ACCEPTABLE OPERATIVE REPORT # 1

This operative report follows the standards set by the JCAHO and AAAHC for sufficient information to:

- **identify the patient**
- **support the diagnosis**
- **justify the treatment**
- **document the postoperative course and results**
- **promote continuity of care**

This operative report also provides:

- **name of facility where procedure was performed**
- **date of procedure**
- **patient history**
- **CPT code**

Blair General Hospital
123 Main Street
Anytown, USA 56789

Patient Name: Betty Doe

Date: January 1, 2005

Preoperative Diagnosis: Bilateral upper eyelid dermatochalasis

Postoperative Diagnosis: Same

Procedure: Bilateral upper lid blepharopoasty, (CPT 15822)

Surgeon: John D. Good, M.D.

Assistant: N/A

NAME: Doe, William

Anesthesia: Lidocaine with l:100,000 epinephrine

Anesthesiologist: John Smith, M.D.

Dictated by: John D. Good, M.D.

This 65-year-old female demonstrates conditions described above of excess and redundant eyelid skin with puffiness and has requested surgical correction. The

procedure, alternatives, risks and limitations in this individual case have been very carefully discussed with the patient. All questions have been thoroughly answered, and the patient understands the surgery indicated. She has requested this corrective repair be undertaken, and a consent was signed.

The patient was brought into the operating room and placed in the supine position on the operating table. An intravenous line was started, and sedation and sedation anesthesia was administered IV after preoperative P.O. sedation. The patient was monitored for cardiac rate, blood pressure, and oxygen saturation continuously.

The excess and redundant skin of the upper lids producing redundancy and impairment of lateral vision was carefully measured, and the incisions were marked for fusiform excision with a marking pen. The surgical calipers were used to measure the supratarsal incisions so that the incision was symmetrical from the ciliary margin bilaterally.

The upper eyelid areas were bilaterally injected with 1% Lidocaine with 1:100,000 Epinephrine for anesthesia and vasoconstriction. The plane of injection was superficial and external to the orbital septum of the upper and lower eyelids bilaterally.

The face was prepped and draped in the usual sterile manner.

After waiting a period of approximately ten minutes for adequate vasoconstriction, the previously outlined excessive skin of the right upper eyelid was excised with blunt dissection. Hemostasis was obtained with a bipolar cautery. A thin strip of orbicularis oculi muscle was excised in order to expose the orbital septum on the right. The defect in the orbital septum was identified, and herniated orbital fat was exposed. The abnormally protruding positions in the medial pocket were carefully excised and the stalk meticulously cauterized with the bipolar cautery unit. A similar procedure was performed exposing herniated portion of the nasal pocket. Great care was taken to obtain perfect hemostasis with this maneuver. A similar procedure of removing skin and taking care of the herniated fat was performed on the left upper eyelid in the same fashion. Careful hemostasis had been obtained on the upper lid areas. The lateral aspects of the upper eyelid incisions were closed with a couple of interrupted 7 – 0 blue prolene sutures.

At the end of the operation the patient's vision and extraocular muscle movements were checked and found to be intact. There was no diplopia,no ptosis, no ectropion. Wounds were reexamined for hemostasis, and no hematomas were noted. Cooled saline compresses were placed over the upper and lower eyelid regions bilaterally,

The procedures were completed without complication and tolerated well. The patient left the operating room in satisfactory condition. A follow-up appointment was scheduled, routine post-op medications prescribed, and post-op instructions given to the responsible party.

The patient was released to return home in satisfactory condition.

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John D. Good, M.D.

ACCEPTABLE OPERATIVE REPORT # 2

This operative report follows the standards set by the JCAHO and AAAHC for sufficient information to:

- **identify the patient**
- **support the diagnosis**
- **justify the treatment**
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- **promote continuity of care**

This operative report also provides:

- **name of facility where procedure was performed**
- **date of procedure**
- **patient history**
- **CPT code**

Patient Name: Jane Doe

Date: January 8, 2005

Location of surgery:
Riverview Surgical Center
123 Main Street
Hometown, USA 56789

Preoperative Diagnosis: Facial and neck skin ptosis
Cheek, neck, and jowl lipotosis
Facial rhytids

Postoperative Diagnosis: Same

Procedure: Temporal cheek-neck facelift (CPT 15825)
Submental suction assisted lipectomy (CPT 15876)

Surgeon: John D. Good, M.D.

Assistant: None

Anesthesia: General

Anesthesiologist: John Smith, M.D.

