COMPLETE CODING KNOWLEDGE AND SKILLS ASSESSMENT

A. ICD-9-CM / CPT Coding Exercises

The following multiple-choice questions reflect the types of coding issues often encountered at hospital-based coding sites. Questions relate to Inpatient, Outpatient Surgery, and ED/ER encounters. Please select the letter which most appropriately and accurately answers the question.

1) A 45-year-old patient is taken to the Emergency Room with severe chest pain. The patient has a history of arteriosclerotic coronary artery disease, status post PTCA. Discharge diagnosis given by the attending ER physician was “Chest pain, noncardiac possible angina.” The appropriate primary diagnosis is:

a) Chest pain
b) Unstable angina
c) CAD of native coronary vessels
d) Acute coronary syndrome

2) An elderly 77-year-old male patient with a history of atrial fibrillation on Coumadin therapy is seen in the Emergency Room due to recurrent epistaxis. The physician documents ‘Epistaxis secondary to Coumadin therapy coagulopathy’. The appropriate primary diagnosis should be:

a) 784.7
b) 286.5
c) 286.9
d) 286.7

3) A patient with worsening cough and shortness of breath is sent to the Emergency Room and a chest x-ray is ordered and taken. The radiologist documents “Large apical chest wall mass and multiple lung densities, consistent with chest wall malignancy with a lung cancer primary” as the impression on the radiology report. The Emergency room physician documents, “Chest mass, probable lung cancer”. What diagnosis (es) should be reported and the correct sequence:

a) 786.6, 198.89
b) 198.89, 162.9
c) 195.1
d) 786.6, 786.05, 786.2
e) 162.9, 198.89

4) A patient came to the emergency room with hypotension and tachycardia. Upon exam, the patient’s condition was determined to be the result of a tetanus toxoid that was administered four hours earlier. Which of the following is the appropriate sequencing?

a) Hypotension; tachycardia; and accidental poisoning due to tetanus toxoid
b) Unspecified adverse reaction and undetermined cause E code
c) Poisoning due to tetanus toxoid and therapeutic use E code for tetanus toxoid
d) Hypotension; tachycardia; and therapeutic use E code for tetanus toxoid
5) The following ICD-9-CM index entries appear:

- Encephalitis
  - Infectious (acute) (virus) NEC 049.8
  - Postinfectious NEC 136.9 [323.62]

The diagnosis listed by the physician is “encephalitis after infection.” Which of the following represents the correct coding and sequencing?

a) 049.8  
b) 323.62  
c) 136.9; 323.62  
d) 049.8; 136.9

6) Child presents to emergency room accompanied by parents. The patient has a large 1.5 cm splinter lodged on the sole of his foot superficially, after playing on a wooden floor in his bare feet at home. The physician prepares the area with Betadine, and pulls the splinter out with tweezers without making an incision. The appropriate CPT code is:

a) An appropriate evaluation/management code for emergency room services. (99185-99285)  
b) 28190   Removal of foreign body, foot; subcutaneous  
c) 10120  Incision and removal of foreign body, subcutaneous tissues; simple  
d) A and B

7) An ambulatory surgery patient had a colonoscopy performed because of intermittent severe constipation. Abdominal ultrasound done one-week prior revealed a possible small mass near the ascending colon. The physician utilized a standard colonoscope to view the entire colon, and then employed an echoendoscope, utilizing a balloon tipped transducer housing to visualize the ascending colon in the area where the suspicious mass and stricture was visualized. The balloon was filled with water, and imaging and dilation of the one area was performed to identify any extrinsic mass, which may have been causing the compression/stricture of the bowel. No extrinsic mass or lesion was visualized to explain the patient’s symptoms; therefore further diagnostic treatment was not indicated. The appropriate CPT code(s) for this procedure is:

a) 45341   Sigmoidoscopy, flexible; with endoscopic ultrasound examination  
b) 45391   Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination  
c) 45378   Colonoscopy, flexible, proximal to splenic flexure; diagnostic with/without collection of specimen (s) by brushing/washing, with/without colon decompression (separate procedure)  
d) 45386   Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures

