STS General Thoracic Data Specifications
Changes Between Versions 2.07 and 2.081

This document current as of: Friday, September 05, 2008

NOTE: This document itemizes ALL changes between the two data versions, including minor changes.

50 **Version Of STS Data Specification**

Detail changed:	Changed from:	Changed to:
HarvestCoding	2.07	2.081
Definition	Version number of the STS Data Specifications/Dictionary, to which the record conforms. The value will identify which fields should have data, and what are the valid data for those fields. It must be the version implemented in the software at the time the record was created. The value must be entered into the record automatically by the software.	Version number of the STS Data Specifications/Dictionary, to which the record conforms. The value will identify which fields should have data, and what are the valid data values for those fields. It must be the version implemented in the software at the time the record was created. The value must be entered into the record automatically by the software.
Format	Text length 8	Text

60 **Record complete**

Detail changed:	Changed from:	Changed to:
Core	Yes	No

100 **Demographics Table Data Version**

Detail changed:	Changed from:	Changed to:
Format	Text length 8	Text
HarvestCoding	2.07	2.081

110 **Medical Record #**

Detail changed:	Changed from:	Changed to:
Definition	Indicate the hospital medical number assigned to the patient.	Indicate the patient's medical record number at the hospital where surgery occurred. This field should be collected in compliance with state/local privacy laws.
Harvest	No	Optional

120 **Patient's First Name**

Detail changed:	Changed from:	Changed to:
Definition	Indicate the first name of the patient.	Indicate the patient's first name documented in the medical record. This field should be collected in compliance with state/local privacy laws.
Format	Text length 20	Text
Harvest	No	Optional

130 **Patient's Middle Initial**

Detail changed:	Changed from:	Changed to:
Definition	Indicate the middle initial of the patient.	Indicate the patient's middle initial documented in the medical record. Leave "blank" if no middle name. This field should be collected in compliance with state/local privacy laws.
Harvest	No	Optional

140 **Patient's Last Name**

Detail changed:	Changed from:	Changed to:
Harvest	No	Optional
Format	Text length 25	Text
Definition	Indicate the last name of the patient.	Indicate the patient's last name documented in the medical record. This field should be collected in compliance with state/local privacy laws.

150 **Social Security Number**

Detail changed:	Changed from:	Changed to:
Harvest	No	Optional
Definition	Indicate the nine-digit Patient’s Social Security Number (SSN). Although this is the Social Security Number in the USA, other countries may have a different National Patient Identifier Number. For example in Canada, this would be the Social Insurance Number.	Indicate the nine-digit Patient’s Social Security Number (SSN). Although this is the Social Security Number in the USA, other countries may have a different National Patient Identifier Number. For example in Canada, this would be the Social Insurance Number. This field should be collected in compliance with state/local privacy laws.

160 **STS Trial Link Number**

Detail changed:	Changed from:	Changed to:
ShortName	<Blank>	STSTLink
Format	<Blank>	Text
RequiredForRecordInclusion	<Blank>	No
Harvest	<Blank>	Yes
DataSource	<Blank>	User
TableName	<Blank>	Demographics
Definition	<Blank>	The unique identification number assigned by the STS indicating the clinical trial in which this patient is participating. This field should be left blank if the patient is not participating in a clinical trial associated with the STS.
FieldName	<Blank>	STS Trial Link Number
Core	<Blank>	Yes

230 **Patient's race includes Hispanic**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

260 **Race - Native Hawaiian / Pacific Islander**

Detail changed:	Changed from:	Changed to:
HarvestCoding	<Blank>	1 = Yes 2 = No
DataSource	<Blank>	User
ValidData	<Blank>	Yes; No
RequiredForRecordInclusion	<Blank>	Yes
FieldName	<Blank>	Race - Native Hawaiian / Pacific Islander
ShortName	<Blank>	RacNativePacific
TableName	<Blank>	Demographics
Harvest	<Blank>	Yes
Core	<Blank>	Yes
Definition	<Blank>	Indicate whether the patient's race, as determined by the patient or family, includes Native Hawaiian / Pacific Islander. This includes a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. Definition source: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity : The minimum categories for data on race and ethnicity for Federal statistics, program administrative reporting, and civil rights compliance reporting. (www.whitehouse.gov/omb/fedreg/1997standards.html)
Format	<Blank>	Text (categorical values specified by STS)

270 **Patient's race includes any other race**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

280 **Hispanic Or Latino Ethnicity**

Detail changed:	Changed from:	Changed to:
ShortName	<Blank>	Ethnicity
Core	<Blank>	Yes

HarvestCoding	<Blank>	1 = Yes 2 = No
Definition	<Blank>	Indicate if the patient is of Hispanic or Latino ethnicity as determined by the patient / family. Hispanic or Latino ethnicity includes patient report of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
DataSource	<Blank>	User
TableName	<Blank>	Demographics
Format	<Blank>	Text (categorical values specified by STS)
FieldName	<Blank>	Hispanic Or Latino Ethnicity
Harvest	<Blank>	Yes
RequiredForRecordInclusion	<Blank>	No
ValidData	<Blank>	Yes; No

290 **Admission Status**

Detail changed:	Changed from:	Changed to:
Harvest	<Blank>	Yes
TableName	<Blank>	Operations
Format	<Blank>	Text (categorical values specified by STS)
DataSource	<Blank>	User
Core	<Blank>	Yes
HarvestCoding	<Blank>	1 = Inpatient 2 = Outpatient / Observation
FieldName	<Blank>	Admission Status
ValidData	<Blank>	Inpatient; Outpatient / Observation
RequiredForRecordInclusion	<Blank>	Yes
ShortName	<Blank>	AdmissionStat
Definition	<Blank>	Indicate whether the procedure was an Inpatient or Outpatient / Observation procedure.

300 **Admission Date**

Detail changed:	Changed from:	Changed to:
Definition	Indicate the date of admission. For those patients who originally enter the hospital in an out-patient capacity (i.e. catheterization), the admit date is the date the patient's status changes to in-patient.	Indicate the date of admission. For those patients who originally enter the hospital in an out-patient capacity, the admit date is the date the patient's status changes to in-patient.
ParentValue	<Blank>	Inpatient

ParentField	<Blank>	Admission Status

310 **Payor - Government Health Insurance**

Detail changed:	Changed from:	Changed to:
FieldName	<Blank>	Payor - Government Health Insurance
Definition	<Blank>	Indicate whether government insurance was used by the patient to pay for part or all of this admission. Government insurance refers to patients who are covered by government-reimbursed care. This includes Medicare, Medicaid, Military Health Care (e.g., TriCare), State-Specific Plan, and Indian Health Service.
HarvestCoding	<Blank>	1 = Yes 2 = No
ShortName	<Blank>	PayorGov
Core	<Blank>	Yes
ValidData	<Blank>	Yes; No
Harvest	<Blank>	Yes
RequiredForRecordInclusion	<Blank>	No
Format	<Blank>	Text (categorical values specified by STS)
DataSource	<Blank>	User
TableName	<Blank>	Operations

320 **Payor - Government Health Insurance - Medicare**

Detail changed:	Changed from:	Changed to:
ParentValue	<Blank>	Yes
ShortName	<Blank>	PayorGovMcare
ValidData	<Blank>	Yes; No
ParentField	<Blank>	Payor - Government Health Insurance
DataSource	<Blank>	User
HarvestCoding	<Blank>	1 = Yes 2 = No
TableName	<Blank>	Operations
Harvest	<Blank>	Yes
Definition	<Blank>	Indicate whether the government insurance used by the patient to pay for part or all of this admission included Medicare.
Core	<Blank>	Yes

FieldName	<Blank>	Payor - Government Health Insurance - Medicare
RequiredForRecordInclusion	<Blank>	No
Format	<Blank>	Text (categorical values specified by STS)

330 **Medicare Fee For Service**

Detail changed:	Changed from:	Changed to:
RequiredForRecordInclusion	<Blank>	No
TableName	<Blank>	Operations
Format	<Blank>	Text (categorical values specified by STS)
Harvest	<Blank>	Yes
ParentField	<Blank>	Payor - Government Health Insurance - Medicare
ParentValue	<Blank>	Yes
Core	<Blank>	Yes
HarvestCoding	<Blank>	1 = Yes 2 = No
ValidData	<Blank>	Yes; No
Definition	<Blank>	Indicate whether the patient is a Medicare Fee For Service (FFS) patient. Medicare FFS = Medicare Part B.
FieldName	<Blank>	Medicare Fee For Service
DataSource	<Blank>	User
ShortName	<Blank>	MedicareFFS

340 **Health Insurance Claim Number**

Detail changed:	Changed from:	Changed to:
Format	<Blank>	Text
Definition	<Blank>	Indicate the Health Insurance Claim (HIC) number of the primary beneficiary. The HIC number consists of the Social Security number and an alpha-numeric identifier (usually one digit but may be two digits). It is the number found on a patient's Medicare card. This field should be collected in compliance with state/local privacy laws.
Harvest	<Blank>	Optional
ShortName	<Blank>	HICNumber
DataSource	<Blank>	User
TableName	<Blank>	Demographics

Core	<Blank>	Yes
FieldName	<Blank>	Health Insurance Claim Number
RequiredForRecordInclusion	<Blank>	No

350

Payor - Government Health Insurance - Medicaid

Detail changed:	Changed from:	Changed to:
Core	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)
Harvest	<Blank>	Yes
ParentField	<Blank>	Payor - Government Health Insurance
Definition	<Blank>	Indicate whether the government insurance used by the patient to pay for part or all of this admission included Medicaid
ValidData	<Blank>	Yes; No
HarvestCoding	<Blank>	1 = Yes 2 = No
DataSource	<Blank>	User
RequiredForRecordInclusion	<Blank>	No
FieldName	<Blank>	Payor - Government Health Insurance - Medicaid
ParentValue	<Blank>	Yes
TableName	<Blank>	Operations
ShortName	<Blank>	PayorGovMcaid

360

Payor - Government Health Insurance - Military Health Care

Detail changed:	Changed from:	Changed to:
DataSource	<Blank>	User
ParentField	<Blank>	Payor - Government Health Insurance
HarvestCoding	<Blank>	1 = Yes 2 = No
RequiredForRecordInclusion	<Blank>	No
ShortName	<Blank>	PayorGovMil
Harvest	<Blank>	Yes
ValidData	<Blank>	Yes; No
Format	<Blank>	Text (categorical values specified by STS)
TableName	<Blank>	Operations

Definition	<Blank>	Indicate whether the government insurance used by the patient to pay for part or all of this admission included Military Health Care.
ParentValue	<Blank>	Yes
Core	<Blank>	Yes
FieldName	<Blank>	Payor - Government Health Insurance - Military Health Care

370

Payor - Government Health Insurance - State-Specific Plan

Detail changed:	**Changed from:**	**Changed to:**
DataSource	<Blank>	User
ValidData	<Blank>	Yes; No
ShortName	<Blank>	PayorGovState
Core	<Blank>	Yes
TableName	<Blank>	Operations
HarvestCoding	<Blank>	1 = Yes 2 = No
ParentField	<Blank>	Payor - Government Health Insurance
ParentValue	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)
Definition	<Blank>	Indicate whether the government insurance used by the patient to pay for part or all of this admission included State-Specific Plan.
FieldName	<Blank>	Payor - Government Health Insurance - State-Specific Plan
RequiredForRecordInclusion	<Blank>	No
Harvest	<Blank>	Yes

380

Payor - Government Health Insurance - Indian Health Service

Detail changed:	**Changed from:**	**Changed to:**
ParentField	<Blank>	Payor - Government Health Insurance
Format	<Blank>	Text (categorical values specified by STS)
TableName	<Blank>	Operations
ValidData	<Blank>	Yes; No
FieldName	<Blank>	Payor - Government Health Insurance - Indian Health Service

Definition	<Blank>	Indicate whether the government insurance used by the patient to pay for part or all of this admission included Indian Health Service.
DataSource	<Blank>	User
Core	<Blank>	Yes
Harvest	<Blank>	Yes
RequiredForRecordInclusion	<Blank>	No
HarvestCoding	<Blank>	1 = Yes 2 = No
ParentValue	<Blank>	Yes
ShortName	<Blank>	PayorGovIHS

390 **Payor - Commercial Health Insurance**

Detail changed:	Changed from:	Changed to:
DataSource	<Blank>	User
HarvestCoding	<Blank>	1 = Yes 2 = No
ShortName	<Blank>	PayorCom
ValidData	<Blank>	Yes; No
Definition	<Blank>	Indicate whether commercial insurance was used by the patient to pay for part or all of this admission. Commercial insurance refers to all indemnity (fee-for-service) carriers and Preferred Provider Organizations (PPOs), (e.g., Blue Cross and Blue Shield).
RequiredForRecordInclusion	<Blank>	No
Harvest	<Blank>	Yes
Core	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)
FieldName	<Blank>	Payor - Commercial Health Insurance
TableName	<Blank>	Operations

400 **Payor - Health Maintenance Organization**

Detail changed:	Changed from:	Changed to:
Harvest	<Blank>	Yes
Definition	<Blank>	Indicate whether a Health Maintenance Organization (HMO) insurance was used by the patient to pay for part or all of this admission. HMO refers to a Health Maintenance Organization characterized by coverage that provides health care services for members on a pre-paid basis.

HarvestCoding	<Blank>	1 = Yes 2 = No
Format	<Blank>	Text (categorical values specified by STS)
ValidData	<Blank>	Yes; No
RequiredForRecordInclusion	<Blank>	No
TableName	<Blank>	Operations
FieldName	<Blank>	Payor - Health Maintenance Organization
Core	<Blank>	Yes
ShortName	<Blank>	PayorHMO
DataSource	<Blank>	User

410 **Payor - Non-U.S. Insurance**

Detail changed:	**Changed from:**	**Changed to:**
FieldName	<Blank>	Payor - Non-U.S. Insurance
ShortName	<Blank>	PayorNonUS
HarvestCoding	<Blank>	1 = Yes 2 = No
Definition	<Blank>	Indicate whether any non-U.S. insurance was used by the patient to pay for part or all of this admission.
Core	<Blank>	Yes
RequiredForRecordInclusion	<Blank>	No
ValidData	<Blank>	Yes; No
Harvest	<Blank>	Yes
TableName	<Blank>	Operations
DataSource	<Blank>	User
Format	<Blank>	Text (categorical values specified by STS)

420 **Payor - None / Self**

Detail changed:	**Changed from:**	**Changed to:**
ShortName	<Blank>	PayorNS
DataSource	<Blank>	User
Harvest	<Blank>	Yes
HarvestCoding	<Blank>	1 = Yes 2 = No
RequiredForRecordInclusion	<Blank>	No

Format	<Blank>	Text (categorical values specified by STS)
ValidData	<Blank>	Yes; No
FieldName	<Blank>	Payor - None / Self
Definition	<Blank>	Indicate whether no insurance was used by the patient to pay for this admission. None refers to individuals with no or limited health insurance; thus, the individual is the payor regardless of ability to pay. Only mark "None" when "self" or "none" is denoted as the first insurance in the medical record.
Core	<Blank>	Yes
TableName	<Blank>	Operations

440 **Surgeon's UPIN number**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

450 **Surgeon's National Provider Identifier**

Detail changed:	Changed from:	Changed to:
TableName	<Blank>	Operations
ValidData	<Blank>	(elements of user list)
Definition	<Blank>	Indicate the individual-level National Provider Identifier of the surgeon performing the procedure.
Format	<Blank>	Text (categorical values specified by User)
Core	<Blank>	Yes
Harvest	<Blank>	Yes
ShortName	<Blank>	SurgNPI
DataSource	<Blank>	User
FieldName	<Blank>	Surgeon's National Provider Identifier
RequiredForRecordInclusion	<Blank>	Yes

460 **Taxpayer Identification Number**

Detail changed:	Changed from:	Changed to:
ShortName	<Blank>	TIN
ValidData	<Blank>	(elements of user list)
FieldName	<Blank>	Taxpayer Identification Number
Harvest	<Blank>	Yes

DataSource	<Blank>	Lookup
Format	<Blank>	Text (categorical values specified by User)
Core	<Blank>	Yes
RequiredForRecordInclusion	<Blank>	No
TableName	<Blank>	Operations
Definition	<Blank>	Indicate the group-level Taxpayer Identification Number for the Taxpayer holder of record for the Surgeon's National Provider Identifier that performed the procedure.