Dictated by: John D. Good, M.D.

This patent is a 65-year old female who has progressive aging changes of the face and neck. The patient demonstrates the deformities described above and has requested surgical correction. The procedure, risks, limitations, and alternatives in this individual case have been very carefully discussed with the patient. The patient has consented to surgery.

The patient was brought into the operating room and placed in the supine position on the operating table. An intravenous line was started and anesthesia was maintained throughout the case. The patient was monitored for cardiac, blood pressure, and oxygen saturation continuously.

The hair was prepared and secured with rubber bands and micropore tape along the incision line. A marking pen had been used to outline the area of the incisions, which included the preauricular area to the level of the tragus, the post-tragal region, the post auricular region and into the hairline. In addition, the incision was marked in the temporal area in the event of a temporal lift, then across the coronal scalp for the forehead lift. The incision was marked in the submental crease for the submental lipectomy and liposuction. The incision in the post auricular area extended up on the posterior aspect of the ear and ended near the occipital hairline.

The areas to be operated on were injected with 1% Lidocaine containing 1:100,000 Epinephrine. This provided local anesthesia and vasoconstriction. The total of Lidocaine used throughout the procedure was maintained at no more than 500mg.

SUBMENTAL SUCTION ASSISTED LIPECTOMY
The incision was made, as previously outlined, in the submental crease in a transverse direction, through the skin and subcutaneous tissue, and hemostasis was obtained with bipolar cautery. A Metzenbaum scissors was used to elevate the area in the submental region for about 2 or 3 cm and making radial tunnels from the angle of the mandible all the way to the next angle of the mandible. 4 mm liposuction cannula was then introduced along these previously outlined tunnels into the jowl on both sides and down top the anterior border of the sternocleidomastoid laterally and just past the thyroid notch interiorly. The tunnels were enlarged with a 6 mm flat liposuction cannula.

Then with the Wells-Johnson liposuction machine 27-29 inches of underwater mercury suction was accomplished in all tunnels. Care was taken not to turn the opening of the suction cannula up to the dermis, but it was rotated in and out taking a symmetrical amount of fat from each area. A similar procedure was performed with the 4 mm cannula cleaning the area. Bilateral areas were palpated for symmetry, and any remaining fat was then suctioned directly.

A triangular wedge of anterior platysma border was cauterized and excised at the cervical mental angle. A plication stitch of 3-0 Vicryl was placed.

When a satisfactory visible result had been accomplished from the liposuction, the inferior flap was then advanced over anteriorly and the overlying skin excised in an incremental fashion. 5-0 plain catgut was used for closure in a running interlocking fashion. The wound was cleaned at the end, dried, and Mastisol applied. Then tan micropore tape was placed for support to the entire area.

FACELIFT
After waiting approximately 10-15 minutes for adequate vasoconstriction the post auricular incision was started at the earlobe and continued up on the posterior aspect of the ear for approximately 2 cm just superior to the external auditory canal. A gentle curve was then made, and again the incision was carried down to and into the posterior hairline paralleling the hair follicles and directed posteriorly towards the occipital region. A preauricular incision was carried into the natural crease superior to the tragus, curved posterior to the tragus bilaterally then brought out inferiorly in the natural crease between the lobule and preauricuar skin. The incision was made in the temporal area beveling parallel with the hair follicles. (The incision had been designed with curve underneath the sideburn in order to maintain the sideburn hair locations and then curved posteriorly.)

The plane of dissection in the hairbearing area was kept deep to the roots of the hair follicles and superficial to the fascia of the temporalis muscle and sternocleidomastoid. The dissection over the temporalis muscle was continued anteriorly towards the anterior hairline and underneath the frontalis to the supraorbital rim. At the superior level of the zygoma and at the level of the sideburn, dissection was brought more superficially in order to avoid the nerves and vessels in the areas, specifically the frontalis branch of the facial nerve.

The facial flaps were then elevated with both blunt and sharp dissection with the Kahn facelift dissecting scissors in the post auricular region to pass the angle of the mandible. This area of undermining was connected with an area of undermining starting with the temporal region extending in the preauricular area of the cheek out to the jowl. Great care was taken to direct the plane of dissecting superficial to the parotid fascia or SMAS. The entire dissection was carried in a radial fashion from the ear for approximately 4 cm at the lateral canthal area to 8-10 cm in the neck region. When the areas of dissection had been connected carefully, hemostasis was obtained and all areas inspected. At no point were muscle fibers or major vessels or nerves encountered in the dissection.

