

SCQR Certification Exam Answers and Rationale

November 2016

Text highlighted in yellow indicates the correct answer.

Text highlighted in green is information from the scenario that supports the answer to the exam question.

Text highlighted in blue is rationale inserted from the Manual or CPT code reference.

Preoperative Risk Factors

Department of Anesthesiology
Preoperative Evaluation 10/15/15

SURGERY INFORMATION: Admit date: 10/16/15; Surgery Date: 10/16/15 07:30
Proposed Operation: midline ileostomy or colostomy takedown
Surgical Diagnosis: S/P colostomy after closure of enterocutaneous fistula,

HISTORY:

HPI: 64 yo F w/ S/P colostomy after closure of enterocutaneous fistula, presenting for MIDLINE ILEOSTOMY OR COLOSTOMY TAKEDOWN
Social History: History of Smoking (quit 4/1/2015). Denies etoh use; PONV Hx: No; Hx Motion Sickness: No; Nausea while reading in moving car: No

MEDICATIONS: carvedilol (coreg), spironolactone (aldactone), warfarin (coumadin), lomotil (atropine sulfate; diphenoxylate hydrochloride), cholecalciferol, imodium (loperamide hydrochloride), budesonide and formoterol (symbicort) QD.

Last took warfarin 6 days ago, taking lovenox BID since then- last dose 10/15/15 at 9am;
Beta Blocker Continued: Yes - Date and Time of last beta blocker dose 10/16/15 04:00

ALLERGIES: dilaudid - itching

PAST SURGICAL HISTORY: Cholecystectomy, Exploratory Laparotomy, Hysterectomy, numerous wound debridements, Salpingo-oophorectomy, Small Bowel Resection, Abdominoplasty, Cardiac Cath

ANESTHESIA HISTORY: Prev Anesthetic Problem: (None); Family Hx of Anesth Problem: (None); Previous Intraoperative Record: 09/23/2014 – Grade: Grade 2a - Partial view of Vocal Cords Laryngoscopic View. Required Cricothyroid Pressure? Yes, 09/23/14- Mask ventilation Grade 1: Ventilated by mask, 09/23 10:09 Orally intubated using MacIntosh #3 blade after first attempt without bougie

CARDIAC:

Functional Capacity: Moderate; Symptoms: (None); Hypertension: Yes; CAD: Yes; Family Hx CAD: Mother; Congestive Heart Failure: (None); MI: (None); Cardiac/Other: nonischemic cardiomyopathy, unknown etiology, EF previously 25%, now 55% per TTE 9/2014, LHC 2011 reportedly with minimal CAD, Saw cards 8/21/15, felt no additional stress testing needed before ostomy take-down

PULMONARY:

Symptoms: (None); URI/Pneumonia: (None); Asthma: (None); COPD: Yes; Sleep Apnea: History of sleep apnea, states that it has resolved following weight loss; Snoring: Yes; Pulmonary /Other: (None)

GI / GU / GYN:

Sign and Sx: (None); Liver Disease: (None); NPO Status: Solids > 8 hours and clear liquids > 2 hours; GI - Other: hx enterocutaneous fistula requiring ileocecal and sigmoid resection and colostomy 2014; Renal Failure: (None); GU - Other: (None); LNMP: s/p TAH; Pregnant: No; GYN -Benign: (None)

ENDOCRINE / NEURO / PAIN:

Diabetes: Type 2, not currently on medications; Endo - Other: Obesity; Neuro Symptoms: Hx of thrombotic CVA in 2011 with residual left sided weakness (ambulates with a cane and has unsteady gait, performs own ADL's); TIA or Stroke: TIA/CVA 2011- on warfarin, presumed cardioembolic; Other - Neuro: (None); Seizure: (None); Chronic Steroid Use: (None); Psychiatric Disorder: (None); Pain Score: 0 - None

MS / HEME / ONC:

Inflammatory Arthritis: (None); Other-MS: (None); Bleeding Diathesis: (None); Other - Heme: Anemia, Iron Deficiency; Anticoagulation: Name: Coumadin (Warfarin) Indication: Cerebral Vascular Disease, history of portal vein thrombosis in 2011; Malignancy: hx endometrial cancer s/p TAH and chemo/radiation in 2011 in remission.

AIRWAY:

Dentition: Normal; Beard: No; Mouth Opening: >= 3 cm mouth opening; Mallampati Sitting Looking Forward (no phonation): I; Mallampati Full Neck Extension (no phonation): C-Spine: Normal; Existing Airway: None; Neck Anatomy: (Normal); Jaw Protrusion: A: Normal, lower incisors can protrude past upper incisors

LABS/STUDIES:

Labs: 10/2/2015 Hemoglobin: 13.6, Platelets: 187, PTT: 27.7, INR: 1.8, Potassium: 4.5, Calcium: 9.9, Glucose: 82, Creatinine: 0.90; EKG 10/2/15 sinus w/ frequent PVCs

PHYSICAL EXAM:

Body Mass Index: 33.68, Obesity; Ideal Body Weight: 54.7; Ideal Body Weight %: 163.0; Height: 64; Weight (kg): 89; Temperature (c): 36.4; BP Sys: 134; BP Dias: 60; HR: 71; RR: 12; RAO2 (%): 97; Neurologic: Grossly normal; Lung: Clear Bilat; Cardiac: S1, S2

ASSESSMENT AND PLAN:

Physical Status: ASA 3; Aspiration Risk: No; Blood Products: T&S; Technique: General, ET; Monitors: 5-Lead EKG, Art Line to be done in the OR; Postop Pain: IV Meds, Epidural;

Summary: Ms M is a 64 yo ASA 3, with hx endometrial cancer s/p TAH and chemo/radiation in 2011, subsequent enterocutaneous fistula requiring ileocecal and sigmoid resection and colostomy 2014 who is scheduled for colostomy takedown on 10/16. She also has a history of cardiomyopathy (EF previously 25%, now 55% per TTE 9/2014, LHC 2011 reportedly with minimal CAD), stroke, DM2 (resolved with weight loss), and HTN. Her functional status has improved to water walking and light resistance training. She denies

orthopnea, shortness of breath. She has tolerated anesthesia in 9/2014, and has no new symptoms since then. She was cleared by cardiology who didn't recommend any further stress testing at this time given her stable cardiac risk and improved functional status. Cardiologist also recommended to check A1C and lipid panel and to restart metformin/statin if abnormal prior to surgery. She will get these labs drawn at her PCP who will initiate treatment if indicated. Comments: consented for postop thoracic epidural if needed (unable to place preop as most recent enoxaparin 1 mg/kg dose was 10/15/16 at 0900)