480 **Hospital code = AHA number**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

500 **Hospital State**

Detail changed:	Changed from:	Changed to:
FieldName	<Blank>	Hospital State
RequiredForRecordInclusion	<Blank>	No
Core	<Blank>	Yes
Harvest	<Blank>	Yes
Format	<Blank>	Text - Length exactly 2
Definition	<Blank>	Indicate the abbreviation of the state or province in which the hospital is located.
DataSource	<Blank>	Lookup
ShortName	<Blank>	HospStat
TableName	<Blank>	Operations

510 **Hospital National Provider Identifier**

Detail changed:	Changed from:	Changed to:
TableName	<Blank>	Operations
Format	<Blank>	Text (categorical values specified by User)
Definition	<Blank>	Indicate the hospital's National Provider Identifier (NPI). This number, assigned by the Center for Medicare and Medicaid Services (CMS), is used to uniquely identify facilities for Medicare billing purposes.
Harvest	<Blank>	Yes
RequiredForRecordInclusion	<Blank>	No

DataSource	<Blank>	Lookup
Core	<Blank>	Yes
ShortName	<Blank>	HospNPI
FieldName	<Blank>	Hospital National Provider Identifier
ValidData	<Blank>	(elements of user list)

530 **Height in inches**

Detail changed:	Changed from:	Changed to:
Core	Yes	No

550 **Weight in pounds**

Detail changed:	Changed from:	Changed to:
Core	Yes	No

570 **Comorbidities**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

580 **Hypertension**

Detail changed:	Changed from:	Changed to:
ParentField	Comorbidities	<Blank>
ParentValue	Yes	<Blank>
Definition	Indicate whether the patient has a diagnosis of hypertension, documented by one of the following: 1. Documented history of hypertension diagnosed and treated with medication, diet and/or exercise 2. Blood pressure >140 systolic or >90 diastolic on at least 2 occasions.	Indicate whether the patient has a diagnosis of hypertension, documented by one of the following: a. Documented history of hypertension diagnosed and treated with medication, diet and/or exercise b. Prior documentation of blood pressure >140 mmHg systolic or 90 mmHg diastolic for patients without diabetes or chronic kidney disease, or prior documentation of blood pressure >130 mmHg systolic or 80 mmHg diastolic on at least 2 occasions for patients with diabetes or chronic kidney disease c. Currently on pharmacologic therapy to control hypertension

590 **Steroids**

Detail changed:	Changed from:	Changed to:
ParentField	Comorbidities	<Blank>
ParentValue	Yes	<Blank>

Definition	Indicate whether the patient was taking steroids within 24 hours of surgery and does not include a one time dose related to prophylaxis therapy (i.e. IV dye exposure for cath procedure or surgery pre-induction period) Non-systemic medications are not included in this category (i.e. nasal sprays, topical creams).	Indicate whether the patient was taking oral or IV steroids within 24 hours of surgery. This does not include a one-time dose related to prophylaxis therapy (i.e., IV dye exposure for cath procedure or surgery pre-induction), or non-systemic medications (i.e., nasal sprays, inhalers, topical creams).

600

Congestive Heart Failure

Detail changed:	Changed from:	Changed to:
ParentField	Comorbidities	<Blank>
ParentValue	Yes	<Blank>

610

Coronary Artery Disease

Detail changed:	Changed from:	Changed to:
ParentValue	Yes	<Blank>
ParentField	Comorbidities	<Blank>

620

Peripheral Vascular Disease

Detail changed:	Changed from:	Changed to:
ParentValue	Yes	<Blank>
ParentField	Comorbidities	<Blank>

630

Prior Cardiothoracic Surgery

Detail changed:	Changed from:	Changed to:
ParentValue	Yes	<Blank>
ParentField	Comorbidities	<Blank>

640

When Prior CT Surgery Was Performed

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

650

Preoperative chemotherapy

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

660

Preoperative chemotherapy - When

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No

Core	Yes	No

670 **Preoperative Chemo - Current Malignancy**

Detail changed:	Changed from:	Changed to:
Harvest	<Blank>	Yes
TableName	<Blank>	Operations
Core	<Blank>	Yes
HarvestCoding	<Blank>	1 = Yes 2 = No
Format	<Blank>	Text (categorical values specified by STS)
RequiredForRecordInclusion	<Blank>	No
ShortName	<Blank>	PreopChemoCur
DataSource	<Blank>	User
Definition	<Blank>	Indicate whether the patient received preoperative chemotherapy for a current thoracic malignancy. Do not report treatment for prior cancers.
ValidData	<Blank>	Yes; No
FieldName	<Blank>	Preoperative Chemo - Current Malignancy

680 **Preoperative Chemo - Current Malignancy - When**

Detail changed:	Changed from:	Changed to:
ParentValue	<Blank>	Yes
RequiredForRecordInclusion	<Blank>	No
ParentField	<Blank>	Preoperative Chemo - Current Malignancy
Definition	<Blank>	Indicate when the patient received preoperative chemotherapy for the current thoracic malignancy.
Core	<Blank>	Yes
FieldName	<Blank>	Preoperative Chemo - Current Malignancy - When
Harvest	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)
HarvestCoding	<Blank>	1 = <= 6 Months 2 = > 6 Months
DataSource	<Blank>	User
ValidData	<Blank>	<= 6 Months; > 6 Months
TableName	<Blank>	Operations
ShortName	<Blank>	PreopChemoCurWhen

690 **Preoperative Thoracic Radiation Therapy**

Detail changed:	Changed from:	Changed to:
ParentField	Comorbidities	<Blank>
ParentValue	Yes	<Blank>

700 **Preoperative Thoracic Radiation Therapy - When**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

710 **Preoperative Thoracic Radiation Therapy - Disease And When Treated**

Detail changed:	Changed from:	Changed to:
Harvest	<Blank>	Yes
ParentField	<Blank>	Preoperative Thoracic Radiation Therapy
FieldName	<Blank>	Preoperative Thoracic Radiation Therapy - Disease And When Treated
DataSource	<Blank>	User
Format	<Blank>	Text (categorical values specified by STS)
Definition	<Blank>	Indicate when the patient received preoperative thoracic radiation therapy and for what disease.
HarvestCoding	<Blank>	1 = Same disease, <= 6 months 2 = Same disease, > 6 months 3 = Unrelated disease, <= 6 months 4 = Unrelated disease, > 6 months
ShortName	<Blank>	PreopXRTDisWhen
ValidData	<Blank>	Same disease, <= 6 months; Same disease, > 6 months; Unrelated disease, <= 6 months; Unrelated disease, > 6 months
TableName	<Blank>	Operations
RequiredForRecordInclusion	<Blank>	No
Core	<Blank>	Yes
ParentValue	<Blank>	Yes

720 **Cerebrovascular History**

Detail changed:	Changed from:	Changed to:

Definition	Indicate whether the patient has a history of Cerebro-Vascular Disease, documented by any one of the following: Unresponsive coma > 24 hrs; CVA (symptoms > 72 hrs after onset); RIND (recovery within 72 hrs); TIA (recovery within 24 hrs); Non-invasive carotid test with > 75% occlusion.; or Prior carotid surgery. Does not include neurological disease processes such as metabolic and/or anoxic ischemic encephalopathy.	Indicate whether the patient has a history of cerebrovascular disease, documented by any one of the following: Unresponsive coma > 24 hrs; CVA (symptoms > 72 hrs after onset); RIND (recovery within 72 hrs); TIA (recovery within 24 hrs); Non-invasive carotid test with > 79% occlusion; or prior carotid surgery. Does not include neurological disease processes such as metabolic and/or anoxic ischemic encephalopathy.

730

Pulmonary Hypertension

Detail changed:	Changed from:	Changed to:
FieldName	<Blank>	Pulmonary Hypertension
HarvestCoding	<Blank>	1 = Yes 2 = No 3 = Not applicable (not documented)
DataSource	<Blank>	User
ShortName	<Blank>	PulmHypertn
Core	<Blank>	Yes
TableName	<Blank>	Operations
Definition	<Blank>	Indicate whether Pulmonary Artery Pressure (PAP) is >=45.
RequiredForRecordInclusion	<Blank>	No
ValidData	<Blank>	Yes; No; Not applicable (not documented)
Format	<Blank>	Text (categorical values specified by STS)
Harvest	<Blank>	Yes

740

Diabetes

Detail changed:	Changed from:	Changed to:
Definition	Indicate whether the patient has a history of diabetes, regardless of duration of disease or need for anti-diabetic agents. Includes on admission or preoperative diagnosis. Does not include gestational diabetes	Indicate whether the patient has a history of diabetes, regardless of duration of disease or need for anti-diabetic agents. Does not include gestational diabetes

750

Diabetes Control

Detail changed:	Changed from:	Changed to:
ValidData	None; Diet; Oral; Insulin	None; Diet; Oral or other non-insulin; Insulin

Definition	Indicate the diabetic control method the patient presented with on admission. Patients placed on a pre-operative diabetic pathway of insulin drip but at admission were controlled with “None”, diet or oral methods are not coded as insulin dependent. Choices are : None = No treatment for diabetes Diet = Diet treatment only Oral = Oral agent treatment only Insulin = Insulin treatment (includes any combination with insulin)	Indicate the diabetic control method. Patients placed on a preoperative diabetic pathway of insulin drip, then were controlled with “None”, diet or oral methods, are not coded as insulin dependent. Choices are : None = No treatment for diabetes Diet = Diet treatment only Oral = Oral agent or other non-insulin treatment only Insulin = Insulin treatment (includes any combination with insulin)
HarvestCoding	1 = None 2 = Diet 3 = Oral 4 = Insulin	1 = None 2 = Diet 3 = Oral or other non-insulin 4 = Insulin

760

Renal insufficiency history

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

770

Creatinine Level Measured

Detail changed:	Changed from:	Changed to:
Harvest	<Blank>	Yes
Core	<Blank>	Yes
FieldName	<Blank>	Creatinine Level Measured
Format	<Blank>	Text (categorical values specified by STS)
TableName	<Blank>	Operations
DataSource	<Blank>	Automatic
ValidData	<Blank>	Yes; No
Definition	<Blank>	Indicate whether the creatinine level was measured prior to the surgical procedure.
ShortName	<Blank>	CreatMeasured
HarvestCoding	<Blank>	1 = Yes 2 = No
RequiredForRecordInclusion	<Blank>	No

780

Last Creatinine Level

Detail changed:	Changed from:	Changed to:
Format	<Blank>	Real
ParentValue	<Blank>	Yes
ShortName	<Blank>	CreatLst

ValidData	<Blank>	0.1 - 30.0
Core	<Blank>	Yes
DataSource	<Blank>	User
ParentField	<Blank>	Creatinine Level Measured
Harvest	<Blank>	Yes
UsualRange	<Blank>	0.1 - 9.0
RequiredForRecordInclusion	<Blank>	No
Definition	<Blank>	Indicate the creatinine level closest to the date and time prior surgery.
TableName	<Blank>	Operations
FieldName	<Blank>	Last Creatinine Level

790 **Currently On Dialysis**

Detail changed:	Changed from:	Changed to:
FieldName	<Blank>	Currently On Dialysis
Core	<Blank>	Yes
Definition	<Blank>	Indicate whether the patient is currently undergoing dialysis. This includes ultrafiltration.
ShortName	<Blank>	Dialysis
Format	<Blank>	Text (categorical values specified by STS)
ValidData	<Blank>	Yes; No
RequiredForRecordInclusion	<Blank>	No
TableName	<Blank>	Operations
Harvest	<Blank>	Yes
DataSource	<Blank>	User
HarvestCoding	<Blank>	1 = Yes 2 = No

800 **Hemoglobin Level Measured**

Detail changed:	Changed from:	Changed to:
DataSource	<Blank>	User
Harvest	<Blank>	Yes
Definition	<Blank>	Indicate whether the patient's hemoglobin level was measured prior to this surgical procedure.
TableName	<Blank>	Operations

RequiredForRecordInclusion	<Blank>	No
ValidData	<Blank>	Yes; No
ShortName	<Blank>	HemoglobinMeasured
Core	<Blank>	Yes
FieldName	<Blank>	Hemoglobin Level Measured
HarvestCoding	<Blank>	1 = Yes 2 = No
Format	<Blank>	Text (categorical values specified by STS)

810 **Last Hemoglobin Level**

Detail changed:	Changed from:	Changed to:
UsualRange	<Blank>	8.0 - 16.0
RequiredForRecordInclusion	<Blank>	No
Definition	<Blank>	Indicate the hemoglobin level closest to the date and time prior surgery.
TableName	<Blank>	Operations
DataSource	<Blank>	User
ParentValue	<Blank>	Yes
Harvest	<Blank>	Yes
Format	<Blank>	Real
ParentField	<Blank>	Hemoglobin Level Measured
ValidData	<Blank>	5.0 - 20.0
ShortName	<Blank>	HemoglobinLst
FieldName	<Blank>	Last Hemoglobin Level
Core	<Blank>	Yes

820 **COPD**

Detail changed:	Changed from:	Changed to:
Harvest	<Blank>	Yes
HarvestCoding	<Blank>	1 = Yes 2 = No
Format	<Blank>	Text (categorical values specified by STS)
ValidData	<Blank>	Yes; No
Core	<Blank>	Yes

ShortName	<Blank>	COPD
DataSource	<Blank>	User
TableName	<Blank>	Operations
FieldName	<Blank>	COPD
RequiredForRecordInclusion	<Blank>	No
Definition	<Blank>	Indicate whether the patient has a history of chronic obstructive pulmonary disease (COPD) as evidenced by previous diagnosis, treatment, and/or spirometric evidence.

830 **Interstitial Fibrosis**

Detail changed:	Changed from:	Changed to:
FieldName	<Blank>	Interstitial Fibrosis
RequiredForRecordInclusion	<Blank>	No
HarvestCoding	<Blank>	1 = Yes 2 = No
ValidData	<Blank>	Yes; No
Format	<Blank>	Text (categorical values specified by STS)
Harvest	<Blank>	Yes
Definition	<Blank>	Indicate whether the patient has a diagnosis of interstitial fibrosis.
ShortName	<Blank>	InterstitialFib
Core	<Blank>	Yes
TableName	<Blank>	Operations
DataSource	<Blank>	User

840 **Tobacco Use**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

850 **Smokeless tobacco use**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

860 **Cigarette use**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

870 **Pipe or cigar use**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

880 **Other tobacco use**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

890 **When Patient Quit Smoking**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

900 **Cigarette Smoking**

Detail changed:	Changed from:	Changed to:
Core	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)
DataSource	<Blank>	User
RequiredForRecordInclusion	<Blank>	Yes
Harvest	<Blank>	Yes
FieldName	<Blank>	Cigarette Smoking
ShortName	<Blank>	CigSmoking
Definition	<Blank>	Indicate the patient's history of smoking cigarettes.
HarvestCoding	<Blank>	1 = Never smoked 2 = Past smoker (stopped more than 1 month prior to operation) 3 = Current smoker
TableName	<Blank>	Operations
ValidData	<Blank>	Never smoked; Past smoker (stopped more than 1 month prior to operation); Current smoker

910 **Pack-Years Of Cigarette Use**

Detail changed:	Changed from:	Changed to:
ParentValue	Yes	"Past smoker (stopped more than 1 month prior to operation)" or "Current smoker"
ParentField	Cigarette use	Cigarette smoking

920 **Other comorbidity**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

930 **Lung Infection Type**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

940 **Trauma Requiring OR Intervention**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

950 **Trauma Type**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

970 **Forced Vital Capacity Test Done**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

980 **FVC actual**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

990 **FVC predicted**

Detail changed:	Changed from:	Changed to:

Core	Yes	No
Harvest	Yes	No

1000 **Forced Expiratory Volume Test Performed**

Detail changed:	Changed from:	Changed to:
Definition	Indicate whether a Forced Expiratory Volume at 1 second (FEV1) test was done.	Indicate whether a Forced Expiratory Volume at 1 second (FEV1) test was performed. FEV1 test should be performed for a major lung resection (e.g., wedge resection, segmentectomy, lobectomy, sleeve lobectomy, bilobectomy, or pneumonectomy). Select "Not applicable" ONLY if none of these procedures was performed.
FieldName	Forced Expiratory Volume Test Done	Forced Expiratory Volume Test Performed
RequiredForRecordInclusion	No	Yes
ParentField	<Blank>	Pulmonary Function Tests Performed
ValidData	Yes; No	Yes; No; Not applicable
ParentValue	<Blank>	Yes
HarvestCoding	1 = Yes 2 = No	1 = Yes 2 = No 3 = Not applicable

1010 **FEV1 actual**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1020 **FEV1 Predicted**

Detail changed:	Changed from:	Changed to:
ParentValue	<> "Yes"	Yes
RequiredForRecordInclusion	No	Yes
ParentField	FEV1 Test Not Done	Forced Expiratory Volume Test Performed
ValidData	0 - 200	10 - 150

1030 **DLCO Test Performed**

Detail changed:	Changed from:	Changed to:
Definition	Indicate whether a lung diffusion measured with carbon monoxide (DLCO) test was done.	Indicate whether a lung diffusion test (DLCO) was performed. DLCO test should be collected for a major lung resection (e.g., wedge resection, segmentectomy, lobectomy, sleeve lobectomy, bilobectomy, or pneumonectomy). Select "Not applicable" ONLY if none of these procedures was collected.
FieldName	Lung Diffusion Measured With Carbon Monoxide	DLCO Test Performed

ParentField	<Blank>	Pulmonary Function Tests Performed
HarvestCoding	1 = Yes 2 = No	1 = Yes 2 = No 3 = Not applicable
ParentValue	<Blank>	Yes
ValidData	Yes; No	Yes; No; Not applicable

1040

DLCO Predicted

Detail changed:	Changed from:	Changed to:
ValidData	0 - 200	10 - 150
ParentField	DLCO Test Not Done	DLCO Test Performed
ParentValue	<> "Yes"	Yes

1050

Zubrod Score

Detail changed:	Changed from:	Changed to:
RequiredForRecordInclusion	No	Yes
FieldName	Patient's Zubrod score	Zubrod Score
HarvestCoding	0 = Normal activity, no sysmptoms 1 = Symptoms but fully ambulatory 2 = Symptoms but in bed less than 50% of the time 3 = Symptoms but in bed >50% but less than 100% 4 = Bedridden 5 = Moribund	0 = Normal activity, no symptoms 1 = Symptoms, fully ambulatory 2 = Symptoms, in bed <= 50% of time 3 = Symptoms, in bed >50% but less than 100% of time 4 = Bedridden 5 = Moribund
ValidData	Normal activity, no sysmptoms; Symptoms but fully ambulatory; Symptoms but in bed less than 50% of the time; Symptoms but in bed >50% but less than 100%; Bedridden; Moribund	Normal activity, no symptoms; Symptoms, fully ambulatory; Symptoms, in bed <= 50% of time; Symptoms, in bed >50% but less than 100% of time; Bedridden; Moribund

