The Society of Thoracic Surgeons

General Thoracic Surgery Database Monthly Webinar

October 8, 2025

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

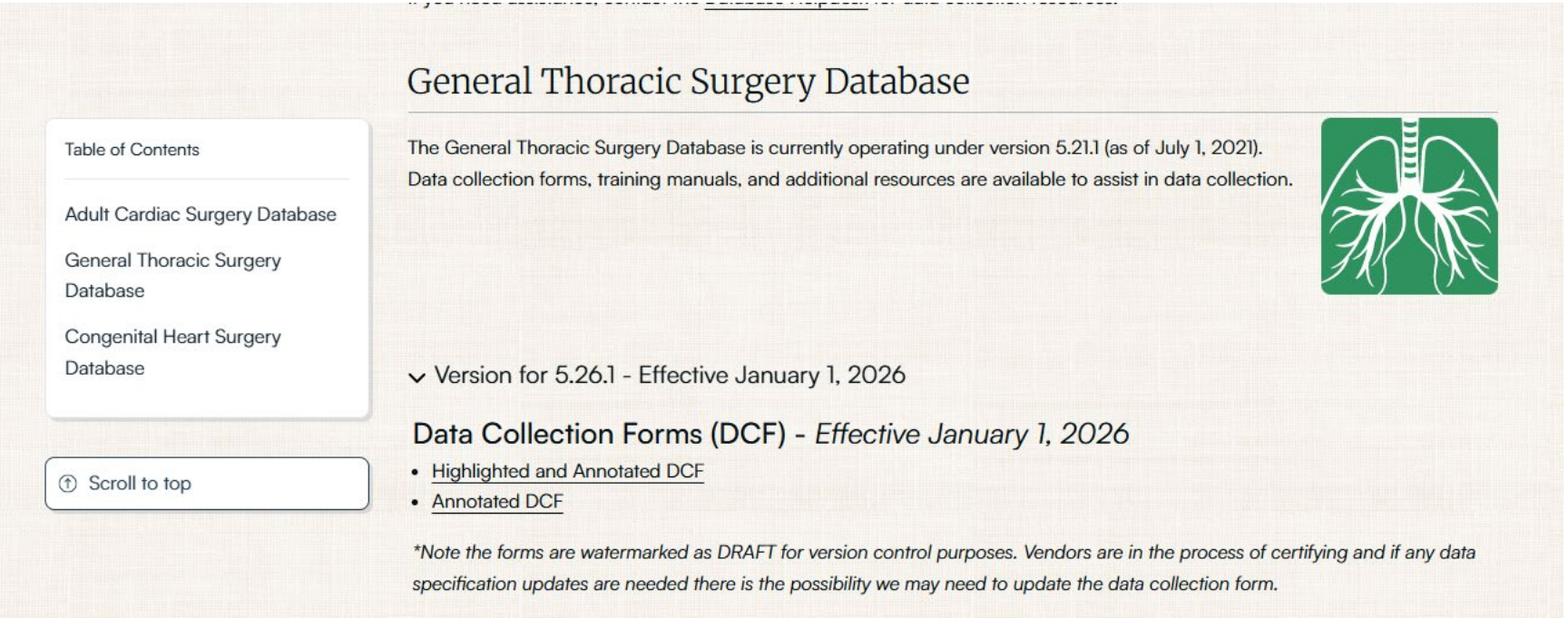
Agenda

- Welcome and Introduction
- STS Updates
- Data Manager Education
- Q&A

STS Updates

- Fall 2025 Harvest (Includes Surgery dates July 1, 2022 – June 30, 2025)
  - Analysis results are being reviewed and should be available to Participants next week.
  - Official email communication will be sent once results have been posted
- 2026 Harvest Dates coming soon!
- ‘Draft’ v5.26.1 Data Collection Form Posted on STS website

STS Updates



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General Thoracic Surgery Database

The General Thoracic Surgery Database is currently operating under version 5.21.1 (as of July 1, 2021). Data collection forms, training manuals, and additional resources are available to assist in data collection.

