CODING KNOWLEDGE AND SKILLS ASSESSMENT
Inpatient Coding

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. Please select the letter, which most appropriately and accurately answers the question.

1) 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

2) 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

3) A patient with a history of alcoholic cirrhosis is admitted to the hospital with hematemesis. The patient had an EGD and was found to have an oozing gastric varix, as well as esophageal varices, which were not actively bleeding during the endoscopy. The appropriate principal diagnosis is:
   a) Alcoholic cirrhosis
   b) Gastric varix
   c) Hematemesis
   d) Esophageal varices in diseases classified elsewhere without mention of bleeding

4) A patient is admitted with severe chest pain. The patient has a history of arteriosclerotic coronary artery disease, status post PTCA. The patient was taken to the cardiac cath lab and had a left heart catheterization, selective angiogram and left ventriculogram. Discharge diagnosis given by the attending physician was “Chest pain, noncardiac.” The appropriate principal diagnosis is:
   a) Chest pain
   b) Unstable angina
   c) CAD of native coronary vessels
   d) Acute coronary syndrome

5) An elderly patient with a history of atrial fibrillation on Coumadin therapy is admitted for treatment of epistaxis. The patient has nasal packing inserted to control the bleeding. The physician documents ‘Epistaxis secondary to Coumadin therapy coagulopathy’. The appropriate principal diagnosis should be:
   a) 784.7
   b) 286.5
   c) 286.9
   d) 286.7
6) A patient is admitted with left-sided weakness, slurred speech and confusion. Physician documented on admission “Possible TIA, rule out CVA. The patient had a CT scan and MRI of the brain, the results of which showed a small acute lacunar infarction. The attending physician does not reference the imaging finding, but only documents ‘cerebrovascular accident’ on the discharge summary. The patient was discharged home without any residual weakness or slurred speech. The appropriate code(s) are:

a) 434.91  
b) 436, 342.90, 782.5  
c) 436  
d) 435.9

7) 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

8) A 76 year-old female is admitted with gastrointestinal bleeding. An AV malformation is found. A surgeon is called in and the decision is made to perform a resection of the large bowel with end-to-end anastomosis, which is then performed. Correct codes and sequencing are:

a) 569.85; 45.79; 45.94  
b) 747.61; 578.9; 45.79; 45.94  
c) 569.85; 578.9; 45.79  
d) 747.61; 45.79

9) A comatose patient is admitted to the hospital via the Emergency Room in acute respiratory failure for which patient was intubated and ventilated. An MRI and CT scan of the brain reveal massive intracerebral hemorrhage. Aspiration pneumonia subsequently develops on the third day of hospitalization. The appropriate sequence of diagnoses codes for proper DRG assignment is:

a) 518.81, 431, 507.0, 780.01  
b) 507.0, 431, 518.81, 780.01  
c) 780.01, 518.81, 431, 507.0  
d) 431, 518.81, 507.0, 780.01

10) 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
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. An elderly gentleman with an indwelling catheter is admitted to the hospital with fever, chills, and mental confusion. The diagnosis is UTI and Urosepsis. The progress note on the 2nd day states, sepsis due to Foley catheter and UTI. The patient is discharge after 4 days.
   Based on this documentation what ICD-9-CM codes would be assigned and in what sequence?: ________________________________

6. 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?: ________________________________
C. Inpatient 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

PROGRESS NOTES

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 DIAGNOSES:
1. Fall with fracture of right hip
2. Dehydration
3. Ascites

DISCHARGE DIAGNOSES:
1. Fracture of femoral neck and intertrochanteric right hip
2. Severe osteoarthritis of hip
3. Postoperative blood loss anemia
4. Hyperkalemia
5. Dehydration – resolved
6. Ascites in alcoholic liver cirrhosis
7. Hyperammonemia

PROCEDURE PERFORMED:
1. Hemiarthroplasty of right hip
2. Transfusion of RPBC – 2 units
3. Paracentesis

HOSPITAL COURSE: The patient was admitted to the hospital for bed rest, hydration, monitoring of blood pressure and pain medication. The orthopedic surgeon examined the patient and concurred with diagnosis of femoral neck fracture of the right hip. Performed a hemiarthroplasty and found an additional fracture of the greater trochanter – patient tolerated the procedure well. The patient had significant pain after the surgery and experienced severe blood loss anemia following surgery. Transfusion of packed cells was given and patient improved. Blood pressure fluctuated slightly and was controlled well with medication.