1060

Category of disease

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

1070

Category Of Disease - Primary

Detail changed:	Changed from:	Changed to:
ShortName	<Blank>	CategoryPrim

ValidData	<Blank>	Tracheomalacia-congenital-748.3; Tracheomalacia-acquired-519.1; Tracheostenosis-congenital-748.3; Tracheostenosis-acquired (postintubation)-519.1; Tracheostomy-hemorrhage-519.09; Tracheostomy related stenosis-519.02; Tracheal tumor, malignant-162.0; Tracheal tumor, benign-212.2; Tracheal tumor, metastatic-197.3; Subglottic stenosis-congenital-748.3; Subglottic stenosis-acquired (postintubation)-478.74; Vocal cord paralysis-478.3; Lung tumor, metastatic-197.0; Lung tumor, benign-212.3; Lung cancer, main bronchus, carina-162.2; Lung cancer, upper lobe-162.3; Lung cancer, middle lobe-162.4; Lung cancer, lower lobe-162.5; Lung cancer, location unspecified-162.9; Lung abscess-513.0; Pneumothorax-512.8; Bronchiectasis-494.0; Empyema with fistula-510.0; Empyema without fistula-510.9; Emphysema-492.8; Emphysematous bleb-492.0; Interstitial lung disease/fibrosis-516.3; Pneumonia-486; Pulmonary insufficiency following surgery/trauma (ARDS)-518.5; Hemothorax-511.8; Lung nodule, benign (not a tumor, e.g., granuloma, subpleural lymph node, pulmonary infarct)-518.89; Mediastinitis-519.2; Mediastinal nodes, metastatic-196.1; Mediastinal nodes, benign-229.0; Anterior mediastinal tumor primary (germ cell cancer, seminoma)-164.2; Anterior mediastinal tumor-metastatic-197.1; Anterior mediastinal tumor-benign-(e.g., teratoma)-212.5; Anterior mediastinal tumor-thymus tumor (thymoma, thymic carcinoma)-164.0; Lymphoma, intrathoracic-202.82; Posterior mediastinal malignant tumor- primary-164.3; Posterior mediastinal tumor-metastatic-197.1; Posterior mediastinal tumor-benign (i.e., neurogenic tumor)- 212.5; Myasthenia gravis-358.0; Mediastinal cyst, Bronchogenic-519.3; Mediastinal cyst, Foregut duplication-519.3; Mediastinal cyst, Pericardial-519.3; Mediastinal cyst, Thymic-519.3; Pleural effusion (sterile)-511.9; Pleural effusion, infected- (empyema)-511.1; Pleural effusion, malignant-197.2; Pleural tumor, malignant (e.g., mesothelioma)-163.9; Pleural tumor, metastatic-197.2; Pleural tumor, benign-212.4; Pleural thickening-511.0; Pectus excavatum-754.81; Pectus carinatum-754.82; Sternal tumor, malignant-170.3; Sternal tumor, metastatic-198.5; Sternal tumor, benign-213.3; Rib tumor, malignant-(e.g., osteosarcoma, chondrosarcoma)-170.3; Rib tumor, metastatic-198.5; Rib tumor, benign-(e.g., fibrous dysplasia)-213.3; Thoracic outlet syndrome-353.0; Diaphragmatic paralysis-519.4; Diaphragm tumor, malignant-171.4; Diaphragm tumor, metastatic-198.89; Diaphragm tumor, benign-215.4; Esophageal cancer-lower third-150.5; Esophageal cancer, middle third-150.4; Esophageal cancer, upper third-150.3; Esophageal cancer, esophagogastric junction (cardia)-151.0; Esophageal tumor-benign (i.e., leiomyoma)-211.0; Esophageal stricture-530.3; Barrett's esophagus-530.85; Achalasia of esophagus-530.0; Esophageal perforation-530.4; Zenkers diverticulum-530.6; Epiphrenic diverticulum-530.4; Gastroesophageal reflux (GERD)-530.81; Tracheoesophageal fistula-530.84; Acquired pyloric stenosis-537.0; Acquired absence of esophagus (i.e., post esophagectomy)-V45.79; Goiter, nodular-241.9; Thyroid neoplasm, malignant-193; Thyroid neoplasm, benign-226; Rib fracture-807.0; Sternal fracture-807.2; Flail chest-807.4; Tracheal injury-807.5; Traumatic pneumothorax-860.0; Traumatic hemothorax-860.2; Traumatic hemopneumothorax-860.4; Lung contusion-861.21; Lung laceration-861.22; Diaphragm injury-862.0; Esophageal injury-862.22; Bronchus injury-862.21; Pericarditis with effusion-420.90; Pericardial effusion, malignant-198.89; SVC Syndrome-459.2; Hyperhidrosis, focal (e.g., palmaror axillary

		hyperhidrosis)-705.21; Lymphadenopathy-785.6; Abnormal radiologic finding-793.1
DataSource	<Blank>	User
Harvest	<Blank>	Yes
Core	<Blank>	Yes
TableName	<Blank>	Operations
Format	<Blank>	Text (categorical values specified by STS)
FieldName	<Blank>	Category Of Disease - Primary
Definition	<Blank>	Indicate the PRIMARY category of disease for which the procedure was performed. For the majority of cases, there will be only one condition treated (i.e., lung cancer treated by lobectomy and lymph node disection). Rarely, there will be cases where two unrelated conditions are treated at one time (i.e., a thymoma and a lung cancer). In these rare cases, indicate the primary or most important diagnosis in this "Category of Diesease - Primary" field, followed by the secondary or lesser diagnosis treated in the "Category of Disease - Secondary". For example, in the case of lung cancer with incidental thymoma, the primary category of disease = lung cancer, and the secondary category of disease = thymoma.
RequiredForRecordInclusion	<Blank>	Yes

HarvestCoding	<Blank>	10 = Tracheomalacia-congenital-748.3 20 = Tracheomalacia-acquired-519.1 30 = Tracheostenosis-congenital-748.3 40 = Tracheostenosis-acquired (postintubation)-519.1 50 = Tracheostomy-hemorrhage-519.09 60 = Tracheostomy related stenosis-519.02 70 = Tracheal tumor, malignant-162.0 80 = Tracheal tumor, benign-212.2 90 = Tracheal tumor, metastatic-197.3 100 = Subglottic stenosis-congenital-748.3 110 = Subglottic stenosis-acquired (postintubation)-478.74 120 = Vocal cord paralysis-478.3 130 = Lung tumor, metastatic-197.0 140 = Lung tumor, benign-212.3 150 = Lung cancer, main bronchus, carina-162.2 160 = Lung cancer, upper lobe-162.3 170 = Lung cancer, middle lobe-162.4 180 = Lung cancer, lower lobe-162.5 190 = Lung cancer, location unspecified-162.9 200 = Lung abscess-513.0 210 = Pneumothorax-512.8 220 = Bronchiectasis-494.0 230 = Empyema with fistula-510.0 240 = Empyema without fistula-510.9 250 = Emphysema-492.8 260 = Emphysematous bleb-492.0 270 = Interstitial lung disease/fibrosis-516.3 280 = Pneumonia-486 290 = Pulmonary insufficiency following surgery/trauma (ARDS)-518.5 300 = Hemothorax-511.8 310 = Lung nodule, benign (not a tumor, e.g., granuloma, subpleural lymph node, pulmonary infarct)-518.89 320 = Mediastinitis-519.2 330 = Mediastinal nodes, metastatic-196.1 340 = Mediastinal nodes, benign-229.0 350 = Anterior mediastinal tumor primary (germ cell cancer, seminoma)-164.2 360 = Anterior mediastinal tumor-metastatic-197.1 370 = Anterior mediastinal tumor-benign-(e.g., teratoma)-212.5 380 = Anterior mediastinal tumor-thymus tumor (thymoma, thymic carcinoma)-164.0 390 = Lymphoma, intrathoracic-202.82 400 = Posterior mediastinal malignant tumor- primary-164.3 410 = Posterior mediastinal tumor-metastatic-197.1 420 = Posterior mediastinal tumor-benign (i.e., neurogenic tumor)- 212.5 430 = Myasthenia gravis-358.0 440 = Mediastinal cyst, Bronchogenic-519.3 450 = Mediastinal cyst, Foregut duplication-519.3 460 = Mediastinal cyst, Pericardial-519.3 470 = Mediastinal cyst, Thymic-519.3 480 = Pleural effusion (sterile)-511.9 490 = Pleural effusion, infected- (empyema)-511.1 500 = Pleural effusion, malignant-197.2 510 = Pleural tumor, malignant (e.g., mesothelioma)-163.9 520 = Pleural tumor, metastatic-197.2 530 = Pleural tumor, benign-212.4 540 = Pleural thickening-511.0 550 = Pectus excavatum-754.81 560 = Pectus carinatum-754.82 570 = Sternal tumor, malignant-170.3 580 = Sternal tumor, metastatic-198.5 590 = Sternal tumor, benign-213.3 600 = Rib tumor, malignant-(e.g., osteosarcoma, chondrosarcoma)-170.3 610 = Rib tumor, metastatic-198.5

		620 = Rib tumor, benign-(e.g., fibrous dysplasia)-213.3 630 = Thoracic outlet syndrome-353.0 640 = Diaphragmatic paralysis-519.4 650 = Diaphragm tumor, malignant-171.4 660 = Diaphragm tumor, metastatic-198.89 670 = Diaphragm tumor, benign-215.4 680 = Esophageal cancer-lower third-150.5 690 = Esophageal cancer, middle third-150.4 700 = Esophageal cancer, upper third-150.3 710 = Esophageal cancer, esophagogastric junction (cardia)-151.0 720 = Esophageal tumor-benign (i.e., leiomyoma)-211.0 730 = Esophageal stricture-530.3 740 = Barrett's esophagus-530.85 750 = Achalasia of esophagus-530.0 760 = Esophageal perforation-530.4 770 = Zenkers diverticulum-530.6 780 = Epiphrenic diverticulum-530.4 790 = Gastroesophageal reflux (GERD)-530.81 800 = Tracheoesophageal fistula-530.84 810 = Acquired pyloric stenosis-537.0 820 = Acquired absence of esophagus (i.e., post esophagectomy)-V45.79 830 = Goiter, nodular-241.9 840 = Thyroid neoplasm, malignant-193 850 = Thyroid neoplasm, benign-226 860 = Rib fracture-807.0 870 = Sternal fracture-807.2 880 = Flail chest-807.4 890 = Tracheal injury-807.5 900 = Traumatic pneumothorax-860.0 910 = Traumatic hemothorax-860.2 920 = Traumatic hemopneumothorax-860.4 930 = Lung contusion-861.21 940 = Lung laceration-861.22 950 = Diaphragm injury-862.0 960 = Esophageal injury-862.22 970 = Bronchus injury-862.21 980 = Pericarditis with effusion-420.90 990 = Pericardial effusion, malignant-198.89 1000 = SVC Syndrome-459.2 1010 = Hyperhidrosis, focal (e.g., palmaror axillary hyperhidrosis)-705.21 1020 = Lymphadenopathy-785.6 1030 = Abnormal radiologic finding-793.1

1080

Category Of Disease - Secondary

Detail changed:	Changed from:	Changed to:
FieldName	<Blank>	Category Of Disease - Secondary
DataSource	<Blank>	User
Definition	<Blank>	Indicate the SECONDARY category of disease for which the procedure was performed.

HarvestCoding	<Blank>	10 = Tracheomalacia-congenital-748.3 20 = Tracheomalacia-acquired-519.1 30 = Tracheostenosis-congenital-748.3 40 = Tracheostenosis-acquired (postintubation)-519.1 50 = Tracheostomy-hemorrhage-519.09 60 = Tracheostomy related stenosis-519.02 70 = Tracheal tumor, malignant-162.0 80 = Tracheal tumor, benign-212.2 90 = Tracheal tumor, metastatic-197.3 100 = Subglottic stenosis-congenital-748.3 110 = Subglottic stenosis-acquired (postintubation)-478.74 120 = Vocal cord paralysis-478.3 130 = Lung tumor, metastatic-197.0 140 = Lung tumor, benign-212.3 150 = Lung cancer, main bronchus, carina-162.2 160 = Lung cancer, upper lobe-162.3 170 = Lung cancer, middle lobe-162.4 180 = Lung cancer, lower lobe-162.5 190 = Lung cancer, location unspecified-162.9 200 = Lung abscess-513.0 210 = Pneumothorax-512.8 220 = Bronchiectasis-494.0 230 = Empyema with fistula-510.0 240 = Empyema without fistula-510.9 250 = Emphysema-492.8 260 = Emphysematous bleb-492.0 270 = Interstitial lung disease/fibrosis-516.3 280 = Pneumonia-486 290 = Pulmonary insufficiency following surgery/trauma (ARDS)-518.5 300 = Hemothorax-511.8 310 = Lung nodule, benign (not a tumor, e.g., granuloma, subpleural lymph node, pulmonary infarct)-518.89 320 = Mediastinitis-519.2 330 = Mediastinal nodes, metastatic-196.1 340 = Mediastinal nodes, benign-229.0 350 = Anterior mediastinal tumor primary (germ cell cancer, seminoma)-164.2 360 = Anterior mediastinal tumor-metastatic-197.1 370 = Anterior mediastinal tumor-benign-(e.g., teratoma)-212.5 380 = Anterior mediastinal tumor-thymus tumor (thymoma, thymic carcinoma)-164.0 390 = Lymphoma, intrathoracic-202.82 400 = Posterior mediastinal malignant tumor- primary-164.3 410 = Posterior mediastinal tumor-metastatic-197.1 420 = Posterior mediastinal tumor-benign (i.e., neurogenic tumor)- 212.5 430 = Myasthenia gravis-358.0 440 = Mediastinal cyst, Bronchogenic-519.3 450 = Mediastinal cyst, Foregut duplication-519.3 460 = Mediastinal cyst, Pericardial-519.3 470 = Mediastinal cyst, Thymic-519.3 480 = Pleural effusion (sterile)-511.9 490 = Pleural effusion, infected- (empyema)-511.1 500 = Pleural effusion, malignant-197.2 510 = Pleural tumor, malignant (e.g., mesothelioma)-163.9 520 = Pleural tumor, metastatic-197.2 530 = Pleural tumor, benign-212.4 540 = Pleural thickening-511.0 550 = Pectus excavatum-754.81 560 = Pectus carinatum-754.82 570 = Sternal tumor, malignant-170.3 580 = Sternal tumor, metastatic-198.5 590 = Sternal tumor, benign-213.3 600 = Rib tumor, malignant-(e.g., osteosarcoma, chondrosarcoma)-170.3 610 = Rib tumor, metastatic-198.5

		620 = Rib tumor, benign-(e.g., fibrous dysplasia)-213.3 630 = Thoracic outlet syndrome-353.0 640 = Diaphragmatic paralysis-519.4 650 = Diaphragm tumor, malignant-171.4 660 = Diaphragm tumor, metastatic-198.89 670 = Diaphragm tumor, benign-215.4 680 = Esophageal cancer-lower third-150.5 690 = Esophageal cancer, middle third-150.4 700 = Esophageal cancer, upper third-150.3 710 = Esophageal cancer, esophagogastric junction (cardia)-151.0 720 = Esophageal tumor-benign (i.e., leiomyoma)-211.0 730 = Esophageal stricture-530.3 740 = Barrett's esophagus-530.85 750 = Achalasia of esophagus-530.0 760 = Esophageal perforation-530.4 770 = Zenkers diverticulum-530.6 780 = Epiphrenic diverticulum-530.4 790 = Gastroesophageal reflux (GERD)-530.81 800 = Tracheoesophageal fistula-530.84 810 = Acquired pyloric stenosis-537.0 820 = Acquired absence of esophagus (i.e., post esophagectomy)-V45.79 830 = Goiter, nodular-241.9 840 = Thyroid neoplasm, malignant-193 850 = Thyroid neoplasm, benign-226 860 = Rib fracture-807.0 870 = Sternal fracture-807.2 880 = Flail chest-807.4 890 = Tracheal injury-807.5 900 = Traumatic pneumothorax-860.0 910 = Traumatic hemothorax-860.2 920 = Traumatic hemopneumothorax-860.4 930 = Lung contusion-861.21 940 = Lung laceration-861.22 950 = Diaphragm injury-862.0 960 = Esophageal injury-862.22 970 = Bronchus injury-862.21 980 = Pericarditis with effusion-420.90 990 = Pericardial effusion, malignant-198.89 1000 = SVC Syndrome-459.2 1010 = Hyperhidrosis, focal (e.g., palmaror axillary hyperhidrosis)-705.21 1020 = Lymphadenopathy-785.6 1030 = Abnormal radiologic finding-793.1
Core	<Blank>	Yes
ShortName	<Blank>	CategorySecond
ParentField	<Blank>	Category Of Disease - Primary
Harvest	<Blank>	Yes

