The Society of Thoracic Surgeons

Adult Cardiac Surgery Database

Monthly Webinar

June 3, 2026

STS National Database™
Trusted. Transformed. Real-Time.

Agenda

- Welcome and Introductions
- STS Updates
- Aorta Session #4
  Primary Indication-Dissection
- Q&A

Important Dates-Timeline

June 3

ACSD Monthly Webinar
2 pm CT/3 pm ET

June 12

AQO Abstract Submission Deadline

July 15

ACSD Quality Improvement Series Webinar
2 pm CT/3 pm ET

August 5

ACSD Monthly Webinar
2 pm CT/3 pm ET

August 19

ACSD Quality Improvement Series Webinar
2 pm CT/3 pm ET

August 28

2026 Harvest 3 closes
Surgery Dates July 1, 2023-June 30, 2026
Opt-out deadline September 1, 2026

Important Dates-2026 Harvest

2026 Harvest

Term	Harvest Submission Window Close	Opt-Out Date	Includes Procedures Performed Through:	Report Posting	Comments
Harvest 1	February 20	February 24	December 31, 2025	Spring 2026	Star Rating
Harvest 2	May 29	June 2	March 31, 2026	Summer 2026	
Harvest 3	August 28	September 1	June 30, 2026	Fall 2026	Star Rating
Harvest 4	November 20	November 24	September 30, 2026	Winter 2026/2027	
Analysis for each harvest is based on a 36-month window.					

Data Submission Open is continuous for all harvest terms. Submission Close occurs at 11:59 p.m. Eastern on the date listed.

Harvest Opt-Out closes at 5:00 p.m. Eastern on the date listed.

AQO 2026 – New Orleans

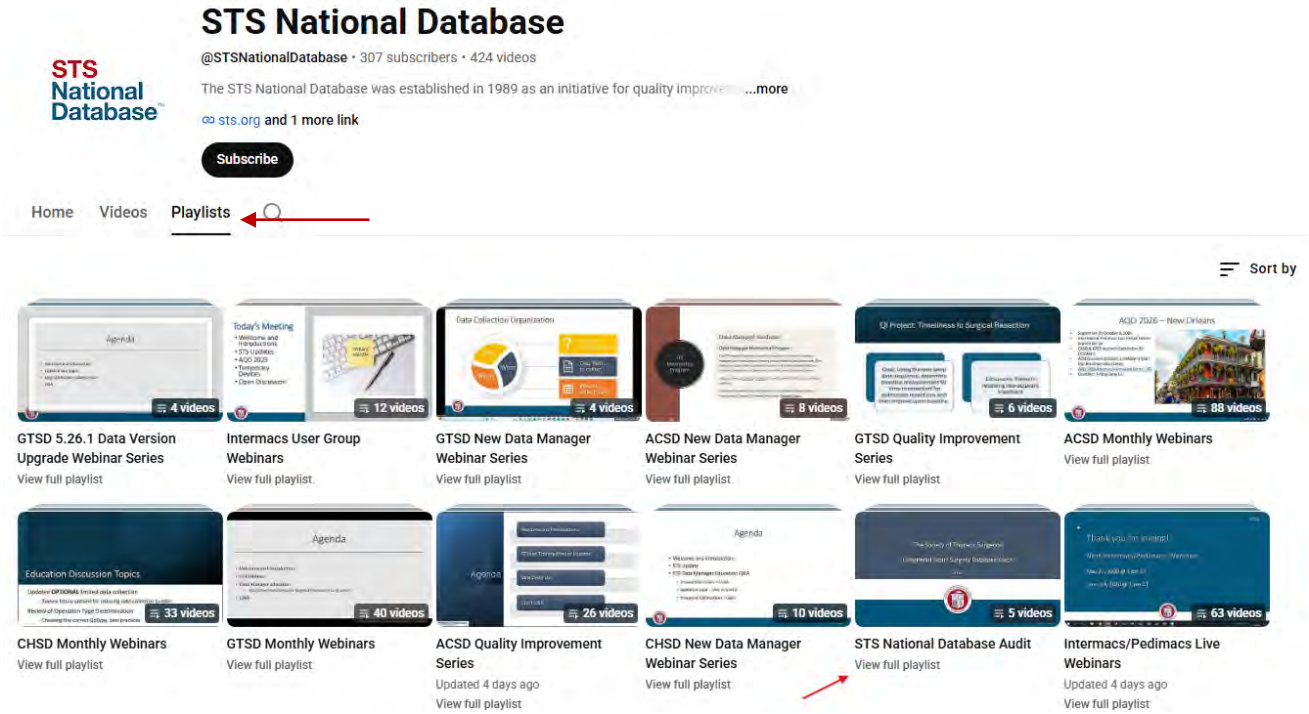
- September 30-October 2, 2026
- Intermacs & Pedimacs-Live Virtual Forum-September 24
- CHSD & GTSD Sessions-September 30-October 1
- ACSD Sessions-October 1-October 2 (half day-breakout discussions)
- AQO 2026 Abstract Submission Form | STS

  Deadline: Friday, June 12

2026 ACSD Audit

- The 2026 STS ACSD Audit is underway
- The Audit Webinar took place yesterday
- The recording will be posted here:
  STS National Database – YouTube
- General information:
  Contact: Emily Conrad, STS National Database Education Manager at econrad@sts.org
- For questions related to submitting your documentation, bookmarking, OR and 30-day follow-up logs:
  Contact: HMS Audit Team at STS@hcmsllc.com

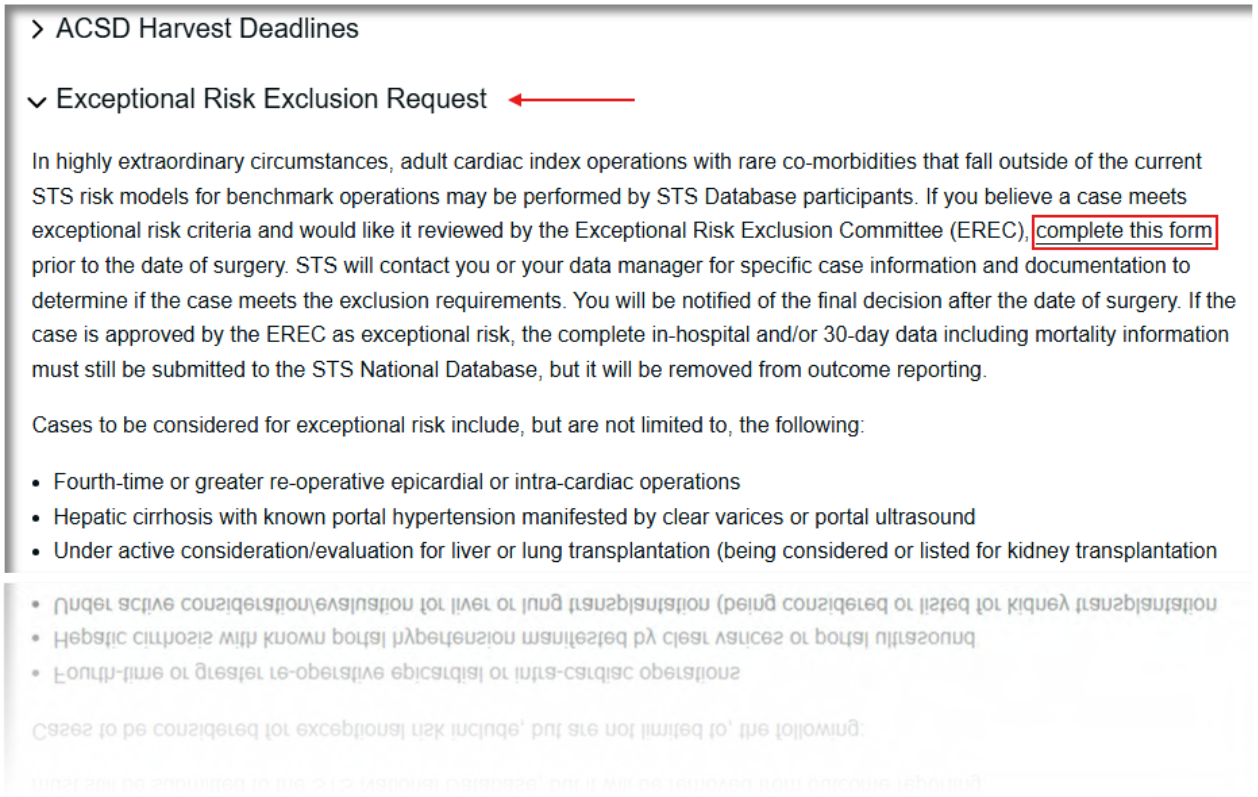
Be sure to include your STS Participant ID in all communications.



STS National Database Audit Policy | STS

Exceptional Risk Exclusion

- The Exceptional Risk Exclusion applies to analyzed cases only.
- Request for exclusion must be made prior to surgery.
- Please send your records as an attachment as a reply to the encrypted request for documentation that you receive from the STS.
- PDF format is preferred.
- IMPORTANT! Your documentation MUST be free from all PHI, hospital identifiers, patient identifiers and provider identifiers.
    - Hospital name, address, phone number
    - Transferring hospital name, address, phone number
    - Patient name, medical record number (you may include DOB)
    - ALL provider identifiers-this includes all surgeons, cardiologists, anesthesiologists, APPs, radiologists, nurses, OR staff, etc.



