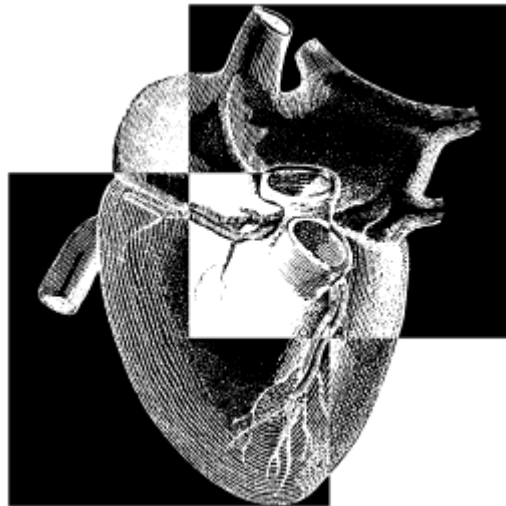


ASCTS Cardiac Surgery Database Project



Data Definitions

Version 1
30/04/01

An initiative of the Australasian Society of Cardiac and Thoracic Surgeons (ASCTS)
In association with The Baker Medical Research Institute and Melbourne Information Management Pty Ltd

ã 2001 ASCTS (Vic)

Section 1: Patient Demographics

(old #) **FUNCTIONAL DEFINITIONS**

1 (4)	NAME: HOSPITAL MEDICAL RECORD NUMBER Definition: Patient medical record number at the hospital where surgery occurred. Data: (free text)
2 (5)	NAME: PATIENT LAST NAME Definition: The last name (surname) of the patient Data: (free text)
3 (6)	NAME: PATIENT FIRST NAME Definition: The first name (Christian name / Given name) of the patient Data: (free text)
4 (7)	NAME: PATIENT MIDDLE NAME Definition: The middle name of the patient Data: (free text)
5 (8)	NAME: DATE OF BIRTH Definition: The date of birth of the patient Data: (Before system date)
6 (10)	NAME: SEX Definition: The sex of the patient Data: Male Female
7 (11)	NAME: MEDICARE NUMBER Definition: The Full Medicare number of the patient (i.e. family number plus person number) if the patient is registered with Medicare Data:
8 (12)	NAME: PATIENT DOES NOT HAVE A MEDICARE NUMBER Definition: Tick the box on the form if the patient is not registered with Medicare (eg. Overseas patient) Data:

FUNCTIONAL DEFINITIONS
(old #)

<p>9 (13)</p>	<p>NAME: PATIENT POST CODE</p> <p>Definition: The Post Code of the patient's residence. We will need a field for non residents</p> <p>Data:</p>
<p>10 (14)</p>	<p>NAME: INDIGENOUS STATUS (1)</p> <p>Definition: Is the patient Aboriginal and/or Torres Strait</p> <p>Data: Yes No</p>
<p>11 (15)</p>	<p>NAME: INDIGENOUS STATUS (2)</p> <p>Definition: Does racial group include Aboriginal</p> <p>Data: Aboriginal</p>
<p>12 (15)</p>	<p>NAME: INDIGENOUS STATUS (3)</p> <p>Definition: Does racial group include Torres Strait</p> <p>Data: Torres Strait Is.</p>
<p>13 (16)</p>	<p>NAME: INSURANCE</p> <p>Definition: Select the category which most accurately describes the patient's insurance status:</p> <p>Data: Private: patient has private health insurance DVA: patient is funded by Department of Veteran Affairs Self-insured: patient is self-funded (private patient without private health insurance) Overseas: patient is an overseas visitor Medicare: patient is funded by medicare Other: all other payment classes (eg TAC, Australian Military, Seamen, Work cover)</p>
<p>14 (17)</p>	<p>NAME: ELECTIVE DAY OF SURGERY (DOSA) ADMIT</p> <p>Definition: Patient admitted for scheduled elective procedure on same day as procedure.</p> <p>Data: Yes No</p>
<p>15 (18)</p>	<p>NAME: DATE OF ADMISSION</p> <p>Definition: Date Patient admitted/transferred to hospital where surgery performed</p> <p>Data:</p>
<p>16 (19)</p>	<p>NAME: DATE OF SURGERY</p> <p>Definition: Date on which the first surgical incision was made for the current Cardiac Surgical Procedure</p> <p>Data:</p>

FUNCTIONAL DEFINITIONS
(old #)

17 (20)	<p>NAME: DATE OF DISCHARGE</p> <p>Definition: Date Patient discharged from being an inpatient</p> <p>Data:</p>
18 (21)	<p>NAME: RECORD COMPLETE?</p> <p>Definition: Are all parts of the data collection form complete?</p> <p>Data: Yes</p>
19 (22)	<p>NAME: WHO HAS CHECKED RECORD COMPLETE?</p> <p>Definition: Which of the following has performed the final check that the data is complete and accurate.</p> <p>Data: Surgeon Registrar Database Manager</p>

