

# Electronic Interventional Case Studies

## Table of Contents

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<b>Case 1</b> .....	<b>1</b>
CERVIAL AND CEREBRAL CAROTID ANGIOGRAPHY, VERTEBRAL ANGIOGRAPHY, THROMBOLYSIS AND THROMBECTOMY	
<b>Case 2</b> .....	<b>3</b>
INTRACRANIAL ANGIOPLASTY AND STENTING	
<b>Case 3</b> .....	<b>5</b>
SELECTIVE CORONARY ANGIOGRAPHY WITH SELECTIVE LEFT SUBCLAVIAN ANGIO	
<b>Case 4</b> .....	<b>6</b>
AORTOGRAM WITH RUNOFF, LEFT POPLITEAL ARTERY ANGIOPLASTY AND STENT PLACEMENT	
<b>Case 5</b> .....	<b>7</b>
INSERTION OF NEW TUNNELED DIALYSIS CATHETER/REMOVAL OF OLD THC	
<b>How Did You Do?</b> .....	<b>9</b>

*Yellow highlighted areas in the case studies are key phrases from the documentation used to help you arrive at the appropriate CPT code(s) for the studies performed.*

*Green highlighted areas in the case studies are key phrases from the documentation used to help you arrive at the appropriate ICD-9 code(s) for the studies performed.*

*Blue highlighted areas in the case studies are areas where key phrases used to help you arrive at the appropriate CPT code(s) and ICD-9 code(s) overlap.*

## CASE 1

### CERVIAL AND CEREBRAL CAROTID ANGIOGRAPHY, VERTEBRAL ANGIOGRAPHY, THROMBOLYSIS AND THROMBECTOMY

#### Procedures

1. Diagnostic carotid vertebral and cerebral angiography with subselective right common, right internal, left common, left internal and left vertebral artery angiography focused on the neck and intracranial vasculature in multiple projections.
2. Primary mechanical thrombectomy and additional secondary mechanical thrombectomy of the distal left internal carotid artery and M1 segment of the left middle cerebral artery in the context of acute occlusive thromboembolism involving the distal left internal carotid artery terminus as well as extending into the M1 segment of left middle cerebral artery.
3. Direct intraarterial thrombolysis of an occlusive thromboembolism involving the distal left internal carotid artery and M1 segment of the left middle cerebral artery with intraarterial TPA and Integrilin.

#### Clinical History

xx-year-old with known history of atrial fibrillation was last seen normal at 1030 hours, today at 12 noon by telephone the patient was noted to have markedly garbled speech. The patient was brought to the hospital and on arrival at the hospital clinical assessment and neurologic assessments demonstrated a complete right-sided hemiparesis, right-sided neglect, right hemisensory deficit, complete receptive and expressive aphasia and a left gaze preference with a NIH stroke scale of 20. CT scan of the brain was performed demonstrating a clot sign within the left middle cerebral artery distribution. Emergency department personnel consulted Dr. xxxxxx of neurology and the discussion was made to progress to intraarterial intervention for potential acute left hemispheric stroke.

The risks and potential complications associated with intraarterial thrombolysis and mechanical thrombectomy were explained to the patient's family. The patient's family was quoted a 15% risk of clinically significant and potentially life threatening bleeding.

Informed verbal and written consent was obtained.

#### Technique

Utilizing sterile technique and local anesthesia, direct percutaneous puncture of the right

## CASE 1 ... from page 1

femoral artery was performed and a 5F sheath was placed subselectively into the right femoral artery. And a 6F sheath was placed subselectively into the right femoral artery. It should be noted that the procedure began at 1435 hours. Through this 6F sheath a 5F diagnostic catheter was initially utilized to subselectively catheterize the right common carotid artery, the cervical right internal carotid artery, the left common carotid artery, the cervical left internal carotid artery and the left vertebral artery in sequential fashion.