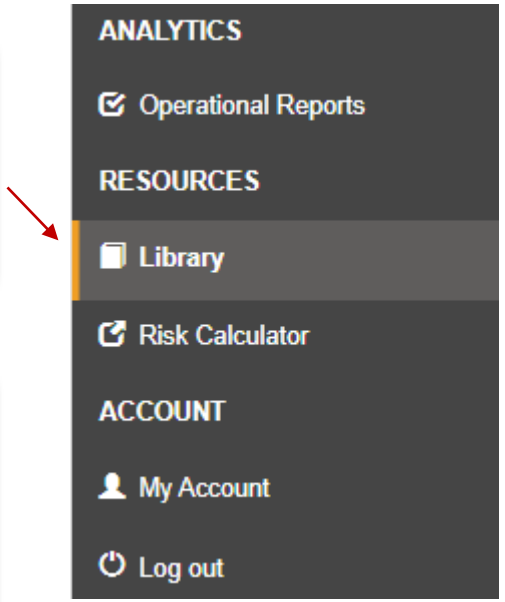
Un-redacted records will be returned to you.

ACSD Reporting Enhancements

Case Mix Report

Failure to Rescue

Surgical Treatment of Afib Process Measure



Report Overview Documents

- ACSD Training Manual V4.20.2_Oct 2025
- Contact List Report (UPDATED) 12052022
- COVID-Positive Patients Included in Risk-Adjusted Analysis
- Database Data Collection Resources (ACSD)
- Database Transition Resources
- Direct Data Entry FAQ
- Longitudinal Outcomes Dashboard Analyzed Overview (ACSD)
- Missing Variable Report Overview (ACSD)
- Participant Dashboard Non-Analyzed Report Overview (ACSD) UPDATED 12312021
- Risk Adjusted Dashboard Overview (ACSD)
- STS Database IQVIA Role Mapping
- ACSD Executive Dashboard Report (Updated May 12, 2025)
- Surgeon Composite Report Overview
- Uploader Instructions
- Harvest Summary Report Overview 8MAY2024

Case Mix Index Report

- ACSD 2026 Harvest 1 Case Mix Report ←

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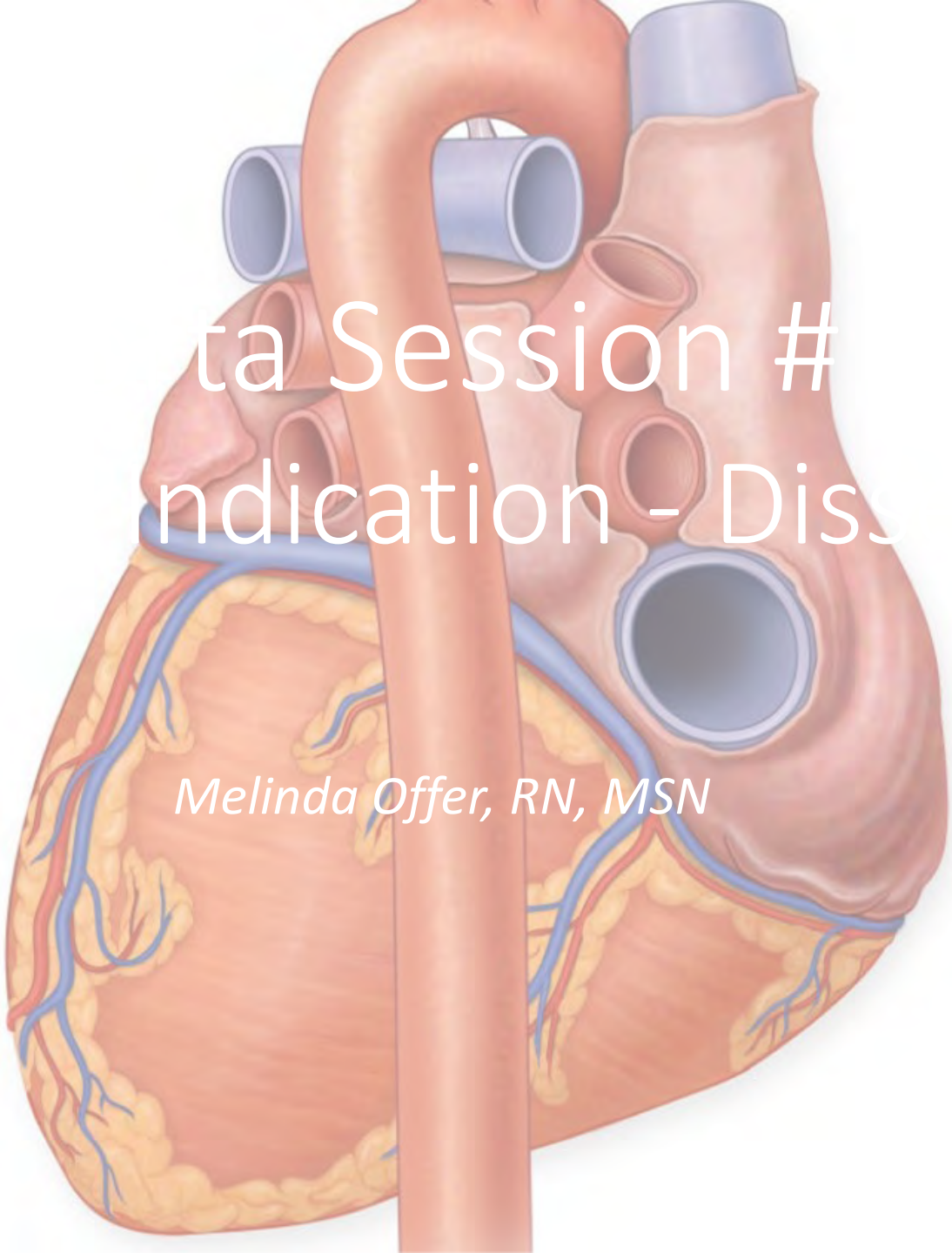
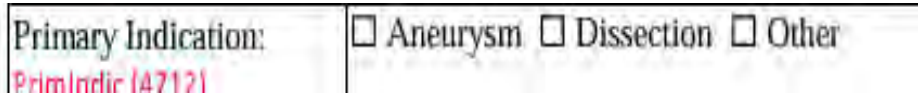


Melinda Offer, RN, MSN

Primary Indication for Aorta Intervention

Long Name: Aorta Primary indication
Definition: Indicate the primary indication for intervention
Intent/Clarification: The intent is to determine the specific condition, diagnosis, or pathology that prompted the patient's entry to the operating room for surgical intervention.

DCF Choices:

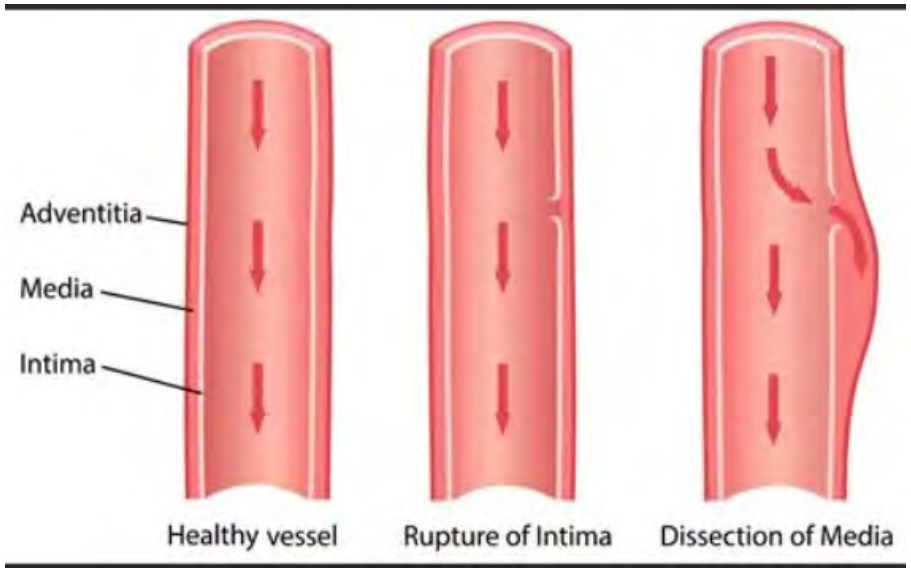


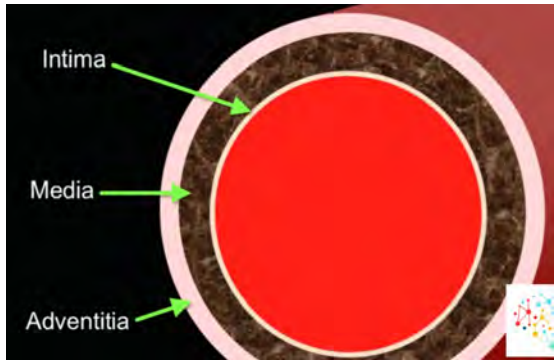
Key Points:

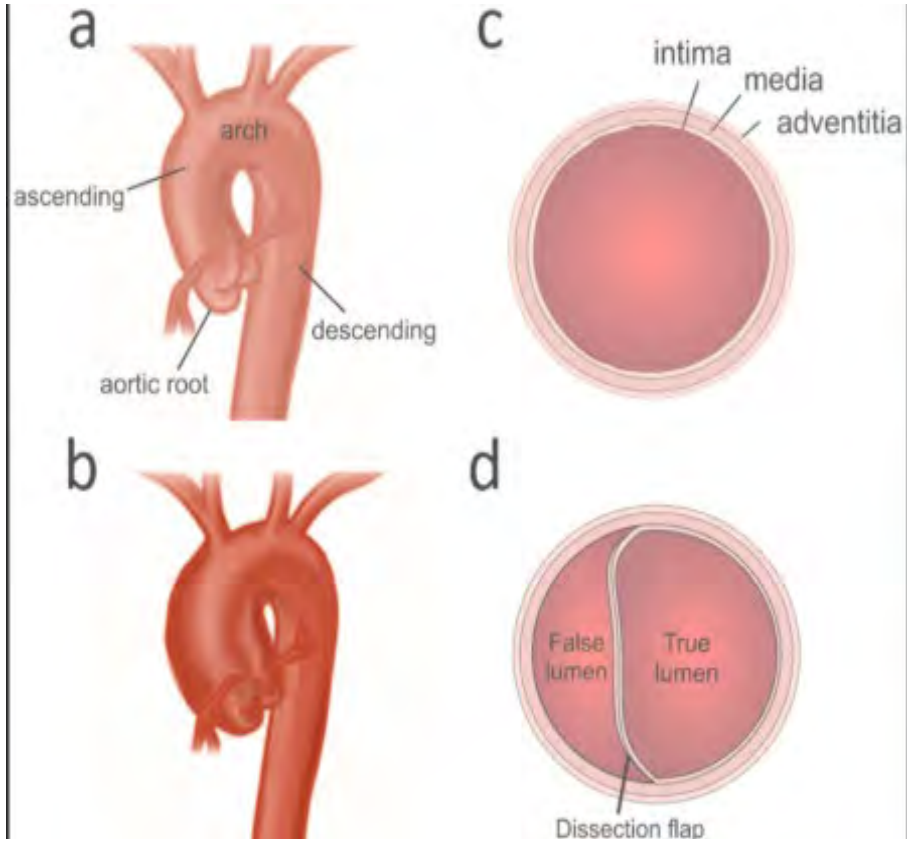
- Intent is to choose the specific condition, diagnosis, or pathology that prompted the patient's entry to the operating room for surgical intervention on the aorta.
- This is a select one choice.
- There is no specific hierarchy, and the primary presenting symptom should be indicated by the surgeon.

Primary Indication for Aorta Intervention - Dissection

An aortic dissection is a tear happens in the inner layer (intima) of the aorta. Blood escapes through the tear. This causes the inner and middle layers of the artery to split creating a dissection flap and false lumen.



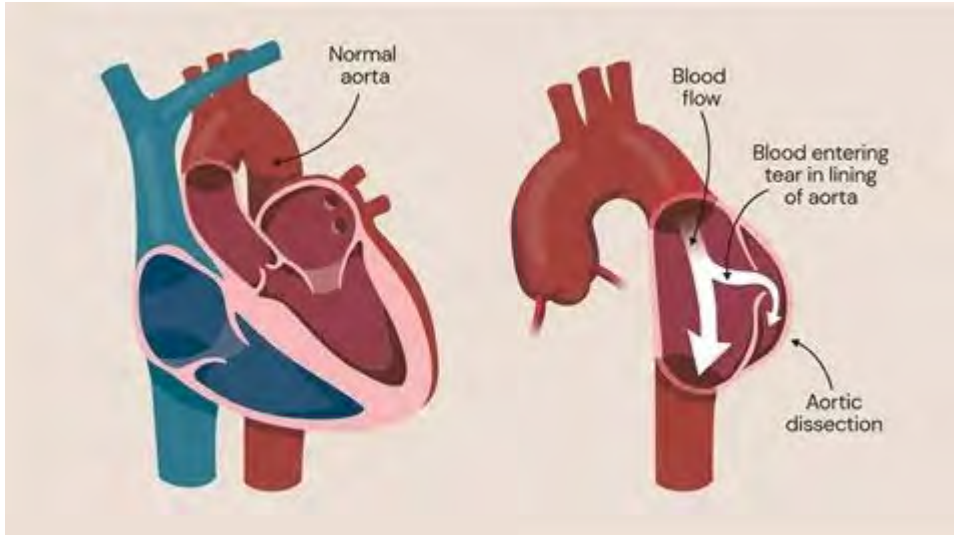




Primary Indication for Aorta Intervention - Dissection

Symptoms of aortic dissection may include:

- Sudden severe chest or upper back pain. The pain may feel like something is tearing or ripping.
- Loss of consciousness
- Shortness of breath
- Symptoms of a stroke
- Leg pain, trouble walking, paralysis



What are some of the causes an aortic dissection?

- Hypertension that is not under control
- Aortic aneurysm
- Connective tissue diseases, such as Marfan's syndrome, Ehlers-Danlos syndrome
- Chest injury or trauma, such as from a car accident
- Strenuous activities, such as heavy weightlifting

Primary Indication for Aorta Intervention – Dissection Timing

Long Name: Dissection
Definition: Indicate the timing of the aortic dissection

Intent/Clarification:

- The intent is to define the time interval from occurrence of dissection until presentation of the patient.
- The best assessment of dissection is the onset of symptoms.
- Usually found either in the EMS report or history of present illness on the H&P, record the time from first onset of symptoms until the patient is evaluated for treatment.

DCF Choices:

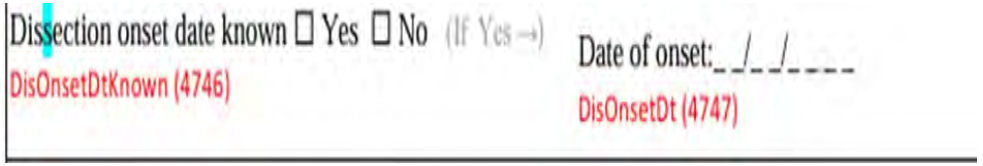
Note: Report "unknown" ONLY if the patient cannot describe a specific onset of symptoms.

Primary Indication for Aorta Intervention – Dissection Onset Date

Long Name: Dissection Onset Date Known
Definition: Indicate whether the date of dissection onset is known
Intent/Clarification: The intent is to confirm the duration of symptoms preceding the patient's evaluation for treatment.

Key Points:

- This sequence refers to the patient's recall of specific date when symptoms were first felt.
- Report "no" ONLY for any patient whose dissection is incidentally discovered or if the patient does not recall the onset of symptoms
- For patients who have a chronic dissection following a previous repair, code the previous date of surgery as the timing for onset.



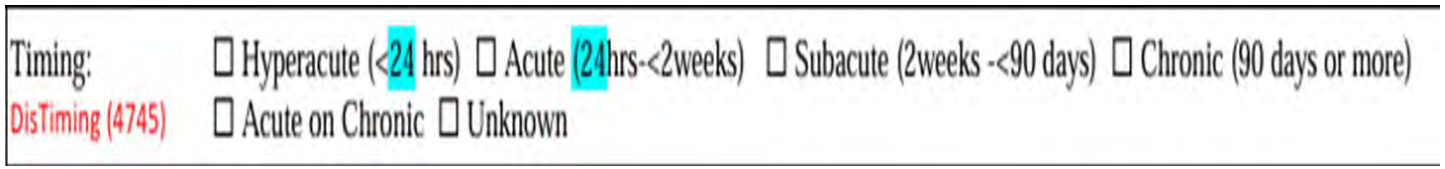
Long Name: Dissection Onset Date
Definition: Indicate dissection onset date
Intent/Clarification:

- Report the date of symptoms onset if it is known by the patient.
- If the patient's recall is non-specific (e.g., "sometime last week") leave this item blank.

Primary Indication for Aorta Intervention – Dissection Timing Scenarios

Answer Key:

A. Hyperacute
B. Acute
C. Subacute
D. Chronic
E. Acute on Chronic
F. Unknown



Patient has onset of pain symptom on 12/3 but didn't present to the ER until 12/8. No worsening of pain during that time. Patient was diagnosed with a dissection upon admission.

Acute

Patient came to ED at 0800 3/5 complaining of ripping like back pain starting the in evening of 3/4, found to have an aortic dissection.

Hyperacute

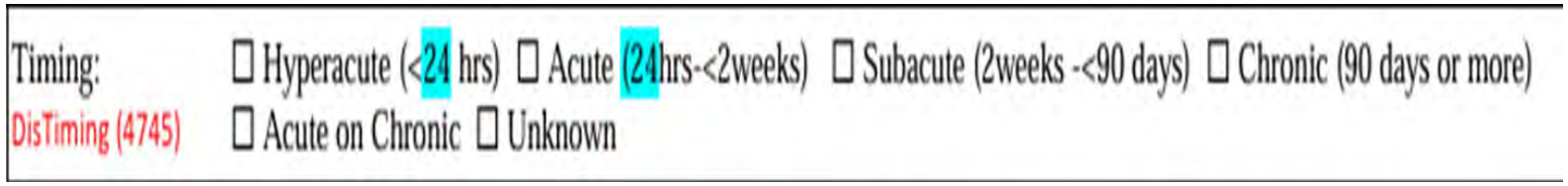
Patient Type B dissection that was diagnosed 1/15 and medically managed. On the morning of 3/1, the patient started having chest pain radiating to his back and presented to the ED. A CT scan showed contained rupture of the Type B dissection requiring urgent surgery.

