



STS National DatabaseTM

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Society of Thoracic Surgeons

General Thoracic Surgery Database
Monthly Webinar

January 12, 2022



GTSD Monthly Webinar

- Welcome and Introductions
- STS Updates
- Education (Ruth Raleigh, GTSD Consultant)
- IQVIA Update
- User Feedback
 - Include Ticket Number/Case Number

STS Updates

- **January Training Manual Coming Soon**
 - Waiting on FAQ Response?
 - Core Group Call Scheduled for Tomorrow
- **Fall 2021 Harvest Update**
 - Analysis Data set received from DCRI
 - Risk Adjusted Report will be available in the coming weeks
 - New Pulmonary Resection Composite implemented
 - Presented during November Monthly webinar
- **Covid Update**
 - **12/28/2021 - Official STS communication sent to STS Database Participants**
 - Any Covid positive patient will continue to be excluded from current analyses (2021 and Spring 2022)
 - Impacts 2.61% of all cases in GTSD
 - Analysis exclusions will cease for any record with a surgery date of January 1, 2022 forward
 - Continue to collect Covid variables until further notice



STS Updates

- 2022 Harvest Schedule Now Available
 - Spring 2022 - Submit your data now!!!

General Thoracic Surgery Database - 2022

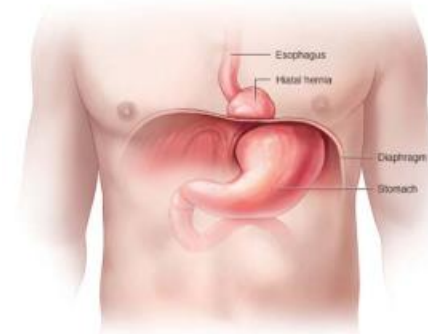
	Harvest Submission Window Close	Opt-Out Date	Includes Procedures Performed Through:	Report Posting	Comments
Spring 2022	3/4/2022	3/8/2022	12/31/2021	Summer 2022	Star Rating
Fall 2022	9/9/2022	9/13/2022	6/30/2022	Winter 2022	Star Rating



Ruth Raleigh
GTSD Consultant/Core Group
St. Joseph Mercy Hospital

Hernia Inclusion Criteria - UPDATE

- Code 'yes' to seq 1560 if a hiatal hernia aka paraesophageal hernia repair is completed.
- Code 'no' to seq 1560 for all types of diaphragmatic hernia repairs – including congenital and acquired.

