



Society of Thoracic Surgeons

General Thoracic Surgery Database
Monthly Webinar

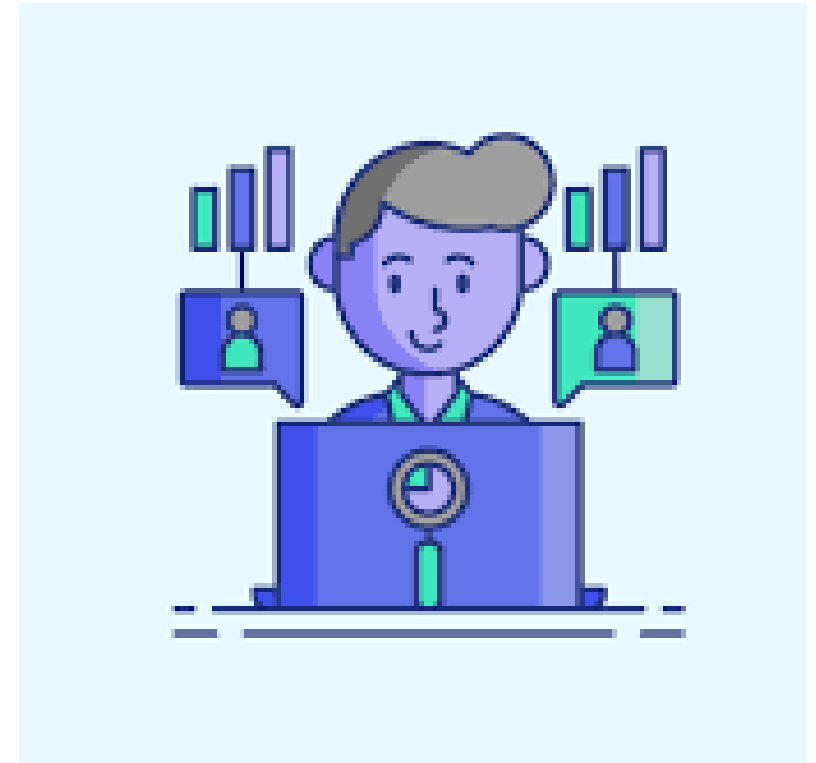
September 13, 2023

Agenda

- Welcome and Introduction
- STS Updates
- Temporary Fields (Dr. Chris Seder, GTSD Task Force Chair)
- Education Update (Ruth Raleigh, GTSD Consultant)
- Q&A

STS Updates

- September Training Manual to be posted by end of week
- Fall 2023 Harvest Close closed Friday, Sept. 8th
 - Surgery dates 7/1/2020 – 6/30/2023
- GTSD Public Reporting
 - Next update scheduled for Winter 2023 and will reflect 2023 Fall Harvest results
- Spring 24 Harvest is underway
 - Surgery dates 1/1/2021 – 12/31/2023
 - Official harvest close date coming soon!



STS Updates

- Activating two of the STS Temporary Fields – **October 1, 2023**
 - Seq. 4580 - TempYN1
 - Seq. 4620 – TempText
 - STS will send formal communication to all GTSD Participants and Vendors
 - **IF you are currently using these two fields STOP!**

Long Name: Temporary Yes/No Field #1 *SeqNo:* 4580
Short Name: **TempYN1** *Core:* Yes
Section Name: STS Temporary Fields *Harvest:* Yes
DBTableName Operations
Definition: This is a temporary field that should not be used for data collection until expressly instructed to by the STS.
Data Source: User *Format:* Text (categorical values specified by STS)

Harvest Codes:

