The Society of Thoracic Surgeons

Frequently Asked Questions: General Thoracic Database

Version 2.07

December 2008

How to use the "interactive" FAQ Document:

1. To review all clinical questions in an individual section, click on the section title below.

Section A: seq# 10 - 190	**Section C: seq# 285 - 650**	**Section E: seq# 770 - 1210**
Section B: seq# 200 - 260	**Section D: seq# 660 - 750**	**Section F: seq# 1220 - 1340**

2. To review an individual Seq# clinical question, click on the Seq# title below.

Participation in both General Thoracic and Adult Cardiac Databases

GENERAL STATEMENT #2

Seq# 200: Zubrod Score
Seq# 300: WtLoss3Kg
Seq# 310: Category of disease
Seq# 390: PreOp Chemotherapy
Seq# 400: PreOp Thoracic RT
Seq# 430: Other Cormorbidity
Seq# 540: Clinical Stage Not Applicable (2.06)
Seq# 725: Reoperation
Seq# 740: Procedure
Seq# 750: Primary Procedure
Seq# 751: Thoracoscopy Approach
Seq# 775: Postop Events
Seq# 860: Pneumonia
Seq# 930: Other Pulmonary Event
Seq# 940: Atrial Arrhythmia
Seq# 1020: Anastomotic leak
Seq# 1190: Empyema
Seq# 1200: Other event req. Rx
Seq# 1250: 30 Day Status
Seq# 1280: Chest Tube Out Date

NEW	Date	SeqNo	FieldName	Definition	
	3/06		Participation in both General Thoracic and Adult Cardiac Databases	*We participate in both Adult Cardiac and General Thoracic Database. Our question pertains to whether the patient should end up in both databases. Scenario--We had a patient who had an aortic aneurysm repair (arch/descending thoracic) and was entered into the Adult Cardiac Database. Less than 30 days after original surgery, he is readmitted with chylothorax, and undergoes Thoracic Duct Ligation. We recorded the surgery as an "other procedure" under Procedure performed on readmission. Our question really is whether we should enter the patient into the Adult Cardiac Database for the first surgery, but enter them into the General Thoracic Database for the second surgery (which was a complication of the first).*	*Yes, enter into both. In the Adult Cardiac DB, the primary procedure would be Seq# 1310 OpOCard=Yes; Seq# 2510 ONCAoAn=Yes; Seq# 2530 ONCArch=Yes; Seq# 2540 ONCDesc=Yes; Seq# 3220 Readm30=Yes; Seq# ReadmRsn=either Pneumonia or other Respiratory Complication or Other-Related Readmission; Seq# 3240 ReadmPro=Other Procedure. In the GTDB, code Seq# 740 Proc=Thoracic Duct Ligation*
	3/06			*We currently participate in the Adult Cardiac Surgery database and are considering participation in the Thoracic Surgery database. Could you please let me know what diagnosis codes this database covers, and if we just abstract charts from the*	*The diagnoses covered can be found on the v2.07 Data Collection Form (available on www.sts.org). Procedures included in the database should be performed by CARDIOTHORACIC surgeons only.*

				Cardiothoracic Surgeons, or does it also include General Surgeons?	
	10/06			*Short Field Name: cardiac/pericardium/great vess* *Message: In 2004 the STS adult cardiac vs. 2.41 was not capturing VAD patients. We had a patient that had a VAD inserted and the patient was captured in the GTS database under Cardiac/pericardium/great vessels. Should we have captured this patient in the Adult cardiac under other cardiac knowing that some fields were have been left blank? Please advise.*	*Yes, it should have been captured in the Adult Cardiac database.*
	10/06			*If a patient has a mini-maze and a wedge resection at the same time, do I fill out a form for both the STS Adult Cardiac and STS Thoracic?*	*Yes.*
	12/06			*Which database should the following be entered in?* *Example: Endovascular thoracic aortic stents – Should they be recorded as (Seq. #2510) Aortic Aneurysm in the Adult Cardiac or do they belong in the GTS database?* *Example: Patient with history of colon and renal ca had a subxiphoid pericardial window performed.*	*Record in the Adult Cardiac database as (Seq. #2510) Aortic Aneurysm.* *A pericardial window should only be entered in the Adult Cardiac database if it was performed because of an open heart surgery complication. If the pericardial window was performed for any other reason (as in the example) it should be entered in the General Thoracic database.*
	8/04		**GENERAL STATEMENT #1**	*In version 2.06 there is no field to capture surgeries that were completed with robotic assistance. The STS will consider adding a field to collect this data in the next version of the software.*	
	12/04		**GENERAL STATEMENT #2**	*Version 2.06: The General Thoracic Database:* *1.) Designed to capture all General Thoracic procedures performed in the OR (OR, Endoscopy Suite, Out Patient Surgical Center) by a General Thoracic Surgeon, i.e., include those General Thoracic procedures that generate an operative note* *2.) Designed to have a new Data Collection Form (DCF) populated each time a patient enters the OR to undergo a General Thoracic procedures performed by a General Thoracic Surgeon* *3.) Designed to capture General Thoracic procedures performed by a General Thoracic Surgeon even if the OR visit is a return visit to the OR as a result of a postoperative event from a previous General Thoracic procedure* *4.) Section E, "Post Operative Events" is designed to only capture those postoperative events that result from the General Thoracic procedure for which the DCF was generated for in the first place*	
	3/06			*If a patient has a thoracic surgery by one surgeon, but during the same hospitalization he has another thoracic procedure by yet another surgeon is that second procedure captured in the other surgery field?*	*The 2nd procedure would be captured on a new data collection form (DCF).*
	10/06			*Are we to complete STS forms for the donor of a lung transplant? On the procedure list, "lung donor harvest" is an option. Would that impact our mortality rate??*	*Complete a data collection form for the transplant recipient only (no form for the donor). The lung donor harvest should be conducted by a surgeon at your facility and from a living donor (not cadaver).*
	10/06			*I have a general question as to whether or not cardiac surgery patients should be coded in the thoracic database when they have other procedures during the CABG admission. For instance, a CABG patient develops a sternal dehiscence. He is brought back to the OR for mediastinal exploration and sternal debridement. He is brought back to the OR again for additional cleanup and muscle flap with closure. Say he also has a tracheostomy or EDG at another point. Should these 3 procedures be coded in the thoracic database or should they be coded only as re-ops in the STS cardiac database? If they are to be coded in the thoracic*	*All postoperative events should be documented and are to be captured according to the surgeon who performs the procedure. It is assumed that a CV surgeon would be conducting the reops for sternal dehiscence, etc. in your example and if so, should be coded in the STS Adult Cardiac database. If a General Thoracic surgeon performs the re-ops they would be collected on the STS General Thoracic form. Any complications directly resulting from the thoracic procedures should be counted on the thoracic form as well. A separate data collection form should be completed for each visit to the OR.*

				database this brings up a prior question sent to you but not yet answered - what to do about post-op events. Post-op events have already been coded in the cardiac database. Many are related to the original CABG. Do these also get coded in the thoracic database (assuming these procedures are even coded as thoracic procedures)? The post op events renal failure, blood products) have no relationship to a tracheostomy or EDG. Please answer both parts of my question. Thank you	
		10	Operations Table Record Identifier	An arbitrary, unique number that permanently identifies each record in the participant's database (note that unlike the PatID value, this does not identify the individual patient). Once assigned to a record, this number can never be changed or reused. The value by itself can be used to identify the record in the participant's database. When used in conjunction with the ParticID value, it can identify the record in the data warehouse database. The data warehouse will use this value to communicate issues about individual records with the participant. This value may also be at the warehouse to link to other clinical data.	
		20	Procedures Table Record Identifier	This field is the foreign key that links this record with the associated records in the "Operations" table.	
		30	Software vendor's identification	Software vendor's identification assigned by the STS.	
		40	Vendor's software version number	Vendor's software product version number identifying the software which created this record. Vendor controls the value in this field. Version passing certification/harvest testing will be noted at warehouse.	
		50	Version of STS Data Specification	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.	
		60	Record complete	Indicate whether the record data is complete or not. This entry is made by the software data quality check process. This field does not impact a procedure's harvest status. It is intended as an internal quality control field for data managers at site.	
		70	Participant ID	Participant ID is a unique number assigned to each database Participant by the STS. A database Participant is defined as one entity that signs a Participation Agreement with the STS, submits one data file to the harvest, and gets back one report on their data. The ParticipantID must be entered into each record.	
		80	Operations Table Patient Identifier	The foreign key that links this record with the associated records in the "PatientInfo" table.	
		90	Demographics Table Patient Identifier	An arbitrary number that uniquely identifies this patient in the database. This field is the primary key that links this record with the associated records in the "STSData" table. The value in this field can not be a value that would identify the patient outside of the database (such as Medical Record Number or Social Security Number). Once a value is assigned to a patient, it can never be changed or reused.	
		100	Medical Record #	Indicate the hospital medical number assigned to the patient.	
		110	Patient's first name	Indicate the first name of the patient.	
		120	Patient's middle initial	Indicate the middle initial of the patient.	
		130	Patient's last name	Indicate the last name of the patient.	
		140	Social Security 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.	
		150	Date of birth	Patient Date of Birth using 4-digit format for year. Harvest is Optional due to a variety of confidentiality issues at facilities. Participant will choose whether Harvest=Yes or	
		160	Patient's zip code	The ZIP Code of the patient's residence. Outside the USA, this data may be known by other names such as Postal Code (6 characters). Software should allow sites to collect up to 10 characters to allow for Zip+4 values. Harvest is Optional due to a variety of confidentiality issues at facilities. Participant will choose whether Harvest=Yes or Harvest=No.	
		170	Gender	Indicate the patient's gender at birth as either male or female.	
		180	Patient's race	Indicate the patient's race as determined by the patient or family.	
	10/06			*My software vendor (Cedaron) says that we can choose more than one race in Version 2.07.* *Is that the intent? When querying for race in*	*Yes, the intent in Version 2.07 is to indicate the patient's race(s) as determined by the patient or family. Many national databases now include multiple options for race.*