On postoperative day two, patient underwent paracentesis for removal of 2.5 liters of ascites. Postoperative course was further complicated by the rise in ammonia. This came down with Lactulose.

Patient was discharged to the subacute unit for physical therapy. To be maintained on a low salt diet with moderate fluid restriction.

HISTORY AND PHYSICAL

REASON FOR ADMISSION: Fracture of right hip

HISTORY OF PRESENT ILLNESS: A 84 year-old-female was walking down the stairs at home when she tripped and fell, landing on her right side. She believed she broke her hip. Unable to walk and in severe pain she called her family and they brought her to the hospital.

Examination and x-ray determined a right hip fracture of the femoral neck with severe osteoarthritis of the same hip.

PAST MEDICAL HISTORY: Significant for long standing alcoholic liver disease with cirrhosis and ascites. And he was found to have massive ascites.

SOCIAL HISTORY: Lives alone with her many cats.

REVIEW OF SYSTEMS: Massive ascites, liver spans about 2-3 fingers below costal margin and is firm.

PHYSICAL EXAMINATION: Well-developed female in considerable distress due to fall. Blood pressure 180/110, pulse 88, marked muscle wasting.
IMPRESSION:
1. Femoral neck fracture of right hip secondary to fall at home
2. Dehydration
3. Chronic cirrhosis

PROGRESS NOTES

DAY 1 – Fracture of right femoral neck
   Postoperative anemia due to blood loss – transfusion given
   Pain – severe
   Complete bed rest

DAY 2 – Postoperative care given
   Transfusion given
   Paracentesis performed
   Elevated ammonia level

DAY 3 – Pain in right hip, 'it feels too heavy'
   Lungs clear
   CVS – RRR
   Abdomen soft – stools normal
   Edema of ankle
   Hyperkalemia

DAY 4 – Pain is much better
   Compression stockings in place
   Anemia stable
   Ammonia level within normal limits, abdomen less tense

DAY 5 – Discharge to subacute unit for physical therapy

OPERATIVE REPORT

NAME OF OPERATION: Hemiarthroplasty of right hip

DESCRIPTION OF PROCEDURE: An incision was made centered over the greater trochanter, carried down to the skin, subcutaneous tissue, fascia lata, and incised in line with the femur. Following this, the posterior aspect of the hip is exposed and the short external rotators are dissected sharply from the proximal femur, and the piriformis is also incised and saved for later repair. Incision retractor is placed. Following this, the fracture is identified and the femoral head is delivered from the acetabulum after opening the capsule in a T fashion.

At this point, the attention was turned to the fracture and the fracture was somewhat lower than originally expected and the attempt was made to broach the femur for the hemiarthroplasty. It was noted that there was an additional fracture, which was present on the lateral aspect of the trochanter and this later was significant to the point where it was felt that it required cable fixation. At this point the greater trochanter was reducted and a trochanteric claw is utilized to grasp the trochanter and this is affixed with 2 cables. A 3rd cable is placed over the main fracture. Satisfactory fixation was accomplished.

At this point, the leg was rolled 90 degrees, the foot was raised 90 degrees to the floor and the broaching was done utilizing a 10 Biomet fracture stem and the broach was positioned appropriately. At this point, the cement was mixed and the cement was passed into the proximal femur and the 10 Biomet fracture stem was inserted, approximately 6-7 degrees of femoral anteversion. The standard was perhaps too tight and a –3 was placed and the hip was stable with flexion and internal rotation. Following this the hip is prepared and the cement is dried and the –3 head is placed and the bipolar is assembled and a 47 outer bearing is placed. The hip is located and again there is good stability. The capsule is repaired utilizing #0 Vicryl. The piriformis is repaired utilizing #1 Vicryl. The
fascia lata is closed utilizing a running double #1 Vicryl. The subcutaneous tissue is closed, the deep tissue with 0 Vicryl, the more subcutaneous tissue with 2-0 Vicryl and the skin with skin clips. Hemovac was placed in the depths of the wound and the soft compression dressing was applied. The patient was placed in an abduction pillow and rolled supine and then was awakened and taken to the recovery room.

Replacement was 2 units of packed red blood cells. Additional 2 units are available. The patient will have a repeat hemoglobin and hematocrit in the recovery room. The patient was given Ancef at the start of the case and at the end of the case and this will be continued postoperatively.
INPATIENT CASE STUDY 3

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 4

DISCHARGE SUMMARY

ADMITTING DIAGNOSIS:  Shortness of breath

HOSPITAL COURSE:  A 79-year-old female who had been coughing and short of breath for the last month was directly admitted from home. For the last 24 hours prior to her admission, her cough and chest congestion has become worse and she has started to feel weak.