Subacute

Primary Indication for Aorta Intervention – Dissection Timing Scenarios

Answer Key:

A. Hyperacute
B. Acute
C. Subacute
D. Chronic
E. Acute on Chronic
F. Unknown



Patient presented with a type B dissection 10/19/25. She was discharged on 10/28/25 with medical management. On 11/6/25 she presented with worsening symptoms. A CT scan was done and showed an acute Type A dissection requiring emergent surgery following the CT scan.

Hyperacute

Patient first had symptoms on 11/2, presented to ED on 11/6 when pain got significantly worse and had hemodynamic instability in ED leading to emergent aortic dissection surgery 11/6

Acute

The patient has a history of type B aortic dissection followed since 2016. On the morning of presentation in Jan 2025, the patient experienced significant back pain and presented to the ED. A CT scan showed new expansion of the chronic Type B dissection requiring emergent surgery.

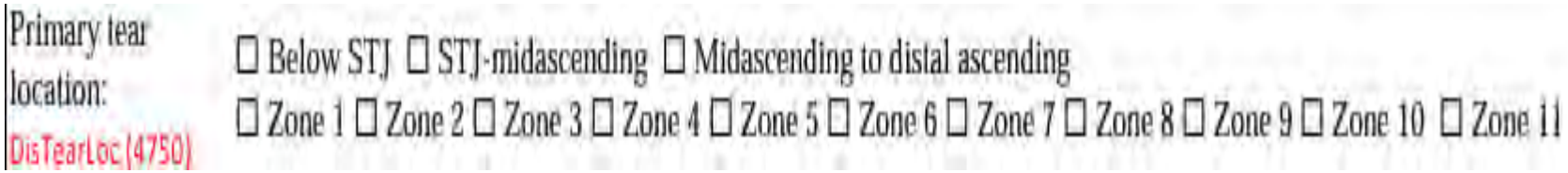
Acute on Chronic

Dissection Primary Tear Location

Long Name: Dissection - Primary Tear Location
Definition: Indicate location of the primary tear
Intent/Clarification:

- The intent is to identify the primary entry tear for the dissection.
- As most dissections include multiple re-entry tears it may be difficult to confirm the primary site and the **surgeon MUST be the final arbiter** of this definition. The op note is a great place to obtain this information.
- This is the site identified by the surgeon at an open operation or judged by the surgeon from imaging as the primary site to be covered by endovascular stent.
- If the radiology report names a primary entry point and the surgeon concurs, report this location.

DCF Choices:

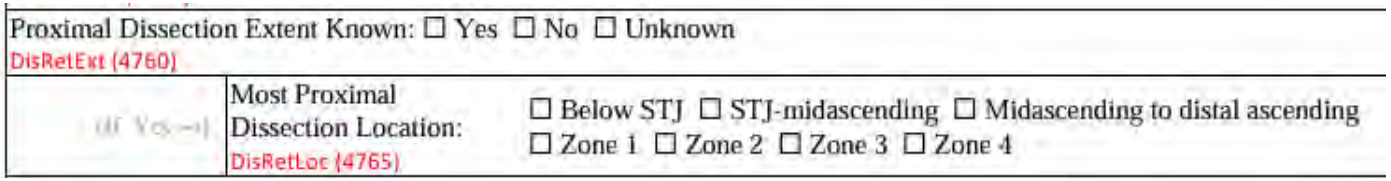


Dissection Proximal Extent Known & Most Proximal Dissection Location

Long Name: Proximal Dissection Extent Known
Definition: Indicate if proximal (toward heart) dissection extent is known.
Intent/Clarification:

- The intent is to determine whether the dissection propagates proximal (retrograde) toward the aortic valve from the primary tear location.

- Report yes if imaging indicates an extension of the false lumen proximal (retrograde) toward the aortic valve to the primary tear location.



Long Name: Most Proximal Dissection Location
Definition: Indicate location of most proximal (closest to heart) dissection location.
Intent/Clarification:

- The intent is to define how far the proximal dissection extends toward the aortic valve.

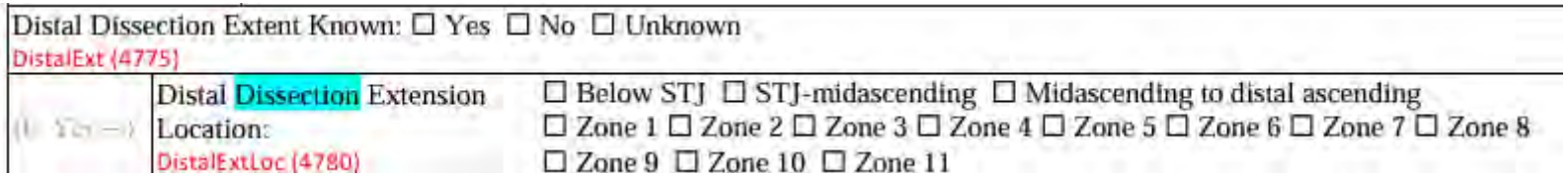
- This would be the point at which the false lumen comes closest to the aortic valve.

- The surgeon or radiologist can be the final arbiter of this definition.

Dissection Distal Extent Known & Most Distal Dissection Location

Long Name: Distal Dissection Extent Known
Definition: Indicate if distal (away from heart) dissection is known.
Intent/Clarification: The intent is to identify where distal (antegrade) dissection occurred or extended.

DCF Choices:



Long Name: Distal Dissection Extension Location
Definition: Indicate location of most distal (away from heart) dissection location
Intent/Clarification:

- The intent is to define the how far along the aorta (away from the valve) any new or extended dissection goes.
- This would be the point at which the false lumen is furthest away from the aortic valve.
- The surgeon or radiologist can be the final arbiter of this definition.

Dissection Stanford Classification

Long Name: Stanford Classification Known
Definition: Indicate if the Stanford classification is known.
Intent/Clarification: The intent is to identify the Stanford Classification of the dissection

Key Points

- The Stanford classification is the most widely used system for categorizing aortic dissections based on the location of t he dissection rather than the site of the initial tear.

- The Stanford system is simpler and more clinically oriented, focusing on whether the ascending aorta is involved which directly influences management decisions.

- The DeBakey classification divides dissections into 3 types (I, II, III) based on the site of the intimal tear and extent of propagation. Type III is further divided into IIIa and IIIb.

Notes:

- Ascending aortic dissection generally requires primary surgical treatment.

- Type B dissections generally are treated medically as initial treatment with surgery reserved for any complications.

Dissection Stanford Classification

DCF Choices:

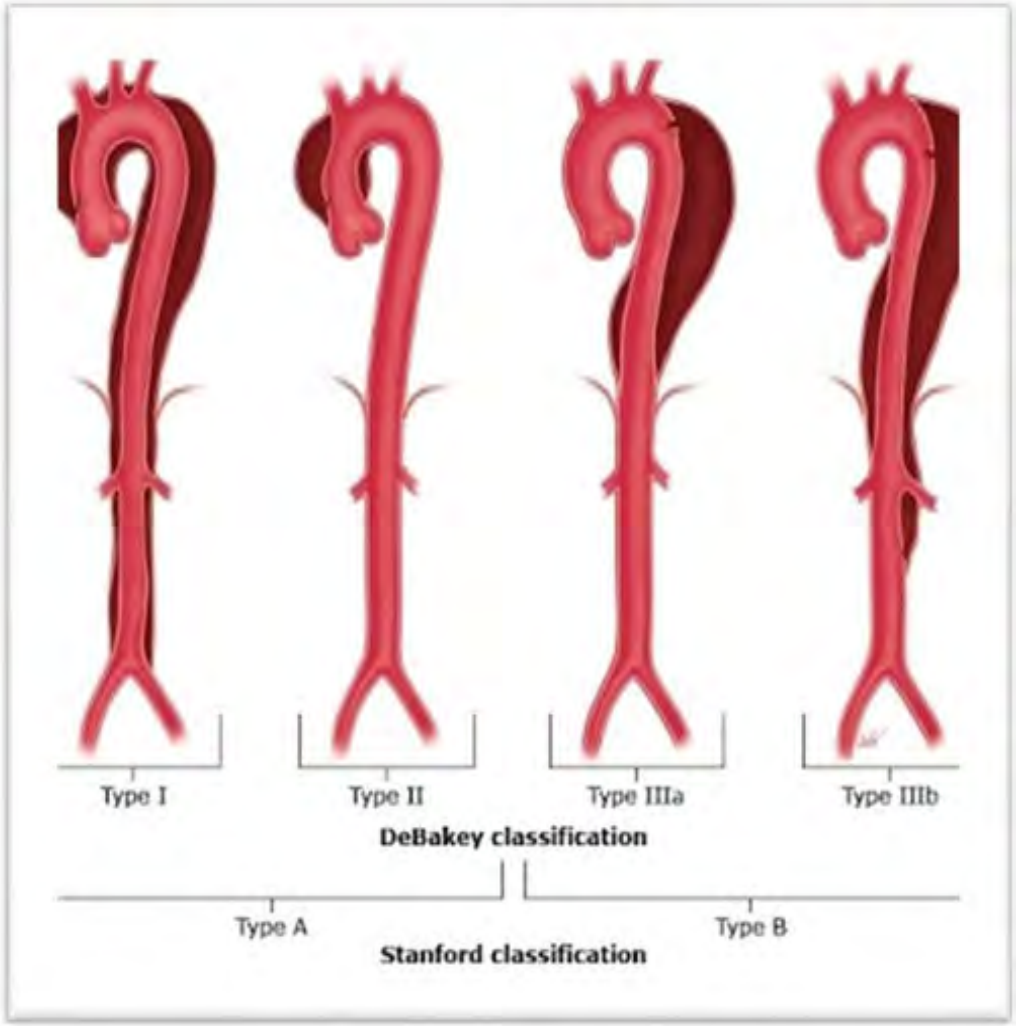
Stanford Classification: ☐ Type A ☐ Type B ☐ Unknown ☐ Other
StanfordClass (4781)

- **Type A** – Stanford Type A is a dissection involves Zone 0. The dissection involves the ascending aorta, without or without extension into the aortic arch or descending aorta. Type A involves any part of the aorta proximal to the origin of the left subclavian artery. It includes DeBakey Types I and II.