				the future, we will have to look at each race field independently. We can no longer click on Race and then filter out the one we want to look at. Doesn't seem correct.	
		190	Age at time of surgery	Indicate the patient's age in years, at time of surgery. This should be calculated from the date of birth and the date of surgery, according to the convention used in the USA (the number of birth date anniversaries reached by the date of surgery).	
		200	Patient's Zubrod score	The Zubrod performance scale should be marked to indicate the level of the patient's performance measured within two weeks of the surgery date. The Zubrod performance scale is a measure of the patients function. Select the one description that best fits the patient.	
	3/06			*If the patient presents with a 1 on the Zubrod scale but their condition declines during the hospitalization to a 3(in the two week window) would you code them as a 3.*	*The Intent of Seq #200 Zubrod is to capture the patient's level of performance within 2 weeks of the surgery date. Please code as a value of 1.*
	3/06			*The STS definition of the Zubrod score states "...indicate the level of the patient's performance measured within two weeks of the surgery date..."* *For a patient whose function is normal (Zubrod=0) up to the point of hospitalization then consequently hospitalized (Zubrod score 3) prior to surgery, how should their Zubrod score be documented on the data collection form?*	*Code the most severe Zubrod score within two weeks of surgery. In the scenario presented, code 3.*
	4/07			*Is the rule to capture the most current/recent pre-op Zubrod score of the patient? In an FAQ dated 3/06, Scenario 1, the Zubrod score of 3 is the most current score prior to surgery, so why is the answer to code as a "1"?* *If a patient 2 weeks prior to surgery had a Zubrod score of 1, then 5 days after surgery had a complication and went back to the OR for bleeding (Zubrod score of 3), should the second DCF have a Zubrod score of 3? Or do we go back to the Zubrod score of 1 (which was the score pre-op)?*	*The intent is to capture the Zubrod score within 2 weeks of the surgery date to establish a baseline, not to capture the score closest to the surgery date. If the hospitalization extended to several weeks and the patient returned to the OR after several weeks, then the Zubrod score could possibly change from the baseline.*
	11/07			*I have a patient with FC III NYHA regarding his heart failure. He is SOB with minimal activity and takes frequent rest periods. However, his diagnosis is tracheal stenosis and is not necessarily associated with his SOB and limited activity level. He would be classified as a 2 related to heart failure, but a 1 regarding his stridor. How should I code this?*	*As the Zubrod score is related to overall level of function, please code this as "2".*
		210	Surgeon's name	Indicate the surgeon's name. This field must have controlled data entry where a user selects the SurgeonName from a user list. This will remove variation in spelling, abbreviations and punctuation within the field. Note: Surgeon name is encrypted in the analysis database. Punctuation, abbreviations and spacing differences can not be corrected at the warehouse.	
		220	Surgeon's UPIN number	Surgeon's UPIN Number. This value is automatically inserted into the record when the user selects the surgeon. The list of surgeons and associated UPIN values are maintained by the user.	
		230	Hospital Name	Indicate he full name of the facility where the procedure was performed. Values should be full, official hospital names with no abbreviations or variations in spelling for a single hospital. Values should also be in mixed-case.	
		240	Hospital code = AHA number	Indicate the Hospital code or AHA number. Values are automatically inserted into the record when the user selects the hospital name. The list of hospital names and associated hospital codes are maintained by the user.	
		245	Hospital postal code	Indicate the ZIP Code of the hospital. Outside the USA, this data may be known by other names such as "Postal Code".	
		250	Admission date	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.	
		260	Date of surgery	Indicate the date of surgery, which equals the date the patient enters the OR.	
		280	Height in centimeters	Indicate the height of the patient in centimeters.	

		285	Height in inches	Indicate the height of the patient in inches.	
		290	Weight in kilograms	Indicate the weight of the patient in kilograms.	
		295	Weight in pounds	Indicate the weight of the patient in pounds.	
		300	Weight loss in the three months	Indicate by the number of kilograms lost, whether the patient has experienced any weight loss in the last three months. Enter "0" if answer is "none".	
	3/06			*If the patient has unintentional weight loss of 10 lbs in 2 months, that is more relevant," how can we indicate that if the data specs say 3 months? Most of our patients who have weight loss, it is relative. Most of the time it is not with 3 months. Is there anyway to have a field "weight loss" and an added field of "weight loss duration?*	*The intent is to capture unintended weight loss. The response initially sent was illustrating that losing 10 pound over 2 months is more relevant that losing 10 pounds over 2 years. The response also states: "...intent with this seq# is to capture a weight loss over the last three months." as indicated in the data specs.*
		310	Category of disease	Indicate to which disease category the patient's primary disease process belongs. Indicate the disease category if known preoperatively, if unknown preoperatively, may enter postoperatively.	
	4/04 Rev. 05/08			*When I have a patient with metastasis to the lung from another type of cancer (i.e. renal cell), do I code this as:* *1. Metastasis – Lung* *or* *2. Metastasis – Other* *Does "metastasis – lung" mean to the lung or another spot/spread from the lung cancer?*	*In this scenario, code as Metastasis – Lung.* *Metastasis – Lung = Metastasis <u>to</u> the lung from any type of cancer.* *Metastasis – Other = Metastasis <u>from</u> lung, esophageal, or other type of cancer to areas in the thorax outside of the lung (e.g., mediastinum, chest wall, pleura).*
	4/04			*Which category of disease should we place idiopathic, interstitial, or connective tissue disease?*	*Code as Lung - Benign.*
	12/04			*1. Since we can only code one harvest code option for seq#310, what is the order of priority for categories if a patient has more than one disease process?* *A. Benign lung w/incidental (+) cultures found on final path* *2. Does category of disease pertain only to the procedure performed?* *B. Patient has thoracic cancer but procedure is a tracheostomy for respiratory failure*	*The definition states "Indicate to which disease category the patient's primary disease process belongs…."* *Based on the definition, coding should be based on the primary disease process, which may not necessarily be the procedure being performed. For your first example code Lung - Benign. For your second example code Lung - Primary.*
	3/06			*If a patient has a malignant pleural effusion of a non-thoracic primary and does not also have a thoracic tumor, how should we capture this?*	*Code Seq# 310 Category = Metastatic-Other*
	3/06			*This question applies to version 2.07. Comorbitities have changed to Yes/No instead of choosing "none" or appropriate selection. If comorbidities are unknown for whatever reason - not documented, unable to obtain, etc., should "unknown" be included as a choice?*	*This would require adding a choice of Unknown to all comorbidity fields. Will consider for next spec upgrade. However, if the H&P that is in the patient's chart prior to surgery does not document the comorbidity, please code No. There should be a level of comfort in taking what is in the patient's chart as an accurate list of preop patient conditions. Another suggestion would be to talk with the docs re: specifically documenting yes/no to all of the comorbidities listed on the DCF, possibly a pre-printed H&P.*
	10/06			*Under category of disease, there is no category for diaphragm. Under what category should they be captured?*	*for current version under mediastinal; next update it's own category*
	10/06			*This is the STS definition of category of disease: Indicate to which disease category the patient's primary disease process belongs. Indicate the disease category if known preoperatively, if unknown preoperatively, may enter postoperatively. How do you account for pre-op diagnoses which are different than final diagnoses? This is an area of ongoing interest to many thoracic surgeons.* *For example: pre-op suspected malignancies*	*Patients would be clinically staged for suspected lung or esophageal cancer. Since they would have a benign pathology, there would be no pathological staging. The opposite staging would be true for suspected benign with a final path of lung or esophageal cancer. On cases other than lung or esophageal cancer, there is no way to account for discrepancies in pre- and post-op diagnoses in the current General Thoracic database.*

			which are, on final pathology, benign?	
	10/06		*If a patient had a lung cancer in 1993 and are post pneumonectomy, then develops a recurring bronchopleural fistula w/empyema gram neg. in 2005 and undergoes C/W resection w/flaps and repair of fistula X 2 Is the category of disease still a lung primary even though all procedures are a result of recurring infections?*	*Yes, the Category remains Lung - Primary according to the current data definitions.*
	10/06		*Primary Chest Wall - Is this only for tumor or does it include all chest wall categories?*	*All chest wall categories.*
	10/06		*Does a perforated esophagus from an attempted dilatation fit in the "Trauma" category? It appears that the trauma given as examples were more "traumatic", as in MVA or GSW.*	*No, it should be coded as "Esophagus-Benign". The procedure is "Repair, Perforation of esophagus-Iatrogenic.*
	10/06		*I need some help picking the category of disease in order to give you what you're looking for. Example:* *A patient has esophageal cancer and has an esophagectomy with gastric conduit. Here the category of disease is clearly "esophagus-primary." The patient comes back in due to an esophageal stricture requiring dilation. There is no evidence of recurrent cancer. Does the category of disease remain "esophagus-primary" or because the patient is coming in due to a benign esophageal stricture, is the category of disease "esophagus-benign"? Later the patient returns to have a port-a-cath removed because his chemo is complete (no evidence of cancer). Is the category of disease esophagus-primary (portacath put in for chemo) or "other" as patient has no evidence of esophageal cancer at this point? Thanks very much.*	*Yes, the Category remains Esophagus - Primary according to the current data definitions "Indicate to which disease category the patient's primary disease process belongs."*
	10/06		*Our surgeon performed a repair chest wall after a dehiscence of an access thoracotomy for spinal fusion surgery. We captured this procedure in the Chest wall primary section. Is this correct, or do we just collect patients that have surgery for chest wall cancers? If it is just for tumors of the chest wall would it be captured under other or trauma? Please advise.*	*The Category section is under Pre-Operative Risk Factors. It should be coded as "Other" as there is no primary chest wall cancer. The Procedure should be coded as "Other Chest Wall Repair". Dehiscence should be captured as a "Complication" on the first OR data collection form. This Re-Op requires a new data collection form.*
	11/06		*This patient was in the EP lab status post attempted placement of an ICD device w/complications of hemoptysis and hypoxia with possible pneumothorax. This patient had a bronch/thoroscopy with partial lung decortication. Should this be captured in the GTS database? If so, under what category?*	*This procedure should be documented in the GTS database and the Category of disease is Pleura-Other.*
	11/06		*A patient has lung cancer on the left in 2004. A year or so later he returns with mets to the right lung. His primary category of disease is really still lung cancer. However, do I change the category of disease to "metastasis - lung" at this point since that is what is bringing him in now and since that option is available? Or because his original problem was "lung - primary" does it remain that?*	*As the patient's lung cancer has metastasized, the Category of disease for this admission is "Metastases - Lung".*
	12/06		*On 1/06 in the FAQ, it said that if a pt pre-op is suspected of ca, then post-op has a benign disease we should keep track of that by entering the clinical stage of pt, and because it is benign there would be no path staging. Is there a way to account for discrepancies in pre- and post-op diagnoses?*	*The Category of disease would be Lung-Benign that is consistent with the post-op diagnosis.*
	01/07		*In the FAQ document there is a question asking if all chest wall disease should be coded under Primary Chest Wall, or just*	*No, all chest wall diseases should not be coded as Category: Primary Chest Wall.* *In the current database, chest wall disease (not*

