

Principles of

BASIC SURGICAL PRACTICE

Edited by

Edwin C. James

Robert J. Corry

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FOREWORD

When Dr. Edwin James, the Senior Editor of this book, approached me about writing a foreword, I must admit that I was a bit skeptical. With all the current very fine textbooks of surgery, why was another one necessary? During our first visit, Dr. James and I had an opportunity to discuss the underlying concept of the new book, namely to produce a volume which would be manageable to anyone at the medical student level—manageable both for reading it completely during the ever shorter surgical clerkship and manageable for understanding surgical principles and the assorted jargon.

The classic textbook of surgery often appears as an enormous hurdle to the new clinical clerk. This is recognized by the faculty in many departments of surgery and only selected pages in the textbook are assigned for student perusal rather than requiring the entire tome to be read. Moreover, the usual textbooks of surgery are apt to be aimed at the surgical resident

level and may not be understandable to the third year medical student. Of course, there are some condensed textbooks of surgery on the market, but they are often so compact that they serve more as textbook manuals than as utilizable textbooks of surgery for medical students.

The editors of *Principles of Basic Surgical Practice* are to be congratulated on producing a book so readable at the level for which it was intended, i.e., by the medical student, while at the same time transmitting the salient principles pertaining to the discipline of general surgery. After all, the goal of a third year surgical clerkship should be to familiarize the student with basic surgical tenets rather than technical facility, despite the fact that many students anticipate gaining the latter from such a clerkship. This book could be recommended to any and all medical students as a valuable and illuminating substitute to the more ponderous standard textbooks of surgery.

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The editors are indebted to the numerous contributors who accepted the challenge, among their many other commitments, to make *Principles of Basic Surgical Practice* a concise, practical and informative textbook for the teaching of medical students and residents in the ever-expanding field of medical and surgical knowledge and technology. We are grateful to Randall Haight and Gerald Olson of the University of North Dakota (UND) Biomedical Communications and Academic Media Departments, respectively, for preparation and processing of photographs and illustrations. Also, special recognition is given to Claudia Lund of the UND Press for her cheerful and very efficient typesetting services; to Karla James Roisum of

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PREFACE

As its name implies, *Principles of Basic Surgical Practice* is designed unabashedly for students. The editors acknowledge that the major textbooks are superbly designed as comprehensive surveys of the universe of surgery. However, we have found them cumbersome to use in student teaching and even, on occasion, in the routine circumstances of surgical practice and the teaching of surgical and family medicine residents. Furthermore, the demands on the reading time of students, residents, surgeons and clinical practitioners have never been greater, and the editors have borne in mind one of the principal definitions of their task—to omit or eliminate, and to delete.

Our editorial challenge has also been one of selection, to choose the key topics in the vast accumulated knowledge of surgery that make up a solid foundation for understanding the

scientific basis and practical skills of the modern general surgeon. This has not been easy, but we were sharply aware from our day-to-day experience with students, and from witnessing a new breed of shorter books succeed in other disciplines of medicine (e.g., internal medicine), that a need existed. Obviously, we have not explored the finer points of surgical complications or the frontiers of surgical advances, but almost all of the knowledge that one can reasonably expect the student to possess upon completion of a surgical clerkship is contained herein, either in the text or in the numerous tables and illustrations. The object, to provide a basic, well-organized, carefully illustrated and, most importantly, accessible textbook, we believe has been met.

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THE MEDICAL RECORD

PATIENT DATA BASE

The Medical History
Physical Examination

DIFFERENTIAL DIAGNOSIS

PLAN

Diagnostic
Therapeutic

PROGNOSIS

The medical record should be correctly developed and properly maintained for every hospitalized patient. It is essential for documentation of patient care and, as such, becomes a legal document. The medical record must be complete, legible, authentic and confidential. It is prepared for the patient, the medical staff and the hospital and eventually it becomes the property of the hospital. Access by other physicians, clinics, hospitals and nonmedical agencies is only with written consent of the patient. However, attending, consulting and referring physicians are usually given copies of reports and the discharge summary for their own personal records. For the preparation of medical records, hospitals have established accreditation guidelines, which usually conform to the recommendations of most medical texts on the subject. In general, the medical record should:

- Address the current illness of the patient
- Show development of primary and secondary diagnoses
- Indicate reasons for diagnostic investigations
- Recommend and justify treatment regimens
- Accurately record medical data
- Accurately record operative and special procedures
- Summarize the hospital course of the patient

PATIENT DATA BASE

The medical history, physical examination and laboratory data (Table I) make up the patient data base and can be quite comprehensive or oriented toward a surgical specialty, depending on the specific health problems of the patient or reasons for admission.