<u>Code:</u>	<u>Value:</u>
1	Yes
2	No

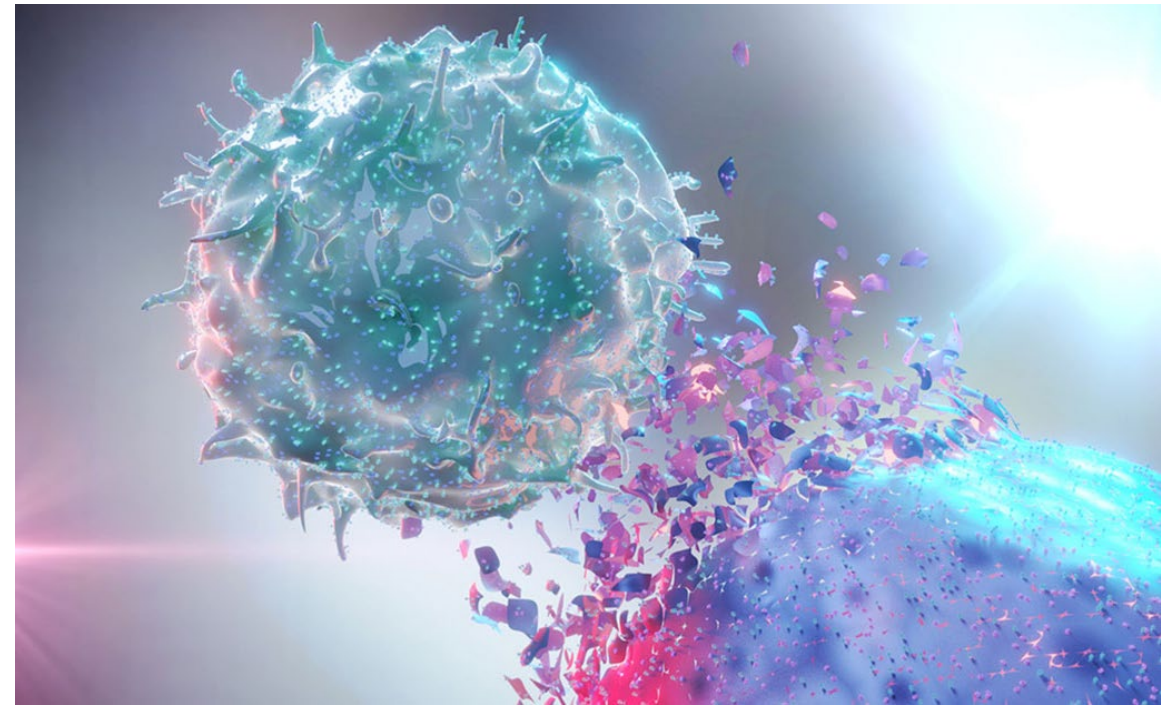
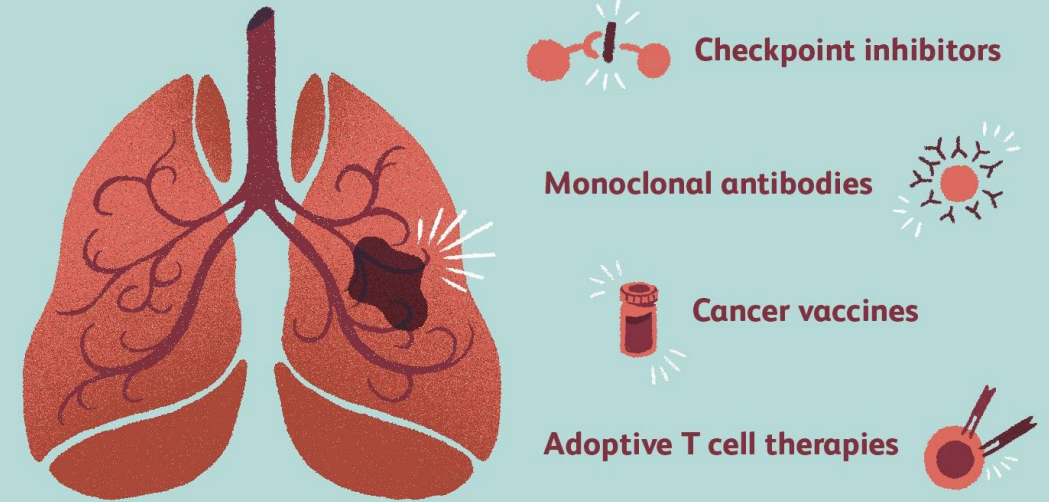
STS General Thoracic Database Version 5.21.1

Long Name: Temporary Text Field *SeqNo:* 4620
Short Name: **TempText** *Core:* Yes
Section Name: STS Temporary Fields *Harvest:* Yes
DBTableName Operations
Definition: This is a temporary field that should not be used for data collection until expressly instructed to by the STS.
Data Source: User *Format:* Text

STS Updates

- Why are we activating these two fields?
- TempY/N1 (Seq. 4580) : Did the patient receive induction immunotherapy or a targeted agent directed at the lung cancer of interest?
- TempText (Seq.4620): If so, what agent?

Common Immunotherapy Treatments for Lung Cancer





ADVANCES IN QUALITY & OUTCOMES: A Data Managers Meeting

- AQO 2023 will be a virtual conference
 - **Registration is NOW OPEN**
- AQO 2024 back to in person conference
- **AQO 2023: September 26 – 29**
 - Tuesday, September 26 – Intermacs/Pedimacs
 - **Wednesday, September 27 – General Thoracic**
 - Thursday, September 28 – Adult Cardiac
 - Friday, September 29 – Congenital





STS Education
Ruth Raleigh
(GTSD Consultant)

Clinical Staging: When?

When is lung cancer staged?

