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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.
Case 1

**Preoperative Diagnosis:** Desire for sterilization.

**Postoperative Diagnosis:** Desire for sterilization.

**Operation:** Essure.

**Anesthesia:** IV sedation.

**Gross Findings:** Evaluation under anesthesia revealed normal sized and shaped uterus. No adnexal masses were palpated. Hysteroscopic visualization of the cervix revealed no lesion. Hysteroscopic visualization of the endometrial cavity revealed no lesion. The cavity was normal size, shape and contour.

**Procedure:** After adequate IV sedation, the patient was placed in dorsal lithotomy position. The vaginal area was prepped with Betadine and aseptically draped. Anterior cervical lip was grasped with Behr’s clamp. Hysteroscope was passed using normal saline to expand the cavity. Both tubal ostia were identified. The Essure device was placed in each tubal ostia without difficulty. There were four coils noted from each ostia. The hysteroscope was removed. The instruments were removed from the vagina. Patient was taken to the recovery room in satisfactory condition. The patient was advised at 90 days, she needs a hysterosalpingogram.

**ICD-10-CM code(s):** __________________________

Case 2

**Preoperative Diagnosis:** Retained intrauterine device

**Postoperative Diagnosis:** Retained intrauterine device

**Operation:** 1. Evaluation under anesthesia. 2. Removal of intrauterine device

**Anesthesia:** Laryngeal mask airway (LMA).

**Findings:** Normal ParaGard intrauterine device (IUD), not sent to pathology

**Indication for Procedure:** The patient is a 32-year-old female with a ParaGard intrauterine device IUD placed approximately 10 years ago. She presented to the office for a removal recently. Upon attempts in the office, the IUD string detached from the IUD. Multiple attempts in the office utilizing polyp forceps and ultrasound guidance were unsuccessful in removing the IUD. Decision was made to bring the patient back for evaluation under anesthesia and removal.

**Description of Operation:**

**Complications:** None.
Disposal: Stable.

**Estimated Blood Loss:** Less than 10 mL. After informed consent was obtained, the patient was brought back to the operative suite where adequate general anesthesia was obtained. The patient was then placed in dorsal lithotomy position and prepped and draped in a sterile fashion. A weighted speculum was placed inside the vagina, and the anterior lip of the cervix was grasped with a long Allis clamp. Upon examination after relaxation, it was noted that the IUD was in the lower uterine segment. Utilizing polyp forceps, the IUD was able to be grasped at its base and removed from the uterus. Minimal bleeding was occurred. No hysteroscopy was necessary. Vaginal instruments were then removed.

The patient was then awoken from the general anesthesia and transferred to the recovery room in stable condition.

ICD-10-CM code(s): ________________________________

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**Case 3**

**Female Age:** 80-year-old patient presents today for pessary cleaning. Patient offers no complaints. Wt: 118 Exam: Ext Gen +BUS.WNL. Vaginal spec exam reveals no lesions. Pessary was removed, scrubbed, vagina swabbed with Betadine, and pessary replaced. For F/U in ~ 4 months.

ICD-10-CM code(s): ________________________________

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**Case 4**

**CC:** OB with gestational diabetes, here for regular prenatal visit.

**HPI:** Gestational diabetic at 29 - 3 weeks using oral medications and diet that was diagnosed two weeks ago. Patient feeling well and taking medication as prescribed, see flow sheet. Patient tries to follow diet and exercises sporadically. Patient uses OneTouch Ultra and keeps a log book. Glucose readings are in the range of 110-135. No hypoglycemic episodes. Patient to have bi-weekly NST and BPP until delivery.

**Assessment:**

1. Gestational Diabetes mellitus without complications; will check Hg A1c. Refills on med
2. Patient to continue bi-weekly NST and BPP until delivery.

ICD-10-CM code(s): ________________________________
Case 5

S: The patient is here because she feels like her uterine fibroids are giving her problems. She has not had periods for several years. She is due for a physical in the not too distant future. She has not had any vaginal bleeding, no trouble urinating or moving her bowels. No blood in her stool or urine. No nausea or vomiting.

0: Blood pressure is 120/70. No exam was done, discussion only.

A: Uterine fibroids

P:
1. Ultrasound of the pelvis
2. Appointment with Dr. Knight or Dr. Day for consultation regarding fibroids.
3. Follow up with us for a physical at her convenience.
4. Return check otherwise p.r.n.

ICD-10-CM code(s):
________________________________________

Case 6

15-year-old female presents with lump on left breast. Pt states she first noticed 2 weeks ago. Not painful.

Chief Complaint: Patient present with a breast lump.

HPI: Patient feeling well. No pain with the lump. Noticed 2 weeks ago. Affects outer left quadrant of the left breast at the 3 o'clock position. Rated as mild. Has shown no change since onset. Reports associated family history of breast cancer, but denies associated nipple discharge, rash, skin changes and skin irritation. Mom had breast cancer in 2000 at age 44. She has not had a reoccurrence of breast cancer. MGM also has breast cancer.


Current Meds: none

Allergies: NKDA

Past Medical History: Eye exam in 2006. No medical problems. Pt had eye surgery for lazy eye at 18 mos of age.

Family History: Diabetes Mellitus II, Hypertension, Breast Cancer, and Heart Disease.

Social History: Former cigarette smoke—quit beginning 10-07. The child lives with the mother and two sisters. The home is smoke free.

**Exam:** Const: Appears well and comfortable. No signs of apparent distress present. Resp: Respiration rate is normal. No wheezing. Auscultate good airflow. Lungs are clear bilaterally. CV: Rate is regular. Rhythm is regular. No heart murmur appreciated. Extremities: No clubbing, cyanosis or edema. Breasts: Breast exam was performed while patient was in a supine position. Exam was done with a chaperone present, mother in room. Breasts normal on inspection. There are no skin changes. Left cyst, located at 2 o’clock position and left breast is nontender. Right breast is normal. Cyst are in the skin and not the breast tissue. Was able to pick it up and move it around. Pea size. Nipples: No discharge of the nipples bilaterally. Axillae: Axillae normal. Musculo: Walks with a normal gait. Skin: Skin in warm and dry.