Diagnostic angiography was performed in each of these separate catheter positions focused in the neck and intracranial vasculature in multiple projections.

### Findings

Diagnostic angiographic images of the left internal carotid artery demonstrate or suggest complete occlusion of the distal left internal carotid artery extending into the M1 segment of the left middle cerebral artery into the proximal A1 segment of the left anterior cerebral artery, a so called carotid TE lesion, clot was visualized at approximately 1446 hours. Right internal carotid injection does demonstrate spontaneous cross filling from right to left into the left anterior cerebral artery with collateralization or partial collateralization of the distal left middle cerebral artery territory via anterior cerebral artery collaterals.

Left vertebral artery angiography fails to demonstrate a posterior communicating artery on the left and therefore minimal collateralization of left MCA territory is identified with evaluation or assessment of the posterior circulation. The remaining intra and extracranial vasculature are otherwise unremarkable. The degree of left middle cerebral collateral is provided by the anterior cerebral arteries would be described as mild to moderate.

Following identification of a distal left internal carotid artery terminus occlusion as described above the procedure continued with direct intraarterial thrombolysis and primary mechanical thrombectomy.

### Technique

The 5F catheter was removed and exchanged for a 6F sheath catheter which was placed into the proximal left internal carotid artery over a guidewire under fluoroscopic guidance. A microcatheter was inserted into the patient over a microguidewire and was utilized to subselectively catheterize the distal left internal carotid artery and the M1 and M2 segment of the left middle cerebral artery. Microcatheter angiography was performed at approximately 1515 hours within the proximal M2 segment of the left middle cerebral artery to confirm microcatheter position

prior to intraarterial thrombolysis. Intraarterial thrombolysis or infusion was then begun at 1515 hours and continued until 1541 hours. Over that time frame the patient received a total 15 mg of TPA directly intraarterially into the proximal M2 segment of the left middle cerebral artery, the M1 segment of the left middle cerebral artery and the distal left internal carotid artery. Over that same time frame the patient also received 3 cc or 6 mg of Integrilin in those same vascular locations.

A total of 14 follow up check angiograms were performed either through the microcatheter or the base catheter over this time frame to assess the degree and extent of thrombolysis. Following administration of the thrombolytic agents during that time frame and in that amount as described above diagnostic angiography failed to demonstrate or suggest recanalization of either the distal left internal carotid artery or the M1 segment of the left middle cerebral artery and therefore the procedure transitioned to primary mechanical thrombectomy.

The microcatheter was removed from the patient and a Penumbra 041 aspiration catheter was inserted into the patient again over a microguide wire and was utilized to subselectively catheterize the distal left internal carotid artery where primary mechanical thrombectomy was then begun at approximately 1547 hours. From 1547 hours until 1655 hours the patient underwent primary mechanical thrombectomy of the distal left internal carotid artery, a second order branch, and the proximal A1 segment of left middle cerebral artery, a third order branch possibly representing a secondary mechanical thrombectomy event.

During this timeframe a total of 12 separate follow up or check angiograms were performed through the left internal carotid artery catheter to assess the degree and extent of mechanical thrombectomy. During this time frame left internal carotid artery angiography did demonstrate partial success of mechanical thrombectomy in that there appeared to be clot aspiration from the distal left internal carotid artery as well as the proximal M1 segment of the left middle cerebral artery resulting in complete and resumed antegrade flow from the left internal carotid artery into the left anterior cerebral artery. However, the mid to distal left middle cerebral artery remained occluded and therefore after attempts with the Penumbra 04 system, in fact two separate 041 catheters, the decision was made to attempt mechanical thrombectomy utilizing the Concentric Merci L5 Retriever device. The Penumbra device was then removed from the patient and a Merci L5 and a Merci 14L microcatheter was inserted over a microguidewire and was utilized to subselectively catheterize the distal left internal carotid artery, the M1 and M2 segment of the left middle cerebral artery. The microwire was

