Introduction

This manual is intended to clarify field definition and intent. This document contains the most up to date instructions for v. 2.9 data abstraction. Do not refer to old manuals or other data definitions. Please review this document prior to submitting clinical questions. FAQs will be added to the document in red to provide additional examples and clarification. Please do not print this document since it will change frequently. Using the web version will ensure that you have the most up to date information. Occasionally there may be changes or important information that will be highlighted here and will be also included in STS Database Newsletters. Use the Ctrl + F function to search for a number or term of interest.

General Information:
The STS data collection forms should be held for two years.
If you only collect data directly to the software you are not required to create data collection forms to save.

Adult Cardiac Anesthesiology

SEQ. #: 7310
Long Name: Primary Anesthesiologist Name
Short Name: PrimAnesName
Definition: Indicate the full name of the primary anesthesiologist for the procedure.

Intent/Clarification:
Field must be populated. Missing data or information for an anesthesiologist not on your current contract with the STS will cause your data file submission not to process.

SEQ. #: 7315
Long Name: Primary Anesthesiologist National Provider Identifier
Short Name: PrimAnesNPI
Definition: Indicate the individual-level National Provider Identifier (NPI) of the primary anesthesiologist for the procedure.

Intent/Clarification:
Field must be populated. Missing or inaccurate data will cause your data file submission not to process. It is crucial to enter the correct anesthesiologist identifier.

SEQ. #: 7320
Long Name: Care Team Model
Short Name: AnesCareTeamMod
Definition: Indicate the anesthesia care team assigned for the predominant portion of the procedure.

Intent/Clarification:
Determine the care model primarily responsible for providing anesthesia to the patient intraoperatively. This information can be found on the anesthesia record. Check with your anesthesia team or leave blank if the data is not available.

SEQ. #: 7325
Long Name: Pain Score Baseline
Short Name: PainScorePre
Definition: Indicate the highest baseline (preoperative) pain score on the 0-10 integer scale, or indicate that the score was not recorded.

Intent/Clarification:
Pain score, which is a quality metric, is routinely assessed as part of preoperative holding area check in list. This information should be obtainable from a progress note or similar documentation completed by preoperative nurse closest to the OR Entry time.
SEQ. #: 7330
Long Name: Transfusion Algorithm to Guide Transfusion
Short Name: TransfAlg
Definition: Indicate whether a transfusion algorithm or guideline was used to guide transfusion in the patient.

Intent/Clarification:
A transfusion algorithm or guideline is a predetermined set of treatment plans specific to various patient specific criteria to aid in transfusing the patient. Check with your anesthesia team or leave blank if the data is not available.

SEQ. #: 7335
Long Name: Cell saver volume
Short Name: CellSavVol
Definition: Indicate the volume of cell-saver blood that was transfused intraoperatively. Include any volume started in the OR, even if the infusion completed postoperatively. Do not include autologous, allogeneic, pump-residual, or chest-tube recirculated blood. Value should be recorded in milliliters.

Intent/Clarification:
Cell-saver blood is blood that the patient loses during surgery which is transfused back to the patient. Time frame includes any cell-saver infusions started intraoperatively regardless if they completion time is after OR Exit date/time. This type of data could be obtained from the Perfusionist record who was assigned to that specific case.

Some hospitals will bag the residual pump blood and the anesthesiologist hangs it and gives some extra protamine. This is not the same as Cell Saver blood and should not be included here.

SEQ. #: 7340
Long Name: Heparin Total Dose
Short Name: TotHep
Definition: Indicate the total dose of heparin that was administered intraoperatively prior to the initiation of first cardiopulmonary bypass.

Include all doses of heparin given prior to the first cardiopulmonary bypass. Value should be recorded in units.
**Intent/Clarification:**
Heparin administered after OR Entry time and prior to the initiation of cardiopulmonary bypass. Measurement should be recorded in units.

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**SEQ. #: 7345**  
**Long Name:** Heparin Management  
**Short Name:** HepMgmt  
**Definition:** Indicate the method of heparin management used intraoperatively.

Different approaches are utilized to measure the adequacy of heparinization for anticoagulation.

**Intent/Clarification:**
The adequacy of heparinization determines the coaguability of the patient’s blood. Heparin titration based on activated clotting time (ACT) measures how quickly the blood will clot. The larger the number the longer it will take for the blood to clot. Heparin titration based on heparin concentration (Hepcon System) measures the concentration of heparin in the blood. If either of these two measurements are not used to determine the level of heparinization then "other" should be chosen.

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**SEQ. #: 7350**  
**Long Name:** Protamine total dose  
**Short Name:** TotProt  
**Definition:** Indicate the total dose of protamine given intraoperatively to reverse heparinization after first cardiopulmonary bypass.

Value should be recorded in milligrams. Do not include doses given in the ICU.

**Intent/Clarification:**
Protamine is a medication given used to reverse the effects of heparin within the operating room. Time frame should be after the initiation of cardiopulmonary bypass and prior to ICU admission.

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**SEQ. #: 7351**  
**Long Name:** Antithrombin III Total Dose  
**Short Name:** AntithromDose
**Definition:** indicate the total dose of antithrombin III

**Intent/Clarification:**
Antithrombin III is a medication given to enhance the heparin effect to achieve adequate anticoagulation. Time frame should be any amount given within the intraoperative phase after OR Entry time.

**SEQ. #: 7360**
**Long Name:** Viscoelastic Testing Used During Operation
**Short Name:** IntraViscoTest
**Definition:** Indicate whether viscoelastic testing was used intraoperatively (example: TEG, TEG-FF, or ROTEM).

Viscoelastic testing is a method of measuring coagulation in the blood.

**Intent/Clarification:**
Viscoelastic testing is used to determine which coagulation products to administer when the patient has an anticipated coagulopathy or non-surgical cause of bleeding. CT anesthesia team or patient’s lab record may be useful to see whether any of the above indicated viscoelastic tests has been performed.

**SEQ. #: 7365**
**Long Name:** Volatile Agent Used
**Short Name:** VolAgentUsed
**Definition:** Indicate whether a volatile agent was used.

**Intent/Clarification:**
A volatile anesthetic is an inhaled anesthetic administered via an anesthetic gas machine or via the cardiopulmonary bypass machine.