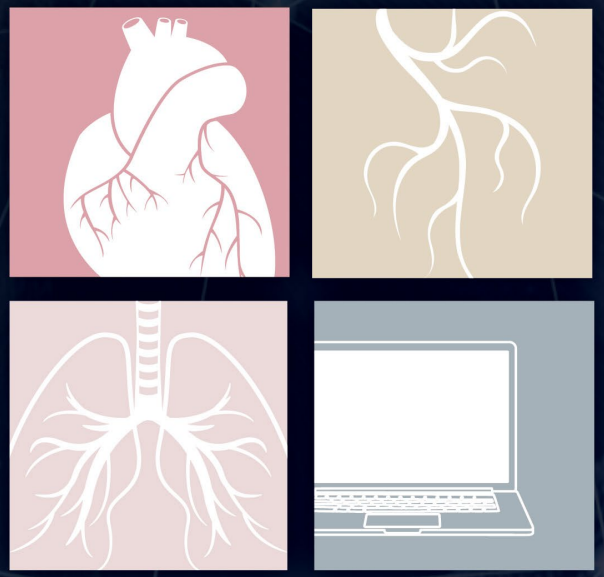
Version for 5.26.1 - Effective January 1, 2026

Data Collection Forms (DCF) - *Effective January 1, 2026*

- Highlighted and Annotated DCF
- Annotated DCF

**Note the forms are watermarked as DRAFT for version control purposes. Vendors are in the process of certifying and if any data specification updates are needed there is the possibility we may need to update the data collection form.*

- Should only be used with OR dates January 1, 2026, forward
- Vendors are updating software and will begin certifications in the coming months
- Upgrade webinars will begin in November (exact dates/times coming soon!)
  - Email communication will be sent with webinar details



ADVANCES IN QUALITY & OUTCOMES:

A Data Managers Meeting

SEPTEMBER 25-26, 2025 • SAN ANTONIO, TX

#AQO2025


Thank you!

AQO 2026 – New Orleans

- September 23 – 25, 2026
- GTSD Session will be held Sept 23rd and 24th
  - Wednesday – full day of content
  - Thursday – Breakout Sessions 8am -11am

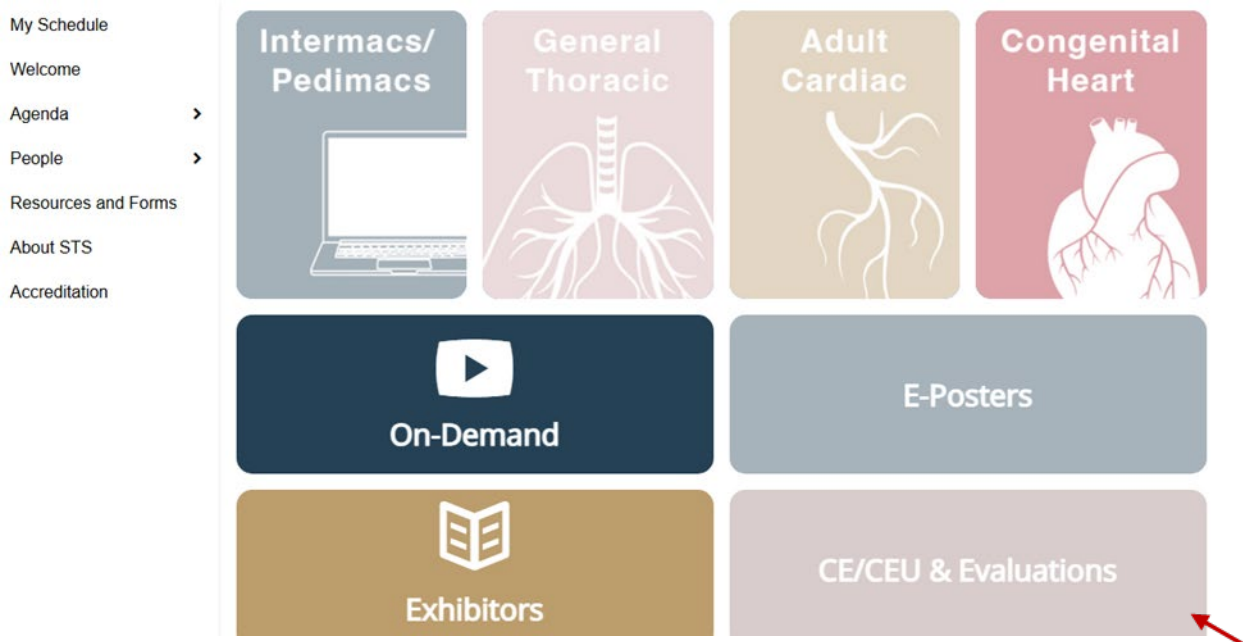
Virtual Pass Still Available!

