine with epinephrine. Approximately 6 mL was used. A vertical incision was made approximately 2 cm below the urethral orifice, down towards the apex of the vagina. This was only approximately 2–3 cm in length. It was then bluntly and sharply dissected off the mucosa off the underlying structures. This was carried retropubically with the surgeon’s hand. Two suprapubic punches were placed 2 fingerbreadths away from the midline of the pubic symphysis and then the Lynx needles were placed through the suprapubic incisions and brought down retropubically, guiding them with the surgeon’s hands on either side of the urethra. Once these were left in place, the Foley was removed and the cystoscope was placed.

Indigo carmine was given IV by anesthesia. The ureters were noted to be normal. The interior of the bladder was noted to be normal. There were no intravesicular lesions or intravesicular placement of the needles. The cystoscope was then removed. The Foley catheter was replaced. The Lynx sling was then placed retropubically by attaching the Lynx needles, and these were retracted up, behind the pubic symphysis, up out through the suprapubic incisions. This was not significantly tightened down as there was space between the midurethra and the sling by using a Kelly, once the plastic coating was removed, the sling was then trimmed at the level of the suprapubic incisions and the Kelly was then removed. The incision in the vagina was then closed with figure-of-eight 0 Vicryl interrupted sutures. Vaginal packing was placed and the urine was noted to be draining into the Foley clear blue and the procedure was terminated. All sponge and needle counts were correct in the case. Estimated blood loss was less than 50 mL and the patient was taken to the recovery room in satisfactory condition after being awakened.

ICD-10-CM Code(s): _____

Case 12

Postoperative Diagnosis: Hydronephrosis

Preoperative Diagnosis: Rule-out left renal obstruction

Procedure: Percutaneous nephrostomy, Whittaker test

Consent: Informed consent was obtained for the procedure after discussing the potential risks and benefits of the procedure. Potential risks such as vascular injury, vascular occlusion, bleeding infection were discussed. After I answered all their questions they gave their informed consent.

Anesthesia: Local anesthesia with conscious sedation

Medications: Fentanyl & Versed

Introduction: The patient was placed prone on the angiography table. Using ultrasound transducer the location of the lower pole of the left kidney was marked. The area was then sterilely draped and prepped. After conscious sedation was administered and after the use of 1 percent lidocaine two-provide local anesthesia in the soft tissues of the left back under ultrasound guidance a 21-gauge Neff needle was advanced into the lower pole calix. Small amount of contrast was injected confirming location within the lower pole calix. Over the wire and dilator was advanced and subsequently a 6.5 French APD catheter was advanced into the lower pole calix and subsequently deployed within the left renal collecting system. A Foley catheter was positioned within the bladder. The Foley catheter was then clamped and the nephrostomy catheter was infused with normal saline at a rate of 600cc/hr for a period of 10 minutes after which manometry of both the kidney/nephrostomy tube and a Foley catheter was performed demonstrating a normal pressure gradient of 11. The nephrostomy averaged approximately 21 mm of water while the Foley average approximately 9 mm of water. The Foley was unclamped fair amount of pink bloody urine was drained subsequently the nephrostomy catheter was removed over a wire. Patient was then sent to recovery area. He tolerated the procedure well.

Impression: No significant pressure differential to suggest obstruction. If you have any questions regarding this procedure or regarding the patient please do not hesitate to contact me.

ICD-10-CM Code(s): _____

Case 13

Preoperative Diagnosis: Penile concealment.

Postoperative Diagnosis: Penile concealment.

Procedure Performed: Correction of penile concealment.

Anesthesia: General endotracheal and caudal block.

Estimated Blood Loss: Negligible.

Findings: Paucity of penile skin.

Indication for Operation: The patient is a 12-month-old male with a history of circumcision soon after birth who presents with penile concealment. He has developed some mild preputial adhesions which have been unresponsive to medical therapy.

Procedure in Detail: After informed consent was obtained, the patient was brought to the operating suite and placed supine on the operating room table. General endotracheal anesthesia was induced. The patient was turned to the lateral position and a caudal block was performed. The patient was returned to the supine position. The lower abdomen and perioscrotal region were sterilely prepped and draped in the usual manner. The gland adhesions were manually reduced. A glans retraction suture was placed. A scrotal raphe retraction suture was also placed. An incision was made on the mucosal surface circumferentially creating a mucosal collar. A ventral raphe incision was carried down to the scrotum. The penile skin was then degloved from the shaft circumferentially. This dissection was carried down to the pubis dorsally and to the scrotum ventrally. Adherent Dartos was dissected from the corporal bodies ventrally. After achieving penile length with extensive bulbar dissection, the Dartos fascia was approximated in the corporal bodies ventrally with 5-0 clear nylon suture on either side into the corporal bodies. Attention was then turned to reconfiguring the penopubic angle. Again, the Scarpas fascia was approximated to the corporal bodies with 5-0 clear nylon suture on either side. A penile block was performed at this time. After recreating the penopubic and penoscrotal angle, attention was then turned to the redistribution of the penile skin. Given the paucity of penile skin, care was taken not to distribute it discordantly. The dorsal skin was divided in the midline. It was then reapproximated to the mucosal collar at the 12:00 position with a 7-0 Vicryl suture. The mucosal collar, which had been created earlier was trimmed in the midline and approximated with running 7-0 Vicryl. The resultant penile skin flaps were then brought around ventrally. The skin flaps were trimmed in midline. The penile raphe was then recreated with a running 7-0 Vicryl suture. The penile skin was then approximated to the mucosal collar ventrally at the 6:00 position with interrupted 7-0 Vicryl suture. The excess skin was trimmed on either side and then the penile skin was approximated to the mucosal collar circumferentially with a running 7-0 Vicryl suture. Upon completion of this, the patient's bladder was drained with a #8 French sugar Firlit catheter, which was subsequently removed. A complex penile dressing was placed. This was comprised of Owens gauze soaked in Benzoin and wrapped around the penis, secured with Coban wrapped around the penis, which was secured with Transpore tape. The patient was awakened from general anesthesia. He was transferred to the PACU in stable condition.

ICD-10-CM Code(s): _____

Case 14

Cystoscopy: Patient presents for elective cystoscopy today as part of his workup for unexplained voiding symptoms. See my prior note which was reviewed in detail. There is no change in diagnoses, medications, ROS. Uroimaging: Ultrasound in March showed a questionable bladder polyp. Urine cytology - none done

Cystoscopy Consent: The indications were reviewed and his questions were encouraged and answered. The procedure, alternatives and risks were discussed and his informed consent obtained.