The SMAS was sharply incised in a semilunar fashion in front of the ear and in front of the anterior border of the SCM. The SMAS flap was then advanced

posteriorly and superiorly. The SMAS was split at the level of the earlobe, and the inferior portion was sutured to the mastoid periosteum. The excess SMAS was trimmed and excised from the portion anterior to the auricle. The SMAS was then imbricated with 2-0 Surgidak interrupted sutures.

The area was then inspected for any bleeding points and careful hemostasis obtained. The flaps were then rotated and advanced posteriorly and then superiorly, and incremental cuts were made and the suspension points in the pre and post auricular area were done with 2-0 Tycron suture. The excess and redundant amount of skin were then excised and trimmed cautiously so as not to cause any downward pull on the ear lobule or any stretching of the scars in the healing period. Skin closure was accomplished in the hairbearing areas with 5-0 Nylon in the preauricular tuft and 4-0 Nylon interrupted in the post auricular area. The pre auricular area was closed first with 5-0 Dexon at the ear lobules, and 6-0 Nylon at the lobules, and 5-0 plain catgut in a running interlocking fashion. 5-0 plain catgut was used in the post auricular area as well, leaving ample room for serosanguinous drainage into the dressing. The post tragal incision was closed with interrupted and running interlocking 5-0 plain catgut. The exact similar procedure was repeated on the left side.

At the end of this procedure, all flaps were inspected for adequate capillary filling or any evidence of hematoma formation. Any small amount of fluid was expressed post-auricularly. A fully perforated bulb suction drain was placed under the flap and exited posterior to the hairline on each side prior to the suture closure. A Bacitracin impregnated nonstick dressing was cut to conform to the pre and post auricular area and placed over the incision lines.

ABD padding over 4X4 gauze was used to cover the pre and post auricular areas. This was wrapped around the head in a vertical circumferential fashion and anchored with white micropore tape in a non-constricting but secured fashion. The entire dressing complex was secured with a pre-formed elastic stretch wrap device. All branches of the facial nerve were checked and appeared to be functioning normally.

The procedures were completed without complication and tolerated well. The patient left the operating room in satisfactory condition. A follow-up appointment was scheduled, routine post-op medications prescribed, and post-op instructions given to the responsible party.

The patient was released to return home in satisfactory condition.

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John D. Good, M.D.

ACCEPTABLE OPERATIVE REPORT # 3

This operative report follows the standards set by the JCAHO and AAAHC for sufficient information to:

- **identify the patient**
- **support the diagnosis**
- **justify the treatment**
- **document the postoperative course and results**
- **promote continuity of care**

This operative report also provides:

- **name of facility where procedure was performed**
- **date of procedure**
- **patient history**
- **CPT code**

Medical Office Tower, Suite 645
987 Central Avenue
Metropolis, USA 99887

Patient Name: Larry Doe

Date: January 9, 2005

Preoperative Diagnosis: Nasal deformity, status post rhinoplasy

Postoperative Diagnosis: Same

Procedure: Revision rhinoplasy (CPT 30450)
Left conchal cartilage harvest (CPT 21235)

Surgeon: John D. Good, M.D.

Assistant: None

Anesthesia: General

Anesthesiologist: John Smith, M.D.

Dictated by: John D. Good, M.D.

Indications for the Procedure:
This patient is an otherwise healthy male who had a previous nasal fracture. During his healing, perioperatively he did sustain a hockey puck to the nose resulting in a saddle-nose deformity with septal hematoma. The patient healed

status post rhinoplasty as a result but was left with a persistent saddle-nose dorsal defect. The patient was consented for the above-stated procedure. The risks, benefits, and alternatives were discussed.

Description of Procedure:
The patient was prepped and draped in the usual sterile fashion. The patient did have approximately 12 mL of Lidocaine with epinephrine 1% with 1:100,000 infiltrated into the nasal soft tissues. In addition to this, cocaine pledgets were placed to assist with hemostasis.