**Assessment and Plan:** Left breast lump. I will get an ultrasound of the left breast. I instructed the patient to follow up after the test and also if the symptoms get worse or changes. I will give her Gardasil #2 shot today.

**ICD-10-CM code(s):** ____________________________

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**Case 7**

**Fetal Biophysical Profile**

Patient appears in the office for BPP

**Indication:** Decreased fetal movement at 36 weeks.

**Findings:** Movement: 2

- Tone: 2
- Breathing: 2
- Amniotic fluid: 2

**BPP score:** 8/8

**Impression:** Normal BPP

**ICD-10-CM code(s):** ____________________________
Case 8

The patient is admitted by her OB. She is a 17-year-old G1P0 at 39-2 weeks. Admitted with contractions and is quite uncomfortable. She is 4–5 cm on admission, 80 percent and -2 station. She continues to labor throughout the morning and got to 7 cm when rupture of membranes occurred spontaneously. Over the course of the next hour she progressed to complete AND +2 STATION. She instructed on pushing, pushing effectively, and at 15:08 a spontaneous delivery was completed. The baby’s nose and mouth were bulb suctioned. The baby was vigorous upon delivery and was placed on the mother’s abdomen, and he was dried thoroughly. The cord was doubly clamped and cut. Cord blood was obtained. This was followed by spontaneous delivery of placenta with an eccentric insertion of a 3-vessel cord. The fundus firmed with massage and 20 units Pitocin was added to the IV fluid. Inspection of the perineum and vaginal vault revealed no lacerations or tears. Estimated blood loss was 300 ml. This is a male Infant weighing 6-13, 20 Inches with Apgars of 8 and 9. Mom and baby are both stable.

ICD-10-CM code(s): ____________________________________________

Case 9

Patient at 18 weeks is sent for ultrasound for a genetic screening. The patient has no complaints and family history is negative for genetic conditions on both the maternal and paternal sides. The ultrasound is performed and a report sent to the referring physician. Code for the ultrasound order.

ICD-10-CM code(s): ____________________________________________

Case 10

Operation: Chromotubation.

Anesthesia: General endotracheal.

Preoperative Diagnoses: Infertility. Right Hydrosalpinx, menorrhagia


Operative Indications: Patient is a 36-year-old GO with primary infertility. Patient underwent an HSG, which showed a normal uterine cavity. The left fallopian tube, which showed to be patent on HSG, but the right tube showed distal hydrosalpinx with possible loculation. Because of these findings and the patient’s persistent symptoms, we discussed with the patient, desires to proceed with diagnostic laparoscopy, possible neosalpingostomy if necessary. Patient demonstrated understanding of the findings and agreed to proceed with the procedure.

Operative Findings: There was noted to be normal fallopian tube on the left, hydrosalpinx on the right with normal ovaries bilaterally with spill during chromotubation on the left side and blocked right tube with hydrosalpinx. The right tube was noted to be enlarged with no leakage of fluid.

Operative Procedure: Patient was taken to the Operating Room with informed consent. Patient was placed under general anesthesia without difficulty. Patient was placed in the dorsal lithotomy position using Allen stirrups with attention not to hyperflex or hyperextend her legs. She was then
prepped and draped in the usual sterile fashion. An orogastric tube was also in place. Lid speculum was then inserted into the vagina anteriorly to the cervix, was grasped with the tenaculum. The HUMI uterine manipulator was then advanced into the uterus to provide a means to manipulate the uterus without difficulty and provide a means to chromotubation. The speculum and tenaculum was then removed from the vagina. The Foley catheter was also placed. The surgeon’s gloves were then changed. At this time, attention was then turned to the patient’s abdomen. A vertical skin incision was then made within the umbilicus to accommodate a 10 mm trocar, which was then inserted directly while tending up on the abdominal wall. Intraperitoneal placement was then confirmed with the laparoscope. A pneumoperitoneum was achieved with CO₂ gas. The patient was then placed in Trendelenburg position. Survey of the patient’s pelvis and abdomen revealed the findings as noted above. Examination of the upper abdomen revealed a normal liver, normal appendix, and no obvious other abnormalities. At this time, it was decided to place a second port to proceed with the procedure. A horizontal skin incision was made suprapubically and enough to accommodate a 5 mm trocar. A 5 mm trocar, which was then inserted under direct visualization without difficulty. Chromotubation was then undertaken and there was noted to be spill from the fallopian tubes bilaterally. Fallopian tubes and ovaries were noted above and in correct anatomic position. Patient’s pelvis was then irrigated and suction dry. At this time, the procedure was felt to be complete. The fascia on the 10 mm port was closed with 0 Vicryl using Endoclose. A 5 mm trocar was then removed as well. The subcutaneous tissue was reapproximated with 4-0 Vicryl in a subcuticular fashion. The patient was taken down from the dorsal lithotomy position. She was then awakened from general anesthesia. The HUMI manipulator had been removed from vagina. Patient was taken to the Recovery Room in stable condition.

ICD-10-CM code(s): ________________________________

Case 11

Preoperative Diagnosis: Intrauterine pregnancy at term (39 weeks) prior Cesarean section desiring elective repeat due to scar

Postoperative Diagnosis: Same

Procedure: Repeat low transverse Cesarean section

Assistant: Dr. B.

Anesthesia: Spinal

Estimated Blood Loss: 500 cc

Complications: None

Findings: A Normal appearing female infant weighing 6 lb, 9 oz. Apgars were 8 at 1 minute and 9 at 5 minutes. A normal appearing post partum uterus. Normal appearing tubes and ovaries.