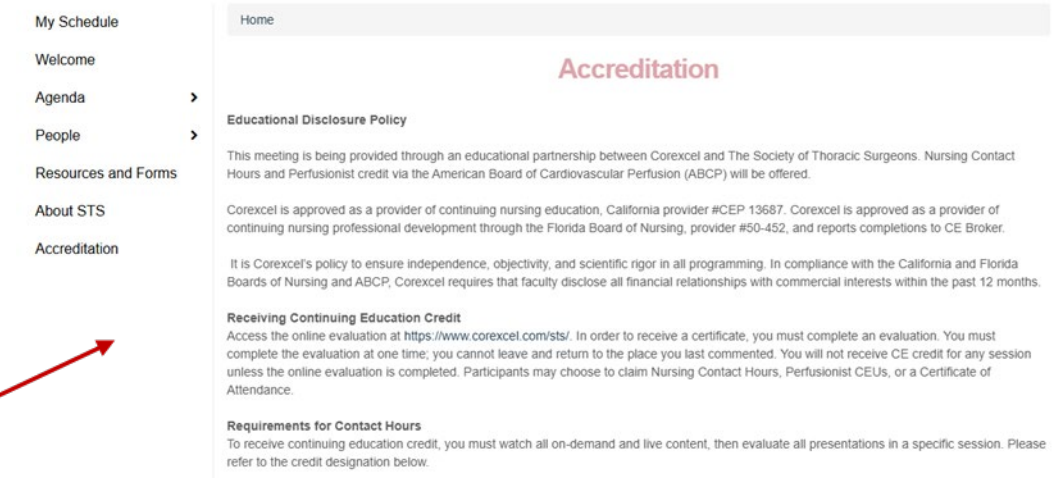
- Purchase Virtual Pass
- Last day to purchase is November 21st

Post AQO - Content Availability

- Recordings of the live sessions will be available in early October and will remain on the virtual platform until mid-December
  - AQO Meeting Platform
- Content will then move to the STS Learning Center
- Attendees will have access to all PowerPoint slides, Handouts, Case Scenarios and videos until AQO 2026!

CE/CEU Evaluations





- Don’t forget to view all on-demand content and live content prior to completing your evaluations.
- You must complete the evaluation at one time; you cannot leave and return to the place you last commented.
- **Deadline to claim credit is Friday, December 26, 2025.**

AQO GTSD Hot Topics Webinar

- The AQO Hot Topics Webinar is planned for November 3rd 10amCT – 2pmCT.
- We will bring back select speakers and provide additional opportunities for Q & A.
- A webinar link will be sent via email.

STS Education

CASE INCLUSION

CASE INCLUSION

Only NEW lung and esophageal cancer cases with a therapeutic resection are required for entry.

This excludes:

-Diagnostic procedures

-Procedures for patients with cancer that is recurrent (i.e. previously definitively treated with either resection or chemo/RT

-Patients previously definitively treated with SBRT (i.e. cyberknife)

-Patients with final pathology that is not lung cancer (i.e. mesothelioma, metastatic cancer, benign nodules etc.)

This includes:

- Patients that go to the OR with a lung nodule with final pathology of lung cancer w/ therapeutic resections

CASE INCLUSION

What about incidentally resected lung cancers?

For the current version, lung cancers that are therapeutically coincidentally resected must be entered.

For example, your cardiothoracic surgeon wedges out a lung nodule during a CABG with final path positive for lung cancer. No additional treatment for lung cancer is completed. This case must be entered.

