
Documentation Dissection

PREOPERATIVE DIAGNOSES

Massive splenomegaly.

Newly diagnosed lymphoma.

POSTOPERATIVE DIAGNOSES

Massive splenomegaly ^[1].

Newly diagnosed lymphoma ^[1].

PROCEDURE PERFORMED: Laparoscopic takedown of the short gastric vessels with conversion to an **open** ^[2] splenectomy and appendectomy.

ANESTHESIA: General endotracheal anesthesia.

ESTIMATED BLOOD LOSS: Approximately 500 ml.

BLOOD PRODUCTS RECEIVED: 1 unit of packed red blood cells and 5 units of platelets.

INDICATIONS FOR PROCEDURE: The patient is a Caucasian female with a 2-month history of progressive abdominal distention and severe pain. She presented to the emergency room for this symptom and her evaluation showed a spleen approximately 32 cm in its maximum dimension, pancytopenia and she has undergone a bone marrow biopsy consistent with lymphoma. **Splenectomy is indicated for symptom control and to assist with final diagnosis** ^[3].

DESCRIPTION OF PROCEDURE: The patient was brought into the operating room and after the administration of general endotracheal anesthesia, a Foley catheter and an NG tube were placed. A Cordis right internal jugular vein catheter was placed by the Anesthesia service. Her arms were tucked at her sides and then her abdomen was prepped and draped in the usual sterile fashion.

A 5 mm trocar was used to enter into the abdominal cavity under direct vision by dissecting out the tissue planes with the trocar itself with the camera advanced into the trocar. Once in the abdominal cavity, a massive spleen was readily appreciated. Three additional 5 mm trocars were placed along the right abdominal ^[4] wall and a fan retractor was then advanced into the abdomen to elevate the spleen. Traction was placed on the stomach, pulling it toward the right side and the short gastric vessels were taken down with the Harmonic scalpel. Once the short gastrics were taken down, there was really no operative space to dissect out the splenic hilum. It should be noted that her splenic artery was embolized 24 hours prior, but there was still 1 large vessel supplying the spleen that was not able to be embolized.

At this time the decision was made to convert to a laparotomy and the trocars were removed and a **midline** ^[5] incision was made with a #10 scalpel blade. **The spleen was exteriorized quite easily and the splenic hilum was dissected, dissecting out the splenic artery and vein that were divided with an Echelon 60 stapling device with a white vascular load. Each vessel was divided separately. The tail of the pancreas was certainly at the level of the splenic hilum but was able to be completely dissected. The staple line was certainly intact** ^[6]. **There was a little bit of bleeding from the anterior surface of the pancreas and this was controlled with light cautery, a piece of Surgicel and Tisseel** ^[7].

After division of the splenic vessels, the spleen was then passed off the field as a specimen. She was noted to have 2 accessory spleens in the left upper quadrant. These were previously identified on a preoperative CAT scan. These were excised in a similar fashion with 1 small arterial and venous supply controlled with the Echelon 60 stapling device with a white vascular load. These were passed off the field as a separate specimen.

Remaining abdominal cavity was surveyed and she had a couple of enlarged lymph nodes at the **proximal** ^[8] area of the splenic artery left in site. The small bowel appeared grossly normal, along with the colon. She had a fecalith in the appendix and, therefore, the decision was made to remove the appendix to prevent future appendicitis with need for another surgical procedure.

The appendiceal vessels were divided with the Echelon 60 stapling device with a white vascular load and then **the appendix was divided from the base of the cecum using the Echelon 60 stapler** ^[9] with a blue tissue load. Seprafilm was placed in the abdominal cavity in each of the 4 quadrants and then the midline fascia was reapproximated with a #1 looped PDS suture. **Before closure of the abdominal cavity, the NG tube placement was confirmed in the body of the stomach** ^[10]. **After closure of the fascia, the skin was**

closed with staples. The prior trocar sites were closed with interrupted 4-0 Vicryl sutures. Appropriate dressings were applied, and the patient was extubated and taken to recovery in stable condition ^[11].

Pathology report confirmed lymphoma ^[12].

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- ^[1] The postoperative diagnosis is massive splenomegaly due to the lymphoma.
 - ^[2] This was started as a laparoscopic procedure and converted to laparotomy (open).
 - ^[3] Massive splenomegaly is the reason for the splenectomy. The lymphoma is still in process of being diagnosed, and the type of lymphoma is not yet specified in this case.
 - ^[4] Use of trocars and camera support the procedure as being performed by laparoscope.
 - ^[5] Began as a laparoscopy but after findings of limited operative space and the recent embolization, a decision was made to perform the splenectomy via laparotomy, therefore CPT code must be excision section, under Spleen and not a Laparoscopy or repair.
 - ^[6] Spleen is removed by dissection of the supporting structures (the arteries, ligaments, and veins attaching the spleen to other structures).
 - ^[7] Control of bleeding is not separately reported.
 - ^[8] A laparoscopy was closed and a laparotomy was performed.
 - ^[9] The removal of the appendix is separately reported.
 - ^[10] NG Tube placement is not separately reported.
 - ^[11] The closure of all incision is documented and not separately reported.
 - ^[12] Confirmation of lymphoma.

What are the CPT® and ICD-10-CM codes reported?

CPT® Codes: 38100, 44955

ICD-10-CM Codes: R16.1, K38.1, C85.90

Rationales:

CPT®: In the CPT® Index look for Spleen/Excision referring you to 38100–38102. In reviewing 38100–38102, 38100 is the appropriate code. CPT® 38101 is partial and 38102 total, en bloc is for extensive disease, in conjunction with other procedure. 38102 does not match the above case. In addition, 38102 is an add-on code and cannot be coded alone or as a first-listed code. First a laparoscopy was performed and because the spleen could not be safely removed via that route, the surgeon performed a laparotomy or open procedure with an excision into the abdominal cavity. When an endoscopic procedure is converted to an open procedure; report only the open procedure. An appendectomy was also performed. This is not incidental, because a fecalith was found. Look in the CPT® Index for Appendix/Excision referring you to 44950, 44955, 44960, 44870. Report add-on code 44955.

ICD-10-CM: In the ICD-10-CM Alphabetic Index, look for Splenomegaly (Bengal), (cryptogenic), (idiopathic), (topical) which directs you to R16.1. In the Tabular List, code selection is confirmed. Next in the Alphabetic Index look for Fecalith/appendix referring you to K38.1. The cause of the massive splenomegaly is lymphoma; therefore, is it reported. Look in the Alphabetic Index for Lymphoma referring you to C85.90. Verify in the Tabular List.