The Medical History

The medical history generally provides clues which lead to the correct diagnosis in 60-70% of patients. A commonly used format for the medical history is as follows:

- **Name, Age, Sex and Occupation**
- **Chief Complaint (CC) and Duration**—The CC is the primary reason the patient seeks medical care. It is usually obtained directly from the patient, but if the patient cannot specifically state a CC, one should be formulated with the help of family members or from the physician's own assessment of the clinical problem. The CC designation is important because it helps to insure that adequate attention is given to the major health concern of the patient and should, when possible, be recorded in the patient's own words.

OTHER MEDICAL RECORD DATA

Hospital Progress Notes
Diagnostic, Therapeutic, Operative and Special
Procedures
Discharge Summary
Summary Sheet

PROBLEM-ORIENTED MEDICAL RECORD

ERRORS TO AVOID IN THE MEDICAL RECORD

DIAGNOSTIC-RELATED GROUPS

- **Source(s) and Reliability**—The source and reliability of the medical history should be noted for every patient. This helps to place the information recorded in proper context and interpretation.
- **History of the Present Illness (HPI)**—The HPI provides details pertinent to the current illness. By definition, it is a transcription of the major medical problems as discussed directly by the patient in the interview and subsequently augmented by the review of systems. Pertinent negative information, as well as the results of known previous laboratory studies, should also be recorded. Information in the HPI should include the following:
 1. **Onset**—Date of onset; manner (gradual or sudden) and precipitating or predisposing factors
 2. **Characteristics**—Character (quality, quantity and consistency); location and radiation pattern; intensity or severity; timing (continuous or intermittent duration, temporal relationship to other events); aggravating and relieving factors; associated symptoms and functional impairment
 3. **Course since onset**—Incidence (single episode or recurrent, daily or periodic, continuous or chronic); progress (improved, worse, unchanged); current and past therapy and effects of therapy
- **Past Medical History (PMH)**—The PMH is a listing of prior medical problems or conditions, allergies, medications, transfusions, immunizations, skin tests, other medical treatment, special procedures and operations. It helps to place

TABLE I. PATIENT DATA BASE

THE MEDICAL HISTORY

1. Name, Age, Sex and Occupation
2. Chief Complaint — Duration
3. Source(s) and Reliability
4. History of the Present Illness
5. Past Medical History
6. Family Medical History
7. Social History
8. Review of Systems

PHYSICAL EXAMINATION

LABORATORY DATA

the patient's current medical status into proper perspective and often adds information which is essential to patient management or planned surgery.

- **Family Medical History**—This information may be significant to the current illness of the patient and must be thoroughly reviewed and recorded. The use of "family trees" is an efficient method of recording data.
- **Social History**—This is an assessment of the patient's emotional, behavioral and social characteristics which may impact on the medical illness.
- **Review of Systems (ROS)**—The ROS segment of the interview and medical record consists of a check-list of historical symptoms and signs, usually arranged according to organ systems. It is specifically designed to identify medical problems previously neglected or missed. Properly recorded, this step-by-step review will occasionally denote medical problems of major importance. The review of systems does not generally reflect current or major past data from systems reviews. Pertinent information in these areas is more appropriately included in the history of the present illness. A commonly used format and some abbreviations for transcribing this segment of the medical history are represented in the following outline:

1. **General**—Weight change, malaise, fatigue/weakness, appetite disturbance, sleep disturbance, fever/chills, night sweats, growths, swelling, discomfort/pain, bleeding tendency
2. **Skin**—Color change, skin lesions, pruritis, rash, ecchymosis, petechiae, texture, abnormal growth/loss of hair
3. **Endocrine**—Polyuria/polydipsia, temperature intolerance, goiter/thyroid treatment, tetany/muscle spasms, weight gain
4. **Mental Status**—Memory, orientation, mood, anxiety, depression, hallucinations, prior psychological aid
5. **Ears**—Hearing loss, tinnitus, aching/pain, drainage, vertigo
6. **Eyes**—Visual acuity, glasses, discomfort (dryness, redness, tearing, pain), diplopia, glaucoma, scotomata
7. **Nose/Sinuses**—Epistaxis, obstruction, trauma, rhinorrhea, postnasal drip, sinusitis
8. **Mouth/Pharynx**—Teeth, dentures, bleeding, soreness, ulcerations, lesions, voice change (hoarseness), tonsillitis
9. **Respiratory**—Cough, sputum production (amount, color), hemoptysis (amount), dyspnea (rest, exercise), wheezing, pleuritis, previous chest x-rays
10. **Cardiovascular (CV)**—Chest discomfort (pain), dyspnea (rest, exertion), orthopnea/paroxysmal nocturnal dyspnea (PND), edema, palpitations, syncope, history of ~~thrombosis~~ claudication, thrombophlebitis, varicose veins, blood clots, hypertension, cyanosis, drugs, previous electrocardiograms
11. **Breasts**—Lumps, pain/tenderness, nipple discharge, change in size
12. **Abdomen (Gastrointestinal-GI)**—Discomfort/pain, pyrosis, dysphagia, odynophagia, nausea/emesis, ulcers, use of antacids, change in bowel habit, constipation, diarrhea, melena, hematemesis, hemorrhoids, rectal discomfort, hematochezia, hernia, abdominal swelling, jaundice
13. **Genitourinary (GU)**—Frequency, nocturia, dysuria, incontinence, hematuria, flank pain, hesitancy, decreased stream, infections, calculi, venereal disease:
 - a. For the male—Circumcision, urethral discharge, testicular pain/swelling, impotence, prostate abnormality, sexual dysfunction

- b. For the female—Pregnancy, contraception, vaginal discharge, infertility, discomfort/dyspareunia, sexual dysfunction, dysmenorrhea (frequency, duration, quantity)

14. **Musculoskeletal (MS)**—Bone pain, joints (pain, redness, stiffness, swelling) trauma, decreased range of motion, muscle weakness/tenderness
15. **Peripheral Vascular (PV)**—Extracranial occlusive: Transient ischemic attacks (TIA's), amaurosis fugax, vertebrobasilar signs, arm pain. Visceral occlusive: abdominal angina, malabsorption, flatulence, weight loss. Aortoileofemoral occlusive: claudication, rest pain, impotence
16. **Neurological (Neuro)**—Handedness (right or left), headache, lightheadedness/vertigo, convulsions, stroke/focal weakness, head or spinal trauma, memory loss, speech problems, tremor/spasticity, incoordination, gait, numbness/paresthesias, unconsciousness

For surgical emergencies, a record of the medical history is completed shortly after admission to the hospital. For all elective surgical procedures, this information should be completed prior to admission and interval changes duly recorded. Questions with positive or negative answers in the review of systems, and which relate to the major health concerns of the patient, are best incorporated into the history of the present illness section. In contrast, the recording of minor problems of the patient is more appropriately transcribed in the review of systems section.

Previously recorded medical data are acceptable as long as they are reviewed and authenticated. For example, a preoperative history, prepared within 30 days of hospital admission can be utilized as long as interval changes are noted and recorded in an addendum transcription. Additional information from family members, witnesses and old medical records is incorporated into the history when appropriate. Also, the results of previous laboratory investigations and the patient's response to previous therapeutic regimens are recorded.

Physical Examination

The physical examination is the physician's objective evaluation of the patient (see Chapter 2) and, in emergencies, should be recorded immediately after admission. For elective surgical procedures, the examination should be completed within one week prior to admission, either in the doctor's office or clinic. As with the medical history, interval changes, if pertinent, are noted and recorded in an addendum summary.

The experienced physician will follow a careful routine that allows branching points for more detailed examinations as needed to clarify and correlate with the history and physical findings. Specific physical findings must be emphasized when organ involvement is suggested. For example, a finding of dyspnea should prompt a detailed cardiopulmonary examination. Correspondingly, the finding of an asymptomatic cardiac murmur or carotid bruit should prompt a careful cardiopulmonary history and a detailed examination for other abnormal cardiovascular findings.