Description: After informed consent obtained and after the operative consent signed and in order, the patient brought to Operating Room and placed on the Operating Room table in the left lateral tilt position in preparation for her C-section. After an adequate level of spinal anesthesia was noted, she was routinely prepped and draped in the usual sterile manner. A timeout was performed. An incision was made then made in the skin with a knife through the patient’s prior incision. The incision was extended down to the level of the fascia. The fascia nicked in the midline and the
incision was extended bilaterally. Two Kocher clamps were then used to grasp the upper edge of
the fascia. The underlying muscle was dissected off the overlying fascia superiorly. The same was
then done inferiorly. The midline between the rectus muscles was identified and entered sharply.
The peritoneum was then entered sharply. This was bluntly extended. The bladder blade was placed
into position. A small incision was scored into the uterus with a knife. Upon entry into the uterine
cavity, clear fluid was noted. This then bluntly extended in the transverse fashion. The vertex was
then brought up and the infant was easily delivered. There was a spontaneous delivery of an intact
Schultze placenta with 2 arteries and 1 vein. The uterus was exteriorized and wiped out with a
wet lap pack. The incision was then closed using a 0 Vicryl in a running locking fashion, followed
by a second imbricating layer of 0 Vicryl. The uterus was then replaced into the abdominal cavity. The
abdominal cavity was copiously irrigated and suctioned. Reinspection of the incision showed some
bleeding coming from the left edge, which was over sewn using 0 Vicryl in interrupted figure-of-
eight fashion. Once this was done, no additional bleeding was noted and the operative site was
watched for 5 minutes. At this point, the peritoneum was closed using 3-0 Vicryl and the muscle
layer was inspected and appeared hemostatic. The fascia was closed using 0 PDS. The subcutaneous
layer was irrigated and suctioned. All bleeding that was noted was cauterized. The skin was closed
using 3-0 Monocryl. A sterile pressure dressing was applied. The patient tolerated the procedure
well and will go to recovery room in a stable condition.

ICD-10-CM code(s):

Case 12

Preoperative Diagnosis: Missed abortion.

Postoperative Diagnosis: Missed abortion.

Procedure: Suction dilatation and curettage.

Anesthesia: General.

Complications: None.

History: This is a 22-year-old white female, gravida 1, para 0, at 14 weeks by dates, with
spotting only and nonviable intrauterine pregnancy. It was seen by ultrasound with the crown-
rump measuring approximately 5 to 6 weeks’ size. The patient had originally waited to allow a
spontaneous miscarriage but has decided for a D&C. Maternal blood type is A positive.

Details of Procedure: After consent was obtained, the patient was taken to the operative suite.
She was given general anesthetic and placed in the dorsal lithotomy position and prepped and
 draped in the usual sterile fashion. Her bladder was drained with a red Robinson catheter. The
bimanual exam revealed a slightly enlarged retroverted uterus. A weighted speculum was placed
in the posterior vaginal vault, and the anterior lip of the cervix was identified and grasped with
single-tooth tenaculum. The uterus sounded to 10 cm and serially dilated to a 7 Hegar dilator, and
a 7 curved suction curette was then placed into the uterine cavity. Suction curettage was performed
with a moderate to large amount of tissue obtained, approximately 300 of blood loss. Sharp
curettage was, likewise, performed; no further tissue obtained and very scant bleeding. IV Pitocin
was then infused. Tenaculum was removed from the cervix. The speculum was removed from the
vagina. The patient was awakened, taken to the recovery room in satisfactory condition.

ICD-10-CM code(s): __________________________
Case 13

Subjective: Established patient presents for left breast mastitis due to breastfeeding. The problem started Tuesday and appears to be worsening. Vaginal birth 4 weeks ago. She was delivered by me. The patient has been on antibiotics since Tuesday. Fever resolved but no improvement in the breast. Patient area at 11 on breast still somewhat firm. Seems to be breast feeding fine and breast decompresses well.


Current Meds: Amoxicillin/Potassium Clavulanate 500 mg, Camila 0.35 mg, Keflex 500 mg, Macrobid 100 mg, Prenate Elite, Percocet 5-325 mg, Augmentin

Allergies: NKDA

Past Medical History:

Medical Problems: Kidney Stones, Vaginal Cyst
Surgeries: ESWL – Shocking of kidney stones
Ob/Gyn Hx: Gravidity: (3) Parity: Living (3)

Delivery: NSVD. Delivery at: G.C.M.C 40 week gestation

Family History: Diabetes, Hypertension

Negative for Deep Vein Thrombosis. Reviewed, no changes.

Social History: Marital: married.


Objective: Wt: 129 lb Wt Prior: 132 lb as of 02/04/08 Wt Dif: -3 lb BP: 122/76 Ht: 63" 5’3”

 Constitutional: Appears the stated age, healthy and well groomed. Appears to weigh within normal range.

Breasts: Left nipple very red. Induration of left breast 11 o'clock position. Tried to massage and break up, but do not feel it is collection or abscess, rather just induration.

Assessment and Plan: Mastitis nonpurulent, postpartum condition or complication. Rx antibiotics. Will get US in the office today to rule out abscess.

X-ray: Ultrasound, Breast, Left. Will contact patient with US results after they are read in the office tomorrow.

ICD-10-CM code(s): ____________________________
Case 14

This 37-year-old patient is seen for a screening Pap and pelvic gyn examination at our office today. She is an established patient and complaining of abnormal vaginal discharge for approximately three weeks. She denied any trauma. Patient is sexually active and her LMP was ten days ago. She denies any chest pain, shortness of breath, or urinary problems. Patient has Pap and pelvic exam one year ago and is requesting a Pap and pelvic exam today.

Past Medical History: Two vaginal deliveries without complications. Allergies, unknown. Medications include Micardis 80 mg for hypertension. She does not smoke or drink. She is married and lives with her husband.

Examination: Vital Signs: BP 125/70; Pulse 85, Respirations 20. Height 5’ 5”, Weight 135 lb. Well developed, well nourished female in no acute distress.

HEENT: Pupils equal, round and reactive to light and accommodation. Extraocular muscles are intact:

Neck: Thyroid not palpable. No jugular distention. Carotid pulses are present bilaterally.

Breasts: Manual breast exam reveals no masses, tenderness or nipple discharge. The breasts are asymmetrical with no nipple discharge.

Abdomen: No masses or tenderness noted. No hernias appreciated. No enlargement of the liver or spleen.