CASE 1 ... continued on page 3

## CASE 1 ... from page 2

then withdrawn and the Merci L5 device was then advanced through the microcatheter into the M1 segment of the left middle cerebral artery and mechanical thrombectomy utilizing the Merci device was performed at 720 hours and then repeated at 729 hours. After initial performance diagnostic left internal carotid artery angiography demonstrated or suggested partial recanalization of the mid aspect of the left M1 segment but unfortunately suggested an embolic focus within the anterior cerebral artery which was not previously present suggesting that upon clot retrieval that a portion of the clot broke loose from the device and embolized into the anterior cerebral artery territory diminishing somewhat the collateral of blood supply to the left middle cerebral artery territory. A total of five separate follow up check angiograms were performed during mechanical thrombectomy utilizing the Merci device as described above and the attempts with the Merci device concluded at 729 hours and final diagnostic angiography on this patient was performed at 1734 hours. Final diagnostic angiography demonstrated and suggested again recanalization of the distal left internal carotid artery with antegrade flow into the left anterior cerebral artery and significant 50-60% recanalization of the M1 segment of the left middle cerebral artery but not complete recanalization of the M1 segment. Again there appeared to be a persistent embolic occlusion of the distal A3 segment of the left anterior cerebral artery at the conclusion of the procedure.

At this point of the procedure, the procedure was terminated as described above. All catheters were removed from the patient. The right femoral arterial sheath remained in place and will be removed on 6/1/08. There were no apparent clinical complications to the procedure identified at the time of the procedure, and following the procedure a head CT was performed which demonstrated only a 1 cm focus of presumed contrast staining within the medial left temporal lobe but no evidence of defini-

tive hemorrhage or CT complication associated with the procedure. Patient was then transferred to the ICU.

It should be noted the procedure was performed with IV sedation and continuous physical and nurse monitoring. Total sedation time 120 minutes. Total Versed 2 mg IV. Total Fentanyl 125 mcg IV. Total Zofran 4 mg IV. Total TPA 15 mg IA left MCA territory. Total Integrilin 3 mL or 6 mg IA distal left ICA and left M1 segment.

**Total Fluoro Time**

72.9 minutes

**Total Contrast**

225 mL of Optiray 320

**Total Anesthetic**

8 mL sub q Lidocaine right groin

**Conclusion**

Acute thromboembolic occlusion of the distal left internal carotid artery, proximal A1 segment of left anterior cerebral artery and M1 segment of left middle cerebral artery presumably secondary to patient's underlying atrial fibrillation resulting in an acute left hemispheric ischemic stroke syndrome manifested in complete right-sided hemiparesis and a complete receptive and expressive aphasia with NIA stroke scale of 20. Partially successful direct intraarterial thrombolysis and primary mechanical thrombectomy resulting in partial recanalization of the M1 segment of the left middle cerebral artery and complete recanalization of the distal left internal carotid artery as described above.

## CASE 2

### INTRACRANIAL ANGIOPLASTY AND STENTING

**Procedure**

Two angiogram with angioplasty and stenting of the intracranial segment of the left vertebral artery.

**Clinical Information**

Patient is a 65-year-old male with history of two transient neurological attacks localizing to the posterior circulation.

MRI revealed a small left cerebellar restricted diffusion weighted spot. Cerebral angiogram showed intracranial segment stenosis approximately 70%. Patient was brought for treatment with angioplasty and stenting for symptomatic stenosis.

CASE 2 ... continued on page 4

## CASE 2 ... from page 3

**Consent**

The risks, benefits of a conventional diagnostic cerebral angiography were discussed with the patient who agreed to proceed.

**Anesthesia**

Local anesthesia and conscious sedation were provided.

