Operative Note 8:
Hip arthroscopy/synovectomy and bursectomy

Preoperative diagnoses

1. Persistent left hip pain following open surgical treatment of femoral acetabular impingement with labral repair
2. Symptomatic hardware, left hip, with trochanteric bursitis

Postoperative diagnoses

1. Healed anterior labrum, left hip
2. Moderate synovitis, left hip, with grade III posterior inferior femoral head chondrosis
3. Symptomatic hardware, left hip
4. Trochanteric bursitis secondary to left greater trochanteric screws

Operative procedures

1. Left hip arthroscopy
2. Arthroscopic major synovectomy, left hip
3. Through a separate incision, open hardware removal left greater trochanter
4. Left greater trochanteric bursectomy

Anesthesia

General

Indications

The partient is a 38-year-old woman who has had surgery bilaterally for femoral acetabular impingemen. She had a right hip surgical dislocation in April of 2005 and a similar surgery on the left in October of 2005. Since December of 2007, she had re-developed left hip pain, described as a frequent intermittent sharp groin and buttock pain, dull and achy, sharp with rotational activities, relieved by rest. Her pain has failed to respond to any conservative treatment and she desires arthroscopy for examination of the hip to determine whether or not her labrum has healed adequately and also to determine whether or not there is any other pathology that might be responsible for her pain. In addition, she had some lateral trochanteric discomfort and desires to have her hardware removed and trochanteric bursectomy.

She is well aware of the indications for surgery and the risks, including the possibility of injury to the lateral femoral cutaneous nerve, femoral nerve, sciatic nerve, pudendal nerve, numbness or pain in the groin, foot, or thigh, superficial or deep infection, deep venous thrombosis, pulmonary embolus, etc., and she consents to proceed.

Operative findings

Operative Note 13:
Manipulation, left knee

Bold text indicates portion of operative note that validates code selection.

Codes to use

27570, 718.46, 905.4

NOTE: Don't forget the late effects ICD-9 code since it states 'status post' previous fracture. Even though there is reference to wound cleaning, it appears that when they did the manipulation the previous wound site split. So the treating of that would be considered inherent in the manipulation.

Preoperative diagnosis

Adhesions, left knee and left quad tendon, status post open left distal femur fracture

Postoperative diagnosis

Adhesions, left knee and left quad tendon, status post open left distal femur fracture

Operative procedure

Manipulation, left knee

Description of procedures

Patient was taken to the operating room where epidural and general anesthesia was achieved. Patient was placed supine on the operating room table. **Patient's initial range of motion was approximately 10 degrees short of full extension to approximately 40 to 45 degrees. First attention was directed towards trying to manipulate patient into full extension. This was carried out gently stretching the knee to full extension approximately 2 to 3 degrees of terminal hyperextension could be reestablished easily and maintained with simple gravity. Next, gentle manipulation was carried out to improve flexion. Care was taken to gently massage and stretch the tissues around the patella. Manipulation was carried out sequentially until the patient's knee could be flexed past 130 degrees without difficulty and could hang in at least 120 degrees of flexion just based on gravity. No disruption of the quad tendon could be noted or palpated (27570)**. The skin of the patient's compounding wound anteriorly over her distal femur did split at the previous wound site. This wound measured approximately 2 to 3 cm in length and only involved the skin and minimal superficial subcutaneous tissue. In addition, patient had several eschars over the proximal tibia distally where she had taken initial impact. These were all cleansed with Alcohol and Betadine as was the dehiscence of the skin of her compounding wound, and after sterile prep with alcohol and Betadine and draping in the usual fashion, the edges of the eschar were debrided at any place where they were not attached and then the skin was closed with interrupted sutures of 3-0 nylon. The areas of eschar and the skin wound were dressed with Xeroform and sterile dressings and Kerlix roll and an Ace Bandage.