Pelvic: Vaginal examination reveals no lesions or masses. Discharge is noted and a sample was collected for testing and sent to an outside laboratory for testing. No bleeding noted. Examination of the external genitalia reveals normal pubic hair distribution. The vulva appears to be within normal limits. There are no lesions noted. A speculum is inserted. There is no evidence of prolapse. The cervix appears normal. A cervical smear is obtained and will be sent to pathology. The speculum is removed and a manual pelvic examination is performed. It appears that the uterus is smooth and no masses can be felt. Rectal examination is within normal limits. Screening occult blood is negative. Uterus is not enlarged. Urethral meatus is normal. No masses noted for urethra or bladder.

Assessment and Plan: Vaginal Discharge, Routine Pap and Pelvic performed today. Patient had Pap and pelvic examination one year ago. Patient was sent to our in-house lab for blood draw today and she is to follow-up in one week for lab results.

ICD-10-CM code(s): ____________________________
Case 15

Procedure Performed: Diagnostic laparoscopy

Preoperative Diagnosis: Chronic pelvic pain

Postoperative Diagnosis: Chronic pelvic pain

Anesthesia: General

Description of Procedure: The patient was placed on the operating table in dorsal supine position. She was induced with general anesthesia. She was then placed in a modified lithotomy position using Allen universal stirrups. The bladder was drained. A Hulka tenaculum was attached to the cervix for uterine manipulation. A small incision was now made in the umbilicus through which the trocar and cannula were inserted under laparoscopic guidance. A second trocar site of 5 mm was made in the suprapubic area. The intraperitoneal organs were examined. The liver was seen. The gallbladder appeared to be beneath the liver. Of note, there were numerous adhesions between the liver and the overlying abdominal wall. There appeared to be “violin string” adhesions, possible secondary to previous infection. No intestinal lesions were noted. The appendix was seen and appeared to be grossly normal.

Looking into the pelvis there were several adhesions about the anterior aspect of the uterus, possibly due to previous infection. The uterus itself appeared to be mildly enlarged with a somewhat “angry” appearance. There did appear to be a somewhat injected appearance of the uterine serosa. The uterus also had a somewhat irregular shaped appearance, possibly secondary to small leiomyomatous changes versus adenomyosis. Both ovaries appeared to be grossly normal. There was evidence of previous tubal ligation. There appeared to be no obvious adhesions, secondary to the tubal ligation.

Looking into the posterior cul-de-sac powder burn lesions of endometriosis were seen. Otherwise, the pelvic appearance was grossly normal.

The procedure was now terminated. All instruments were removed from the patient as was the insufflated gas. Incision was closed using 0 Vicryl on the fascia and 4-0 Vicryl on the skin. The patient was taken to the recovery room in stable condition.

ICD-10-CM code(s): ________________

Case 16

New patient, referred by Dr Bello. Positive pregnancy test in his office. No bleeding, but is tired and some light cramping. She is concerned about her weight and asks about losing weight and exercise. Discussion about eating healthy and not starting new exercise program.

Married, former smoker, no alcohol consumption. She works full time.

Ht 5’ 9” Wt 235 BMI 34.84

Constitutional: WDWNWF

Neck: Normal
Respiratory: Effort normal, no rales, wheezes

Cardiovascular: Normal RRR, peripheral vascular exam normal

Genitourinary: External genitalia normal, vagina normal, urethra normal (See US report)

Abdomen: Normal, obese, lap band felt LUQ – no hepatosplenomegaly

Psych: Oriented to time, place, and person. Normal mood and affect

Transvaginal US was performed today—A gestational sac is seen in the cavity but no fetal pole can be seen.

Plan: She is advised to continue her prenatal vitamins and eat healthy. Stay active, do not start any new exercise program at this time. Repeat ultrasound in 10 days. All questions answered.

ICD-10-CM code(s): ________________________________

Case 17

Preoperative Diagnosis: Large left ovarian complex cyst, 15 weeks gestation.

Postoperative Diagnosis: Same

Operation: Exploratory laparotomy, left oophorectomy, pelvic washings.

Anesthesia: Spinal

Gross Findings: Upon entering the abdomen, there was a 15-week sized uterus. There was one mild omental adhesion to the front of the uterus. The left ovary was smooth, nonadherent, in the cul-de-sac approximately 10 to 12 cm in size. It appeared to be predominantly cystic. The right ovary was normal in size, shape, contour. No other pelvic pathology noted.

Operative Procedure: After adequate spinal anesthesia, the patient was frog-legged. The Foley catheter was inserted. Patient was placed in a dorsal supine position. The abdominal area was prepped with Betadine. It was aseptically draped. A midline vertical incision was made, carried through the peritoneum, peritoneum elevated with two straights, entered carefully with a scalpel. Pelvic washings were performed. The left ovary was delivered through the incision. A clamp was placed across the infundibulopelvic ligament. A window was placed. A second clamp was placed over the infundibulopelvic ligament. The ovary was excised. It was sent for frozen section and returned as benign. The infundibulopelvic ligament was suture ligated with chromic and #1 Vicryl. Good hemostasis was noted. All sponge, needle and instrument counts were correct. The peritoneum was reapproximated with a running suture of 0-PDS. The skin was reapproximated with a staple gun and interrupted 4-0 Rapide sutures. Estimated blood loss 10cc. Patient was taken to the recovery room in satisfactory condition. Fetal heart tones were noted in the recovery room.

ICD-10-CM code(s): ________________________________
Case 18

Surgeon: Dr. X

Preoperative Diagnosis: Menorrhagia and irregular enlarged uterus

Postoperative Diagnosis: Menorrhagia and irregular enlarged uterus

Operation: TAH

Anesthesia: General

Gross Findings: Slightly irregular-shaped uterus with increased vascularity. Normal tubes and ovaries

Operative Procedure: Patient was taken to the operating room where anesthesia was induced, prepped and draped in a sterile fashion in the supine position. A Pfannenstiel skin incision was made and carried down through the fascia and the fascia was incised and extended laterally and dissected off the rectus muscle. Rectus muscles were divided in the midline. Peritoneum tented up and entered sharply and extended superiorly inferiorly with good visualization of the bladder.

Upper abdomen explored. Kidneys were normal. There were adhesions of the omentum to the anterior abdominal wall.