Procedure: CYSTOSCOPY: Patient was consented, sterilely prepped and draped and had a flexible cystoscopy. Local anesthesia was instilled with lidocaine jelly. The flexible cystoscope was passed into the bladder with copious lubrication and irrigation. Anterior bulbar and membranous urethra were normal. Prostatic urethra demonstrated trilobar hypertrophy. Bladder was entered. No mucosal lesions were noted. Ureteral orifices: clear efflux R and L. in their anatomically correct location. Cystoscope was removed.

Assessment: No bladder tumor seen. Area on ultrasound probably just the intravesical intrusion of prostate from the middle lobe.

Plan: Cipro 500 mg now for prophylaxis. Urine cytology recommended -I will call pt if cytology is abnormal. Return 6 months- Pt instructed to expect some burning on urination and light bleeding in the urine for several days. Instructed to drink lots of fluids. Instructed to call back immediately or go to Urology clinic/ER if pt has fever, chills, heavy bleeding in urine, difficulty urinating or emptying bladder or if there is pain that is not relieved by pain medication.

ICD-10-CM Code(s): _____

Case 15

Preoperative Diagnoses: 1. Recurrent urinary tract infections. 2. Suspected interstitial cystitis.

Postoperative Diagnosis: Recurrent urinary tract infections

Surgical Procedure Performed: Cystourethroscopic examination, with hydrodistention.

Anesthesia: General anesthesia.

Specimens: Urine for culture and sensitivity (C&S).

Indication for the Procedure: The patient has been diagnosed in the past by Dr. X with interstitial cystitis and was managed with Elmiron, Atarax, and Detrol LA. The patient continues to have significant voiding dysfunction and was evaluated in the past, in 2006, and again in 2008. The patient was advised cystoscopy with hydrodistention to confirm the diagnosis made by Dr.X. The patient also is complaining of the recent onset of urinary tract infection (UTI)-like symptoms, and a urine culture was advised preoperatively.

Operative Findings: The patient has no abnormality in the introital area. No urethral stricture noted, the urethra is normal. The bladder neck is normal. The bladder is normal. Both orifices are normal. Bladder capacity is 700 mL. No hemorrhagic changes or glomerulation of the mucosa was

noted following the hydrodistention of the bladder for the full 10 minutes, and the bladder capacity remained consistent at 700 mL pre- and post hydrodistention. No terminal hematuria was noted.

Procedure: After the induction of adequate general anesthesia and prep and drape, the introitus was examined and no abnormality was noted. Urethrosopic examination followed by the cystoscopic examination was performed using a 30- and 70-degree telescope, and a completely normal bladder was identified. Prehydrodistention photographs of the bladder and the orifices and the bladder neck were made, followed by the hydrodistention of the bladder, raising the water column to 72 to 80 mL of height and allowing the bladder to fill. The bladder capacity remained at 700 to 750 mL, with the above noted findings following the hydrodistention. At this stage the patient was discharged with the following instructions: 1. Clear liquid-to-regular diet. 2. Regular activity. 3. Await urine cultures before any antibiotics are prescribed. 4. The patient can use Detrol LA empirically for bladder irritative symptoms. 5. The patient is to be managed only symptomatically, and the UTI will be treated only if the urine cultures are positive. 6. The patient is advised close follow-up at 4 to 6 weeks' interval, with a repeat urological evaluation and cultures as necessary. 7. If the patient's stress incontinence does not improve with medications and behavior modification, the patient may be considered for a vaginal sling at a later date.

ICD-10-CM Code(s): _____

Case 16

Operative Report

Preoperative Diagnosis: Left ureter stone.

Postoperative Diagnosis: Left ureter stone.

Operative Procedure: Left extracorporeal shock wave lithotripsy.

Anesthesia: General.

Description of Procedure: After informed consent was obtained, the patient was brought to the operating suite, general anesthesia performed. She received IV Levaquin. She was placed over the optic iris and imaged in both the AP and oblique position. The stone was easily visualized. It was placed in the treatment range. Treatment was begun at a power setting of 3 and increased to a power setting of 5 after 300 shocks. A total of 3,000 shocks were given to the stone. Intermittently the stone was imaged and was always maintained in the treatment area. There were no complications. The patient had some minimal change in appearance consistent with some fragmentation but at the end of the procedure there also remained a fairly residual stone burden and she is likely to need a second treatment. This option was discussed with her previously. She will follow up in two weeks' time with preclinic KUB. She will strain all of her urine and if she is not having significant stone passage, we will make arrangements in the next four to six weeks to treat her residual stone burden.

ICD-10-CM Code(s): _____

Case 17

Preoperative Diagnosis: Bladder calculus

Postoperative Diagnosis: Bladder calculus

Anesthesia: General endotracheal and caudal block

Findings: Single 1.5 cm bladder calculus removed in toto

Estimated Blood Loss: Negligible

Drains: 10 french Foley catheter per urethra

Indication for Operation: a 4-year-old male who recently presented with dysuria. He has undergone treatment for a presumed medial baffle. After a similar episode of dysuria yesterday he was seen at an outside facility where a CT scan was obtained that showed a bladder calculus. He presents for surgical management.

Procedure in Detail: After informed consent was obtained the patient was brought to the operating suite and placed supine on the OR table. General endotracheal anesthesia was induced. The patient was administered IV Cefazolin. The lower abdomen and penoscrotal region were sterilely prepped and draped in the usual manner. An expressed void showed no deflection of his urinary stream. A 10 french Foley catheter was inserted per urethra, and the bladder was filled with warm saline until it was palpable. A low transverse incision was made. This was carried through the subcutaneous tissue with electrocautery. The fascia was divided transversely yielding the underlying rectus muscle. The rectus muscles were separated in the midline yielding the bladder. Retraction sutures were placed on either side of the bladder, and the bladder was opened in the midline. After the bladder was evacuated, a ringed forceps was passed into the bladder, and the calculus was removed. It was sent for chemical analysis. The bladder was then closed in three layers using 4-0 chromic suture in a running fashion. First the mucosa was closed. This was followed by a two layer muscle closure. The rectus muscles were reapproximated with interrupted 4-0 Vicryl suture. The fascial layers were reapproximated with 4-0 Vicryl in a running fashion. The subcutaneous tissues were reapproximated with 4-0 Vicryl in interrupted fashion, and the skin was closed with 4-0 Vicryl in a subcuticular fashion. Mastisol and steri strips were applied to the incision. The patients Foley catheter was connected to a drainage bag. He was then turned to the lateral position, and caudal block was performed by anesthesiology. He was returned to the supine position and awakened from general anesthesia. He was transferred to the post anesthetic care unit in stable condition.

ICD-10-CM Code(s): _____

Case 18

Preoperative Diagnosis: 1. Urethral stricture. 2. Multiple large bladder calculi.

Postoperative Diagnosis: 1. Urethral stricture. 2. Multiple large bladder calculi.