**SEQ. #: 7366**
**Long Name:** Volatile Agent - Isoflurane
**Short Name:** VolAgentIso
**Definition:** Indicate whether the volatile agent used was Isoflurane

**Intent/Clarification:**
Indicate if isoflurane was the volatile anesthetic used to provide anesthesia.
SEQ. #: 7367
Long Name: Volatile Agent - Sevoflurane  
Short Name: VolAgentSevo  
Definition: Indicate whether the volatile agent used was Sevoflurane

Intent/Clarification:  
Indicate if sevoflurane the volatile anesthetic used to provide anesthesia.

SEQ. #: 7368
Long Name: Volatile Agent - Desflurane  
Short Name: VolAgentDes  
Definition: Indicate whether the volatile agent used was Desflurane

Intent/Clarification:  
Indicate if desflurane was the volatile anesthetic used to provide anesthesia.

SEQ. #: 7369
Long Name: Volatile Agent - Other  
Short Name: VolAgentOth  
Definition: Indicate whether any other volatile agent was used

Intent/Clarification:  
Although highly unlikely, indicate if any other volatile agents were used to provide anesthesia. Information may be obtained from anesthesia record or perfusion record.

SEQ. #: 7370
Long Name: Volatile Agent Timing - Pre-CPB  
Short Name: VolAgentTimPre  
Definition: Indicate whether the volatile agent was used prior to the patient being on CPB.

Intent/Clarification:  
Time frame of administering a volatile agent is after OR entry and prior to CPB initiation.
**SEQ. #: 7375**

**Long Name:** Volatile Agent Timing - During CPB  
**Short Name:** VolAgentTimDur  
**Definition:** Indicate whether the volatile agent was used during the period when patient was on CPB.

**Intent/Clarification:**  
A volatile agent was administered during the use of cardiopulmonary bypass. This information will either come from intraoperative anesthesia chart or perfusion chart. Leave blank if the information is unavailable.

**SEQ. #: 7380**

**Long Name:** Volatile Agent Timing - Post CPB  
**Short Name:** VolAgentTimPost  
**Definition:** Indicate whether the volatile agent was used after the patient was taken off CPB.

**Intent/Clarification:**  
Indicate if a volatile agent was administered after the discontinuation of cardiopulmonary bypass and prior to admission to the ICU.

**SEQ. #: 7385**

**Long Name:** Volatile Agent Timing - Maintenance (no CPB)  
**Short Name:** VolAgentTimMaint  
**Definition:** Indicate whether a volatile agent was used for maintenance in a non-pump case (no CPB).

**Intent/Clarification:**  
A volatile agent was administered after entry into the OR and prior to ICU admission in off-pump cases.
**Long Name:** Intraop Infusion: Dexmedetomidine  
**Short Name:** DexIntra  
**Definition:** Indicate the use of dexmedetomidine infusion during surgery.

Any use of dexmedetomidine infusion during the intraoperative period, usually but not always, in the post-bypass period.

**Intent/Clarification:**  
Indicate if dexmedetomidine was administered after OR Entry time and prior to OR Exit time.

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**SEQ. #: 7395**  
**Long Name:** Intraop Infusion: Propofol  
**Short Name:** PropIntra  
**Definition:** Indicate the use of propofol infusion during surgery.

Any use of a propofol infusion during the intraoperative period, usually but not always, in the post-bypass period.

**Intent/Clarification:**  
Indicate if Propofol was administered by infusion after OR Entry time and prior to OR Exit time.  
Specific attention should be paid to exclude bolus Propofol administration during any time of the intraoperative phase.

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**SEQ. #: 7400**  
**Long Name:** Intraop Mgs of Midazolam  
**Short Name:** MidazIntra  
**Definition:** Indicate the intraoperative does of midazolam in milligrams. Enter zero if no midazolam used.

**Intent/Clarification:**  
Record in milligrams the amount of midazolam administered after OR Entry and prior to OR Exit. Record “0mg” if no midazolam was administered intraoperatively.

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**SEQ. #: 7405**
**Long Name:** Intraop Insulin Total Dose (max units)  
**Short Name:** TotInsuIntra  
**Definition:** Indicate the total units (bolus and infusion) of insulin administered intraoperatively. Enter zero if no insulin was given.

**Intent/Clarification:**  
Record, in units, the amount of insulin administered after OR Entry and prior to OR Exit. This includes bolus and infusion doses. Record “0 units” if no insulin was administered intraoperatively.

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**SEQ. #:** 7410  
**Long Name:** Blood Pressure Baseline (Pre-Anesthetic Induction) - Systolic  
**Short Name:** PreAnesthBPSys  
**Definition:** Indicate the most representative preoperative blood pressure upon arrival in the operating room.

The most representative initial blood pressure (systolic) should be recorded. This number may be an initial single recording or the average or median of a series of BP determinations. In all cases, the values should be recorded in the operating room prior to the induction of anesthesia.

**Intent/Clarification:**  
Record the systolic blood pressure closest to, but prior to induction of anesthesia, that is most representative of the patient’s preoperative status. If the blood pressure closes to induction is debatably abnormal for the patient (erroneously high or low), then a median of the first five (5) blood pressures measurements by the automated record keeping system obtained after OR Entry may be used.

If this information is not available, leave blank.

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**SEQ. #:** 7415  
**Long Name:** Blood Pressure Baseline (Pre-Anesthetic Induction) - Diastolic  
**Short Name:** PreAnesthBPDia  
**Definition:** Indicate the most representative preoperative blood pressure upon arrival in the operating room.

The most representative initial blood pressure (diastolic) should be recorded. This number may be an initial single recording or the average or median of a series of BP determinations. In all cases, the values should be recorded in the operating room prior to the induction of anesthesia.
**Intent/Clarification:**
Record the diastolic blood pressure closest to, but prior to induction of anesthesia, that is most representative of the patient’s preoperative status.

If the blood pressure closes to induction is debatably abnormal for the patient, then a median of blood pressures obtained after OR Entry may be used. If the blood pressure closes to induction is debatably abnormal for the patient (erroneously high or low), then a median of the first five (5) blood pressures measurements by the automated record keeping system obtained after OR Entry may be used.

If this information is not available, leave blank.

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**SEQ. #: 7420**
**Long Name:** Blood Pressure Baseline (Pre-Anesthetic Induction) - Mean
**Short Name:** PreAnesthBPMean
**Definition:** Indicate the most representative preoperative blood pressure upon arrival in the operating room.

The most representative initial blood pressure (mean) should be recorded. This number may be an initial single recording or the average or median of a series of BP determinations. In all cases, the values should be recorded in the operating room prior to the induction of anesthesia.