**Fluoro Time**

40.4 minutes

**Contrast Used**

150 cc of Opti-240

**Technique/Findings**

Patient was brought to the angiography suite and placed in supine position. Patient's right groin was prepped and draped in standard fashion. The right common femoral artery was palpated. The artery was accessed with a 19-gauge needle and was exchanged with a 6-French sheath over a wire. The sheath was connected to a continuous Heparinized saline flush. Through the 6-French sheath, a 6-French MPD guide catheter was advanced into the abdominal and thoracic aorta over a 0.035 inches Terumo guidewire.

**Left vertebral artery: Cervical view**

Under fluoroscopic guidance the catheter was advanced into the origin of the left vertebral artery that was selectively catheterized. Biplane angiography was performed over the cranium. Cervical view of the left vertebral artery in the AP projection demonstrated normal cervical left vertebral artery without any significant stenosis.

**Left vertebral artery: Intracranial view**

With the guide catheter positioned in the left vertebral artery biplane angiography was performed over the cranium. Intracranial view of the left vertebral artery in the AP, lateral and oblique projections demonstrates stenosis of the intracranial segment of the left vertebral artery just before the PICA origin. Left vertebral artery measures 4.4 mm pre and 4.4 mm post stenosis. The stenotic segment measures 1.35 mm. Basilar artery patent and bifurcates into bilateral posterior cerebral arteries with prominent right posterior cerebral artery and minimal visualization of the left posterior cerebral artery which is known to have a large supply from Pcomm on the left side.

**1 – Angioplasty of the left vertebral artery**

With the guide catheter positioned in the left vertebral artery, the Gateway: 3.5 mm x 9 mm size was advanced over a 0.014 inches transend exchange microwire into the left vertebral artery. The balloon and the microwire was advanced into the distal left vertebral artery and the balloon was positioned in the stenotic segment of the left vertebral artery.

**Left vertebral artery: Intracranial view**

With the catheter positioned in the left vertebral artery biplane angiography was performed over the cranium. This demonstrated the balloon positioned over the stenotic segment of the left vertebral artery.

At this point the balloon was slowly inflated to up to 5 ATP under angiographic guidance. And then slowly deflated.

**Left vertebral artery: Intracranial view post angioplasty #1**

With the catheter positioned in the left vertebral artery biplane angiography was performed over the cranium. This demonstrated significant improvement in the size of the stenotic segment of the left vertebral artery.

Following this the balloon and the exchange length microwire was removed.

**2 – Stenting of the intracranial left vertebral artery**

Under fluoroscopic visualization and using roadmap techniques Wingspan stent 4.5 mm x 15 mm was advanced over a transend 0.014 inches microwire into the left vertebral artery. The stent was advanced over the stenotic segment. Under fluoroscopic visualization the stent was successfully deployed over the stenotic segment.

**Left vertebral artery: Intracranial view Post-stenting #1**

With the guide catheter positioned in the left vertebral artery biplane angiography was performed. This demonstrated successful deployment of the stent into intracranial portion of the left vertebral artery. There is patent flow in the basilar artery. There is no dissection or extravasation of contrast.

**Left vertebral artery: Intracranial view Post-stenting #2**

With the guide catheter positioned in the left vertebral artery biplane angiography was performed. This demonstrated patency

CASE 2 ... continued on page 5

## CASE 2 ... from page 4

of the stent in the intracranial portion of the left vertebral artery. There is no dissection or extravasation of contrast. Basilar arteries visualized patent and terminates in the bilateral posterior cerebral arteries which is right one is more dominant. Bilateral superior cerebellar arteries are visualized normal. Left PICA is filling normally. Distal branches of the posterior cerebral arteries visualized normal.

**Right common femoral artery: Pelvic view**

Through the 5-French sheath angiography was performed over the right groin. Pelvic view of the right common femoral artery demonstrates a normal right common femoral artery and its branches of the superficial and deep femoral arteries. The

sheath is located above the bifurcation. There is no significant stenosis, no dissection or pseudoaneurysm.

Upon completion of the procedure the sheath was sutured into the groin.