At this point, attention was turned to the left ear. Approximately 3 mL of 1% Lidocaine with 1:100,000 epinephrine was infiltrated into the subcutaneous tissues of the conchal bulb. Betadine was utilized for preparation. A 15 blade was used to incise along the posterior conchal area and a Freer elevator was utilized to lift the soft tissues off the conchal cartilage in a submucoperichondrial plane. I then completed this along the posterior aspect of the conchal cartilage, was transected in the concha cavum and concha cymba, both were harvested. These were placed aside in saline. Hemostatsis was obtained with bipolar electrocauterization. Bovie electrocauterization was also employed as needed. The entire length of the wound was then closed with 5-0 plain running locking suture. The patient then had a Telfa placed both anterior and posterior to the conchal defect and placed in a sandwich dressing utilizing a 2-0 Prolene suture. Antibiotic ointment was applied generously.

Next, attention was turned to opening and lifting the soft tissues of the nose. A typical external columella inverted V gullwing incision was placed on the columella and trailed into a marginal incision. The soft tissues of the nose were then elevated using curved sharp scissors and Metzenbaums. Soft tissues were elevated over the lower lateral cartilages, upper lateral cartilages onto the nasal dorsum. At this point, attention was turned to osteotomies and examination of the external cartilages.

The patient did have very broad lower lateral cartilages leading to a bulbous tip. The lower lateral cartilages were trimmed in a symmetrical fashion leaving at least 8 mm of lower lateral cartilage bilaterally along the lateral aspect. Having completed this, the patient had medial and lateral osteotomies performed with a 2-mm osteotome. These were done transmucosally after elevating the tract using a Cottle elevator. Direct hemostasis pressure was applied to assist with bruising.

Next, attention was turned to tip mechanisms. The patient had a series of double-dome sutures placed into the nasal tip. Then, 5-0 Dexon was employed for intradomal suturing, 5-0 clear Prolene was used for interdomal suturing. Having completed this, a 5-0 clear Prolene alar spanning suture was employed to narrow the superior tip area.

Next, attention was turned to dorsal augmentation. A Gore-Tex small implant had been selected, previously incised. This was taken to the back table and carved under sterile conditions. The patient then had the implant placed into the super-tip area to assist with support of the nasal dorsum. It was placed into a precise pocket and remained in the midline.

Next, attention was turned to performing a columella strut. The cartilage from the concha was shaped into a strut and placed into a precision pocket between the medial footplate of the lower lateral cartilage. This was fixed into position utilizing a 5-0 Dexon suture.

Having completed placement of all augmentation grafts, the patient was examined for hemostasis. The external columella inverted gullwing incision along the nasal tip was closed with a series of interrupted everting 6-0 black nylon sutures. The entire marginal incisions for cosmetic rhinoplasty were closed utilizing a series of 5-0 plain interrupted sutures.

At the termination of the case, the ear was inspected and the position of the conchal cartilage harvest was hemostatic. There was no evidence of hematoma, and the patient had a series of brown Steri-Strips and Aquaplast cast placed over the nasal dorsum. The inner nasal area was then examined at the termination of the case and it seemed to be hemostatic as well.

The patient was transferred to the PACU in stable condition He was charged to home on antibiotics to prevent infection both from the left ear conchal cartilage harvest and also the Gore-Tex implant area. He was asked to follow up in 4 days for removal of the bolster overlying the conchal cartilage harvest.

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John D. Good, M.D.

ACCEPTABLE OPERATIVE REPORT # 4

This operative report follows the standards set by the JCAHO and AAAHC for sufficient information to:

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This operative report also provides:

- **name of facility where procedure was performed**
- **date of procedure**
- **patient history**
- **CPT code**

Northeast Doctors Group
2233 Medical Center Drive
Edge City, USA 00110

Patient Name: John Doe

Date: January 8, 2005

Preoperative Diagnosis: Squamous cell carcinoma of the scalp

Postoperative Diagnosis: Same

Operation Performed: Radical resection of tumor of the scalp (CPT 11643)

Advancement flap closure, with total undermined area 18 centimeters by 16 centimeters (CPT 14300)

Surgeon: John D. Good, M.D.

Assistant: None
NAME: Doe, William

Anesthesia: General endotracheal anesthesia

Anesthesiologist: John Smith, M.D.

INDICATIONS: This is an 81-year-old male who has a large exophytic 7 cm lesion of the anterior midline scalp which is biopsy-positive for skin malignancy,

specifically, squamous cell carcinoma. This appears to be affixed to the underlying scalp.

PLAN: Radical resection with frozen sections to clear margins thereafter, with planned reconstruction.

CONSENT: I have discussed with the patient the possible risks of bleeding, infection, renal problems, scar formation, injury to muscle, nerves, and possible need for additional surgery with possible recurrence of the patient's carcinoma, with review of detailed informed consent with the patient, who understood, and wished to proceed.