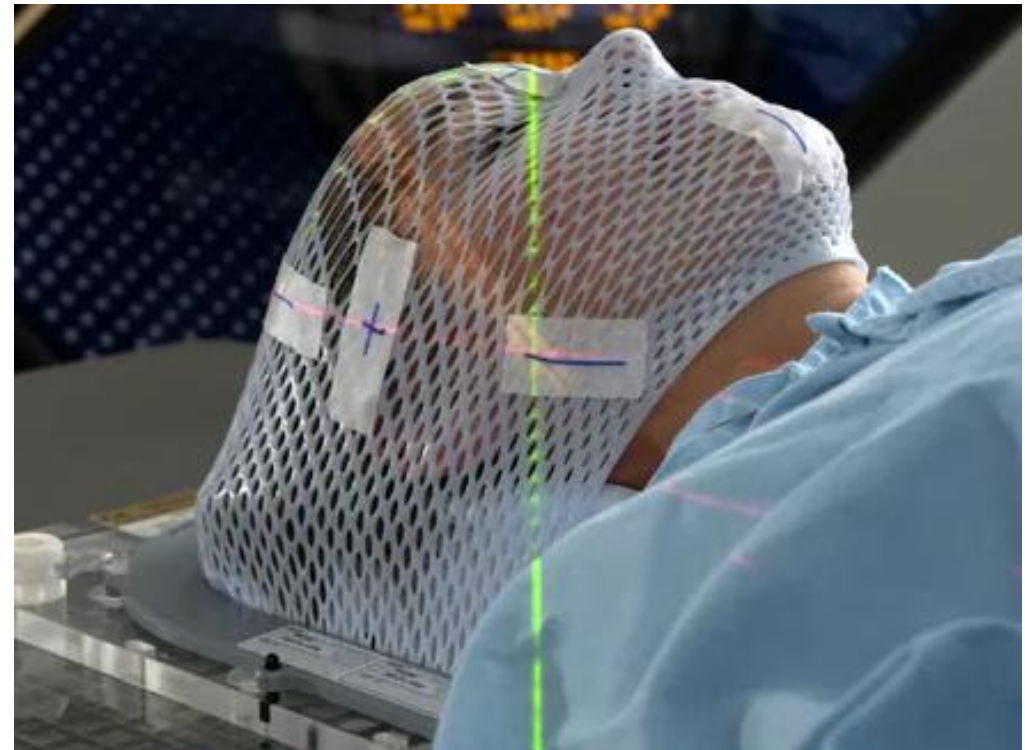


Procedure Laterality: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Not applicable		
Primary Lung Cancer Resection Performed	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, complete Section F)
Esophageal Cancer Resection Performed	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, complete Section G)
Thymus / Mediastinal Mass Resection/ Myasthenia Gravis	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, complete Section H)
Tracheal Resection	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, complete Section I)
Hiatal Hernia / Diaphragmatic Hernia / GERD	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, complete Section J)

Pathological M Staging – Seq 2060

If a patient has oligometastatic disease (commonly to the brain or adrenal glands), a curative lung resection may still be performed. The surgeon will generally note the plan for treatment of the metastasis in their pre-op note.

In these cases, the pathological M stage will not be taken from the pathology report but rather your surgeon or oncologists note.



Seq 4030

- Code 'yes' to sequence 4030 for a chest tube incision that meets the clinical criteria for an SSI. Chest tube incisions are considered secondary incisions.

Surgical Site Infection (SSI): Superficial incisional SSI Must meet the following criteria:

Date of event for infection occurs within 30 days after any NHSN operative procedure (where day 0 = the procedure date) AND involves only skin and subcutaneous tissue of the incision AND patient has at least one of the following:

- a. purulent drainage from the superficial incision.
- b. organisms identified from an aseptically obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (for example, not Active Surveillance Culture/Testing (ASC/AST).
- c. superficial incision that is deliberately opened by a surgeon, attending physician** or other designee and culture or non-culture based testing is not performed. AND patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat.
- d. diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.

There are two specific types of superficial incisional SSIs:

1. Superficial Incisional Primary (SIP) – a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (for example, C-section incision or chest incision for CBGB)
2. Superficial Incisional Secondary (SIS) – a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (for example, donor site incision for CBGB)

An infected burn wound is classified as BURN and is not an SSI.

Seq 870 – ECOG

Provider documented Zubrod or Karnofsky Performance Scale Score may be crosswalked to ECOG and coded for sequence 870. Your site must keep a record of the crosswalk used for entry and it must be used for all cases.

Karnofsky Status	Karnofsky Grade	ECOG Grade	ECOG Status
Normal, no complaints.	100	0	Fully active, able to carry on all pre-disease performance without restriction.
Able to carry on normal activities. Minor signs or symptoms of disease.	90	1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
Normal activity with effort.	80	1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
Care for self. Unable to carry on normal activity or to do active work.	70	2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours.
Requires occasional assistance, but able to care for most of his needs.	60	2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours.
Requires considerable assistance and frequent medical care.	50	3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours.
Disabled. Requires special care and assistance.	40	3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours.
Severely disabled. Hospitalisation indicated though death nonimminent.	30	4	Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair.
Very sick. Hospitalisation necessary. Active supportive treatment necessary.	20	4	Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair.
Moribund	10	4	Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair.



More on ECOG

Q: In Epic, there is a cancer staging tab which includes clinical and pathological sections. The ECOG score is documented in the pathologic section. Is this a score that I can abstract or is this considered post-op since it is in the pathologic section?