- **Type B** – Stanford Type B arises distal to the left subclavian artery starting in Zone 3. The dissection involves the descending aorta or the arch (distal to the left subclavian artery), without involvement of the ascending aorta. It includes DeBakey type IIIa and IIIb.

- **Unknown**

- **Other** – Non-A and Non-B aortic dissection refers to a type of aortic dissection that does not fit into the traditional classifications of Stanford Type A or Type B. These can include Zone 1 and Zone 2 dissections without involvement of Zone 0 which are less common.



Dissection - Retrograde Dissection s/p TEVAR

Long Name: Retrograde dissection caused by Aortic Stent Graft (Post TEVAR)
Definition: Indicate if there was a proximal dissection (toward the heart) caused by an aortic stent graft (post TEVAR).

Intent/Clarification: The intent is to identify whether RETROGRADE dissection occurred or extended **during TEVAR (Thoracic Endovascular Aortic Repair)**

Report yes if:

- Retrograde dissection is noted on post TEVAR imaging that was not present on imaging before TEVAR

OR

- Retrograde dissection (false lumen) extends closer to the aortic valve than was noted on pre TEVAR imaging

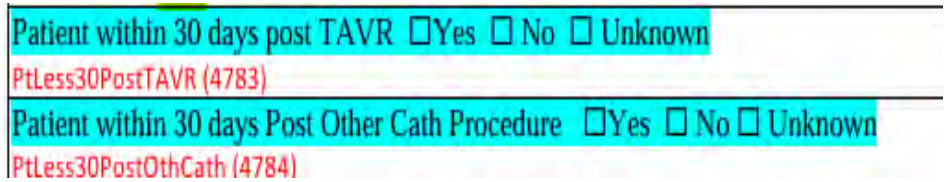
DCF Choices:

Dissection – Patient with TAVR or Other Cath Procedure within 30 days

Key Point:

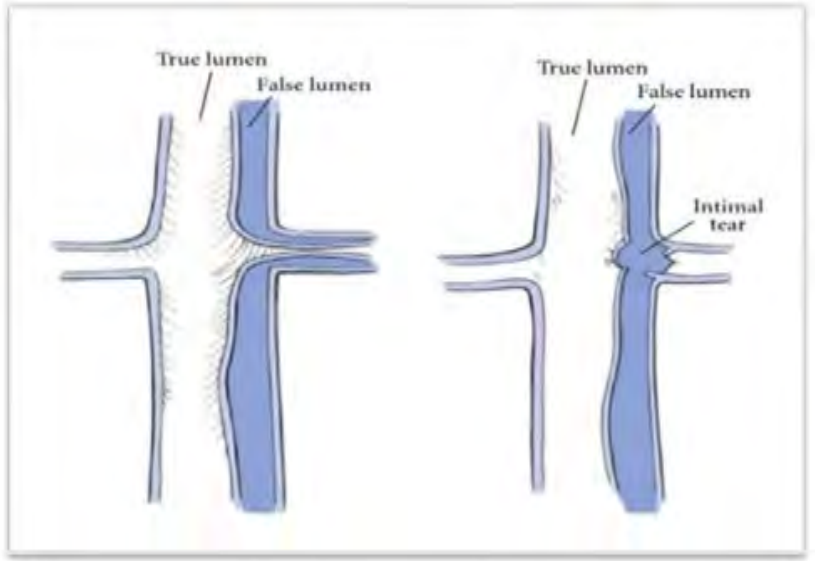
- **This is a no "judgement field". It is simply to note the incidence of dissection within 30 days of these procedures**

Long Name: Patient within 30 days post TAVR
Definition: Indicate if the patient had a TAVR within the last 30 days.
Intent/Clarification: This field is not meant to specify that the TAVR is the reason for current procedure.



Long Name: Patient within 30 days Post Other Cath Procedure
Definition: Indicate if the patient had any catheter-based procedure, other than TAVR, within the last 30 days.
Intent/Clarification: This field is not meant to specify that the catheter-based procedure is the reason for current procedure.

Dissection - Malperfusion



Long Name: Dissection - Malperfusion
Definition: Indicate whether malperfusion was present

Intent/Clarification: Malperfusion is defined as inadequate blood flow to a tissue bed. **The surgeon must identify and document if malperfusion is present. It is not up to the Data Manager to look at imaging results and determine if malperfusion is present.**

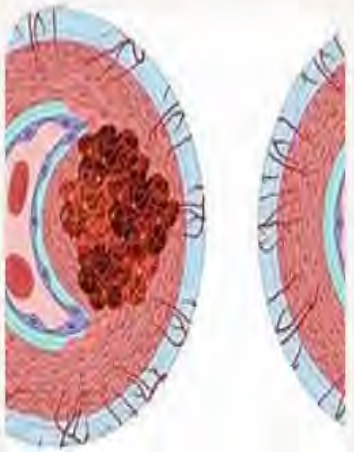
Key Points:

- Code 'Yes' if the Surgeon documents that any vessel is malperfused.
- Unknown - code "unknown" if the surgeon indicates that the imaging is inadequate to confirm the presence or absence of malperfusion.
- Timeframe for documentation of the presence of malperfusion is patient presentation until OR exit time. This field does not include the post-op timeframe.

Malperfusion: ☐ Yes ☐ No ☐ Unknown
DisMal (4785)

If you have a false lumen do you have malperfusion in dissection?

Having a false lumen in an aortic dissection does not necessarily mean that you have malperfusion. The presence of a false lumen can lead to malperfusion if it affects the flow through the true lumen, which can occur in certain types of aortic dissections. Malperfusion can manifest as compromised flow to a downstream vascular territory, leading to ischemia and potential permanent damage to the affected organs. The diagnosis of malperfusion in aortic dissection is based on imaging findings and clinical signs of end-organ ischemia.



Typical Rates of Malperfusion:

- Any limb malperfusion 12%
- Iliofemoral malperfusion at 11%,
- Coronary artery malperfusion 10%
- Cerebral malperfusion 10%
- Mesenteric malperfusion 6%
- Spinal malperfusion 1%

Arterial dissections become life-threatening when growth of the false lumen prevents perfusion of the true lumen and the related end organs.

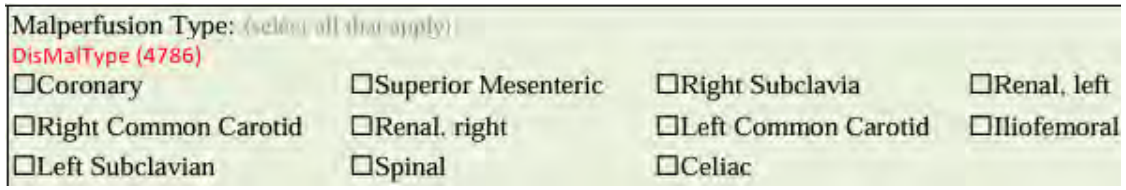
Vessels and organs that are perfused from a false lumen may be well-perfused to varying degrees, from normal perfusion to no perfusion. In some cases, little to no end-organ damage or failure may be seen. Similarly, vessels and organs perfused from the true lumen but distal to the dissection may be perfused to varying degrees

Dissection Malperfusion Type

Long Name: Dissection - Malperfusion Type
Definition: Indicate where malperfusion occurred. If malperfusion occurred in more than one location, select all that apply.

Intent/Clarification: The intent is to identify which vessels have compromised flow because of the dissection or repair. **The surgeon is the final arbiter of this definition. The surgeon must identify and document the type of malperfusion present. It is not up to the Data Manager to look at imaging results and determine the malperfusion type.**

DCF Choices: This is a select all that apply field


Malperfusion Type: (select all that apply)
DisMalType (4786)

☐Coronary	☐Superior Mesenteric	☐Right Subclavia	☐Renal, left
☐Right Common Carotid	☐Renal, right	☐Left Common Carotid	☐Iliofemoral
☐Left Subclavian	☐Spinal	☐Celiac	

- **Coronary Artery Malperfusion** – Coronary artery malperfusion is when a coronary artery is compressed, kinked, or occluded by the dissection flap and blood flow to the heart muscle is impaired, leading to myocardial ischemia.