**Intent/Clarification:** Record the mean arterial pressure obtained from the arterial line closest to the induction of anesthesia. If the mean arterial pressure closes to induction is debatably abnormal for the patient, then a median of arterial pressures obtained after OR Entry may be used. If the arterial pressure closes to induction is debatably abnormal for the patient (erroneously high or low), then a median of the first five (5) arterial pressures measurements by the automated record keeping system obtained after OR Entry may be used.

If no mean arterial pressure is available, leave blank.

Do not capture mean cuff pressure (NBP).

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**SEQ. #: 7425**
**Long Name:** Heart Rate Baseline (Pre-Anesthetic Induction)
**Short Name:** PreAnesthHR
**Definition:** Indicate the most representative preoperative heart rate upon arrival in the operating room.

The most representative initial heart rate should be recorded. This number may be an initial single recording or the average or median of a series of heart rate determinations. In all cases, the values should be recorded in the operating room prior to the induction of anesthesia. The source of heart rate should derive from the ECG monitor, since pulse rates derived from pulse oximetry/plethysmography or arterial tracings may underestimate the heart rate in tachyarrhythmias and other circumstances.

**Intent/Clarification:**
Record the heart rate closest to, but prior to induction of anesthesia, that is most representative of the patient’s preoperative status. If the heart rate closest to induction is debatably abnormal for the patient, then a median of five (5) heart rates obtained after OR Entry may be used.

If no heart rate is available, leave blank.

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**SEQ. #: 7430**
**Long Name:** Pulmonary Artery Catheter Used
**Short Name:** PACIntra

**Definition:** Indicate the preoperative or intraoperative placement of a pulmonary artery catheter (Swan-Ganz type-catheter).

Placement of a pulmonary artery catheter (PAC) in the preoperative or intraoperative period and use of this catheter during the intraoperative period.

**Intent/Clarification:**
Identify if a pulmonary artery catheter was placed pre or intra-operatively and used during the intraoperative period.

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**SEQ. #: 7435**
**Long Name:** Core Temperature Source
**Short Name:** CoreTempSrc

**Definition:** Indicate the source of core temperature data used to guide cooling and/or rewarming during cardiac surgery.

Cardiac centers utilize various sites for measuring core temperature during cardiac procedures. These may include the esophageal, bladder, nasopharyngeal, pulmonary
artery catheter thermistor, tympanic, or rectal sources. If more than one temperature is being recorded, the value selected as the core should be noted.

**Intent/Clarification:** Identify what source was used for determining the core temperature. This should coincide with data reported in the Operative section of the adult cardiac surgery data collection form.

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**SEQ. #:** 7440  
**Long Name:** Core Temperature Maximum  
**Short Name:** CoreTempMax  
**Definition:** Indicate the patient's highest core temperature during the procedure in degrees centigrade.

**Intent/Clarification:**  
Indicate the patient's highest core temperature after the induction of anesthesia, prior to OR Exit.

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**SEQ. #:** 7445  
**Long Name:** Nitric Oxide Therapy Begun Intraoperatively  
**Short Name:** NitricOxIntraop  
**Definition:** Indicate the usage of inhaled nitric oxide.

Inhaled nitric oxide is used in the treatment of pulmonary hypertension and right ventricular failure. The intent is to capture the usage of inhaled nitric oxide during the cardiac surgical procedure. Do not record the usage of inhaled vasodilating substances other than nitric oxide in this data field.

**Intent/Clarification:**  
Indicated if nitric oxide was used intraoperatively; after OR Entry but prior to OR Exit.

The Nitric Oxide (NO) machine is kept separate from the anesthesia machine and is often recorded by the Respiratory Therapist. The information is most likely found on the Respiratory Therapist record if not on the anesthesia record.

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**SEQ. #:** 7450  
**Long Name:** Total Crystalloid Administered by Anesthesia Care Team  
**Short Name:** TotCrystAnesth
**Definition:** Indicate the total volume of intravenous crystalloid administered by the anesthesia care team. The data should be recorded in milliliters. Enter zero if no crystalloid used.

There is continuing controversy as to the risks and benefits of liberal or restrictive intravenous fluid regimens. Record the total volume of all crystalloid intravenous fluids administered by the anesthesia care team. Do not record any blood products in this data field.

**Intent/Clarification:**
Indicate if crystalloid fluids were administered in the OR by the anesthesia care team. **This does not include fluid administered by perfusion.** Record in milliliters. Enter “0” if no crystalloid fluids were administered by anesthesia.

Common crystalloid fluids include 0.9% NaCl, Lactated Ringers, Plasmalyte and D5 ½ 0.9%Saline.

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**SEQ. #: 7455**
**Long Name:** Total Synthetic Colloid Administered by Anesthesia Care Team  
**Short Name:** TotColloidAnesth  
**Definition:** Indicate the total volume of intravenous synthetic colloid fluid administered by the anesthesia care team. The data should be recorded in milliliters. Enter zero if no synthetic colloid used.

There is continuing controversy as to the risks and benefits of liberal or restrictive intravenous fluid regimens. Record the total volume of all synthetic colloid intravenous fluids administered by the anesthesia care team. Do not record any blood products in this data field.

**Intent/Clarification:**  
Indicate if colloid fluids were administered in the OR by the anesthesia care team. **This does not include fluid administered by perfusion.** Record in milliliters. Enter “0” if no colloid fluids were administered by anesthesia.

Common colloid fluids are Hespan and Voluven.

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**SEQ. #: 7460**  
**Long Name:** Total Albumin Administered by Anesthesia Care Team  
**Short Name:** TotAlbumAnesth
**Definition:** Indicate the total volume of intravenous human serum albumin fluid administered by the anesthesia care team. The data should be recorded in milliliters. Enter zero if no albumin was used.

There is continuing controversy as to the risks and benefits of liberal or restrictive intravenous fluid regimens. Record the total volume of all human serum albumin fluid administered by the anesthesia care team. Do not record any blood products in this data field.

**Intent/Clarification:**
Indicate if Albumin was administered in the OR by the anesthesia care team. **This does not include administration by perfusion.** Record in milliliters. Enter “0” if no albumin was administered by anesthesia.

Albumin solutions include: Albumin 5%, Albumin 20% and Plasmanate 5%.

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**SEQ. #: 7470**
**Long Name:** Intraoperative Glucose Trough Value
**Short Name:** GlucTroughIntraop
**Definition:** Indicate the trough value of intraoperative glucose in mg/dl.

Intraoperative glucose values vary widely in cardiac surgery. Administration of glucose containing fluids, stress, insulin, and glucorticoids may all affect intraoperative glycemic levels.