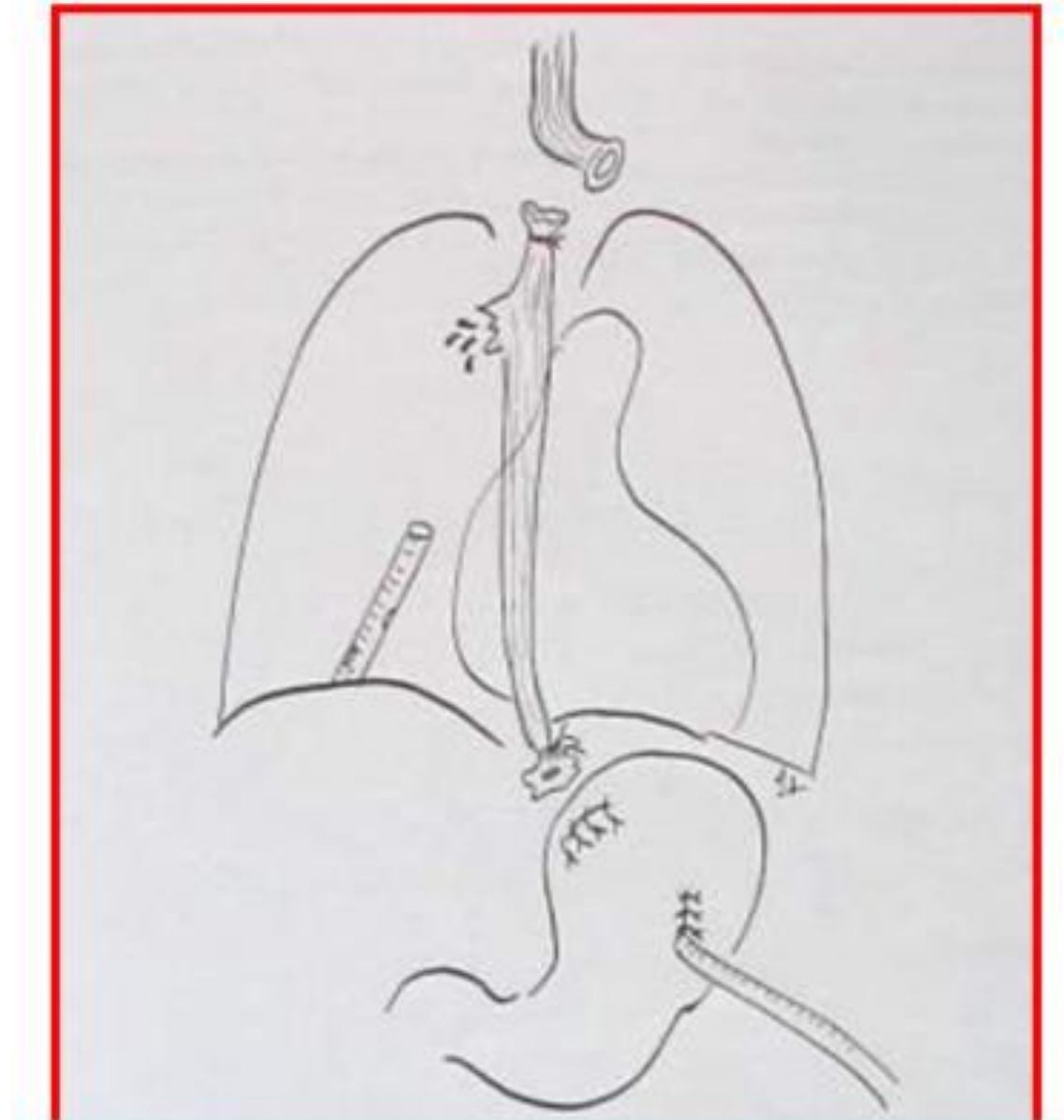
A: To use the ECOG score documented in that location you would need to know who entered it and when it was entered. A post-operatively assigned ECOG score cannot be coded.

Seq 2360/2370 – Anastomotic Method & Conduit

Leave 2360 and 2370 blank if a
bipolar exclusion of the esophagus
is performed.