ValidData	<Blank>	Tracheomalacia-congenital-748.3; Tracheomalacia-acquired-519.1; Tracheostenosis-congenital-748.3; Tracheostenosis-acquired (postintubation)-519.1; Tracheostomy-hemorrhage-519.09; Tracheostomy related stenosis-519.02; Tracheal tumor, malignant-162.0; Tracheal tumor, benign-212.2; Tracheal tumor, metastatic-197.3; Subglottic stenosis-congenital-748.3; Subglottic stenosis-acquired (postintubation)-478.74; Vocal cord paralysis-478.3; Lung tumor, metastatic-197.0; Lung tumor, benign-212.3; Lung cancer, main bronchus, carina-162.2; Lung cancer, upper lobe-162.3; Lung cancer, middle lobe-162.4; Lung cancer, lower lobe-162.5; Lung cancer, location unspecified-162.9; Lung abscess-513.0; Pneumothorax-512.8; Bronchiectasis-494.0; Empyema with fistula-510.0; Empyema without fistula-510.9; Emphysema-492.8; Emphysematous bleb-492.0; Interstitial lung disease/fibrosis-516.3; Pneumonia-486; Pulmonary insufficiency following surgery/trauma (ARDS)-518.5; Hemothorax-511.8; Lung nodule, benign (not a tumor, e.g., granuloma, subpleural lymph node, pulmonary infarct)-518.89; Mediastinitis-519.2; Mediastinal nodes, metastatic-196.1; Mediastinal nodes, benign-229.0; Anterior mediastinal tumor primary (germ cell cancer, seminoma)-164.2; Anterior mediastinal tumor-metastatic-197.1; Anterior mediastinal tumor-benign-(e.g., teratoma)-212.5; Anterior mediastinal tumor-thymus tumor (thymoma, thymic carcinoma)-164.0; Lymphoma, intrathoracic-202.82; Posterior mediastinal malignant tumor- primary-164.3; Posterior mediastinal tumor-metastatic-197.1; Posterior mediastinal tumor-benign (i.e., neurogenic tumor)- 212.5; Myasthenia gravis-358.0; Mediastinal cyst, Bronchogenic-519.3; Mediastinal cyst, Foregut duplication-519.3; Mediastinal cyst, Pericardial-519.3; Mediastinal cyst, Thymic-519.3; Pleural effusion (sterile)-511.9; Pleural effusion, infected- (empyema)-511.1; Pleural effusion, malignant-197.2; Pleural tumor, malignant (e.g., mesothelioma)-163.9; Pleural tumor, metastatic-197.2; Pleural tumor, benign-212.4; Pleural thickening-511.0; Pectus excavatum-754.81; Pectus carinatum-754.82; Sternal tumor, malignant-170.3; Sternal tumor, metastatic-198.5; Sternal tumor, benign-213.3; Rib tumor, malignant-(e.g., osteosarcoma, chondrosarcoma)-170.3; Rib tumor, metastatic-198.5; Rib tumor, benign-(e.g., fibrous dysplasia)-213.3; Thoracic outlet syndrome-353.0; Diaphragmatic paralysis-519.4; Diaphragm tumor, malignant-171.4; Diaphragm tumor, metastatic-198.89; Diaphragm tumor, benign-215.4; Esophageal cancer-lower third-150.5; Esophageal cancer, middle third-150.4; Esophageal cancer, upper third-150.3; Esophageal cancer, esophagogastric junction (cardia)-151.0; Esophageal tumor-benign (i.e., leiomyoma)-211.0; Esophageal stricture-530.3; Barrett's esophagus-530.85; Achalasia of esophagus-530.0; Esophageal perforation-530.4; Zenkers diverticulum-530.6; Epiphrenic diverticulum-530.4; Gastroesophageal reflux (GERD)-530.81; Tracheoesophageal fistula-530.84; Acquired pyloric stenosis-537.0; Acquired absence of esophagus (i.e., post esophagectomy)-V45.79; Goiter, nodular-241.9; Thyroid neoplasm, malignant-193; Thyroid neoplasm, benign-226; Rib fracture-807.0; Sternal fracture-807.2; Flail chest-807.4; Tracheal injury-807.5; Traumatic pneumothorax-860.0; Traumatic hemothorax-860.2; Traumatic hemopneumothorax-860.4; Lung contusion-861.21; Lung laceration-861.22; Diaphragm injury-862.0; Esophageal injury-862.22; Bronchus injury-862.21; Pericarditis with effusion-420.90; Pericardial effusion, malignant-198.89; SVC Syndrome-459.2; Hyperhidrosis, focal (e.g., palmaror axillary

		hyperhidrosis)-705.21; Lymphadenopathy-785.6; Abnormal radiologic finding-793.1
Format	<Blank>	Text (categorical values specified by STS)
ParentValue	<Blank>	Not null
TableName	<Blank>	Operations
RequiredForRecordInclusion	<Blank>	No

1090 **Organ system**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1130 **Anesthesia Start Time**

Detail changed:	Changed from:	Changed to:
TableName	<Blank>	Operations
Definition	<Blank>	Indicate the time of anesthesia induction (includes conscious sedation).
Harvest	<Blank>	Yes
ShortName	<Blank>	AnesthStartT
RequiredForRecordInclusion	<Blank>	No
Core	<Blank>	Yes
DataSource	<Blank>	User
Format	<Blank>	Time in 24-hour hh:mm format
FieldName	<Blank>	Anesthesia Start Time

1140 **Anesthesia End Time**

Detail changed:	Changed from:	Changed to:
Definition	<Blank>	Indicate the time of extubation or conclusion of anesthesia.
RequiredForRecordInclusion	<Blank>	No
Harvest	<Blank>	Yes
Format	<Blank>	Time in 24-hour hh:mm format
Core	<Blank>	Yes
DataSource	<Blank>	User
ShortName	<Blank>	AnesthEndT
TableName	<Blank>	Operations

FieldName	<Blank>	Anesthesia End Time

1150 **Time Of Skin Opening**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

1160 **Time Of Skin Closure**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1170 **Procedure Start Time**

Detail changed:	Changed from:	Changed to:
DataSource	<Blank>	User
FieldName	<Blank>	Procedure Start Time
RequiredForRecordInclusion	<Blank>	Yes
TableName	<Blank>	Operations
Format	<Blank>	Time in 24-hour hh:mm format
Definition	<Blank>	Indicate the time the procedure started.
Harvest	<Blank>	Yes
ShortName	<Blank>	ProcStartT
Core	<Blank>	Yes

1180 **Procedure End Time**

Detail changed:	Changed from:	Changed to:
Core	<Blank>	Yes
Format	<Blank>	Time in 24-hour hh:mm format
Harvest	<Blank>	Yes
FieldName	<Blank>	Procedure End Time
Definition	<Blank>	Indicate the time the procedure ended.
DataSource	<Blank>	User
RequiredForRecordInclusion	<Blank>	Yes
TableName	<Blank>	Operations
ShortName	<Blank>	ProcEndT

1210 **Reoperation**

Detail changed:	Changed from:	Changed to:
Definition	Indicate whether this is a general thoracic re-operation:i.e., patient has a history of a general thoracic surgical procedure in the same cavity or organ any time prior to this operation.	Indicate whether this is a cardiac or thoracic re-operation that affects this operative field (i.e., patient has had a previous surgical procedure in the same cavity or organ).

1220 **Robotic Technology Assisted**

Detail changed:	Changed from:	Changed to:
ShortName	<Blank>	Robotic
RequiredForRecordInclusion	<Blank>	No
Core	<Blank>	Yes
FieldName	<Blank>	Robotic Technology Assisted
HarvestCoding	<Blank>	1 = Yes 2 = No
Harvest	<Blank>	Yes
ValidData	<Blank>	Yes; No
DataSource	<Blank>	User
TableName	<Blank>	Operations
Format	<Blank>	Text (categorical values specified by STS)
Definition	<Blank>	Indicate whether the thoracic surgery was assisted by robotic technology.

1230 **Blood transfusion - Intraop**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1240 **Intraoperative Packed Red Blood Cells**

Detail changed:	Changed from:	Changed to:
DataSource	<Blank>	User
ShortName	<Blank>	IntraopPRBC
TableName	<Blank>	Operations
Core	<Blank>	Yes
ValidData	<Blank>	Yes; No
Harvest	<Blank>	Yes

FieldName	<Blank>	Intraoperative Packed Red Blood Cells
HarvestCoding	<Blank>	1 = Yes 2 = No
RequiredForRecordInclusion	<Blank>	No
Definition	<Blank>	Indicate whether the patient received packed Red Blood Cells intraoperatively.
Format	<Blank>	Text (categorical values specified by STS)

1250 **Intraoperative Packed Red Blood Cells - Number**

Detail changed:	Changed from:	Changed to:
Core	<Blank>	Yes
Definition	<Blank>	Indicate the number of units of packed Red Blood Cells the patient received intraoperatively.
DataSource	<Blank>	User
Format	<Blank>	Integer
RequiredForRecordInclusion	<Blank>	No
ParentField	<Blank>	Intraoperative Packed Red Blood Cells
ValidData	<Blank>	1 - 50
Harvest	<Blank>	Yes
ParentValue	<Blank>	Yes
TableName	<Blank>	Operations
UsualRange	<Blank>	1 - 10
FieldName	<Blank>	Intraoperative Packed Red Blood Cells - Number
ShortName	<Blank>	IntraopPRBCNum

1270 **Procedure**

Detail changed:	Changed from:	Changed to:
Definition	Indicate the general thoracic procedures being performed during this operating room visit. Please note: A separate General Thoracic Database Data Collection Form should be completed for each general thoracic operating room or endoscopy suite visit.	Indicate the general thoracic procedures being performed during this operating room visit. Please note: A separate data collection form should be completed for each general thoracic operating room or endoscopy suite visit.

HarvestCoding

10 = Chest Wall Biopsy
20 = Rib Resection (single)
30 = First/Cervical Rib Resection
40 = Chest Wall Resection
50 = Chest Wall Reconstruction
60 = Thoracoplasty
70 = Pectus Repair
80 = Sternectomy, complete
90 = Sternectomy, partial
95 = Muscle Flap
100 = Other Chest Wall Repair
110 = Mediastinal LN Biopsy
120 = Mediastinoscopy
130 = Anterior Mediastinotom
140 = Extended Cervical Mediastinoscopy
150 = Mediastinal Lymph Node Dissection
160 = Mediastinal Lymph Node Sampling
170 = Biopsy, Mediastinal Mass
180 = Resection, Mediastinal Mass
190 = Thymectomy
200 = Sympathectomy
210 = Thoracic duct ligation
220 = Other Mediastinal/Neck procedure
230 = Flexible Bronchoscopy
240 = Rigid Bronchoscopy
250 = Removal of Foreign Body (Tracheobronchial)
260 = Endobronchial Ablation, Laser / PDT
265 = Endobronchial Ablation, Mechanical
270 = Tracheal/Bronchial Stent
280 = Tracheostomy
290 = Tracheal Repair
300 = Tracheal Stricture Resection
310 = Tracheal Tumor Resection
320 = Carinal Resection (no lung resection)
330 = Bronchotomy
340 = Bronchial Repair
350 = Bronchoplasty
370 = TE Fistula Repair
380 = Other Tracheobroncial procedure
390 = Wedge Resection, single
400 = Wedge Resection, multiple
410 = Segmentectomy
420 = Lobectomy
425 = Sleeve Lobectomy
430 = Bilobectomy
440 = Pneumonectomy, standard
445 = Pneumonectomy, Carinal
450 = Completion pneumonectomy
460 = Extrapleural pneumonectomy
470 = Pneumonectomy, intrapericardial
480 = Lung Volume Reduction
490 = Bullectomy / repair
500 = Hydatid Cyst Resection
510 = Single Lung Transplant
520 = Double Lung Transplant
530 = Lung Donor Harvest
540 = Other Lung procedure
550 = Esophagoscopy, flexible
560 = Esophagoscopy, rigid
570 = Removal of Foreign Body (Esophagogastric)
580 = Dilation of Esophagus
590 = Esophageal Tumor Ablation, Laser / PDT
600 = Stent Placement
610 = Cervical esophagostomy
620 = Anterior Thoracic Esophagostomy
630 = Zenker's Diverticulum Repair
640 = Myotocomy, cricopharyngeal
650 = Myotomy, esophageal (long)
660 = Myotomy, cardia (short)
670 = Resection, intrathoracic diverticulum
680 = Resection, esophagus (esophagectomy)
690 = Resection, esophageal wall leasion

2000 = Muscle flap, neck (15732)
2010 = Muscle flap; trunk (i.e., intercostal, pectoralis or serratus muscle) (15734)
2020 = Excision of chest wall tumor including ribs (19260)
2030 = Excision of chest wall tumor involving ribs, with reconstruction (19271)
2040 = Excision tumor, soft tissue of neck or thorax; subcutaneous (21555)
2050 = Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular (21556)
2060 = Radical resection of tumor (e.g., malignant neoplasm), soft tissue of neck or thorax (21557)
2070 = Excision of rib, partial (21600)
2080 = Excision first and/or cervical rib (21615)
2090 = Excision first and/or cervical rib; with sympathectomy (21616)
2100 = Radical resection of sternum (21630)
2110 = Radical resection of sternum; with mediastinal lymphadenectomy (21632)
2120 = Hyoid myotomy and suspension (21685)
2130 = Division of scalenus anticus; without resection of cervical rib (21700)
2140 = Division of scalenus anticus; with resection of cervical rib (21705)
2150 = Reconstructive repair of pectus excavatum or carinatum; open (21740)
2160 = Reconstructive repair of pectus, minimally invasive approach (Nuss procedure), without thoracoscopy (21742)
2170 = Reconstructive repair of pectus, minimally invasive approach (Nuss procedure), with thoracoscopy (21743)
2180 = Open treatment of sternum fracture with or without skeletal fixation (21825)
2190 = Unlisted procedure, neck or thorax (21899)
2200 = Tracheoplasty; cervical (31750)
2210 = Tracheoplasty; intrathoracic (31760)
2220 = Carinal reconstruction (31766)
2230 = Bronchoplasty; excision stenosis and anastomosis (31775)
2240 = Excision tracheal stenosis and anastomosis; cervical (31780)
2250 = Excision tracheal stenosis and anastomosis; cervicothoracic (31781)
2260 = Excision of tracheal tumor or carcinoma; cervical (31785)
2270 = Excision of tracheal tumor or carcinoma; thoracic (31786)
2280 = Suture of tracheal wound or injury; cervical (31800)
2290 = Suture of tracheal wound or injury; intrathoracic (31805)
2300 = Unlisted procedure, trachea, bronchi (31899)
2310 = Thoracostomy; with rib resection for empyema (32035)
2320 = Thoracostomy; with open flap drainage for empyema (32036)
2330 = Thoracotomy, limited, for biopsy of lung or pleura (i.e.; open lung biopsy) (32095)
2340 = Thoracotomy, major; with exploration and biopsy (32100)
2350 = Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear (32110)
2360 = Thoracotomy, major; for postoperative complications (32120)
2370 = Thoracotomy, major; with cyst(s) removal, with or without a pleural procedure (32140)
2380 = Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure (32141)
2390 = Thoracotomy, major; with removal of intrapleural foreign body or hematoma (32150)

695 = Repair, perforation of esophagus - Iatrogenic
696 = Repair, perforation of esophagus - Malignant
697 = Repair, perforation of esophagus - Other
700 = Fundoplication, circumferentia
710 = Fundoplication, partial
720 = Gastroplasty
730 = Pyloroplasty
740 = Pyloromyotomy
750 = Gastrectomy
760 = Gastrostomy
770 = Jejunostomy
780 = Conduit, gastric
790 = Conduit, colon
800 = Conduit, jejunum
810 = Conduit, other
820 = Anastomosis, neck
830 = Anastomosis, Chest
840 = Other Esophageal procedure
850 = Other GI procedure
860 = Pericardial Window
870 = Pericardiectomy
880 = Repair Cardiac Laceration
890 = Other Pericardial Procedure
900 = Repair / Reconstruction, thoracic aorta
910 = Repair / Reconstruction, abd aorta
920 = Repair / Reconstruction, SVC
930 = Repair / Reconstruction, IVC
940 = Repair / Reconstruction, pulmonary artery
950 = Repair / Reconstruction, pulmonary vein(s)
960 = Repair / Reconstruction, left atrium
965 = Repair / Reconstruction, Subclavian Artery
970 = Cardiopulmonary Bypass
980 = Other Cardiac procedure
990 = Plication of Diaphragm
1000 = Diaphragmatic Hernia Repair, acute
1010 = Diaphragmatic Hernia Repair, chronic
1020 = Resection of Diaphragm
1030 = Reconstruction of Diaphragm
1040 = Other Diaphragm procedure
1050 = Pleural Drainage Procedure - Open
1060 = Pleural Drainage Procedure - Closed
1070 = Pleural Biopsy
1080 = Pleurodesis
1090 = Pleurectomy
1100 = Decortication
1110 = Clagett Procedure
1120 = Other Pleural procedure
1130 = Fibrin Glue
1140 = Pericardial Strips
1150 = Lung Sealant
1160 = Pleural Tent
1170 = Other Air Leak Control Measures
2400 = Thoracotomy with cardiac massage (32160)
2410 = Pleural scarification for repeat pneumothorax (32215)
2420 = Decortication, pulmonary, total (32220)
2430 = Decortication, pulmonary, partial (32225)
2440 = Pleurectomy, parietal (32310)
2450 = Decortication and parietal pleurectomy (32320)
2460 = Biopsy, pleura; open (32402)
2470 = Removal of lung, total pneumonectomy; (32440)
2480 = Removal of lung, sleeve (carinal) pneumonectomy (32442)
2490 = Removal of lung, total pneumonectomy; extrapleural (32445)
2500 = Removal of lung, single lobe (lobectomy) (32480)
2510 = Removal of lung, two lobes (bilobectomy) (32482)
2520 = Removal of lung, single segment (segmentectomy) (32484)
2530 = Removal of lung, sleeve lobectomy (32486)
2540 = Removal of lung, completion pneumonectomy (32488)
2550 = Removal of lung, excision-plication of emphysematous lung(s) for lung volume reduction (LVRS) (32491)
2560 = Removal of lung, wedge resection, single or multiple (32500)
2570 = Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (32501)
2580 = Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, without chest wall reconstruction(s) (32503)
2590 = Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, with chest wall reconstruction (32504)
2600 = Extrapleural enucleation of empyema (empyemectomy) (32540)
2610 = Thoracoscopy, diagnostic lungs and pleural space, without biopsy (32601)
2620 = Thoracoscopy, diagnostic lungs and pleural space, with biopsy (32602)
2630 = Thoracoscopy, diagnostic pericardial sac, without biopsy (32603)
2640 = Thoracoscopy, diagnostic pericardial sac, with biopsy (32604)
2650 = Thoracoscopy, diagnostic mediastinal space, without biopsy (32605)
2660 = Thoracoscopy, diagnostic; mediastinal space, with biopsy (32606)
2670 = Thoracoscopy, surgical; with pleurodesis (e.g., mechanical or chemical) (32650)
2680 = Thoracoscopy, surgical; with partial pulmonary decortication (32651)
2690 = Thoracoscopy, surgical; with total pulmonary decortication (32652)
2700 = Thoracoscopy, surgical; with removal of intrapleural foreign body or fibrin deposit (32653)
2710 = Thoracoscopy, surgical; with control of traumatic hemorrhage (32654)
2720 = Thoracoscopy, surgical; with excision-plication of bullae, including any pleural procedure (32655)
2730 = Thoracoscopy, surgical; with parietal pleurectomy (32656)
2740 = Thoracoscopy, surgical; with wedge resection of lung, single or multiple (32657)
2750 = Thoracoscopy, surgical; with removal of clot or foreign body from pericardial sac (32658)
2760 = Thoracoscopy, surgical; with creation of pericardial window or partial resection of pericardial sac for drainage (32659)
2770 = Thoracoscopy, surgical; with total