FINDINGS: The patient had a 7 cm large exophytic lesion which appeared to be invasive into the superficial table of the skull. The final periosteal margin which centrally appeared was positive for carcinoma. The final margins peripherally were all negative.

DESCRIPTION OF PROCEDURE IN DETAIL: The patient was taken to the operating room and there was placed supine on the operating room table.

General endotracheal anesthesia was administered after endotracheal tube intubation was performed by the Anesthesia Service personnel. The patient was thereafter prepped and draped in the usual sterile manner using Betadine Scrub and Betadine paint. Thereafter, the local anesthesia was injected into the area around the tumor. A ____type excision was planned down to the periosteum. A supraperiosteal radical resection was performed.

It was obvious that there was tumor at the deep margin, involving the periosteum. The edges were marked along the four quadrants, at the 12 o'clock, 3 o'clock, 6 o'clock, and the 9 o'clock positions, and these were sent for frozen section evaluation. Frozen section revealed positive margins at one end of the resection. Therefore, an additional circumferential resection was performed and the final margins were all negative.

Following completion of the resection, the area was irrigated with copious amounts of saline. Thereafter, advancement flaps were created, both on the left and the right side of the scalp, with the total undermined area being approximately 18 cm by 16 cm. The galea was incised in multiple areas, to provide for additional mobilization of the tissue. The tissue was closed under tension with 3-0 Vicryl suture deep in the galea and surgical staples superficially.

The patient was awakened from anesthetic, was extubated and was taken to the recovery room in stable condition.

DISPOSITION: The patient was discharged to home with antibiotics and analgesics, to follow-up in approximately one week.

NOTE: The final margins of both periosteal, as well as skin were negative circumferentially, around the tumor.

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John D. Good, M.D.

ACCEPTABLE OPERATIVE REPORT # 5

This operative report follows the standards set by the JCAHO and AAAHC for sufficient information to:

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This operative report also provides:

- **name of facility where procedure was performed**
- **date of procedure**
- **patient history**
- **CPT code**

Sweetwater Surgical Facility
828 Creekside Drive
Sweetwater, USA 12345

OPERATIVE REPORT

NAME: Doe, William

Date of Operation: 1/2/09

Dictating Physician: L. Gillespie, M.D.
Attending Physician: James Kildare, M.D.

Primary Surgeon: Dr. James Kildare
Assistant Surgeon: Dr. Leonard Gillespie
Anesthetic: General endotracheal

OPERATIONS PERFORMED:
1. Bilateral blepharoplasty, upper lid. CPT Code 15822
2. Lateral brow lift. CPT Code 15824
3. Excision of a midforehead mole.

COMPLICATIONS: None

EBL: 20 mL

FLUIDS RECEIVED: 1200 mL

LOCAL ANESTHETIC: 0.5% Marcaine with epinephrine mixed with 2% Xylocaine with epinephrine 50:50, a total of 7 mL was used.

FINDINGS: The patient had lateral brow ptosis, lateral hooding with upper lid dermatochalasis, as well as a central midforehead mole.

INDICATIONS: This is a 62-year-old male, who has a functional visual deficit secondary to upper lid dermatochalasis with lateral hooding, as well as brow ptosis and a mole in the middle of his forehead. He requests removal of this mole. The patient was consented and brought to the Operating Room for the above-stated procedures.

PROCEDURE: The patient was brought to the Operating Room and placed in a supine position. Standard monitors were applied. Endotracheal intubation was achieved, and general anesthesia was administered.

The patient was rotated 180 degrees to the right, and standard prepping and draping was carried out for a bilateral temporal brow lift, bilateral upper lid blepharoplasty and excision of a midforehead mole. The forehead lift was carried out first in the temporal region. Incisions were marked bilaterally superior to the temporal hair tuft and carried with small extensions exiting the hair for around 1 cm into naturally occurring forehead rhytids. A # 10 blade was used to incise the previously marked skin ellipse making sure to bevel the blade in order to preserve hair follicles. Incisions were closed with running locking 5-0 nylon bilaterally. With the bilateral temporal forehead lift completed, attention was then turned to the upper lids.