1. In terms of sleep apnea, how would you capture this case (Section D)?

A. Level 1

B. Level 2

C. Level 3

Dx of sleep apnea in PULM, resolved with weight loss and using STOP BANG Criteria- Snoring: Yes; high blood pressure- yes, Age >50

2. How would you capture hypertension in this case (Section D)?

A. Yes

B. No

Hypertension documented and requires antihypertension medications- Coreg, Aldactone

3. How would smoking be captured for this case (Section D)?

A. Yes

B. No

History of Smoking within 1 year (quit 4/1/2015). Surgery Date: 10/16/15

4. Functional health status (Section D) would be captured as Partially Dependent in this case.

A. True

B. False

performs own ADL's...functional status has improved to water walking and light resistance training

5. Use of Steroid/Immunosuppressive Drugs for Chronic Condition (Section D) would be captured as:

A. Yes

B. No

Chronic Steroid Use: (None); budesonide and formoterol (symbicort) QD. (available only as inhaler)

6. How would you capture current cancer/malignancy in this case (Section D)?

A. Yes

B. No

Malignancy: hx endometrial cancer s/p TAH and chemo/radiation in 2011 in remission.

7. For personal history of DVT/PE (Section D), how would you capture this?

A. Yes

B. No

history of portal vein thrombosis

8. For family history of DVT/PE (Section D), how would you capture this?

A. Yes

B. No

No family history noted in chart

9. What would you select for COPD (Section D)?

A. Yes

B. No

COPD: diagnosis and QD inhaler use

10. What would you capture for Diabetes Mellitus (Section D)?

A. Diet-control

B. Non-insulin

C. Insulin

D. No diagnosis

Diabetes: Type 2, not currently on medications

11. In terms of History of CAD (Section D), how would you capture this?

A. Yes

B. No

hx of CAD noted; LHC 2011 reportedly with minimal CAD, but was non-interventional

12. What would you select for CHF (Section D)?

A. Yes

B. No

Congestive Heart Failure: (None); MI: (None); She denies orthopnea, shortness of breath. She was cleared by cardiology who didn't recommend any further stress testing at this time given her stable cardiac risk and improved functional status

Pneumonia

HISTORY OF PRESENT ILLNESS: Patient is a 45-year-old woman with a past medical history significant for coronary artery disease and 2 stents as well as COPD and hypertension on aspirin and Plavix, who earlier in the evening complained of headache, nausea, and vomiting. Shortly thereafter, her alertness deteriorated to the point where she was unresponsive to her family; they called 911. She was taken to ABC Hospital where she was given paralytics and intubated and found to have a large cerebellar bleed. She was subsequently transferred to DEF Hospital for further evaluation. When she arrived at DEF on 10/16, Neurosurgery was consulted. Patient is now status post craniotomy for hematoma evacuation on 10/16. Patient remained intubated and transferred to ICU for further monitoring.

10/17:

Currently ventilating and oxygenating well on mechanical ventilation and titrate mechanical ventilator support, bronchodilators with albuterol and ipratropium, continuous pulse oximetry monitoring.

Respiratory: PPD/aggressive pulmonary hygiene, obtain weaning parameters and pressure support as tolerated

VS: 37.0, 78, 14, 121/58, 98% on vent

Scant amount of clear sputum during suction

10/18:

This afternoon patient developed high grade fever (39). Cultures obtained. Tracheal aspirate with numerous gram negative rods. Empiric antibiotics initiated.

Pulmonary: Currently, ventilating and oxygenating well on mechanical ventilation, Attempt to titrate mechanical ventilator support, bronchodilators with albuterol and ipratropium, continuous pulse oximetry monitoring.
Infectious Disease: Evidence of systemic inflammatory response syndrome (fever, tachycardia, tachypnea), no definitive source of infection. Empiric cefepime, vancomycin, metronidazole. Await culture results.
She has also developed abdominal distension with findings of small and large bowel distension.
VS at 1500: 39.0, 121, 27 117/70, 97% on vent
Labs 1700: WBC 17.0, BG 143
Moderate amount of thick yellow sputum during suction

10/19:

OR for exploratory laparotomy, subtotal colectomy, end ileostomy, mucus fistula due to acute colon ischemia
Infectious Disease: Antibiotics- Cefepime & Vancomycin for ? Sepsis. Plan: obtain chest xray

10/20:

Pulmonary: Worsened oxygenation overnight
Infectious Disease: Positive Cultures: Gram negative rods in ET aspirate 10/18
Antibiotics- Cefepime & Metronidazole for ? pneumonia (fever, worsened oxygenation, atelectasis vs consolidation on US/CXR). Can discontinue Vancomycin

10/21:

Pulmonary: Plan bedside tracheostomy today. She is oxygenating adequately.
Infectious Disease: Positive Cultures: Morganella and Klebsiella in ET aspirate from 10/18
Antibiotics- Ceftriaxone for possible Morganella/ Klebsiella pneumonia

10/22:

Infectious Disease: Positive Cultures: Morganella and Klebsiella in ET aspirate from 10/18
Antibiotics- Ceftriaxone for possible Morganella/ Klebsiella pneumonia
VS: 36.6, 93, 16, 149/83, 109, 96% on vent

RADIOLOGY STUDIES:

Lung US: 10/19 at 8:20 AM revealed moderate hypoechoic left effusion with some atelectasis, likely not safe for bedside thoracentesis. Hold off for now in view of relatively small size, hypoechoic nature.

Chest Xray: 10/19 at 10:30 AM largely unremarkable

Chest Xray: 10/20 at 11:40 AM

1. Endotracheal tube tip in the lower thoracic trachea tip about 5 cm above the carina, Left PICC with tip at SVC right atrial junction. Feeding tube tip below diaphragm, tip not visualized. NG tube tip below diaphragm, tip not visualized.
2. Minimal bibasilar atelectasis. No visible pleural effusion or pneumothorax.
3. Stable normal size cardiac silhouette.

Chest Xray: 10/21 at 8:30 AM

1. Lines and tubes: Interval removal of endotracheal tube with new placement of tracheostomy tube with tip 5.1 cm above the carina. Redemonstration of gastric drainage tube and enteric feeding tube coursing below the diaphragm. Left PICC with tip in the lower SVC.
2. Mild left base opacity possibly representing pneumonia.

Chest Xray: 10/21 at 2:12 PM

1. Lines and Tubes: Stable support apparatus compared to prior study.

- Interval increase in left lower lobe opacity, likely representing pneumonia.