O’connor-Sullivan was placed into the incision, bowel packed away with moist laparotomy sponges and retracted bladder blade and bowel retractor were placed.

Uterus was grabbed and rounds were clamped bilaterally, transected and suture ligated. Next, windows were made and broad ligaments and the uterine ovarian ligaments were clamped, transected and doubly ligated. The peritoneum was taken down along the bladder flap and bladder flap pushed down with a sponge stick easily. The uterine artery was re-clamped bilaterally, transected and doubly ligated. Next, straights were used to take down the cardinal and uterosacral ligaments; these were clamped, transected and Heaney ligated. The anterior vagina was entered and the uterus and cervix were amputated using Jorgensen scissors. A running locking stitch 0 chromic was used to make the vaginal mucosal hemostatic. The uterosacral and cardinal ligaments were reimplanted and then 2-0 Chromic was used to close the cuff.

Irrigation was done. There was a small areal of bleeding along the bladder flap. This was bovied and all areas were hemostatic. T-drain was placed. The peritoneum closed over the cuff. Irrigation was done. All retractors, laps and sponges were removed. Peritoneum was closed with a running locking stitch of Chromic. Irrigation was done and the muscles were put together with a Chromic stitch. Irrigation was done again. All subfascial tissues were hemostatic. Fascia was closed with PDS. Irrigation was done again in the subcutaneous tissues; these were hemostatic and a flat drain was placed. Skin was closed with staples and interrupted 4-0 repeat. Sponge, lap and needle counts were correct x 2. Patient tolerated procedure well and was taken to recovery room.

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

Patient is 23-year-old G3P2002 here for a prenatal visit with MC/DA twins. GA is 36-1. Seen in the Norfolk office and sent for MFM consultation. Patient states she is feeling well.

**OB history:** 2 previous deliveries at 40 weeks with no complications

BP 107/67 RUE sitting Ht: 63 inches Wt: 184.2 BMI: 32.64

**Physical Exam:** general appearance normal. Estimated GA 36 weeks 1 day. Fetal position vertex X 2. Fetal heart sounds are present. UA normal

**Assessment:** Multiple gestations, twins

**Plan:** Continue with NST and BPP as scheduled.

**US today:** MC/DA twins with concordant growth. Normal amniotic fluid. No complaints- no contractions or bleeding or leaking fluid. GBS negative. Labor precautions given, fetal kicks counts

Scheduled for induction in 2 weeks.

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

Case 20

Patient is seen by MFM for elevated BP, headaches. She is DI-Di twin gestation at 29 weeks gestation. She continues to have a previa on US. No bleeding, no loss of fluid, no RUQ pain, does report headache. 24 hour urine is ordered by primary OB.

BP 140/78 Pulse 90 Temp 98.9 Ht 5’4” Wt 157 BMI 27.10

**Examination:** She is gravid, alert, cooperative, healthy female

**Cardiovascular:** Regular rate and rhythm

**Pulmonary:** Breath sounds normal and effort normal

**Abdominal:** Gravid, appearance normal, soft and non-tender

**Extremities:** No clubbing/cyanosis/edema

**Speculum Exam:** Deferred Cervix: deferred

**US Results from Today:**

Placenta previa is still present

Twin gestation – Di-Di with no discordance

Bilateral renal pyelectasis on Baby B

**Assessment:** 30-year-old G1P0 with Di-Di IUP with placenta previa at 29+4 with elevated BP, swelling with headache. (labs ordered) Admit for steroids, 24 hour urine, start BMZ, continue monitoring

**ICD-10-CM code(s):**
Case 21

Patient is here to discuss pap smear results, possible colposcopy, patient is cramping. She is G1Po at 11 weeks for colposcopy for high grade SIL on pap. She had HPV in 2006. She has had normal Paps after that until October 2012. No discharge, itching, or burning.

Risks and benefits of the procedure were explained and all questions answered. Consent were signed.

Procedure: the squamocolumnar junction was fully visualized. Observation without stating showed a 1–2 cm polyp at the os. After bathing the cervix in acetic acid, evaluation showed acetowhite changes at (moderate) 8-12 o’clock, but no punctuation, no mosaicism, and no atypical vessels. Polyp was removed with ring forceps easily. ECC was not performed, hemostasis was obtained with monsels solution and direct pressure. The patient tolerated the procedure well, no complications.

Plan: Explained in detail about the polyp and findings. I recommend the patient return at 6 week post partum for further colposcopy and possible biopsy.

ICD-10-CM code(s): __________________________

Case 22

Chief Complaint: Abdominal pain for 1 year, abnormal menses

Patient reports shooting pelvic pain and pressure (5/10 intensity) last for a few minutes at a time, has been going on for a year. It is made worse by sitting and standing. Also has episodes of pain at the umbilicus at times. She denied changes to her menstrual cycles. She reports that she was tested and found to be + GC, Chlamydia, and BV in October 2012. She and her partner were treated and test of cure has been done. She states she feels better after treatment for the STDs.

She discussed her pain with her PCP in the past who recommended OCPs. She tried the OCPs but stopped taking them due to nausea and weight gain. She has her normal and expected cycle after the pak of OCPs, reports very irregular cycles and never has a period 2 months in a row. She is currently not using any form of birth control including condoms. She would like to get pregnant is possible.

Physical Exam:

General appearance: Normal
External genitalia: Normal
Vagina: Normal
Urethra: Normal
Bladder: Normal
Cervix: cormal
Uterus: Normal
Adnexa: Normal
Abdomen: Normal
Liver and Spleen: Normal no hernia noted
Palpation of lymph nodes in axillae, groin, all negative
Orientation to time, place, person all normal
Mood and Effect: Normal
**Assessment:** Chronic pelvic pain
- History of STD
- Irregular menses
- Dysfunctional uterine bleeding

**Plan:** Possible cause of pelvic pain reviewed including PID, endometriosis. Discussed reasons for irregular periods such as PCOS, hormone imbalance. Discussed use of OCP for PCOS/irregular cycle management and endometriosis management. Discussed possibility of PID and patient desires treatment—antibiotics e-prescribed and dosing reviewed. To start OCP after completion of the antibiotics. Diet and exercise encouraged to prevent weight gain from OCP.

