**Surgery- Integumentary system**

1. James suffered a severe crushing injury to his left upper leg. Two days after surgery, Dr. Barnes completed a dressing change under general anesthesia. How would you report this service?
2. Dr. Jess removed a 4.5 cm (excised diameter) cystic lesion from Amy’s forehead. The ulcerated lesion was anesthetized with 20 mg of 1% Lidocaine and then elliptically excised. The wound was closed with a layered suture technique and a sterile dressing applied. The wound closure, according to Dr. Jess’s documentation, was 5.3 cm. How would you report this procedure?
3. Martha has a non-healing wound on the tip of her nose. After an evaluation by Dr. Martino, a dermatologist, Martha is scheduled for a procedure the following week. Dr. Martino documented an autologous split thickness skin graft to the tip of Martha’s nose. A simple debridement of granulated tissues is completed prior to the placement. Using a dermatome, a split thickness skin graft was harvested from the left thigh. The graft is placed onto the nose defect and secured with sutures. The donor site is examined, which confirms good hemostasis.
4. A patient had a chest wall tumor excised. The procedure involved the ribs with plastic reconstruction, and mediastinal lymphadenectomy.
5. Dr. Alexis completed Mohs surgery on Ralph’s left arm. She reported routine stains on all slides, mapping, and color coding of specimens. The procedure was accomplished in three stages with a total of seven blocks in the second stage. How would you report Dr. Alexis’ services?
6. Tina fell from a step ladder while clearing drain gutters at her home. She suffered contusions and multiple lacerations. At the emergency room she received sutures for lacerations to her arm, hand, and foot. The doctor completed the following repairs: superficial repair to the arm of 12.8 cm, a single-layered closure of 7.9 cm that required extensive cleaning and removal of glass from the hand, and a simple repair to the foot of 9.6 cm.
7. Which modifier would you use if a re-excision procedure is performed during the postoperative period of the primary excision of a malignant lesion?
8. James had a malignant lesion removed from his right arm (excised diameter 4.6 cm). During the same visit the dermatologist noticed a new growth on James’ left arm. Dr. Terry took a biopsy of the new lesion and sent it in for pathology. The biopsy site required a simple closure.
9. 46 year old female had a previous biopsy that indicated positive margins anteriorly on the right side of her neck. A 0.5 cm margin was drawn out and a 15 blade scalpel was used for full excision of an 8cm lesion. Light undermining of all margins was performed along with layered closure. The specimen was sent for permanent histopathologic examination.
10. 30 year old female is having debridement performed on an infected ulcer with eschar on the right foot. Using sharp dissection, the ulcer and eschar infection was debrided all the way to down to the bone of the foot. The bone had to be minimally trimmed because of a sharp point at the end of the metatarsal. After debriding the area, there was minimal bleeding because of very poor circulation of the foot. It seems that the toes next to the ulcer may have some involvement and cultures were taken. The area was dressed with sterile saline and dressings and then wrapped.
11. 64 year old female who has multiple sclerosis fell from her walker and landed on a glass table. She lacerated her forehead, cheek and chin and the total length of these lacerations was 6 cm. Her right arm and left leg had deep cuts measuring 5 cm on each extremity. Her right hand and right foot had a total of 3 cm lacerations. The ED physician repaired the lacerations as follows: The forehead, cheek, and chin had debridement and cleaning of glass debris with the lacerations being closed with 6-0 Prolene sutures. The arm and leg were repaired by 6-0 Vicryl subcutaneous sutures and prolene sutures on the skin. The hand and foot were closed with adhesive strips.
12. PRE OP DIAGNOSIS: Left Breast Abnormal MMX or Palpable Mass; Other Disorders Of Breast PROCEDURE: Automated Stereotactic Biopsy Left Breast FINDINGS: Lesion is located in the lateral region, just at or below the level of the nipple on the 90 degree lateral view. There is a subglandular implant in place. I discussed the procedure with the patient today including risks, benefits and alternatives. Specifically discussed was the fact that the implant would be displaced out of the way during this biopsy procedure. Possibility of injury to the implant was discussed with the patient. Patient has signed the consent form and wishes to proceed with the biopsy. The patient was placed prone on the stereotactic table; the left breast was then imaged from the inferior approach. The lesion of interest is in the anterior portion of the breast away from the implant which was displaced back toward the chest wall. After imaging was obtained and stereotactic guidance used to target coordinates for the biopsy, the left breast was prepped with Betadine. 1% lidocaine was injected subcutaneously for local anesthetic. Additional lidocaine with epinephrine was then injected through the indwelling needle. The SenoRx needle was then placed into the area of interest. Under stereotactic guidance we obtained 9 core biopsy samples using vacuum and cutting technique. The specimen radiograph confirmed representative sample of calcification was removed. The tissue marking clip was deployed into the biopsy cavity successfully. This was confirmed by final stereotactic digital image and confirmed by post core biopsy mammogram left breast. The clip is visualized projecting over the lateral anterior left breast in satisfactory position. No obvious calcium is visible on the final post core biopsy image in the area of interest. The patient tolerated the procedure well. There were no apparent complications. The biopsy site was dressed with Steri-Strips, bandage and ice pack in the usual manner. The patient did receive written and verbal post-biopsy instructions. The patient left our department in good condition. IMPRESSION: 1. SUCCESSFUL STEREOTACTIC CORE BIOPSY OF LEFT BREAST CALCIFICATIONS. 2. SUCCESSFUL DEPLOYMENT OF THE TISSUE MARKING CLIP INTO THE BIOPSY CAVITY 3. PATIENT LEFT OUR DEPARTMENT IN GOOD CONDITION TODAY WITH POST-BIOPSY INSTRUCTIONS. 4. PATHOLOGY REPORT IS PENDING; AN ADDENDUM WILL BE ISSUED AFTER WE RECEIVE THE PATHOLOGY REPORT. What are the codes for the procedures?