Chest Xray: 10/22 at 9:44 AM

- Lines and Tubes: Stable support apparatus compared to prior study.
- Continued worsening of left lower lobe opacity, likely representing pneumonia

Pneumonia Worksheet

Date(s)	10/14	10/15	10/16	10/17	10/18	10/19	10/20	10/21	10/22	10/23	10/24	25
EVENTS Adm, Surg, S/S, XR, CT					T 39 RR27 WBC							
					sputum		O ₂ worse	+CXR 0830 +CXR 1421	+ CXR 0944			
						OR						
7day Infection Window (IW)				3 days before		xx	3 days after					
Occurrence (DOO)					XX							
Present on Admission (POA)			admit									
Repeat Infection Timeframe (RIT)					Day 1 = 10/18 → Day 14 = 10/31							

13. What is the date of occurrence for this patient's pneumonia (Section D or L)?

- Patient does not meet criteria for pneumonia
- Date of Occurrence: 10/17
- Date of Occurrence: 10/18 first day that PNA criteria that met in Infection Window
- Date of Occurrence: 10/20

The patient met the 1 general s/sx and 2 PNA s/sx criteria within the Infection Window:

10/18: Temp 39, RR 27, on vent, Labs @ 1700: WBC 17.0, thick yellow sputum (clear the day before)

10/20: Worsening O₂

Patient had 2 new/progressive +CXR with the Infection Window that were at least 12 hours apart.

*Since not all criteria met in the Infection Window using 10/18 and 3 days before and 3 days after, the Window can be moved like a bubble to the next criteria that meets- 10/20. All criteria align within this Infection Window.

14. Is this pneumonia a preoperative or postoperative event (Section D or L)?

- Preoperative
- Postoperative

The DOO is 11/18, OR was on 11/19, so this is considered preop PNA

D10) Pneumonia Definition: Enter "Yes" if the patient has new pneumonia or recently diagnosed pneumonia (eligible time frame to consider is seven (7) days preoperatively) and on current antibiotic treatment at the time the patient is brought to the OR.

15. What date would the patient be eligible to assign another occurrence of pneumonia using the repeat infection timeframe (Section D or L)?

- A. 10/17
- B. 10/18
- C. 10/20
- D. 11/1

RIT Window starts on DOO (Day 1), goes through 14 days which is 10/31.

D10) Pneumonia Repeat Infection Timeframe (RIT): see Note #5: RIT is the 14 consecutive days initiated by the 'date of occurrence'.

16. In order to meet criteria to assign pneumonia to this patient, you are required to have how many imaging studies (Section D or L)?

- A. One
- B. Two
- C. None

The pneumonia DOO was after the POA window and the patient has hx of COPD, so the patient will need 2 imaging studies.

17. Another preoperative risk factor that can be assigned based on this case study? Select the best answer.

- A. Sepsis due to bowel ischemia
- B. Sepsis due to pneumonia
- C. Severe sepsis due to bowel ischemia
- D. None

VS 10/18 @ 1500: temp 39, HR 121, RR 27

Labs 10/18 @ 1700: WBC 17.0, BG 143 (cannot assign sepsis using BG since hx of DMII)

Infx Source: 10/18 Assigned PNA meeting MSQC criteria; and PNA suspected by physician

- Labs and VS are within 12 hours of another
- Infection source is new and within 72 of surgery start time on 10/20
- < 1 calendar day between infx source and s/sx

Sigmoid Resection

PROCEDURE: Laparoscopic-assisted sigmoid resection with low anterior anastomosis and mobilization of the splenic flexure.

ANESTHESIA:

General endotracheal.

INDICATIONS:

The patient is a 68-year-old female who has had at least 7 episodes of acute diverticulitis, now with persistent pain in the left lower quadrant and CT and colonoscopic evidence of diverticulosis with diverticulitis. In view of persistent disabling symptoms, laparoscopic-assisted sigmoid resection, possible open, was recommended and informed consent was obtained. Procedure was explained to her including potential complications, particularly of bleeding, infection, recurrent symptoms, pain, leak, hematoma, seroma, surrounding injury, etc. She understood and agreed to proceed.

DESCRIPTION OF PROCEDURE:

After induction of general endotracheal anesthesia, orogastric tube and Foley catheter were placed. Both lower extremities were placed in low lithotomy position. The abdominal wall and perianal rectal area and perineum were prepped with Betadine and draped. A Veress needle was then inserted under local anesthesia through a small 5 mm incision just above to the right of the umbilicus. With a satisfactory saline drop test, the peritoneal cavity was inflated with carbon dioxide to a pressure approximately 15 mmHg. The needle was replaced with a 5 mm trocar and the laparoscope was inserted. A 5 mm trocar was placed in the right lower quadrant and a 12 mm trocar also in the right lower quadrant suprapubically under direct vision under local anesthesia. Visual exploration confirmed diverticulosis with thickening of the sigmoid wall in the left lower quadrant area. Visual exploration revealed no other abnormalities other than several ovarian cysts bilaterally and slightly enlarged uterus.

With the patient was placed in the Trendelenburg position and rotated towards the right, the distal side of resection was selected in the upper rectum, just below the lower most diverticulum where the adjacent fat and peritoneum were incised. The peritoneum was scored close to the bowel wall, all the way up to the proximal side of resection which was selected in the proximal sigmoid colon to include all the indurated diseased sigmoid. A window was created in the mesentery. The ureter was well identified and visualized throughout its length and preserved. The sigmoid colon and upper rectum and descending colon were mobilized by division of lateral peritoneal attachments. In view of the extent of involvement of the sigmoid colon, we decided to mobilize also the splenic flexure using the laparoscopic LigaSure instrument both in the medial and lateral aspect of the mesentery.

The bowel was then cleaned at the distal side of resection in the upper rectum where the adjacent fat and mesentery were cleaned off and the bowel divided with the Endo 45 GIA stapler. A transverse incision was then made suprapubically in the midline area extending from the larger trocar site across the midline towards the left side about 4 cm length. The wound protector was placed. The specimens were then brought out through this incision. Pursestring suture was placed across the bowel wall and the bowel was then divided and the specimen removed. A 29 mm head of the circular stapler was then inserted into the proximal bowel in the pursestring fashion onto the shaft. This was then returned into the peritoneal cavity, which was then reinflated. The circular stapler was then inserted through the rectum and advanced until it butted against the staple line. The instrument was opened and the proximal bowel and shaft of the head was inserted into the lower part of the instrument securely and instrument closed and the anastomosis completed. When tested under saline with the sigmoidoscope inserted through the rectum, there was no evidence of any leakage. There were 2 intact rings of tissue on the shaft of the instrument indicating an intact anastomosis. There was no tension at the anastomosis. The pelvis was thoroughly irrigated. Hemostasis was good and the field was dry. All trocars were then removed under direct vision. The posterior sheath and peritoneum were closed, at the larger incision in the suprapubic area with running 2-0 Vicryl and the anterior sheath with running #1 PDS. The suture lines were infiltrated with Marcaine. All skin incisions were then closed with 4-0 Monocryl subcuticular sutures and Steri-Strips. Dressings were applied. All counts were correct. Blood loss was minimal, less than 50 mL. The patient remained stable and was transferred to the Recovery Room in good and stable condition.