Procedure was completed without any complications. Patient was transferred to the surgical ICU in stable condition.

Staff Dr. was present for the entire procedure.

**Impression**

Successful angioplasty and stenting of intracranial left vertebral artery stenotic segment with Wingspan 4.5 mm x 15 mm stent. Postprocedure there was residual 40% narrowing left.

**CASE 3****SELECTIVE CORONARY ANGIOGRAPHY WITH SELECTIVE LEFT SUBCLAVIAN ANGIO****Procedures Done**

1. Subclavian angiogram.
2. Brief coronary angiogram.

**Indication**

Angina.

**History**

This is an 86-year-old white female with past medical history for known coronary artery disease, status post coronary artery bypass surgery, status post stents to the native RCA artery as well as the SVG graft to the RCA on 07/03/08 by myself, and at that time, patient was found to have lesion in the left subclavian artery. As patient also has a LIMA graft which comes off from the subclavian artery to the left anterior descending artery, and stress test showed minimal anterior wall ischemia, I recalled the patient to look at the suspicious lesion in the left subclavian artery.

**Procedure Details**

The patient was explained the risks, benefits, including the alternative therapies about this procedure, and patient agreed and consented for the procedure. This peripheral angiogram and brief coronary angiogram were performed with standard sterile techniques.

A 6-French sheath is introduced into the right femoral artery under local anesthesia.

**Peripheral Angiogram**

A 6-French JR4 diagnostic catheter is used to engage the subclavian artery and tried to pass the wire across the suspicious lesion in the left subclavian artery, and unable to pass the wire as JR4 is not able to give much support, then 6-French LIMA catheter was taken and engaged the subclavian artery, then as a regular J-wire was not able to go through the lesion, a guidewire was used to cross the suspicious lesion in the subclavian artery, then a 5-French glide catheter was taken and exchanged over the wire with LIMA catheter. Then, a small injection is done in subclavian artery to confirm the placement as it is thought to be in the true lumen, then the glide catheter is slowly withdrawn from distal to the lesion, across the lesion and into the proximal part of the subclavian artery. There is about a 7-mm gradient across the lesion. Also, several views of the subclavian lesion were taken, both in the LAO 40-degree and RAO 40-degree angulations. Appears to be this lesion is not a significant lesion as well as it is in a bend of the subclavian artery and as well as the gradient is not significant, we decided that this lesion is not significant, so aborted the procedure further as the patient does not need any intervention.

CASE 3 ... continued on page 6

## CASE 3 ... from page 5

**Brief Angiogram**

We used a JR4 diagnostic catheter and engaged the right coronary artery to look at the stents in the SVG graft to the right coronary artery as well in the native coronary artery that were placed on 07/03/08. Both the stents in the SVG graft to the RCA as well as in the native RCA appear widely patent without any stenosis.

Patient tolerated the procedure well without any complications.

**Adjunctive Pharmacotherapy**

Considering that subclavian lesion might be true as we are trying different wires, we used Angiomax as adjunctive pharmacotherapy, and patient has taken her usual Plavix and aspirin in the morning.

**Conclusions**

1. No significant stenosis in the subclavian artery.
2. Patent stents in the saphenous vein graft to the right coronary artery as well as in the native right coronary artery that were placed on 07/03/08.

**Recommendations**

1. Continue aspirin and Plavix as patient was taking before.
2. Aggressive medical therapy for coronary artery disease.

**CASE 4****AORTOGRAM WITH RUNOFF, LEFT POPLITEAL ARTERY ANGIOPLASTY AND STENT PLACEMENT****Procedure Performed**

Arterial angioplasty, transluminal balloon with supervision/interpretation.

Conscious sedation.

Stent placement with supervision/interpretation.

Rhythm ECG with interpretation.

3rd Order Cath.

Aorto Ileo Femoral Arteriogram.

Extremity Arteriogram Bilateral.

**Diagnosis**

ASO with rest pain.