DIFFERENTIAL DIAGNOSIS

The medical record should reflect the history both from the patient's point of view and from the thought processes of the physician in defining specific problem areas in a systematized and organized manner. The medical data base from the history and physical examination must be carefully analyzed and an initial provisional diagnostic list formulated. This differential

diagnosis is often recorded in the medical record as a set of problems, which helps to formulate primary and secondary diagnoses. Each diagnosis is then developed separately according to the degree of assessed probability.

It is helpful to relate or associate medical problems whenever possible. However, the conclusions drawn should be substantiated by the available medical data. The admitting primary and secondary diagnoses are stated as concisely as possible and to the highest degree of clinical certainty. In this section of the medical record, different medical problems might be recorded as follows:

- An established or known diagnosis (e.g., diabetes mellitus, chronic obstructive pulmonary disease)
- A pathophysiologic finding secondary to an established diagnosis (e.g., congestive heart failure)
- A pathophysiologic finding secondary to an unknown diagnosis (e.g., metabolic acidosis)
- A symptom or abnormal physical finding (e.g., dyspnea, rales, ischemic foot ulcer)
- An abnormal laboratory result (e.g., anemia, infiltrate on chest x-ray)
- An abnormal psychological or social disturbance

PLAN

Diagnostic

Based on the information from the history, physical examination and initial laboratory investigations, a diagnostic plan, which includes anticipated diagnostic studies, procedures and consultations, should be listed. Requested tests and procedures should relate to the differential diagnosis (or problem list) in an efficient and meaningful way. A logical, chronological sequence is suggested by the proper order of this list. For example, a barium enema is usually performed before a small bowel series in order to decrease the amount of preparation time.

Therapeutic

For established diagnoses which require therapy or invasive interventions, the modalities of proposed therapy should be listed. With this list, consideration of objective monitoring criteria should also be mentioned.

PROGNOSIS

Whenever possible, a prognosis concerning the patient's condition should be postulated. This is often the most difficult aspect of the medical record for the medical student or inexperienced house officer and may not even be easy for the most seasoned clinician. For a patient with multiple problems, the prognosis is often different for each diagnosis. For example, a patient with coronary artery disease and acute pulmonary edema may have a poor prognosis for the underlying heart disease but a good prognosis for the pulmonary edema. In general, the discussion of the patient's prognosis with the patient and family should be the responsibility of the primary physician, the senior resident or attending physician and not the responsibility of the student.

OTHER MEDICAL RECORD DATA

Hospital Progress Notes

Doctors' progress notes should reflect a pertinent chronological report of the patient's hospital course, noting any

change in medical status, therapeutic plan and responses to treatment or the development of any complications. The hospital progress notes must be dated, signed and provide adequate information to permit a current assessment of medical problems and to allow a prompt status report on any hospital patient. Progress notes are usually written on a daily basis but may be required several times daily in some patients, particularly in the early postoperative recovery period or in the intensive care unit. Nurses' progress notes constitute an important part of the medical record and should be reviewed daily by the physician. In medical-legal arbitrations, progress notes by doctors and nurses represent important documents which can support or contradict allegations of malpractice.

Diagnostic, Therapeutic, Operative and Special Procedures

Informed, written (signed and witnessed) consent on special hospital consent forms should be obtained from all patients for diagnostic, therapeutic, operative and special procedures of any type, followed by written and dictated descriptive reports for the medical record. These are usually dictated narrative reports, accompanied by brief written descriptions in the doctors' progress notes. An acceptable format is shown in Table II.

The details in either a written or narrative report will depend on the type of technical or operative procedure performed, departmental or hospital policy requirements, and the training, experience and individual assertiveness of the surgeon. However, information placed in the medical record should be expedient, accurate, conclusive and complete.

Discharge Summary

At the time of the patient's discharge from the hospital, a discharge summary of the hospital events must be written or dictated for the medical record. Although many hospital medical records departments require an abbreviated written report in the hospital progress notes, this does not replace a concise discharge summary, which should include the following information:

- Admitting and discharge diagnoses
- Diagnostic and therapeutic procedures, including operations and complications
- A clinical resume of the hospitalization. This resume should include:
 1. Reason(s) for hospitalization
 2. Significant history and physical findings