pericardiectomy (32660)
2780 = Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass (32661)
2790 = Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass (32662)
2800 = Thoracoscopy, surgical; with lobectomy, total or segmental (32663)
2810 = Thoracoscopy, surgical; with thoracic sympathectomy (32664)
2820 = Thoracoscopy, surgical; with esophagomyotomy (Heller type) (32665)
2830 = Insertion indwelling tunneled pleural catheter (32550)
2840 = Repair lung hernia through chest wall (32800)
2850 = Closure of chest wall following open flap drainage for empyema (Clagett type procedure) (32810)
2860 = Open closure of major bronchial fistula (32815)
2870 = Major reconstruction, chest wall (posttraumatic) (32820)
2880 = Thoracoplasty with closure of bronchopleural fistula (32906)
2890 = Total lung lavage (for alveolar protenosis) (32997)
2900 = Radio-frequency ablation (RFA) lung tumor (32998)
2910 = Single lung transplant (32851)
2920 = Single lung transplant with CPB (32852)
2930 = Double lung transplant (32853)
2940 = Double lung transplant with CPB (32854)
2950 = Unlisted procedure, lung (32999)
2960 = Tracheobronchoscopy through established tracheostomy incision (31615)
2970 = Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (31620)
2980 = Bronchoscopy, diagnostic, with or without cell washing (31622)
2990 = Bronchoscopy, with brushing or protected brushings (31623)
3000 = Bronchoscopy, with bronchial alveolar lavage (BAL) (31624)
3010 = Bronchoscopy, with bronchial or endobronchial biopsy(s), single or multiple sites (31625)
3020 = Bronchoscopy, with transbronchial lung biopsy(s), single lobe (31628)
3030 = Bronchoscopy, with transbronchial needle aspiration biopsy(s) (31629)
3040 = Bronchoscopy, with tracheal/bronchial dilation or closed reduction of fracture (31630)
3050 = Bronchoscopy, with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required) (31631)
3060 = Bronchoscopy, with transbronchial lung biopsy(s), each additional lobe (31632)
3070 = Bronchoscopy, with transbronchial needle aspiration biopsy(s), each additional lobe (31633)
3080 = Bronchoscopy, with removal of foreign body (31635)
3090 = Bronchoscopy, with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus (31636)
3100 = Bronchoscopy, each additional major bronchus stented (31637)
3110 = Bronchoscopy, with revision of tracheal or bronchial stent inserted at previous session (31638)
3120 = Bronchoscopy, with excision of tumor (31640)
3130 = Bronchoscopy, with destruction of tumor or relief of stenosis by any method other than excision (e.g., laser therapy) (31641)
3140 = Bronchoscopy, with placement of catheter(s) for intracavitary radioelement application (31643)
3150 = Bronchoscopy, with therapeutic aspiration of

tracheobronchial tree, initial (V2_0_17, drainage of lung abscess) (31645)
3160 = Bronchoscopy, with therapeutic aspiration of tracheobronchial tree, subsequent (31646)
3170 = Thoracic lymphadenectomy, regional, including mediastinal and peritracheal nodes (38746)
3180 = Mediastinotomy with exploration or biopsy; cervical approach (39000)
3190 = Mediastinotomy with exploration or biopsy; transthoracic approach (39010)
3200 = Excision of mediastinal cyst (39200)
3210 = Excision of mediastinal tumor (39220)
3220 = Mediastinoscopy, with or without biopsy (39400)
3230 = Unlisted procedure, mediastinum (39499)
3240 = Repair, laceration of diaphragm, any approach (39501)
3250 = Repair of paraesophageal hiatus hernia, transabdominal with or without fundoplasty (39502)
3260 = Repair, diaphragmatic hernia (other than neonatal), traumatic; acute (39540)
3270 = Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic (39541)
3280 = Imbrication (i.e., plication) of diaphragm (39545)
3290 = Resection, diaphragm; with simple repair (e.g., primary suture) (39560)
3300 = Resection, diaphragm; with complex repair (e.g., prosthetic material, local muscle flap) (39561)
3310 = Unlisted procedure, diaphragm (39599)
3320 = Transhiatal-Total esophagectomy, without thoracotomy, with cervical esophagogastrostomy (43107)
3330 = Three hole-Total esophagectomy with thoracotomy; with cervical esophagogastrostomy (43112)
3340 = Ivor Lewis-Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision (43117)
3350 = Thoracoabdominal-Partial esophagectomy, thoracoabdominal approach (43122)
3360 = Minimally invasive esophagectomy, Ivor Lewis approach (43XXX)
3370 = Minimally invasive esophagectomy, Abdominal and neck approach (43XXX)
3380 = Total esophagectomy without thoracotomy; with colon interposition or small intestine reconstruction (43108)
3390 = Total esophagectomy with thoracotomy; with colon interposition or small intestine reconstruction (43113)
3400 = Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis (43116)
3410 = Partial esophagectomy, with thoracotomy and separate abdominal incision with colon interposition or small intestine (43118)
3420 = Partial esophagectomy, distal two-thirds, with thoracotomy only (43121)
3430 = Partial esophagectomy, thoracoabdominal with colon interposition or small intestine (43123)
3440 = Total or partial esophagectomy, without reconstruction with cervical esophagostomy (43124)
3450 = Cricopharyngeal myotomy (43030)
3460 = Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach (43130)
3470 = Diverticulectomy of hypopharynx or esophagus, with or without myotomy; thoracic approach (43135)
3480 = Laparoscopy, surgical, esophagogastric fundoplasty (e.g., Nissen, Toupet procedures) (43280)
3490 = Laparoscopic esophageal myotomy (432XX)

3500 = Esophagogastric fundoplasty (e.g., Nissen, Belsey IV, Hill procedures) (43324)
3510 = Esophagogastric fundoplasty; with gastroplasty (e.g., Collis) (43326)
3520 = Esophagomyotomy (Heller type); thoracic approach (43331)
3530 = Esophagostomy, fistulization of esophagus, external; cervical approach (43352)
3540 = Gastrointestinal reconstruction for previous esophagectomy with stomach (43360)
3550 = Gastrointestinal reconstruction for previous esophagectomy with colon interposition or small intestine (43361)
3560 = Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation (43405)
3570 = Suture of esophageal wound or injury; cervical approach (43410)
3580 = Suture of esophageal wound or injury; transthoracic or transabdominal approach (43415)
3590 = Closure of esophagostomy or fistula; cervical approach (43420)
3600 = Free jejunum transfer with microvascular anastomosis (43496)
3610 = Total gastrectomy with esophagoenterostomy (43620)
3620 = Total gastrectomy with Roux-en-Y reconstruction (43621)
3630 = Unlisted procedure, esophagus (43499)
3640 = Esophagoscopy (43200)
3650 = Esophagoscopy with biopsy (43202)
3660 = Esophagoscopy with removal of foreign body (43215)
3670 = Esophagoscopy with insertion of stent (43219)
3680 = Esophagoscopy with balloon dilation (43220)
3690 = Esophagoscopy with insertion of guide wire followed by dilation over guide wire (43226)
3700 = Esophagoscopy with ablation of tumor (43228)
3710 = Esophagoscopy with endoscopic ultrasound examination (EUS) (43231)
3720 = Esophagoscopy with transendoscopic ultrasound-guided fine needle aspiration (43232)
3730 = Upper gastrointestinal endoscopy, diagnostic (43235)
3740 = Upper gastrointestinal endoscopy with endoscopic ultrasound examination limited to the esophagus (43237)
3750 = Upper gastrointestinal endoscopy with transendoscopic ultrasound-guided FNA (43238)
3760 = Upper gastrointestinal endoscopy with biopsy (43239)
3770 = Upper gastrointestinal endoscopy with dilation of gastric outlet for obstruction (43245)
3780 = Upper gastrointestinal endoscopy with directed placement of percutaneous gastrostomy tube (43246)
3790 = Upper gastrointestinal endoscopy with removal of foreign body (43247)
3800 = Upper gastrointestinal endoscopy with insertion of guide wire followed by dilation of esophagus (43248)
3810 = Upper gastrointestinal endoscopy with balloon dilation of esophagus (43249)
3820 = Upper gastrointestinal endoscopy with transendoscopic stent placement (43256)
3830 = Upper gastrointestinal endoscopy with ablation of tumor (43258)
3840 = Thymectomy, transcervical approach (60520)
3850 = Thymectomy, transthoracic approach (60521)
3860 = Thymectomy, transthoracic approach, with radical mediastinal dissection (60522)
3870 = VATS thymectomy (605XX)
3880 = Partial laryngectomy (31370)
3890 = Ligation thoracic duct (38381)
3900 = Intraoperative jejunostomy (44015)

3910 = Omental flap (49904)
3920 = Transthoracic thyroidectomy (60270)
3930 = Removal substernal thyroid, cervical approach (60271)
3940 = Tube pericardiostomy (33015)
3950 = Pericardial window (33025)
3960 = SVC resection and reconstruction (34502)
3970 = Other (XXXX)

ValidData	Chest Wall Biopsy; Rib Resection (single); First/Cervical Rib Resection; Chest Wall Resection; Chest Wall Reconstruction; Thoracoplasty; Pectus Repair; Sternectomy, complete; Sternectomy, partial; Muscle Flap; Other Chest Wall Repair; Mediastinal LN Biopsy; Mediastinoscopy; Anterior Mediastinotomy; Extended Cervical Mediastinoscopy; Mediastinal Lymph Node Dissection; Mediastinal Lymph Node Sampling; Biopsy, Mediastinal Mass; Resection, Mediastinal Mass; Thymectomy; Sympathectomy; Thoracic duct ligation; Other Mediastinal/Neck procedure; Flexible Bronchoscopy; Rigid Bronchoscopy; Removal of Foreign Body (Tracheobronchial); Endobronchial Ablation, Laser / PDT; Endobronchial Ablation, Mechanical; Tracheal/Bronchial Stent; Tracheostomy; Tracheal Repair; Tracheal Stricture Resection; Tracheal Tumor Resection; Carinal Resection (no lung resection); Bronchotomy; Bronchial Repair; Bronchoplasty; TE Fistula Repair; Other Tracheobroncial procedure; Wedge Resection, single; Wedge Resection, multiple; Segmentectomy; Lobectomy; Sleeve Lobectomy; Bilobectomy; Pneumonectomy, standard; Pneumonectomy, Carinal; Completion pneumonectomy; Extrapleural pneumonectomy; Pneumonectomy, intrapericardial; Lung Volume Reduction; Bullectomy / repair; Hydatid Cyst Resection; Single Lung Transplant; Double Lung Transplant; Lung Donor Harvest; Other Lung procedure; Esophagoscopy, flexible; Esophagoscopy, rigid;Removal of Foreign Body (Esophagogastric); Dilation of Esophagus; Esophageal Tumor Ablation, Laser / PDT; Stent Placement; Cervical esophagostomy; Anterior Thoracic Esophagostomy; Zenker's Diverticulum Repair; Myotocomy, cricopharyngeal; Myotomy, esophageal (long); Myotomy, cardia (short); Resection, intrathoracic diverticulum; Resection, esophagus (esophagectomy); Resection, esophageal wall leasion; Fundoplication, circumferentia; Fundoplication, partial; Gastroplasty; Pyloroplasty; Pyloromyotomy; Gastrectomy; Gastrostomy; Jejunostomy; Conduit, gastric; Conduit, colon; Conduit, jejunum; Conduit, other; Anastomosis, neck; Anastomosis, Chest; Other Esophageal procedure; Other GI procedure; Pericardial Window; Pericardiectomy; Repair Cardiac Laceration; Other Pericardial Procedure; Repair / Reconstruction, thoracic aorta; Repair / Reconstruction, abd aorta; Repair / Reconstruction, SVC; Repair / Reconstruction, IVC; Repair / Reconstruction, pulmonary artery; Repair / Reconstruction, pulmonary vein(s); Repair / Reconstruction, left atrium; Repair / Reconstruction, Subclavian Artery; Cardiopulmonary Bypass; Other Cardiac procedure; Plication of Diaphragm; Diaphragmatic Hernia Repair, acute; Diaphragmatic Hernia Repair, chronic; Resection of Diaphragm; Reconstruction of Diaphragm; Other Diaphragm procedure; Pleural Drainage Procedure - Open; Pleural Drainage Procedure - Closed; Pleural Biopsy; Pleurodesis; Pleurectomy; Decortication; Clagett Procedure; Other Pleural procedure; Fibrin Glue; Pericardial Strips; Lung Sealant; Pleural Tent; Other Air Leak Control Measures	Muscle flap, neck (15732); Muscle flap; trunk (i.e., intercostal, pectoralis or serratus muscle) (15734); Excision of chest wall tumor including ribs (19260); Excision of chest wall tumor involving ribs, with reconstruction (19271); Excision tumor, soft tissue of neck or thorax; subcutaneous (21555); Excision tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular (21556); Radical resection of tumor (e.g., malignant neoplasm), soft tissue of neck or thorax (21557); Excision of rib, partial (21600); Excision first and/or cervical rib (21615); Excision first and/or cervical rib; with sympathectomy (21616); Radical resection of sternum (21630); Radical resection of sternum; with mediastinal lymphadenectomy (21632); Hyoid myotomy and suspension (21685); Division of scalenus anticus; without resection of cervical rib (21700); Division of scalenus anticus; with resection of cervical rib (21705); Reconstructive repair of pectus excavatum or carinatum; open (21740); Reconstructive repair of pectus, minimally invasive approach (Nuss procedure), without thoracoscopy (21742); Reconstructive repair of pectus, minimally invasive approach (Nuss procedure), with thoracoscopy (21743); Open treatment of sternum fracture with or without skeletal fixation (21825); Unlisted procedure, neck or thorax (21899); Tracheoplasty; cervical (31750); Tracheoplasty; intrathoracic (31760); Carinal reconstruction (31766); Bronchoplasty; excision stenosis and anastomosis (31775); Excision tracheal stenosis and anastomosis; cervical (31780); Excision tracheal stenosis and anastomosis; cervicothoracic (31781); Excision of tracheal tumor or carcinoma; cervical (31785); Excision of tracheal tumor or carcinoma; thoracic (31786); Suture of tracheal wound or injury; cervical (31800); Suture of tracheal wound or injury; intrathoracic (31805); Unlisted procedure, trachea, bronchi (31899); Thoracostomy; with rib resection for empyema (32035); Thoracostomy; with open flap drainage for empyema (32036); Thoracotomy, limited, for biopsy of lung or pleura (i.e.; open lung biopsy) (32095); Thoracotomy, major; with exploration and biopsy (32100); Thoracotomy, major; with control of traumatic hemorrhage and/or repair of lung tear (32110); Thoracotomy, major; for postoperative complications (32120); Thoracotomy, major; with cyst(s) removal, with or without a pleural procedure (32140); Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure (32141); Thoracotomy, major; with removal of intrapleural foreign body or hematoma (32150); Thoracotomy with cardiac massage (32160); Pleural scarification for repeat pneumothorax (32215); Decortication, pulmonary, total (32220); Decortication, pulmonary, partial (32225); Pleurectomy, parietal (32310); Decortication and parietal pleurectomy (32320); Biopsy, pleura; open (32402); Removal of lung, total pneumonectomy; (32440); Removal of lung, sleeve (carinal) pneumonectomy (32442); Removal of lung, total pneumonectomy; extrapleural (32445); Removal of lung, single lobe (lobectomy) (32480); Removal of lung, two lobes (bilobectomy) (32482); Removal of lung, single segment (segmentectomy) (32484); Removal of lung, sleeve lobectomy (32486); Removal of lung, completion pneumonectomy (32488); Removal of lung, excision-plication of emphysematous lung(s) for lung volume reduction (LVRS) (32491); Removal of lung, wedge resection, single or multiple (32500); Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (32501); Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall

resection, without chest wall reconstruction(s) (32503); Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, with chest wall reconstruction (32504); Extrapleural enucleation of empyema (empyemectomy) (32540); Thoracoscopy, diagnostic lungs and pleural space, without biopsy (32601); Thoracoscopy, diagnostic lungs and pleural space, with biopsy (32602); Thoracoscopy, diagnostic pericardial sac, without biopsy (32603); Thoracoscopy, diagnostic pericardial sac, with biopsy (32604); Thoracoscopy, diagnostic mediastinal space, without biopsy (32605); Thoracoscopy, diagnostic; mediastinal space, with biopsy (32606); Thoracoscopy, surgical; with pleurodesis (e.g., mechanical or chemical) (32650); Thoracoscopy, surgical; with partial pulmonary decortication (32651); Thoracoscopy, surgical; with total pulmonary decortication (32652); Thoracoscopy, surgical; with removal of intrapleural foreign body or fibrin deposit (32653); Thoracoscopy, surgical; with control of traumatic hemorrhage (32654); Thoracoscopy, surgical; with excision-plication of bullae, including any pleural procedure (32655); Thoracoscopy, surgical; with parietal pleurectomy (32656); Thoracoscopy, surgical; with wedge resection of lung, single or multiple (32657); Thoracoscopy, surgical; with removal of clot or foreign body from pericardial sac (32658); Thoracoscopy, surgical; with creation of pericardial window or partial resection of pericardial sac for drainage (32659); Thoracoscopy, surgical; with total pericardiectomy (32660); Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass (32661); Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass (32662); Thoracoscopy, surgical; with lobectomy, total or segmental (32663); Thoracoscopy, surgical; with thoracic sympathectomy (32664); Thoracoscopy, surgical; with esophagomyotomy (Heller type) (32665); Insertion indwelling tunneled pleural catheter (32550); Repair lung hernia through chest wall (32800); Closure of chest wall following open flap drainage for empyema (Clagett type procedure) (32810); Open closure of major bronchial fistula (32815); Major reconstruction, chest wall (posttraumatic) (32820); Thoracoplasty with closure of bronchopleural fistula (32906); Total lung lavage (for alveolar protenosis) (32997); Radio-frequency ablation (RFA) lung tumor (32998); Single lung transplant (32851); Single lung transplant with CPB (32852); Double lung transplant (32853); Double lung transplant with CPB (32854); Unlisted procedure, lung (32999); Tracheobronchoscopy through established tracheostomy incision (31615); Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (31620); Bronchoscopy, diagnostic, with or without cell washing (31622); Bronchoscopy, with brushing or protected brushings (31623); Bronchoscopy, with bronchial alveolar lavage (BAL) (31624); Bronchoscopy, with bronchial or endobronchial biopsy(s), single or multiple sites (31625); Bronchoscopy, with transbronchial lung biopsy(s), single lobe (31628); Bronchoscopy, with transbronchial needle aspiration biopsy(s) (31629); Bronchoscopy, with tracheal/bronchial dilation or closed reduction of fracture (31630); Bronchoscopy, with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required) (31631); Bronchoscopy, with transbronchial lung biopsy(s), each additional lobe (31632); Bronchoscopy, with transbronchial needle aspiration biopsy(s), each additional lobe (31633); Bronchoscopy, with removal of foreign body (31635); Bronchoscopy, with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus

(31636); Bronchoscopy, each additional major bronchus stented (31637); Bronchoscopy, with revision of tracheal or bronchial stent inserted at previous session (31638); Bronchoscopy, with excision of tumor (31640); Bronchoscopy, with destruction of tumor or relief of stenosis by any method other than excision (e.g., laser therapy) (31641); Bronchoscopy, with placement of catheter(s) for intracavitary radioelement application (31643); Bronchoscopy, with therapeutic aspiration of tracheobronchial tree, initial (V2_0_17, drainage of lung abscess) (31645); Bronchoscopy, with therapeutic aspiration of tracheobronchial tree, subsequent (31646); Thoracic lymphadenectomy, regional, including mediastinal and peritracheal nodes (38746); Mediastinotomy with exploration or biopsy; cervical approach (39000); Mediastinotomy with exploration or biopsy; transthoracic approach (39010); Excision of mediastinal cyst (39200); Excision of mediastinal tumor (39220); Mediastinoscopy, with or without biopsy (39400); Unlisted procedure, mediastinum (39499); Repair, laceration of diaphragm, any approach (39501); Repair of paraesophageal hiatus hernia, transabdominal with or without fundoplasty (39502); Repair, diaphragmatic hernia (other than neonatal), traumatic; acute (39540); Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic (39541); Imbrication (i.e., plication) of diaphragm (39545); Resection, diaphragm; with simple repair (e.g., primary suture) (39560); Resection, diaphragm; with complex repair (e.g., prosthetic material, local muscle flap) (39561); Unlisted procedure, diaphragm (39599); Transhiatal-Total esophagectomy, without thoracotomy, with cervical esophagogastrostomy (43107); Three hole-Total esophagectomy with thoracotomy; with cervical esophagogastrostomy (43112); Ivor Lewis-Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision (43117); Thoracoabdominal-Partial esophagectomy, thoracoabdominal approach (43122); Minimally invasive esophagectomy, Ivor Lewis approach (43XXX); Minimally invasive esophagectomy, Abdominal and neck approach (43XXX); Total esophagectomy without thoracotomy; with colon interposition or small intestine reconstruction (43108); Total esophagectomy with thoracotomy; with colon interposition or small intestine reconstruction (43113); Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis (43116); Partial esophagectomy, with thoracotomy and separate abdominal incision with colon interposition or small intestine (43118); Partial esophagectomy, distal two-thirds, with thoracotomy only (43121); Partial esophagectomy, thoracoabdominal with colon interposition or small intestine (43123); Total or partial esophagectomy, without reconstruction with cervical esophagostomy (43124); Cricopharyngeal myotomy (43030); Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach (43130); Diverticulectomy of hypopharynx or esophagus, with or without myotomy; thoracic approach (43135); Laparoscopy, surgical, esophagogastric fundoplasty (e.g., Nissen, Toupet procedures) (43280); Laparoscopic esophageal myotomy (432XX); Esophagogastric fundoplasty (e.g., Nissen, Belsey IV, Hill procedures) (43324); Esophagogastric fundoplasty; with gastroplasty (e.g., Collis) (43326); Esophagomyotomy (Heller type); thoracic approach (43331); Esophagostomy, fistulization of esophagus, external; cervical approach (43352); Gastrointestinal reconstruction for previous esophagectomy with stomach (43360);

		Gastrointestinal reconstruction for previous esophagectomy with colon interposition or small intestine (43361); Ligation or stapling at gastroesophageal junction for pre-existing esophageal perforation (43405); Suture of esophageal wound or injury; cervical approach (43410); Suture of esophageal wound or injury; transthoracic or transabdominal approach (43415); Closure of esophagostomy or fistula; cervical approach (43420); Free jejunum transfer with microvascular anastomosis (43496); Total gastrectomy with esophagoenterostomy (43620); Total gastrectomy with Roux-en-Y reconstruction (43621); Unlisted procedure, esophagus (43499); Esophagoscopy (43200); Esophagoscopy with biopsy (43202); Esophagoscopy with removal of foreign body (43215); Esophagoscopy with insertion of stent (43219); Esophagoscopy with balloon dilation (43220); Esophagoscopy with insertion of guide wire followed by dilation over guide wire (43226); Esophagoscopy with ablation of tumor (43228); Esophagoscopy with endoscopic ultrasound examination (EUS) (43231); Esophagoscopy with transendoscopic ultrasound-guided fine needle aspiration (43232); Upper gastrointestinal endoscopy, diagnostic (43235); Upper gastrointestinal endoscopy with endoscopic ultrasound examination limited to the esophagus (43237); Upper gastrointestinal endoscopy with transendoscopic ultrasound-guided FNA (43238); Upper gastrointestinal endoscopy with biopsy (43239); Upper gastrointestinal endoscopy with dilation of gastric outlet for obstruction (43245); Upper gastrointestinal endoscopy with directed placement of percutaneous gastrostomy tube (43246); Upper gastrointestinal endoscopy with removal of foreign body (43247); Upper gastrointestinal endoscopy with insertion of guide wire followed by dilation of esophagus (43248); Upper gastrointestinal endoscopy with balloon dilation of esophagus (43249); Upper gastrointestinal endoscopy with transendoscopic stent placement (43256); Upper gastrointestinal endoscopy with ablation of tumor (43258); Thymectomy, transcervical approach (60520); Thymectomy, transthoracic approach (60521); Thymectomy, transthoracic approach, with radical mediastinal dissection (60522); VATS thymectomy (605XX); Partial laryngectomy (31370); Ligation thoracic duct (38381); Intraoperative jejunostomy (44015); Omental flap (49904); Transthoracic thyroidectomy (60270); Removal substernal thyroid, cervical approach (60271); Tube pericardiostomy (33015); Pericardial window (33025); SVC resection and reconstruction (34502); Other (XXXX)
RequiredForRecordInclusion	No	Yes

1280

Primary Procedure

Detail changed:	Changed from:	Changed to:
Definition	Indicate whehter this is the primary surgical procedure.	Indicate whether this is the primary surgical procedure.

1290

Approach - Thoracoscopy

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1300 **Approach - Thoracotomy**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1310 **Approach - Thoracoabdominal**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

1320 **Approach - Median Sternotomy**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1330 **Approach - Partial Sternotomy**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

1340 **Approach - Transverse Sternotomy**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1350 **Approach - Laparotomy**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1360 **Approach - Laparoscopy**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1370 **Approach - Cervical**

Detail changed:	Changed from:	Changed to:

Core	Yes	No
Harvest	Yes	No

1380 **Approach - Subxyphoid**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1390 **Approach - Other Approach**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1400 **Lung Resection Performed**

Detail changed:	Changed from:	Changed to:
HarvestCoding	<Blank>	1 = Yes 2 = No
Format	<Blank>	Text (categorical values specified by STS)
RequiredForRecordInclusion	<Blank>	No
DataSource	<Blank>	User
Harvest	<Blank>	Yes
TableName	<Blank>	Operations
FieldName	<Blank>	Lung Resection Performed
ShortName	<Blank>	LungResect
Core	<Blank>	Yes
Definition	<Blank>	Indicate whether a lung resection procedure was performed.
ValidData	<Blank>	Yes; No

1410 **Laterality**

Detail changed:	Changed from:	Changed to:
Definition	Indicate the laterality of the primary surgical procedure.	For lung resections only, indicate the laterality of the primary surgical procedure.
ParentField	<Blank>	Lung Resection Performed
HarvestCoding	1 = Right 2 = Left 3 = Both	1 = Right 2 = Left 3 = Bilateral (i.e., bilateral VATS) 4 = Not applicable (i.e., median sternotomy, clam shell incisions)

ValidData	Right; Left; Both	Right; Left; Bilateral (i.e., bilateral VATS); Not applicable (i.e., median sternotomy, clam shell incisions)
ParentValue	<Blank>	Yes

1420 **Patient Disposition**

Detail changed:	Changed from:	Changed to:
TableName	<Blank>	Operations
Format	<Blank>	Text (categorical values specified by STS)
ParentField	<Blank>	Admission Status
RequiredForRecordInclusion	<Blank>	Yes
Core	<Blank>	Yes
Harvest	<Blank>	Yes
ParentValue	<Blank>	Inpatient
HarvestCoding	<Blank>	1 = ICU 2 = Intermediate Care Unit 3 = Regular floor bed 4 = Not applicable (expired in OR)
FieldName	<Blank>	Patient Disposition
ValidData	<Blank>	ICU ; Intermediate Care Unit; Regular floor bed; Not applicable (expired in OR)
DataSource	<Blank>	User
Definition	<Blank>	Indicate the location to where the patient was transferred after leaving the OR.
ShortName	<Blank>	PatDisp

1430 **Total Number Of ICU Days**

Detail changed:	Changed from:	Changed to:
ShortName	<Blank>	ICUDays
Definition	<Blank>	Indicate the TOTAL number of days patient spent in the ICU during this entire admission (include any unplanned return to ICU days in total number). Note: <24 hours= 1 day.
Harvest	<Blank>	Yes
Core	<Blank>	Yes
ParentField	<Blank>	Admission Status
DataSource	<Blank>	User
TableName	<Blank>	Operations

UsualRange	<Blank>	0 - 30
FieldName	<Blank>	Total Number Of ICU Days
Format	<Blank>	Integer
ValidData	<Blank>	0 - 200
ParentValue	<Blank>	Inpatient
RequiredForRecordInclusion	<Blank>	No

1440 **Clinical Staging**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

1450 **Clinical stage T**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

1460 **Clinical stage N**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1470 **Clinical stage M**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

1480 **Clinical stage Ma, b**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

1490 **Lung Cancer**

Detail changed:	Changed from:	Changed to:
Harvest	<Blank>	Yes
Core	<Blank>	Yes

TableName	<Blank>	Operations
ShortName	<Blank>	LungCancer
HarvestCoding	<Blank>	1 = Yes 2 = No
RequiredForRecordInclusion	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)
DataSource	<Blank>	User
FieldName	<Blank>	Lung Cancer
Definition	<Blank>	Indicate whether the patient has lung cancer documented with one of the following Categories of Disease: 150 = Lung cancer, main bronchus, carina-162.2 160 = Lung cancer, upper lobe-162.3, 170 = Lung cancer, middle lobe-162.4 180 = Lung cancer, lower lobe-162.5 190 = Lung cancer, location unspecified-162.9 AND, was treated with one of the following Procedures: 2450 = Removal of lung, total pneumonectomy; (32440) 2480 = Removal of lung, single lobe (lobectomy) (32480) 2490 = Removal of lung, two lobes (bilobectomy) (32482) 2500 = Removal of lung, single segment (segmentectomy) (32484) 2510 = Removal of lung, sleeve lobectomy (32486) 2520 = Removal of lung, completion pneumonectomy (32488) 2540 = Removal of lung, wedge resection, single or multiple (32500) 2560 = Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, without chest wall reconstruction(s) (32503) 2570 = Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, with chest wall reconstruction (32504) 2720 = Thoracoscopy, surgical; with wedge resection of lung, single or multiple (32657) 2780 = Thoracoscopy, surgical; with lobectomy, total or segmental (32663).
ValidData	<Blank>	Yes; No

1500 **Esophageal Cancer**

Detail changed:	Changed from:	Changed to:
FieldName	<Blank>	Esophageal Cancer
TableName	<Blank>	Operations
DataSource	<Blank>	User
HarvestCoding	<Blank>	1 = Yes 2 = No

RequiredForRecordInclusion	<Blank>	Yes
Definition	<Blank>	Indicate whether the patient has esophageal cancer documented with one of the following Categories of Disease: 690 = Esophageal cancer-lower third-150.5 700 = Esophageal cancer, middle third-150.4 710 = Esophageal cancer, upper third-150.3 720 = Esophageal cancer, esophagogastric junction (cardia)-151.0 AND was treated with one of the following Procedures: 3280 = Transhiatal-Total esophagectomy, without thoracotomy, with cervical esophagogastrostomy (43107) 3290 = Three hole-Total esophagectomy with thoracotomy; with cervical esophagogastrostomy (43112) 3300 = Ivor Lewis-Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision (43117) 3310 = Thoracoabdominal-Partial esophagectomy, thoracoabdominal approach (43122) 3320 = Minimally invasive esophagectomy, Ivor Lewis approach (43XXX) 3330 = Minimally invasive esophagectomy, Abdominal and neck approach (43XXX) 3340 = Total esophagectomy without thoracotomy; with colon interposition or small intestine reconstruction (43108) 3350 = Total esophagectomy with thoracotomy; with colon interposition or small intestine reconstruction (43113) 3360 = Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis (43116) 3370 = Partial esophagectomy, with thoracotomy and separate abdominal incision with colon interposition or small intestine (43118) 3380 = Partial esophagectomy, distal two-thirds, with thoracotomy only (43121) 3390 = Partial esophagectomy, thoracoabdominal with colon interposition or small intestine (43123)
Format	<Blank>	Text (categorical values specified by STS)
ShortName	<Blank>	EsophCancer
ValidData	<Blank>	Yes; No
Harvest	<Blank>	Yes
Core	<Blank>	Yes

1510 **Clinical Staging - Lung Cancer - T**

Detail changed:	Changed from:	Changed to:
ParentValue	<Blank>	Yes
DataSource	<Blank>	User
Format	<Blank>	Text (categorical values specified by STS)
Harvest	<Blank>	Yes

Core	<Blank>	Yes
FieldName	<Blank>	Clinical Staging - Lung Cancer - T
ShortName	<Blank>	ClinStageLungT
ValidData	<Blank>	T1a (Tumor <= 2cm, surrounded by lung, not in the main bronchus); T1b (Tumor >2cm, <= 3cm, surrounded by lung, not in the main bronchus); T2a (Tumor > 3cm, <= 5 cm, or invades visceral pleura, involves main bronchus > 2 cm from carina, associated with atelectasis that extends to the hilum but not the entire lung); T2b (Tumor > 5 cm, <=7 cm, or invades visceral pleura, involves main bronchus > 2 cm from carina, associated with atelectasis that extends to the hilum but not the entire lung); T3 (Tumor > 7 cm or invasion of chest wall, diaphragm, phrenic nerve, mediastinal pleura, pericardium; or tumor in the main bronchus <= 2 cm from carina, or atelectasis of the entire lung, or separate tumor nodules in the same lobe); T4 (Tumor of any size that invades mediastinum, heart, great vessels, recurrent laryngeal nerve, esophagus, vertebral body, carina; separate tumor nodule in a different ipsilateral lobe)
Definition	<Blank>	Indicate the appropriate descriptor for the lung cancer primary tumor. Stage both non-small cell and small cell lung cancer the same. Clinical staging is based on the PREOPERATIVE ESTIMATED staging workup which may include CT scan, PET scan, endoscopic ultrasound, etc.
HarvestCoding	<Blank>	1 = T1a (Tumor <= 2cm, surrounded by lung, not in the main bronchus) 2 = T1b (Tumor >2cm, <= 3cm, surrounded by lung, not in the main bronchus) 3 = T2a (Tumor > 3cm, <= 5 cm, or invades visceral pleura, involves main bronchus > 2 cm from carina, associated with atelectasis that extends to the hilum but not the entire lung) 4 = T2b (Tumor > 5 cm, <=7 cm, or invades visceral pleura, involves main bronchus > 2 cm from carina, associated with atelectasis that extends to the hilum but not the entire lung) 5 = T3 (Tumor > 7 cm or invasion of chest wall, diaphragm, phrenic nerve, mediastinal pleura, pericardium; or tumor in the main bronchus <= 2 cm from carina, or atelectasis of the entire lung, or separate tumor nodules in the same lobe) 6 = T4 (Tumor of any size that invades mediastinum, heart, great vessels, recurrent laryngeal nerve, esophagus, vertebral body, carina; separate tumor nodule in a different ipsilateral lobe)
TableName	<Blank>	Operations
ParentField	<Blank>	Lung Cancer
RequiredForRecordInclusion	<Blank>	No