Procedure: Cystoscopy with urethral dilatation; cystolithopaxy.

Type of Anesthesia: General.

Catheter: 22 French 10 cc two-way Foley.

Description of Procedure: Under general anesthesia the patient was placed in the lithotomy position. The skin of the perineum was prepped with Betadine and the patient was draped. An attempt was made to pass Van Buren sounds which was unsuccessful. The 17 cystoscope was then passed using saline for irrigation under direct vision, I was able to negotiate my way beyond an anterior false passage and down and up to a prostatic urethra. There was a high median bar that was relatively difficult to overcome. The bladder was emptied and filled with saline, inspection revealed three light-tan bladder calculi which were smooth and measured about 1.5 centimeters. The CyberWand was passed through the offset cystoscope. The stones were encountered and quite a bit of time was used trying to break them. This would make dense in the outside wall of the stone, but never broke a stone or reduced its size very much. The CyberWand was removed. The laser fiber to the Domier Holmium Laser was now passed. This was much more satisfactory and did start breaking the stones into smaller fragments. Occasionally would stop to suck out fragments using the Ellik evacuator. Finally no visible stones remained. This did cause a little damage to the trigone before the bladder with some bleeding. It was relatively easy now to pass a 22 French 10 cc Foley. The bladder was irrigated. We will watch in the recovery room, if the urine is not too dark he can go home with the catheter. In that event, we will see him back in three days for a "fill and full" and removal of his catheter, if it stays too bloody, we will substitute the catheter for a three-way and plan to keep him at least overnight. He is given a prescription for Cipro 500 milligrams #14 one twice a day. Loroet Plus for pain.

ICD-10-CM Code(s): _____

Case 19

Preoperative Diagnoses: 1. Benign prostatic hypertrophy with obstruction 2. Urinary retention

Postoperative Diagnoses: 1. Benign prostatic hypertrophy with obstruction 2. Urinary retention

Name of Operation: Cystoscopy and contact laser transurethral resection of the prostate

Description of Procedure: The patient was brought to the operating suite and, after a general anesthetic, he was placed in the lithotomy position, prepped and draped in the usual fashion. The continuous-flow laser cystoscope was placed into the bladder and the laser fiber was placed through it. Upon inspecting the bladder and finding there to be no significant median lobe, but a high bladder neck and large lateral lobes, the remainder of the bladder was perfectly normal. Both orifices were identified and had clear efflux. At this point, the laser fiber was placed through the scope and vaporization of the prostate was then carried out, first starting at the bladder neck, taking it down to the circular muscle fibers, all the way back to the verumontanum. I then took down both lateral lobes without difficulty. The patient tolerated the procedure nicely. There was no

bleeding during the procedure. There was an excellent cavitation of his prostatic fossa by the end of the procedure. He was awakened, extubated and transferred to recovery in satisfactory condition. A 22 French Foley catheter was placed to gravity drainage at the end and he will be discharged home with this.

ICD-10-CM Code(s): _____

Case 20

Preoperative Diagnosis: Bilateral ureteral obstruction

Postoperative Diagnosis: Bilateral ureteral obstruction

Name of Operation: 1. Cystoscopy 2. Removal of bilateral ureteral stents 3. Bilateral retrograde pyelograms 4. Placement of bilateral ureteral stents

Operative Indications: The patient is a 70-year-old white female with a history of chronic left ureteral obstruction secondary to radiation therapy for colorectal malignancy. The patient also now has right ureteral obstruction secondary to extrinsic compression from recurrent colorectal malignancy. The patient is presently managed with bilateral ureteral stents which were last replaced in January of this year.

Description of Procedure: The patient was admitted to the surgery center on July 14th. Later that day, the patient was premedicated and brought to the operating room where she was placed in the supine position. The patient was then placed under general anesthesia and intubated. The patient was then placed in the dorsal lithotomy position, prepped and draped in a routine manner for cystoscopy. Examination under fluoroscopy showed good position of both previously placed ureteral stents and no evidence of calcifications along the courses of the stents. A 21 French cystoscopic sheath with a 30-degree lens was then introduced transurethrally into the bladder. The distal end of the most recently placed left ureteral stent was then grasped with alligator forceps and brought to just outside the external urethral meatus. A 0.038 glide wire was then used to intubate the stent. The tip of the glide wire was advanced up the ureter via the stent and the stent was then withdrawn, leaving the glide wire in place. A 5 French Pollack ureteral catheter was then advanced over the glide wire, up to the level of the renal collecting system, and the glide wire was withdrawn. Contrast was then instilled into the mildly dilated renal collecting system. The glide wire was then advanced back through the lumen of the 5 French catheter which was then withdrawn, leaving the glide wire in place. An 8 French 24 cm Contour ureteral stent was then placed over the glide wire in proper position in the ureter. The glide wire was then withdrawn, leaving the stent in good position. The pullout string was not left attached to the distal end of the stent. The patient then underwent replacement of the right ureteral stent and right retrograde pyelogram in a similar manner. The final examination under fluoroscopy showed good position of both ureteral stents with the proximal ends of the stents curled within the renal pelves. The distal ends of the stents were curled in the bladder. The patient's bladder was emptied through the scope and the scope was withdrawn from the patient. The patient tolerated the procedure without complications, was extubated in the operating room, and was taken to the recovery room in stable condition.

ICD-10-CM Code(s): _____

Case 21

Operation: Percutaneous epididymal sperm aspiration.

Anesthesia: Local with monitored anesthesia sedation.

Preoperative Diagnosis: Obstructive azoospermia.

Postoperative Diagnosis: Obstructive azoospermia.

Operative Indications: Patient is an African-American male who was found to have obstructive azoospermia and congenital bilateral absence of the vas deferens on exam. He is positive for 1 mutation cystic fibrosis gene. He has been counseled as to the implications of this and its various treatment options. He has elected to undergo epididymal sperm aspiration with cryopreservation of the sperm for possible future use with in vitro fertilization. He is counseled as to the risks, benefits, and alternatives of this procedure.

Operative Findings: Numerous motile sperm.

Operative Procedure: Patient was brought to the In Vitro Fertilization Operating Suite and placed supine. Conscious sedation was administered by Anesthesia and a time-out was performed with andrology lab personnel, anesthesia personnel, and the operating personnel to confirm proper patient and proper procedure. Subsequently, the scrotum was prepped and draped in the usual sterile fashion. On exam, both epididymal heads were full; however, the left side felt slightly fuller, and therefore, it was chosen. The left epididymal head was isolated under the scrotal skin, and the skin overlying this area was infiltrated with 1 percent plain lidocaine for local anesthesia. Subsequently, a 23-gauge butterfly needle attached to a 3-way stopcock and 60 cc syringe for suction and 1 cc tuberculin syringe filled with human tubular fluid for irrigation. The needle was used to percutaneously infiltrate the left epididymal head, and fluid was aspirated. It took 3 passes with the needle; however, this yielded numerous motile sperm that was more than adequate for cryopreservation and use with in vitro fertilization and intracytoplasmic sperm injection. At this point, it was decided to terminate the procedure. Patient was then cleaned and taken to Recovery in stable condition.