18. Please select the primary 5 digit CPT code for this case (CPT code reference of your choice):

- A. 44207
- B. 44208
- C. 44140
- D. 44151

A Veress needle was then inserted under local anesthesia through a small 5 mm incision just above to the right of the umbilicus. With a satisfactory saline drop test, the peritoneal cavity was inflated with carbon dioxide to a pressure approximately 15 mmHg. The needle was replaced with a 5 mm trocar and the laparoscope was inserted. A 5 mm trocar was placed in the right lower quadrant and a 12 mm

trocars also in the right lower quadrant suprapubically under direct vision under local anesthesia.

CPT 44207, Under Laparoscopic Excision Procedures on the Intestines (Except Rectum)

The Current Procedural Terminology (CPT) code 44207: Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)

19. What is the surgical approach for this operative episode (Section G)?

- A. Open
- B. Laparoscopic converted to open
- C. Laparoscopic**
- D. Open with laparoscopic-assist

See above

20. What is the wound classification for this procedure (Section G)?

- A. Clean
- B. Clean/Contaminated**
- C. Contaminated
- D. Dirty/infected

G1) Wound Classification CLEAN/CONTAMINATED/Class 2 - Operative wounds in which the respiratory, alimentary, genital, or urinary tracts are entered under controlled conditions and without unusual contamination.

21. What type of bowel anastomosis was performed (Section G)?

- A. Stapled with GIA (side-to-side)
- B. Stapled with EEA (end-to-end)**
- C. Stapled with EEA (side-to-end)
- D. Stapled with EEA (pouch or coloplasty)
- E. Hand-sutured (abdomen)
- F. Hand Sutured (anus)

A 29 mm head of the circular stapler was then inserted into the proximal bowel in the pursestring fashion onto the shaft. This was then returned into the peritoneal cavity, which was then reinflated. The circular stapler was then inserted through the rectum and advanced until it butted against the staple line.

Wound Classification

PREOPERATIVE DIAGNOSIS: Right foot infection with leg cellulitis.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE PERFORMED: Right below-knee amputation.

INDICATIONS: This is a 37-year-old male with uncontrolled diabetes who has previously had a hemoglobin A1c of 15. He also has diabetic neuropathy. Approximately 4 weeks ago he sustained a wound to the right foot, which then became necrotic and he presented to the hospital. He initially had a right foot partial amputation by Dr. H. on 11/11. Due to the extensive nature of the multiple wounds and cellulitis in this right lower extremity, salvage of the right foot at this point was not able to be performed. Extensive conversation with the patient regarding reconstruction of the right lower extremity by below-knee amputation was discussed and the patient did wish to undergo amputation. Risks, benefits, and alternatives to this procedure were also discussed.

PROCEDURE: The patient was met in the preoperative holding area where informed consent and operative site were confirmed. The patient was brought to the operating room, laid supine on the operating room table. A

timeout was performed and general anesthesia was induced. All bony prominences were well padded and the right lower extremity was then prepped and draped in the usual sterile fashion. Incision was made approximately 4 centimeters distal to the right tibial tubercle. A posterior flap was made. Strict hemostasis was achieved while dissecting down to the level of the fascia and then the fascia was incised. Muscles from the anterior and lateral compartments were then transected at the level of the anterior incision. There was no evidence of infection at the areas of the flap and fascia.

An oscillating saw was used to then cut the fibula and the tibia. The fibula was osteotomized approximately 1 cm proximal to the tibia cut. The anterior portion of the distal tibia was beveled and then a rasp was used to smooth out any rough edges. Care was taken to protect the blood vessels. Next, the amputation was completed with the posterior compartment muscles left intact up until approximately 15 centimeters distal to the anterior incision. Strict hemostasis was achieved while cutting these muscles. Nerves were transected as proximally as possible and buried in muscle tissue. We then reflected the posterior flap to the anterior incision and 0 Vicryl sutures were used to sew the deep fascial layers together. A 2-0 Vicryl was used to sew the superficial layers together and staples were used to close the skin layer. Sterile dressings were then applied. The patient was awoken, extubated, and taken to the PACU in stable condition. All the counts were correct at the end of the case, and I was present and scrubbed for all portions of this procedure.

Pathology Results:

Diagnosis:

Right lower extremity, below knee amputation: Ulcer and gangrenous necrosis of skin and soft tissue, and underlying necrotic bones in the foot.

Gross Description:

"Right BKA" Received fresh is a below the knee right lower extremity amputated to the tibia and fibula. Length is 31 cm; circumference of calf 16 cm; foot 22 cm. Only three digits are present, missing digits 1 and 2. The digits were amputated previously. There is a 12 x 9.5 x 9.5 cm area of exposed soft tissue with purulent material at the ankle. The underlying bone is not exposed. The posterior tibial artery and dorsalis pedis artery are both patent. The bone, soft tissue, skin at resection margin are unremarkable.

22. Based on this information, assign the appropriate wound classification for this case (Section G):

A. Clean/contaminated

B. Contaminated

C. Dirty/infected

D. Clean

The bone, soft tissue, skin at resection margin are unremarkable.

Wound Classification 2

PREOPERATIVE DIAGNOSIS: Chronic Cholecystitis

POSTOPERATIVE DIAGNOSIS: Chronic Cholecystitis

OPERATION PERFORMED: Laparoscopic cholecystectomy.

OPERATIVE FINDINGS: Scarred and shrunken gallbladder with additional acute inflammation.

PROCEDURE: The patient was placed on the operating table in supine position and a time-out was performed confirming patient identification and operative site. After satisfactory induction of general anesthesia,

examination showed an enlarged gallbladder extending down to the level of the umbilicus. The abdomen was prepped and draped in the usual sterile fashion.