				chest wall tumors. The answer listed states "All chest wall categories". However a few lines down there is a question about chest wall dehiscence. The answer given states that in that case it should be coded as "Other" because "there is no primary chest wall cancer". *Which answer is correct? Are all chest wall diseases coded as Primary chest wall or just chest wall cancer?*	*cancer) should be coded as Category: "Other".*
	4/07			*a) A patient had lobectomy (Lung, benign) surgery complicated by respiratory failure and the patient went back to OR for tracheostony. Later on, the patient went back to the OR for a re-do trach due to tracheal strictures. What will be the Category of Disease for the re-do trach? Is it Lung, benign or is it Trachea, benign?* *b) Is Pleura-neoplastic that same as pleura-primary (mesothelioma)? Such that neoplastic pleura related to "breast cancer-primary" should be a Category of "Metastases-other" and not Pleura-neoplastic?*	*a) Based on the current data definitions, the Primary disease process is Lung, benign and remains Lung, benign.* *b) If the patient has mesothelioma, the Category would be Pleura, neoplastic, and if it is metastatic cancer, the Category is Mets-Other.*
	6/07			*A patient has a thorascopic blebs resection and pleurodesis for a spontaneous pneumothorax. Is the Category captured as Pleura-Other or Lung-Benign?*	*The Category of disease would be Lung-Benign.*
	10/08			*Patient has a paraspinal mass located near T12-L2(path report>spindle cell neoplasm). Procedure performed was Rt. Retroperitoneal paraspinal mass resection with thoracoabdominal approach, partial resection of diaphragm, primary reconstruction of diaphragm, resection of 12th rib.* *What is the category of disease? Other or primary chest wall?*	*The Category of disease is Primary Chest Wall.*
	10/08			*1) Patient has Mediastinal Mass and lymphadenopathy. Path report=Hodgkins lymphoma.* *What is category of disease? Other or Mets.Other?* *2)Another patient has mediastinal lymphadenopathy. Path report>sarcoidosis. What is category of disease? Other?* *3)What diagnoses are included in the category of disease Mediastinum? Only cancer?*	*1) Neither. The Category of disease is Mediastinum.* *2) No. The Category of disease is also Mediastinum.* *3) No, not just cancer. For example, Benign mediastinum is also included. The new 2.081 data specifications eliminates this confusion.*
		320	Lung Infection Type	Indicate the type of lung or pleural infection.	
	12/04			*Should mediastinal infections be included under seq# 320, "Lung Infection Type?"*	*The definition limits the infections sites to the lungs and pleural. Therefore, mediastinal infection would not be captured via seq# 320 or anywhere in the General Thoracic Surgery Database.*
		322	Trauma Requiring OR Intervention	Indicate whether a recent trauma resulted in a primary diagnosis that required OR intervention during this hospitalization.	
		325	Trauma Type	Indicate the type of trauma that resulted in a primary diagnosis that required OR intervention during this hospitalization.	
		330	No comorbidities	Indicate if the patient has NO comorbid factors. If this value is Yes, then no other co-morbidities can be selected.	
		340	Hypertension	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.	

		350	Steroids	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).	
		360	Congestive heart failure	Indicate whether, within 2 weeks prior to the primary surgical procedure, a physician has diagnosed that the patient is currently in congestive heart failure (CHF). CHF can be diagnosed based on a careful history and physical exam, or by one of the following criteria: 1. Paroxysmal nocturnal dyspnea (PND) 2. Dyspnea on exertion (DOE) due to heart failure 3. Chest X-Ray (CXR) showing pulmonary congestion 4. Pedal edema or dyspnea and receiving diuretics or digoxin	
		370	Coronary artery disease	Indicate whether the patient has a history of coronary artery disease (CAD) as evidenced by one of the following: 1. Currently receiving medical treatment for CAD 2. History of Myocardial Infarction 3. Prior CV intervention including, but not limited to, CABG and/or PCI	
		380	Peripheral vascular disease	Indicate whether the patient has Peripheral Vascular Disease, as indicated by claudication either with exertion or rest; amputation for arterial insufficiency; aorto-iliac occlusive disease reconstruction; peripheral vascular bypass surgery, angioplasty, or stent; documented AAA, AAA repair, or stent; positive non-invasive testing documented. Does not include procedures such as vein stripping, carotid disease, or procedures originating above the diaphragm.	
		390	Preoperative chemotherapy	Indicate if the patient has received preoperative chemotherapy for any reason prior to this operation. May be included as a component of a chemotherapy radiation induction therapy. This item should also be selected if the medical oncologist gave the patient chemotherapy prior to sending the patient for any surgical evaluation, if the intent of the medical oncologist was to "shrink the tumor" prior to surgical intervention.	
	3/06			*I have a patient who has a category of disease Pleura-Neoplastic. Her primary was breast cancer. Is her pre-op chemo given for her breast cancer considered "same disease" or "unrelated"? Is her breast cancer considered "the same primary disease process that is being treated during this hospitalization"? (since her breast primary is why she has a Pleura-Neoplastic diagnosis)*	*The patient's breast cancer is considered Unrelated. The Pre-Op chemo was given for the breast cancer BEFORE the Pleural diagnosis.*
		395	Preoperative chemotherapy - When	Indicate whether the prior chemotherapy treatment was: 1 = received any time prior to this hospitalization to treat this occurrence or any previous occurrence of the same primary disease process that is being treated during this hospitalization 2 = received within 6 months of this hospitalization to treat an unrelated disease 3 = received more than 6 months prior to this hospitalization to treat an unrelated disease.	
	10/06			*For the response "any time, same disease" are you looking to determine only if the pt got chemo related to the current occurrence of tumor? I have a pt who had lung cancer L and R sides in 2004. By her history, she had a resection on the left, not on the right as PET scan was apparently neg on right. (not really sure why right sided tumor wasn't resected). Chemotherapy was given. Now she returns in 2005 with an enlarging right-sided mass (turns out to be same type lung cancer as previously) which is resected. No chemoRx given prior to current resection. Would her chemo in 2004 be considered "anytime, same disease" because the lung cancer now is the same type as previously? OR would the 2004 chemo be considered "unrelated, > 6 months" because no chemo was given pre-op for the current increase in size of the R-sided mass?*	*Yes, as per the data definition - "indicate whether the prior chemotherapy treatment was received <u>any time</u> prior to this hospitalization to treat this occurrence or any previous occurrence of the <u>same primary disease process</u> that is being treated during this hospitalization."*
	10/06			*A pt. had chemo/xrt for cancer of the tonsil. She developed an esophageal stricture and requires dilation. Would the xrt be considered "anytime - same disease" because it is the xrt that caused the stricture... even though the category is esophagus - benign.*	*The Category is Esophagus-benign. The PreopChemoWhen field should be coded as an unrelated disease (to the appropriate timeframe - harvest code 2 or 3).*
		400	Preoperative Thoracic Radiation Therapy	Indicate if the patient has received preoperative radiation therapy to the chest for any reason prior to this operation. May be included as a component of a chemotherapy radiation induction therapy. This item should also be selected if the radiation oncologist gave the patient radiation	

				therapy prior to sending the patient for any surgical evaluation, if the intent of the radiation oncologist was to "shrink the tumor" prior to surgical intervention.	
	3/06			*Does this sequence number only refer to RT to the chest?* *A patient has had gamma knife therapy for a metastatic renal cell carcinoma who now has a new metastatic lesion in the hilum.*	*Yes, Pre-Op Thoracic Radiation Therapy only refers to RT to the chest related to the surgery*
		405	Preoperative Thoracic Radiation Therapy - When	Indicate whether the prior radiation therapy was: 1 = received any time prior to this hospitalization to treat this occurrence or any previous occurrence of the same primary disease process that is being treated during this hospitalization 2 = received within 6 months of this hospitalization to treat an unrelated disease 3 = received more than 6 months prior to this hospitalization to treat an unrelated disease.	
		410	Prior Cardiothoracic Surgery	Indicate whether the patient has undergone any prior cardiac and/or general thoracic surgical procedure that required a general anesthetic and an incision into the chest or mediastinum. A thoracotomy, median sternotomy, anterior mediastinotomy or thoracoscopy would be included here. A cervical mediastinoscopy or tube thoracostomy would not be included.	
		420	When Prior CT Surgery was Performed	Indicate when the prior cardiac and/or general thoracic surgery was done. If patient has history of more than one prior cardiac and/or general thoracic surgery, indicate the time frame for the most recent procedure.	
		430	Other comorbidity	Indicate whether the patient had one or more other co-morbidities not listed above.	
	3/06			*What are some examples of "other cormorbidities not listed above?"*	*Pulmonary Embolism and Atrial Fibrillation prior to surgery*
	12/06			*Are COPD and emphysema to be captured as co-morbidities under "Other"?*	*Update to previous answer of "Yes" in October 06 FAQ:* *STS recommends not to code as "Other" in the current database as there is no way to analyze this category. As COPD and emphysema are indeed considered a co-morbidities, the fields will most probably be added in future database upgrades.*
		440	Tobacco use - None	Indicate if the patient has had No tobacco use.	
		450	Smokeless tobacco use	Indicate whether the patient has a history of using smokeless tobacco.	
		460	Cigarette use	Indicate whether the patient has a history of using cigarettes.	
		470	Pack-years of cigarette use	Indicate the number of pack-years by multiplying the average number of packs of cigarettes smoked per day by the number of years of smoking. For example if the patient smoked 1 ppd for 10 years and 3 ppd for the next 10 years, the average ppd would be 2 ppd x 20 years = 40 pack-years of smoking.	
		480	Pipe or cigar use	Indicate whether the patient has a history of using pipe or cigars.	
		490	Other tobacco use	Indicate whether the patient has a history of any other tobacco or tobacco related product use.	
		500	When Patient Quit Smoking	Indicate how many days prior to the operation the patient quit smoking. Choose "0-14 days pre-op" of the patient is a current smoker.	
		510	Cerebrovascular history	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.	
		522	Diabetes	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.	
		525	Diabetes control	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)	
		530	Renal insufficiency history	Indicate whether the patient has: 1. a documented history of renal failure and/or 2. a history of creatinine > 2.0. Prior renal transplant patients are not included as pre-op renal failure unless since transplantation their creatinine has been or currently is > 2.0.	