8) A patient is treated in ambulatory surgery for bunion and hammertoe deformity right foot. Procedures performed were bunionectomy with prosthesis of metacarpophalangeal joint on right first (great) toe, and correction of hammertoe on right 2nd toe. The appropriate CPT code(s) (with modifiers) is/are:

a) 28293 T5 Rt   Hallux valgus (bunion) correction; resection of joint with implant  
b) 26531 TA Rt   Arthroplasty, metacarpophalangeal joint; with prosthetic implant, each joint  
c) 28285 T6 Rt   Correction of hammer toe, (eg, interphalangeal fusion, partial or total phalangectomy)  
d) A and C
9) A patient who is status-post meniscectomy has persistent knee pain, which limits his activity significantly. He undergoes a left medial meniscal transplant (which requires that the remnant of the meniscus be removed), accomplished via arthroscope. The appropriate CPT codes(s) is (are):

a) 29881-LT  Knee arthroscopy, surgical; with meniscectomy (medial or lateral, including meniscal shaving).
b) 29882-LT  Knee arthroscopy, surgical; with meniscus repair (medial or lateral)
c) 29881-LT  Knee arthroscopy, surgical; with meniscectomy (medial or lateral, including meniscal shaving); and 29868-LT  Knee arthroscopy, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
d) 29868-LT Knee arthroscopy, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral

10) A 39 year old male underwent colon resection for carcinoma of the transverse colon. The progress note on post-op day 2 states anemia. How is this anemia coded?

a) 285.1
b) 998.11, 285.1
c) 998.11
d) unable to code, must query the physician

11) A 75-year-old male patient is admitted with second- and third-degree burns of the back and second- and third-degree burns of the upper arm. Which of the following diagnosis codes would be correct?

a) 942.34, 942.24, 943.33, 943.23
b) 946.3
c) 942.34, 943.33
d) 942.24, 943.23

12) A cause-and-effect relationship between hypertension and which of the following conditions may be assumed?

a) Chronic kidney disease
b) Heart failure
c) Neither condition
d) Both heart and chronic kidney disease

13) A patient is admitted with chief complaints of fever, cough, weakness, and confusion. The patient's chest x-ray revealed a right-sided infiltrate and pneumonia was confirmed. The patient was also found to be in renal failure. The following day, patient's blood cultures were positive for E-coli and the attending physician documented, "placed patient on broad antibiotic coverage for patient's septic condition." The discharge summary listed severe e-coli sepsis, pneumonia, and acute renal failure. The appropriate sequence of codes for proper DRG assignment is:

a) 038.9, 785.52, 486, 584.9
b) 038.42, 995.92, 486, 584.9
c) 995.91, 038.42, 486, 584.9
d) 038.42, 995.91, 486, 584.9
B. Case Examples Using Your Coding Books

1. A 35-year-old male patient is admitted to the hospital and the documentation states “dementia due to advanced HIV disease”. Assign the correct ICD-9-CM code(s): _________________________________

2. A 52-year-old male patient, sustained second-degree burns of forearm and palm of hand, and first degree of face (accidental steam burn in factory). He was seen in the emergency room and then admitted to the hospital. Assign the correct ICD-9-CM codes to assign?: _________________________________

3. A 76-year-old male patient was admitted with a decubitus ulcer and cellulitis of the left heel. The patient complained of pain and swelling. The ulcer is open and draining purulent material. After IV antibiotics and wound cleansing for three days the decision was made to have the wound care nurse perform an excisional debridement at bedside. The debridement was performed using a scalpel, removing nonviable tissue and skin. The depth of the debridement was subcutaneous. The wound was cleansed again and a dressing applied. What ICD-9-CM Diagnosis and procedure code would be assigned for the debridement?: _________________________________________________