1520

Clinical Staging - Lung Cancer - N

Detail changed:	**Changed from:**	**Changed to:**
ShortName	<Blank>	ClinStageLungN

FieldName	<Blank>	Clinical Staging - Lung Cancer - N
Core	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)
HarvestCoding	<Blank>	1 = N0 (No nodal metastases) 2 = N1 (Nodal metastases to ipsilateral hilar or peribronchial nodes) 3 = N2 (Nodal metastases to ipsilateral mediastinal and/or subcarinal nodes) 4 = N3 (Nodal metastases to contralateral mediastinal, contralateral hilar, and either ipsilateral or contralateral scalene or supraclavicular nodes)
ParentValue	<Blank>	Yes
Definition	<Blank>	Indicate the appropriate descriptor for the lung cancer nodal metastases. Clinical staging is based on the PREOPERATIVE ESTIMATED staging workup which may include CT scan, PET scan, endoscopic ultrasound, etc.
DataSource	<Blank>	User
TableName	<Blank>	Operations
Harvest	<Blank>	Yes
RequiredForRecordInclusion	<Blank>	No
ParentField	<Blank>	Lung Cancer
ValidData	<Blank>	N0 (No nodal metastases); N1 (Nodal metastases to ipsilateral hilar or peribronchial nodes); N2 (Nodal metastases to ipsilateral mediastinal and/or subcarinal nodes); N3 (Nodal metastases to contralateral mediastinal, contralateral hilar, and either ipsilateral or contralateral scalene or supraclavicular nodes)

1530 **Clinical Staging - Lung Cancer - M**

Detail changed:	Changed from:	Changed to:
Definition	<Blank>	Indicate the appropriate descriptor for the lung cancer distant metastases. Clinical staging is based on the PREOPERATIVE ESTIMATED staging workup which may include CT scan, PET scan, endoscopic ultrasound, etc.
ParentField	<Blank>	Lung Cancer
Harvest	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)
ValidData	<Blank>	M0 (No distant metastases); M1a (Separate tumor nodule in a contralateral lobe, tumor with pleural nodules or malignant pleural or pericardial effusion); M1b (Distant metastases)
ShortName	<Blank>	ClinStageLungM

HarvestCoding	<Blank>	1 = M0 (No distant metastases) 2 = M1a (Separate tumor nodule in a contralateral lobe, tumor with pleural nodules or malignant pleural or pericardial effusion) 3 = M1b (Distant metastases)
RequiredForRecordInclusion	<Blank>	No
Core	<Blank>	Yes
ParentValue	<Blank>	Yes
FieldName	<Blank>	Clinical Staging - Lung Cancer - M
TableName	<Blank>	Operations
DataSource	<Blank>	User

1540 **Clinical Staging - Esophageal Cancer - T**

Detail changed:	**Changed from:**	**Changed to:**
Harvest	<Blank>	Yes
TableName	<Blank>	Operations
ShortName	<Blank>	ClinStageEsophT
Definition	<Blank>	Indicate the appropriate descriptor for the esophageal cancer primary tumor. Clinical staging is based on the PREOPERATIVE ESTIMATED staging workup which may include CT scan, PET scan, endoscopic ultrasound, etc.
HarvestCoding	<Blank>	1 = T0 (No evidence of tumor) 2 = Tis (High grade dysplasia-HGD) 3 = T1a (Tumor invades lamina propria or muscularis mucosae) 4 = T1b (Tumor invades submucosa) 5 = T2 (Tumor invades muscularis propria) 6 = T3 (Tumor invades adventitia) 7 = T4a (Tumor invades adjacent structures-pleura, pericardium, diaphragm) 8 = T4b (Tumor invades other adjacent structures)
Format	<Blank>	Text (categorical values specified by STS)
RequiredForRecordInclusion	<Blank>	No
DataSource	<Blank>	User
ValidData	<Blank>	T0 (No evidence of tumor); Tis (High grade dysplasia-HGD); T1a (Tumor invades lamina propria or muscularis mucosae); T1b (Tumor invades submucosa); T2 (Tumor invades muscularis propria); T3 (Tumor invades adventitia); T4a (Tumor invades adjacent structures-pleura, pericardium, diaphragm); T4b (Tumor invades other adjacent structures)
Core	<Blank>	Yes
ParentValue	<Blank>	Yes
ParentField	<Blank>	Esophageal Cancer

FieldName	<Blank>	Clinical Staging - Esophageal Cancer - T

1550 **Clinical Staging - Esophageal Cancer - N**

Detail changed:	Changed from:	Changed to:
DataSource	<Blank>	User
Core	<Blank>	Yes
ParentValue	<Blank>	Yes
Harvest	<Blank>	Yes
ParentField	<Blank>	Esophageal Cancer
HarvestCoding	<Blank>	1 = N0 (No nodal metastases) 2 = N1a (Nodal metastases to 1 or 2 nodes) 3 = N1b (Nodal metastases to 3 to 5 nodes) 4 = N2 (Nodal metastases to 6 to 9 nodes) 5 = N3 (Nodal metastases to 10 or more nodes)
Format	<Blank>	Text (categorical values specified by STS)
ShortName	<Blank>	ClinStageEsophN
Definition	<Blank>	Indicate the appropriate descriptor for the esophageal cancer regional lymph nodes. Clinical staging is based on the PREOPERATIVE ESTIMATED staging workup which may include CT scan, PET scan, endoscopic ultrasound, etc.
FieldName	<Blank>	Clinical Staging - Esophageal Cancer - N
ValidData	<Blank>	N0 (No nodal metastases); N1a (Nodal metastases to 1 or 2 nodes); N1b (Nodal metastases to 3 to 5 nodes); N2 (Nodal metastases to 6 to 9 nodes); N3 (Nodal metastases to 10 or more nodes)
RequiredForRecordInclusion	<Blank>	No
TableName	<Blank>	Operations

1560 **Clinical Staging - Esophageal Cancer - M**

Detail changed:	Changed from:	Changed to:
ValidData	<Blank>	M0 (No distant metastases); M1 (Distant metastases)
Format	<Blank>	Text (categorical values specified by STS)
FieldName	<Blank>	Clinical Staging - Esophageal Cancer - M
TableName	<Blank>	Operations
Definition	<Blank>	Indicate the appropriate descriptor for the esophageal cancer distant metasteasis. Clinical staging is based on the PREOPERATIVE ESTIMATED staging workup which may include CT scan, PET scan, endoscopic ultrasound, etc.

ParentField	<Blank>	Esophageal Cancer
ParentValue	<Blank>	Yes
Harvest	<Blank>	Yes
DataSource	<Blank>	User
RequiredForRecordInclusion	<Blank>	No
Core	<Blank>	Yes
ShortName	<Blank>	ClinStageEsophM
HarvestCoding	<Blank>	1 = M0 (No distant metastases) 2 = M1 (Distant metastases)

1570 **Clinical Staging - Esophageal Cancer - H**

Detail changed:	Changed from:	Changed to:
TableName	<Blank>	Operations
FieldName	<Blank>	Clinical Staging - Esophageal Cancer - H
RequiredForRecordInclusion	<Blank>	No
ShortName	<Blank>	ClinStageEsophH
Harvest	<Blank>	Yes
HarvestCoding	<Blank>	1 = H1 (Squamous carcinoma) 2 = H2 (Adenocarcinoma)
Definition	<Blank>	Indicate the appropriate descriptor for the esophageal cancer histopathologic type. Clinical staging is based on the PREOPERATIVE ESTIMATED staging workup which may include CT scan, PET scan, endoscopic ultrasound, etc.
ParentValue	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)
DataSource	<Blank>	User
Core	<Blank>	Yes
ValidData	<Blank>	H1 (Squamous carcinoma); H2 (Adenocarcinoma)
ParentField	<Blank>	Esophageal Cancer

1580 **Clinical Staging - Esophageal Cancer - G**

Detail changed:	Changed from:	Changed to:
Format	<Blank>	Text (categorical values specified by STS)

HarvestCoding	<Blank>	1 = GX (Grade cannot be assessed) 2 = G1 (Well differentiated) 3 = G2 (Moderately differentiated) 4 = G3 (Poorly differentiated) 5 = G4 (Undifferentiated)
ValidData	<Blank>	GX (Grade cannot be assessed); G1 (Well differentiated); G2 (Moderately differentiated); G3 (Poorly differentiated); G4 (Undifferentiated)
RequiredForRecordInclusion	<Blank>	No
Harvest	<Blank>	Yes
Core	<Blank>	Yes
FieldName	<Blank>	Clinical Staging - Esophageal Cancer - G
ParentValue	<Blank>	Yes
TableName	<Blank>	Operations
Definition	<Blank>	Indicate the appropriate descriptor for the esophageal cancer histologic grade. Clinical staging is based on the PREOPERATIVE ESTIMATED staging workup which may include CT scan, PET scan, endoscopic ultrasound, etc.
ParentField	<Blank>	Esophageal Cancer
ShortName	<Blank>	ClinStageEsophG
DataSource	<Blank>	User

1590 **Unexpected Return To The OR**

Detail changed:	Changed from:	Changed to:
ParentValue	<Blank>	"ICU", "Intermediate Care Unit" or "Regular floor bed"
DataSource	<Blank>	User
ShortName	<Blank>	ReturnOR
TableName	<Blank>	Operations
Format	<Blank>	Text (categorical values specified by STS)
Harvest	<Blank>	Yes
Definition	<Blank>	Indicate whether the patient was unexpectedly returned to the OR during this hospital visit.
ValidData	<Blank>	Yes; No
FieldName	<Blank>	Unexpected Return To The OR
Core	<Blank>	Yes
RequiredForRecordInclusion	<Blank>	No
ParentField	<Blank>	Patient Disposition

HarvestCoding	<Blank>	1 = Yes 2 = No

1600 **Reop For Bleeding**

Detail changed:	Changed from:	Changed to:
Definition	Indicate whether an operative reintervention was required for bleeding.	Indicate whether bleeding was the reason for returning to the OR.
FieldName	Bleeding requiring reoperation	Reop For Bleeding
ParentField	Postoperative Events Occurred	Unexpected Return To The OR

1610 **Postoperative Events Occurred**

Detail changed:	Changed from:	Changed to:
Definition	Indicate whether the patient experienced any postoperative events.	Indicate whether the patient experienced a postoperative event at any time during this hospital visit regardless of length of stay, and/or events that occur within 30 days of surgery if discharged from the hospital.
RequiredForRecordInclusion	No	Yes

1680 **Pneumothorax**

Detail changed:	Changed from:	Changed to:
ParentValue	<Blank>	Yes
ShortName	<Blank>	Pneumo
ValidData	<Blank>	Yes; No
Format	<Blank>	Text (categorical values specified by STS)
RequiredForRecordInclusion	<Blank>	No
Harvest	<Blank>	Yes
Definition	<Blank>	Indicate whether the patient experienced a postoperative pneumothorax requiring chest tube REinsertion.
ParentField	<Blank>	Postoperative Events Occurred
Core	<Blank>	Yes
TableName	<Blank>	Operations
DataSource	<Blank>	User
FieldName	<Blank>	Pneumothorax
HarvestCoding	<Blank>	1 = Yes 2 = No

1730 **Atrial Arrhythmia Requiring Treatment**

Detail changed:	Changed from:	Changed to:

Definition	Indicate whether the patient, in the post-operative period, experienced atrial fibrillation and/or atrial flutter that has been clinically documented or treated with any of the following treatment modalities: 1. ablation therapy 2. permanent pacemaker 3. pharmachological treatment 4. electrocardioversion Note: If patient has a preoperative history of atrial arrhythmia, then atrial arrhythmia would not be considered a postoperative event.	Indicate whether the patient had a new onset of atrial fibrillation/flutter (AF) requiring treatment. Does not include recurrence of AF which had been present preoperatively.

1740

Ventricular Arrhythmia Requiring Treatment

Detail changed:	Changed from:	Changed to:
Definition	Indicate whether the patient, in the post-operative period, experienced sustained ventricular tachycardia and/or ventricular fibrillation that has been clinically documented or treated with any of the following treatment modalities: 1. ablation therapy 2. AICD 3. permanent pacemaker 4. pharmachologic treatment 5. electrocardioversion	Indicate whether the patient, in the postoperative period, experienced sustained ventricular tachycardia and/or ventricular fibrillation that has been clinically documented and treated with any of the following treatment modalities: 1. ablation therapy 2. AICD 3. permanent pacemaker 4. pharmacologic treatment 5. cardioversion

1840

Blood Transfusion - Postop

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

1850

Postoperative Packed Red Blood Cells

Detail changed:	Changed from:	Changed to:
Core	<Blank>	Yes
DataSource	<Blank>	User
TableName	<Blank>	Operations
HarvestCoding	<Blank>	1 = Yes 2 = No
ValidData	<Blank>	Yes; No
RequiredForRecordInclusion	<Blank>	No
ParentField	<Blank>	Postoperative Events Occurred
ShortName	<Blank>	PostopPRBC
FieldName	<Blank>	Postoperative Packed Red Blood Cells
Harvest	<Blank>	Yes
Definition	<Blank>	Indicate whether the patient received packed Red Blood Cells (RBC) postoperatively.

ParentValue	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)

1860

Postoperative Packed Red Blood Cells - Units

Detail changed:	Changed from:	Changed to:
DataSource	<Blank>	User
Core	<Blank>	Yes
Harvest	<Blank>	Yes
ValidData	<Blank>	1 - 50
RequiredForRecordInclusion	<Blank>	No
ParentValue	<Blank>	Yes
UsualRange	<Blank>	1 - 10
Format	<Blank>	Integer
TableName	<Blank>	Operations
FieldName	<Blank>	Postoperative Packed Red Blood Cells - Units
Definition	<Blank>	Indicate the number of packed RBC units the patient received postoperatviely prior to discharge.
ParentField	<Blank>	Postoperative Packed Red Blood Cells
ShortName	<Blank>	PostopPRBCUnits

1870

Other hematology or bleeding event requiring treatment

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

1920

Other Infection Requiring IV Antibiotics

Detail changed:	Changed from:	Changed to:
RequiredForRecordInclusion	<Blank>	No
Harvest	<Blank>	Yes
TableName	<Blank>	Operations
ValidData	<Blank>	Yes; No
ShortName	<Blank>	OtherInfect
FieldName	<Blank>	Other Infection Requiring IV Antibiotics
HarvestCoding	<Blank>	1 = Yes 2 = No

Format	<Blank>	Text (categorical values specified by STS)
DataSource	<Blank>	User
ParentValue	<Blank>	Yes
Definition	<Blank>	Inidicate whether the patient experienced any other infection requiring IV antibiotics.
Core	<Blank>	Yes
ParentField	<Blank>	Postoperative Events Occurred

2000 **Other events requiring medical treatment**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

2020 **Unexpected Admission To ICU**

Detail changed:	Changed from:	Changed to:
ParentValue	<Blank>	Inpatient
TableName	<Blank>	Operations
Format	<Blank>	Text (categorical values specified by STS)
FieldName	<Blank>	Unexpected Admission To ICU
ParentField	<Blank>	Admission Status
ShortName	<Blank>	UnexpectAdmitICU
Definition	<Blank>	Indicate whether there was an unplanned transfer of the patient to the ICU due to deterioration in the condition of the patient.
DataSource	<Blank>	User
HarvestCoding	<Blank>	1 = Yes 2 = No
Core	<Blank>	Yes
ValidData	<Blank>	Yes; No
Harvest	<Blank>	Yes
RequiredForRecordInclusion	<Blank>	No

2030 **Discharge Date**

Detail changed:	Changed from:	Changed to:
RequiredForRecordInclusion	No	Yes
ParentValue	<Blank>	Inpatient

ParentField	<Blank>	Admission Status

2050 **Discharge Location**

Detail changed:	Changed from:	Changed to:
RequiredForRecordInclusion	<Blank>	No
ParentField	<Blank>	Discharge status
Definition	<Blank>	Indicate the location to where the patient was discharged.
Harvest	<Blank>	Yes
Core	<Blank>	Yes
DataSource	<Blank>	User
FieldName	<Blank>	Discharge Location
Format	<Blank>	Text (categorical values specified by STS)
TableName	<Blank>	Operations
ValidData	<Blank>	Home; Extended Care/Transitional Care Unit/Rehab; Other Hospital; Nursing Home; Hospice; Other
ShortName	<Blank>	DisLoctn
ParentValue	<Blank>	Alive
HarvestCoding	<Blank>	1 = Home 2 = Extended Care/Transitional Care Unit/Rehab 3 = Other Hospital 4 = Nursing Home 5 = Hospice 777 = Other

2060 **Readmit Within 30 Days Of Procedure**

Detail changed:	Changed from:	Changed to:
ValidData	<Blank>	Yes; No
HarvestCoding	<Blank>	1 = Yes 2 = No
Harvest	<Blank>	Yes
Definition	<Blank>	Indicate whether the patient was unexpectedly readmitted to ANY hospital within 30 days of the procedure for a reason related to this procedure.
ParentField	<Blank>	Discharge status
FieldName	<Blank>	Readmit Within 30 Days Of Procedure
DataSource	<Blank>	User
Core	<Blank>	Yes

ParentValue	<Blank>	Alive
TableName	<Blank>	Operations
RequiredForRecordInclusion	<Blank>	No
Format	<Blank>	Text (categorical values specified by STS)
ShortName	<Blank>	Readm30

2070 **Status 30 Days After Surgery**

Detail changed:	Changed from:	Changed to:
ParentField	<Blank>	Admission Status
FieldName	Status 30 days after surgery - alive or dead	Status 30 Days After Surgery
ParentValue	<Blank>	Inpatient
RequiredForRecordInclusion	No	Yes

2080 **Date Of Death**

Detail changed:	Changed from:	Changed to:
FieldName	Date of death if death occurs after discharge	Date Of Death
Definition	Indicate the date the patient was diagnosed clinically dead.	Indicate the date the patient died (even after discharge, if known).