- **Right Common Carotid Malperfusion** - The right common carotid artery branches from the brachiocephalic trunk in the neck. It divides into the external and internal carotid arteries, which supply the head, neck, and brain. When the right common carotid artery (RCCA) is malperfused, it can lead to reduced cerebral blood flow.

- **Left Subclavian Malperfusion-** The left subclavian artery supplies the left arm and also gives off the vertebral artery (to the brain and spinal cord) and the internal thoracic artery (to the chest wall). Any compromise can cause acute left arm ischemia, stroke, or myocardial ischemia.

Dissection Malperfusion Type

Long Name: Dissection - Malperfusion Type
Definition: Indicate where malperfusion occurred. If malperfusion occurred in more than one location, select all that apply.

Intent/Clarification: The intent is to identify which vessels have compromised flow because of the dissection or repair. **The surgeon is the final arbiter of this definition. The surgeon must identify and document the type of malperfusion present. It is not up to the Data Manager to look at imaging results and determine if malperfusion type.**

DCF Choices: **This is a select all that apply field**

Malperfusion Type: (select all that apply)
DisMalType (4786)

☐Coronary	☐Superior Mesenteric	☐Right Subclavia	☐Renal, left
☐Right Common Carotid	☐Renal, right	☐Left Common Carotid	☐Iliofemoral
☐Left Subclavian	☐Spinal	☐Celiac	

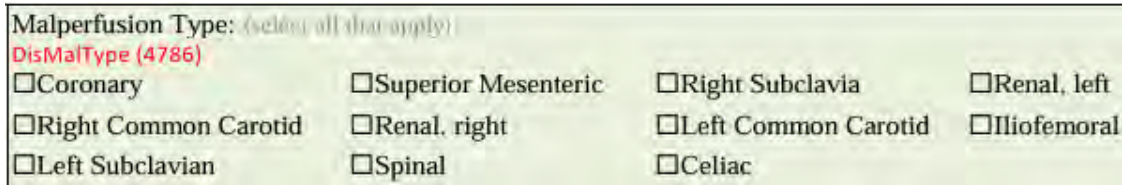
- **Superior Mesenteric / Inferior Mesenteric Malperfusion** - Superior and inferior mesenteric artery malperfusion refers to a condition in which the blood supply to the intestines is reduced or blocked, leading to inadequate oxygen and nutrient delivery to the bowel. This can occur in both the superior mesenteric artery (SMA) and inferior mesenteric artery (IMA), which are the two main arteries supplying the small and large intestines.
- **Renal, Right Artery Malperfusion-** Right renal artery malperfusion refers to a condition in which the right kidney is not receiving adequate blood flow.
- **Spinal Artery Malperfusion** - Spinal artery malperfusion refers to reduced blood flow to the spinal cord due to compromise of the spinal artery.

Dissection Malperfusion Type

Long Name: Dissection - Malperfusion Type
Definition: Indicate where malperfusion occurred. If malperfusion occurred in more than one location, select all that apply.

Intent/Clarification: The intent is to identify which vessels have compromised flow because of the dissection or repair. **The surgeon is the final arbiter of this definition. The surgeon must identify and document the type of malperfusion present. It is not up to the Data Manager to look at imaging results and determine if malperfusion type.**

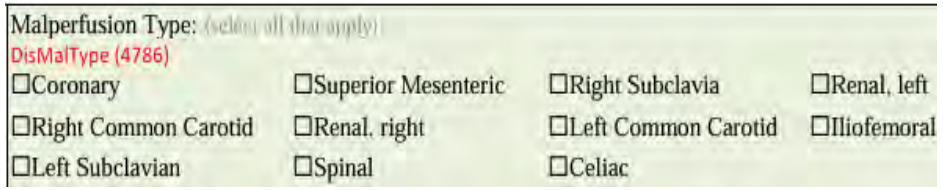
DCF Choices: **This is a select all that apply field**


Malperfusion Type: (select all that apply)
DisMalType (4786)

☐Coronary	☐Superior Mesenteric	☐Right Subclavia	☐Renal, left
☐Right Common Carotid	☐Renal, right	☐Left Common Carotid	☐Iliofemoral
☐Left Subclavian	☐Spinal	☐Celiac	

- **Right Subclavian Malperfusion-** Right subclavian malperfusion is a situation where the right subclavian artery blood supply to the right arm and/or brain is compromised.
- **Left Common Carotid Malperfusion-** Left common carotid artery malperfusion can lead to reduced cerebral blood flow.
- **Celiac Artery Malperfusion** – Celiac artery malperfusion is reduced blood flow to the celiac artery leading to ischemia in the organs it supplies — the stomach, liver, spleen, and parts of the pancreas.

Dissection Malperfusion Type Continued


Malperfusion Type: (select all that apply)
DisMalType (4786)

☐Coronary	☐Superior Mesenteric	☐Right Subclavia	☐Renal, left
☐Right Common Carotid	☐Renal, right	☐Left Common Carotid	☐Iliofemoral
☐Left Subclavian	☐Spinal	☐Celiac	

- **Renal, Left Artery Malperfusion** – Left renal artery malperfusion refers to a condition in which the left kidney is not receiving adequate blood flow.

- **Iliofemoral Artery Malperfusion-** The Iliofemoral system includes the internal iliac vein, the external iliac vein, the common iliac vein, the femoral artery and the popliteal artery. This results in of inadequate blood flow to the lower extremities due to disruption of the aortic supply to the iliac and femoral arteries.

Note:

Update March 2023 – In V 4.2, **there is no choice for innominate artery malperfusion**.

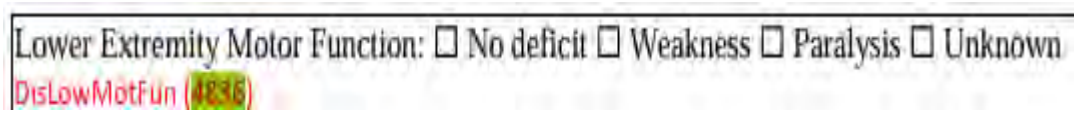
If there is no aortic arch anomaly documented and malperfusion of the innominate artery is documented, code “Yes” to right subclavian malperfusion and “Yes” to right carotid malperfusion since both vessels come off the innominate artery.

Dissection – Lower Extremity Motor Function

Long Name: Dissection - Lower Extremity Motor Function
Definition: Indicate if any NEW motor deficit of either lower extremity was present preoperatively.
Intent/Clarification:

- The intent is to identify if the patient has any **NEW motor deficit of either lower extremity** as a presenting symptom.
- This is preoperative status and does not include new post-operative paralysis or paraplegia.
- Only report “unknown” if there is no comment in the medical record regarding motor function in the lower extremities.

DCF Choices:



Difference Between Paresis and Paralysis:

- Paresis is a condition typified by a weakness of voluntary movement, or by partial loss of voluntary movement or by impaired movement.
- Paralysis is a loss of purposeful movement. Loss of motor function may be complete (paralysis); unilateral (hemiplegic) or bilateral confined to the lower extremities (paraplegic) or present in all four extremities (quadriplegic); and may be accompanied by increased muscular tension and hyperactive reflexes (spastic) or by loss of reflexes (flaccid).

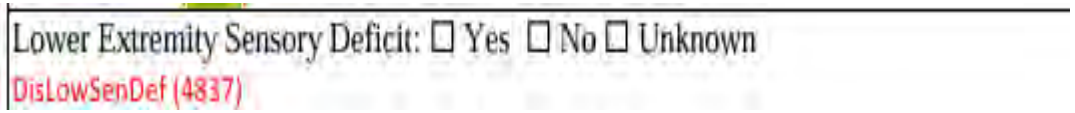
Dissection – Lower Extremity Sensory Deficit

Long Name: Dissection - Lower Extremity Sensory Deficit
Definition: Indicate if any NEW sensory deficit of either lower extremity was present preoperatively.

Intent/Clarification:

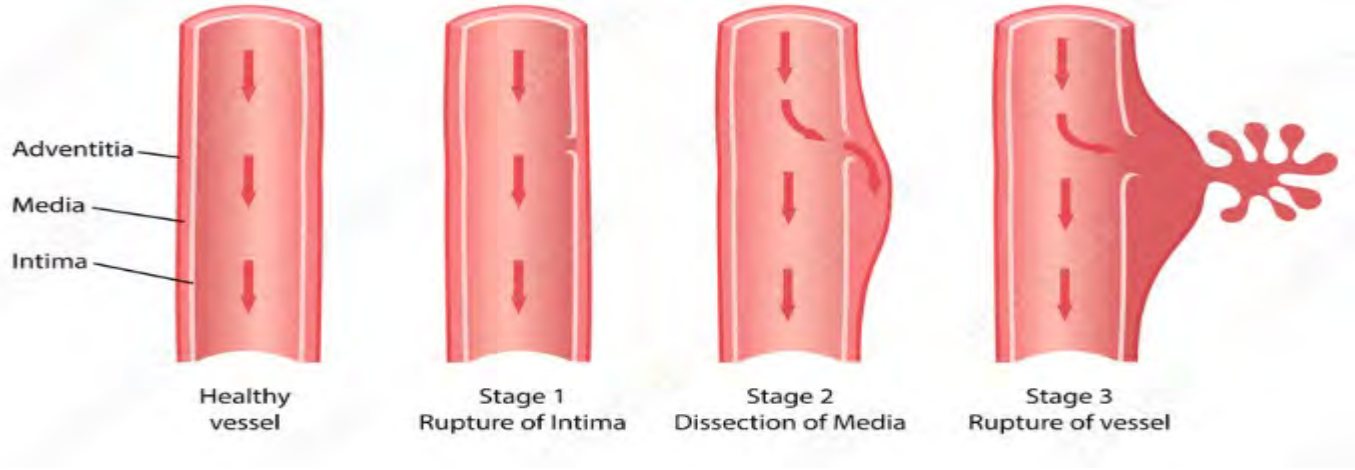
- The intent is to identify if the patient has any NEW sensory deficit of either lower extremity as a presenting symptom.
- Report “yes” if any note comments on numbness or insensate areas that were not recorded in the past medical history.
- Only report “unknown” if there is no comment in the medical record regarding sensation in the lower extremities.
- This is preoperative status and does not include post-operative paralysis or paraplegia.

