

Case 5

Preoperative Diagnoses:

1. Intrauterine pregnancy at 40 plus 1 weeks.
2. History of previous cesarean section.
3. Failure to progress.

Postoperative Diagnoses:

2. Intrauterine pregnancy at 40 plus 1 weeks.
2. History of previous cesarean section.
3. Failure to progress.

Procedure Performed: Repeat low transverse cesarean section via Pfannenstiel

Surgeon: OB, MD.

Anesthesia: Spinal. [1]

Complications: None.

Operative Findings: Male infant in cephalic presentation with weight of 7 pounds 2 ounces. Apgars 8 and 9. Infant discharged to nursery. Fluid was clear. Also noted were dense adhesions of the left rectus muscle to the anterior uterus.

Indications for Procedure: The patient is a 29-year-old G4, P2-0-11-2 who presented with contractions. She did have history of previous cesarean section [2] and desired a TOLAC. [3] She did progress to 6-7 cm. However, from there she failed to progress and given her history of previous cesarean section, she was not appropriate candidate for augmentation. [3] The patient also requested cesarean section at this time.

Description of Procedure: The patient was taken to the operating room where she was placed in the dorsal supine position with a leftward tilt. She was prepped and draped in the usual sterile fashion. Pfannenstiel skin incision was made and carried through to the rectus muscles. The fascia was densely scarred. Fascia was incised sharply. Rectus muscles were dissected off the fascia. At this time, entry into the peritoneum was made bluntly. There was a great deal of dense adhesions from the left rectus muscle to the anterior uterus. This was partially taken down. Bladder flap was made both bluntly and sharply. Bladder blade was inserted and uterine incision was made. No meconium noted. Infant's vertex was delivered to the incision without difficulty. Remainder of the infant was delivered. [4] Cord was clamped and cut and the infant was handed off to the awaiting Pediatric team. Placenta was delivered spontaneously. Secondary to adhesions, the uterus was not able to be exteriorized. It was cleared off all clot and debris. The uterus was closed in 1 layer using 0 Monocryl in running locked suture. Secondary to the dense adhesions and proximity to the bladder, the second layer was unable to be placed. Hemostasis was noted. Urine at this time was noted to be clear. The fascia was closed with 0 Vicryl. This was after hemostasis was assured on the fascial edges as well as the rectus muscles. Skin was closed with staples. There were 2 horizontal mattress sutures placed into the subcutaneous tissue. The patient tolerated the procedure well. Sponge, lap and needle counts correct x2. She was taken to recovery room in stable condition.

[1] Type of anesthesia given for the cesarean delivery.

[2] Indication of having a previous cesarean delivery.

[3] Indication of a failed attempted vaginal delivery. TOLAC means trial of labor after cesarean.

[4] Successful cesarean delivery.

Case 7

Operative note

Preoperative diagnosis: Colonic polyposis

Postoperative diagnosis: Colonic polyposis

Operative procedure: Total colonoscopy [1]

Indications:

The patient is a 45-year-old white male, known to me for a number of years, who I have seen for colon polyps. [2] He has been followed by several local doctors over the last few years; however, returns for his routine follow-up colonoscopy. [3] He appears to understand the risks, rationale, expected outcome, typical postoperative course, and is willing to proceed as outlined.

Procedure:

The patient is placed on the table in the left lateral decubitus position, given IV Demerol and propofol for sedation. Following this, a digital rectal examination was performed which was essentially unremarkable. This was followed by introduction of the Olympus video colonoscopy, which was advanced through a mildly tortuous sigmoid colon into the descending, transverse, and ascending colon to the level of the cecum. [4] There were no polyps, telangiectasias, angiodysplasias or other endoluminal abnormalities encountered. The ileocecal valve was visualized without difficulty. The scope was gradually removed and the air evacuated. The scope was removed. The patient tolerated the procedure well and was transferred to the recovery area in stable condition.

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- [1] Indication of procedure being performed.
 - [2] Patient has a history of colon polyps.
 - [3] Indication of a screening.
 - [4] Diagnostic Colonoscopy viewing the colon past the splenic flexure.

26. What is the first listed ICD-9-CM diagnosis code?

- a. 211.3
- b. V76.52
- c. 211.8
- d. V76.51

Rationale: As per ICD-9-CM Official Guidelines, Section I.18.d.5: "A screening code may be a first listed code if the reason for the visit is specifically the screening exam." According to Medicare, no symptoms, high risk, and nothing found equal V76.51 as the primary diagnosis code. This is indexed under Screening/colonoscopy.