The only exception is the incidental resection of cancer in explanted lungs.

*** This guidance may change with the next version.***

CASE INCLUSION

Question:
Question that I received from the site: I have a thoracic case that they made initial incision and then patient arrested and the procedure was aborted. Other than making the initial incision and then closing incision, that was all that happened. That case is excluded from STS, correct? The patient's surgery was rescheduled.

Answer:
Correct, this case would not be included.

If the patient had died and an analyzed procedure was being performed, the case would have been required for entry.

Mar 2022: If a patient goes to the OR for a pulmonary resection of a lung cancer or esophageal resection of an esophageal cancer and dies intraoperatively before the intended primary procedure is performed, code the intended primary procedure and capture the mortality in seq 4220.

CASE INCLUSION

Question:
Lung cancer was suspected- patient had diagnostic wedge done in the OR initially. Frozen path came back as non-cancerous intra operatively therefore no further resection or any node sampling was done. The final path report came back with a diagnosis of lung cancer, however. Should this case be included in the registry? I feel like once the intra-op path came back, the intent of the resection was diagnostic and therefore it should be excluded from the registry. No further resection is planned.

Answer:
The core group indicated this should be captured in the registry as a therapeutic wedge resection.

CASE INCLUSION

Question:

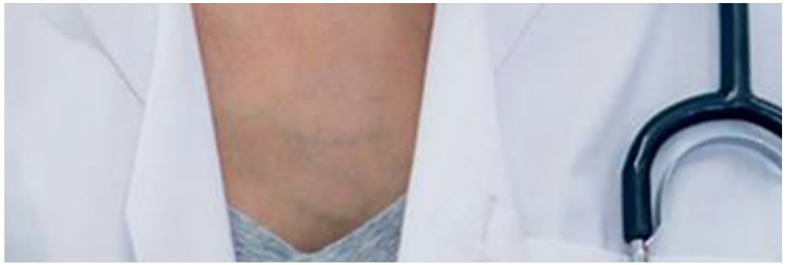
I'm trying to determine if this is a case to include. Pt has complex hx of recurrent squamous cell carcinoma in neck, tongue (mult oral cavity sites). Pt had a new R lung nodule concerning for malignancy. Pt had a wedge section. Path report says : lung tumor could represent metastatic squamous cell from the tongue. tumor shows similar morphology to this lung tumor. staging protocol completed in case it is lung primary. MD in OV after surgery states: I strongly suspect this is a metastatic lesion from his oral cavity cancer and less likely a lung primary.

Answer:

You will need to ask your surgeon if the case should be abstracted as a primary lung cancer or excluded as metastatic disease. The language in their note is not definitive.

Alternately, you can see if there is an oncology note that delineates if this was managed as metastatic vs primary disease.

SYNCHRONOUS PRIMARIES



SYNCHRONOUS PRIMARIES

The goal was and will remain to capture the data that most impacts your patients outcomes without collecting data that is unnecessary.

You should always:
Code your most invasive procedure as your primary procedure.
Code the final pathology of the lesion most likely to impact your patients long-term survival.
Provide clinical staging information as directed by your surgeon

In some cases, these data points will not all line up nicely.

For example: Patient w/ RLL wedge and RUL lobectomy with more aggressive pathology in RLL.

- Primary Proc: Lobe
- Final Path: RLL wedge lesion
- Clinical Staging: You may need to clarify with surgeon if they give two possible clinical stages

SYNCHRONOUS PRIMARIES

New sequence: ‘Synchronous Primaries Resected (same encounter)’ Yes/No

Surgeon leadership did not endorse collected path for all lesions resected. Burdensome and not meaningful data.

DIAGNOSTIC VS THERAPEUTIC RESECTIONS

DIAGNOSTIC VS THERAPEUTIC RESECTIONS

Takes practice.

Operative notes in isolation can be misleading.

Read your post-op visit note, oncology notes etc.

When in doubt, ask your surgeon.