4. A 25-year-old female patient is 3 months pregnant for the first time and is seen due to pain and burning on urination (she has a history of UTIs in the past) and with a UTI now. Assign the correct codes and sequence to be assigned?: _______________________

5. A patient is admitted to the hospital with severe Staphylococcus aureus sepsis and acute respiratory failure. The patient was in ICD for 3 days on mechanical ventilation. The patient also has CHF and is on Lasix. The patient also has diabetes type II with nephropathy. Assign the correct ICD-9-CM codes and in the correct sequence?: ____________________________

6. A 6 yr old patient presents for a primary tonsillectomy. Anesthesia is administered and procedure commenced. Physician removes tonsils only on the right side, but decides nothing needs done on the left. Assign the correct CPT code(s): ______________________________

7. Procedure: Repair deep laceration of the right arm and shoulder. Clinical Indication/Diagnosis: Deep laceration of right arm/shoulder from broken glass Technique/Details: A 2.8 cm simple laceration was repaired on the right arm. A 2.6 cm laceration on the shoulder was also repaired via simple closure and extensive removal of glass. Assign the correct CPT code(s): __________________________________

8. A 55-year-old patient with known GI problems come to the ER complaining of abdominal pain and feeling weak and faint. Lab work reveals a low Hct/hgb. The patient receives a blood transfusion of 2 units whole blood without any adverse effects. Assign the correct CPT code(s): ______________________________

9. What is the appropriate E/M code for a new patient office visit in which a comprehensive history and comprehensive physical exam were performed and medical decision making was of high complexity? Select the correct E/M code:_______________________________
C. Case Studies

**INPATIENT**
**CASE STUDY 1**

**DISCHARGE SUMMARY**

**ADMITTING DIAGNOSES:**
1. Pneumonia, community acquired vs bacterial
2. Bronchitis, chronic
3. Anemia
4. Cellulitis of legs
5. CHF

**FINAL DIAGNOSES:**
1. Pneumonia, probable bacterial
2. COPD exacerbated
3. Anemia of chronic disease
4. Cellulitis of legs improving
5. CHF

**PROCEDURE PERFORMED:**
1. Wound care to left leg
2. Insertion of CVP

**HISTORY OF PRESENT ILLNESS:** This is a 61 year-old-male, a nursing home resident, who was admitted with cough and severe shortness of breath for one week. He had a chest x-ray taken at the nursing home which showed bibasilar infiltrates. The patient was given Zithromax and Clindamycin.

**HOSPITAL COURSE:** The patient has dramatically improved. He was given antibiotics; Vancomycin and Maxipen, which was later, discontinued and changed to Nafcillin as wound cultures grew out MRSA. Wound care performed with good outcome. Since the patient’s wounds are improving and he is becoming more asymptomatic, with no cough and no shortness of breath, the patient will be transferred back to the nursing facility.

**ACTIVITIES:** As tolerated

**FOLLOW UP:** Continue to follow up at the nursing home

**HISTORY AND PHYSICAL**

**CHIEF COMPLAINT:** Shortness of breath

**HISTORY OF PRESENT ILLNESS:** This is a 61 year-old-male, a nursing home resident, who was admitted with cough and severe shortness of breath for one week. He had a chest x-ray taken at the nursing home which showed bibasilar infiltrates. The patient was given Zithromax and Clindamycin.

**PAST MEDICAL HISTORY:** Patient has a previous history of congestive heart failure, hypertension, chronic obstructive pulmonary disease, cellulitis of both legs and GERD.

**PHYSICAL EXAMINATION:** Mental status normal, patient is single and lives alone. All vitals are stable. Denies alcohol or tobacco use.
ALLERGIES: NKDA

CLINICAL IMPRESSION:

1. Pneumonia, community acquired vs bacterial
2. Congestive Heart Disease
3. Chronic Obstructive Pulmonary Disease
4. Cellulitis of legs
5. Chronic bronchitis

PLAN:

1. Admit to hospital for bronchodilator therapy
2. Wound care

DAY 1 – Patient very short of breath, very labored. Epistaxis for unknown reason. Cellulitis of both legs, but left leg much worse – to have wound care by nurse. Bronchodilators began and anemia being monitored.

