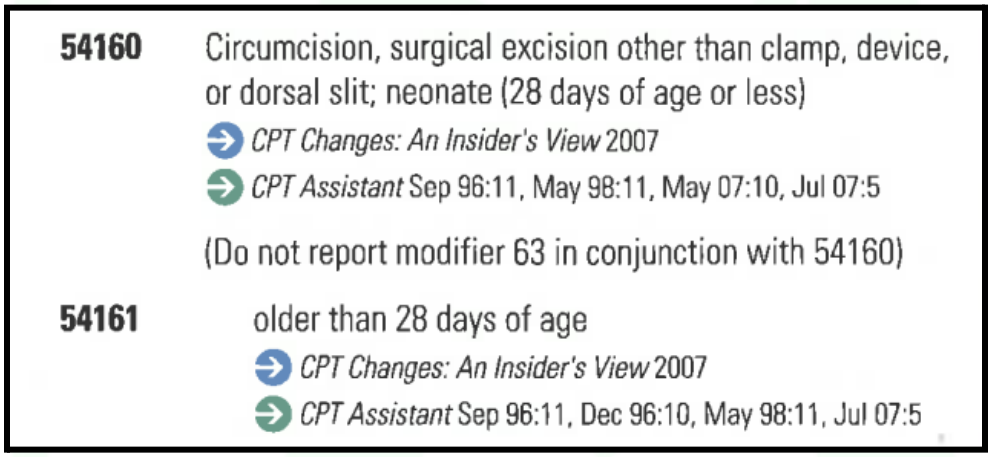
An Operation (OP) Report is the official surgical record. It contains standard components to document what was planned, performed, and the outcome.

**Components of an Operation (OP) Report**

**1. Patient Identification**

- Patient name
- Age
- Sex
- Hospital number
- Date of surgery



**54160** Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less)

*CPT Changes: An Insider's View* 2007

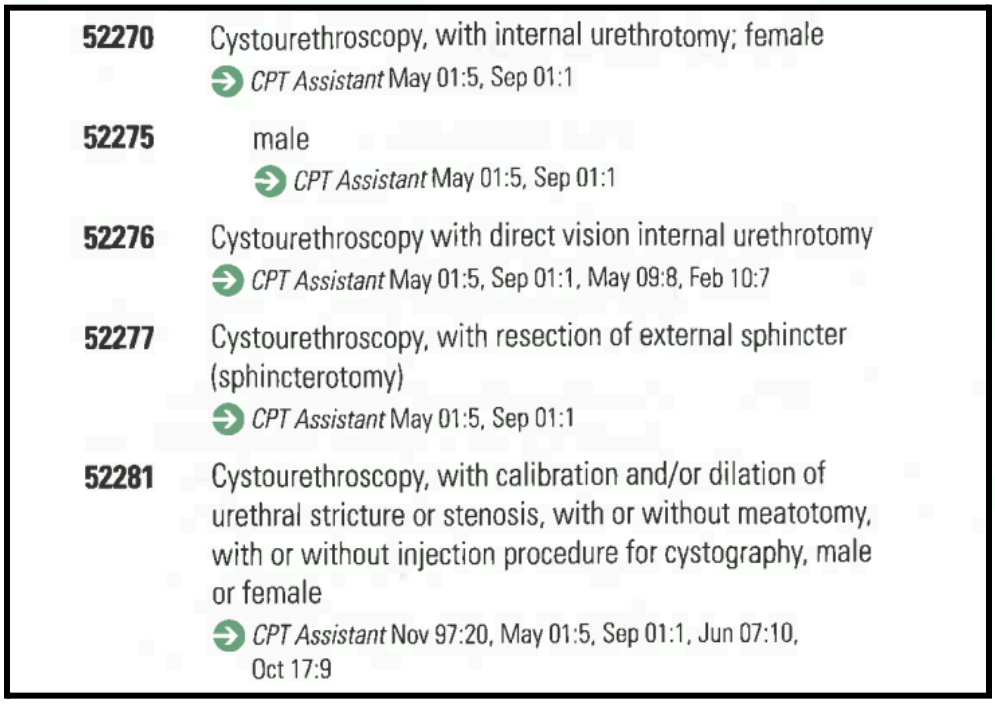
*CPT Assistant* Sep 96:11, May 98:11, May 07:10, Jul 07:5

(Do not report modifier 63 in conjunction with 54160)

**54161** older than 28 days of age

*CPT Changes: An Insider's View* 2007

*CPT Assistant* Sep 96:11, Dec 96:10, May 98:11, Jul 07:5



**52270** Cystourethroscopy, with internal urethrotomy; female

*CPT Assistant* May 01:5, Sep 01:1

**52275** male

*CPT Assistant* May 01:5, Sep 01:1

**52276** Cystourethroscopy with direct vision internal urethrotomy

*CPT Assistant* May 01:5, Sep 01:1, May 09:8, Feb 10:7

**52277** Cystourethroscopy, with resection of external sphincter (sphincterotomy)

*CPT Assistant* May 01:5, Sep 01:1

**52281** Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female

*CPT Assistant* Nov 97:20, May 01:5, Sep 01:1, Jun 07:10, Oct 17:9

## 2. Pre-operative Details

- Pre-operative diagnosis
- Indication for surgery

### Pre-operative Diagnosis

Advanced osteoarthritis of the **right / left knee** with severe pain and functional limitation, refractory to conservative management.

### Post-operative Diagnosis

Advanced osteoarthritis of the **right / left knee** – same as pre-operative diagnosis.