**Indications**

The patient is a ninety year old female with right leg rest pain with a palpable left femoral pulse. She will undergo angiographic evaluation and possible angioplasty.

**Procedure**

The patients right and left groins were prepped and draped. Versed and Fentanyl were given intravenously for sedation.

Patient was sedated for 20 minutes and because of this and past history EKG monitoring was used throughout. The right common femoral artery was percutaneously cannulated and a 6-French sheath was inserted over a guidewire. A VCF catheter and guidewire were passed into the abdominal aorta. An abdominal aortogram and pelvic arteriogram were performed. This showed a significant stenosis in left popliteal artery. The aortic bifurcation was crossed using the VCF catheter and a guidewire. The popliteal artery was selectively catheterized. The popliteal artery stenosis was crossed using the guidewire. The patient was systemically Heparinized. The 6-French sheath was exchanged for a long 6-French sheath that was positioned in the left common iliac artery. The popliteal artery stenosis was then dilated using an 5x12 Balloon. Following this, the angiographic result was not adequate. A 7x150 EV3 stent was then placed. It was post dilated with the 8x4 balloon. Following this, there was a much improved angiographic result. A left leg run-off arteriogram was then performed. The sheath was then pulled back into the right iliac artery for a right leg run-off arteriogram. The sheath was removed over a guidewire and the puncture site closed with an Angioseal device. The patient was transferred into the Recovery area in stable condition.

CASE 4 ... continued on page 7

## CASE 4 ... from page 6

**Findings****Aortoiliac Arteriogram**

The abdominal aorta is patent without significant narrowing. There are single renal arteries bilaterally without significant narrowing. The right iliac artery is patent without narrowing. As is the left iliac system. The remainder of the left iliac system has no significant narrowing.

**Right Leg Arteriogram**

The right common, profunda and superficial femoral arteries are patent without significant narrowing. The popliteal artery is occluded above the knee and reconstitutes at the knee. There is three vessel run-off to the lower leg and foot.

**Left Leg Arteriogram**

The left common, profunda, and superficial femoral arteries are

patent. The popliteal artery becomes occluded at Hunter's canal with three vessel run-off to the lower leg and foot.

**Left Popliteal Artery Angioplasty**

Following angioplasty there is significant residual stenosis in the left popliteal artery.

**Left Popliteal Artery Stent Placement**

Following stent placement there is no significant residual narrowing in the left artery.

**Summary**

Successful angioplasty and stenting of left popliteal artery stenosis. No other significant stenosis identified.

**CASE 5****INSERTION OF NEW TUNNELED DIALYSIS CATHETER/REMOVAL OF OLD THC****Indication**

Infected dialysis catheter  
ESRD

**Procedure Performed**

Rhythm ECG with interpretation.  
Fluoroscopic guidance for catheter placement.  
Tunneled catheter insertion.  
Ultrasound guidance.  
Removal of tunneled catheter.  
Selective catheterization of second order vein.

**Diagnosis****Other complications.**

Access failure.

**Cannulation of Vein**

There is a little pus at the exit site of the old catheter. By ultrasound there is a generous sized right internal jugular vein. She

has a high degree of stridor due to prior tracheal injury. After a little versed the stridor is worse, This increased the inspiratory negative pressure and we needed to take additional precautions to prevent air embolus. The skin over the base of the right neck was anesthetized using 1% Xylocaine. The right internal jugular vein was visualized using ultrasound and it was cannulated with ultrasound localization using micropuncture technique. The first puncture entered the artery and pressure was held until no hematoma or bleeding was seen. After successful venous puncture, a 5 F dilator was inserted. An angiogram was performed of the SVC which was normal. We could not time inspiration and expiration and be quick enough to place the guidewire into the microdilator before she took a breath and entrained an estimated 1 cc of air. Now her nose and mouth were briefly held, while the wire was inserted into the microdilator. We inserted a short 7 r sheath. A nimble floppy Roadrunner guidewire was inserted into the sheath and the wire and a guiding Berenstein catheter were directed into the pulmonary artery where a small air bubble was seen. The air was completely aspirated out. Now the wire was redirected using the Berenstein catheter into the IVC. The Catheter was removed and an angiogram was performed. The SVC was normal. No air was seen in the right atrium or in the pulmonary artery.