DIAGNOSTIC VS THERAPEUTIC PROCEDURES

Question:
My patient was scheduled for a LLL lobectomy for biopsy proven LLL and L11 NSCLC-adenocarcinoma. Neoadjuvant chemo with post treatment PET/CT - EBUS. During the case there were several areas of abnormal appearing tissue on the posterior and posterior-lateral pleura as well as the diaphragm. Multiple biopsies was sent. Station 8 was sent for pathology. My surgeon noted a nodule at the base of the lingula and he did a diagnostic wedge of this. The frozen results returned with malignant cells of the pleural biopsies. He decided to abort the left lower lobectomy. Do I code this Upper Lobe, Lung cancer (C34.10) instead of Lung Cancer Lower Lobe (C34.30)? If I do, do I change the diagnostic wedge to therapeutic? 1510 Primary Lung Cancer, would this be No because it is metastatic? Or Would this be yes because the final path of the wedge was T3N1M1a, invasive adenocarcinoma, moderately differentiated.

Answer:

It sounds like your surgeon decided that based on intraoperative findings the patient was not a candidate for a therapeutic resection.

You do not need to enter the case. If you do choose to enter the case, your primary procedure will become the diagnostic wedge and it will be thrown out of analysis. You will say no to lung cancer because you do not have a surgery with curative intent.

Because the case will not be analyzed, you can really choose whatever location you would prefer to capture as the site of primary disease. If it was me, I'd keep the site of origination as the primary and not the location of the metastasis.

ANASTOMOTIC LEAKS

IS IT A LEAK?

Post-op UGI:
1/10/2025
"IMPRESSION:
1. Tiny projection of contrast at the level of anastomosis as described above. May be postsurgical change or mucosal redundancy, leak cannot be completely excluded. Consider short-term follow-up.
2. Delayed emptying of the intrathoracic stomach. No evidence of leak at pyloromyotomy."
1/12/2025
"IMPRESSION:
Postsurgical changes from esophagectomy and anastomosis of remnant esophagus with the stomach, without evidence of leak or stricture."
Treatment:
1/10/2025 Remained NPO with NG to LIS
1/10/2025 Note "Surgical Oncology would like us to hold off on starting empiric antimicrobial coverage due to potential anastomotic leak noted on UGI. They will re-evaluate if he develops a fever or otherwise clinically deteriorates."
1/12/2025 Started sips/chips

No – radiology hedged their bet. There was never a leak definitively diagnosed.

IS IT A LEAK?

Post-op UGI:
04/29/2025
"IMPRESSION:
1. No evidence of postoperative leak.
2. Small pneumothorax with chest tubes in place. Attention on follow-up can be performed"
4/30/2024 CT d/t Hypoxia
"IMPRESSION:
1. No evidence of an acute pulmonary embolus.
2. Large left hydropneumothorax.
3. Tiny right pneumothorax.
4. There are locules of pneumomediastinum along the inferior margin of the gastric pull-through tracking into the lower mediastinum and potentially into the left pleural space, suspicious for leak.
5. Atelectasis throughout both lung fields relating to volume loss and mass effect from the gastric pull-through.
6. There appear to be superimposed bilateral infectious/inflammatory airspace infiltrates.
7. Retained or aspirated fluid debris in the mainstem bronchi."
5/3/2024 Repeat UGI
"IMPRESSION:
1. No evidence of leak at the esophagogastric anastomosis.
2. Obstruction of contrast at the level of the the distal aspect of the gastric conduit. Suspect stricture at the level of the diaphragmatic crus. Due to inadequate contrast in the distal aspect of the stomach, unable to rule out leak in this area. Consider follow-up CT scan for further evaluation if warranted. Consider maintaining NG tube to low to intermittent suction.
3. Air-fluid levels of the bowel. Suspect ileus.
4. Small aspiration of contrast. Most likely related to NG tube. Consider reevaluation with video swallow study after NG tube removal."

Treatment:
4/30/2024 Chest Tube placed and NPO with NG to LIS
5/3/2025 remained NPO with BG to LIS d/t gastroparesis, with minimal gastric emptying
5/5/2025 Botox given and diliation via EGD
5/8/2025 Clear liquids started

HEDGING IN RADIOLOGY REPORTS

SPEAKING OF LANGUAGE

JENNY K. HOANG, MBBS

Do Not Hedge When There Is Certainty

Impression: (1) No definite fracture seen on cervical spine CT. (2) A 3-cm spiculated mass in the right upper lobe could possibly represent malignancy.