Estimated Blood Loss: None.

Drains: None.

Specimens: Left epididymal fluid to Andrology Lab for cryopreservation.

Complications: None.

ICD-10-CM Code(s): _____

Case 22

Preoperative Diagnosis: Right ureteral duplication with ectopic ureter.

Postoperative Diagnosis: Right ureteral duplication with ectopic ureter.

Procedure Performed: Lateral ureteral ureterostomy.

Anesthesia: General endotracheal on local.

Findings: Dilated upper pole ureter.

Estimated Blood Loss: 20 mL IV FLUIDS: 1250 mL crystalloid

Drains: 10 French Foley catheter per urethra.

Indication for Operation: The patient is a 4-year-old female who was recently evaluated for inability to potty train due to constant wetness. Renal ultrasound showed a dilated upper pole on the right. Cystoscopic evaluation revealed an ectopic upper pole ureter at the urethral meatus. She presents for surgical management of this.

Procedure in Detail: After informed consent was obtained, the patient was brought to the operating suite and placed supine on the OR table. General endotracheal anesthesia was induced. The patient had a Foley catheter inserted under sterile conditions and a urine specimen was sent for culture and sensitivity. The catheter was placed to passive inflow with warm saline with amikacin. The patient was administered IV cefazolin. The abdomen was sterilely prepped and draped in the usual manner. A Pfannenstiel incision was made. This was carried down through the sub-q with electrocautery. The rectus sheath was incised transversely and elevated off the underlying rectus muscle. The rectus muscle was separated in the midline yielding the prevesical space. The right perivesical space was developed. Dennis-Brown ring retractor was brought onto field to help maintain exposure. Initial exposure of the perivesical space was with a medium sized Beaver retractors on Robot table holders. The right ureteral duplication was identified. The ureters were encircled with Vessel loops and elevated. The upper pole ureter was clamped with a tight angle clamp and amputated at the level of the detrusor hiatus. It was oversewn with 3-0 chromic suture. A 1 cm segment was sent for pathologic examination. The lower pole ureter was elevated with vessel loops and then incised for approximately 1 cm with a micro knife. The upper pole ureter was then anastomosed to the lower pole Ureter in an end to side fashion with running 5-0 Chromic suture. After the anastomosis was completed, the site was inspected for hemostasis. The retractors were removed. The rectus muscles were reapproximated with 3-0 PDS in figure-of-eight fashion. The fascia was closed in 2 layers with 3-0 PDS in running fashion. The sub-q and the fascia were infiltrated with 0.5 percent Marcaine for postoperative analgesia. The subcutaneous tissues were reapproximated with 4-0 Vicryl suture in interrupted fashion. The skin was closed with 4-0 Vicryl in subcuticular fashion. Mastisol and Steri-Strips were applied to the Pfannenstiel incision. The catheter was secured to a StatLock device and left to gravity drainage. The patient was awakened from general anesthesia. She was transferred to the Post Anesthetic Care Unit in stable condition.

ICD-10-CM Code(s): _____

Case 23

Gravity Cystogram Findings: Scout images show a hazy soft-tissue density in the upper left abdomen and pelvic area of uncertain significance. The bowel seems somewhat displaced by this mass. Next image show filling of the bladder with contrast material in the normal retrograde fashion. Foley catheter balloon is easily identified. Next images show full-capacity bladder in a triangular shape. There did not appear to be any extrinsic compression of the bladder. There is no vesicoureteral reflux. Final images show adequate drainage on post-void film, drained through the Foley catheter. There is no hint of residual contrast and there is no reflux.

Overall Impression: Soft-tissue density mass in the left side of the abdomen of uncertain etiology. Further studies with CT scan may be indicated. No evidence of vesicoureteral reflux with adequate-capacity bladder.

ICD-10-CM Code(s): _____

Case 24

Preoperative Diagnosis: Bladder outlet obstruction.

Postoperative Diagnosis: Bladder outlet obstruction.

Operation: Cystoscopy with transurethral incision of the prostate.

Anesthesia: General

Estimated Blood Loss: 5 to 10 mL.

Specimens: None.

Drains: 22 French Foley catheter.

Complications: None.

Findings: Elevated bladder neck. Moderate bladder trabeculation. Mild lateral lobe enlargement of the prostate.

Indications: This is a gentleman with significant outlet obstruction, documented urodynamically with elevated voiding pressures and poor flow rate. He has a constellation of symptoms, including frequent urination, nocturia, urgency and diminished urinary stream. He presents now for the above procedure after thorough discussion about the risks and benefits. He has a history of elevated PSA. Previous prostate ultrasound done in May revealed a 40-gram prostate. His biopsies were all negative. He understands the risks of infection, bleeding, postoperative incontinence. He also understands that he will have retrograde ejaculation following this procedure as a natural result of the procedure.

Technique: The patient was given prophylactic antibiotics. He was administered general anesthesia by LMA. He was then prepped and draped in lithotomy position. The 24 French resectoscope sheath was introduced with the Timberlake obturator. Using a 12-degree lens and a Collins knife, the incision was made at the 6 o'clock position after identifying the orifices and carefully avoiding them throughout the procedure. The incision was made from just inside the bladder neck and

carried all the way to the verumontanum. This was a full-thickness incision through all muscle layers, which resulted in a wide-open outlet. Spot cautery was then used for any hemostasis. No significant bleeding was noted. A 22 French Foley catheter was introduced with a catheter guide. A leg bag was applied. The patient was taken back to the recovery room in stable condition. I will see him back tomorrow for catheter removal in the office.

ICD-10-CM Code(s): _____

Case 25

Preprocedure Diagnosis: Right renal calculus.

Postprocedure Diagnosis: Right renal calculus.

Procedure: Extracorporeal shock wave lithotripsy. ANES: General

Operative Findings & Procedure: Following induction of anesthesia the stone in the right kidney was localized with a biplanar X-ray of the extracorporeal shock wave lithotripsy unit. The stone appeared to be about 2.5 cm in diameter. Disintegration was begun at a power setting of 2 and gradually increased to power maximum of 8. A total of 2500 shocks were given. The stone did seem to show lightening but the basic outlet was still present at the end of the procedure. At this point the procedure was stopped, the patient left in good condition, no complications were noted.