		540	Clinical stage n/a	Indicate if clinical staging is not applicable. Clinical stage is defined as stage of cancer based on non-operative techniques (history, physical exam, radiological tests). For benign disease, or pulmonary metastases of any type, pathological staging is not applicable.	
	4/04			*Lung and Esophageal cancer staging is the **only** staging applicable in the STS General Thoracic Database.*	
	4/04			*Please define the difference between clinical staging and pathological staging.*	*Clinicopathological staging of cancer: Staging is the clinical or pathological assessment of the extent of tumor spread.* *Clinical staging is a preoperative assessment. It is based on clinical, radiological and operative information. Clinical Staging is used to determine treatment offered to patients.* *Pathological staging is a postoperative assessment that is based on pathological testing results. Provides useful prognostic information and allows decisions to be made regarding adjuvant therapy.*
	3/06			*If patient has had a recurrence of a lung primary---document current stage of cancer, or stage when the primary was initially diagnosed?*	*If the patient goes to the OR for a recurrence of a lung primary, stage for the current procedure*
	10/06			*How would you clinically stage a patient who has a lung nodule which the surgeon isn't sure if it's a primary lung cancer or a met from another site?*	*Please document any preop lung or esophageal cancer clinical staging. If clinical staging is not documented preoperatively, "No" should be documented. Lung and esophageal cancer staging is the only staging applicable in the STS General Thoracic Database.*
	10/06			*I have a patient who has Stage 4 breast cancer with mets to bone and liver. The procedure performed was a VATS with talc pleurodesis. The pleural fluid did not contain any malignant cells. Should the staging question be answered in regards to any lung involvement? Which appears to be negative or unknown at this time, or should the staging be based on her breast cancer?*	*No, there is no clinical staging of breast cancer in this database (only lung and esophageal).*
	06/07			*Scenario: Esophageal mass stages on CT/Pet scan as T3 N1 M0. This mass is not considered respectable initially, but responds well to chemo/radiation, and subsequent scan downstages mass, making surgical resection acceptable. Do I use the pre-chemo/radiation staging or the pre-surgical staging which has improved?*	*Please use the pre-chemo/radiation staging.*
NEW!	**12/08**			*A patient has a clinical staging of T2 No MX for Esophagus CA. They under go Neoadjuvant chemo radiation and return for an IVOR Lewis status post chemo. Upon readmission for the surgery would the clinical staging be the pre- chemo? And would the Pathological staging be the results from the esophagectomy?*	*Yes, the Clinical staging is for the original clinical state before any treatment is given (pre-chemo). Yes, the Pathological staging from esophagectomy results.*
		550	Clinical stage T	Indicate the appropriate descriptor for tumor based on all the clinical staging characteristics of the tumor. (See Appendix A for full description.)	
		560	Clinical stage N	Indicate the appropriate descriptor for nodes based on all the clinical staging characteristics of the lymph nodes. (See Appendix A for full description.)	
		570	Clinical stage M	Indicate the appropriate descriptor for metastases based upon all the clinical staging characteristics of the metastases. (See Appendix A for full description.)	
		580	Clinical stage Ma, b	Indicate for esophagus procedures only the clinical staging of Ma, b. (See Appendix A for full description.)	
		590	Preop PFTs not done	Indicate whether Pulmonary Function Tests (PFT's) were not done prior to this operation. PFT's done > 12 months prior to the primary surgical procedure should be coded as "No".	
		595	FVC Test Not Done	Indicate whether a Forced Vital Capacity (FVC) test was done.	
		600	FVC actual	Indicate the actual FVC obtained for the patient.	
	4/04			*Should we be recording pre-bronchodilator or post-bronchodilator values?*	*If both the pre-bronchodilator and post-bronchodilator values are recorded, collect the better of the two results.*

		610	FVC predicted	Indicate the % predicted FVC obtained for the patient.	
	4/04			*Should we be recording pre-bronchodilator or post-bronchodilator values?*	*If both the pre-bronchodilator and post-bronchodilator values are recorded, collect the better of the two results.*
		615	FEV1 Test Not Done	Indicate whether a Forced Expiratory Volume at 1 second (FEV1) test was not done.	
		620	FEV1 actual	Indicate the actual FEV1 obtained for the patient.	
	4/04			*Should we be recording pre-bronchodilator or post-bronchodilator values?*	*If both the pre-bronchodilator and post-bronchodilator values are recorded, collect the better of the two results.*
		630	FEV1 predicted	Indicate the % predicted actual FEV1 obtained for the patient.	
	4/04			*Should we be recording pre-bronchodilator or post-bronchodilator values?*	*If both the pre-bronchodilator and post-bronchodilator values are recorded, collect the better of the two results.*
		635	DLCO Test Not Done	Indicate whether a lung diffusion measured with carbon monoxide (DLCO) test was not done.	
		650	DLCO predicted	Indicate the % predicted DLCO value obtained for the patient.	
		660	ASA class 1-5	Indicate the patient's American Society of Anesthesiologists Risk Scale for this admissions surgical procedure. This information can be found in the OR Anesthesia Record.	
		670	Time when patient entered Operating Room	Indicate to the nearest minute (using 24 hour clock) the time the patient enters the OR.	
		680	Time of skin opening	Indicate to the nearest minute (using 24 hour clock) the time the skin incision was made.	
		690	Time of skin closure	Indicate to the nearest minute (using 24 hour clock) the time the skin incision was closed. If patient leaves the OR with an open incision, collect the time the dressings were applied to the incision.	
		700	Time when patient exits Operating Room	Indicate to the nearest minute (using 24 hour clock) the time the patient exits the OR.	
		710	Did operation go through midnight (24:00)	Indicate whether the operation continued through midnight from one day to the next.	
		720	Clinical Status of the Patient	Select the status that best describes the clinical status of the patient at the time of the primary surgical procedure. 1. Emergent: The surgical procedure must be performed within 24 hours of presentation. 2. Urgent: All of the following conditions are met: a. Not elective status b. Not emergent status. c. Procedure required during same hospitalization in order to minimize choice of further clinical deterioration. 3. Elective: The patient has been stable in the days or weeks prior to the operation. The procedure could be deferred without increased risk of compromise for the cardiac outcome.	
	03/07			*Pt was scheduled for thoracotomy/lobectomy after completion of chemo. Was admitted with empyema in same area prior to scheduling elective surgery for lobectomy. Surgeon decided to do decortication and drainage of empyema due to urgent nature of problem, along with the lobectomy. Elective lobectomy as primary due to amt of tissue removed. Urgent treatment of empyema necessitated surgery on this admission. Is this still an elective procedure based on the primary, or is it urgent due to pat's worsening condition from the empyema?*	*This procedure should be documented as "Urgent".* *Category of Disease is Primary – Lung, with the Primary Procedure of lobectomy.*
	03/08			*I've been entering my lung transplants as elective procedures, yet I notice anesthesia classifies them as emergent on their record. If the viability of the donor lungs is considered, the surgery is certainly emergent. If the survival of the patient is considered, then most of the time it would be elective. What would be the correct status for this procedure?*	*The STS data definition(s) may not always coincide with anesthesia or other records. Please capture fields in the Database according to the STS data definitions.* *This field is directly related to the clinical status of the patient at the time of surgery. If a lung transplant patient has been waiting at home and is admitted once a donor is found, please code this as "Elective". An example of an Emergent lung transplant patient would be a patient that is in-house, unstable, and on a vent.*

		725	Reoperation	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.	
	3/06			*Reop - a patient has had a prior thoracentesis, is the answer "yes."*	*The definition states, "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.* *For a thoracentesis to be coded as Reop=Yes, the thoracentesis would have had to have been done in the OR as an operation versus a very minor procedure in a hospital room or doctors office and the primary procedure needs to also be a pleural procedure.*
	10/06			*Short Field Name: Reoperation* *Message: A patient has primary lung cancer and had a previous mediastinoscopy. He comes in now with primary lung cancer and has a right thoracotomy with mediastinal lymph node dissection and right upper lobectomy. Is reoperation "yes" because he had a mediastinal procedure in the past and is now having the mediastinum re-entered for a lymph node dissection or "no" because the previous procedure was a mediastinoscopy and the current procedure is a thoracotomy? Are you trying to get at whether or not the same cavity/organ has been surgically entered before or whether or not the approach into that cavity/organ is the same?*	*Reoperation is "No" because the previous procedure was a mediastinoscopy and the current procedure is a thoracotomy and lobectomy. The primary purpose for each procedure was different. The mediastinoscopy is not the same procedure as the thoracotomy and lobectomy.*
	04/07			*A patient had a previous right lobectomy for benign lung – and is now back for esophagectomy for primary esophageal ca. The surgeon spotted and excised a nodule (wedge resection) of the left lung. Is this surgery considered a "re-op"?*	*No, it would not be considered a re-op, as it is not on the same side nor the same incision location. The Primary procedure is esophageal. A re-op would be the same side and the same incision location.*
		730	Organ system	Indicate the organ system on which the surgical procedure is being performed.	
		740	Procedure	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 visit.	
	4/04			*What are considered open pleural drainage procedures and what are considered closed pleural drainage procedures?*	*<u>Open</u> pleural drainage procedure would include video thoracoscopy or thoracotomy for drainage of effusion.* *<u>Closed</u> pleural drainage procedure would include placement of chest tube, tube thoracostomy, and placement of pleur-x catheter, other drainage tube, or even thoracentesis.*
	4/04			*Do we need to fill out an additional data collection form for a patient that returns to the OR for a tracheostomy or an esophageal dilation? I ask because these are post-op event choices. With this new version you say you want a collection form for every trip to the OR. Which is correct?*	*The General Thoracic Data Specifications do state that a new Data Collection Form (DCF) is needed for each visit to the OR, seq# 740, Procedure, definition:* *Indicate the general thoracic procedure being performed during this operating room visit. Please note: A separate General Thoracic Database DCF should be completed for each general thoracic operating room visit.* *With the examples that you have given, capture the postoperative tracheostomy or esophageal dilation in section "E" Post Op Events. If the patient returns to the OR for these procedures, you also need to complete a DCF to capture the return visit to the OR. If the patient does not return to the OR for these procedures, capture the procedures in section "E" and do not fill out an additional DCF.*
	8/04			*Should we include Enterostomy as a procedure in the General Thoracic Database? If yes, which procedure should we code?*	*Seq# 740, version 2.06: An enterostomy is an operation in which the surgeon makes a passage into the patient's small intestine through the abdomen with an opening to allow for drainage*