The impression of the radiology report reflects the radiologist's interpretation of actionable findings on the imaging study. Sometimes radiologists cannot be certain of the diagnosis and may provide differential diagnoses and recommend additional or follow-up imaging. However, when there is near certainty about the diagnosis and there is no differential diagnosis, radiologists should convey confidence. There should be no hedging.

Phrases that impart high confidence to readers are "characteristic/pathognomonic," "consistent with," or simply the diagnosis with no qualifier [1]. Unfortunately, some radiologists too often use words and phrases such as "likely," "possible," "may represent," and "could represent," even if the diagnosis is certain. Many also qualify their interpretations of normal studies with "no definite/apparent" and "not seen/appreciated." In both sets of circumstances, their failure to be definitive incorrectly implies doubt when there is no doubt.

Not communicating certainty may be due to lack of experience, fear of medicolegal liability for misdiagnosis, or just the opinion that imaging is not definitive. However, this practice is potentially harmful. Inappropriately implying doubt when the diagnosis is definite could delay management, lead to unnecessary investigations, or waste precious physician time through unnecessary consultation between the radiologist and the referrer. Aside from eroding the reputation of the individual radiologist, it also perpetuates the opinion that our profession too frequently "hedges" and does not share responsibility in patient care. In the example mentioned previously the radiologist would better serve herself and readers by using language that expresses certainty and inverting the two impressions so that the more important one comes first by stating, "(1) A 3-cm spiculated mass in the right upper lobe is consistent with malignancy. (2) No fracture."

In conclusion, both what we say and how we say it matter. Radiologists should not hedge when there is certainty. Our reports should leave no room for miscommunication.

REFERENCE

1. Lindley SW, Gillies EM, Hassell LA. Communicating diagnostic uncertainty in surgical pathology reports: disparities between sender and receiver. Pathol Res Pract 2014;210:628-33.

http://dx.doi.org/10.1016/j.jacr.2016.08.027 ■ S1546-1440(16)30803-1

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1546-1440/16/$36.00 ■ http://dx.doi.org/10.1016/j.jacr.2016.09.045

VERSION UPGRADE

Start working with your pathologists now if you are commonly missing information in path reports!

To: Surgeon or Pathologist

Subject: STS Thoracic Registry- Entry help needed

Greeting

Dear _____,

Short statement/clear question

Can you help me clarify a nodal station for the patient below?

Pt information etc.

Give STS requirements (statements, snips from the training manual, etc.)

On the STS Thoracic Registry data collection form, I need to give the status (benign, malignant, not sampled) of all nodal stations.

Provide information about the question or situation that you need help with. (Include screenshots as appropriate.)

Is a station 9 lymph node what is being reported as "A" in the Final Diagnosis section?


Final Diagnosis
A. LEFT CHEST LYMPH NODE, BIOPSY:
One lymph node negative for carcinoma (0/1)

The Gross Description lists - A "left chest lymph node#9"