### Indication for Surgery

The patient is a known case of advanced osteoarthritis of the knee joint, presenting with chronic knee pain, stiffness, and progressive limitation of activities of daily living. Symptoms have failed to respond to conservative management, including analgesics, anti-inflammatory medications, physiotherapy, activity modification, and intra-articular injections. Radiological evaluation revealed severe degenerative changes with joint space narrowing, osteophyte formation, and deformity. In view of persistent pain, functional disability, and poor quality of life, the patient was planned for knee arthroplasty after informed consent.

## 3. Operative Details

- Name of operation performed
- Surgeon and assistants
- Anesthetist Type of anesthesia (general, spinal, local)
- Position of patient

**Procedure Performed:** Total Knee Arthroplasty (Right / Left).

**Anesthesia Type** : General

## 4. Incision and Findings

- Type and site of incision
- Operative findings (normal/abnormal anatomy, pathology)

## 5. Procedure Description

- Step-by-step description of the operation
- Structures handled or removed
- Any complications encountered

## 6. Closure

- Method of closure (layers, sutures used)
- Drains placed (type and site)

## 7. Post-operative Details

- Estimated blood loss
- Specimens sent (e.g., biopsy)
- Final post-operative diagnosis
- Patient condition at end of surgery

## 8. Post-operative Instructions

- Antibiotics Analgesics IV fluids
- Diet
- Drain care
- Follow-up instructions

## 9. Signatures

Surgeon’s name and signature - Electronic Signature or Handwritten Signature

Date and time

## Operative Note Colonoscopy: Sample 1

**Patient Name**: Medycoder
**Date of Birth**: 20/03/1960
**Procedure Date**: 14/02/2025
Insurance: Blue Cross
Admit Type: Outpatient
Gender: Male

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**Indication**: Rectal Bleeding

**Medication**: Monitored Anesthesia Care

**Complication**: None

**Specimen:** None

**Procedure:** The risks and benefits of the procedure and the sedation options and risks were discussed with the patient. All questions were answered, and informed consent was obtained. Prior Anticoagulants: The patient has taken no previous anticoagulant or antiplatelet agents. ASA Grade Assessment: A normal, healthy patient. After reviewing the risks and benefits, the patient was deemed in satisfactory condition to undergo the procedure. After I obtained informed consent, the scope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse, and oxygen saturations were monitored continuously.

The colonoscope was introduced through the anus and advanced to the cecum, identified by appendiceal orifice & ileocecal valve. The colonoscopy was performed without difficulty. The patient tolerated the procedure well. The quality of the bowel preparation was good.

**Findings**:

Throughout the examination, scattered diverticula were noted in the descending and sigmoid colon, consistent with diverticulosis. No evidence of active diverticulitis, perforation, or stricture was observed.

The rectum and sigmoid colon displayed mild erythematous mucosa, suggestive of proctosigmoiditis. No ulcers, friability, or exudates were present.

Internal hemorrhoids (Grade I) were noted during retroflexion, appearing non-bleeding and non-thrombosed.

Mild colonic spasm was observed in the transverse colon, but no strictures, mass lesions, or obstructive findings were present.

No polyps, tumors, or suspicious lesions were identified during the examination.

The remainder of the colonic mucosa appeared normal, with no evidence of bleeding, inflammation, or malignancy.

**Impression**:

- Scattered diverticula in the descending and sigmoid colon, consistent with diverticulosis.
- Mild erythematous mucosa in the rectum and sigmoid colon, suggestive of proctosigmoiditis.
- Internal hemorrhoids (Grade I) without active bleeding.
- Mild colonic spasm observed in the transverse colon.
- No polyps, masses, or malignancies visualized.

## Path Report Sample 1

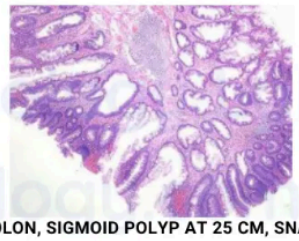
# HISTOPATHOLOGY COLONOSCOPY WITH POLYPECTOMY BIOPSY

**CLINICAL DATA:** **COLONOSCOPY WITH POLYPECTOMY,**
**A: VERY SMALL POLYP QUESTIONABLE RETRIEVAL**
**B: POLYPECTOMY,**
**C: NONE PROVIDED**

**SPECIMEN :**
A. CECAL POLYP HOT SNARE
B. @ 30 CM SIGMOID (POLYP PER BOTTLE) HOT SNARE
C. @ 25 CM SIGMOID POLYP SNARE

**DIAGNOSIS :**
**A. COLON, CECAL POLYP, SNARE: TUBULAR ADENOMA.**
**B. COLON, SIGMOID POLYP AT 30 CM, SNARE:**
1. TUBULOVILLOUS ADENOMA.
2. THE POLYP STALK MARGIN APPEARS NEGATIVE FOR ADENOMATOUS EPITHELIUM (ENDOSCOPIC CORRELATION RECOMMENDED).

**C. COLON, SIGMOID POLYP AT 25 CM, SNARE: SESSILE SERRATED ADENOMA WITH LOW-GRADE DYSPLASIA.**



**C. COLON, SIGMOID POLYP AT 25 CM, SNARE**

**NOTE:**
C. Multiple levels were examined. The polyp is a sessile serrated adenoma with low grade dysplasia. Colonic mucosal sessile serrated adenomas (sessile serrated polyps) have a unique histologic appearance. The importance of this diagnosis is that there is an increased association of this type of polyp with microsatellite instability (MSI) adenocarcinoma of the colon. These polyps, often sessile grossly, should be completely removed. If there is adjacent frank adenomatous change in the polyp, a more aggressive approach might be warranted including reducing the colonoscopic surveillance interval.

**GROSS DESCRIPTION: MS:kg**
A. Received in formalin in a container labeled with the patient's name and "cecal polyp (snare)" is a single tan soft tissue fragment measuring 0.2 x 0.1 x 0.1 cm. The specimen is entirely submitted between sponges in cassette A.