ICD-10-CM Code(s): _____

Case 26

She is 69-years-old female who had history of cystocele, rectocele, and sling. The patient complains that she's doing fine except she sees some spots of blood coming from the vagina. She has had a hysterectomy and she said it was benign. Her family physician advised her to keep continuing on the Vagifem. However I will order a pelvic CT on her, together with abdominal CT because she had significant microhematuria. We'll check that. She's never been a smoker; this is very comforting. It's very rare to develop bladder cancer if she was never a smoker. Otherwise she will continue doing the same thing on the Vagifem. We will see her in six months. If there is anything unusual I will be alerted and we will call her earlier. **DIAGNOSIS:** Microhematuria, significant Vaginal bleeding

ICD-10-CM Code(s): _____

Case 27

Preoperative Diagnosis: Right renal calculus, Right ureteric stent in situ

Postoperative Diagnosis: Right renal calculus, Right ureteric stent in situ

Operative Procedure: Cystourethroscopy, right ureteric stent removal, right ureteric dilatation, right flexible ureteroscopy and laser lithotripsy, right renal calculus stone basketing, and right ureteric stent placement

Anesthesia: Endotracheal general anesthesia

Complications: None

Indications: This 26-year-old female patient has a history of left proximal ureteric calculus with significant obstruction and a stent was placed, pushing the stone into the left renal pelvis. The patient came to the office and we discussed all treatment options, including electroshock lithotripsy, laser lithotripsy, open surgery or percutaneous nephrolithomy. After thorough discussion, it was decided to go for laser lithotripsy. All the procedure, its complications and expectations, risks, and benefits were very clearly explained. Infection, bleeding, anesthetic complications, ureteric injury, urinary extravasation, ureteric stricture formation, stent irritation, failure of the operation to remove the stone, further treatment may be needed all were very clearly discussed. The patient agreed to undergo the procedure and signed the consent form.

Operative Procedure: The patient was identified in the operating room. She was given endotracheal general anesthesia satisfactorily. She was kept on the operating table in the modified dorsal lithotomy position. Her genitalia were thoroughly cleaned with Betadine solution and she was draped. I inserted 22 French cystourethroscope and started inspection. The left ureteric stent was seen emanating from the left ureteric orifice. With the grasping forceps, this was brought outside. Through this we passed 0.35-guide wire and we also passed a 0.38-guide wire and over the 0.35 wire, Applied medical dilator was used to dilate the ureter. It was only going half of the ureter because of significant tightness and so it was attempted to push further to prevent any ureteric damage. Through this we passed a flexible ureteroscope all the way into the left renal pelvis area and identified the stone. Using laser lithotripsy and using holmium on 8 watts, the stone was broken in pieces and most of the specimens were basketed using nitinol basket and there was remaining only powder and tiny fragments left. There were some blood clots noted in the kidney as well. It was making visualization rather difficult; however we managed to break the stone and remove most of the bigger sized fragments easily without any problem. At the end of the procedure, over the guide wire a 6 French 26 cm ureteric stent was pushed all the way into the left renal pelvis. After removing the guide wire, the upper end looped well inside the left renal pelvis. After removing the guide wire completely, the lower end looped inside the bladder. The cystourethroscope was then removed after emptying the bladder. The patient tolerated the procedure extremely well and was taken to the recovery room in stable condition. The patient denied any pain or discomfort during the entire procedure.

Further Treatment Plan: The patient will be seen back in the office in a week to ten days' time to remove the stent under local anesthesia. The removed stones were sent for chemical analysis.

ICD-10-CM Code(s): _____

Case 28

Preoperative Diagnosis: Right hydrocele.

Postoperative Diagnosis: Right hydrocele.

Procedure: Right hydrocelectomy.

Type of Anesthesia: General.

Indications for Procedure: This is a gentleman who had right epididymitis orchitis and developed an acute reactive hydrocele while at Vanderbilt with his wife who was in the hospital. He was treated with antibiotics and urinalysis cleared appropriately. A reactive hydrocele stayed and was uncomfortable and he would like to have it surgically removed. An ultrasound did show normal testicles and normal flow. Risks and benefits of the procedure including bleeding, infection, damage to the testicle or cord were discussed as well as anesthesia risks and the patient is willing to proceed.

Description of Procedure: The patient was brought into the operating room on a stretcher and transferred from the stretcher to the OR table where general anesthesia was induced. Ancef one gram IV was given for prophylactic antibiotics. The patient was then prepped and draped in the usual sterile fashion. An approximately 4H3m incision was made in the scrotal raphe with a 15-blade scalpel. The electrocautery was used to dissect down to the Dartos. The incision had to be extended approximately 1.5 cm to deliver the testicle into the wound. The Dartos was then opened and the hydrocele was drained. Approximately 75 cc of clear yellow fluid was obtained. The hydrocele sac was then completely opened and inverted. The edges were cauterized to help with hemostasis. A 3-0 running chromic was used to invert the sac behind the testicle. A short amount of sac was left free and was oversewn with a 3-0 chromic. Hemostasis was obtained. Copious irrigation was used. The Dartos was closed with 3-0 running Vicryl suture. The skin was then closed with interrupted vertical mattresses with 3-0 chromic. Triple antibiotic ointment was applied to the wound and a scrotal fluff and jock strap was applied.

Estimated Blood Loss: 10 cc.

ICD-10-CM Code(s): _____

Case 29

Preoperative Diagnosis: Right mid to lower ureteric calculus, Right ureteric stent in situ

Postoperative Diagnosis: Right mid to lower ureteric calculus, Right ureteric stent in situ

Operative Procedure: Cystourethroscopy, right ureteric stent change, right rigid ureteroscopy, laser treatment of right ureteric calculus and ureteric stone basketing, and right ureteric stent placement

Anesthesia: Endotracheal general anesthesia

Complications: None

Blood Loss: Minimal

Indications: This is a 47-year-old male patient who had a history of right flank pain. He was investigated and found to have right mid to proximal lower ureteric calculus. The patient waited for some time. He did not pass the stone. Repeat X-ray still revealed the presence of stone in that side. Because of this we decided to go for electroshock lithotripsy or laser lithotripsy, open surgery or percutaneous surgery. All of these were discussed. Because of the position of the stone, just lying down over the external common iliac vessel in the possible midurethral level, shock lithotripsy was not recommended because of the position of the stone. We finally decided to go for laser lithotripsy as an option and we discussed this in detail. Infection, bleeding, anesthetic complications, ureteric injury, urinary extravasation, ureteric stricture formation, failure of the operation to remove the stone and further treatment may be needed, stent irritation, stent may be kept for a variable period of time all were very clearly discussed. The patient agreed to undergo the procedure and signed the consent form.