					or to insert a tube for feeding. The opening is called a stoma. Enterostomies may be either temporary or permanent. They are classified according to the part of the intestine that is used to create the stoma. If the ileum, which is the lowest of the three sections of the small intestine, is used to make the stoma, the operation is called an ileostomy. If this is the procedure that your surgeon has done, collect under Esophagogastric, Other GI procedures. If the jejunum, which is the middle section of the small intestine, is used, the operation is called a jejunostomy. If this is the procedure that your surgeon has done, collect under Esophagogastric, Jejunostomy.
	8/04			*Do we collect data on Bronchoscopy procedures, in the General Thoracic Database? What if it is the only procedure done in the OR?*	*If the Bronchoscopy is done in the postoperative period due to a complication, code in the "Post Operative Events" section under "Atelectasis req bronch" or "Other pulmonary event."* *If the patient has a Bronchoscopy done as the primary surgical procedure and/or as the only procedure, this should be coded under seq# 740, Tracheobronchial: Flexible Bronchoscopy or Rigid Bronchoscopy.*
	03/06			*Thoracic physicians may perform operations to insert venous access devices (Port A Cath.) Do we collect data on these procedures? If so what type of procedure are they?*	*The GTDB FAQ v2.06 General Statement #2 states, "The General Thoracic Database: 1.) Designed to capture all General Thoracic procedures performed in the OR (OR Endoscopy Suite, Out Patient Surgical Center) by a General Thoracic Surgeon (i.e., include those General Thoracic procedures that generate an operative note..."* *Insertion of a Port A Cath would generate an operative note, so it would be included. It can be coded as Seq#740 Proc=Other Mediastinal/neck procedure or a custom field could be created to capture.*
	3/06			*A patient has a left pleur-x catheter placed one day, the right placed two days later prior to his thoracic surgery. Should a DCF be completed for each pleur-x catheter placement?*	*If the pleur-x catheters were placed in the OR, generate a DCF for each placement and for the actual thoracic surgery.*
	3/06			*Pneumonolysis is the separation of an adherent lung from the pleura. Should this be documented as "other lung procedure" or "other pleural procedure?"*	*Pneumonolysis should not be coded as a separate procedure. There is a primary procedure done in conjunction with Pneumonolysis.*
	3/06			*If our organization is registered with the STS as an institution are we required to complete a separate case report form for each operating room visit regardless if an incision was made and/or it is the only procedure done during the operating room visit (i.e. bronchoscope procedures?) Several pulmonary physicians or general surgeons may perform some of the thoracic procedures (less invasive procedures) listed in Section D during a patient's hospitalization. If we do complete separate DCF's for all OR visits including bronchoscopes do we leave the questions regarding skin incision time and approach blank.*	*Yes, leave those fields blank. As an STS participating Thoracic Surgery site, please capture data on cases done by Thoracic Surgeons only. If a patient has a bronchoscopy done by a pulmonologist, the case should not be included in the STS GTDB.*
	3/06			*After reading the FAQ for return to OR (740) it was not clear to me. I had a patient that returned to the OR for removal of a hematoma, then he returned for a redo thorocotomy for air leak resulting in a pleurodesis. These returns were captured as post op complications. The hematoma was capture in the other category pulm event. And the air leak was captured in post op complications air leak > 5 days. DO we*	*Yes, all returns to the OR are collected on separate DCF's*

			capture all returns to the OR on separate tools even if they are related to complications? Thank you	
	3/06		*A patient who underwent a myocardial revascularization went to back the OR for a mediastinal exploration which resulted in an evacuation of a hematoma. Is a data collection form completed for this "exploratory" thoracic surgery.*	*If you participate in the STS Adult Cardiac National Database, the re-exploration would be coded as Seq# 2710 Complics=Yes; Seq#2760 COpReNon=Yes. If you participate in the STS General Thoracic Database, code Seq# 740 Proc=Other Mediastinal/neck procedure. If you participate in both the Adult Cardiac and GTDB, code as above. The patient would be entered in both databases.*
	3/06		*A patient's has a flexible thoracoscopy and placement of a CT to drain recurrent empyema. Is the placement of the CT considered a open or closed pleural drainage procedure*	*If the flexible bronchoscopy and CT placement was done in the OR, the procedure would be coded as "Open"*
	3/06		*A patient has had an Infuse-A Port placed during her thoracic procedure. If collecting this information under what category (procedure) should it be included.*	*This is procedure would be coded as either Other Mediastinal/neck procedure or in a user-created custom field*
	3/06		*Typically a chest tube is inserted during an open thoracic procedure. Do you capture this placement of the chest tube as a closed pleural drainage procedure? Or is this only to be "checked" if the chest tube placement is specifically for a pleural effusion?*	*Code Seq# 740 as Pleural drainage procedure-closed or opened if the chest tube is inserted for a pleural effusion. The chest tube is inserted after an open thoracic procedure to regulate the change in pressure in the pleural space and is considered part of the procedure.*
	3/06		*Surgery was done on a patient. The surgeon performed a thorocotomy for a paraspinal mass. It is not clear as to which category to capture this surgery. The path report was negative stating consistent with bronchogenic*	*There is no field for a paraspinal mass. It could be coded as Other Mediastinal (if approach was through the mediastinum) or Other Tracheobronchial. The key is to be consistent in coding all paraspinal mass surgeries at your site.*
	10/06		*Is there a way to capture an Internal Mammary artery pedicle flap as an anastomotic reinforcement to the bronchial stump after a sleeve lobectomy OR is this an Other procedure?*	*other air leak control measures*
	10/06		*Proc* *Message: Do we include Aortic Aneurysm repair in this data base (Repair/Reconstruction thoracic aorta)?*	*Yes, if the repair was conducted by a cardiothoracic surgeon. Please indicate whether the repair was Repair/Reconstruction thoracic aorta or Repair/Reconstruction abd aorta.*
	10/06		*Biopsy* *Message: If the patient has a wedge done for a small nodule removal is this a wedge resection or should this be coded as a lung biopsy?*	*Code as Wedge Resection. Whether diagnostic or interventional, it is still a wedge resection of the lung.*
	10/06		*Short Field Name: Air Leak* *Message: When the surgeon covers the bronchial stump with tissue is this to be captured as an air leak control?*	*Yes, code as "Other Air Leak Control Measures". Note: Air leak measures are defined on the Clinical Support website document "General Thoracic Surgery Database Procedures Defined".*
	10/06		*Short Field Name: cardiac/pericardium/great vess* *Message: For patients that are having an Isolated procedure for pericardial window, repair cardiac laceration or any other procedure in this field. Is it better to capture these procedures in the GTS database or should I capture them in the Adult Cardiac Surgery database as an other, knowing that all the data elements may not be completed?*	*The GTS database should be used to capture all general thoracic procedures performed in the OR (OR, Endoscopy Suite, Out Patient Surgical Center) by a participating General Thoracic surgeon.*
	10/06		*When the thoracic physician assist ENT or Neuro and does an access thoracotomy should this assist procedure be captured? If so how should it be captured?*	*No. The current database does not have a field to capture the assist at this time. Further database upgrades will consider this option.*
	11/06		*The patient had a history of colon and renal cancer. The patient had a subxiphoid pericardial window performed. The fluid and biopsies came back negative for malignancy. Is this captured in the GTS data base or the Adult Cardiac data base?*	*A pericardial window should only be entered in the Adult Cardiac database if it was performed because of an open heart surgery complication. If the pericardial window was performed for any other reason, it should be entered in the General Thoracic database.*
	12/06		*Should patients who only had an esophagoscopy, bronchoscopy or*	*Yes, these procedures should be entered.*

			mediastinoscopy be entered in the database?	
	12/06		*How do I code Lung Biopsy? Is it pleural biopsy, wedge resection or "other" lung procedure?*	*A lung biopsy should be coded as "Wedge resection, single".*
	03/07		*For blebectomy and bullectomy, is the GTS using these terms interchangeably?*	*Yes, these two terms are used interchangeably.*
	03/07		*The patient has a spontaneous pneumothorax. The surgeon does an apical blebectomy and pleurodesis. How is this captured? As a single wedge resection or a bilobectomy?*	*This procedure should be documented as a "Bullectomy/repair".*
	04/07		*Under what Primary procedure should we classify a tracheostomy revision? (A tracheostomy was done, for one reason or another and now needs revision.) Is it Other-tracheobronchial procedure?*	*If the tracheostomy was replaced in the 2nd surgery, the Primary procedure remains tracheostomy. If the surgery was actually a tracheal revision, it should be coded as Other, tracheobronchial procedure.*
	06/07		*There is an issue of contention at my site among our thoracic and cardiothoracic surgeons. General thoracic surgeons who do full thorascopic lobectomies object to others who start with thorascopic ports in, but eventually extend one of those incisions to 4-5 centimeters, use a retractor, and then complete the lobectomy through that site. There is some concern that this technique is then referred to as a thoracic lobectomy, both in the OR report, and in subsequent charting, although a few do refer to it as a "mini thoracotomy". How should I code this Primary procedure?*	*In the STS General Thoracic Surgery Database, please use the following as guidance for capturing this type of procedure:* *If the ribs are spread, that is a thoracotomy and regular lobectomy. A 4-5cm incision is still compatible with a vats lobe. The real issue is rib spreading. If the ribs are spread, it is a video-assisted lobectomy, but still a standard lobectomy.*
	11/07		*We have a number of patients who have more than one biopsy of their lung in order to obtain tissue for diagnosis. I have been coding them as wedge resection, multiple. Our surgeons think that is incorrect and should only count as a single wedge resection. Could you comment?*	*In the current database, there is no option to code for a lung biopsy(s). You are correct in coding multiple lung biopsies as "wedge resection, multiple."*
	11/07		*How should we code a tracheobronchial dilation? Would it just be included as part of the bronchoscopy, or should it be "other"?*	*Please code a dilation under "other tracheobronchial procedure. (It is planned to have tracheobronchial dilation as an option to code in the next spec upgrade.)*
	11/07		*If a patient has a blebs resection with mechanical pleurodesis, is the pleurodesis collected as a separate pleural procedure, or would it be included in Bullectomy/repair?*	*It would not be collected as a separate procedure, but as part of the Bullectomy.*
	12/07		*Surgical procedure: Right Thoracotomy with Intrapericardial Pneumonectomy and Intercostal Muscle Flap Closure of Bronchus. Under which category is the Intercostal Muscle Flap Closure of Bronchus?*	*Please code as: Other air leak control measure.*
	01/08		*If stent placement was attempted, but had to be removed, then the patient underwent balloon dilation of their trach - the balloon dilation will be recorded as "Other tracheobronchial procedures", but the attempted stent - is this coded as "Tracheal/bronchial stent"? Or not at all?*	*The attempted stent would not be coded at all.*
	02/08		*Pt has the following: right latissimus & serratus muscle flap transfer into chest, right 2,3,4,5,6 rib thoracoplasty, partial right scapular resection & bronch. Which procedure should be coded as the Primary? And should scapular resection be captured under "other chest wall repair"?*	*The primary procedure is the right 2,3,4,5,6 rib thoracoplasty. Yes, please capture the scapular resection under "Other chest wall repair."*
	03/08		*Regarding patients who have a pleurodesis have a pleural effusion that is drained prior to instillation of the talc: Do you count the pleural drainage as a minor procedure with Pleurodesis as the Major Procedure, or is the pleural drainage just considered to be part of a Pleurodesis?*	*They would be captured as two different procedures. Capture Pleurodesis as the Primary Procedure. The pleural drainage would be captured as Pleural Drainage-Open.*