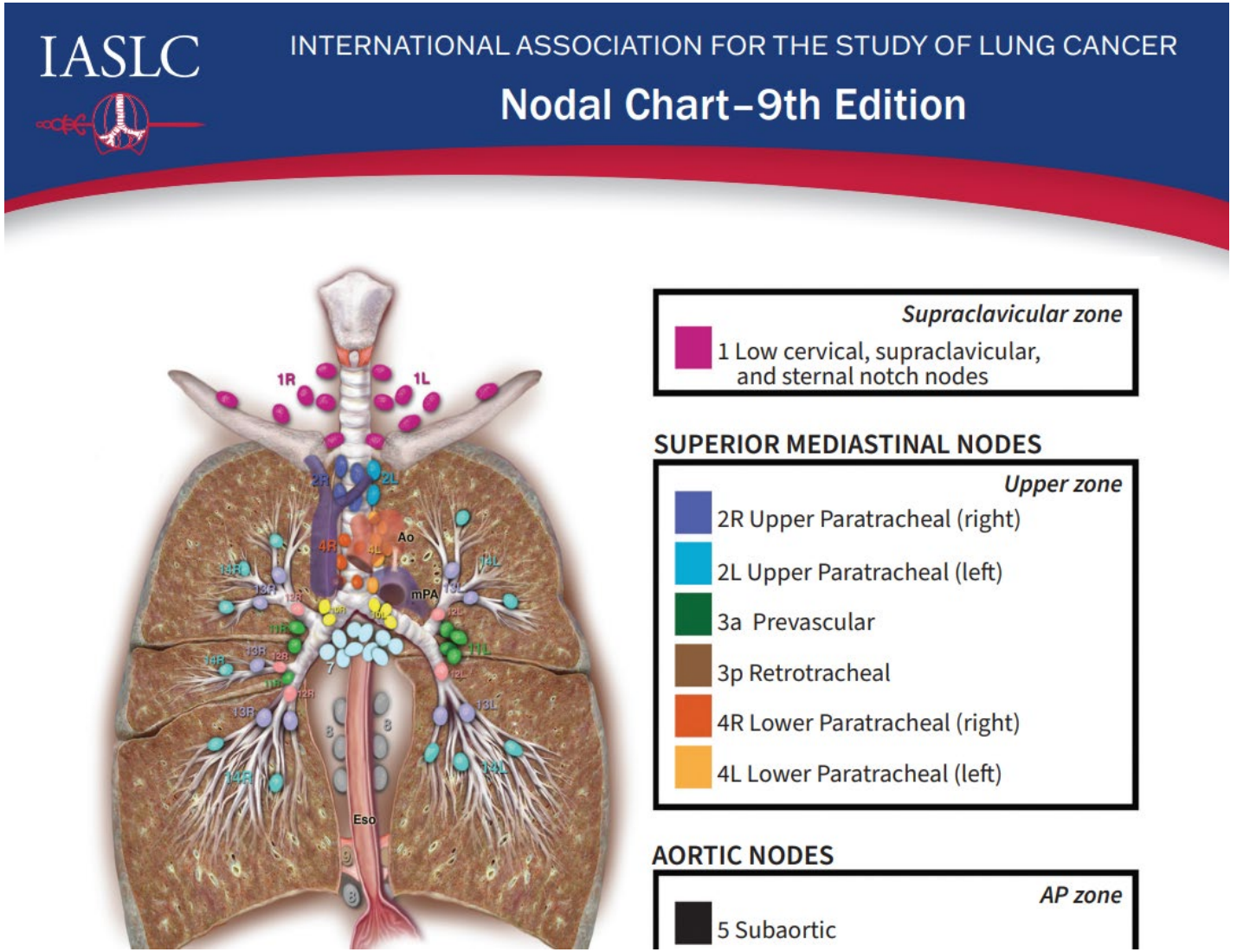

Gross Description
A.
Received fresh, and subsequently placed in formalin, and labeled with the patient's name, medical record number, and "left chest lymph node #9"

The Synoptic Checklist does not include Station 9


Nodal Site(s) Examined
7: Subcarinal
5: Subaortic / aortopulmonary (AP) / AP window
10L: Hilar
11L: Interlobar
Left: Peribronchial and parenchymal

VERSION UPGRADE: ONCOLOGY FOCUSED

Free Download: https://www.iaslc.org/research-education/publications-resources-guidelines/staging-cards-thoracic-oncology-9th-edition



Open Discussion

Please use the Q&A Function.

We will answer as many questions as possible.

We encourage your feedback and want to hear from you!

Upcoming GTSD Webinars

Monthly Webinar

- November 12 @ 2:30ET (1:30CT)
- December 10 @ 2:30ET (1:30CT)

AQO Hot Topics

- November 3 @ 11:00amET (10:00amCT)

Contact Information

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- Ljones@sts.org
- 312-202-5822

Helpdesk Support

(Harvest Questions/Analysis Report Questions)

- STSDB_helpdesk@sts.org

Database Operational Questions

(Database Participation, Contracts, etc.)

- STSDB@sts.org

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THANK YOU FOR JOINING!