The patient's medical history is unremarkable and she apparently has not had any kind of checkup in a very long time. The chest x-ray done in the emergency room indicated congestive heart failure.

Diagnostic studies indicate congestive heart failure – treatment rendered. EKG showed a prior myocardial infarction.

FINAL DIAGNOSIS:  Congestive heart failure

PLAN:  Discharged home and follow up with a cardiologist

HISTORY AND PHYSICAL

CHIEF COMPLAINT:  Shortness of breath

HISTORY OF PRESENT ILLNESS:  A 79-year-old female who had been coughing and short of breath for the last month was directly admitted from home. For the last 24 hours prior to her admission, her cough and chest congestion has become worse and she has started to feel weak.

PAST MEDICAL HISTORY:  Past history is positive for chronic obstructive pulmonary disease, atrial fibrillation, coronary artery disease, renal insufficiency, old MI and a past history of smoking. Patient denies any previous stroke, leg swelling or high blood pressure.

PHYSICAL EXAMINATION:  Blood pressure 181/100, pulse 121, respirations 32 and temperature 98.8.

ASSESSMENT:  Early CHF

PLAN:  Admit for treatment and evaluation

PROGRESS NOTES

DAY 1 – Visited with patient for about 2 hours, delightful woman. Has considerable wheezing and tachypnea, takes short breaths – solumedral started. EKG abnormal, but no EKG to compare with. I don’t see any hyperacute changes. Cardiac enzymes are negative. Patient’s WBC is normal; creatine level is at 1.7 indicating renal insufficiency.

DAY 2 – Decreased chest congestion but still complains of shortness of breath. Afebrile, B/P 140/81, R 24. A/P – CHF exacerbated/COPD acute exacerbated/AF.

DAY 3 – Patient with elevated blood pressure, tachycardiac, wheezing. Patient now comfortable but very short of breath.

DAY 4 – Still struggling to breathe – advanced CHF. Patient placed on digoxin last night by my colleague.

DAY 5 – Patient stable – may return home
INPATIENT
CASE STUDY 5

DISCHARGE SUMMARY

ADMITTING DIAGNOSES:

1. Fever
2. Urosepsis

HOSPITAL COURSE:  This is a 5-year-old child who was admitted for fever to rule out sepsis.  Patient was doing well until 3 -4 days prior to admission when mother noted he was running a fever.  There was no vomiting or diarrhea.  There was a persistent cough and runny nose.  One day prior to admission he had a fever of 101.  He was given Tylenol and brought to the hospital.  Chest x-ray was done and this was normal.  CBC revealed a white count of 10,400 and urine culture revealed positive nitrites and 300,000 colonies of E. Coli.  Patient will be discharged home today on Keflex 2 ml or 50 mgs 4 x a day for 10 days.  Follow up with your physician.

FINAL DIAGNOSIS:

1. Urinary tract infection with E. Coli
2. Acute pharyngitis

HISTORY AND PHYSICAL

CHIEF COMPLAINT:  Fever, to rule out sepsis

HISTORY OF PRESENT ILLNESS:  This is a 5-year-old child who was admitted for fever to rule out sepsis.  Patient was doing well until 3 -4 days prior to admission when mother noted he was running a fever.  There was no vomiting or diarrhea.  There was a persistent cough and runny nose.  One day prior to admission he had a fever of 101.  He was given Tylenol and brought to the hospital.  Chest x-ray was done and this was normal.  CBC revealed a white count of 10,400 and urine culture revealed positive nitrites and 300,000 colonies of E. Coli.  Patient will be discharged home today on Keflex 2 ml or 50 mgs 4 x a day for 10 days.  Follow up with your physician.

PAST MEDICAL HISTORY:  Has been quite unremarkable

IMPRESSION:  Urosepsis

PLAN:  Admit for meds, repeat urinalysis tomorrow

PROGRESS NOTES

DAY 1 – Febrile 102.1 – very irritable
Blood cultures – negative
Renal ultrasound – normal
Given antibiotic injection

DAY 2 – Febrile 101 – eating better
UA positive for E. Coli
Sleeping

DAY 3 – Afebrile
Eating well
D/C home with Keflex
INPATIENT
CASE STUDY 6

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