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 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 is admitted to the Emergency Room with chief complaints of fever, cough, and weakness. 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 discharge note of the Emergency Room Physician lists, pneumonia, and acute renal failure. The appropriate sequence of codes for proper ICD-9-CM code assignment is:
   a) 785.52, 486, 584.9
   b) 486, 584.9
   c) 486, 584.9, 785.52
   d) 486, 785.2, 584.9

5) 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
6) 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

7) 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

8) A patient had a septoplasty, and bilateral submucous resection inferior turbinate. What CPT code or codes would be assigned?

   a) 30520 and 30930-50 
   b) 30520 and 30140 
   c) 30140-50 and 42145 
   d) 30520 and 30140-50

9) The patient presented through the ED with severe abdominal pain, amenorrhea. Patient was diagnosed with tubal pregnancy. A unilateral salpingectomy with removal of tubal pregnancy was performed. Which of the following is the correct code assignment?

   a) 633.10, 66.4 
   b) 633.80, 66.62 
   c) 633.10, 66.62 
   d) 633.10, 66.02

10) 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
11) A patient had an arthroscopic subacromial decompression of the right shoulder with excision of the right distal clavicle. The appropriate CPT code(s) for this encounter is:

a) 29826-RT  Shoulder arthroscopy, surgical; decompression of subacromial space partial acromioplasty with/without coracoacromial release
b) 23200-RT  Radical resection for tumor; clavicle
c) 29826-RT  Shoulder arthroscopy, surgical; decompression of subacromial space partial acromioplasty with/without coracoacromial release; and 29824-RT  Partial excision of distal clavicle
d) 23140-RT  Excision/curettage of bone cyst/benign tumor of clavicle.
e) 23420-RT  Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty) and claviculectomy.

12) Patient has a diagnosis of deviated septum with nasal deformity bilateral. The patient has ambulatory surgery performed with nasal reconstruction via bilaterally septoplasty with bilateral submucous resection of superior nasal turbinates. The appropriate CPT code(s) for this encounter are:

a) 30520-50  Septoplasty or submucous resection, with/without cartilage scoring, contouring or replacement with graft and 30999 Unlisted procedure, nose.
b) 30520  Septoplasty or submucous resection, with/without cartilage scoring, contouring or replacement with graft; and 30999-50  Unlisted procedure, nose
c) 30520  Septoplasty or submucous resection, with/without cartilage scoring, contouring or replacement with graft.
d) 30520  Septoplasty or submucous resection, with/without cartilage scoring, contouring or replacement with graft; and 30140-50  Submucous resection inferior turbinate, partial or complete, any method; and 30999-50  Unlisted procedure, nose.

13) 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 phalangeectomy)
d) A and C

14) 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
B. Outpatient Surgery & Emergency Room Case Examples Using Your CPT Book:

Assign the appropriate CPT code and modifier.

1. A 64 yr old woman with history of right breast cancer, surgically removed, presents with pain with deep breathing. Chest x-ray shows enlarged paratracheal nodes compressing the trachea on the right side. Bronchoscopy with transbronchial needle aspiration biopsy of paratracheal node.
Assign the correct CPT Code(s): _____________________________

2. 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): ______________________________

3. 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): ______________________________

4. Patient age six, comes to the ED/ER with a 4 cm laceration of the right hand due to a knife (while preparing food). Active bleeding is noted. The wound is cleansed with saline and examined. The decision is made to repair the wound/laceration with sutures.
Procedure: The wound was infiltrated with lidocaine as a local anesthetic. The physician uses nylon sutures to close the single-layer, simple 4-cm laceration without incident. Steri-strips are applied to the skin.
Assign the correct CPT code(s): ______________________________

5. Procedure: Cataract removal and lens insertion, left eye
Clinical Indication/Diagnosis: Left senile cataract
Technique/Details: The patient is brought into the operating room and is prepped and draped in the usual sterile fashion. A lid speculum between the patient's eyelids and an incision is made in the corneal-scleral juncture. Via phacoemulsification, the lens is removed in parts: first the anterior lens, then the inner, hard nucleus. The clear, posterior capsule remains. A bubble of air is injected into the anterior chamber to protect the cornea. The intraocular implant is then guided into the eye. The haptics lodge into the ciliary sulcus or the lens capsule, occupying the exact position of the original cataract. The incision is closed with sutures and the intraocular pressure is restored with an injection of saline. A topical antibiotic or pressure patch is applied.
Assign the correct CPT code(s): ______________________________
AMBULATORY CARE

CASE STUDY 1

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.
HISTORY AND PHYSICAL

CHIEF COMPLAINT: Gastrointestinal hemorrhage, heartburn on therapy.