	04/08			*How should we code a flexible esophagogastroduodenscopy? As Esophagoscopy, Flexible? Also, would this include an endoscopic biopsy or would that be coded separately? If so, how? How is an endoscopic ultrasound coded?*	*Code as Esophagoscopy, Flexible. Endoscopic biopsy is included and would not be coded separately. Endoscopic ultrasound should be coded as "Other, Esophageal Procedure".*
	05/08			*How would you classify bronchial stump reinforcement with pleural or muscle flap?*	*Code as "Other air leak control measures."*
	05/08			*In thoracic cases where the pericardium is reconstructed along with resection- how is that classified?*	*It is classified as "Other pericardial procedure."*
	06/08			*The patient had a thoracotomy for excision of large mass in the left lower chest. The mass is described as an encapsulated Schwannoma located along the posterior chest wall at the level of the diaphragm (not adherent to the lung). To which category and what primary procedure does this procedure belong?*	*The Category would be "Other" and the Primary Procedure should be coded as "Chest wall resection".*
	09/08			*How should I code a patient with an esophagogastrectomy and esophagogastrostomy?*	*If the procedure conducted was a standard esophagogastrectomy, please capture as 1) Resection, esophagus (esophagectomy), 2) Conduit, gastric, AND 3) Anastomosis, chest. The Primary procedure is the esophagectomy.*
	10/08			*Patient has a paraspinal mass located near T12-L2(path report>spindle cell neoplasm). Procedure performed was Rt. Retroperitoneal paraspinal mass resection with thoracoabdominal approach, partial resection of diaphragm, primary reconstruction of diaphragm, resection of 12th rib. What procedure would you list for the resection of the paraspinal mass? chest wall resection or other chest wall repair?*	*Neither. The Procedure for the resection of the paraspinal mass is Chest Wall Resection.*
NEW!	**12/08**			*Surgeon states in the operative report that he performed extensive adhesiolysis and pneumonolysis. Is this considered the same as decortication*	*No, this is not the same as decortication. It is part of the inherent procedure.*
		750	Primary	Indicate whether this is the primary surgical procedure.	
	3/06			*The following procedures were done during the same surgical procedure: flexible bronchoscopy, multiple wedge resection, lobectomy and a mediastinal LN biopsy. What criteria should be used for selecting the "primary" procedure?*	*The Primary procedure in the scenario presented is the lobectomy. The flexible bronch was most probably diagnostic, the wedge resections and lymph nodes were for biopsy to determine if the entire lobe would need to be removed. Criteria for selecting Primary procedure is to select the most "invasive" or the procedure that removes the most tissue.*
	10/06			*If the patient has a Mediastinoscopy and Lymph Node Biopsy - or any type of tissue biopsy from the mediastinum, which is the "Primary" - the Med or the biopsy procedure? The Med itself seems the "most invasive" but the biopsy "removes the most tissue".*	*In this example, the Primary procedure is the Mediastinoscopy. If a Mediastinal Lymph Node Biopsy was the only procedure conducted, it would be the primary.*
	02/08			*If a pt has an anterior pericardectomy & also resection of mediastinal mass for treatment of a necrotic mass & recurrent pericardial effusions which of the two procedures should I code as the Primary Procedure?*	*The Resection of Mediastinal Mass would be the Primary procedure.*
	06/08			*The patient had a thoracotomy for excision of large mass in the left lower chest. The mass is described as an encapsulated Schwannoma located along the posterior chest wall at the level of the diaphragm (not adherent to the lung). To which category and what primary procedure does this procedure belong?*	*The Category would be "Other" and the Primary Procedure should be coded as "Chest wall resection".*
	06/08			*Pt had (L) thoracoscopy with stapling of apical bleb & mechanical & talc pleurodesis. Which procedure would you code as the primary procedure...the stapling or the pleurodesis?*	*The Stapling of the bleb is the Primary procedure.*

	06/08			*A VATS partial decort was done, and because the lung was involved with tumor it would not completely fill the hemithorax so a tunneled Pleurax catheter was placed. Is the primary proc the Partial Decort or the Pleurax because the Decort failed?*	*The Partial Decortication is the Primary procedure.*
	09/08			*How would you classify a mini invasive esophagogastrectomy? The surgery included a VATS, neck incision, laparoscopy, and a feeding jejunostomy.*	*The Primary procedure is the esophagectomy.*
		751	Approach - Thoracoscopy	Indicate whether a Thoracoscopy approach was used for the primary surgical procedure.	
	3/06			*Regarding the primary procedure it is requested to select the approach. Since you can only select one primary procedure are you requesting the approach only for that procedure? Clarification is needed since in parenthesis is (select all that apply.)*	*It is possible to have multiple attempted approaches to the one procedure that was coded as the primary procedure. For example, if the primary procedure was a Wedge Resection-Singe that was started with a Thoracoscopic (Seq# 751) approach that ended up having to be converted to Thoracotomy (752), both 751 and 752 would be selected.*
	10/06			*Our surgeon is using the DAVINCI robot for thoracoscopy approach. We are capturing the use of this robotics by the surgical approach used. Is this correct or should it be captured as Other?*	*Correct. If you need to distinguish DAVINCI from regular thoracoscopy, you can add a custom field.*
	09/08			*The mini invasive esophagogastrectomy surgery included a VATS, neck incision, laparoscopy, and a feeding jejunostomy. Is the Primary approach: Laparoscopy or thoracoscopy?*	*Please capture all the applicable approaches: laparoscopy, thoracoscopy and cervical.*
		752	Approach - Thoracotomy	Indicate whether a Thoracotomy approach was used for the primary surgical procedure.	
		753	Approach - Thoracoabdominal	Indicate whether a Thoracoabdominal approach was used for the primary surgical procedure.	
		754	Approach - Median Sternotomy	Indicate whether a Median Sternotomy approach was used for the primary surgical procedure.	
		755	Approach - Partial Sternotomy	Indicate whether a Partial Sternotomy approach was used for the primary surgical procedure.	
		756	Approach - Transverse Sternotomy	Indicate whether a Transverse Sternotomy approach was used for the primary surgical procedure.	
		757	Approach - Laparotomy	Indicate whether a Laparotomy approach was used for the primary surgical procedure.	
		758	Approach - Laparoscopy	Indicate whether a Laparoscopy approach was used for the primary surgical procedure.	
		759	Approach - Cervical	Indicate whether a Cervical approach was used for the primary surgical procedure.	
		760	Approach - Subxyphoid	Indicate whether a Subxyphoid approach was used for the primary surgical procedure.	
		761	Approach - Other Approach	Indicate whether any other approach was used for the primary surgical procedure.	
	10/06			*Is a Chamberlain Procedure considered the same as the Anterior Mediastinoscopy? What would be the approach?*	*Yes. It should be coded as "ApprOther".*
	12/06			*When entering a patient with a bronchoscopy or esophagoscopy only, how do we enter Approach?*	*The Approach should be documented in the operative record and appropriately recorded.*
	05/08			*When coding for placement of a Pleur-x catheter in the OR, the procedure is "pleural drainage procedure-closed", but what do we code for "approach"?*	*Code as "Other approach".*
		765	Laterality	Indicate the laterality of the primary surgical procedure.	
	10/06			*"Laterality" gives a choice of left, right, or both. I think of "both" as entering both the left and right sides, as is sometimes the case in some procedures. How do you want us to code in the case of midline procedures, for example esophagoscopy? Putting "both" is not really correct. I've tried leaving the field blank, and can't get the procedure to validate. Will STS accept a blank in this field*	*For your example and given the options in the current database the Laterality should be left blank/null. Leaving this field blank will not result in this record being excluded from analysis. It will be reported as missing data though in your site's data quality report. Additional laterality options will be considered in future database revisions.*

				for a midline procedure?	
	12/06			*How do we enter "Laterality" for bronchoscopy or esophagoscopy-only procedures?*	*Same as above.*
	8/04		GENERAL STATEMENT Section "E", Post Operative Events	The postoperative period, in which postoperative events can be captured, is defined as one of the following: 1. Immediately postoperatively until discharge from the acute care facility, if discharged > 30 days after procedure. 2. Immediately postoperatively, up to 30 days, if discharged from the acute care facility prior to 30 days.	
		770	No postop events occurred	Indicate whether the patient did not experience any postoperative events.	
		775	Postop Events Occurred	Indicate whether the patient experienced any postoperative events.	
	3/06			*How should we collect intra-operative complications?*	*There is currently no intraoperative complication fields in the GTDB. If there is a desire to track intraoperative complications, these will have to be collected as custom fields.*
	3/06			*Just because a person is taken back to the OR doesn't necessarily mean it is due for a complication. At our institution, post sleeve or tracheal resection anastomosis check, etc are standard of care. In these instances, would this be considered a complication?*	*No. If this is the standard practice, it would not be coded as a postoperative event. However, if a patient did go back for a planned procedure, a new data collection form would need to be initiated for the 2nd procedure.*
	10/06			*When tracking post op events, do we collect complications on procedures we do for/with other services - IE exposures & closures, tracheostomy, etc? What about traumas? Examples:* *Cardiac surgery pt needs trach for resp failure. Any subsequent complications after trach is a thoracic complication?* *Pt who has resp failure from prior existing condition with/without other surgeries. Any subsequent complications after trach is a thoracic complication?* *We perform exposure or other assistance with another service. Any subsequent complication after other service surgery is a thoracic complication?*	*All postoperative events should be documented.*
	10/06			*Message: In your new FAQ's, the beginning of section E describes the time period over which post-op events can be captured (through DC if DC is >30d's from the procedure and for up to 30 d's from procedure if the pt is discharged before 30 d's). My question is what events to capture. Your new 2.07 FAQ's under general statement #2 say the post op events section is designed to only capture those postop events that result from the General Thoracic procedure for which the DCF was generated in the first place. Please consider the following scenario: a 64 yo woman has a large mediastinal mass plus separate lung masses. She is bronchoscoped by our thoracic surgeon in the OR. Biopsies can be done of the mediastinal mass because it has invaded the trachea. She has small cell lung CA. No post op problems relate to the bronchoscopy. Due to her disease and chemo/radiation, however, she develops SIADH; nausea, vomiting and pain requiring gastroscopy (done by GI), a UTI, needs blood transfusion, and ileus. Do these all get coded as events even though they don't relate to the bronch? Also, 10 d's after the bronch she had a port-a-cath but in by another surgeon (not someone we code in this database). Does the timing of this second procedure have any significance in terms of the post-op events for our earlier*	*For your scenario: 1. No, these GI, UTI and other events following an uneventful bronchoscopy would not be coded.* *2. Only participating cardiothoracic surgeons should have procedures coded in the database.*