Operative Procedure: The patient was identified in the operating room. He was given endotracheal general anesthesia satisfactorily. He was kept on the operating table in the modified dorsal lithotomy position. His genitalia were thoroughly cleaned with Betadine solution and he was draped. We inserted a 22 French cystourethroscope and started inspecting. The right ureteric stent was seen emanating from the right ureteric orifice. Initially a 0.38-guide wire was placed along the side of the stent and after grasping the stent it was brought outside and through this a 0.35-guide wire and the stent was removed. After this, along the side of the stent we passed a rigid ureteroscope easily. The stone was easily shown in the midureter. Using electroshock lithotripsy on 9 watts the stone was broken in multiple fragments and one large fragment was then basketed out using the Segura basket and removed out. On looking back again there was no ureteric injury and no extravasation of the urine. No significant problem noted. Because of this we decided to place a stent. Over the guide wire a 6 French 28 cm ureteric stent was pushed all the way into the right renal pelvis. After removing the guide wire the upper end looped well inside the right renal pelvis. After removing the guide wire completely the lower end looped inside in the bladder. The cystourethroscope was then removed after emptying the bladder. The patient tolerated the procedure extremely well and was taken to the recovery room in stable condition. The patient denied having pain or discomfort during the entire procedure. The removed stone pieces were sent for chemical analysis.

Further Treatment Plan: The patient will be seen back in the office in a week's time when we will discuss when we will remove the stent using flexible cystourethroscope in the office. We will discuss treatment options, including the possibility of stone prevention in the office after getting the stone analysis report.

ICD-10-CM Code(s): _____

Case 30

He's a 16-years-old boy complaining of a burning when he urinates but he says when his bladder is full it doesn't burn. He was placed on low spice and I told him OK, don't urinate unless it's full so it doesn't burn. His hemoglobin was a little above 15 and usually this could be associated with some renal tumor but his ultrasound was negative so he was reassured. We'll see him in six months. He will stay on low spice and urinate whenever his bladder is full, and we'll take it from there.

Diagnosis: Just burning with urination

ICD-10-CM Code(s): _____

Case 31

Preoperative Diagnosis: History of bladder carcinoma

Postoperative Diagnosis: No recurrent bladder tumor

Operative Procedure: Review cystourethroscopy

Anesthesia: IV sedation

Indications: This is a 69-year-old male patient who is known to me in the past. The patient has a history of radical prostatectomy for prostate cancer and also had bilateral tumor for which he has been coming for review cystoscopy. The last review cystoscopy in October did not reveal any bladder tumor. The patient is now here for further review cystoscopy and he agreed to undergo the procedure and signed the consent form.

Operative Procedure: The patient was identified in the operating room. He underwent intravenous sedation. His genitalia were thoroughly cleaned with Betadine solution and he was draped. We instilled Lidocaine into his urethra and inserted a 22 French cystourethroscope and started inspecting. There was no evidence of any recurrent bladder tumor seen. There is slightly congested bladder mucosa, otherwise no significant findings were seen. The cystourethroscope was then removed after emptying the bladder. Rectal examination revealed no anastomotic thickening at the prostatectomy site. The patient tolerated the procedure well and was taken to the recovery room in stable condition. The patient denied having any pain or discomfort during the entire procedure.

Further Treatment Plan: The patient will be seen back in the office in five months' time, for further review cystoscopy in six months' time.

ICD-10-CM Code(s): _____

Case 32

The gentleman is 79-years-old, white male who fell in urinary retention while in the hospital. Now he comes in and said he has severe urge incontinence. He was placed on Flomax at that time. The patient had no PSA. He had a catheterization at that time so he had no PSA this time. His postvoiding residual is 0 so I placed him on Avodart and Flomax and the medication Jayln one capsule daily. I ordered today PSA on him. We'll reevaluate him in three months, to see how he is doing. If not we will add to the medication some Vesicare and we'll see how he will respond to that.

Diagnosis: Severe urge incontinence

ICD-10-CM Code(s): _____

Case 33

The gentleman is 38-years-old, white male, has two children. He is coming here for voluntary sterilization or elective sterilization. The patient was explained the sterility takes place after two months at least, after a semen analysis shows no sperm. He has no allergies. Physical examination shows head and neck negative. Chest is symmetrical. Lungs are clear. Heart NSR. Abdomen soft, no organomegaly. Genitalia showed meatal stenosis and the vas deferens are present on both sides. Extremities, no edema. Neurological findings, no deficit.

Diagnosis: Elective sterilization

ICD-10-CM Code(s): _____

Case 34

The gentleman is 31-years-old male, healthy otherwise, had left renal colic found in the ER yesterday, about a 5 mm obstructing stone. He was given analgesics, Vicodin. He seems to be OK but he still has pain. He didn't pass it. He was booked for tomorrow for cystoscopy, stone manipulation, possible extraction by basket, under general anesthesia. His past history, he has asthma but not severe. He has no heart disease, lung disease, no diabetes. His blood pressure is slightly high, maybe because of the hydronephrosis; it is 140/90. He has no change in his temperature. He has no known allergies. Physical examination showed head and neck negative. Chest symmetrical. Lungs clear. Heart NSR. Abdomen soft, flat, no organomegaly. Extremities, no edema. Neurological findings, no deficit. Skin, no obvious disease. Left CVA tenderness positive.

Diagnosis: Left hydronephrosis, Left distal ureteric obstructing stone, 5 mm

For cystoscopy and stone extraction by ureteroscopy under general tomorrow.

ICD-10-CM Code(s): _____

Case 35

Preoperative Diagnosis: 8–9 mm calculus, upper third, right ureter, below the ureteropelvic junction

Postoperative Diagnosis: 8–9 mm calculus, upper third, right ureter, below the ureteropelvic junction

Operative Procedure: Electrohydraulic shock wave lithotripsy

Anesthesia: General

Estimated Blood Loss: None

Procedure: The patient was placed on the lithotripsy table under general anesthesia. The stone is localized; it is just below the L3 transverse process, very close to the midline. The stone is easily identified and placed in the crosshair and lithotripsy begun at 60 shocks per minute with KVL for 14. Gradually the KV was brought up to 22 and the rate was gated until the electrocardiogram roughly ranged between 80 to 90 shocks per minute based on the patient's heart rate. After we had

delivered about 1500 shocks, it was seen the stone had disintegrated and a portion of the stone migrated a little below where we started and none of the fragments went about an inch above the original location of the stone. Another 1000 shocks were given to the stone that was below the lower fragment and the stone is spread out nicely. It is felt the stone is well pulverized and then the last 500 shocks were given to the stone fragment which had migrated a little bit up and this was also pulverized. Total shocks given – 3000. The patient tolerated the procedure well. At the completion of the procedure the patient received 30 mg of Toradol and 10 mg of Lasix. The patient came out of the anesthesia uneventfully. She left the operating room in good condition.