Section 2: Patient Risk Factors

20 (23)	<p>NAME: SMOKER</p> <p>Definition: A history confirming any form of tobacco use in the past.</p> <p>Data: Yes No</p>
21 (24)	<p>NAME: SMOKER - CURRENT</p> <p>Definition: Patients having smoked cigarettes within one month of surgery are considered to be current smokers.</p> <p>Data: Yes No</p>
22 (25)	<p>NAME: FAMILY HISTORY CAD</p> <p>Definition: Whether any direct blood relatives (parents, siblings, children) have had any of the following at age <55:</p> <p style="margin-left: 40px;">a. Angina b. Myocardial infarction (MI) c. Sudden cardiac death presumed to be from ischaemic heart disease because of no other obvious cause. d. Coronary intervention</p> <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

<p>23 (26)</p>	<p>NAME: DIABETES</p> <p>Definition: A history of diabetes, regardless of duration of disease or need for anti-diabetic agents.</p> <p>Data: Yes No</p>
<p>24 (27)</p>	<p>NAME: DIABETES - CONTROL</p> <p>Definition: Method of diabetic control, at time of intervention. Choices are (one choice only):</p> <p>Data: None: No treatment for diabetes. Diet: Diet treatment only. Oral: Oral agent treatment. Insulin: Insulin treatment (includes any combination with insulin).</p>
<p>25 (28)</p>	<p>NAME: HYPERCHOLESTEROLAEMIA</p> <p>Definition: Whether the patient has a history of hypercholesterolaemia diagnosed and or treated by a physician, and/or Cholesterol > 5.0 mmol</p> <p>Data: Yes No</p>
<p>26 (29)</p>	<p>NAME: LAST PRE-OP CREATININE LEVEL</p> <p>Definition: Last serum creatinine recorded prior to surgery.</p> <p>Data: mmol/l</p>
<p>27 (30)</p>	<p>NAME: RENAL FAILURE - DIALYSIS</p> <p>Definition: Is the patient on dialysis pre-operatively?</p> <p>Data: Yes No</p>
<p>28 (31)</p>	<p>NAME: HYPERTENSION</p> <p>Definition: Does the patient have a diagnosis of hypertension documented by one of the following:</p> <ul style="list-style-type: none"> a. Documented history of hypertension diagnosed and treated with medication, diet and/or exercise. b. Blood pressure >140 systolic or >90 diastolic on at least 2 occasions. c. Currently on antihypertensive medication. <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

<p>29 (32)</p>	<p>NAME: CEREBROVASCULAR DISEASE</p> <p>Definition: Whether the patient has had Cerebro-Vascular Disease, documented by any one of the following:</p> <ul style="list-style-type: none"> a. Unresponsive coma >24 hrs b. CVA (symptoms >72 hrs after onset) c. RIND (recovery within 72 hrs) d. TIA (recovery within 24 hrs) e. Non-invasive carotid test with >75% occlusion. <p>Data: Yes No</p>
<p>30 (33)</p>	<p>NAME: CEREBROVASCULAR DISEASE TYPE</p> <p>Definition: What type of Cerebro-Vascular Disease does the patient have? Choose one of the following:</p> <p>Data: Coma: Unresponsive Coma >24 hrs CVA: CVA (symptoms >72 hrs after onset) RIND: RIND (recovery within 72 hrs) TIA: TIA (recovery within 24 hrs) Carotid>75%: Non-invasive carotid test with >75% occlusion.</p>
<p>31 (34)</p>	<p>NAME: CVA - WHEN</p> <p>Definition: Those events occurring within two weeks of the surgical procedure are considered recent, while all others are considered remote</p> <p>Data: Recent (<=2 wks); Remote (>2 wks)</p>
<p>32 (35)</p>	<p>NAME: PERIPHERAL VASCULAR DISEASE</p> <p>Definition: 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.</p> <p>Data: Yes No</p>
<p>33 (36)</p>	<p>NAME: RESPIRATORY DISEASE</p> <p>Definition: Specify if the patient has chronic lung disease, and the severity level according to the following classification:</p> <p>Data: No: Mild: on chronic inhaled or oral bronchodilator therapy. Moderate: on chronic oral steroid therapy aimed at lung disease. Severe: Room Air pO₂ < 60 or Room Air pCO₂ > 50.</p>

FUNCTIONAL DEFINITIONS
(old #)