**Intent/Clarification:**
Indicate the patient’s lowest intraoperative glucose level in mg/dL. Time frame is after induction of anesthesia and prior to OR Exit time.

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**SEQ. #: 7475**
**Long Name:** Vasodilators used
**Short Name:** VasodilIntraop
**Definition:** Indicate the usage of intravenous vasodilating drugs administered by continuous infusion during the intraoperative phase of cardiac surgery.

Vasodilators are used commonly in cardiac surgical patients for the control of intraoperative hypertension and for afterload reduction to improve ventricular function. For the purposes of this data field, infusions of milrinone and pure vasodilating drugs, such as nitroglycerin, nitroprusside, and nicardipine, should be recorded.
**Intent/Clarification:**
Indicate if the patient received continuous infusion of vasodilating drugs intraoperatively. Do not include one-time dose.

Could include but not limited to: Apresoline/hydralazine, nitroglycerin, nitroprusside, nicardipine, Esmolol, and milrinone.

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**SEQ. #: 7476**
**Long Name:** Intraoperative Processed EEG (BIS)
**Short Name:** IntraProcEEG
**Definition:** Indicate whether an intraoperative processed EEG (BIS) was monitored

**Intent/Clarification:**
Indicate if a processed EEG was utilized intraoperatively regardless if it was a BIS or other similar device.

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**SEQ. #: 7480**
**Long Name:** Intraoperative Pre-procedure TEE Performed
**Short Name:** IntraOpPreTEE
**Definition:** Indicate whether intraoperative TEE was performed pre-procedure.

**Intent/Clarification:**
Indicate if an intraoperative TEE was performed after OR Entry time after induction, but prior to Incision time.

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**SEQ. #: 7485**
**Long Name:** Pre-Procedure Left Ventricular Ejection Fraction Measured
**Short Name:** PreLVEFMeas
**Definition:** Indicate whether left ventricular ejection fraction was measured

**Intent/Clarification:**
Indicate if an ejection fraction was measured during the intraoperative TEE after OR Entry time after induction, but prior to Incision time.

This field is a child to Seq # 7480.
SEQ. #: 7490
**Long Name:** Left Ventricular Ejection Fraction Estimate
**Short Name:** PreLVEF
**Definition:** Indicate the estimate of Left Ventricular ejection fraction determined by intraoperative transesophageal echocardiography.

Enter a range of 1-99. If a percentage range is reported, report a whole number using the “mean” (i.e., 50-55% is reported as 53%). The following guideline is to be used when the EF is not documented as a percentage; but rather, the EF is documented using a word descriptor:

Normal = 60%
Good function = 50%
Mildly reduced = 45%
Fair function = 40%
Moderately reduced = 30%
Poor function = 25%
Severely reduced = 20%

**Intent/Clarification:**
Use the ejection fraction obtained after OR Entry after induction, but prior to incision time. Report the mean number if a range is given (i.e. 50-55% should be reported at 53%).

Use the defining terms/percentages listed above to remain consistent with Adult Cardiac Database reporting.

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SEQ. #: 7495
**Long Name:** Pre-Procedure Right Ventricular Function
**Short Name:** PreRVFx
**Definition:** Indicate the estimate of RV function determined by intraoperative transesophageal echocardiography.

**Intent/Clarification:**
Use the Right Ventricular function obtained between OR Entry and incision time, but after induction.
SEQ. #: 7500
Long Name: Mitral Regurgitation
Short Name: PreMR
Definition: Indicate the degree of mitral valve regurgitation from intraoperative transesophageal echocardiography.

Enter the highest level recorded in the chart, i.e., worst performance level. “Moderately severe” should be coded as “severe”.

Intent/Clarification:
Use the degree of mitral valve regurgitation obtained between OR Entry and incision time, but after induction. Enter the highest level of regurgitation in the chart.

SEQ. #: 7505
Long Name: Mitral Stenosis
Short Name: PreMS
Definition: Indicate the degree of mitral valve stenosis from intraoperative transesophageal echocardiography.

Enter the highest level recorded in the chart, i.e., worst performance level. “Moderately severe” should be coded as “severe”.

Intent/Clarification:
Use the degree of mitral valve regurgitation obtained between OR Entry and incision time, but after induction. Enter the highest level of mitral valve stenosis in the chart.

SEQ. #: 7510
Long Name: Aortic Regurgitation
Short Name: PreAR
Definition: Indicate the degree of aortic valve regurgitation from intraoperative transesophageal echocardiography.

Enter the highest level recorded in the chart, i.e., worst performance level. “Moderately severe” should be coded as “severe”.

Intent/Clarification:
Use the degree of aortic valve regurgitation obtained between OR Entry and incision time, but after induction. Enter the highest level of aortic valve regurgitation in the chart.
SEQ. #: 7515
Long Name: Aortic Stenosis
Short Name: PreAS
Definition: Indicate the degree of aortic valve stenosis from intraoperative transesophageal echocardiography.

Enter the highest level recorded in the chart, i.e., worst performance level. “Moderately severe” should be coded as “severe”.

Intent/Clarification:
Use the degree of aortic valve stenosis obtained between OR Entry and incision time, but after induction. Enter the highest level of aortic valve stenosis in the chart.

SEQ. #: 7520
Long Name: Aortic Valve Area Assessed
Short Name: PreAVAAssessed
Definition: Indicate whether the aortic valve areas was assessed from intraoperative transesophageal echocardiography.

Intent/Clarification:
Time frame is after OR Entry time.

SEQ. #: 7525
Long Name: Aortic Valve Area
Short Name: PreAVA
Definition: Indicate the aortic valve area from intraoperative transesophageal echocardiography.

Enter numeric value in square centimeters for aortic valve.

Intent/Clarification:
Report the aortic valve area obtained between OR Entry and incision time, but after induction. Answer in cm².
**Long Name:** Tricuspid Regurgitation  
**Short Name:** PreTR  
**Definition:** Indicate the degree of tricuspid valve regurgitation from intraoperative transesophageal echocardiography.

Enter the highest level recorded in the chart, i.e., worst performance level. “Moderately severe” should be coded as “severe”.

**Intent/Clarification:**  
Enter the highest level of tricuspid valve regurgitation obtained between OR Entry and incision time, but after induction.

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**SEQ. #: 7535**  
**Long Name:** Patent Foramen Ovale  
**Short Name:** PrePFO  
**Definition:** Indicate the presence of patent foramen ovale diagnosed by intraoperative transesophageal echocardiography.

**Intent/Clarification:**  
Indicated if a patent foramen ovale was identified on the intraoperative TEE. Time frame is between OR Entry and incision time, but after induction.