The upper lids were marked in standard fashion taking care to leave 8 mm between the upper lid margin and the lower limb of the blepharoplasty incision, and this was carried out slightly lateral to the lateral canthus in a natural rhytid. The area was then injected with local, and a period of time elapsed prior to the first incision. The incision was made in the area that was marked for the left eye, and a cutaneous layer only was excised. A second separate portion of the orbicularis was then removed using sharp scissors, and hemostasis was carried out with Bovie cautery on low setting with Colorado needle tip. The orbital septum was opened, and the middle and medial fat pads were identified and this was excised conservatively. The medial fat pads were not addressed as aggressively as they were not as significant a contributor to his upper lid pathology. Once again, hemostasis was ensured, and the upper lid was closed with a running 7 – 0 locking nylon suture from the medial portion to the area in the region of the lateral canthus. The remainder of the incision was closed with 7 – 0 nylon vertical mattress sutures. With this eye complete, saline ice packs were placed, and our attention was directed to the contralateral eye.

In standard fashion just as with the left eye, the right eye was incised, de-epithelialized, and a muscle strip was taken. Hemostasis was carried out. The orbital septum was entered. The medial and middle fat pads were identified and excised conservatively, and hemostasis was then carried out. The skin was then closed in standard fashion with a 7-0 nylon running, locking medially to the lateral canthus, and the remainder of the incision was closed with vertical mattress 7-0 nylon sutures. The dressing of the lateral aspect of the incision was Mastisol and Steri-Strips.

The midforehead mole was ellipsed in standard fashion with a 15-blade carried down to the subcutaneous layer. This was excised off and passed to the back table. A small amount of undermining was carried out in order to close the wound. Hemostasis was completed with Bovie-tip cautery. It was then closed with interrupted deep dermal 4-0 Vicryl and the skin was closed with 6-0 Prolene interrupted sutures. The dressing was completed with Steri-Strips and Mastisol.

The patient was then turned over to anesthesia, awakened without any difficulty, and transferred to the PACU in stable condition.

FOLLOW UP CARE:
The patient was sent home the same day with a comprehensive pre-prepared set of instructions for home care. He received pain medications, and a packet of supplies for wound care and eye care and was to return on POD #4 for suture removal and wound check.

Dr. Kildare was in the room throughout the entirety of the case.

Reviewed by:
L. Gillespie, M.D.
J. Kildare, M.D.

ACCEPTABLE OPERATIVE REPORT # 6

This operative report follows the standards set by the JCAHO and AAAHC for sufficient information to:

- **identify the patient**
- **support the diagnosis**
- **justify the treatment**
- **document the postoperative course and results**
- **promote continuity of care**

This operative report also provides:

- **name of facility where procedure was performed**
- **date of procedure**
- **patient history**
- **CPT code**

Northeast Doctors Group
2233 Medical Center Drive
Edge City, USA 00110

OPERATIVE REPORT

NAME: Susan Doe

Date of Operation: 1/3/09

Dictating Physician: G. House, M.D.
Attending Physician: G. House, M.D.

Primary Surgeon: Dr. Gregory House
Anesthetic: General endotracheal

PREOPERATIVE DIAGNOSES:
1. Deviated septum.
2. Nasal dyspnea
3. Inferior nasal turbinate hypertrophy
4. Acquired nasal deformity

POSTOPERATIVE DIAGNOSES:
1. Deviated septum
2. Nasal dyspnea
3, Inferior nasal turbinate hypertrophy
4. Acquired nasal deformity

EBL: 25 mL

PROCEDURES PERFORMED:
1. Septo-rhinoplasty, CPT 30420

FINDINGS:
1. correction of severe septal deviation
2. hump removal
3. autospreader grafts
4. columellar strut
5. tip graft

FLUIDS RECEIVED: 1600 mL

URINE OUTPUT: 125 mL

INDICATIONS: This very pleasant 28-year-old patient had a large fractured septum, due to injury with a softball, which gave her difficulty breathing, mostly on her right side. She also had a very large hump in her mid dorsum that was mostly cartilaginous but part of it was bony due to a previous trauma. We therefore are taking her to the operating room in order to give her a better airway by straightening her septum and to give her a more appealing appearance.

PROCEDURE: The patient was brought to the operating room and placed in the supine position. She was placed under general anesthesia and intubated by a member of the anesthesiology unit. The head of the bed was turned 180 degrees, and the patient was prepped and draped in the sterile fashion. She was injected with a mixture of lidocaine and Marcaine with approximately 6 mL altogether. We injected in her septum and along her bony dorsum and thenasal sidewalls. We also injected the columella and the tip. We placed cocaine pledgets and allowed her to sit for five to ten minutes.