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

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**Case 23**

35-year-old G8P6 here for prenatal visit. EDC is 5/18/201X with EGA 33-6 weeks. She is followed by our clinic.

**Active Problems:**
- Chronic hepatitis B virus
- Elderly multigravida

Ht 64 inches Wt 154.5 BP 114/67 FHR 159

Patient denies vaginal bleeding, no leakage of fluid, no vaginal discharge. She is experiencing fetal movement. Urine negative

**ICD-10-CM code(s):**
**Case 24**

Mrs. Nicholson is here for a prenatal visit at 28-6 weeks with 3 previous pre-term deliveries. She reports no contractions, no VB, no leakage of fluid. She experiences appropriate fetal movement. She feels well, no complaints.

Ht 61” Wt 169 BP 132/78 FHR 153 Urine negative

**Assessment:** High risk pregnancy

**Plan:** Follow-up in 2 weeks, schedule US for r/o cervical shortening

**ICD-10-CM code(s):** __________________________________________

**Case 25**

28-year-old G5P0121 presents for a prenatal visit at 35-6. She is feeling well with no contraction, no VB, no abdominal cramping.

**OB History:**

- 2004 SAB
- 2006 SAB
- 2010 C/sec stillbirth
- 2011 EAB

**Current Meds:** Prenatal vitamins, 1 daily; Iron 325 1 daily; Colace 100 mg capsule 1 daily; Methadone HCl tabs

BP 109/67 HR 87 Ht 5-5 Wt 162 BMI 37.7 Urine—trace protein

**Exam:** General appearance normal—no edema present, fundal height 36 fetal heart rate 157

**Assessment:** Prenatal exam of high-risk pregnancy

- Opioid dependence -

**Plan:** Follow-up one week—continue twice weekly antenatal testing BPP and NST, serial US for growth, continue daily Methadone use for Opioid dependence. Anesthesia will be notified. Will be scheduled for repeat cesarean. Preterm labor precautions given, kick counts instructed.

**ICD-10-CM code(s):** __________________________________________
Case 26

Patient is here for re-pap. History of LSIL pap, last pap was normal. Complains of worsening irritability, would like to restart Zoloft. Periods are very irregular, having hot flashes and night sweats.

**ROS:**

Constitutional: no unexpected change is weight, no weakness, no fatigue, fever, sweats, or chills

GI: no abdominal pain, no change in bowel habits, no significant change in appetite, no nausea or vomiting

GU: no vaginal bleeding, discharge, pelvic pain

**Examination:** Alert and oriented X 3. No acute distress

GU: Normal vaginal exam without cervical motion tenderness, no vaginal discharge, no adnexal enlargement

Psych: irritation

**A/P:**

Abnormal Pap

Irritability

**Orders:** Pap with reflex if abnormal

Zoloft 1 tablet by mouth every day (30)

**ICD-10-CM code(s):** ________________________________

Case 27

Patient presents for gyn examination. Complaints of periods q 2 weeks, vaginal dryness. Also had an MRI that shows ovarian cyst, possible dermoid. Complains of crying spells and mood swings. Heavy 5–7 day periods since January.

**ROS:**

Constitutional: Normal

HEENT: Negative

Resp: Normal

Cardio: Normal

GI: Normal

GU: Positive for menstrual problem – no urgency, discharge, vaginal sores, vaginal pain
Skin: Negative
Neurological: Negative
Hematological: Negative
Psychiatric: Negative

**Exam:**

She is oriented to time place and person. WDWN
Head normocephalic
Ears, nose, throat: Normal
Eyes: No scleral icterus
Neck: Normal ROM, no thyromegaly present
Cardio: RRR
Pulmonary: Normal effort and breath sounds normal no wheezes, rales, or tenderness
No adenopathy of axillae
Abdominal sounds are normal
GU: Rectum normal, vagina normal, uterus normal, no breast swelling, tenderness, discharge, or bleeding. Cervix is normal exhibits no motion tenderness, no mass in adnexa, no tenderness or fullness. Pap is obtained.
Skin: Warm and dry
Bladder: Normal
Urethra: Normal

**A&P:** Menopausal symptoms—will order lab for FSH, LH, estradiol, Vit B12, progesterone. Pap sent. Will call patient with lab results.

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

**Case 28**

Patient presents for new OB visit at 7 weeks. Complains of significant nausea and vomiting with this pregnancy.

**Sonogram:** Mono-Di twins- CM X1, second baby measuring 5W6D with no CM. Consistent with vanishing twin.

**ICD-10-CM code(s):**
Case 29
Patient presents for HPV #2. No problems with the previous immunization. Immunization is given, IM, Left deltoid.

ICD-10-CM code(s): ________________________________

Case 30
Patient is here for follow-up of D&C. She is having itching reaction to Percocet and we will change her to Lortab 5/325. She also feels like she may be experiencing post partum depression. She has trouble getting out of bed and motivating herself. She is offered medication and is given samples to try.

ROS: Itching of skin
Psych: Depressed, weepy
GI: Cramping

Exam: Constitutional: patient is weepy
Abdomen: No HSM, no tenderness
GU: Deferred at this time
Extremities: No edema

A&P: post partum depression, status post D&C for missed AB, mild reaction to Percocet
Sample RX given Vibyrd for depression, Lortab 5/325 mg I q 6 hours #15 no refills.