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**SEQ. #: 7540**  
**Long Name:** Ascending Aorta Assessed  
**Short Name:** AscAoAssessed  
**Definition:** Indicate whether the ascending aorta was assessed using TEE.

**Intent/Clarification:**  
The ascending aorta includes the area from the aortic root to proximal of the innominate artery. Indicate if a TEE was performed intraoperatively to assess the ascending aorta. Time frame is after OR Entry time prior to incision, but after induction.

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**SEQ. #: 7545**  
**Long Name:** Maximal Ascending Aortic Diameter  
**Short Name:** MxAscAo  
**Definition:** Indicate the maximal diameter of ascending aorta as determined by intraoperative transesophageal echocardiography.
Indicate maximal diameter of ascending aorta in centimeters as determined by intraoperative transesophageal echocardiography.

**Intent/Clarification:**
Record the maximal diameter of the ascending aorta in centimeters using data obtained from an intraoperative TEE. Time frame is after OR Entry time prior to incision, but after induction.

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**SEQ. #: 7550**
**Long Name:** Maximal Ascending Aortic Atheroma Thickness
**Short Name:** MxAscAoThick
**Definition:** Indicate the maximal ascending aortic atherosclerotic thickness as measured by intraoperative transesophageal echocardiography.

Indicate maximal thickness of ascending aorta plaque in millimeters as determined by intraoperative transesophageal echocardiography. If only intimal thickening and no plaque put numeric value of zero.

**Intent/Clarification:**
Time frame is after OR Entry time prior to incision, but after induction.

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**SEQ. #: 7555**
**Long Name:** Ascending Aortic Atheroma Mobility
**Short Name:** AsAthMo
**Definition:** Indicate the ascending aortic atheroma mobility as measured by intraoperative transesophageal echocardiography.

**Intent/Clarification:**
Indicate if there was atheroma mobility within the ascending aorta. Time frame is after OR Entry time prior to incision, but after induction.

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**EQ. #: 7560**
**Long Name:** Aortic Arch Visualized
**Short Name:** AoArcVis
**Definition:** Indicate whether the aortic arch was visualized.
**Intent/Clarification:**
Indicate if an intraoperative TEE was performed that assessed the aortic arch. The aortic arch is normally located between the innominate artery and left subclavian artery. Time frame is after OR Entry time prior to incision, but after induction.

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**SEQ. #: 7565**
**Long Name:** Maximal Aortic Arch Atheroma Thickness
**Short Name:** MxArcAth
**Definition:** Indicate the maximal aortic arch atherosclerotic thickness as measured by intraoperative transesophageal echocardiography.

Indicate maximal thickness of aortic arch plaque in millimeters as determined by intraoperative transesophageal echocardiography. If only intimal thickening and no plaque put numeric value of zero.

**Intent/Clarification:**
Time frame is after OR Entry time prior to incision, but after induction.

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**SEQ. #: 7570**
**Long Name:** Aortic Arch Atheroma Mobility
**Short Name:** ArcAthMo
**Definition:** Indicate the aortic arch atheroma mobility as measured by pre-CPB intraoperative transesophageal echocardiography.

**Intent/Clarification:**
Indicate if aortic arch atheroma mobility was noted on the intraoperative TEE. Time frame is after OR Entry time prior to incision, but after induction.

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**SEQ. #: 7575**
**Long Name:** Cardiopulmonary Bypass Used
**Short Name:** CPBUUsed
**Definition:** Indicate whether cardiopulmonary bypass was used.

**Intent/Clarification:**
Indicate if the patient was placed on cardiopulmonary bypass for any portion of the procedure.
SEQ. #: 7580
Long Name: Retrograde Autologous Priming of CPB Circuit
Short Name: RetrAutolPrim
Definition: Indicate whether retrograde autologous priming was used by the cardiopulmonary perfusion team prior to the onset of cardiopulmonary bypass.

Retrograde autologous priming is technique used by cardiopulmonary perfusionists to minimize hemodilution and hypotension during onset of cardiopulmonary bypass.

Intent/Clarification:
Indicate if retrograde autologous priming was used by Perfusion. This information can usually be obtained in the perfusion record.

SEQ. #: 7585
Long Name: Total Fluids Crystalloid Administered by Perfusion Team
Short Name: TotCrystPerf
Definition: Indicate the total volume of intravenous crystalloid fluids administered by cardiopulmonary perfusion team. The data should be record in milliliters. Enter zero if fluid crystalloid not used by perfusion team.

There is continuing controversy as to the risks and benefits of liberal or restrictive intravenous fluid regimens. Record the total of all crystalloid intravenous fluids given by the cardiopulmonary perfusion team. Do not record any blood products in this data field.

Intent/Clarification:
Record the entire amount of crystalloid fluids administered intravenously by the perfusion team as recorded on the perfusion record. Do not include amount given by anesthesia, this is captured in SEQ. #7450. If input and output amounts are listed, record the input amount.

Common crystalloid fluids include 0.9% NaCl, Lactated Ringers, and D5 ½-0.9% NaCl.

SEQ. #: 7590
Long Name: Total Synthetic Colloid Administered by Perfusion Team
Short Name: TotColloidPerf
**Definition:** Indicate the total volume of intravenous synthetic colloid fluids (of any concentration) administered by the cardiopulmonary perfusion team. The data should be recorded in milliliters. Enter zero if synthetic colloid not administered by perfusion team.

There is continuing controversy as to the risks and benefits of liberal or restrictive intravenous fluid regimens. Record the total of all synthetic colloid intravenous fluids given by the cardiopulmonary perfusion team. Synthetic colloids of all concentrations and substitution ratios should be included, Do not record any blood products in this data field.

**Intent/Clarification:**
Record the entire amount of colloid fluids administered intravenously by the perfusion team as recorded on the perfusion record. Do not include amount given by anesthesia, this is captured in SEQ. #7455. If input and output amounts are listed, record the input amount.

Common colloid fluids used in the OR are Hespan and Voluven.

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**SEQ. #: 7595**
**Long Name:** Total Albumin Administered by Perfusion Team
**Short Name:** TotAlbumPerf
**Definition:** Indicate the total volume of intravenous human serum albumin fluids (of any concentration) administered by the cardiopulmonary perfusion team. The data should be recorded in milliliters. Enter zero if albumin not administered by perfusion team.

