

Adjectives play an important role in medical writing, by helping to describe patient conditions and medical procedures and to express degrees of comparison important to medical reports. For example, a patient's chest pain may be moderately severe, or a patient may show *favorable* signs of recovery. Adjectives are also helpful in distinguishing types of reports; for example, radiology reports may often contain terms ending in *-scopy* or *-graphy*. All medical reports contain descriptions of various medical conditions and treatments, so understanding the use of adjectives is essential when writing reports.

Radiology and Imaging Report

A *radiology and imaging report* is a report of what a radiologist interprets from a diagnostic procedure (Figure 4-2). This report is usually filed within four to eight hours of the procedure.

RADIOLOGY REPORT

Patient Name: Marietta Mosley → missing DOB

Hospital No.: 11446 - remove

X-ray No.: 98-2801 - remove

Admitting Physician: John Youngblood, M.D.

Procedure: Left hip x-ray.

Date: 08/05/20XX

PRIMARY DIAGNOSIS: Fractured left hip.

CLINICAL INFORMATION: Left hip pain. - clinical hx No known allergies.

Orthopedic device is noted transfixing the left femoral neck. I have no old films available for comparison. The left femoral neck region appears anatomically aligned. At the level of an orthopedic screw along the lateral aspect of the femoral neck, approximately at the level of the lesser trochanter, there is a radiolucent band consistent with a fracture of indeterminate age that shows probable nonunion. There is bilateral marginal sclerosis and moderate offset and angulation at this site.

Fairly exuberant callus formation is noted laterally along the femoral shaft.

- IMPRESSION:**
1. No evidence for significant displacement at the femoral neck.
 2. Probable nonunion of fracture transversely through the shaft of the femur at about the level of the lesser trochanter.

Neil Nofsinger, M.D.

NN:xx

D:08/05/20XX

T:08/05/20XX



Examples of such procedures are x-rays, CT (computed tomography) scans, MRIs (magnetic resonance imaging), upper GI series, fluoroscopic studies, nuclear medicine, and ultrasonograms. These medical procedures provide visual images to aid in diagnosis.

Pathology Report

A *pathology report* contains a description of tissue samples removed from the body (Figure 4-3). The removal of a tissue sample for examination is called a *biopsy*. The *pathologist* is the person who studies the tissue samples and generates the pathology report.


<p>PATHOLOGY REPORT</p> <p>Patient Name: Sumio Yukimura</p> <p>Hospital No.: 11449</p> <p>Pathology Report No.: 98-S-942</p> <p>Admitting Physician: Donna Yates, M.D.</p> <p>Preoperative Diagnosis: Cholelithiasis.</p> <p>Postoperative Diagnosis: Cholelithiasis.</p> <p>Specimen Submitted: Gallbladder and stone.</p> <p>Date Received: 06/05/20XX</p> <p>Date Reported: 06/06/20XX</p> <p>GROSS DESCRIPTION: Specimen received in one container labeled "gallbladder." Specimen consists of a 9-cm gallbladder measuring 2 cm in average diameter. The serosal surface demonstrates diffuse fibrous adhesion. The wall is thickened and hemorrhagic. The mucosa is eroded, and there is a single large stone measuring 2 cm in diameter within the lumen. Representative sections are submitted in one cassette.</p> <p>GROSS DIAGNOSIS: Gallstone.</p> <p>KM:xx</p> <p>D:06/05/20XX</p> <p>T:06/05/20XX</p> <p>MICROSCOPIC DIAGNOSIS: Gallbladder, hemorrhagic chronic cholecystitis with cholelithiasis.</p> <p>RT:xx</p> <p>D:06/06/20XX</p> <p>T:06/06/20XX</p>	 <p>Robert Thompson, M.D.</p>
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FIGURE 4-3 Sample Pathology Report

M.A. Novak and P.A. Ireland, *Hillcrest Medical Center Beginning Medical Transcription Course*, 6th ed. Albany, NY: Delmar Thomson Learning, 2005, p. 20.

The focus of the pathology report is twofold:

1. Macroscopic findings (also called gross description, gross examination). This component describes how the specimen looks to the naked eye. It describes the size, general color, and texture.
2. Microscopic findings (also called microscopic description). This component describes how tissue looks when examined under a microscope.

The report usually ends with a diagnosis of the findings or an impression.

The pathology report is the examination of specific tissues. The pathology report becomes a permanent part of the patient's medical record. A sample pathology report is provided. This report is completed within 24 hours after receiving the laboratory information.

Discharge Summary

The *discharge summary* is a report that is required for all patients who leave the health care facility (Figure 4-4). It is a summary of the patient's condition during his or her stay at the facility. Data in the discharge summary include the following:

- Reason for admittance ✓
- History of present illness ✓
- Social history ✓
- Physical exam and laboratory data ✓
- Events that occurred during the patient's stay ✓
- Follow-up instructions ✓
- Discharge medications ✓

The report concludes with the condition of the patient at the time of discharge and the discharge prognosis. The Joint Commission requires that it be in the patient's chart 48 to 72 hours after discharge from the facility. If the patient expires during the hospital or facility stay, it is then called a "Death Summary."