DAY 2 – Acute COPD, very short of breath, vitals stable – continue using bronchodilators

DAY 3 – Mild SOB, coughing and wheezing. Wound care performed on the left leg – thoroughly cleansed, non-excisional debridement, wound covered with a 4x4.

DAY 4 – Mild SOB, persistent cough, sputum positive for MRSA Pneumonia – continue using bronchodilators

DAY 5 – Placed a central venous catheter – tolerated procedure well

DAY 6 – Friendly, smiling and very talkative – hypertension well controlled. No cough or shortness of breath. Continue wound care.

DAY 7 – Patient stable and ready for discharge back to ECF.

PHYSICIAN ORDERS

DAY 1 – Admit to hospital
    Diet 1800 cal ADA
    Labs – Sputum C&S, wound swab – UA sent to lab – T3, T4, TSH, Lipid panel

DAY 2 – Vancomycin 1 gr stat
    Advair 100/50 1 puff bid
    Alphagan 0.2% 1 gtt os tid
    Tylenol 5 po prn

DAY 3 – Colace 100 mg po tid
    Norvasc 10 mg po qid

DAY 4 – Change Vancomycin to NPB q24 hr start now

DAY 5 – Ativan 1 mg q2 hr prn

DAY 6 – Transfer to 5th floor with same orders

DAY 7 – Discontinue Vancomycin, Alphagan, Ativan
    Discharge to ECF
INPATIENT
CASE STUDY 2

DISCHARGE SUMMARY

ADMITTING DIAGNOSIS: Malaise and fatigue

HOSPITAL COURSE: A 78-year-old male with a past medical history of hypertension, diabetes, seizure disorder, CVA, coronary artery disease. Patient was found to have facial droop and lethargy and therefore admitted to the hospital. CT scan done in the emergency room showed a possible right CVA. Patient began on Aggrenox, and physical therapy. Recovered well, remains bedridden will be discharged to the nursing facility with continued physical therapy.

DISCHARGE DIAGNOSES:

1. CVA with dysphagia
2. Hypertension
3. Diabetes II
4. GERD
5. Coronary artery disease
6. Seizure disorder
7. Old CVA with left hemiparesis
8. Dehydration

Will continue follow the patient in the nursing home, PT to be continued.

HISTORY AND PHYSICAL

CHIEF COMPLAINT: Increased lethargy, facial droop, left sided weakness

HISTORY OF PRESENT ILLNESS: A 78 year-old-male with a past medical history of hypertension, diabetes, seizure disorder, CVA, coronary artery disease. Patient was found to have facial droop and lethargy and therefore admitted to the hospital. CT scan done in the emergency room showed a possible right CVA. Patient began on Aggrenox, physical therapy.

PAST MEDICAL HISTORY: As per history of present illness

ALLERGY HISTORY: None known

SOCIAL HISTORY: Resident of a nursing home. Patient does not drink or smoke. Family history is noncontributory.

REVIEW OF SYSTEMS: Unable to obtain as the patient is confused

PHYSICAL EXAMINATION: In general, an elderly man lying in bed with obvious left facial droop, but in no acute distress.

IMPRESSION:

1. TIA – rule out CVA
2. Seizure disorder
3. History of CVA with left hemiparesis
4. Coronary artery disease
5. Hypertension
6. Dehydration
7. Chronic renal failure
8. Diabetic nephropathy
9. DM II
10. GERD

**PLAN:** Urinalysis, C&S if indicated. Telemetry monitoring and serial cardiac enzymes and electrocardiograms. Keep NPO for now.

**PROGRESS NOTES:**

**DAY 1** – Altered mental status probably due to TIA, however will need to rule out CVA, urinary tract infection and acute coronary syndrome. Facial droop, weakness and lethargy were noted.