HISTORY OF PRESENT ILLNESS: 76-year-old male who is wheelchair bound has been passing blood per rectum, blood mixed in the stool, separate from the stool. The patient has a history of a right cerebrovascular accident with left hemiparesis and cannot get onto the examination table.

PAST MEDICAL HISTORY: Motor vehicle accident thirty years ago. Essential hypertension. Old right cerebrovascular accident with left hemiparesis.

ALLERGIES: Plavic causes rash and itching

REVIEW OF SYSTEMS: Essentially as in the history of present illness

PHYSICAL EXAMINATION: Unremarkable

IMPRESSIONS: 76-year-old male with the above-described history is a candidate for further evaluation via fiberoptic colonoscopic examination as well as fiberoptic upper endoscopic examination.

PLAN: Discussed risks, benefits and alternatives of the above procedure with the patient. He understands and wants to go ahead with the procedure.

PROCEDURE REPORT

NAME OF PROCEDURE: Fiberoptic colonoscopy with possible biopsy and polypectomy

INDICATION FOR PROCEDURE: Refer to History and Physical

PREOPERATIVE DIAGNOSIS: GI bleeding

POSTOPERATIVE DIAGNOSES:
1. 2 to 3 internal hemorrhoids within the anal verge causing the lower GI bleeding
2. Sessile polyp of the distal rectum

PROCEDURE: The patient was brought to the endoscopy unit. The endoscope was introduced into the rectum and advanced under direct visualization all the way up to the cecum and then withdrawn. Tubular views of the cecum and the rest of the colon were normal. There was a 7 mm polyp at the anal verge just below the anal verge. A hot polypectomy with biopsy was performed, also noted internal hemorrhoids with traces of recent blood.

PLAN: Reassurance to the patient, use Metamucil daily and review pathology report

PROCEDURE REPORT

NAME OF PROCEDURE: Fiberoptic esophagogastroduodenoscopy with biopsies

INDICATION FOR PROCEDURE: 79 year-old-male with anemia due to blood loss, negative colonoscopy except hemorrhoids with bleed, polyp of rectum, is being evaluated via upper endoscope examination for etiology of heartburn.

PREOPERATIVE DIAGNOSIS: Heartburn

POSTOPERATIVE DIAGNOSES:
1. Large hiatal hernia
2. Barrett’s esophagus of the distal esophagus

PROCEDURE: The patient was brought to the endoscopy unit. The endoscope was introduced into the cervical esophagus and advanced. The GE line was identified. There was extension of the gastric mucosa of the distal esophagus. The proximal folds of the body of the stomach were normal. A biopsy was taken for the Helicobacter pylori. Pyloric channel, duodenal bulb and descending duodenum were normal. The endoscope was retroflexed. The incisura, cardiac and the fundic portion of the stomach were normal and a large hiatal hernia was seen.

PLAN: Reassurance to the patient, continue therapy and review pathology report.

POSTOPERATIVE NOTE

Reviewed pathology report negative for H. pylori and negative for cancer – patient reassured.

FINAL DIAGNOSES:

1. Internal hemorrhoids, bleeding
2. Chronic blood loss anemia
3. Barrett’s esophagus
4. Large hiatal hernia
5. Rectal polyp
6. Hypertension
7. Old CVA with hemiparesis

Patient ready to be discharged home.
HISTORY AND PHYSICAL

CHIEF COMPLAINT: Right flank pain

HISTORY OF PRESENT ILLNESS: This is a 72-year-old male who has a neurogenic bladder. He had an ultrasound of the kidneys performed, which revealed the presence of hydronephrosis on the right side. The patient had a cystoscopic examination performed and was thought to have findings consistent with a neurogenic bladder. His right orifice could not be identified at that time. He has persisted in having pyuria, as well as some right flank pain.