An incision was made at the umbilicus, and this was carried through the subcutaneous tissue. The fascia was identified and divided. The peritoneum was carefully entered. Fascial stay sutures were placed, and then a blunt-tip Hassan port was placed into the peritoneal cavity and secured with the previously placed fascial sutures. CO2 insufflation of the abdomen was instituted. The laparoscope was inserted, and inspection of the abdomen showed no evidence of injury during the entry process. Laparoscopic exploration showed normal-appearing omentum, small bowel, liver, and stomach. The gallbladder appeared to be both **acutely and chronically inflamed** with multiple omental adhesions. A port was placed in the upper midline. Two 5-mm ports were placed in the right subcostal region; one in the right anterior axillary, and one in the mid clavicular line. The gallbladder was aspirated with removal of 20 cc of bile to decompress the gallbladder. Then 5-mm graspers were introduced and used to retract the gallbladder superiorly and laterally. The peritoneum was stripped from the infundibulum of the gallbladder to clearly identify the junction of the infundibulum with the cystic duct. The cystic duct was carefully dissected from the surrounding structures using blunt dissection. The cystic artery was identified and separated from adjacent tissues. The critical view of safety was achieved. The cystic duct was clipped and then divided. The cystic artery was clipped and then divided. The gallbladder was then dissected from its bed using the electrocautery. The gallbladder was placed into an Endocatch bag which was brought out through the umbilical port.

The specimen was examined on the back table and found to have several small stones.

Attention was returned to the abdomen where the right upper quadrant was irrigated and evacuated. The ports were withdrawn under direct visualization. A large flat Blake drain was placed in the subhepatic space and brought out through the lateral most trocar site. The abdomen was desufflated. The fascia at the infraumbilical incision was closed using interrupted 0-Vicryl sutures. The wounds were infiltrated with 0.50% Marcaine for postoperative pain relief. The skin was closed using 4-0 Monocryl subcuticular sutures at all sites, as well as benzoin and Steri-Strips. Dressings were applied. The patient tolerated the procedure well. All sponge and instrument counts were reported to me as correct at the end of the operation.

Pathology Results:

Diagnosis:

Gallbladder, excision: Acute on Chronic Cholecystitis with cholelithiasis

History:

Source of specimen: Gallbladder. History: 54-year-old female with history significant for breast cancer, status post lumpectomy and radiation therapy with acute cholecystitis.

Gross Description:

"Gallbladder" Received in formalin in a small container is a 7.2 x 4.5 x 3.2 cm previously opened gallbladder. Cystic duct probes with ease. Gallbladder is remarkable for green, bosselated calculi ranging up to 0.4 cm. Mucosa is red-tan and granular. The wall is thickened up to 0.9 cm. No other abnormalities are noted.

23. Based on this information, assign the appropriate wound classification for this case (Section G):

A. Clean

B. Clean/contaminated

C. Contaminated

D. Dirty/infected

In Op Report: "additional acute inflammation", "acutely and chronically inflamed"

Pathology Results/Diagnosis: Acute on Chronic Cholecystitis with cholelithiasis

UTI

Patient admitted for a TAH with BSO, lymphadenectomy, omentectomy performed on 10/9.

10/10: Foley present that was placed during 10/9 procedure. D/C foley POD#1.

VS: 36.9, 111, 16, 120/71

10/11: Acute urinary retention. Timed voids with ISC

Urine culture obtained: 10/11; Final Result: 10/14 Escherichia coli >100,000 cfu/mL

VS: 36.9, 108, 18, 117/75

Nursing Documentation: Assessed pt's pain frequently and encouraged pt to use PCA when appropriate.

Assisted pt in positioning for comfort. All needs assessed/addressed at this time, will continue to monitor and notify MD of changes.

10/13: Resolved acute urinary retention. S/P timed voids with ISC, now voiding spontaneously.

Nursing documentation: Pt was up to bathroom voiding frequently with some dysuria, ambulating frequently in her room. Pt expressed discomfort in her abdomen; MD was notified and saw pt at bedside. The decision was made for the patient to stay another day and simethicone was ordered and given. Pain is being adequately managed with oral Norco. VS stable. Pt able to rest today. Continue to monitor and notify MD of any pertinent changes.

24. Based on this case study, the patient meets the following criteria (Section L):

A. CAUTI

B. SUTI

C. Criteria not met

10/9 OR. Foley D/C POD 1: Foley not present >2 days (no CAUTI)

+ Urine culture 10/11; Final Result: 10/14 E.coli >100,000 cfu/mL

10/13: voiding frequently with some dysuria

25. What is the date of occurrence (Section L):

A. 10/11

B. 10/13

C. 10/14

D. Not applicable since patient did not meet criteria to capture SUTI or CAUTI

Urine culture obtained: 10/11; Final Result: 10/14 Escherichia coli >100,000 cfu/mL

L8) SUTI Note 3: Positive (+) Urine Culture: - one of the required criteria for diagnosing UTI; the specimen collection date is the reportable event, not when the specimen results are reported.

AKI

Patient was admitted on 11/8 retroperitoneal sarcoma. He is status post excision of recurrent retroperitoneal sarcoma with en bloc left colectomy with primary anastomosis on 11/9 at 0700.

Date	11/8 1800	11/9 1500	11/10 0600	11/10 1500	11/11 0600	11/11 1600
Creatinine	1.29	1.35	1.69	1.65	1.8	1.3
eGFR	>60	60	46	47	42	60

26. Does this patient meet criterion to capture AKI as a postoperative occurrence (Section L)?

A. Yes- date of occurrence: 11/9

B. Yes- date of occurrence: 11/10

C. Yes- date of occurrence: 11/11

D. Patient does not meet criteria

11/8 @ 1800 Creatinine 1.29

11/10 @ 0600 Creatinine 1.69

Definition 1: the SCr increases ≥ 0.3 mg/dL within 48 hours

27. In the same case example, if the patient also had a comorbidity of End Stage Renal Disease (ESRD), the patient would be excluded from capturing AKI as a postoperative occurrence (Section L).

A. True

B. False

L7) Acute or Worsening Renal Insufficiency and/or Failure: Exclude: 1. Patients who have a preoperative diagnosis of End Stage Renal Disease (ESRD) or patient required preoperative chronic dialysis.

SSI

Patient is status post right hemicolectomy with anastomosis on 11/5.