**DAY 2** – Patient lying in bed, family at bedside, alert, talks with some difficulty because of facial droop but answers questions appropriately. Feels hungry.

**DAY 3** – CVA; Lab results rule out urinary tract infection – blood pressure stable. Ruled out acute coronary syndrome. MRI will be performed tomorrow to confirm infarct.

**DAY 4** – Patient not in any distress, no complaints. Lungs clear – abdomen soft – labs normal

**DAY 5** – MRI results show a possible infarct in the occipital lobe. Patient is anxious to go home – ready for discharge. Discharge diagnosis - CVA
INPATIENT
CASE STUDY 3

DISCHARGE SUMMARY

ADMITTING DIAGNOSIS: Chest pain, rule out acute coronary artery disease

DISCHARGE DIAGNOSES:

1. Acute intermediate coronary syndrome
2. Arteriosclerosis of the native coronary vessels
3. Atrial fibrillation
4. Second degree atrioventricular block
5. Postoperative atelectasis

PROCEDURE PERFORMED:

1. Left heart catheterization, selective coronary angiography, and percutaneous transluminal coronary angioplasty.

HOSPITAL COURSE: This is a 72-year-old female with a history of severe chest pain and atrial fibrillation. She came in with acute intermediate coronary syndrome. A myocardial infarction was ruled out. In view of these events, it was decided to perform a diagnostic heart catheterization and possible percutaneous transluminal coronary angioplasty versus bypass surgery.

A diagnostic heart catheterization was performed and showed the following: the left main coronary artery was open, the left anterior descending artery was open, and there was a totally occluded distal right coronary artery. There was some collateral circulation filling the right coronary artery. In view of this, it was felt that the patient would benefit from percutaneous transluminal coronary angioplasty, so the patient received IV Heparin, ReoPro and intracoronary Nitroglycerin and we were able to open the distal right coronary artery with balloon angioplasty.

The patient began ambulation the day after the above procedure. Patient developed persistent pulmonary atelectasis during the postoperative period. Chest x-ray’s were done daily. The patient is stable at discharge. All medications were changed to po. She will follow a low cholesterol, low fat diet. She is to follow up in my office in one week.

HISTORY AND PHYSICAL

CHIEF COMPLAINT: Chest pain

HISTORY OF PRESENT ILLNESS: A 72-year-old female with a history of severe chest pain for the past couple of days, has taken one aspirin a day. She experienced an episode of palpitation and lightheadedness last night and this morning. The patient called 911 and the EMS staff found her with a very fast rhythm, heart rate of 160 per minute accompanied with atrial fibrillation. She denied any prior history of palpitations prior to this episode. The patient denies diabetes mellitus or high blood pressure. She denies a history of myocardial infarction in the past. She has a strong family history of coronary artery disease. She denies alcohol or smoking.

PAST MEDICAL HISTORY: Only pertinent for persistent chest pain, atrial fibrillation, low HDL and a strong family history of coronary artery disease.

PAST SURGICAL HISTORY: History of back surgery 30 years ago

ALLERGIES: Sulfa

REVIEW OF SYSTEMS: See history of present illness.
ASSESSMENT:
1. Prolonged chest pain, rule out acute coronary artery disease
2. Mobitz type I second degree atrioventricular block
3. Atrial fibrillation

PLAN:
1. Admit to telemetry. Obtain cardiac enzymes.
2. Place on norvasc and nitrates
3. Cardiac catheterization and possible electrophysiology study

PROCEDURE NOTES

PROCEDURE:
1. Left heart catheterization with selective coronary angiography
2. PTCA of distal right coronary artery

PREOPERATIVE DIAGNOSIS: Unstable angina r/o CAD

POSTOPERATIVE DIAGNOSIS: CAD with unstable angina

PROCEDURE NOTE:
A diagnostic left heart catheterization was performed and showed the following: the left main coronary artery was open, the left anterior descending artery was open, and there was a totally occluded distal right coronary artery. There was some collateral circulation filling the right coronary artery. In view of this, it was felt that the patient would benefit from percutaneous transluminal coronary angioplasty, so the patient received IV Heparin, ReoPro and intracoronary Nitroglycerin and we were able to open the distal right coronary artery with balloon angioplasty. There was no clot formation or dissection. The patient returned to the floor in stable condition.