Once there was good vasoconstriction, we then used a #15 blade to perform a full transfixion incision. We then did a submucoperichondrial dissection on both sides of the septum elevating the mucoperichondrial flaps up off of the bone and cartilage down onto the floor. We then took a large portion of the quadrangular cartilage that was tortuous and excised it using a D-knife and #15 blade. We saved this cartilage for further use. We then created a swinging door by removing the redundant portion of the caudal strut inferiorly and then anchored it with a Wright stitch through the mucosa just superior to the crest in order to anchor it back onto the midline. We then closed the incision using 5 – 0 chromic interrupted sutures on both sides. We then used a #15 blade to make an inverted-V transcolumellar incision and connected this to bilateral marginal incisions to open the nose. Once we had sharply dissected up over the cartilaginous domes of the lower lateral cartilages, we then retracted the skin back and were able to view the upper laterals. We used blunt and sharp

dissection to raise a skin/soft tissue envelope flap up over the entire dorsum of the nose up to the radix. We then dissected subperiosteally superiorly over the radix in order to facilitate bone and cartilage removal. Using a cottle elevator, we dissected the mucosa off of the superior aspect of the septum on both sides and then cut sharply down through the upper lateral cartilages separating them from the septum. We then removed the cartilaginous hump with a #15 blade and used the upper lateral excess to create auto-spreader grafts, which were then anchored to the septum using 5 – 0 PDS suture. A rasp was then used to remove some of the excess bone from the bony dorsum. This created a very small but significant open roof deformity. We then did bilateral osteotomies using a 3mm unguarded osteotome in a continuous to close this open roof.

We used the septal cartilage and fashioned a columellar strut out of it. We placed this columellar strut and anchored it with a 5 – 0 PDS horizontal mattress suture. We then used a 5 – 0 chromic suture as a mucosal apposition stitch, which we then placed through the domes. Once this was accomplished, we divided the domes and separated it from the vestibular mucosa below, trimming excess cartilage as was necessary. We then reapproximated these with three interrupted 6 – 0 Prolene sutures bilaterally. We then performed a cephalic trim of the cartilages and then fashioned a tip graft from the septal cartilage and anchored this to the reconstituted domes. We then redraped the skin/soft tissue envelope and closed using interrupted 6 0 Ethilon sutures. We then closed the marginal incisions using 5 – 0 chromic suture interrupted. Doyle splints were then placed and anchored with a single 4 – 0 Prolene suture. Steri-Strips were then placed over the dorsum and an Aquaplast dressing was placed.

The patient tolerated the procedure well and was brought out of anesthesia, extubated and taken to the PACU for further recovery.

FOLLOW UP CARE: The patient was sent home the same day with a comprehensive pre-prepared set of instructions for home care specifically designed for perioperative rhinoplasty patients. She receive pain medications, and a packet of supplies for wound care and was to return on POD #4 for suture removal and wound check.

UNACCEPTABLE OPERATIVE REPORT # 1

This operative report does not provide:

- **an adequate description of the procedures performed**
- **name of facility where procedure was performed**
- **CPT codes**

PATIENT NAME: William Doe
Office/Outpatient Visit
Visit Date: Monday, January 5, 2009
Provider: Mutual Healthcare
Location: San Diego, CA

Patient History: Mr. Doe is a 46-year-old male. He is here for chin implant, neck suction lipectomy, and rhinoplasty. Risks, benefits and potential complications discussed including but not limited to the following: facial nerve paralysis, hairline or earlobe distortion, skin burn, loosing of skin months later and asymmetry of the nose, pain, rejection of sutures or implants if used, skin injury and nasal congestion.

Past Medical History: Gastroesophageal Reflux Disease

Tobacco/Alcohol/Supplements: Does not apply

Allergies: No known drug allergies

Current Medications: Vicodin ES 7.5 mg/750mg

Objective:

Procedures: Rhinoplasty, mentoplasty, and submental liposuction
Surgeon: Gillespie, M.D.
Anesthesia: Local with sedation

Surgery: (Rhinoplasty) After the patient had signed the consent, he was brought into the OR and prepped and draped in the usual manner. The patient was injected with Xylocaine with Epi to the field of surgery. A 15 blade was used to make the incisions to elevate nasal skin. The periostium was elevated with the Mckenty elevator. The dorsal cartilage was lowered using a knife. A rim incision was done and then a cephalic trim performed. Collumella graft used. Medial and lateral osteotomies were performed. Telfa and Bacitration was placed and cast applied. Tissue was not sent to pathology. Post-operative instructions were given. Additional procedures performed were: chin implant placed and suction of the neck performed. Dressings applied as necessary. He was discharged in a stable condition.