ICD-10-CM Code(s): _____

Case 36

Preoperative Diagnosis: Right lower ureteric calculus with obstruction

Postoperative Diagnosis: Right lower ureteric calculus with obstruction

Operative Procedure: Cystourethroscopy, right retrograde ureteropyelogram, right ureteric dilatation, right rigid and flexible ureteroscopy, right renal calculus stone basketing, and right ureteric stent placement

Anesthesia: IV sedation changing into general anesthesia

Complications: None

Indications: This is a 36-year-old male patient who had a history of significant pain for some time, at least two weeks, in the right flank. He was initially investigated two weeks ago and was found to have 3 mm stone in the right lower ureter, causing no obstruction. He was watching it and did not pass the stone. He was also taking Flomax. However finally he decided to go for stone basketing with ureteric dilatation. All the procedure, complications, expectations, risks, and benefits were very clearly explained. Infection, bleeding, anesthetic complications, ureteric injury, urinary extravasation, ureteric stricture formation, failure to correct the problem, further treatment may be needed, all were very clearly discussed with the patient. The patient agreed to undergo this procedure and signed the consent form. Please note that prior to this we also discussed other options, including electrohydraulic shockwave lithotripsy, stent placement followed by laser lithotripsy or electroshock lithotripsy, percutaneous nephrolithotomy. All of this was very clearly discussed; however the patient decided to go for stone basketing after ureteric dilatation as the stone was rather small.

Operative Procedure: The patient was identified in the operating room. He was given intravenous sedation. His genitalia were thoroughly cleaned with Betadine solution and he was draped. We instilled Lidocaine into his urethra and inserted a 22 French cystourethroscope and started inspecting. The right ureteric orifice was seen and it was rather very pinhole. Finally a guide wire was placed and over the guide wire we passed Pollack catheter, 5 French, and injected contrast. There was some tightness noted in the lower ureter; however the stone was not easily identified. On injecting contrast, there was hydronephrosis also noted. After this a 0.35-guide wire was placed. Over the guide wire applied medical dilator dilated the lower ureter and then the rigid ureteroscope was introduced to visualize the ureter. The stone was not identified. Because of this, Applied medical dilator was easily introduced back. Through this we passed flexible ureteroscope and started visualizing. We went all the way into the renal pelvis where the stone was identified. In

the mid caliceal area the stone was identified. It was basketed using Bard 4-wire basket. Multiple pieces were noted and in fact the stone was in fact broken into pieces. Multiple pieces were basketed into the ureter and the renal pelvis area, and thoroughly cleaned out and taken out. Finally over the guide wire, a 6 French 28 cm stent was pushed all the way inside the right renal pelvis. After removing the guide wire the upper end looped well in the right renal pelvis. After removing the guide wire completely the lower end looped inside the bladder. The cystourethroscope was then removed after emptying the bladder. The patient tolerated the procedure extremely well and was taken to the recovery room in stable condition. The patient denied having pain or discomfort during the entire procedure.

Further Treatment Plan: The patient will be seen back in the office in two to three weeks' time for stent removal.

ICD-10-CM Code(s): _____

Case 37

Preoperative Diagnosis: Adenocarcinoma of the prostate.

Postoperative Diagnosis: Adenocarcinoma of the prostate.

Procedure: Robot assisted laparoscopic radial prostatectomy, bilaterally pelvic lymph node dissection, posterior urethral reconstruction.

Type of Anesthesia: General

Specimens: Prostate bilateral pelvic lymph nodes, anterior prostatic fat. NOTE: I did not perform a nerve sparing procedure.

Description of Procedure: The patient was taken to the operating room where general anesthesia was administered. The patient was transferred to low lithotomy position, and abdomen was shaved and prepped with Betadine solution and draped appropriately. All pressure points have been padded. He was draped appropriately. 12 mm incision was made above the umbilicus. A Verres needle was introduced into the abdomen, and insufflation was achieved. 12 mm non-bladed trocar was inserted into the abdomen. Visualization of abdominal contents revealed no intra-abdominal injuries. Three 8 mm ports and 12 mm ports were then placed under direct visual guidance using non-bladed trocars. The bladder was taken down from the anterior abdominal wall using sharp and blunt dissection. Dissection was carried down to the endopelvic fascia on each side. Bilateral pelvic lymph node dissection was then performed. The limbs of this included the external iliac vein anteriorly, pelvic sidewall laterally, pubic ramus distally, obturator nerve posteriorly. Care was taken not to damage these structures. Endopelvic fascia was incised, and I dissected out the apex of the prostate. I then incised the anterior bladder neck and dissected down into the bladder. The posterior bladder neck was then incised. I dissected down to the seminal vesicles and vas deferens which were elevated and mobilized. Denonvilliers fascia was incised, and the rectum was displaced posteriorly. Care was taken not to damage the rectum. I incised the dorsal vein and then the urethra. The prostate was mobilized and placed into an EndoCatch bag. The dorsal vein was controlled with figure-of-eight 3-0 Vicryl suture. A double-armed 3-0 Monocryl suture was then placed in Denonvilliers fascia and attached to the posterior urethral plate and re-approximated in a running fashion. The second arm of the suture was then used to re-approximate the posterior bladder neck to the posterior urethral plate in a running fashion. The bladder neck was then re-approximated to the urethra with a double-

armed 3-0 Monocryl suture starting posteriorly and tied anteriorly. This was a watertight closure. A 2D French Foley catheter was inserted in the patient's bladder with 15 cc of saline. Hemostasis was excellent under low pressure. The robot was then de-docked. All ports were taken down under direct visual guidance, and hemostasis was excellent. The umbilical incision was enlarged, and the prostate was removed. The fascia was reapproximated in interrupted fashion with figure-of-eight 0 Vicryl sutures. The skin incisions were closed with 4-0 Vicryl suture in running subcuticular fashion. DermaBond was placed on the incisions. The patient tolerated the procedure well, was extubated in the operating room and taken to the recovery room in good condition.

ICD-10-CM Code(s): _____

Case 38

Operative Report

Preoperative Diagnosis: Intermittent testicular torsion

Postoperative Diagnosis: Intermittent testicular torsion

Procedure Performed: Bilateral scrotal orchiopexy

Anesthesia: General endotracheal and local

Estimated Blood Loss: Negligible

Indication for Operation: a 15-year-old male who over the past year has had intermittent scrotal pain. He has been evaluated for episodes of torsion. However, his pain is usually relieved prior to presenting for evaluation. He presents for surgical management.