PROGRESS NOTES

DAY 1 – Severe chest pain
   Enzymes negative for AMI
   Unstable angina, probable coronary occlusion
   Heart cath. and possible PTCA

DAY 2 – Patient feels tired, complains of heaviness in chest
   Labs within normal limits; Chest x-ray revealed atelectasis
   CAD
   Observe a few more days

DAY 3 – Some chest pain, heaviness
   Chest x-ray still positive for atelectasis

DAY 4 – Responding to antibiotic
   CXR improving; labs within normal limits

DAY 5 – Atelectasis clearing
   Very anxious to go home

DAY 6 – Ready to go home
   Wounds clean and dry, afebrile, tolerating diet
Chest x-ray clean
Discharge today
AMBULATORY CARE
CASE STUDY 4

HISTORY AND PHYSICAL

CHIEF COMPLAINT: Rule out breast cancer

HISTORY OF PRESENT ILLNESS: 69-year-old lady who discovered a lump in her right breast. Breast is very tender, lump is hard, no discoloration noted.

PHYSICAL EXAMINATION: Well-developed well-nourished, pleasant and highly anxious female

PLAN: She will undergo an excisional breast biopsy in the upper outer quadrant and a biopsy of lymph node. She has been given the typical breast cancer government publication. After a thorough discussion of all this, I think both the patient and her husband understood her situation very well and agreed to proceed.

OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Lump/lesion of the upper outer quadrant of the right breast.

POSTOPERATIVE DIAGNOSIS: Carcinoma of the upper outer quadrant of the right breast with no evidence of metastasis disease to the auxiliary node.

PROCEDURE PERFORMED: Excisional biopsy of right breast with biopsy of lymph node.

INDICATIONS: The patient is a 49-year-old lady who has a breast lesion that is thought to be malignant.

PROCEDURE: An incision was made in the upper outer section of the breast, lesion seen and excision carried out. Another incision was then made in her right axilla and carried down to the deep tissues where the lymphatic vessel was found. It was followed down to the auxiliary node, which was biopsied. Both specimens were given to the pathologist who reported to the surgeon that the breast lesion was positive for cancer but that the lymph node was negative for metastatic disease.

PROGRESS NOTE
Pathology reviewed revealing infiltrate ductal carcinoma of the right breast, without metastasis disease. Patient has no complaints. Some soreness of breast noted, to be expected. Ready for discharge.
AMBULATORY CARE
CASE STUDY 5

HISTORY AND PHYSICAL

CHIEF COMPLAINT: Inguinal hernia

PAST MEDICAL HISTORY: No history of paroxysmal, nocturnal dyspnea, orthopnea or pedal edema. No history of any nausea or vomiting, diarrhea or constipation. Patient has no complaints of pain or burning on urination or difficulty urinating. Patient did have a left hydrocelectomy in the past. No history of any fractures or other abnormalities of this system including arthritis. Trigger finger noted of the right ring finger.

HISTORY OF PRESENT ILLNESS: 76-year-old male with inguinal hernia who desires surgical intervention at this time. Also complains of a trigger finger and wishes a release be performed.

PHYSICAL EXAMINATION: Well developed well-nourished male. Vitals stable

LABORATORY STUDIES: Normal

IMPRESSION: Left inguinal hernia and trigger finger of right ring finger

PLAN: The patient is brought in for hernia repair and trigger finger release.