PAST MEDICAL HISTORY: Coronary artery disease, neurogenic bladder and hydronephrosis

MEDICATIONS: Lanoxin 0.125mg da, Lasix 40mg da, Enalapril 5mg da

ALLERGIES: Penicillin, Sulfa and Iodine

FAMILY HISTORY: Unremarkable

SOCIAL HISTORY: Mental status stable, married. Denies alcohol and tobacco use

SYSTEMS REVIEW: Essentially negative

PHYSICAL EXAM: A well-developed, well-nourished white male seen in no immediate distress. Vitals stable

IMPRESSION: Persistent pyuria. Neurogenic bladder. Arteriosclerosis heart disease. BPH and quadriplegia

FINAL DIAGNOSIS: Neurogenic bladder, right hydronephrosis, bladder lesion refer to pathology report, coronary artery disease, BPH and quadriplegia.

PROGRESS NOTES

PREOPERATIVE DIAGNOSES:
1. Pyuria
2. Neurogenic bladder
3. Hydronephrosis

POSTOPERATIVE DIAGNOSES: Same with bladder lesion – refer to Path report

POSTOPERATIVE NOTE: Patient stable, reassurances given – ready for discharge home.

PLAN: Home today with Foley catheter. Call office to make follow up appointment. Discharged with prescription for Levaquin.

OPERATIVE REPORT

PREOPERATIVE DIAGNOSES:
1. Pyuria
2. Neurogenic bladder
3. Right hydronephrosis
POSTOPERATIVE DIAGNOSES: Same with bladder lesion – refer to pathology report for findings

PROCEDURE PERFORMED:
1. Cystoscopy
2. Urethral dilatation with right retrograde
3. Transurethral resection of bladder lesion

DESCRIPTION OF PROCEDURE: Cystoscope was introduced into the urethra and bladder examination revealed a cloudy like fluid, which was sent to the pathology lab.

Indigo dye was injected and a catheter was passed into the ureter to approximately 15 cm. This outlines the upper ureter and revealed a markedly dilation. There was a marked hydronephrosis noted. Contrast was injected after the passage of the catheter to a 5 cm which revealed the distal ureter very nicely which was markedly dilated. The catheter was subsequently removed and the urethra dilated with Van Buren sounds to a French 30. The French 27 resectoscope sheath with a Timberlake obturator was then passed into the bladder. The resection of a lesion in the right fundal area of the bladder was then performed without difficulty. It was decided to leave the Foley catheter in place until the patient could be seen in the office to prevent any postoperative complications of retention because of the neurogenic bladder. The patient tolerated the procedure well and left the OR in satisfactory condition.

PATHOLOGY REPORT

SPECIMEN: Bladder lesion

SIGNIFICANT CLINICAL DATA: Neurogenic bladder with hydronephrosis

DIAGNOSIS: Benign bladder mucosa with chronic cystitis
HISTORY AND PHYSICAL

CHIEF COMPLAINT: Rectal bleeding

HISTORY OF PRESENT ILLNESS: A 68-year-old male presents with rectal bleeding and a history of inflammatory bowel disease. Grandfather at age 50 died from colon cancer. Father has a history of colon polyps and congestive heart disease.

ALLERGIES: None noted

PAST MEDICAL HISTORY: History of hypertension.

SOCIAL HISTORY: Lives with wife of 43 years

REVIEW OF SYSTEMS: Essentially as in the history

PHYSICAL EXAM: Vitals signs stable; blood pressure 130/86; temperature 98.1; respiratory rate 18; weight 174 pounds.

LABS: Unremarkable

IMPRESSIONS: Rectal bleeding – will undergo further evaluation via fiberoptic colonoscopic examination.

PLAN: Discussed risks, benefits and alternatives of the above procedure with the patient. He understands and wants to go ahead with the procedure.

PROCEDURE REPORT

NAME OF PROCEDURE: Fiberoptic colonoscopy

INDICATION FOR PROCEDURE: A 68-year-old male presents with rectal bleeding and a history of inflammatory bowel disease. Family history of colon cancer and polyps is being evaluated via fiberoptic colonoscopic examination.

PREOPERATIVE DIAGNOSIS: Rectal bleeding

POSTOPERATIVE/FINAL DIAGNOSES:
1. Colon polyp
2. Internal hemorrhoids
3. Diverticulosis of sigmoid
4. Pathology report revealed erosions of the ascending colon.