34 (37)	<p>NAME: INFECTIVE ENDOCARDITIS</p> <p>Definition: A patient presenting with valvular disease of infectious aetiology with positive blood culture, or post-operative pathology confirmation.</p> <p>Data: Yes No</p>
35 (38)	<p>NAME: INFECTIVE ENDOCARDITIS TYPE</p> <p>Definition: If the patient is currently being treated for endocarditis, the disease is considered active. If no antibiotic medication (other than prophylactic medication) is being given at the time of surgery, then the infection is considered treated.</p> <p>Data: Treated Active</p>
36 (39)	<p>NAME: IMMUNOSUPPRESSIVE RX</p> <p>Definition: Use of any form of immunosuppressive therapy, including moderate and high dose steroids (i.e. systemic steroid therapy equivalent to >5mg prednisolone) within 30 days preceding the operative procedure</p> <p>Data: Yes No</p>

Section 3: Pre-Operative Cardiac Status

37 (40)	<p>NAME: MI</p> <p>Definition: Patient hospitalised at any time for a Myocardial Infarction documented in the medical record. Two of the following four criteria are necessary:</p> <ul style="list-style-type: none"> a. Prolonged (>20 min) typical chest pain not relieved by rest and/or nitrates. b. Enzyme level elevation: either (1) CK-MB> 5% of total CK; (2) troponin > 2.0 micrograms/ L c. New wall motion abnormalities. d. Serial ECG (at least two) showing Q waves in at least two (2) leads <p>Data: Yes No</p>
38 (41)	<p>NAME: MI - WHEN</p> <p>Definition: Time period between the last documented myocardial infarction and surgery.</p> <p>Data: <=6hrs >6 hrs but <24hrs 1 to 7 days 8 to21 days >21 days</p>

FUNCTIONAL DEFINITIONS
(old #)

<p>39 (42)</p>	<p>NAME: ANGINA CLASS CLASSIFICATION - CCS</p> <p>Definition: Canadian Cardiovascular Society Classification. The highest class leading to episode of hospitalisation and/or intervention:</p> <p>Data: 0: No angina. 1: Ordinary physical activity, such as walking or climbing the stairs does not cause angina. Angina may occur with strenuous, rapid or prolonged exertion at work or recreation. 2: There is slight limitation of ordinary activity. Angina may occur with moderate activity such as walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals or in the cold, in the wind, or under emotional stress, or walking more than two blocks on the level, and climbing more than one flight of stairs at normal pace under normal conditions. 3: There is marked limitation of ordinary physical activity. Angina may occur after walking one or two blocks on the level or climbing one flight of stairs under normal conditions at a normal pace. 4: There is inability to carry on any physical activity without discomfort; angina may be present at rest.</p>
<p>40 (43)</p>	<p>NAME: ANGINA TYPE</p> <p>Definition: Indicate the type of angina present at the time of surgery:</p> <p>Data: Stable: Angina which is controlled by oral or transcutaneous medication. Unstable: The presence of ischaemia that requires hospitalisation and use of intravenous nitrate, heparin therapy or s.c. clexane (include other low mol. Wt. Heparinoids) for control.</p>
<p>41 (44)</p>	<p>NAME: TREATMENT OF UNSTABLE ANGINA - GTN</p> <p>Definition: Treatment for Unstable Angina includes i-v GTN</p> <p>Data: Yes No</p>
<p>42 (44)</p>	<p>NAME: TREATMENT OF UNSTABLE ANGINA - HEPARIN</p> <p>Definition: Treatment for Unstable Angina includes i-v Heparin</p> <p>Data: Yes No</p>
<p>43 (44)</p>	<p>NAME: TREATMENT OF UNSTABLE ANGINA – LMW HEPARINOIDS</p> <p>Definition: Treatment for Unstable Angina includes s.c. clexane (include. Other low Mol. Wt. Heparinoids)</p> <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

