**Surgery - Digestive System**

1. Lynn has a family history of colon cancer and is scheduled for a screening colonoscopy. During the procedure, three polyps were discovered and removed via hot biopsy forceps technique. The polyps were reported as benign.
2. Dr. Blue performs a secondary closure of the abdominal wall for evisceration (outside the postoperative period). He opens the former incision and removes the remaining sutures; necrotic fascia is debrided down to viable tissue. The abdominal wall is then closed with sutures.
3. Heather lost her teeth following a motorcycle accident. She underwent a posterior, bilateral vestibuloplasty, which allows her to wear complete dentures.
4. Dr. Erin is treating a 58-year-old male patient with a history of chewing tobacco. Dr. Erin finds a 3.4 cm tumor at the base of his tongue. She places needles under fluoroscopic guidance for sub-sequential interstitial radioelement application.
5. An 88-year-old male patient suffering from dementia accidentally pulled out his gastrostomy tube during the night. Dr. Keys, an interventional radiologist, takes him into an angiography suite, administers moderate sedation (an independent observer was present during the procedure), probes the site with a catheter and injects contrast medium for assessment and tube placement. Dr. Keys finds that the entry site remains open and replaced the tube into the proper position. The intra-service time for the procedure took 45 minutes. How would Dr. Keys report his services
6. Katherine had a hernioplasty to repair a recurrent ventral incarcerated hernia with implantation of mesh for closure. The surgeon completed debridement for necrotizing soft tissue due to infection.
7. A 28-year-old patient underwent a proctosigmoidoscopy with ablation of five tumors under moderate sedation. The same provider performed the procedure and the sedation. The intra-service time for the procedure was 30 minutes.
8. A 52-year-old patient is admitted to the hospital for chronic cholecystitis for which a laparoscopic cholecystectomy will be performed. A transverse infraumbilical incision was made sharply dissecting to the subcutaneous tissue down to the fascia using access under direct vision with a Vesi-Port and a scope was placed into the abdomen. Three other ports were inserted under direct vision. The fundus of the gallbladder was grasped through the lateral port, where multiple adhesions to the gallbladder were taken down sharply and bluntly: The gallbladder appeared chronically inflamed. Dissection was carried out to the right of this identifying a small cystic duct and artery, was clipped twice proximally, once distally and transected. The gallbladder was then taken down from the bed using electrocautery, delivering it into an endo-bag and removing it from the abdominal cavity with the umbilical port.
9. A 70-year-old female who has a history of symptomatic ventral hernia was advised to undergo laparoscopic evaluation and repair. An incision was made in the epigastrium and dissection was carried down through the subcutaneous tissue. Two 5-mm trocars were placed, one in the left upper quadrant and one in the left lower quadrant and the laparoscope was inserted. Dissection was carried down to the area of the hernia where a small defect was clearly visualized. There was some omentum, which was adhered to the hernia and this was delivered back into the peritoneal cavity. The mesh was tacked on to cover the defect.
10. An 82-year-old female had a CAT scan which revealed evidence of a proximal small bowel obstruction. She was taken to the Operating Room where an elliptical abdominal incision was made, excising the skin and subcutaneous tissue. There were extensive adhesions along the entire length of the small bowel: the omentum and bowel were stuck up to the anterior abdominal wall. Time- consuming tedious lysis of adhesions was performed to free up the entire length of the gastrointestinal tract from the ligament to Treitz to the ileocolic anastomosis.
11. 55-year-old patient was admitted with massive gastric dilation. The endoscope was inserted with a catheter placement. The endoscope is passed through the cricopharyngeal muscle area without difficulty. Esophagus is normal, some chronic reflux changes at the esophagogastric junction noted. Stomach significant distention with what appears to be multiple encapsulated tablets in the stomach at least 20 to 30 of these are noted. Some of these are partially dissolved. Endoscope could not be engaged due to high grade narrowing in the pyloric channel. It seems to be a high grade outlet obstruction with a superimposed volvulus.
12. The patient is a 78-year-old white female with morbid obesity that presented with small bowel obstruction. She had surgery approximately one week ago and underwent exploration, which required a small bowel resection of the terminal ileum and anastomosis leaving her with a large inferior ventral hernia. Two days ago she started having drainage from her wound which has become more serious. She is now being taken back to the operating room. Reopening the original incision with a scalpel, the intestine was examined and the anastomosis was reopened , excised at both ends, and further excision of intestine. The fresh ends were created to perform another end- to-end anastomosis.