There is continuing controversy as to the risks and benefits of liberal or restrictive intravenous fluid regimens. Record the total of all human serum albumin intravenous fluids given by the cardiopulmonary perfusion team. Albumin-containing fluids of all concentrations should be included. Do not record any blood products in this data field.

**Intent/Clarification:**
Record the entire amount of albumin administered intravenously by the perfusion team. Do not include amount given by anesthesia, this is captured in SEQ. #7460.

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**SEQ. #: 7600**
**Long Name:** Hemofiltration Volume Removed by Perfusion Team **Short Name:** HemofilPerf
**Definition:** Indicate the total volume of ultrafiltrate removed by the cardiopulmonary perfusion team during cardiopulmonary bypass and during modified ultra-hemofiltration post-CPB. Record the data in milliliters.

Hemofiltration is used to concentrate the red blood cells and plasma proteins in the circulation during and immediately following CPB.

**Intent/Clarification:**
Indicate the total volume of fluid removed by hemofiltration intraoperatively after the initiation of the initial cardiopulmonary bypass as record on the perfusion record. Record amount in millimeters. Time frame is at the start of the initial cardiopulmonary bypass to admission to the ICU.

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**SEQ. #: 7605**
**Long Name:** Inotropes used to wean from CPB
**Short Name:** InotropWeanCPB
**Definition:** Indicate the usage of inotropic drug infusions to facilitate weaning from cardiopulmonary bypass. For this data field, any drug infusion with inotropic properties, including catecholamines, phosphodiesterase inhibitors, and calcium sensitizers, should be recorded.

Inotropic drugs infusions are used routinely or as required in many cardiac surgical patients during the process of weaning from CPB. Record all usage of drugs with positive inotropic effect, including epinephrine, norepinephrine, dopamine, dobutamine, levosimendan, and milrinone.

**Intent/Clarification:**
Indicate if inotropes were used to facilitate the weaning process from cardiopulmonary bypass. Select “Yes” if any drug with inotropic property was administered during the weaning process.

Inotropic drugs increase the pumping effect of the heart muscle, making the heart pump stronger. Common inotropic drugs include epinephrine, norepinephrine, dopamine, dobutamine, levosimendan, and milrinone. This also includes drugs with inotropic properties such as catecholamines, phosphodiesterase inhibitors, and calcium sensitizers.

If timing is unclear, obtain clarification regarding timing of the weaning process from the Cardiothoracic Anesthesiology team at your facility.
 SEQ. #: 7610  
Long Name: Vasopressors used to wean from CPB  
Short Name: VasopWeanCPB  
Definition: Indicate the usage of vasoconstrictive drugs to facilitate weaning from cardiopulmonary bypass. For this data field, any drug infusion at a dosage range with clinically vasoconstrictive properties, including catecholamines and pure vasoconstrictors, should be recorded.

Low systemic vascular resistance (a.k.a. vasoplegia) is a common condition during cardiopulmonary bypass that may be related to preoperative vasodilating drugs or certain antiarrhythmic drugs. Include purely vasoconstrictive drugs. Also record usage of drugs with inotropic effects that have vasoconstrictive properties in higher doses, such as dopamine and epinephrine.

Intent/Clarification:  
Indicate if vasopressors were used to facilitate the weaning process from cardiopulmonary bypass. Select “Yes” for any drug with vasoconstrictive property that was administered, this includes inotropic drugs (such as epinephrine and dopamine) that can be dosed at vasoconstrictive levels or pure vasoconstrictors such as vasopressin or phenylephrine. Vasoconstrictive drugs constrict the blood vessels raising blood pressure.

Common vasoconstrictor drugs include dopamine, epinephrine, neosynephrine/phenylephrine, norepinephrine (Levophed) and vasopressin.

If timing is unclear, obtain clarification regarding timing of the weaning process from the Cardiothoracic Anesthesiology team at your facility.

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SEQ. #: 7615  
Long Name: Intraoperative Post-procedure TEE Performed  
Short Name: IntraOpPostTEE  
Definition: Indicate whether intraoperative TEE was performed post-procedure.

Intent/Clarification:  
Indicate if a transesophageal echocardiogram was performed post-procedure intraoperatively. Time frame is after weaning from cardiopulmonary bypass to OR Exit time.

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SEQ. #: 7620  
Long Name: Systolic Anterior Motion of Mitral Valve
**Short Name:** PostSAM  
**Definition:** Indicate the presence of systolic anterior motion (SAM) of the mitral valve as determined by intraoperative transesophageal echocardiography prior to chest closure.

Choose Yes for any SAM between weaning from CPB and chest closure.

**Intent/Clarification:**  
If a post-procedure TEE was performed, indicate if systolic anterior motion of the mitral valve was noted. Choose “Not assessed” if a post-procedure TEE was performed but systolic anterior motion of the mitral valve was not documented. Time frame is after weaning from cardiopulmonary bypass to OR Exit time.

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**SEQ. #:** 7625  
**Long Name:** Return to CPB for Echo-Related Diagnosis  
**Short Name:** RetCPBEch  
**Definition:** Indicate whether surgical revision was performed based on post procedure intraoperative TEE.

**Intent/Clarification:**  
Indicate if the patient had to be placed back on cardiopulmonary bypass for a surgical revisit as a result from findings on the post-procedure TEE prior to OR Exit time.

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**SEQ. #:** 7630  
**Long Name:** Post-Procedure Left Ventricular Ejection Fraction Measured  
**Short Name:** PostLVEFMeas  
**Definition:** Indicate whether left ventricular ejection fraction was measured post-procedure by intraoperative transesophageal echocardiography.

**Intent/Clarification:**  
Time frame for TEE is the closest time before OR Exit time after final discontinuation of cardiopulmonary bypass time.

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**SEQ. #:** 7635  
**Long Name:** Post-Procedure Left Ventricular Ejection Fraction Estimate  
**Short Name:** PostLVEF  
**Definition:** Indicate the post-procedure estimate of left ventricular ejection fraction determined by intraoperative transesophageal echocardiography.
Enter a range of 1-99. If a percentage range is reported, report a whole number using the “mean” (i.e., 50-55% is reported as 53%). The following guideline is to be used when the EF is not documented as a percentage; but rather, the EF is documented using a word descriptor:
Normal = 60%
Good function = 50%
Mildly reduced = 45%
Fair function = 40%
Moderately reduced = 30%
Poor function = 25%
Severely reduced = 20%

**Intent/Clarification:**
Time frame for TEE is the closest time before OR Exit time after final discontinuation of bypass time.

Use the defining terms/percentages listed above to remain consistent with Adult Cardiac Database reporting.