Lung cancer may be staged once or twice. The first staging, which all patients should undergo, is carried out when a patient is initially diagnosed; it should be completed before treatment begins. This type of staging is called clinical staging. Clinical staging is based on the results of various tests, discussed in more detail in the [Diagnosing Lung Cancer](#) section of Lung Cancer 101, including imaging tests and biopsies. The clinical stage is not only the basis for deciding on a patient's treatment plan, but is also the basis for comparison when checking into the patient's response to treatment. The second staging, called pathologic or surgical staging, adds what is learned about the patient's cancer from surgical treatment to the determination of staging. If the pathologic stage differs from the clinical stage (which it may, for example, if it is evident that the lung cancer has spread more than initially estimated), then the healthcare team can adjust the treatment more precisely.^{1,2}

Clinical Staging: What?

Imaging tests cannot confirm that a person has lung cancer. However, they provide a lot of information to help put the whole picture together for the doctor. Imaging tests may be done before a diagnosis of lung cancer, during treatment for lung cancer, and after treatment. They are done for a number of reasons, including:

- To get more specific information about a suspicious area that might be cancerous
- To determine how far cancer may have spread
- To find out if treatment has been effective
- To monitor for possible signs of cancer coming back after treatment^{1,2}


Different imaging tests a person might undergo include chest X-ray, CT (computed tomography or CAT) scan, MRI (magnetic resonance imaging) scan, PET (positron emission tomography) scan, and bone scan. These are

Clinical Staging: What?

Tissue biopsies are tests in which small amounts of tissue are removed for examination to find out if a person has lung cancer and, if so, which type of lung cancer.

Currently, tissue biopsies are the only way to confirm a diagnosis of lung cancer.

- Bronchoscopy
- Endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA)
- Transthoracic needle biopsy
- Thoracentesis
- Thoracoscopy/VATS
- Mediastinoscopy and mediastinotomy



Seq 1600: Clinical Staging Done for Lung Cancer

- If your patient has a therapeutic resection for lung cancer, this will almost always be coded as 'yes'.
- Surgeons have an idea what stage their patients lung cancer is BEFORE operating
- If you disagree with a documented clinical stage, discuss it with your surgeon there is nuance beyond tumor size that impacts staging

Seq 1620: Clinical Staging Methods

Harvest Codes:

<u>Code:</u>	<u>Value:</u>
1	PET/CT
2	CT
3	Brain CT
4	Brain MRI
5	Invasive Mediastinal Staging Performed

-
- This is not a comprehensive list
 - Notably, biopsy of the mass itself is not accounted for
 - CT Guided Bx of Lesion
 - Bronchoscopic Bx of Lesion
 - EBUS of Lesion w/o eval of mediastinum

TNM 8 th - Primary tumor characteristics	
T_x	Tumor in sputum/bronchial washings but not be assessed in imaging or bronchoscopy
T₀	No evidence of tumor
T_{is}	Carcinoma in situ
T₁	≤ 3 cm surrounded by lung/visceral pleura, not involving main bronchus
T_{1a(mi)}	Minimally invasive carcinoma
T_{1a}	≤ 1 cm
T_{1b}	> 1 to ≤ 2 cm
T_{1c}	> 2 to ≤ 3 cm
T₂	> 3 to ≤ 5 cm or involvement of main bronchus without carina, regardless of distance from carina or invasion visceral pleural or atelectasis or post obstructive pneumonitis extending to hilum
T_{2a}	>3 to ≤4cm
T_{2b}	>4 to ≤5cm
T₃	>5 to ≤7cm in greatest dimension or tumor of any size that involves chest wall, pericardium, phrenic nerve or satellite nodules in the same lobe
T₄	> 7cm in greatest dimension or any tumor with invasion of mediastinum, diaphragm, heart, great vessels, recurrent laryngeal nerve, carina, trachea, oesophagus, spine or separate tumor in different lobe of ipsilateral lung
N₁	Ipsilateral peribronchial and/or hilar nodes and intrapulmonary nodes
2	Ipsilateral mediastinal and/or subcarinal nodes
3	Contralateral mediastinal or hilar; ipsilateral/contralateral scalene/supraclavicular
M₁	Distant metastasis
M_{1a}	Tumor in contralateral lung or pleural/pericardial nodule/malignant effusion
M_{1b}	Single extrathoracic metastasis, including single non-regional lymphnode
M_{1c}	Multiple extrathoracic metastases in one or more organs

Seq 1810: Lung Cancer T Stage

- TX/T0 are not options
- This is intentional, if clinical staging was not performed you would code 'no' to 1600 and this sequence will not open.
- Clinical TX/T0 are not indicative of cancer, they are not captured as lung cancer cases.
- Your clinical T stage will not explicitly come from a CT or PET report. It should come from your surgeon's pre-op note. If they do not indicate clinical staging in their notes, it can be determined using the chart linked in the training manual.

Upcoming GTSD Webinars

User Group Call

- September 27 – Cancelled

Monthly Webinar

- October 11 @ 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!

Contact Information

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Database Operational
Questions
(Database Participation,
Contracts, etc.)

- STSDB@sts.org



THANK YOU FOR JOINING!