DCF Choices:



Dissection Rupture

Long Name: Dissection - Rupture
Definition: Indicate whether dissection ruptured



Intent/Clarification:

- Report “yes” if any volume of blood is extravascular (outside the aortic adventitial layer), i.e., beyond the outmost layer of the aortic wall.
- Capture rupture that occurs pre-op or intra-op.
- An aortic dissection can cause the aorta to rupture. This condition is usually fatal without rapid intervention.

DCF Choices:

Rupture: ☐ Yes ☐ No
DisRupt (4840)

(If Yes →)	Contained rupture: DisRuptCon (4845)	☐ Yes ☐ No
	Rupture Location: DisRuptLoc (4850)	☐ Below STJ ☐ STJ-midascending ☐ Midascending to distal ascending ☐ Zone 1 ☐ Zone 2 ☐ Zone 3 ☐ Zone 4 ☐ Zone 5 ☐ Zone 6 ☐ Zone 7 ☐ Zone 8 ☐ Zone 9 ☐ Zone 10 ☐ Zone 11

Dissection Rupture Contained

Long Name: Dissection - Rupture - Contained
Definition: Indicate whether the rupture was contained.

Intent/Clarification: Report “yes” if extravascular blood is contained by surrounding structures such that bleeding has stopped.

- Types of Rupture
  - **Frank aorta rupture** is a complete tear of the aortic wall, causing severe internal bleeding. This condition is life-threatening and that requires immediate emergency surgery.
  - **Contained aorta rupture** refers to a situation where a rupture of the aorta occurs but is limited by surrounding tissues, preventing massive hemorrhage potentially allowing for more stable emergency

DCF Choices:

Rupture: ☐ Yes ☐ No
DisRupt (4840)

(If Yes →)	Contained rupture: DisRuptCon (4845)	☐ Yes ☐ No
	Rupture Location: DisRuptLoc (4850)	☐ Below STJ ☐ STJ-midascending ☐ Midascending to distal ascending ☐ Zone 1 ☐ Zone 2 ☐ Zone 3 ☐ Zone 4 ☐ Zone 5 ☐ Zone 6 ☐ Zone 7 ☐ Zone 8 ☐ Zone 9 ☐ Zone 10 ☐ Zone 11

Dissection Rupture Location

Long Name: Dissection - Rupture Location
Definition: Indicate the rupture location

Intent/Clarification:

- Intent is to identify where the rupture occurred.
- This is the site identified by the surgeon at an open operation or judged by the surgeon or radiologist from imaging as the rupture site to be covered by endovascular stent.

DCF Choices:

Rupture: ☐ Yes ☐ No
DisRupt (4840)

(If Yes →)	Contained rupture: DisRuptCon (4845)	☐ Yes ☐ No
	Rupture Location: DisRuptLoc (4850)	☐ Below STJ ☐ STJ-midascending ☐ Midascending to distal ascending ☐ Zone 1 ☐ Zone 2 ☐ Zone 3 ☐ Zone 4 ☐ Zone 5 ☐ Zone 6 ☐ Zone 7 ☐ Zone 8 ☐ Zone 9 ☐ Zone 10 ☐ Zone 11

What is the Primary Tear Location?

Op Note: The false lumen was traversed, and we entered the true lumen. **We identified the primary tear at the mid ascending aorta along the lesser curvature.** We inspected the aortic root. It was not dilated; the valve was intact and appeared to be competent although slightly prolapsed at the commissure between the right and noncoronary sinuses. The dissection extended into the noncoronary sinus, but only about 30% of the way to the annulus. The intima of the arch appeared to be intact. We were beyond the distal extent of the primary tear.

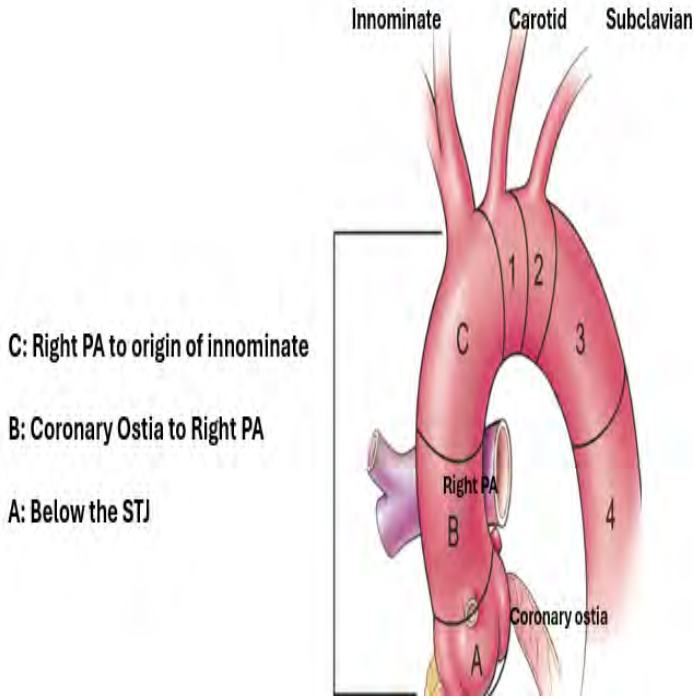
Primary tear location: DisTearLoc (4750)

☐ Below STJ ☐ STJ-midascending ☐ Midascending to distal ascending

☐ Zone 1 ☐ Zone 2 ☐ Zone 3 ☐ Zone 4 ☐ Zone 5 ☐ Zone 6 ☐ Zone 7 ☐ Zone 8 ☐ Zone 9 ☐ Zone 10 ☐ Zone 11

Answer – Mid-Ascending to Distal Ascending

The surgeon MUST be the final arbiter of this definition



Zone 0 - Divided into 3 sections – see figure:

A. **Aortic root** below the sinotubular junction. STJ is the sinotubular junction and identifies the boundary between the aortic root and the ascending aorta. The aortic root, aortic annulus, and the Sinus of Valsalva are below the STJ.

B. **Sinotubular junction to mid ascending** - STJ-mid ascending - The segment of the ascending aorta between the sinotubular junction and the mid-point of the ascending aorta (i.e., proximal tubular ascending aorta) from the coronary ostia to the distal margin of the right pulmonary artery.

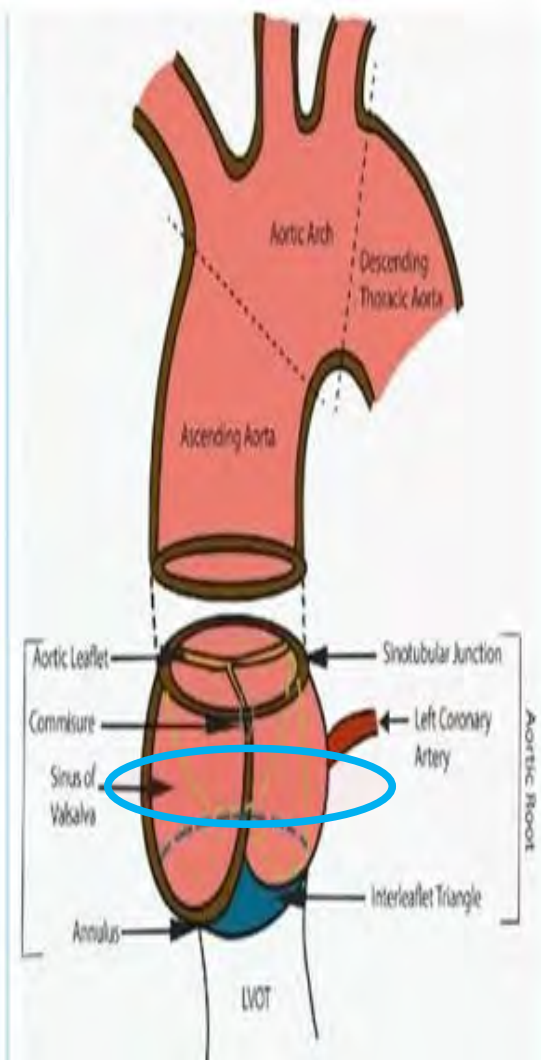
C. **Mid ascending to distal ascending** - The segment of the ascending aorta between the mid-point of the ascending aorta from the right pulmonary artery to the origin of the innominate artery or first branch vessel off the aortic arch.