OPERATIVE REPORT

PREOPERATIVE DIAGNOSES:
1. Left inguinal hernia
2. Right ring trigger finger

POSTOPERATIVE DIAGNOSES: Same as above

PROCEDURE PERFORMED:
1. Repair of inguinal hernia
2. Release of trigger finger

OPERATIVE SUMMARY: A left inguinal incision was carried down through the skin and subcutaneous tissue. The fascia of the external oblique was carefully opened so as not to injure the ilioinguinal or iliohypogastric nerves. There was some direct weakness, but the patient’s main problem was an indirect inguinal hernia. The interior contents were dissected down as far as possible and then the hernia sac was dissected down to the internal ring. It was sutured, ligated and imbricated and then allowed to retract. Forming a piece of prolene mesh into the floor of the inguinal canal, securely sutured in place – repair completed. Attention was then directed toward the ring finger of the right hand where a trigger finger release was performed without any difficulties.

PROGRESS NOTE

POSTOPERATIVE DIAGNOSES:
1. Inguinal hernia
2. Trigger finger

POSTOPERATIVE NOTE: No drainage noted, no complications reported therefore patient would be discharged home within the hour.
EMERGENCY ROOM CARE
CASE STUDY 6

EMERGENCY ROOM REPORT

CHIEF COMPLAINT:  Fall

HISTORY OF PRESENT ILLNESS:  A 86 year old female tripped and fell while shopping in her local grocery store, injuring her right wrist, laceration of forehead, laceration of her right shoulder and right knee.  She was brought to the emergency room by ambulance in quite a bit of distress from the fall.

PAST MEDICAL HISTORY:  Has a history of mild congestive heart failure and osteoporosis.

REVIEW OF SYSTEMS:  Refer to history

PHYSICAL EXAMINATION:  Blood pressure 142/60, pulse 62, respirations 20, temperature 97.5.  There is a dirty 3.0 cm laceration of knee, 2.5 cm laceration of forehead and 3.2 cm laceration of shoulder.

DIAGNOSTIC TEST RESULTS:  X-ray of right wrist indicates a comminuted fracture of the right distal radius.

EMERGENCY ROOM COURSE:  IV was established for administration of Demerol 50 mg and Phenergan 12.5 mg for pain. Cardiac monitor showed a normal sinus rhythm.  Reduction of right distal radius performed under local anesthetic and then placed in an air cast.  Cleansed the affected areas.  Infiltrated with a local anesthetic, simple suture of the forehead with interrupted sutures of 4-0 Vicryl.  Infiltrated with local anesthetic, layered suture of the shoulder with interrupted sutures of 4-0 Vicryl.  Infiltration with local anesthetic thoroughly cleansed dirty laceration, layered suture and debrided the knee with interrupted sutures of 4-0 Vicryl.  All areas were closed with interrupted sutures of 4-0 Ethilon.

FINAL DIAGNOSES:
1. Fracture of distal radius
2. Laceration of knee, shoulder and forehead
3. Osteoporosis
4. Congestive heart disease

PLAN:  Discharged home with pain medications and to follow up with orthopedist within 2 days.
EMERGENCY ROOM REPORT

CASE STUDY 7

CHIEF COMPLAINT: Bloody nose.

HISTORY OF PRESENT ILLNESS: 40 year-old male woke up at 0530 with a bloody nose. No headache. No blurred vision. He presents by ambulance for further evaluation and management.

REVIEW OF SYSTEMS: Bilateral oozing from nose. Alert and oriented to room, respirations regular and unlabored, skin warm and dry.

PAST MEDICAL HISTORY: dm-insulin dependent, htn, gerd.

ADDITIONAL INFO: Non-compliant with meds. Patient states he was ordered by PMD to take anti-hypertensives, but he stopped taking them.

PHYSICAL EXAMINATION: There is no obvious distress. Vital Signs have been reviewed. He is noted to be significantly hypertensive at 231/146. His heart rate was 101.

PROCEDURE: Bilateral anterior packing was performed. Bleeding stopped quickly.

ASSESSMENT:
   1. epistaxis, resolved
   2. hypertensive urgency