11/6: Patient recovering well. Midline incision with steri-strips C/D/I

11/7: Patient recovering well. Midline incision with steri-strips C/D/I

11/8: Midline incision with new erythema. No drainage. Plan: Will treat for wound cellulitis with Keflex 500mg PO BID

28. Based on this information, does this patient meet criteria to report a SSI (Section L)?

A. Yes- superficial incisional SSI

B. Yes- deep incisional SSI

C. Yes- Organ space SSI

D. Patient does not meet criteria to report any SSI

11/8: Midline incision with new erythema. No drainage. Plan: Will treat for wound cellulitis with Keflex 500mg PO BID

L1) Superficial Incisional Surgical Site Infection (SSI) Exclude: 1. Diagnosis/treatment of cellulitis (redness/warmth/swelling), by itself, does not meet criterion "d" for superficial incisional SSI

Patient is status post sigmoid colectomy and colostomy, JP drain placement x4, adhesiolysis x1 hour on 10/31 for perforated feculent diverticulitis. Noted findings during OR included: Feculent stool in entire abdomen with extensive adhesions around the small bowel, grossly necrotic distal sigmoid to proximal rectum (approximately 20 cm) with frank perforation in the posterior rectosigmoid. Incidental finding of small gallbladder polyp at gallbladder fundus

11/2: Abdomen: Midline incision with intermittent open wounds present. Staples in place. No surrounding erythema or warmth. JP drains #1,2,4 with serosanguineous output. JP drain #3 with serous output.

11/5: Abdomen: Midline incision with intermittent open wounds present; repacked with saline-moistened gauze. Staples in place. No surrounding erythema or warmth. JP drains #1,2,4 with serosanguineous output. JP drain #3 with serous output.

11/6: Abdomen: Midline incision with intermittent open wounds present; repacked with saline-moistened gauze. Staples in place. No surrounding erythema or warmth. JP pelvic drains #1,2 both with murky purulent output. JP culture + for E.Coli, Strep Anginosus, anaerobes.

Abdomen CT completed 11/6:

Impression:

1. Status post recent abdominal surgery, including sigmoid colon resection and left lower quadrant colostomy. Post insertion of bilateral lower quadrant surgical drains. Open anterior abdominal wall wound, which contains packing.
2. There are several loculations of gas and fluid in the pelvis, likely abscess formation. One of the larger components in the cul-de-sac is traversed by the bilateral pelvic surgical drains.
3. A fluid collection in the left adnexal region could be related to the above-described process or represent a cystic adnexal lesion, but with the former favored.
4. Moderately dilated loops of proximal to mid small bowel, with more normal caliber distal small bowel. While the appearance could be related to ileus, partial small bowel obstruction is possible.

29. Based on this information, does this patient meet criteria to report a SSI (Section L)?

A. Yes- superficial incisional SSI

B. Yes- deep incisional SSI

C. Yes- Organ space SSI (is deepest level involved)

D. Patient does not meet criteria to report any SSI

Organ Space SSI Initial Criteria:

1. Infection occurs within 30 days of the procedure and (OR 10/31- involved pelvis/sigmoid)
2. Infection involves any part of the body, deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure and (pelvic abscess, pelvic JP drains)
3. Patient has at least one (1) of the following:
 - a. purulent drainage from a drain that is placed into the organ/space (JP drainage with purulence)
 - b. organisms isolated from an aseptically-obtained culture of fluid or tissue in the organ/space (+JP drainage culture)
 - c. an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test and (+ CT likely pelvic abscess)
4. Meets at least one criterion for a specific organ/space infection site listed in Table 1.

Site Specific Criteria- Intra-abdominal:

1. Patient has organisms cultured from abscess and/or purulent material from intraabdominal space. (JP drainage with purulence)

VTE Prophylaxis/Bleeding Disorders

CLINICAL COURSE:

Mr. Q was initially admitted to a general medicine service. He was treated with antibiotics. He also underwent ERCP on 11/7/2015 for stone extraction, sphincterotomy, and stent placement. On 11/8, patient went into atrial fibrillation with RVR. Pt. does have a remote history of a fib but had not had issue with it since his ablation several years ago. Current a fib was managed with a combination of diltiazem, esmolol, and amiodarone. He was started on systemic anticoagulation with heparin infusion. Once his cardiac status stabilized, the patient was taken to the operating room on 11/12/2015 and underwent a lap converted to open cholecystectomy. Given the patient's good clinical progress, Mr. Q was discharged to home on 11/16/2015. Mr. Q was discharged to home with warfarin.

11/12 Anesthesia Times:

Anesthesia Start	Patient In Room	Anesthesia Induction End	Surgical Incision	Surgical Dressing Complete	Assigned Phase I
10:55	11:05	11:37	11:53	15:35	15:43
Patient transported to PACU o2/nc		Phase I Present	Anesthesia End	IP Bed Clean	PostOp Eval Wait
15:49		15:52	16:00	17:09	17:23
PACU Care Complete					
18:00					

MAR:

Hospital Encounter								
11/4/2015 Admission								
All Administrations of heparin infusion for ACS/Afib Anti-Xa Nomogram infusion								
User(s)	Action Time	Recorded Time	Dose/Rate	Route	Site	Comment	Action	Reason
	11/12/15 0005	11/12/15 0005	0 Units/kg/hr	Intravenous			Stopped	
	11/11/15 1028	11/11/15 1031	15.6 Units/kg/hr	Intravenous			New Bag	

Nursing SOAP Note 11/12 1930

Patient transferred back to floor. A&Ox3. VSS. Has MD order for SCDs but patient refusing stating that they are uncomfortable and he will walk tomorrow morning. MD notified. Will continue to monitor.

30. In terms of bleeding disorders (Section D), how would you capture this case?

- A. Yes
- B. No**

Patient on systemic IV Heparin for recurrence of Afib started 11/18 (not for prophylactic use). Needs to be stopped 6 hours prior to OR. Was stopped 11/12 @ 0005, OR 11/12 @1105. Was stopped in appropriate timeframe to answer 'No'.

31. How would you capture perioperative VTE prophylaxis- pharmacological (Section K)?

- A. Yes
- B. No
- C. Exception**

K2) Variable Option – Exception: Patient actively receiving IV heparin prior to surgery for treatment of existing VTE/arterial occlusion or AF/RVR.

32. How would you capture postoperative VTE prophylaxis- mechanical (Section K)?

- A. Yes
- B. No**
- C. Exception

Order for SCDs but patient refusing, there are no exceptions for patient refusal.