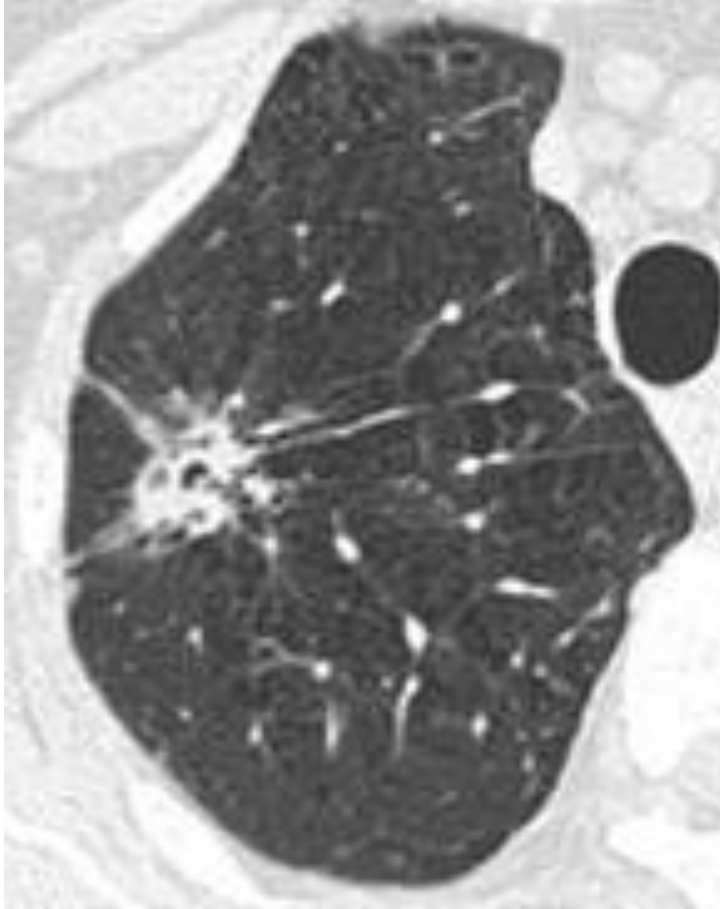
There is no anastomosis or
conduit.

This will be addressed in the next
version.



Clinical Staging Lung Cancer

Tumor Size – Seq 1800



Fleischner guidelines direct radiologists to provide a mean nodule size for nodules less than 10mm. Maximum dimensions are to be reported for nodules greater than 10mm. Given that most resected nodules are greater than 10mm – always report the largest size and not a mean measurement for seq 1800.