ICD-10-CM code(s): ________________________________

Case 31
Preoperative Diagnosis: Persistent menorrhagia leading to profound anemia; submucous uterine fibroid

Postoperative Diagnosis: Persistent menorrhagia leading to profound anemia; submucous uterine fibroid

Operation: Total abdominal hysterectomy and bilateral salpingo-oophorectomy

Anesthesia: General with endotracheal intubation

Gross Findings: Upon entering the abdominal cavity, the lower abdominal wall was greatly distorted from a previous TRAM flap surgery. Much of the abdominal musculature on the right aspect of the lower abdomen was missing from the surgery and had been replaced with surgical mesh. Upon entering the peritoneal cavity, an enlarged lobulated approximately 12-week sized uterus was noted. There was evidence of bilateral tubal ligation in the past. Both ovaries were normal size. Some ovulatory type cysts were evident. Generalized examination of the abdomen was otherwise unremarkable.
Operative Procedure: Following administration of general anesthetic, the patient was frog-legged, a Betadine vaginal preparation performed, and a Foley catheter inserted. She was then repositioned in the dorsal supine position. Her abdomen was prepared with Betadine and draped in the usual manner with sterile drapes. Using a scalpel blade, a 7” transverse lower abdominal incision was made excising the lowest of the patient’s multiple surgical scars. This was carried down through the subcutaneous tissue and opening the rectus fascia transecting through a segment of surgical mesh. The overlying fascia was then dissected off the underlying musculature using the Bovie. Rectus muscles were split in the midline, peritoneum elevated, entered, and opened longitudinally. Following a general examination of the abdomen, an O’Connor-O’Sullivan retractor was placed in the abdomen and the bowel packed away with moist lap sponges. Mass General clamp was placed on the fundus of the uterus and uterus elevated towards the incision. The round ligaments were then bilaterally clamped, cut, doubly suture ligated with #1 chromic, left long, and tagged. Bladder flap was formed by incising the uterovesical peritoneum with Metzenbaum scissors and dissecting the bladder downwards using a sponge suck. The infundibulopelvic ligaments were bilaterally skeletonized a short distance and then were bilaterally clamped, cut and doubly suture ligated with #1 chromic. At this point, the fundus of the uterus was removed using a scalpel blade. The cervical stump was then grasped and the procedure continued. Using straight Heaney clamps, the cardinal ligaments were bilaterally clamped, cut, suture ligated with the #1 chromic and left long. An additional bite was taken bilaterally picking up portions of the uterosacral ligaments and these were similarly cut, ligated, left long and tagged. The vagina was entered anteriorly using a scalpel blade and utilizing Jorgensen scissors and staying within the vaginal fornices, the cervix was excised off the vaginal cuff. The angles of the cuff were grasped and then the cuff run with interlocking baseball stitch of #0 chromic. The cardinal ligament and uterosacral ligaments were then plicated back into the angles of the vagina using free Mayo needles. The cuff was further reduced in size with several simple sutures of 2-0 chromic. A Jackson-Pratt T-tube drain was placed in the cuff and brought out through the vagina. Pelvis was irrigated and suctioned dry and the pelvic peritoneum reapproximated with a continuous running stitch of #0 chromic. Pelvis was reirrigated, bowel replaced into his physiologic position, and all the pecks and instruments were removed from the abdomen. The abdominal peritoneum was closed with a continuous running stitch of #0 chromic. The rectus musculature was reapproximated with a continuous running stitch of the same suture material. The rectus fascia and mesh were then reapproximated with a continuous running stitch of Prolene. Subcutaneous tissue was irrigated and suctioned dry and the skin edge was reapproximated with a series of skin staples followed by a series of vertical mattress sutures of 4-0 Rapide placed between every staple to maintain good skin eversion. Sterile dressing was applied.

ICD-10-CM code(s): __________________________________________
Case 32

Preoperative Diagnosis: Fetal malpresentation. Nonreassuring fetal heart tones

Postoperative Diagnosis: Fetal malpresentation. Nonreassuring fetal heart tones. Nuchal cord and cord around the arm.

Operative Procedure: Primary low transverse Cesarean section – patient has been followed for prenatal care since 7 weeks gestation.

Estimated Blood Loss: 800 ml.

Complications: None.

Findings: Viable male, Apgars 8 and 9, normal uterus, tubes and ovaries. Cord was noted around the baby’s neck and around the baby’s right arm.

Procedure: Risks and benefits of procedure explained to the patient. The patient was taken to the operating room where her epidural was bolused. Adequate anesthesia was achieved. The patient was then prepared and draped in the dorsal lithotomy position with a left forward tilt. A Pfannenstiel skin incision was made 2 cm above the symphysis pubis in the midline and carried through to the underlying layer of fascia. The fascia was incised in the midline and extended bilaterally with Mayo scissors. The superior aspect of the fascial incision was grasped with Kochers and the underlying rectus muscles were dissected off bluntly and with Mayo scissors. Attention was turned to the inferior aspect of the fascial incision, which was grasped with Kochers, and the underlying rectus muscles were dissected off bluntly with Mayo scissors. The peritoneum was entered in sharply and extended superiorly and inferiorly with good visualization of the bladder. The bladder blade was inserted. The vesicouterine perineum was grasped between pickups and entered in sharply and extended bilaterally with Metzenbaum scissors. The bladder flap was created digitally. The bladder blade was reinserted. An incision was made in the lower uterine segment and extended bilaterally with bandage scissors. The baby’s head presented asynclitic and delivered without difficulty. The nuchal cord was noted around the baby’s head, which was reduced. The baby was bulb-suctioned. The body delivered and a cord was noted around the baby’s right arm. The cord was clamped and cut and the baby was handed to the awaiting nurse in stable condition. Cord blood was obtained. The placenta delivered intact. The uterus was cleared of all clots and debris. The uterine incision was closed with 0-Vicryl in a running interlocked fashion. A second layer was placed. Bleeding was noted from the patient’s left portion of the sutures were placed in that area and again hemostasis was assured. The area was copiously irrigated and again hemostasis was assured. The gutters were cleared of all clots and debris. Hemostasis was assured. The peritoneum was closed with 2-0 Vicryl. The fascia was closed with 0 Vicryl in a running interlocked fashion. Hemostasis was assured and the skin incision was closed with staples. The patient tolerated the procedure well. Sponge, lap and needle counts were correct x3.

ICD-10-CM code(s): __________________________________________
Case 33

Preoperative Diagnosis: Cervical incompetence.

Postoperative Diagnosis: Cervical incompetence.

Operation: Placement of cervical Shirodkar cerclage.

Anesthesia: Spinal.

Estimated Blood Loss: Minimal.