What is the most proximal dissection location?

H&P: I reviewed the CTA. I agree that there is an acute dissection of essentially the entire **aorta from the aortic root** and extending past the distal aortic bifurcation.

CT: Large type A dissection **originates at the aortic root with a dominant false lumen**. The dissection involves both common carotid arteries with occlusion on the right and high-grade stenosis on the left as well as the left subclavian artery with
high-grade stenosis

Op Note: The false lumen was traversed, and we entered the true lumen. We identified the primary tear at the mid ascending aorta along the lesser curvature. We inspected the aortic root. It was not dilated; the valve was intact and appeared to be competent although slightly prolapsed at the commissure between the right and noncoronary sinuses. **The dissection extended into the noncoronary sinus, but only about 30% of the way to the annulus.**



Answer - below the STJ

- **The intent is to define how far the retrograde dissection extends toward the aortic valve.**
- **This would be the point at which the false lumen comes closest to the aortic valve.**
- **The surgeon or radiologist can be the final arbiter of this definition.**

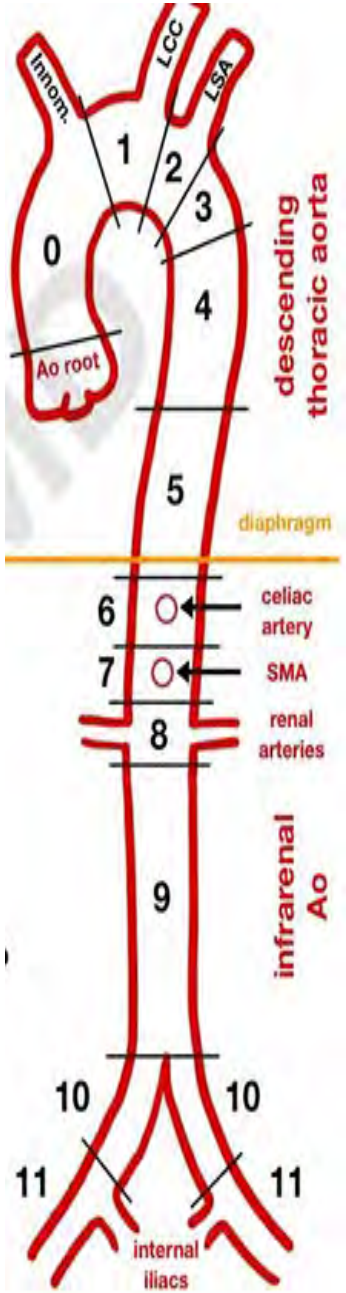
What is the most distal dissection location?

H&P: There is an acute dissection of essentially the **entire aorta from the aortic root and extending past the distal aortic bifurcation.**

CT: Intra-abdominal extension of the dissection which involves the celiac axis with associated high-grade stenosis . The splenic artery originates from the false lumen. High-grade stenosis of the SMA origin which subsequently demonstrates a long segmental occlusion with some distal reconstitution. The left renal artery originates from the false lumen with associated left renal infarcts. **The dissection extends into the left common iliac artery which demonstrates a long segmental occlusion**.

Answer - Zone 10

- **The intent is to define the how far along the aorta (away from the valve) any new or extended dissection goes.**
- **This would be the point at which the false lumen is furthest away from the aortic valve.**
- **The surgeon or radiologist can be the final arbiter of this definition**



Zone 8 - Infrarenal Abdominal zone - renal to infra-renal abdominal aorta of the aorta is the segment of aorta from which all the renal arteries arise (usually two but maybe more) (see figure).

Zone 9 - Infrarenal Abdominal zone - infrarenal abdominal aorta of the aorta is the segment of aorta between the last renal artery take-off and the aortic bifurcation (see figure).

Zone 10 - Infrarenal Abdominal zone is defined as the area where the aorta bifurcates into the right and left common iliac arteries (see figure)

Zone 11 – Infrarenal Abdominal zone – begins at the external iliac arteries (see figure)

Is Malperfusion present?

H&P: Presented with complaints of acute chest pain and a syncopal episode. Workup included a CTA of the chest which confirmed diagnosis of an acute aortic dissection. In the ED, patient was noted to have poor perfusion of the left lower extremity associated with numbness and motor dysfunction. She otherwise appeared to be grossly neurologically intact.

CT: Intra-abdominal extension of the dissection which involves the celiac axis with associated high-grade stenosis . The splenic artery originates from the false lumen. High-grade stenosis of the SMA origin which subsequently demonstrates a long segmental occlusion with some distal reconstitution. The left renal artery originates from the false lumen with associated left renal infarcts. The dissection extends into the left common iliac artery which demonstrates a long segmental occlusion.

Op Note: Acute Stanford type A thoracic aortic dissection
Left lower extremity malperfusion

Answer Yes, patient has malperfusion

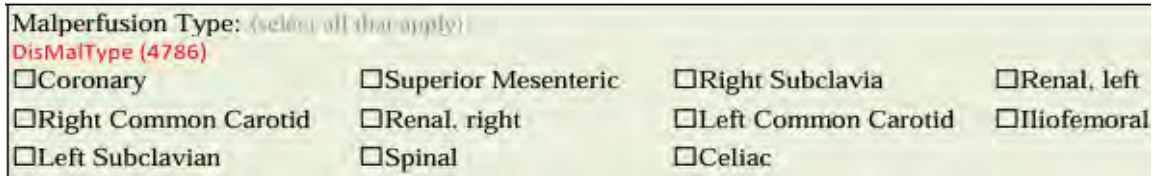
- **The surgeon must identify and document if malperfusion is present. It is not up to the Data Manager to look at imaging results and determine if malperfusion is present.**
- **Code 'Yes' if the Surgeon documents that any vessel is malperfused and has compromised blood flow**
- **Unknown - code "unknown" if the surgeon indicates that the imaging is inadequate to confirm the presence or absence of malperfusion.**

What type of Malperfusion is present?

H&P: Presented with complaints of acute chest pain and a syncopal episode. Workup included a CTA of the chest which confirmed diagnosis of an acute aortic dissection. In the ED, patient was noted to have poor perfusion of the left lower extremity associated with numbness and motor dysfunction. She otherwise appeared to be grossly neurologically intact.

CT: Intra-abdominal extension of the dissection which involves the celiac axis with associated high-grade stenosis . The splenic artery originates from the false lumen. High-grade stenosis of the SMA origin which subsequently demonstrates a long segmental occlusion with some distal reconstitution. The left renal artery originates from the false lumen with associated left renal infarcts. The dissection extends into the left common iliac artery which demonstrates a long segmental occlusion.

Op Note: Acute Stanford type A thoracic aortic dissection
Left lower extremity malperfusion


Malperfusion Type: (select all that apply)
DisMalType (4786)

☐Coronary	☐Superior Mesenteric	☐Right Subclavia	☐Renal, left
☐Right Common Carotid	☐Renal, right	☐Left Common Carotid	☐Iliofemoral
☐Left Subclavian	☐Spinal	☐Celiac	

Answer – Iliofemoral Artery Malperfusion

Iliofemoral Artery Malperfusion- The Iliofemoral system includes the internal iliac vein, the external iliac vein, the common iliac vein, the femoral artery and the popliteal artery. This results in of inadequate blood flow to the lower extremities due to disruption of the aortic supply to the iliac and femoral arteries.

The surgeon must identify and document the type of malperfusion present. It is not up to the Data Manager to look at imaging results and determine if malperfusion type.

What is the Lower Extremity Motor Function?

H&P: Presented with complaints of acute chest pain and a syncopal episode. Workup included a CTA of the chest which confirmed diagnosis of an acute aortic dissection. In the ED, patient was noted to have poor perfusion of the left lower extremity associated with numbness and motor dysfunction. She otherwise appeared to be grossly neurologically intact.

Patient has minimal past medical history. Hypertension, Raynaud's syndrome.

Pulses 2+ right radial, 1+ left radial, 2+ right femoral, absent left femoral.
Abdomen nondistended and nontender.
Marked paresis of the left lower extremity with decreased sensation.

Answer – Weakness

Paresis is a condition typified by a weakness of voluntary movement, or by partial loss of voluntary movement or by impaired movement.

Does the patient have lower extremity sensory deficit?

H&P: Presented with complaints of acute chest pain and a syncopal episode. Workup included a CTA of the chest which confirmed diagnosis of an acute aortic dissection. In the ED, patient was noted to have poor perfusion of the left lower extremity associated with numbness and motor dysfunction. She otherwise appeared to be grossly neurologically intact.

Patient has minimal past medical history. Hypertension, Raynaud's syndrome.

Pulses 2+ right radial, 1+ left radial, 2+ right femoral, absent left femoral.
Abdomen nondistended and nontender.
Marked paresis of the **left lower extremity with decreased sensation.**

Answer – Yes

The intent is to identify if the patient has any NEW sensory deficit of either lower extremity as a presenting symptom.

Report “yes” if any note comments on numbness or insensate areas that were not recorded in the past medical history.

Open Discussion

Please use the raise-hand function.

Please use the Q&A Function.

We will answer as many questions as possible.

We encourage your feedback and want to hear from you!

Thank You for Joining!

Reminder: Our next ACSD QI Series Webinar will be held on Wednesday, July 15, 2026, at 2pm CT/3pm ET.