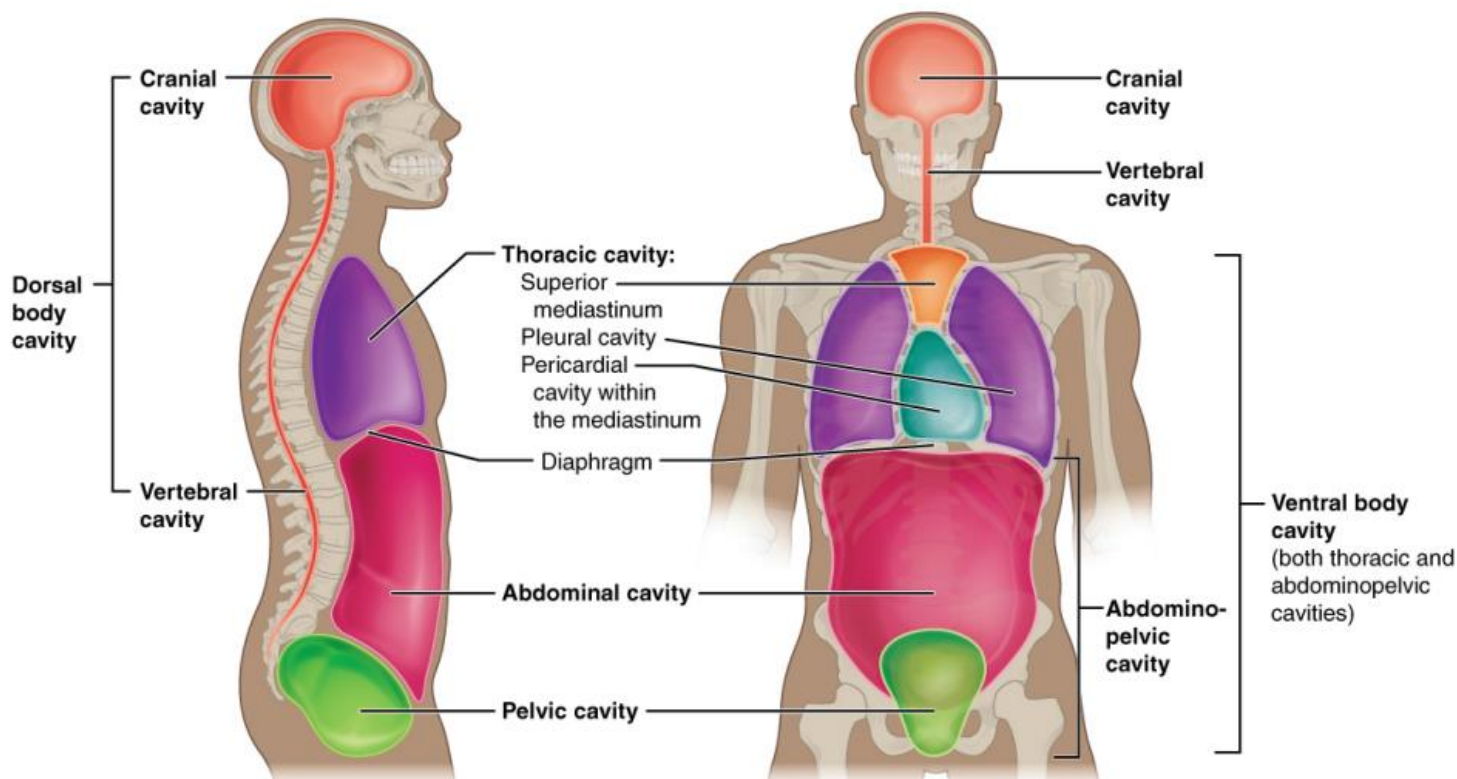
Polling Question

A patient with a history of prior transapical TAVR is now undergoing a lobectomy for lung cancer.

How would you abstract #580 (Prior Surgical History in Planned Operative Field)?

1. Yes

★ 2. No





Polling Question

During clinical staging for lung cancer, a patient undergoes a CT guided needle biopsy of a left lower lobe tumor.

Should this be captured in sequence #1630 (IR Needle Biopsy)?