Operative Report

The *operative report* is a comprehensive description of a surgical procedure performed on a patient (Figure 4-5). The report includes specific details about preoperative, operative, and postoperative experiences such as specimens removed and sent to pathology, diagnosis, type of operation performed, names of surgeons and assistants present, and type of anesthesia, and it may include instruments used, drain packs, closure, sponge count, suture materials and thickness, any unusual circumstances or complications, and estimated blood loss. It is dictated immediately after the operation.

The report may be in narrative form or divided into subheadings, such as "anesthesia," "incision," "findings," "procedures," and "closing." The report details end with the patient going to the recovery room. The operative report must be dictated and filed in medical records as soon as possible after surgery.

DISCHARGE SUMMARY**Patient Name:** Joyce Mabry**Hospital No.:** 11709**Admitted:** 02/18/20XX**Discharged:** 02/24/20XX**Consultations:** Tom Moore, M.D., Hematology**Procedures:** Splenectomy**Complications:** None.**Admitting Diagnosis:** Elective splenectomy for idiopathic thrombocytopenic purpura and systemic lupus erythematosus.

HISTORY: The patient is a 21-year-old white woman who had noted excessive bruising since last June. She was diagnosed as having thrombocytopenic purpura. At the same time, the diagnosis of systemic lupus erythematosus was made. The patient continues with the bruising. The patient had been treated with steroids, prednisone 20 mg; however, the platelet count has remained low, less than 20,000. The patient was admitted for elective splenectomy.

LABORATORY DATA ON ADMISSION: Chest x-ray was negative. Electrocardiogram was normal. Sodium 138, potassium 5.2, chloride 104, CO₂ 25, glucose 111. Urinalysis negative. Hemoglobin 14.8, hematocrit 43.5, white blood cell count 15,000, platelet count 17,000, PT 11.5, PTT 27.

HOSPITAL COURSE: The patient was taken to the operating room on February 19 where a splenectomy was performed. The patient's postoperative course was uncomplicated with the wound healing well. The platelet count was stable for the first 3 postoperative days. The patient was transfused intraoperatively with 10 units of platelets and postoperatively with 10 additional units of platelets. However, on the fourth postoperative day the platelet count had risen to 77,000, which was a significant increase.

The patient was discharged for follow-up in my office. She will also be seen by Dr. Moore, who will follow her SLE and ITP.

DISCHARGE DIAGNOSIS: Idiopathic thrombocytopenic purpura and systemic lupus erythematosus.**DISCHARGE MEDICATIONS:**

1. Prednisone 20 mg q.d.
2. Percocet 1 to 2 p.o. q. 4 h. p.r.n.
3. Multivitamins, 1 in a.m. q.d.

 Carmen Garcia, M.D.

CG:xx

D:02/25/20XX

T:02/26/20XX

FIGURE 4-4 Sample Discharge Summary

M.A. Novak and P.A. Ireland, Hillcrest Medical Center Beginning Medical Transcription Course, 6th ed. Albany, NY: Delmar Thomson Learning, 2005, pp. 23-24.



- MISSING DOBS

(removal of spleen)

- social history

systemic lupus erythematosus

OPERATIVE REPORT

Patient Name: Kathy Sullivan

Hospital No.: 11525

Date of Surgery: 06/25/20XX

Admitting Physician: Taylor Withers, M.D.

Surgeons: Sang Lee, M.D., Taylor Withers, M.D.

Preoperative Diagnosis: Urinary incontinence secondary to cystourethrocele.

Postoperative Diagnosis: Urinary incontinence secondary to cystourethrocele.

Operative Procedure: Total abdominal hysterectomy with Marshall-Marchetti correction.

Anesthesia: General endotracheal.

DESCRIPTION: After an abdominal hysterectomy had been performed by Dr. Withers, the peritoneum was closed by him and the procedure was turned over to me.

At this time the suprapubic space was entered. The anterior portions of the bladder and urethra were dissected free by blunt and sharp dissection. Bleeders were clamped and electrocoagulated as they were encountered. A wedge of the overlying periosteum was taken and roughened with a bone rasp. The urethra was then attached to the overlying symphysis by placing two No. 1 catgut sutures on each side of the urethra and one in the bladder neck. The urethra and bladder neck pulled up to the overlying symphysis bone very easily with no tension on the sutures. Bleeding was controlled by pulling the bladder neck up to the bone. Penrose drains were placed on each side of the vesical gutter. Blood loss was negligible. The procedure was then turned back over to Dr. Withers, who proceeded with closure.

Sang Lee, M.D.

SL:xx

D:06/25/20XX

T:06/26/20XX

FIGURE 4-5 Sample Operative Report

M.A. Novak and P.A. Ireland, *Hillcrest Medical Center Beginning Medical Transcription Course*, 6th ed. Albany, NY: Delmar Thomson Learning, 2005, P