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**SEQ. #:** 7640  
**Long Name:** Post-Procedure Right Ventricular Function  
**Short Name:** PostRVFx  
**Definition:** Indicate the post-procedure estimate of RV function determined by intraoperative transesophageal echocardiography.

**Intent/Clarification:**
Choices are normal, mild dysfunction, moderate dysfunction, severe dysfunction, and not assessed. If a range is reported (i.e. mild-moderate) choose the highest range reported. Choose “unknown” if a post-procedure TEE is performed, but right ventricular dysfunction is not documented. Time frame for TEE is the closest time before OR Exit time after final discontinuation of bypass time.

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**SEQ. #:** 7641  
**Long Name:** Intraoperative Cardiac Arrest Related To Anesthesia Care  
**Short Name:** IntraCardArr  
**Definition:** Indicate whether there was a cardiac arrest related to anesthesia care

**Intent/Clarification:**
Indicate if the patient’s heart arrested post-procedure, intraoperatively. Time frame is before OR Exit time.

SEQ. #: 7645
Long Name: Patient Died Within The OR
Short Name: ORDeath
Definition: Indicate whether the patient died within the OR.

Intent/Clarification:
Time frame is from OR Entry to OR Exit time.

SEQ. #: 7650
Long Name: Core Temperature Upon Entry To ICU/PACU Measured
Short Name: PostTempMeas
Definition: Indicate whether the core temperature was measured upon initial arrival in the ICU/PACU following cardiac surgery.

Intent/Clarification:
Indicate if the core temperature was measured upon arrival to ICU/PACU immediately following cardiac surgery. Core temperature locations include: bladder, rectum, pulmonary artery, esophageal, nasopharyngeal, and tympanic.

SEQ. #: 7655
Long Name: Core Temperature Upon Entry To ICU/PACU
Short Name: PostCoreTemp
Definition: Indicate the core temperature in degrees Centigrade upon initial arrival in the ICU/PACU following cardiac surgery.

Intent/Clarification:
Document the initial CORE temperature in degrees Celsius upon arrival to the ICU/PACU following cardiac surgery.

The intent is to capture the initial documented core temperature in the intensive care unit, as per the normal routine for core temperature monitoring in the ICU/PACU.
SEQ. #: 7660
Long Name: Postoperative INR Measured
Short Name: PostINRMeas
Definition: Indicate whether the International normalized ratio (INR) was measured upon initial arrival in the ICU/PACU following cardiac surgery.

Intent/Clarification:
Document if an initial International Normalized Ratio (INR) was measured upon arrival to the ICU/PACU following cardiac surgery. This lab is usually part of the Prothrombin test (PT/INR).

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SEQ. #: 7665
Long Name: First Postoperative INR
Short Name: PostINR
Definition: Indicate the first international normalized ratio (INR) value upon initial arrival in the ICU/PACU following cardiac surgery.

INR is the standard unit used to report the result of a prothrombin (PT) test. The hospital laboratory report should be accessed first when coding this variable. If this is unavailable, then additional source documents may be referenced for lab results.

Intent/Clarification:
Record the first INR value upon arrival to ICU/PACU following cardiac surgery.

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SEQ. #: 7670
Long Name: WBC Upon Entry To ICU/PACU Measured
Short Name: PostWBCMeas
Definition: Indicate whether the white blood cell count was measured upon initial arrival in the ICU/PACU following cardiac surgery.

Intent/Clarification:
Document if an initial white blood cell count (WBC) was measure upon arrival to the ICU/PACU. This is usually part of the complete blood count (CBC) test.

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SEQ. #: 7675
Long Name: WBC Upon Entry To ICU/PACU
**Short Name:** PostWBC  
**Definition:** Indicate the first white blood cell count upon initial arrival in the ICU/PACU following cardiac surgery.

White Blood Cells (leukocytes) are part of the body's immune defense and are often elevated in the presence of infection. The hospital laboratory report should be accessed first when coding this variable. If this is unavailable, then additional source documents may be referenced for lab results.

**Intent/Clarification:**  
Record the first WBC value upon admission to ICU/PACU following cardiac surgery.

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**SEQ. #: 7680**  
**Long Name:** Platelets Upon Entry To ICU/PACU Measured  
**Short Name:** PostPltMeas  
**Definition:** Indicate whether the platelet count was measured upon initial arrival in the ICU/PACU following cardiac surgery.

**Intent/Clarification:**  
Document if an initial platelet count (PLT) was measure upon arrival to the ICU/PACU. This is usually part of the complete blood count (CBC) test.

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**SEQ. #: 7685**  
**Long Name:** Platelets Upon Entry To ICU/PACU  
**Short Name:** PostPlt  
**Definition:** Indicate the first platelet count upon initial arrival in the ICU/PACU following cardiac surgery.

Platelets are a blood component instrumental in clot formation. The hospital laboratory report should be accessed first when coding this variable. If this is unavailable, then additional source documents may be referenced for lab results.

**Intent/Clarification:**  
Record the first platelet count upon admission to ICU/PACU following cardiac surgery.

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**SEQ. #: 7690**  
**Long Name:** Hematocrit Upon Entry To ICU/PACU Measured
Short Name: PostHCTMeas
Definition: Indicate whether the hematocrit value was measured upon initial arrival in the ICU/PACU following cardiac surgery.

Intent/Clarification:
Document if an initial hematocrit level (HCT) was measure upon arrival to the ICU/PACU. This is usually part of the complete blood count (CBC) test or hemoglobin/hematocrit (H/H) test.

SEQ. #: 7695
Long Name: Hematocrit Upon Entry To ICU/PACU
Short Name: PostHCT
Definition: Indicate the first hematocrit value upon initial arrival in the ICU/PACU following cardiac surgery.

Hct, Hematocrit, is the proportion of red cells in the blood. The hospital laboratory report should be accessed first when coding this variable. If this is unavailable, then additional source documents may be referenced for lab results.

Intent/Clarification:
Record the first hematocrit (Hct) level upon admission to ICU/PACU following cardiac surgery.

SEQ. #: 7696
Long Name: Fibrinogen Upon Entry To ICU/PACU Measured
Short Name: PostFibrinMeas
Definition: Indicate whether fibrinogen was measured upon entry to ICU/PACU

Intent/Clarification:
Document if an initial fibrinogen level was measured upon arrival to the ICU/PACU.

SEQ. #: 7697
Long Name: Fibrinogen Upon Entry To ICU/PACU
Short Name: PostFibrin
Definition: Indicate the fibrinogen level upon entry to ICU/PACU

Intent/Clarification:
Record the first fibrinogen level upon admission to the ICU/PACU following cardiac surgery.