1. Yes

★ 2. No

Aug 2021: Question - How do I capture a Core Needle Biopsy of the lung mass itself preop? It is not a mediastinal lymph node biopsy? Answer – core needle biopsies of the lung mass are not captured in V5.21.



Polling Question

Pathology reports that within the left upper lobe specimen, seven peribronchial nodes were found and are negative.

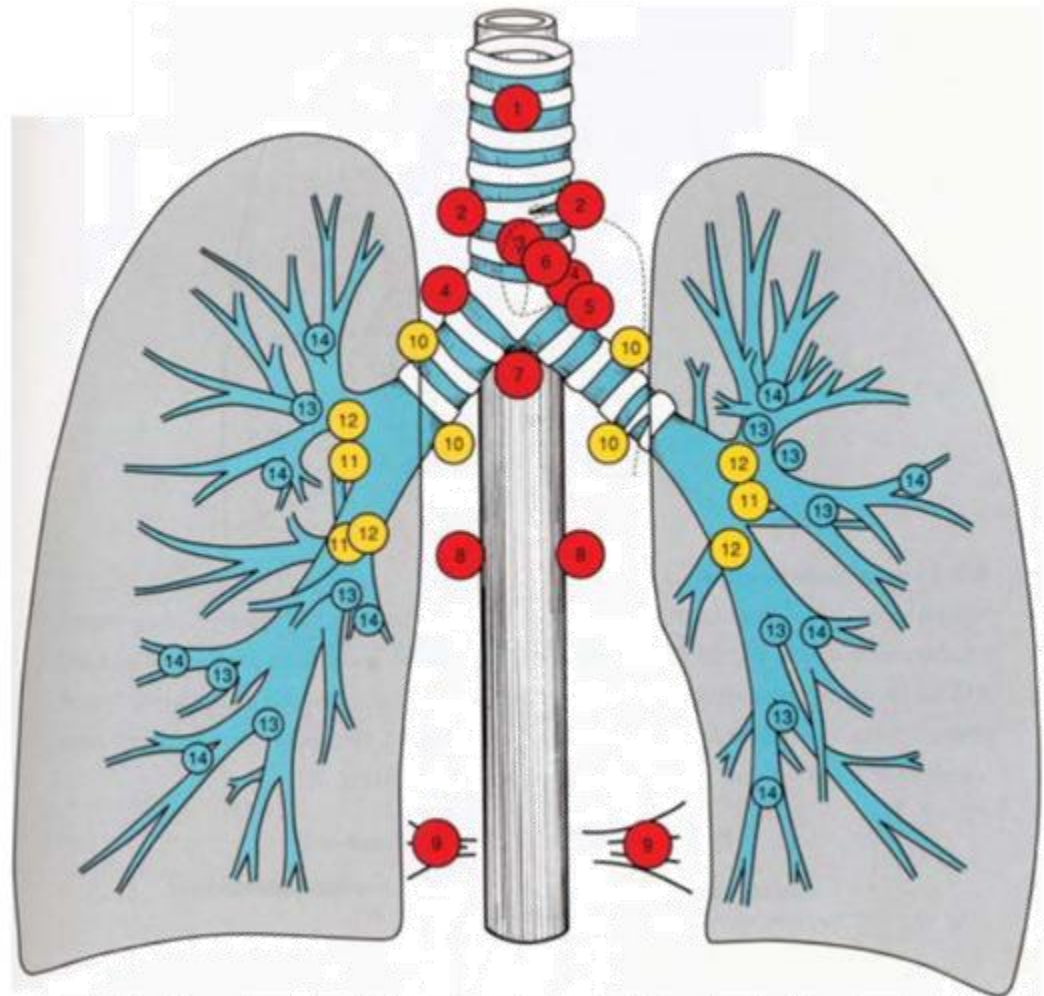
Peribronchial nodes should be captured under which station?