Discharge Medication Order

Current Discharge Medication List

START taking these medications

	Details
acetaminophen (TYLENOL) 500 mg tablet	Take 1 tablet by mouth every four to six hours as needed. Do not take more than 3000 mg in a 24 hour period.
amiodarone (CORDARONE, PACERONE) 200 mg tablet	Take 1 tablet by mouth once daily with breakfast. Qty: 30 tablet, Refills: 0
docusate sodium (COLACE) 100 mg capsule	Take 1 capsule by mouth two times daily.
lisinopril (ZESTRIL) 2.5 mg tablet	Take 1 tablet by mouth once daily. Qty: 30 tablet, Refills: 2
!! metoprolol succinate (TOPROL XL) 25 mg 24 hr tablet	Take 1 tablet by mouth once daily. Qty: 30 tablet, Refills: 2
!! metoprolol succinate (TOPROL XL) 50 mg 24 hr tablet	Take 1 tablet by mouth once daily. Qty: 30 tablet, Refills: 2
oxyCODONE (ROXICODONE) 5 mg tablet	Take 1-2 tablets by mouth every four hours as needed. Qty: 100 tablet, Refills: 0
polyethylene glycol 3350 (MIRALAX) 17 g packet	Mix contents of 1 packet in water and then drink once daily.
senna (SENOKOT) 8.6 mg tablet	Take 1 tablet by mouth once daily.
warfarin (COUMADIN) 5 mg tablet	Take 1 tablet by mouth once daily. Qty: 30 tablet, Refills: 2

33. If this case was CPT code enabled for Patient Discharged With Order for Post-Hospital VTE Prophylaxis (Section B), how would you capture this case?

- A. Yes- LMWH/low molecular weight heparin
- B. Yes- ASA ≥100mg a day
- C. Yes- UFH/unfractionated heparin
- D. Yes- Other
- E. No

Patient was d/c'd with order for 30 tabs of Coumadin which is not LMWH, ASA or UFH.

ED/Readmission/Return to OR

34. A patient returns to the surgeon office for a postoperative follow up visit after a cholecystectomy. You would capture this as (Section M):

- A. Presentation to ED/Urgent Care
- B. Readmission
- C. Return to OR
- D. None- patient does not meet criteria.

A postop follow-up visit is not considered ED/Urgent Care, Readmission or Return to OR, but it can be used to gather the 30 day follow-up information.

M2) Readmission Note 3: Do not report this variable in the workstation if there is no information available to determine whether or not the patient was readmitted to an acute care hospital as an inpatient within 30 days of the principal operative procedure.

35. A patient presented to the ED on 5/11 4 days status post colectomy with nausea and vomiting. The patient is placed in observation status and sent to the floor for further care. Following improvement, the patient was discharged to home on 5/15. You would capture this as (Section M):

A. Presentation to ED/Urgent Care

B. Readmission

C. Return to OR

D. None- patient does not meet criteria.

Although the patient was considered 'observation status' this can be captured as a Readmission using the following:

M2) Readmission Include: Readmissions where the patient stay surpasses two midnights after the initiation of hospital care/services in an Emergency Department, Operating Room or other treatment area at the hospital, regardless of hospital classification/admission status.

36. Following a laparoscopic appendectomy on 2/1, the patient presented to ABC Urgent Care on 2/22 with a fever and sore throat. The patient was diagnosed with streptococcal pharyngitis and sent home with PO antibiotics. You would capture this as (Section M):

A. Presentation to ED/Urgent Care

B. Readmission

C. Return to OR

D. None- patient does not meet criteria.

The patient presented to the urgent care clinic within 30 days of the principal operative procedure. Although unrelated to the original surgery, all visits to ED and Urgent Care need to be captured.

37. A patient who is status post colectomy on 6/30 was readmitted on 7/14 with a wound infection and taken back to the OR for a re-exploration and washout. Following improvement, the patient was discharged on 7/20. You would capture this as (Section M) (SELECT ALL THAT APPLY):

A. Presentation to ED/Urgent Care

B. Readmission

C. Reoperation

D. None- patient does not meet criteria.

The patient was Readmitted and had a Reoperation/Return to OR. They should both be captured.

Hysterectomy- Approach/wound classification/primary CPT code

PROCEDURE PERFORMED: Total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, bilateral pelvic and obturator lymphadenectomy, paraaortic lymphadenectomy, omentectomy, and cystoscopy. Bilateral ureteral catheter placement performed by urology team.

PROCEDURE: The patient was brought to the operating room with an IV in place and anesthetic was administered. She was examined, prepped, and draped in the low anterior lithotomy position using Yellofin stirrups. Her arms were padded with foam and tucked with care to avoid neuropathy. Shoulder bracing system was the TrenGuard. Once all draping was complete, a ZUMI uterine manipulator with a medium size KOH colpotomy ring was placed. Insufflation was carried out through a small incision at the base of the umbilicus after infiltrating with Marcaine. After the insufflation was complete, a 5 millimeter camera port was placed without difficulty. Remaining ports were inserted under laparoscopic guidance including 12 millimeter suprapubic port and 5 millimeter right and left lower quadrant ports. Laparoscopic survey was carried out and washings were obtained.

Retroperitoneum was opened along the right common iliac artery extending along the course of the aorta. Vessels were very tortuous as noted above. Lymph node was removed from the vena cava. The ureter was clearly identified and was well clear of the dissection. The node was at approximately the level of the inferior mesenteric artery. The specimen was retrieved in a specimen retrieval bag. Excellent hemostasis was noted.

The retroperitoneal space in the pelvis was opened by incising lateral and parallel to the infundibulopelvic ligaments. Pelvic vessels and ureters were identified, as were the obturator nerves. Node specimen was mobilized from the vessels using the ligature Maryland bipolar vessel sealer. The boundaries of the node dissection included the bifurcation of the common iliac artery superiorly, psoas muscle laterally, inferiorly border was the inguinal ligament, and the medial border was the anterior division of the hypogastric artery. Posterior boundary was the obturator nerve which was carefully identified and preserved bilaterally. Each specimen was retrieved in a specimen retrieval bag.

The infundibulopelvic ligaments were then sealed and divided, and the mesovarium was skeletonized. Round ligaments were sealed and divided, after which the peritoneum at the vesicouterine fold was divided. The bladder was mobilized to expose the colpotomy ring. Uterine arteries were then isolated, sealed, and divided. A colpotomy incision was made at the apex of the colpotomy ring using the Gyrus spatula bipolar cutting device using electro-surgical cut energy. The colpotomy allowed removal of the uterus with attached tubes and ovaries, after which the vaginal vault was closed with interrupted figure-of-8 stitches placed with the Endo Stitch device using 0 Polysorb suture. Knots were tied extracorporeally. Low-pressure check was carried out and excellent hemostasis was noted.

Trendelenburg was reversed and the omentum was brought into the operative field. The LigaSure was used to remove approximately one-third of the omentum well clear of the transverse colon. The specimen was placed in a specimen retrieval bag and was retrieved. The pelvis and abdomen were inspected and irrigated.