13. PREOPERATIVE DIAGNOSIS: Diverticulitis, perforated diverticula POST OPERATIVE DIAGNOSIS: Diverticulitis, perforated diverticula PROCEDURE: Hartman procedure, which is a sigmoid resection with Hartman pouch and colostomy. DESCRIPTION OF THE PROCEDURE: Patient was prepped and draped in the supine position under general anesthesia. Prior to surgery patient was given 4.5 grams of Zosyn and Rocephin IV piggyback. A lower midline incision was made, abdomen was entered. Upon entry into the abdomen, there was an inflammatory mass in the pelvis and there was a large abscessed cavity, but no feces. The abscess cavity was drained and irrigated out. The left colon was immobilized, taken down the lateral perineal attachments. The sigmoid colon was mobilized. There was an inflammatory mass right at the area of the sigmoid colon consistent with a divertiliculitis or perforation with infection. Proximal to this in the distal left colon, the colon was divided using a GIA stapler with 3.5 mm staples. The sigmoid colon was then mobilized using blunt dissection. The proximal rectum just distal to the inflammatory mass was divided using a GIA stapler with 3.5 mm staples. The mesentary of the sigmoid colon was then taken down and tied using two 0 Vicryl ties. Irrigation was again performed and the sigmoid colon was removed with inflammatory mass. The wall of the abscessed cavity that was next to the sigmoid colon where the inflammatory mass was, showed no leakage of stool, no gross perforation, most likely there is a small perforation in one of the diverticula in this region. Irrigation was again performed throughout the abdomen until totally clear. All excess fluid was removed. The distal descending colon was then brought out through a separate incision in the lower left quadrant area and a large 10 mm 10 French JP drain was placed into the abscessed cavity. The sigmoid colon or the colostomy site was sutured on the inside using interrupted 3-0 Vicryl to the peritoneum and then two sheets of film were placed into the intra- abdominal cavity. The fascia was closed using a running #1 double loop PDS suture and intermittently a #2 nylon retention suture was placed. The colostomy was matured using interrupted 3-0 chromic sutures. I palpated the colostomy; it was completely patent with no obstructions. Dressings were applied. Colostomy bag was applied.
14. Patient is going into the OR for an appendectomy with a ruptured appendicitis. Right lower quadrant transverse incision was made upon entry to the abdomen. In the right lower quadrant there was a large amount of pus consistent with a right lower quadrant abscess. Intraoperative cultures anaerobic and aerobic were taken and sent to microbiology for evaluation. Irrigation of the pus was performed until clear. The base of the appendix right at the margin of the cecum was perforated. The mesoappendix was taken down and tied using 0-Vicryl ties and the appendix fell off completely since it was already ruptured with tissue paper thin membrane at the base. There was no appendiceal stump to close or to tie, just an opening into the cecum; therefore, the appendiceal opening area into the cecum was tied twice using figure of 8 vicryl sutures. Omentum was tacked over this area and anchored in place using interrupted 3-0 Vicryl sutures to secure the repair.
15. 15 year-old female is to have a tonsillectomy performed for chronic tonsillitis and hypertrophied tonsils. A McIver mouth gag was put in place and the tongue was depressed. The nasopharynx was digitalized. No significant adenoid tissue was felt. The tonsils were then removed bilaterally by dissection. The uvula was a huge size because of edema, a part of this was removed and the raw surface oversewn with 3-0 chromic catgut.
16. 34-year-old male developed a ventral hernia when lifting a 60 pound bag. The patient is in surgery for a ventral herniorrhaphy. The abdomen was entered through a short midline incision revealing the fascial defect. The hernia sac and contents were able to easily be reduced and a large plug of mesh was placed into the fascial defect. The edge of the mesh plug was sutured to the fascia.
17. A 67-year-old male patient with a history of carcinoma of the sigmoid colon is referred for a diagnostic colorectal cancer screening. The patient completed all treatment for his cancer in 2004. The physician performed a diagnostic flex sigmoidoscopy exam to screen for recurrent colon cancer and examine the anatomic site. During the exam, the physician found three polyps in the rectosigmoid junction. They were removed by hot biopsy forceps. The path report indicated the polyps were benign.
18. Postoperative Diagnosis: Calculi of the gallbladder Procedure: Removal of gallbladder Indications: The patient is a 40-year-old woman who has a six month history of RUQ pain, which ultrasound revealed to be multiple gallstones. She presents for removal of her gallbladder. Procedure: The patient was brought to the OR and prepped and draped in a normal sterile fashion. After adequate general endotracheal anesthesia was obtained, a trocar was placed and CO2 was insufflated into the abdomen until an adequate pneumoperitoneum was achieved. A camera was placed at the umbilicus and the gallbladder and liver bed were visualized. The gallbladder was enlarged and thickened, and there was evidence of chronic inflammatory changes. Two additional ports were placed and graspers were used to free the gallbladder from the liver bed with a combination of sharp dissection and electrocautery. Several attempts were made before it was decided that additional exposure was needed and I converted to an open approach. The trocars were removed and a midline incision was made. At this time, it was clear that there were multiple adhesions in the area, and once these were carefully taken down, we were able to grasp the gallbladder. The cystic duct was carefully ligated and the gallbladder carefully removed from the field. The area was copiously irrigated, and a needle biopsy of the liver was taken. Then the skin was reapproximated in layers. Sponges and needle counts were correct, and the patient was taken to the recovery room in good condition.
19. A patient with rectal bleeding undergoes a proctosigmoidoscopy. During the proctosigmoidoscopy, the physician identifies internal hemorrhoids. The proctoscope was withdrawn, and the anus was prepped and draped. A field block with Marcaine 0.25% was then placed. Anoscope was inserted. There was a prolapsing hemorrhoid in the anterior midline. This was rubber band ligated by applying two bands. In the posterior midline, there was another hemorrhoid that was banded in the same manner.
20. A patient diagnosed with GERD presents to the same day surgery department for an upper GI endoscopy. The procedure is done in order to treat the GERD by delivering thermal energy to the muscle of the gastric cardia and lower esophageal sphincter. Anesthesia was administered and as the physician begins the procedure, the patient’s blood pressure drops to a dangerously low level. The physician decides not to finish the procedure due to the risk it may cause the patient.