SEQ. #: 7700  
**Long Name:** Lactate Upon Entry To ICU/PACU Measured  
**Short Name:** PostLactMeas  
**Definition:** Indicate whether the lactate value was measured upon initial arrival in the ICU/PACU following cardiac surgery.

**Intent/Clarification:**  
Document if an initial Lactate level (Lactic Acid) was measure upon arrival to the ICU/PACU.

SEQ. #: 7705  
**Long Name:** Lactate Upon Entry To ICU/PACU  
**Short Name:** PostLact  
**Definition:** Indicate the value of lactate in mg/dl upon initial arrival in the ICU/PACU following cardiac surgery. Do not record missing data as a zero value.

Serum lactate is a marker for the duration and severity of malperfusion during critical states. The magnitude of serum lactate has been associated with mortality and adverse outcomes.

**Intent/Clarification:**  
Record the first lactate (lactic acid) level upon admission to the ICU/PACU following cardiac surgery.

SEQ. #: 7710  
**Long Name:** Postop Infusion: Dexmedetomidine  
**Short Name:** DexPost  
**Definition:** Indicate the use of dexmedetomidine infusion after surgery.

Any use of dexmedetomidine infusion during the postoperative period, after transport to the ICU/PACU.

**Intent/Clarification:**
Indicate if dexmedetomidine was administered after admission to the ICU/PACU following cardiac surgery. Time frame is from OR Exit to Discharge.

SEQ. #: 7715
Long Name: Postop Infusion: Propofol
Short Name: PropPost
Definition: Indicate the use of propofol infusion after surgery.

Any use of a Propofol infusion during the postoperative period, after transport to the ICU/PACU.

Intent/Clarification:
Indicate if the patient received a Propofol infusion after admission to the ICU/PACU following cardiac surgery. Time frame is from OR Exit to Discharge.

This does not include bolus doses.

SEQ. #: 7720
Long Name: Postoperative Delirium
Short Name: PostopDel
Definition: Indicate whether the patient experienced postoperative delirium.

Postoperative altered mental state such as loss of memory and cognitive ability, personality changes, inability to concentrate, or lethargy, without actual evidence of stroke or coma.

Intent/Clarification:
Indicate if the patient experienced postoperative delirium as evidenced by change in mental status (including memory loss, personality changes, lethargy, and changes in cognitive ability) without evidence of a stroke or coma. Refer to physician documentation for diagnosis. Time frame is from OR Exit to Discharge.

Definition of Post-operative Delirium
Post-operative delirium is a state of global brain dysfunction occurring after a surgical procedure, the diagnosis of which is made by establishing:

- An acute disturbance in level of arousal (may be thargy-stupor or hypervigilance-agitation) and an acute disturbance in cognition.
  - Identifying these disturbances as representing an acute change in the patient's baseline level of arousal and cognition requires the establishment of baseline functioning in these areas from corroborative sources including
family, friends, and caregivers. \textit{Note}: Even patients with poor baseline levels of cognitive function (i.e. pre-existing Dementia) can develop superimposed delirium.

- The hallmark cognitive changes associated with delirium is a disturbance in attention (reduced ability to direct, focus, sustain, or shift attention) and awareness (reduced orientation to environment).
- These changes must develop over a short period of time (usually hours to a few days).
- These changes in cognition and level of arousal must demonstrate a pattern of fluctuation in severity during course of the day (i.e. there can be intervening periods of lucidity).
- Additional cognitive disturbances which may manifest during an episode of Delirium:
  - Memory deficits
  - Disorientation
  - Language
  - Visuospatial ability
- Additional behavioral disturbances which may manifest during an episode of delirium:
  - Changes in sleep-wake cycle
  - Hostility
  - Verbal and physical aggression
  - Unintentional self-harm (i.e. self-extubation, removal of catheters, falling out of bed)
  - Uncooperativeness with care
  - Euphoria
  - Hallucinations (visual or auditory)
  - Delusions (typically paranoid)
  - Disorganized thinking

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**SEQ. #:** 7725  
**Long Name:** Heparin-Induced Thrombocytopenia (Postop Dx)  
**Short Name:** PostHITAnti  
**Definition:** Indicate whether Heparin Induced Thrombocytopenia, HIT, is confirmed by antibody testing.

Heparin induced thrombocytopenia (HIT) can be defined as any clinical event best explained by platelet factor 4 (PF4)/heparin-reactive antibodies (‘HIT antibodies’) in a patient who is receiving, or who has recently received heparin. Thrombocytopenia is the most common ‘event’ in HIT and occurs in at least 90% of patients, depending upon the definition of thrombocytopenia. A very small proportion of patients with HIT develop thrombosis. Alternative (nonheparin) anticoagulant therapy reduces the risk of subsequent thrombosis.
**Intent/Clarification:**
Indicate if the patient experienced heparin induced thrombocytopenia (HIT) postoperatively. This is evidenced by the presence of HIT antibodies found via specific laboratory test. Consult with your laboratory to determine the test that your facility uses and the number of positive test used to diagnose a patient. Depending upon the test, some facilities require three positive results before confirming the diagnosis. This is sometimes referred to as being “HITA positive” in documentation. Time frame is from OR Exit to Discharge.

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**SEQ. #: 7730**  
**Long Name:** Pain Score POD #3  
**Short Name:** PainScorePOD3  
**Definition:** Indicate the pain score on postoperative day #3 (Integer Rating Scale).

Highest pain score on postoperative day #3 on the 0-10 integer scale, if recorded, or record score as missing.

**Intent/Clarification:**
Record the highest pain score using the integer scale from 0-10 on postoperative day 3. With a score of “0” indicating no pain and a score of “10” indicating the worse possible pain ever imagined. If the patient was evaluated on a non-numerical scale use the corresponding answer related to the 1-10 scale.

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**SEQ. #: 7735**  
**Long Name:** Pain Score Hospital Discharge  
**Short Name:** PainScoreDisch  
**Definition:** Indicate the pain score on day of discharge (Integer Rating Scale).

Highest pain score recorded on day of discharge on the 0-10 integer scale, if recorded, or record score as missing.

**Intent/Clarification:**
Record the highest pain score using the integer scale from 0-10 on the day of discharge from the hospital inpatient stay. With a score of “0” indicating no pain and a score of “10” indicating the worse possible pain ever imagined. If the patient was evaluated on a non-numerical scale use the corresponding answer related to the 1-10 scale.