CASE 5 ... continued on page 8

## CASE 5 ... from page 7

**Sedation**

The patient was sedated with versed 3 mg given via the 5 F dilator. Vital signs were monitored by the monitoring nurse.

**Catheter Insertion**

The venotomy site was dilated using a 14 F Coons dilator passed over the guidewire which had been placed into the inferior vena cava under fluoroscopy guidance. A rubber cap was placed on the end of the Coons before insertion. A 28cm split tip 14 F RMS dialysis catheter was tunneled up from the anterior chest from a new exit site that was created several cm medial and about on the same level as the old exit site. Now the new venotomy site was sutured closed using a single mattress suture to prevent any air from entering via this route while exchanging the catheters. The new catheter was inserted into the IJC without difficulty over a wire without using a peel away sheath. Great care was taken to hold additional pressure over the venotomy site after the Coons was pulled and then again briefly her nares and mouth were occluded while quickly inserting the catheter over the wire and into the internal jugular vein. The tip of the catheter was found to be too deep and the catheter was kinked at the venotomy site, so that the venous aspiration and flushing was delayed. This catheter was removed over a wire that was placed through the venous port after a rubber cap was placed onto the end. The wire was positioned in the lower right atrium. A new 24 cm split tip Med Comp catheter was now positioned to lie within the mid right atrium using fluoroscopic guidance. On final images, there was no evidence of malposition, kink or complication. The catheter flowed well when tested with a 10 cc syringe.

The stay wings of the catheter were now sutured using 4-0 ethilon and the exit site closed over the catheter using 4-0 ethilon.

**Comments**

The catheter is positioned appropriately for dialysis. There is no evidence of pneumothorax or other complication. The catheter is ready to use for hemodialysis.

**EKG Monitoring**

Because of the patient's medical status and the use of sedation, EKG monitoring was used during the procedure (93940). He maintained normal sinus rhythm. The patients BP remained stable.

**Distribution of Report**

Nephrologist.

Dialysis Unit.

**Removal of Old Tunneled Catheter**

Now a Tegederm dressing was placed over the new exit site. The old exit site and the subcutaneous tissue surrounding the cuff were anesthetized with 1% Xylocaine. Using blunt dissection, the cuff was freed from the subcutaneous tissue and removed.

Now, as pressure was placed over the old tunnel, a single 3-0 ethilon suture was placed through the subcutaneous tissue and surrounded the old tunnel several cm from the old exit site. It was tied so as to occlude the old exit site and prevent air from entering.

**Complications**

About 1 cc of air entered the pulmonary artery. This was removed by selective catheterization of the pulmonary artery and aspiration of the air using fluoroscopy.

**Orders for Dialysis Unit**

Please remove the suture closing the old tunnel in 2 days. Remove all the sutures from the venotomy and exit site after 14 days of the new catheter after 14 days.

**Contrast**

3 cc of dilute contrast was used for this procedure.



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## HOW DID YOU DO?

The above cases should be coded as follows:

CASE 1	ICD-9
36217	434.01
36217	427.31
36218	342.90
36216	784.3
75680	
75671	
75685	
75896	
37201	
75898 (x14)	
37184	
37185	
CASE 2	ICD-9
61635	433.20
CASE 3	ICD-9
36215	414.02
75710	414.01
93508	V45.82
93545	413.9
93556	
CASE 4	ICD-9
75625	440.22
75716	
36247	
75962	
35470	
75960	
37205	
CASE 5	ICD-9
36558	996.62
36589	585.6
75998	

**THANK YOU!**