				procedure? Please clarify. Thank you.	
	07/07			*I'm very confused. In your FAQs, one response is that all postoperative events should be captured, regardless of whether it relates to the thoracic procedure. A second FAQ response to a scenario states that events following an uneventful bronchoscopy should not be coded. Which is true?? Should post-op events be recorded regardless of cause of event or not?*	*If an event was related to the thoracic procedure, than it should be reported, i.e., a pneumothorax after a transbronchial lung biopsy. However, if there is an unrelated event, such as a ruptured bleb on the right side requiring a chest tube after a simple left VATS bleb excision, then it is not fair to code it as a complication of the procedure. Obviously judgment must be used and a liberal definition of "related" must be used.*
	04/08			*How do you code "shock" if blood cultures are negative? Postop lobectomy pt experienced decreased UOP, decreased BP, and decreased p02 sat. Pt transferred to ICU and started on pressors and abx.*	*This significant event would be coded to Seq# 980 "Other CV event."*
	07/08			*Postop Day 1 (following Thoracoscopic Wedge resection, DX: Interstitial Lung Disease) patient develops Acute Onset SOB requiring transfer to ICU, Pulmonary evaluation, IV antibiotics + Solu Medrol. Is this coded as "Other pulmonary event" or "Other events req medical Rx (incl. endoscopy)?"*	*Code as "Other pulmonary event".*
		790	Air leak with a duration of more than five days postop	Indicate whether the patient experienced an air leak for more than five days post-operative.	
	04/07			*A patient has a lobectomy and returns to the OR later in the day for a bleed. The bleed/re-op is captured as a post-op event, and another DCF is initiated for the return to OR for the bleed. The chest tube remains in form more than 5 days. Is the air leak as a post-op event, belong to the first surgery, the re-op, or to both.*	*The air leak is a post-op event due to the first operation.*
		850	Atelectasis requiring bronchoscopy	Indicate whether the patient experienced atelectasis requiring a bronchoscopy in the post-operative period.	
		860	Patient experienced pneumonia postoperatively	Indicate if the patient experienced pneumonia in the post-operative period. Pneumonia is defined as meeting three of five characteristics: fever, leukocytosis, CXR with infiltrate, positive culture from sputum, or treatment with antibiotics.	
	3/06			*If a patient has an infection other than pneumonia, they will usually have fever, treatment w/ antibiotics and leucocytosis. Those are three of the five criteria for pneumonia even though it may not be a true pneumonia. Clinical judgment is therefore warranted. Can something to that affect be added to the specifications?*	*The definition states, "…Pneumonia is defined as meeting 3 of the 5 criteria: fever, leukocytosis, CXR with infiltrates, positive culture from sputum, or treatment with antibiotic." Patients with Pneumonia are will usually have some progress notes stating "rule out pneumonia" or "diminished lung sounds". Will consider changing definition for the next upgrade.*
		870	Patient has evidence of Adult Respiratory Distress Syndrome	Indicate whether the patient has evidence of ARDS (Adult respiratory distress syndrome). According to the American-European consensus conference, a diagnosis of ARDS is assigned if all of the following criteria are present: 1. Acute onset 2. Arterial hypoxemia with PaO2/FIO2 lower than 200 (regardless of PEEP level) 3. Bilateral infiltrates seen on chest radiograph 4. Pulmonary artery occlusive pressure lower than 18 mm Hg or no clinical evidence of left atrial hypertension 5. Compatible risk factors	
		880	Bronchopleural fistula	Indicate if the patient experienced a documented bronchopleural fistula in the post-operative period. Bronchopleural fistula is defined as a major bronchial air leak requiring intervention such as a chest tube, operation, or other procedure.	
		890	Pulmonary embolus	Indicate whether the patient experienced a Pulmonary Embolus in the post-operative period as experienced by a V/Q scan, angiogram or spiral CT.	
		900	Initial vent support >48 hours	Indicate if the patient initially was ventilated greater than 48 hours in the post-operative period. If the patient is extubated prior to 48 hours, this item would not be selected. If the patient is reintubated, please select the postoperative event "reintubation" and do not select this element even if the reintubation ventilator support is > 48 hours. Ventilator support ends with the removal of the endotracheal tube or if the patient has a tracheostomy tube, until no longer ventilator dependent.	
		910	Reintubate	Indicate whether the patient was re-intubated during the initial hospital stay after the initial extubation. This may include patients who have been extubated in the OR and require	

				intubation in the postoperative period.	
	10/06			*If a patient is reintubated for a planned bronch post-op - does this count as a reintubation complication??*	*No. Procedure was planned.*
		920	Tracheostomy	Indicate whether the patient required a tracheostomy in the post-operative period.	
	4/04			*Tracheostomy done intraoperatively, during the initial operation, should not be captured in this field.*	
		930	Other pulmonary event	Indicate whether another pulmonary event occurred in the post-operative period.	
	3/06			*An operative report was generated for an insertion of a pleurex catheter (for a recurrent pleural effusion.) In the post operative period the patient was intubated due to increasing oxygen requirements and was intubated for >48hrs. Since the patient was not intubated for the "operative" procedure reintubation (910) and initial vent support >48 hrs (900) is not applicable? Should this be coded as other pulmonary event (930)?*	*Yes, code as Other pulmonary event because the patient was not vented for the procedure.*
	3/06			*Sequence #: 930, 980, 1040, 1070, 1150, 1200, 1210* *The above sequence #'s are the "other" postoperative complications. Can you give examples of what "other" events in each section will include? IE reperfusion injury for other pulmonary, etc.*	*There is no easy answer to what to include in the "Other" postoperative complications. A good rule of thumb is to include but not limit to any postoperative event or complication that extends the length of stay or outcome of the patient. The "Other" categories are not used in any analysis because it is too vague, so it really can be used to collect anything you want to collect that is not specifically included in the other complication fields.*
	02/08			*If a pt has to return to OR in their post-op period for muscle flaps & thoracoplasties, should this complication be captured in this section or is it better to capture in the miscellaneous complications under the "Other events requiring OR with general anesthesia"?*	*Please capture under "Other events requiring OR with general anesthesia.*
		940	Atrial arrhythmia requiring treatment	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. pharmacologic treatment 4. electrocardioversion	
	12/04			*The intent of this field is to capture new onset atrial arrhythmias that occur in the postoperative period that have either been clinically documented or treated. If a patient has a history of atrial arrhythmias preoperatively and the patient experiences atrial arrhythmias postoperatively, do not capture the reoccurrence of the atrial arrhythmias because the atrial arrhythmia is not new in onset.*	
	3/06			*I know the criteria states new arrhythmia. But, what if a patient has a pre-op arrhythmia and post-operative has arrhythmias which prolong their hospital stay and/or becomes uncontrollable, should we capture this as a complication?*	*Yes. If the original treatment for the atrial arrhythmia does not control the arrhythmia, code Seq# 940 AtrialArryth = Yes*
		950	Ventricular arrhythmia requiring treatment	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. pharmacologic treatment 5. electrocardioversion	
		960	Myocardial infarct	Indicate if the patient experienced a MI postoperatively as evidenced by: 1. transmural infarction: Defined by the appearance of a new Q wave in two or more contiguous leads on ECG, or 2. subendocardial infarction: (nonQwave) Infarction, which is considered present in a patient having clinical, angiographic, electrocardiographic, and/or 3. laboratory isoenzyme evidence of myocardial necrosis with an ECG showing no	

				new Q waves
		970	DVT requiring treatment	Indicate whether the patient has experienced a deep venous thrombosis confirmed by doppler study, contrast study, or other study in the post-operative period.
		980	Other cardiovascular event	Indicate whether any other CV event occurred including distal arterial embolism in the post-operative period.
		990	Gastric outlet obstruction	Indicate whether the patient experienced a gastric outlet obstruction requiring intervention, e.g., IV for dehydration, endoscopy and dilation, reoperation, etc., in the post-operative period.
		1000	Patient experienced an ileus postoperatively	Indicate whether the patient experienced an ileus lasting greater than three days as defined by limited GI motility requiring treatment e.g. nasogastric tube insertion for decompression, etc., in the post-operative period.
		1010	Anastomosis requiring medical treatment only	Indicate whether the patient in the post-operative period experienced an esophageal anastomosis leak or abnormality that required medical management only, i.e., NPO, antibiotics, etc. If a leak or an abnormality occurs on Barium Swallow only and does not require surgical intervention /drainage, i.e., treated with NPO and delay in oral intake, then code this element as "yes".
		1020	Anastomosis requiring surgical treatment	Indicate whether the patient in the post-operative period experienced an esophageal anastomosis leak or abnormality that required medical management only, i.e., NPO, antibiotics, etc. If a leak or an abnormality occurs on Barium Swallow only and does not require surgical intervention /drainage, i.e., treated with NPO and delay in oral intake, then code this element as "yes". Indicate whether the patient in the post-operative period experienced an esophageal anastomosis leak that required surgical intervention or manipulation, i.e., reoperation (in the operating room or requiring general anesthesia, repeat thoracotomy for drainage and control of the leak) for the esophageal anastomotic leak. Opening the neck incision for drainage at the bedside would be included here.
	3/06			*Is re-operation for conduit necrosis, etc. also included in "anastomosis requiring surgical treatment" section or is this for leaks only?* — *Yes, code Seq# 1020 AnastoSurg=Yes and initiate a new data collection form (DCF) for the procedure.*
		1030	Dilation of the esophagus prior to discharge	Indicate whether the patient required dilation of the esophagus within the post-operative period.
		1040	Any other GI event occurred	Indicate if the patient experienced any other GI events in the post-operative period.
		1050	Bleeding requiring reoperation	Indicate whether an operative reintervention was required for bleeding.
		1066	Blood transfusion - Intraop	Indicate whether the patient received a blood transfusion intraoperatively. Intraop is defined as any blood started inside of the OR.
		1067	Blood transfusion - Postop	Indicate whether the patient received a blood transfusion postoperatively. Postop is defined as any blood started after the initial surgery, including blood transfused after the initial surgery and any blood transfused during a reoperative surgery.
		1070	Other hematology or bleeding event requiring treatment	Indicate if any other hematology/bleeding event requiring treatment occurred in the post-operative period such as Heparin Induced Thrombocytopenia.
		1080	Urinary tract infection	Indicate if the patient experienced a urinary tract infection (with Positive Urine Cultures postoperatively) requiring treatment.
		1090	Patient experienced empyema requiring treatment	Indicate whether the patient experienced an empyema requiring treatment in the post-operative period, i.e., chest tube drainage by interventional radiology, etc.
		1100	Wound infection	Indicate whether the patient experienced a wound infection in the post-operative period as evidenced by meeting two of the following criteria: 1. Wound opened with excision of tissue (I&D) 2. Positive culture 3. Treatment with antibiotics
		1110	Patient experienced sepsis (septicemia)	Indicate whether the patient experienced septicemia requiring positive blood cultures in the post-operative period.
		1130	New central neurological event	Indicate whether the patient experienced any of the following neurological events in the post-operative period that was not present pre-operatively: 1. A central neurologic deficit persisting postoperatively for > 72 hours. 2. A postoperatively transient neurologic deficit (TIA recovery within 24 hours; RIND recovery within 72 hours). 3. New postoperative coma that persists for at least 24 hours secondary to anoxic/ischemic and/or metabolic encephalopathy, thromboembolic event or cerebral bleed.
		1140	Recurrent laryngeal nerve paresis	Indicate whether the patient experienced in the postoperative period a recurrent laryngeal nerve paresis or paralysis that was not identified during the pre-operative evaluation.
		1150	Other neurological event	Indicate whether the patient experienced any other neurologic event in the post-operative period.
		1160	New renal failure	Indicate whether the patient experienced renal failure in the post-operative period as documented by acute or worsening renal failure resulting in one or more of the following: 1. increase of serum creatinine to > 2.0 and 2x most recent preoperative