TABLE II. REPORT OF OPERATION OR SPECIAL PROCEDURE

DICTATE IN SEQUENCE	
1. DATE AND TIME	8. FLUIDS, ESTIMATED BLOOD LOSS (EBL)
2. PRE-AND-POSTOPERATIVE IMPRESSIONS	9. TRANSFUSIONS
3. NAME OF SURGEON AND ASSISTANT(S)	10. DRAINS OR TUBES
4. ANESTHETIC METHODOLOGY (LOCAL, REGIONAL, GENERAL)	11. COMPLICATIONS
5. NAME OF ANESTHESIOLOGIST AND ASSISTANT(S)	12. POSTOPERATIVE CONDITION OF PATIENT
6. DESCRIPTION OF OPERATION OR PROCEDURE	13. VERIFICATION OF SPONGE AND NEEDLE COUNTS
7. SPECIMENS OR TISSUES TRANSFERRED TO THE LABORATORY FOR EXAMINATION	

3. Pertinent laboratory data
4. A summary of medical and surgical treatment
5. Results of treatment
6. Complications
7. Discharge status
8. Prognosis
9. List of instructions for patient including medications, diet, activities, restrictions and plan for follow-up

In the event of a mortality during the hospitalization, a written, clinical resume, which summarizes 1) date and time of death; 2) cause of death and 3) the events contributing to the death should be included in the medical record. This is best placed in the doctors' progress notes at the time of death, and later should be included in the dictated narrative summary. A report of the postmortem examination, if performed, is also included in the patient's medical record when it is available.

Summary Sheet

In addition to the patient's full name, age, sex and other pertinent features, the summary sheet contains important information relative to the medical condition. This includes the principal diagnosis, secondary diagnoses in proper sequence, the principal and other procedures performed, complications, and the names of the primary and consulting physicians. No abbreviations are allowed on the summary sheet, and only approved abbreviations which vary from hospital to hospital are permitted in the body of the medical record itself. The summary sheet must be reviewed and signed by the primary or responsible physician.

PROBLEM-ORIENTED MEDICAL RECORD

The history, physical examination, diagnostic work-up, laboratory data, planned medical and surgical therapy and anticipated follow-up can be structured in the medical record in a systematized problem-oriented manner. In this type of problem-oriented medical record (POMR), the patient's medical problems are recorded individually, and initial diagnostic and treatment plans then formulated for each problem. Subsequently, all pertinent medical data (e.g., laboratory tests, x-ray reports, results of diagnostic and therapeutic procedures) are filed or arranged separately under each related problem.

Although the POMR has been quite popular in the past, current practice is to utilize the source-oriented medical record system in most hospitals. In the source-oriented medical record system, all information and medical data are arranged according to source (e.g., doctors' and nurses' progress notes, laboratory and pathology report sheets, operative and special procedure sheets). Although particularly useful for physicians in the logical pursuit of problem-solving, the POMR has significant disadvantages in the orderly maintenance of medical record files. The source-oriented medical record is less complex and much simpler to organize and maintain by ward clerks and medical records personnel.

The use of the "S-O-A-P" format for the writing of medical progress notes is a helpful, thorough method for recording daily clinical evaluations and progress:

- **Subjective (S)**—A description of historical data (e.g., symptoms, complaints by patient or family, nursing findings)
- **Objective (O)**—Physical examination findings, diagnostic interpretations, laboratory results
- **Assessment (A)**—Statement of physician regarding the diagnostic impression of the patient, results of therapy, current status, prognosis

- **Plan (P)**—Anticipated course for the patient (e.g., additional treatment, tests, disposition)

ERRORS TO AVOID IN THE MEDICAL RECORD

Physicians, early in their professional years are prone to make frequent errors in physical diagnosis. Many mistakes appear to be procedural rather than factual and should be minimized with improved familiarity and experience with the history and physical examination. The errors cited in one literature report included:

- Use of defective technique, instruments or equipment
- Poor organization and performance of the physical examination
- Improper or embarrassing situations leading to patient discomfort and hostility
- Failure to perform a complete history and physical examination
- Improper detection of physical signs (reporting normal to be abnormal or vice versa)
- Improper interpretation of diagnostic signs and recording of data, poor handwriting and grammar, and the use of abbreviations and misleading terminology

In addition, it follows that other errors in the medical record can be minimized by:

- Prompt recording or dictating of operative or procedural reports, avoiding possibly the subsequent incomplete documentation of pertinent information
- Complete documentation of informed consent from the patient. Although variable in practice, if incidental procedures are to be performed, it is best if they are included on the informed consent form (e.g., incidental appendectomy, cholecystectomy). Accurate documentation of permission for incidental procedures is important when associated complications develop
- Not altering the medical record in any way. Corrections or omissions are best made in a new notation in the progress notes or elsewhere as appropriate. If this is not feasible, then corrections are made which are properly documented as such, dated and initialed
- Prompt dictation and recording of the discharge summary and completion of required medical record review within acceptable guidelines
- Not being critical of previous or concurrent suggestions of other health-related personnel, including nurses, laboratory technicians, physical, occupational and respiratory therapists, and dietitians
- Avoidance of the careless recordings of inappropriate phraseology and maladventures which can lead to possible litigation

DIAGNOSTIC-RELATED GROUPS

Diagnostic related groups (DRG's) are the classification of patients into clinically significant diagnostic and surgical groups based on: 1) diagnosis, 2) procedures performed, 3) age, 4) sex and 5) discharge status. The intent has been to classify patients according to resource consumption, which is measured by the patient's length of stay and cost for hospitalization. The original methodology for DRG's was developed by health researchers at Yale University in the early 1970's. The

first version in 1977 included 383 DRG's; however, the current 1982 revision has been redefined and expanded to include 467 diagnostic-related groups in 23 major diagnostic categories organized by organ system and disease etiology. An additional three are rarely if ever applicable: 1) DRG 468, which represents a discharge with all operating room procedures unrelated to a principal diagnosis; 2) DRG 469, which represents a discharge with a valid diagnosis that is not acceptable as a principal diagnosis and 3) DRG 470, which represents a discharge with invalid data.

The original purpose of DRG's was to assist hospital Utilization Review in the identification of patients with whom the length of stay was abnormally high or low as compared to each diagnostic group. In 1977, New Jersey became the first state to use DRG's for hospital reimbursement purposes and was followed, in October 1983, by the implementation of a National DRG prospective payment system by Medicare. Since that time, every hospital which provides services to Medicare patients is reimbursed a DRG-assigned prospective payment rate instead of a reimbursement for patient cost or a fee for service. The major objective in the implementation of the DRG system was to reduce health care costs and provide hospitals an incentive to improve efficiency.

The pertinent data items are defined by the United States Department of Health and Human Services in the Uniform Hospital Discharge Data Set (UHDDS). Those data items, which play a major role in DRG assignment are:

- **The Principal Diagnosis**—This is the condition established after study to be chiefly responsible for admission of the patient to the hospital. In most instances, the principal diagnosis will be the same as the admitting diagnosis, however, there will be occasions when it will be different. It is important to emphasize that the definition states it is the condition established after study to be chiefly responsible for the admission
- **Secondary Diagnoses**—These are conditions that coexist at the time of admission or which develop thereafter and affect either the treatment received, the length of hospital stay, or both. Many secondary diagnoses affect DRG payment rate and, therefore, it is important that all are listed on the summary sheet
- **Principal and Other Procedures**—These are diagnostic and therapeutic procedures or operations which are performed during a patient's hospital stay
- **Age**—This is the patient's chronological age at the time of admission to the hospital
- **Discharge Status**—This is the disposition status of the

patient upon discharge from the hospital. The significant codes are: 1) routine discharge to home, 2) discharge against medical advice, 3) transferred to another medical or care facility (e.g., hospital, nursing home) and 4) expired

- **Sex**—The patient's sex

Under the DRG system, emphasis is placed on accurate and complete medical record information. Most hospitals utilize a computerized "GROUPE" to combine the data elements mentioned in order to assign the appropriate diagnostic related group. Medical record personnel are responsible for assignment of the proper diagnoses and procedure codes. Misinformation, such as the incorrect principal diagnosis, overlooked or missing secondary diagnoses, unrecorded diagnostic or therapeutic procedures, poorly defined diagnoses (illegibility, improper sequence) and the identification of symptom codes as the principal diagnosis when an underlying disease is listed under another diagnosis, can lead to inappropriate DRG assignment. This may result in the hospital receiving less than the full payment to which it is entitled.

It is the primary role of the medical records department to assure that prompt and accurate records are maintained on all patients. With the current potential for loss of payment to the hospital if medical information is inaccurate or simply incomplete or missing, it is pragmatic for medical records departments to require timely, complete and accurate medical records.

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