1. 4

2. 7

3. 11

★ 4. 12





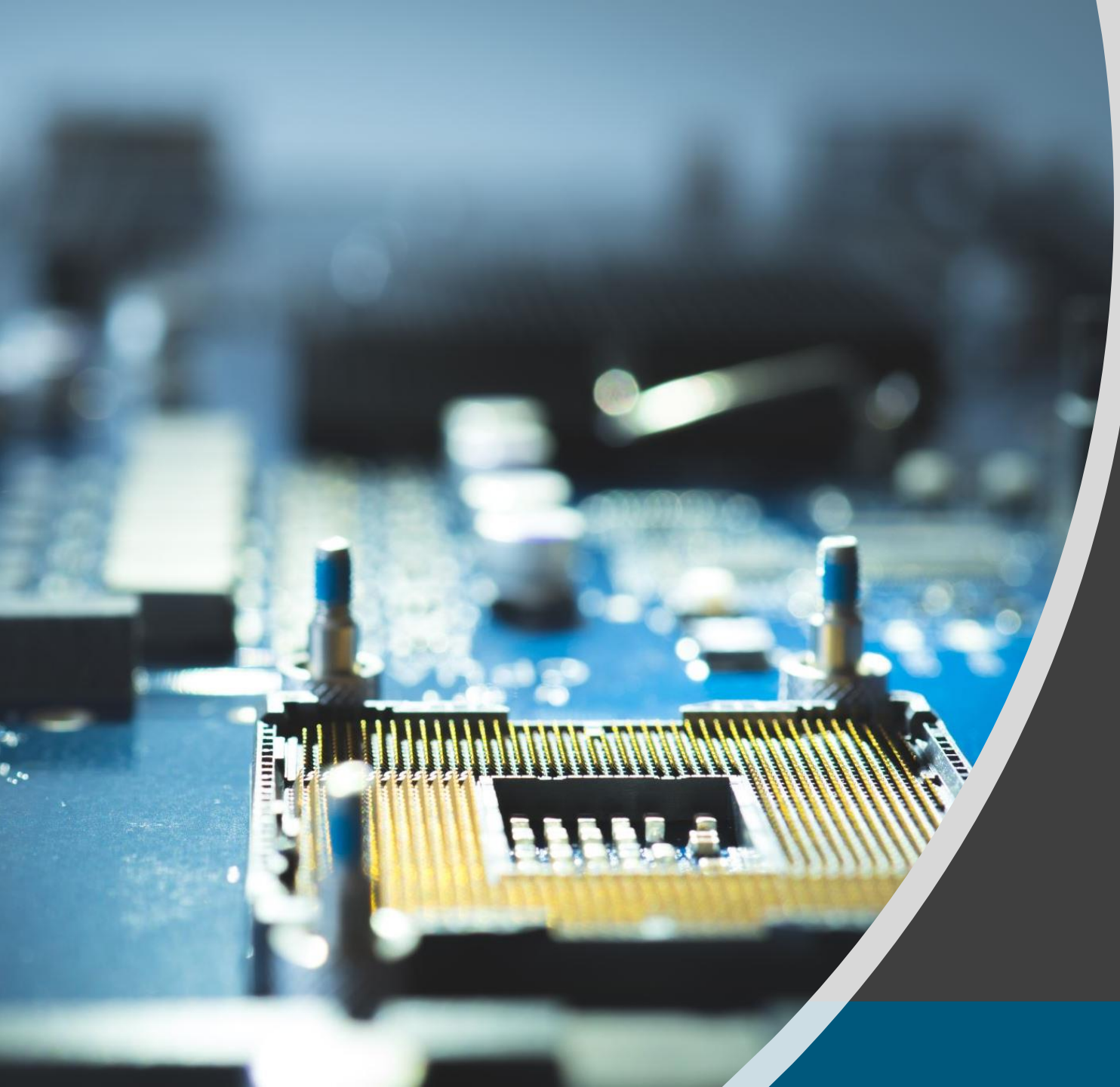
Polling Question

Following an esophagectomy, a patient returns to the operating room due to suspected anastomotic leak. An EGD is performed, the leak is confirmed, and a stent is placed.

How would you capture #3670
(Did the patient have another operation through a new or existing incision)?

1. Yes
- ★ 2. No

Esophagogastric leak from anastomosis, staple line or localized conduit necrosis PosOpProcAL (3920)	<div>✗ Yes <input type="checkbox"/> No</div> <div>(If Yes →)</div>	Type: POTypeAnasLeak (3930) <input type="checkbox"/> Type 1 - Local defect requiring no change in therapy or treated medically or with dietary modification
		✗ Type 2 - Localized defect requiring interventional but not surgical therapy
		<input type="checkbox"/> Type 3 - Localized defect requiring surgical therapy



IQVIA Review

Joe Brower

IQVIA Release December 2021

IQVIA Updates - December 2021 Release

The items below were released in December 2021.

Direct Data Entry (DDE) Validations

- **STS-7157/STS-7239** – User request to reduce the severity level on identified require fields from critical errors to errors for direct data entry users

Risk Adjusted Dashboard Report

- **STS-6817** – Risk Adjusted Report – Report displayed Missing Forced Expiratory Volume Test Performed as “missing” and the variable was not missing.
- **STS-6921** – Risk Adjusted Report – Report displayed a mismatch in the number of operative mortalities count and patients the appeared in the drill down list

IQVIA Release December 2021

IQVIA Updates - December 2021 Release

The items below were released in December 2021.

Missing Variable Report

- **STS-6967** – Missing Variable Report – The report displayed MortDate as missing for all patients who did not expire
- **STS-7050** - Missing Variable Report - The LFUDATE and LFUMORTSTAT is reported as missing when the record is associated with an earlier demographic data version (2.2, 2.081, 2.07, 2.06)
- **STS-7100** – Missing Variable Report – The report is flagging the Racemulti field as missing within the 5.21.1 data version when associated with an earlier demographic data version
- **STS-7332** – Missing Variable Report – Sites are reporting that the Analyzed/Non-Analyzed Procedure Filters are not displaying

IQVIA Release January 2022

IQVIA Updates - January 2022 Release

The GTSD Participant (Non-Analyzed) Dashboard will be updated to include the 5.21.1 data version changes will be released the weekend of January 15.

Users will be able to access the updated report Monday, January 17.

IQVIA and STS will continue to enhance the dashboard report to include additional variables for reporting visibility.

Known Issues Posted to Library

Please note: The full known issues and enhancements list will be posted to the Library in the IQVIA platform for user review.

IQVIA Update

Please note: Submitted tickets are currently under review and the IQVIA support team will follow up on resolution and/or target release confirmation.

The IQVIA Team is currently reviewing items to be targeted for an upcoming release. Those items will be posted to the Notifications section.

Analysis Report Questions

- Please contact IQVIA Support
 - gtsdtechsupport@iqvia.com
- STS/DCRI will be looped in as needed when tickets are escalated to Tier 2



Contact Information

**Leigh Ann Jones, STS
National Database
Manager, Congenital and
General Thoracic**

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

**Database Operational
Questions**

- STSDB@sts.org

Upcoming GTSD Webinars

User Group Call

- January 26@ 2:30CT
- February 23 @ 2:30CT

Monthly Webinar

- February 9 @ 1:30CT
- March 9 @ 1:30CT



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!



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THANK YOU FOR JOINING!