Procedure in Detail: After informed consent was obtained, the patient was brought to the operating suite and placed supine on the OR table. General endotracheal anesthesia was induced. The penoscrotal region was clipped and then prepped and draped in the usual manner. Retraction sutures were placed on either side of the median raphe in the scrotum. A median raphe incision was made. This was carried down through the fascial layers with electrocautery. The right testicle was elevated through the incision, and the tunica vaginalis was entered. The testicular appendage was amputated. The testicle was secured within the tunica vaginalis with 4-0 clear nylon suture on either side and then an additional 4-0 nylon suture superiorly. After securing the right testicle with non-absorbable suture, the tunica vaginalis was closed with 4-0 PDS suture. Attention was then turned to the contralateral testicle for fixation. Again, the fascial layers were divided with electrocautery, and the testicle was elevated. The tunica vaginalis was entered. The testicle was secured within the tunical vaginalis with 4-0 clear nylon on either side to the fascial layers as well as the tunica vaginalis. Again, an additional anterior suture was placed. After securing the testicle with non-absorbable suture, the tunica vaginalis was closed with a running 4-0 PDS suture. The fascial layers were reapproximated with 4-0 Monocryl in a running fashion. The subcutaneous tissue was infiltrated with 0.5 percent Marcaine for postoperative analgesia. The skin was closed with 4-0 chromic in vertical mattress fashion. Bacitracin was applied to the scrotal incision, and gauze was applied over this. The gauze was secured in place with an athletic supporter. The patient was awakened from general anesthesia and was transported to the post anesthetic care unit in stable condition.

ICD-10-CM Code(s): _____

Case 39

Preoperative Diagnosis: Left varicocele.

Postoperative Diagnosis: Left varicocele.

Procedures Performed: Left varicocelectomy.

Anesthesia: General.

Estimated Blood Loss: None.

Drains: None.

Specimens: None.

Complications: None.

Indications for the Procedure: This is a pleasant 27-year-old gentleman with a history of a grade 3 left varicocele. We have been watching this conservatively for almost a year and he had been complaining of increasing pain over the past several months. He presents today for left varicocelectomy. The risks and benefits were explained to include but not limited to bleeding, infection, possibility of damage to testicle, possibility of recurrence of varicocele, chronic pain and hydrocele were discussed. The patient consented to the procedure.

Description of Procedure: After receiving IV antibiotics, he was taken to the operative suite and placed in supine position. His groin was prepped and draped in sterile fashion. A 15 blade knife was used to make a 2 cm infrainguinal incision. Cautery was used to carry the incision down to the cord. The cord was isolated and a Penrose drain was placed behind. At that point, I was able to identify the vas and the rest of the cord was identified. I initially found a very large vein and that was suture ligated with 3-0 silks and transected. Several smaller vessels were identified, small veins were identified and ligated I used an arterial Doppler to identify both the main testicular arteries well as the artery the vas. At that point no other visible veins were noted. I then returned the cord to proper position. In proper position, I then localized the skin with 0.25 percent Marcaine plain. I then closed the subcutaneous tissues with 2-0 Vicryl subcutaneous sutures. Then the skin was then closed with 4-0 Monocryl running subcutaneous stitch. Benzoin and Steri-Strips were placed. Dry dressing and Tegaderm was placed. He was then extubated and taken to PACU in satisfactory condition. He tolerated the procedure well. All instrument and needle counts were correct.

ICD-10-CM Code(s): _____

Case 40

Preoperative Diagnosis: Left renal mass, gross hematuria, left flank pain.

Postoperative Diagnosis: Left renal mass, gross hematuria, left flank pain, frozen section confirms squamous cell carcinoma.

Procedures Performed: Left laparoscopic radical nephrectomy.

Anesthesia: General.

Estimated Blood Loss: About 100 ml or less.

Fluids: 1,500 ml of crystalloid.

Transfusions: None.

Complications: None.

Indications for Procedure: This is a 72-year-old white male presented with gross hematuria with some flank pain with the above-mentioned findings, concerning for the possibility of transitional cell carcinoma. Retrograde pyelogram showed the remainder of the ureter eventually normal. He is to undergo the aforementioned procedure. The procedure attendant risks were discussed not limited to infection, bleeding, contiguous organ injury, transfusions, death, cardiovascular event, possible open operation. Understood and agreed to proceed.

Description of Procedure: Kefzol was given preoperatively. Pneumatic compression stockings were applied. After adequate general endotracheal anesthesia, he was placed very carefully with the left flank up, jackknife position, all pressure points were relieved. Foley catheter had been inserted with sequential stockings as mentioned. He was prepped and draped in a sterile fashion. Four port sites were then made the following: initial port site at the tip of the 12, and then with a pneumatic balloon dissection was able to place the remaining 5 mm port sites, at the tip of 11th and the bottom of the 12th rib, and then two fingerbreadths above the anterior/superior iliac spine in the anterior axillary line. I was able to place another 15 mm port site. Using this with the camera, I was then able to dissect posteriorly off of the psoas muscle, genitofemoral nerve was seen and carefully dissected away. We then carried the dissection up. He had a large amount of very adherent fibroadipose tissue, very sticky, especially up along the renal hilum. He had complex vascular structures. He had multiple veins coming off of the renal vein overlying the renal artery. Then we were able to clip and dissect this. After doing so, found the artery and clipped this as well. Three clips proximally, two clips on the renal side, incision was then made. There was no back bleeding. Further dissection, revealed polar vessels as well, which were then each clipped towards the renal hilum superiorly. After all this had been performed, then endovascular stapler was used to clip the renal vein. We carried our dissection superiorly under the diaphragm and then medially along the aorta. The adrenal gland was incorporated in the end of the specimen. We carried this out anteriorly then inferiorly. Anteriorly there were small rents the peritoneum. Direct visualization showed no injury to the bowel. The tail of Gerota's was then carried down the ureter, down to the pelvic brim which was too large to use a stapler and we used endovascular. After this had been completed, the specimen was then completely liberated. We then checked the renal hilum and FloSeal was placed in this area. A specimen bag was then used to capture the specimen. Once doing so, decrease in our pressure, our retroperitoneum showed no signs of any active back bleeding. The specimen was then brought the lowest portion of the lower incision, just above the anterior/superior iliac spine and sent for frozen section, returning as squamous cell not transitional cell. Hemostasis then checked and verified. #15 Blake drain was placed through the stab wound anchored with a silk. Each of the muscle layers were reapproximated with 0 Vicryl and then undid Vicryl subcuticular with Steri-Strips, and Benzoin's, and dressings applied. Injection each port site with 0.25 percent plain Marcaine. The patient tolerated the procedure well and was sent to the Recovery Room in satisfactory condition. I discussed at length the findings with the family. He will be going to the transitional care unit bed postoperatively.

ICD-10-CM Code(s): _____