Description of Procedure: The patient was taken to the operating room, prepared and draped in normal sterile fashion after being placed in candy-cane stirrups. A weighted speculum was placed in the posterior aspect of the vagina and cervix was grasped at 12 and 6 o’clock and placed on gentle traction. A dissection was performed down the level of the endopelvic fascia both anteriorly and posteriorly and then a suture was passed from anterior to posterior, first on the patient’s left and posterior to anterior on the patient’s right and tied anteriorly. The cervix was closed and approximately 1.5-2 cm long on exam at the end of the procedure. The patient was taken in good condition to post-anesthesia recovery area after the instruments were removed from the vagina. On bedside ultrasound unremarkable fetal heart tones and normal amniotic fluid volume were observed for the 16 week pregnancy.

Attestation: I was present throughout the entire case and performed the surgery myself as the attending physician.

ICD-10-CM code(s):

Case 34

Operative Report


Postoperative Diagnoses: Menorrhagia. Right hydrosalpinx, 5 cm. Small intramural subserosal fibroids


Estimated Blood Loss: Less than 20 mL

Indications: The patient is a 43-year-old female with a significant amount of menorrhagia. On routine ultrasound she was found to have a 5 cm cystic adnexal mass on the right, which was asymptomatic. She had a normal endometrial stripe. The patient wished to have a hydrothermal ablation to help control her disruptive menorrhagia, and because of the large mass greater than 5 cm, she was advised to have a laparoscopy. She is aware that she had a normal CA125 but there is a very unlikely chance, but possible, this could be an ovarian malignancy or premalignancy, and we would do washings and a frozen section biopsy if it looked consistent with something significantly abnormal.
**Description of Procedure:** The patient was taken to the operating room and underwent satisfactory general anesthesia. Prepped and draped in the usual sterile fashion in the dorsal lithotomy position. Bimanual exam revealed a normal-size anteverted uterus and the adnexa were normal size on palpation. The bladder was drained, and then an open-sided speculum was used to visualize the cervix. The anterior lip was grasped with a long Allis and the cervix was easily dilated to admit the hydrothermal ablation hysteroscope. The hysteroscope revealed normal endometrium. The hysteroscope was removed and endometrial biopsies were performed, and then the hysteroscope was replaced. Once adequate placement had been assessed and there was no leaking, hydrothermal ablation was begun according to the steps by the manufacturer’s guidelines. There was a heating-up phase. There was noted to be a good seal. Ten-minute ablation phase at 81 degrees Celsius, and then a cooling-down phase of 1 minute. There was noted to be good ablation. The hysteroscope was then removed when the procedure was completed. A Khan’s cannula was placed on the cervix and attached to the long Allis. Then attention was turned towards the abdominal portion of the procedure. The surgeon’s gloves were changed. Once this had been done, a small infraumbilical skin incision was made, through which a 5 mm atraumatic trocar was placed under direct visualization into the intra-abdominal cavity. Once placement had been checked and noted to be normal, insufflation was performed and then two 5 mm suprapubic punches out laterally to the rectus muscles were placed under direct visualization. These were also blunt. Visualization of the pelvis revealed a large right hydrosalpinx distal to the banding, with adhesions to the right pelvic sidewall. The left tube and ovary were noted to be normal. There were some small fibroids that were intramural and subserosal in the uterus, and there was a normal-appearing right ovary. There were no other adhesions or cul-de-sac masses, or any upper abdominal abnormalities visualized on the laparoscopy. The PlasmaKinetic coagulator was then used to come across the tube, near the attachment to the uterus, and then across the broad ligament and then in between the tubo-ovarian ligament, therefore excising the large hydrosalpinx. There were some adhesions binding this down to the right pelvic sidewall and a peritubular cyst that were excised. Once this had been done, in order to get it out through the small port it was aspirated and then dissected into 3 small pieces, and then these were all removed through the 5 mm port and sent to pathology for permanent section. The abdomen was irrigated and the irrigant fluid was removed. There was no active bleeding under decreased pressure. Therefore, the procedure was terminated. All areas were reinspected and noted to be hemostatic. Once all instruments were removed, the ports were removed after decreasing insufflation, and there was no active bleeding. Then the 5 mm infraumbilical trocar was removed, along with the camera. Once all the gas had been allowed to escape, the 3 small incisions were closed with subcuticular 4-0 Monocryl suture, and then Dermabond was placed. The instruments were removed from the vagina, including an intact Kahn’s cannula with the acorn on the end. The speculum had already been removed, and the Allis was removed. There was only minimal bleeding. The patient was then awakened and extubated and taken to the recovery room in satisfactory condition. Sponge, needle and instrument counts were correct at the end of the case. There were 2 specimens sent to pathology, the right hydrosalpinx and also endometrial biopsies. Pathology Final Report

**ICD-10-CM code(s):** ___________________
Case 35

Preoperative Diagnosis: Abnormal mammogram right breast, two separate abnormal microcalcified areas.

Postoperative Diagnosis: Abnormal microcalcifications

Procedure: Right stereotactic core needle biopsy of two separate abnormal micro calcified areas. These were labeled as 12 o’clock and lateral.

Anesthesia: 1 percent Xylocaine.

Surgeon: Sam Brown, MD

Complications: None.

Estimated Blood Loss: Negligible.

Technique: The 12 o’clock lesion was approached first. A craniocaudad approach was taken with Dr. Brown targeting of both lesions. Pre and post-fire films were taken and a $\frac{3}{4}$ incision made with Xylocaine infiltration. Core samples were obtained with the 8-gauge sampler in 4-quadrant biopsy and post-biopsy film as well as specimen radiography confirmed adequate sampling of the micro calcified areas. A clip was then placed at this site. The lateral lesion was approached with a craniocaudad approach as well. It was necessary to pre-fire. This area was targeted and a $\frac{3}{4}$ incision made. Post-placement film confirmed good placement of the sampler. Core samples were obtained with the 8-gauge sampler in four quadrants and post-biopsy film as well as specimen radiography confirmed adequate sampling. A clip was placed in the lateral lesion similar to the 12 o’clock lesion. Steri-Strips and Benzoin were applied. The patient was taken for film screen mammogram. A pressure dressing was applied and she will call for a pathology report.

ICD-10-CM code(s): ________________________________