Cystoscopy was carried out and the bladder trigone and bladder was intact with no stitches or trauma. Both ureteral orifices were identified and vigorous jetting was seen from each side. Foley catheter was reinserted. The vagina was then inspected and the vaginal apex was noted to be intact and hemostatic. Pneumoperitoneum was released and the 12 millimeter port site was closed with an Endoclose needle using laparoscopic guidance. Ports were then removed and skin was closed with inverted interrupted subcuticular stitches with 4-0 Monocryl. Final sponge, needle, and instrument counts were correct at the completion of the procedure. Patient was awakened and taken to the postanesthesia care unit in stable condition.

38. Please enter the primary CPT code for this case (CPT code reference of your choice).

- A. 58543
- B. 58544
- C. 58548**
- D. 58550

PROCEDURE PERFORMED: Total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, bilateral pelvic and obturator lymphadenectomy, paraaortic lymphadenectomy, omentectomy, and cystoscopy. A colpotomy incision was made at the apex of the colpotomy ring using the Gyrus spatula bipolar cutting device using electro-surgical cut energy. The colpotomy allowed removal of the uterus with attached tubes and ovaries = laparoscopic radical hysterectomy with pelvic lymphadenectomy CPT code (58548)

39. Please enter the two 'other procedures' CPT codes for this case into the box below. (CPT code reference of your choice)

49329

52000

49329 Unlisted laparoscopy procedure, abdomen, peritoneum and omentum
the omentum was brought into the operative field. The LigaSure was used to remove approximately one-third of the omentum well clear of the transverse colon.

52000 Cystourethroscopy

Cystoscopy was carried out (by the primary team) and the bladder trigone and bladder was intact with no stitches or trauma. Both ureteral orifices were identified and vigorous jetting was seen from each side

40. Please select the concurrent procedure CPT code for this case (CPT code reference of your choice).

A. 52332

B. 52005

C. 52330

D. 53241

52005 (cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service

Bilateral ureteral catheter placement performed by urology team.

41. What is the surgical approach for this procedure (Section N)?

A. Laparoscopic

B. Vaginal

C. Laparoscopic-Assisted Vaginal (LAVH)

D. Robotic-Assisted Vaginal (RAVH)

Insufflation was carried out through a small incision at the base of the umbilicus after infiltrating with Marcaine. After the insufflation was complete, a 5 millimeter camera port was placed without difficulty. Remaining ports were inserted under laparoscopic guidance including 12 millimeter suprapubic port and 5 millimeter right and left lower quadrant ports. Laparoscopic survey was carried out and washings were obtained.

MISCELLANEOUS QUESTIONS

42. In order to capture *perioperative* VTE prophylaxis (Section K), you only need to verify that the provider has written an order for pharmacological and mechanical VTE prophylaxis to capture as a "yes".

A. True

B. False

K2) Perioperative VTE Prophylaxis Answer "No" if:

- There is no documentation of administration of pharmacological VTE prophylaxis.
- An order is present but documentation of actual administration is not present.

43. A physician diagnosis of superficial SSI located at a J tube insertion site placed via a stab wound meets definition criteria to capture as a “yes” (Section L).

A. True

B. False

L1) Superficial Incisional Surgical Site Infection (SSI) Exclude: 3. A localized stab wound or pin site infection does not qualify as criterion for meeting the definition of superficial SSI.

44. In regards to family history of DVT/PE, “Unknown” would be the appropriate variable option to capture when a patient is adopted, stated family history is unknown, or when family history is not discussed in the medical record (Section D).

A. True

B. False

D18) Family History of DVT/PE

1. Answer “Yes” if the patient has a first degree (parents, siblings) family history of venous thromboembolism, including pulmonary embolus, or deep vein thrombosis 2. Answer “No” if family history is not discussed in the medical record. 3. Answer “Unknown” only if there is an indication that the patient is adopted or stated family history is unknown

45. During a chart review, you found documentation in the preoperative anesthesia H&P that the patient “drinks socially”. Based on this, you would answer the ETOH variable as (Section D):

A. Yes

B. No

D5) ETOH > 2 Drinks per Day Exclude: 1. Patients whose only documentation of alcohol use is “social drinking”.

46. A patient is assessed by anesthesia in pre-admission testing on 3/14 and is assigned an ASA 2. On 3/18, day of surgery, anesthesia re-assesses the patient and assigns an ASA of 3. Which ASA class would you use (Section H)?

A. ASA-2

B. ASA-3

H6) ASA Classification Notes: 1. Most likely there will be a 2nd assessment of the ASA class prior to anesthesia induction. If this is available, report this most recent assessment.

47. During a chart review for a patient admitted 5/20-5/30 for a colectomy for colon adenocarcinoma, you find physician documentation during assessment from a previous admission on 2/14 that the patient appears thin, frail and reports decreased appetite with weight loss. A nutrition consult was ordered. The nutritionist documented on 2/15 in their consult note that the patient was severely cachectic and recommended supplemental nutrition. Does this patient’s status fit the criterion within the definition of the variable >10% loss of body weight in the 6 months prior to surgery (Section D)?

A. Yes

B. No

D23) > 10% Loss of Body Weight in the 6 Months Prior to Surgery

Definition: A greater than 10% decrease in body weight in the six month interval immediately preceding surgery as manifested by one or more of the following: • serial weights in the chart • report by the patient • a change in clothing size • severe cachexia

48. If there are no intraoperative glucose measurements present in the documentation during patient in room time to patient out of room time, you should enter “0” in the workstation (Section H).

A. True

B. False

H8) Number of Intraoperative Glucose Measurements Variable Options: Record the number of intraoperative glucose measurements in whole numbers: Range is 0-1000

49. In reviewing the anesthesia record, you find documentation that the patient was hypotensive and was given Levophed IVP. Hypotension resolved. You would answer variable ‘Intraoperative use of vasopressor/inotropic medications’ as (Section H):

A. Yes

B. No

H12) Intraoperative Use of Vasopressor/Inotropic Medications Variable Options: Yes: Answer “Yes” if vasopressor/inotropic medication administered to assist or maintain hemodynamic stability

50. In reviewing the anesthesia record, you are not able to find any recorded EBL documented by the anesthesiologist but find the operative report, in which the surgeon documented “EBL=minimal”. You would capture (Section I):

A. 0 mL

B. Minimal

C. 25 mL

D. None

I1) Fluid Volume & Balance

Fluid Volume Subtractions 1. Estimated blood loss (EBL): Milliliters of blood loss • “Minimal” = 25 mL

4. * If any fluid volumes are not recorded by anesthesia in the Anesthesia Record, record what is noted by the surgeon in the Operative Report.