13. 53-year-old male for removal of 2 lesions located on his nose and lower lip. Lesions were identified and marked. Utilizing a 3-mm punch, a biopsy was taken of the left supratip nasal area. The lower lip lesion of 4mm in size was shaved to the level of the superficial dermis.
14. 76-year-old has dermatochalasis on bilateral upper eyelids. A belpharoplasty will be performed on the eyelids. A lower incision line was marked at approximately 5 mm above the lid margin along the crease. Then using a pinch test with forceps the amount of skin to be resected was determined and marked. An elliptical incision was performed on the left eyelid and the skin was excised. In a similar fashion the same procedure was performed on the right eye. The wounds were closed with sutures.
15. Patient has basal cell carcinoma on his upper back. A map was prepared to correspond to the area of skin where the excisions of the tumor will be performed using Mohs micrographic surgery technique. There were three tissue blocks that were prepared for cryostat, sectioned, and removed in the first stage. Then a second stage had six tissue blocks which were also cut and stained for microscopic examination. The entire base and margins of the excised pieces of tissue were examined by the surgeon. No tumor was identified after the final stage of the microscopically controlled surgery.
16. 45 year old male is in outpatient surgery to excise a basal cell carcinoma of the right nose and have reconstruction with an advancement flap. The 1.2 cm lesion with an excised diameter of 1.5 cm was excised with a 15-blade scalpel down to the level of the subcutaneous tissue, totaling a primary defect of 1.8 cm. Electrocautery was used for hemostasis. An adjacent tissue transfer of 3 sq cm was taken from the nasolabial fold and was advanced into the primary defect.
17. 24 year old patient had an abscess by her vulva which burst. She has developed a soft tissue infection caused by gas gangrene. The area was debrided of necrotic infected tissue. All of the pus was removed and irrigation was performed with a liter of saline until clear and clean. The infected area was completely drained and the wound was packed gently with sterile saline moistened gauze and pads were placed on top of this.
18. 76-year-old female had a recent mammographic and ultrasound abnormality in the 6 o’clock position of the left breast. She underwent core biopsies which showed the presence of a papilloma. The plan now is for needle localization with excisional biopsy to rule out occult malignancy. After undergoing preoperative needle localization with hookwire needle injection with methylene blue, the patient was brought to the operating room and was placed on the operating room table in the supine position where she underwent laryngeal mask airway (LMA) anesthesia. The left breast was prepped and draped in a sterile fashion. A radial incision was then made in the 6 o'clock position of the left breast corresponding to the tip of the needle localizing wire. Using blunt and sharp dissection, we performed a generous excisional biopsy around the needle localizing wire including all of the methylene blue-stained tissues. The specimen was then submitted for radiologic confirmation followed by permanent section pathology. Once hemostasis was assured, digital palpation of the depths of the wound field failed to reveal any other palpable abnormalities. At this point, the wound was closed in 2 layers with 3-0 Vicryl and 5-0 Monocryl. Steri-Strips were applied. Local anesthetic was infiltrated for postoperative analgesia.

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1. The physician is called in to perform repairs for a 17-year-old girl involved in a motor vehicle accident. She sustained an 8.6 cm laceration to her forehead, a 5.5 cm laceration to her right cheek, a 4 cm laceration to her left cheek, a 4 cm laceration across her chin, and a 12.5 cm laceration to her chest. The wound on her chin required a layered closure. All other wounds required complex closure.
2. A 36-year-old male presents to have multiple lesions destroyed. Three benign lesions on his face are destroyed and five actinic keratoses on his left arm are destroyed.