				creatinine 2. a new requirement for dialysis postoperatively	
	10/06			*Short Field Name: New renal failure Message: A patient has a history of acute renal failure with creatinine >3.0 in Aug 05. He comes in for a left ventricular lead placement in June 06. Creatinine on admission is 1.0. Post op his creatinine goes as high as 3.1 before coming down. Do I code renal failure as a complication or not given he has a past history of creatinine >3 but also had a normal creatinine on admission?*	*Yes, it should be coded as "New Renal Failure"; as per the definition there has been an increase of serum creatinine to > 2.0 and 2x most recent preoperative creatinine level.*
		1170	Chylothorax requiring drainage/medical treatment only	Indicate whether the patient experienced a chylothorax in the post-operative period that required drainage and medical intervention, i.e., NPO, TPN, etc., only. Chylothorax requiring surgical intervention, i.e., thoracotomy, laparotomy, thoracoscopy, etc., should not be captured here.	
		1180	Chylothorax requiring surgical intervention	Indicate whether the patient experienced a chylothorax in the post-operative period requiring surgical intervention, i.e., thoracotomy, laparotomy, thoracoscopy, etc.	
		1190	Delirium tremens	Indicate whether the patient experienced delirium tremens in the post-operative period marked by illusions, confusion, cerebral excitement, and having a comparatively short course.	
	3/06			*Can you further define delirium tremens? Is this only ETOH withdrawals or can encephalopathy, ICU psychosis, etc. be included?*	*No. Please include all of the symptoms mentioned for Seq# 1190 Delirium.*
	10/06			*Delirium Tremens Message: Delirium tremens refers to symptoms induced by excessive and prolonged use of alcohol which is not mentioned as a part of its definition here. In the clarification written in 3/06, it appears that we are being told that any type of delirium should be included here. If that is the case, the field name should be changed to DELIRIUM rather than delirium tremens, a symptom of alcohol withdrawal. Please clarify for everyone.*	*The clarification written on 3/06 remains correct. In subsequent database revisions, the field name and data definitions may be revised, however in the meantime the field should be marked "Yes" if the patient experienced the symptoms listed.*
		1200	Other events requiring medical treatment	Indicate whether the patient experienced any other medical events in the post-operative period requiring medical treatment, including endoscopy.	
	3/06			*If a patient has pneumothorax in which a chest tube was placed, should "other pulmonary event" be checked or "other events req medical Rx (incl. endoscopy)*	*Code Seq# 1200 OtherMed=Yes*
		1210	Other events requiring OR with general anesthesia	Indicate whether the patient experienced any other surgical events in the post-operative period requiring a procedure with general anesthesia.	
	01/07			*I have questions on three patients – Patient #1 S/P THE with Exploratory Lap for esophageal pseudo-obstruction and redundant conduit. Would this be a Complication of "Anastomotic leak requiring surgery" or "Other events requiring surgery"? Patient #2 S/P esophageal resection had a perforation that was created by image-guided thoracentesis wire and went back to OR for repair of gastric conduit perforation with intercostal muscle flap. Which Complication would this be? Patient #3, S/P THE, had bronchial rupture with bronchial gastric fistula (secondary to anesthesia bronch perforation) with repair of gastric conduit and latissmus flap. Which Complication is this? Are these lumped into the leak/conduit surgery or just placed under "Other event requiring surgery"?*	*Given the current data specifications all three patients should be coded as Seq. # 1210 - Other Events Requiring OR with General Anesthesia. Future upgrades will expand the ability to capture post operative events.*
		1220	Discharge date	Indicate the date the patient was discharged from the hospital (acute care). If the patient expired in the hospital, the discharge date is the date of death.	
		1230	Discharge status - alive or dead	Indicate whether the patient was alive or dead at discharge from the hospitalization in which the primary surgery procedure occurred.	
		1240	Date of death if death occurs after discharge	Indicate the date the patient was diagnosed clinically dead.	

		1250	Status 30 days after surgery - alive or dead	Indicate whether the patient was alive or dead at 30 days post surgery (whether in the hospital or not).	
	3/06			*If the patient is not seen at our institution after surgery (post 30 days) how do we answer. (i.e. it is unknown if the patient is alive or dead--or had post op complications.) How do other institution respond to this question when they have no documentation verifying the patient is alive? Where else might they get the information.*	*This has been resolved in v2.07. "Unknown" was added as a choice for Seq# 1250. For v2.06, there are some proprietary services that are available for contracting to investigate deaths outside of the hospital. Also, there is the National Death Index, which runs approximately 18 months behind. If you have the resources, calling all patients that were discharged alive could be initiated.*
	10/06			*If a patient discharge status is dead, but they were still alive at 30 days, is this counted as an in-hospital mortality but not a 30-day mortality? How is this calculated for the Harvest?*	*Both of these variables appear separately in the report and are handled as separate variables. In your example, if both values are not missing then this record will appear in both denominators but would only appear in the numerator for discharge mortality, not for 30-day mortality.*
	04/07			*When a patient died after the 3rd time in the OR (3 separate DCFs), do we enter mortality information on all 3 DCFs?*	*Yes, each operation should result in a new DCF and each should reflect the mortality. Please note that the mortality is only "counted once" in harvest reports.*
		1275	Patient Discharged with Chest Tube	Indicate whether the patient was discharged with a chest tube.	
		1280	Date chest tube was removed	Indicate the date the last chest tube was removed prior to discharge.	
	3/06			*In reviewing the updated version 2.07, the wording has changed and it is unclear if the date of chest tube removal is only for those who have chest tubes d/c while in house. Do you also want the date the tubes were removed if they were d/c with a chest tube?*	*Seq# 1275 CTubeDis Yes/No is the Parent Field to Seq# 1280 CTubeOutDate. ~~This means that Seq# 1280 will only be required to be answered if Seq# 1275 CTubeDis=Yes.~~* ***ANSWER INCORRECT – SEE EXPLANATION BELOW***
	09/07			*In the 03/06 FAQ to Seq.# 1280 re Chest Tube, I believe that the answer is backwards. According to the data specifications, the parent field to Seq.# 1280 (which is Seq.# 1275) should be "No". In other words, it can only be true that person who had a chest tube removed prior to discharge can have a date entered in response to "Indicate the date the chest tube was removed prior to discharge". So answering "No" to the question "Was the patient discharged with a chest tube?" will allow for entry of the date the chest tube was removed prior to discharge.*	*The FAQ posted since March 2006 is incorrect (good pick up!). It should only be answered if the parent field, Seq.# 1280 is "No".* *Your software also should not allow the date to be completed if the answer is "Yes".*
	09/07			*Two different scenarios:* *1) Our surgeons use a red Robinson balance catheter in pneumonectomy patients which is removed on POD#1. Would this be considered a "chest tube"?* *2) If a patient is discharged with a pleurex catheter – is it the same as being discharged with a chest tube?*	*Yes. Although not a standard chest tube, both scenarios include a tube(s) that can drain air.*
		1300	Pathological stage n/a	Indicate if path staging is not applicable. For benign disease or pulmonary metastases of any type, pathological staging is not applicable.	
	4/04			*Lung and Esophageal cancer staging is the **only** staging applicable in the STS General Thoracic Database.*	
	4/04			*Please define the difference between clinical staging and pathological staging.*	*Clinicopathological staging of cancer: Staging is the clinical or pathological assessment of the extent of tumor spread.* *<u>Clinical</u> staging is a preoperative assessment. It is based on clinical, radiological and operative information. Clinical Staging is used to determine treatment offered to patients.* *<u>Pathological</u> staging is a postoperative assessment that is based on pathological testing results. Provides useful prognostic information and allows decisions to be made regarding adjuvant therapy.*

	10/06			*Are carcinoid (neuroendocrine) tumors staged as lung CA? We have a difference of opinion among our physicians.*	*Stage them as lung cancer.*
	12/06			*When cancer patients who have previously been resected return for other procedures related to that surgery, do we still enter the staging from their original surgery? For example, the esophagectomy patient that returns for multiple dilations.*	*No, do not enter the staging from the original surgery. Remember however, that the Category of disease will remain the same from the original surgery.*
	05/07			*In a patient who receives Neo Adjuvant Chemo/Rad does pathological staging still apply?*	*If a patient receives pre-op chemo/rad they will have a pathological stage. If there is no trace of tumor after surgery (as a result of the chemo/rad), then the stage would be T -X (primary tumor cannot be assessed).* *The N stage would depend on the # of nodes affected. The patient would definitely have a clinical stage. This is the stage prior to the chemo/rad treatment.*
	12/07			*How are we to code staging for small-cell lung cancer? For example, on our path report, it stages the patient at limited stage, since the staging is different for small cell vs. non-small cell.*	*The same staging is used for small cell and non-small cell lung cancer. It would, however, be a very limited stage of small cell lung cancer for the patient to go to the operating room.*
	02/08			*How should be code the pathological staging for a pt who has TWO different primary types of lung cancer? Pt had Bronchioalveolar Carcinoma of RUL & Squamous cell Carcinoma of RLL*	*As the current data specifications do no allow coding for two different primary types, code as Squamous cell carcinoma of RLL --as this diagnosis tends to affect the patient more.*
NEW!	**12/08**			*A patient has a clinical staging of T2 No MX for Esophagus CA. They under go Neoadjuvant chemo radiation and return for an IVOR Lewis status post chemo. Upon readmission for the surgery would the clinical staging be the pre-chemo? And would the Pathological staging be the results from the esophagectomy?*	*Yes, the Clinical staging is for the original clinical state before any treatment is given (pre-chemo). Yes, the Pathological staging from esophagectomy results.*
		1310	Pathological stage T	Indicate the appropriate descriptor for tumor based on the pathological staging characteristics of the tumor. (See Appendix A for full description.)	
		1320	Pathological stage N	Indicate the appropriate descriptor for nodes based on the pathological staging characteristics of the lymph nodes. (See Appendix A for full description.)	
		1330	Pathological stage M	Indicate the appropriate descriptor for metastasis based on the pathological staging characteristics of the metastasis(es). (See Appendix A for full description.)	
		1340	Pathological stage Ma, b	For esophageal carcinoma patients only. Please indicate the appropriate Metastasis descriptor based on the pathological staging of the metastasis(es). (See Appendix A for full description.)	