UNACCEPTABLE OPERATIVE REPORT # 2

This operative report is listed as a septorhinoplasty but contains no information that would allow the Credentials Committee to assign credit for any description that relates to a rhinoplasty procedure. The description did not include reference to:

- **medial or lateral osteotomies**
- **dorsal straightening**
- **alar reduction**
- **tip reduction**
- **any type of augmentation**

This operative report also does not provide:

- **name of facility where procedure was performed**
- **date of procedure**
- **patient history**
- **CPT code**

PATIENT NAME: Robert Doe

MEDICAL RECORD: #23333

SURGEON: Casey, M.D.

Preoperative Diagnosis:	Nasal valve collapse, nasal septal deviation and nasal turbinate hypertrophy.
Postoperative Diagnosis:	Same
Procedure:	Functional septorhinoplasty, inferior turbinate cautery, tonsillectomy
Anesthesia:	General endotracheal
Findings:	Caudal septum deviated to the left. More posteriorly the septum was deviated to the right with almost complete obstruction of her nasal airway. Her dorsum overall was deviated to the right.

Description of Procedure: The patient was brought to the operating room and placed supine on the OR table. General endotracheal anesthesia was introduced. Afrin was used to decongest the nose. 1% Lidocaine with 1:100,000 epinephrine was injected into the septum. A hemitransfixion incision was made. The caudal cartilage was deviated towards the left. Mucoperichondrial layer was elevated on the left-hand side having carried the incision through to the right-

hand side approximately 1 cm behind the caudal most aspect of the cartilage. Deviated areas of cartilage along the floor of the nose were removed. With the bowl of the septal spur inferiorly and the deviated areas of cartilage to the left the more caudal aspect which was deviated and buckled and returned to a more natural and normal position with improvement of her nasal airway on the left. Then two bony deviations to the right were removed. Hemostasis along the floor of the nose with an osteotome was used. At the conclusion the septum was found to fit in the midline with a drastic improvement in her nasal airway and a visibly improved nasal contour.

She was extubated and transferred to recovery in good condition with a nose pad applied over her nose.

UNACCEPTABLE OPERATIVE REPORT # 3

This operative report was deemed too minor by the Credentials Committee. Credit is not awarded for non-malignant, minor excisions that do not involve any repair or reconstruction.

PATIENT NAME: John Doe
Office/Outpatient Visit
Visit Date: Friday, January 2, 2009
Provider: Hometown Healthcare
Location: San Diego, CA

Primary Visit Diagnosis: Accessory Auricle, CPT 69110

Surgeon: James Kildare, M.D.

Description of Procedure: Mr. Doe comes in today for excision of preauricular accessory auricle on the right-hand side. Risks and benefits were explained. Informed consent was obtained. The patient arrived an hour early to haeEmla cream applied. The patient was prepped with Betadine. The skin tag was snipped. Hemostasis was achieved with cautery. A Steri-Strip was applied. The patient tolerated the procedure well.

UNACCEPTABLE OPERATIVE REPORT # 4

This operative report does not provide:

- **name of facility where procedure was performed**
- **patient history**
- **pre-operative or post-operative diagnosis**
- **adequate description of procedure performed**
- **instructions and medications for patient's post-operative care**
- **CPT code**

FACELIFT

Dr. Casey

Patient: Jane Doe

The risks and benefits were reviewed with patient. Skin marker was used to mark incision lines. Local anesthesia carried out with Lidocaine 1% Epinephrine. The patient was prepped and draped in the usual manner.

Beginning on the left side, a left facelift incision was made beginning just below the temporal tuft of hair, continuing in the curve of the pre-auricular area, around the lobule and posteriorly over the mastoid. Using sharp and blunt dissection, a skin flap was elevated over the cheek and neck. Bleeding was controlled with hyfrecator cautery. The SMAS and platysma was then plicated posterosuperiorly with 2-0 nylon suture. The skin flap was repositioned. Skin was trimmed. The incision was closed with a running 5-0 nylon suture. The same was done on the right side to complete the surgery.

The incision lines were cleansed, steri-strips were applied along with antibiotic ointment. The patient left the office in satisfactory condition.

Physician signature: *B.T. Casey*

Date: January 1, 2009