2120 **Pathological Staging Applicable**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

2130 **Pathological stage T**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

2140 **Pathological stage N**

Detail changed:	Changed from:	Changed to:
Core	Yes	No
Harvest	Yes	No

2150 **Pathological stage M**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No

Core	Yes	No

2160 **Pathological stage Ma, b**

Detail changed:	Changed from:	Changed to:
Harvest	Yes	No
Core	Yes	No

2170 **Pathologic Staging - Lung Cancer - T**

Detail changed:	Changed from:	Changed to:
ValidData	<Blank>	T1a (Tumor <= 2cm, surrounded by lung, not in the main bronchus); T1b (Tumor >2cm, <= 3cm, suurrounded by lung, not in the main bronchus); T2a (Tumor > 3cm, <= 5 cm, or invades visceral pleura, involves main bronchus > 2 cm from carina, associated with atelectasis that extends to the hilum but not the entire lung); T2b (Tumor > 5 cm, <=7 cm, or invades visceral pleura, involves main bronchus > 2 cm from carina, associated with atelectasis that extends to the hilum but not the entire lung); T3 (Tumor > 7 cm or invasion of chest wall, diaphragm, phrenic nerve, mediastinal pleura, pericardium; or tumor in the main bronchus <= 2 cm from carina, or atelectasis of the entire lung, or separate tumor nodules in the same lobe); T4 (Tumor of any size that invades mediastinum, heart, great vessels, recurrent laryngeal nerve, esophagus, vertebral body, carina; separate tumor nodule in a different ipsilateral lobe)
Harvest	<Blank>	Yes
HarvestCoding	<Blank>	1 = T1a (Tumor <= 2cm, surrounded by lung, not in the main bronchus) 2 = T1b (Tumor >2cm, <= 3cm, suurrounded by lung, not in the main bronchus) 3 = T2a (Tumor > 3cm, <= 5 cm, or invades visceral pleura, involves main bronchus > 2 cm from carina, associated with atelectasis that extends to the hilum but not the entire lung) 4 = T2b (Tumor > 5 cm, <=7 cm, or invades visceral pleura, involves main bronchus > 2 cm from carina, associated with atelectasis that extends to the hilum but not the entire lung) 5 = T3 (Tumor > 7 cm or invasion of chest wall, diaphragm, phrenic nerve, mediastinal pleura, pericardium; or tumor in the main bronchus <= 2 cm from carina, or atelectasis of the entire lung, or separate tumor nodules in the same lobe) 6 = T4 (Tumor of any size that invades mediastinum, heart, great vessels, recurrent laryngeal nerve, esophagus, vertebral body, carina; separate tumor nodule in a different ipsilateral lobe)
ParentValue	<Blank>	Yes
TableName	<Blank>	Operations
ShortName	<Blank>	PathStageLungT
Format	<Blank>	Text (categorical values specified by STS)
ParentField	<Blank>	Lung Cancer

Core	<Blank>	Yes
FieldName	<Blank>	Pathologic Staging - Lung Cancer - T
Definition	<Blank>	Indicate the appropriate descriptor for the lung cancer primary tumor based on final pathology report.
RequiredForRecordInclusion	<Blank>	No
DataSource	<Blank>	User

2180 **Pathologic Staging - Lung Cancer - N**

Detail changed:	Changed from:	Changed to:
Format	<Blank>	Text (categorical values specified by STS)
ParentValue	<Blank>	Yes
HarvestCoding	<Blank>	1 = N0 (No nodal metastases) 2 = N1 (Nodal metastases to ipsilateral hilar or peribronchial nodes) 3 = N2 (Nodal metastases to ipsilateral mediastinal and/or subcarinal nodes) 4 = N3 (Nodal metastases to contralateral mediastinal, contralateral hilar, and either ipsilateral or contralateral scalene or supraclavicular nodes)
RequiredForRecordInclusion	<Blank>	No
ValidData	<Blank>	N0 (No nodal metastases); N1 (Nodal metastases to ipsilateral hilar or peribronchial nodes); N2 (Nodal metastases to ipsilateral mediastinal and/or subcarinal nodes); N3 (Nodal metastases to contralateral mediastinal, contralateral hilar, and either ipsilateral or contralateral scalene or supraclavicular nodes)
FieldName	<Blank>	Pathologic Staging - Lung Cancer - N
DataSource	<Blank>	User
TableName	<Blank>	Operations
ShortName	<Blank>	PathStageLungN
Core	<Blank>	Yes
Definition	<Blank>	Indicate the appropriate descriptor for the lung cancer regional nodes based on final pathology report.
ParentField	<Blank>	Lung Cancer
Harvest	<Blank>	Yes

2190 **Pathologic Staging - Lung Cancer - M**

Detail changed:	Changed from:	Changed to:
Harvest	<Blank>	Yes
ShortName	<Blank>	PathStageLungM
Core	<Blank>	Yes

Format	<Blank>	Text (categorical values specified by STS)
ParentValue	<Blank>	Yes
ValidData	<Blank>	M0 (No distant metastases); M1a (Separate tumor nodule in a contralateral lobe, tumor with pleural nodules or malignant pleural or pericardial effusion); M1b (Distant metastases)
HarvestCoding	<Blank>	1 = M0 (No distant metastases) 2 = M1a (Separate tumor nodule in a contralateral lobe, tumor with pleural nodules or malignant pleural or pericardial effusion) 3 = M1b (Distant metastases)
FieldName	<Blank>	Pathologic Staging - Lung Cancer - M
TableName	<Blank>	Operations
DataSource	<Blank>	User
Definition	<Blank>	Indicate the appropriate descriptor for the lung cancer metastases based on final pathology report.
ParentField	<Blank>	Lung Cancer
RequiredForRecordInclusion	<Blank>	No

2200 **Pathologic Staging - Esophageal Cancer - T**

Detail changed:	Changed from:	Changed to:
ShortName	<Blank>	PathStageEsophT
RequiredForRecordInclusion	<Blank>	No
DataSource	<Blank>	User
Harvest	<Blank>	Yes
HarvestCoding	<Blank>	1 = T0 (No evidence of tumor) 2 = Tis (High grade dysplasia-HGD) 3 = T1a (Tumor invades lamina propria or muscularis mucosae) 4 = T1b (Tumor invades submucosa) 5 = T2 (Tumor invades muscularis propria) 6 = T3 (Tumor invades adventitia) 7 = T4a (Tumor invades adjacent structures-pleura, pericardium, diaphragm) 8 = T4b (Tumor invades other adjacent structures)
Format	<Blank>	Text (categorical values specified by STS)
ParentValue	<Blank>	Yes
Core	<Blank>	Yes
Definition	<Blank>	Indicate the appropriate descriptor for the esophageal cancer primary tumor based on final pathology report.
TableName	<Blank>	Operations
FieldName	<Blank>	Pathologic Staging - Esophageal Cancer - T

Detail changed:	Changed from:	Changed to:
ValidData	<Blank>	T0 (No evidence of tumor); Tis (High grade dysplasia-HGD); T1a (Tumor invades lamina propria or muscularis mucosae); T1b (Tumor invades submucosa); T2 (Tumor invades muscularis propria); T3 (Tumor invades adventitia); T4a (Tumor invades adjacent structures-pleura, pericardium, diaphragm); T4b (Tumor invades other adjacent structures)
ParentField	<Blank>	Esophageal Cancer

2210

Pathologic Staging - Esophageal Cancer - N

Detail changed:	Changed from:	Changed to:
HarvestCoding	<Blank>	1 = N0 (No nodal metastases) 2 = N1a (Nodal metastases to 1 or 2 nodes) 3 = N1b (Nodal metastases to 3 to 5 nodes) 4 = N2 (Nodal metastases to 6 to 9 nodes) 5 = N3 (Nodal metastases to 10 or more nodes)
Format	<Blank>	Text (categorical values specified by STS)
ShortName	<Blank>	PathStageEsophN
Harvest	<Blank>	Yes
ValidData	<Blank>	N0 (No nodal metastases); N1a (Nodal metastases to 1 or 2 nodes); N1b (Nodal metastases to 3 to 5 nodes); N2 (Nodal metastases to 6 to 9 nodes); N3 (Nodal metastases to 10 or more nodes)
Definition	<Blank>	Indicate the appropriate descriptor for the esophageal cancer regional lymph nodes based on final pathology report.
FieldName	<Blank>	Pathologic Staging - Esophageal Cancer - N
ParentField	<Blank>	Esophageal Cancer
DataSource	<Blank>	User
Core	<Blank>	Yes
ParentValue	<Blank>	Yes
RequiredForRecordInclusion	<Blank>	No
TableName	<Blank>	Operations

2220

Pathologic Staging - Esophageal Cancer - M

Detail changed:	Changed from:	Changed to:
RequiredForRecordInclusion	<Blank>	No
FieldName	<Blank>	Pathologic Staging - Esophageal Cancer - M
TableName	<Blank>	Operations
ValidData	<Blank>	M0 (No distant metastases); M1 (Distant metastases)
HarvestCoding	<Blank>	1 = M0 (No distant metastases) 2 = M1 (Distant metastases)

ParentValue	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)
ShortName	<Blank>	PathStageEsophM
Core	<Blank>	Yes
Harvest	<Blank>	Yes
Definition	<Blank>	Indicate the appropriate descriptor for the esophageal cancer distant metastases based on final pathology report.
DataSource	<Blank>	User
ParentField	<Blank>	Esophageal Cancer

2230 **Pathologic Staging - Esophageal Cancer - H**

Detail changed:	Changed from:	Changed to:
FieldName	<Blank>	Pathologic Staging - Esophageal Cancer - H
RequiredForRecordInclusion	<Blank>	No
Definition	<Blank>	Indicate the appropriate descriptor for the esophageal cancer histopathologic type based on final pathology report.
ValidData	<Blank>	H1 (Squamous carcinoma); H2 (Adenocarcinoma)
HarvestCoding	<Blank>	1 = H1 (Squamous carcinoma) 2 = H2 (Adenocarcinoma)
DataSource	<Blank>	User
ParentValue	<Blank>	Yes
ParentField	<Blank>	Esophageal Cancer
Core	<Blank>	Yes
ShortName	<Blank>	PathStageEsophH
TableName	<Blank>	Operations
Format	<Blank>	Text (categorical values specified by STS)
Harvest	<Blank>	Yes

2240 **Pathologic Staging - Esophageal Cancer - G**

Detail changed:	Changed from:	Changed to:
ParentField	<Blank>	Esophageal Cancer
Core	<Blank>	Yes
TableName	<Blank>	Operations

ValidData	<Blank>	GX (Grade cannot be assessed); G1 (Well differentiated); G2 (Moderately differentiated); G3 (Poorly differentiated); G4 (Undifferentiated)
Definition	<Blank>	Indicate the appropriate descriptor for the esophageal cancer histologic grade based on final pathology report.
Harvest	<Blank>	Yes
RequiredForRecordInclusion	<Blank>	No
HarvestCoding	<Blank>	1 = GX (Grade cannot be assessed) 2 = G1 (Well differentiated) 3 = G2 (Moderately differentiated) 4 = G3 (Poorly differentiated) 5 = G4 (Undifferentiated)
Format	<Blank>	Text (categorical values specified by STS)
ParentValue	<Blank>	Yes
DataSource	<Blank>	User
ShortName	<Blank>	PathStageEsophG
FieldName	<Blank>	Pathologic Staging - Esophageal Cancer - G

2250 **IV Antibiotics Ordered Within One Hour**

Detail changed:	Changed from:	Changed to:
DataSource	<Blank>	User
ParentField	<Blank>	Admission Status
Harvest	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)
ValidData	<Blank>	Yes; No
ShortName	<Blank>	IVAntibioOrdered
HarvestCoding	<Blank>	1 = Yes 2 = No
Definition	<Blank>	Indicate whether an order for IV antibiotics within one hour of the skin incision was given.
TableName	<Blank>	Operations
Core	<Blank>	Yes
FieldName	<Blank>	IV Antibiotics Ordered Within One Hour
RequiredForRecordInclusion	<Blank>	No
ParentValue	<Blank>	Inpatient

2260 **IV Antibiotics Given Within One Hour**

Detail changed:	Changed from:	Changed to:

ParentField	<Blank>	IV Antibiotics Ordered Within One Hour
DataSource	<Blank>	User
ValidData	<Blank>	Yes; No; Not indicated for procedure
FieldName	<Blank>	IV Antibiotics Given Within One Hour
HarvestCoding	<Blank>	1 = Yes 2 = No 3 = Not indicated for procedure
Definition	<Blank>	Indicate whether IV antibiotics were given within one hour of the skin incision.
Harvest	<Blank>	Yes
ParentValue	<Blank>	Yes
ShortName	<Blank>	IVAntibioGiven
Format	<Blank>	Text (categorical values specified by STS)
Core	<Blank>	Yes
TableName	<Blank>	Operations
RequiredForRecordInclusion	<Blank>	No

2270 **Cephalosporin Antibiotic Ordered**

Detail changed:	Changed from:	Changed to:
TableName	<Blank>	Operations
ParentValue	<Blank>	Inpatient
Format	<Blank>	Text (categorical values specified by STS)
Definition	<Blank>	Indicate whether an order for first or second-generation cephalosporin antibiotic for prophylaxis was given.
Core	<Blank>	Yes
FieldName	<Blank>	Cephalosporin Antibiotic Ordered
ValidData	<Blank>	Yes; No; Not indicated for procedure; Not indicated due to documented allergy; another appropriate antibiotic given
RequiredForRecordInclusion	<Blank>	No
ShortName	<Blank>	CephalAntiOrdered
Harvest	<Blank>	Yes
DataSource	<Blank>	User
ParentField	<Blank>	Admission Status

HarvestCoding	<Blank>	1 = Yes 2 = No 3 = Not indicated for procedure 4 = Not indicated due to documented allergy; another appropriate antibiotic given

2280

Prophylactic Antibiotics Discontinuation Ordered

Detail changed:	**Changed from:**	**Changed to:**
HarvestCoding	<Blank>	1 = Yes 2 = No 3 = No, due to documented infection
ParentValue	<Blank>	Inpatient
TableName	<Blank>	Operations
ShortName	<Blank>	AntibioticDiscOrdered
Harvest	<Blank>	Yes
ValidData	<Blank>	Yes; No; No, due to documented infection
DataSource	<Blank>	User
ParentField	<Blank>	Admission Status
FieldName	<Blank>	Prophylactic Antibiotics Discontinuation Ordered
RequiredForRecordInclusion	<Blank>	No
Definition	<Blank>	Indicate whether an order to discontinue prophylactic antibiotics within 24 hours of the procedure was given.
Core	<Blank>	Yes
Format	<Blank>	Text (categorical values specified by STS)

2290

DVT Prophylaxis Measures

Detail changed:	**Changed from:**	**Changed to:**
Core	<Blank>	Yes
ValidData	<Blank>	Yes; No; Not applicable
ParentField	<Blank>	Admission Status
DataSource	<Blank>	User
Format	<Blank>	Text (categorical values specified by STS)
ShortName	<Blank>	DVTProphylaxis
ParentValue	<Blank>	Inpatient
TableName	<Blank>	Operations
Harvest	<Blank>	Yes
FieldName	<Blank>	DVT Prophylaxis Measures

Definition	<Blank>	Indicate whether prophylactic measures (TED stockings, pneumatic compression devices and/or subcutaneous heparin or low molecular weight heparin) were taken to prevent DVT. Select "Not applicable" if not indicated, or due to documented DVT or contraindications to all methods of prophylaxis.
RequiredForRecordInclusion	<Blank>	No
HarvestCoding	<Blank>	1 = Yes 2 = No 3 = Not applicable

2300

Smoking Cessation Counseling

Detail changed:	**Changed from:**	**Changed to:**
ParentField	<Blank>	Cigarette Smoking
Harvest	<Blank>	Yes
ShortName	<Blank>	SmokCoun
DataSource	<Blank>	User
FieldName	<Blank>	Smoking Cessation Counseling
ValidData	<Blank>	Yes; No; Patient refused
RequiredForRecordInclusion	<Blank>	No
Format	<Blank>	Text (categorical values specified by STS)
ParentValue	<Blank>	Current smoker
Core	<Blank>	Yes
Definition	<Blank>	Indicate whether the patient received cigarette smoking cessation counseling (must include oral counseling, written material offered to patient, and offer of referral to smoking cessation program).
HarvestCoding	<Blank>	1 = Yes 2 = No 3 = Patient refused
TableName	<Blank>	Operations