PROCEDURE: The endoscope was introduced into the rectum and advanced under direct visualization all the way up to the cecum, which is clearly recognized by going beyond the ileocecal valve and looking at the appendiceal orifice. A polyp was identified in the sigmoid and removed by snare. A biopsy was taken of the ascending colon. Diverticulosis was also observed within the sigmoid colon. The endoscope was withdrawn. There were 2+ internal hemorrhoids.

PLAN:
1. Reassurance to the patient
2. Continue present treatment
3. Further evaluation if needed
AMBULATORY CARE
CASE STUDY 5

HISTORY AND PHYSICAL

CHIEF COMPLAINT: Foot pain

HISTORY OF PRESENT ILLNESS: A 67 year old male admitted via the Emergency Department for a non-healing right foot ulcer. Patient is postoperative toe amputation recently, is a non-diabetic, and has no history of high blood pressure.

MEDICATIONS: Tylenol, Vicodin and Motrin prn

ALLERGIES: NKDA

PHYSICAL EXAM: Well-developed, well-nourished male in acute distress. Patient is oriented times three. Skin is warm and dry and pupils are round and equal.

FINAL DIAGNOSIS: Non-healing right foot ulcer

PROGRESS NOTE

Postoperative Note: Aortogram performed without complication– refer to radiology report findings.

Patient stable and ready to be discharged home with Vicodin 2 tabs p.o.

DEPARTMENT OF IMAGING SERVICES

ABDOMINAL AORTOGRAHAM AND BILATERAL LOWER EXTREMITY RUNOFF

Reason for exam: Right toe amputation. Patient is a heavy smoker. Complains of non-healing ulcer.

The patient was explained the risks, benefits, alternatives of treatment and consent were obtained. The right common femoral artery was entered using 1% lidocaine for local anesthesia and modified Seldinger technique. The 0.035 wire was advanced with ease into the abdominal aorta. The needle was exchanged for a 4-French shepherd's hook catheter, which was parked in the proximal abdominal aorta. Utilizing digital subtraction technique, an abdominal aortogram was performed. The catheter was then withdrawn up to the aortoiliac bifurcation and a bilateral lower extremity runoff including a pelvic arteriogram was obtained. The catheter was then further withdrawn into the right external iliac artery and repeat arteriogram of the infrageniculate vessels was also obtained only on the right. At the end of the procedure the catheter was withdrawn and hemostasis obtained with manual compression. The patient tolerated the procedure well with no immediate complications.

Contrast used: 200 cc Isovue

The abdominal aortogram demonstrates irregularity of the infrarenal abdominal aorta suggestive of arteriosclerotic disease. Flash filling of the celiac, superior mesenteric and single bilateral renal arteries is seen. The common iliac, external iliac, internal iliac and common femoral arteries are patent bilaterally. Focal mild narrowing of the common femoral artery is noted at the level of the femoral head on the left.

The right (more symptomatic side) superficial femoral artery although patent, demonstrates multifocal moderate to severe stenosis throughout the entire course most marked at the level of the adductor canal. The popliteal artery is patent and bifurcates into a tibioperoneal trunk and anterior tibial artery. The tibioperoneal trunk then continues into a peroneal artery, which is attenuated in caliber, which extends across the ankle joint and tapers off into fine collaterals. The anterior tibial artery is of good caliber at origin but demonstrates mild stenosis in its proximal on third although patent throughout its entire course. It crosses the ankle and tapers off into small collaterals. The digital arteries are seen reconstituting from collaterals. No major tarsal arch notes.
On the left, the superficial femoral artery demonstrates long segment mild stenosis in its proximal one third with focal areas of mild to moderate stenoses noted in its mid and distal third but appears patent and continues across as a patent popliteal artery. The popliteal artery then bifurcates into a patent anterior tibial artery, which continues across the ankle to form the runoff vessel. The tibioperoneal trunk continues into a peroneal artery of marked attenuated caliber. The posterior tibial arteries are not seen on either side or taper off just beyond origin. The possibility of a variant cannot be excluded. The anterior tibial artery is the major runoff vessel across the left ankle.

**IMPRESSION:** Multifocal superficial femoral artery stenosis worse on the right with absent posterior tibial arteries noted on both sides.
Although the peroneal artery and the anterior tibial artery extend up to the level of the ankle joint, there is no major runoff vessels noted beyond it with the digital arteries perfused from collaterals.
Anterior tibial artery is the only runoff vessel across the left ankle.
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.

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.

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.