<p>44 (45)</p>	<p>NAME: CONGESTIVE HEART FAILURE</p> <p>Definition: Whether a physician has ever diagnosed Congestive Heart Failure (CHF) by one of the following:</p> <ul style="list-style-type: none"> a. Paroxysmal nocturnal dyspnoea (PND); b. Dyspnoea on exertion (DOE) due to heart failure; c. Chest X-ray (CXR) showing pulmonary congestion, OR d. Patient has received treatment for this – ACE inhibition , diuretics , Carvedilol or digoxin <p>Data: Yes No</p>
<p>45 (46)</p>	<p>NAME: DYSPNOEA CLASS CLASSIFICATION - NYHA</p> <p>Definition: NYHA: New York Heart Association Class - the highest level leading to episode of hospitalisation and/or procedure.</p> <p>Data: I: Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnoea, or anginal pain. II: Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitations, dyspnoea, or anginal pain. III: Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity results in fatigue, palpitations, dyspnoea, or anginal pain. IV: Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.</p>
<p>46 (47)</p>	<p>NAME: CHF - CURRENT ADMISSION</p> <p>Definition: The diagnosis and management of CHF was made this admission, OR The management changed due to deterioration in CHF.</p> <p>Data: Yes No</p>
<p>47 (48)</p>	<p>NAME: CARIOGENIC SHOCK</p> <p>Definition: Is the patient, at the time of procedure, in a clinical state of hypoperfusion according to either of the following criteria:</p> <ul style="list-style-type: none"> a. Systolic BP <= 80 and/or Cardiac Index <= 1.8 despite maximal treatment; b. IV inotropes and/or IABP necessary to maintain Systolic BP > 80 and/or CI > 1.8. <p>Data: Yes No</p>
<p>48 (49)</p>	<p>NAME: RESUSCITATION</p> <p>Definition: The patient required cardiopulmonary resuscitation within one hour before the start of the operative procedure</p> <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

<p>49 (50)</p>	<p>NAME: ARRHYTHMIA</p> <p>Definition: Is there a pre-operative arrhythmia present within two weeks of the procedure, by clinical documentation of any one of the following:</p> <ul style="list-style-type: none"> a. Atrial fibrillation/flutter requiring Rx; b. Heart block; c. Sustained Ventricular Tachycardia or Ventricular Fibrillation requiring cardioversion and/or IV Amiodarone. d. Other arrhythmia (eg Sick Sinus Syndrome) <p>Data: Yes No</p>
<p>50 (51)</p>	<p>NAME: ARRHYTHMIA TYPE</p> <p>Definition: Which arrhythmia present within two weeks of the procedure; choose one:</p> <p>Data: Atrial: Atrial fibrillation/flutter requiring Rx; Heart Block: Heart block; Ventricular: Sustained Ventricular Tachycardia or Ventricular Fibrillation requiring cardioversion and/or IV Amiodarone. Other: Other arrhythmia (eg Sick Sinus Syndrome)</p>

Medications at Time of Surgery

<p>51 (52)</p>	<p>NAME: INOTROPES</p> <p>Definition: Pt. on inotropes at time of surgery, for haemodynamic support excluding renal dose Dopamine</p> <p>Data: Yes No</p>
<p>52 (53)</p>	<p>NAME: NITRATES - IV</p> <p>Definition: Patient on this Medication at time of surgery</p> <p>Data: Yes No</p>
<p>53 (54)</p>	<p>NAME: ANTICOAGULANTS</p> <p>Definition: Patient on warfarin/heparin/low Mol. Wt heparinoid at time of surgery</p> <p>Data: Yes No</p>
<p>54 (55)</p>	<p>NAME: STEROIDS</p> <p>Definition: Patient on systemic steroids at time of surgery</p> <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

55 (56)	<p>NAME: ASPIRIN OR OTHER ANTI-PLATELET AGENT</p> <p>Definition: Patient has taken aspirin or other anti-platelet agent in the last 7 days</p> <p>Data: Yes No</p>
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Section 4: Previous Interventions

56 (57)	<p>NAME: PREVIOUS CARDIOTHORACIC OR CORONARY INTERVENTION</p> <p>Definition: Has the patient undergone any previous cardiovascular intervention, either surgical or non-surgical, which may include those done during the current admission. This includes all forms of percutaneous angioplasty and thrombolytic therapy for cardiac indications.</p> <p>Data: Yes No</p>
57 (58)	<p>NAME: PRIOR CARDIAC OPERATIONS REQUIRING BYPASS</p> <p>Definition: Prior to this operation, how many cardiac surgical operations were performed on this patient utilising cardiopulmonary bypass.</p> <p>Data: 0 – 9</p>
58 (59)	<p>NAME: PRIOR BEATING HEART SURGERY</p> <p>Definition: Prior to this operation, how many cardiac surgical operations were performed on this patient without cardiopulmonary bypass.</p> <p>Data: 0 – 9</p>
59 (60)	<p>NAME: PREVIOUS CABG</p> <p>Definition: Previous Coronary Artery Bypass surgery by any approach.</p> <p>Data: Yes No</p>
60 (61)	<p>NAME: PREVIOUS OFF-PUMP CABG</p> <p>Definition: Previous coronary artery bypass surgery performed without the use of cardiopulmonary bypass</p> <p>Data: Yes No</p>
61 (62)	<p>NAME: PREVIOUS VALVE</p> <p>Definition: Previous surgical replacement and/or repair of a cardiac valve, by any approach.</p> <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

62 (63)	NAME: PREVIOUS CARDIAC OPERATION - OTHER Definition: Any other previous cardiac surgery, including operation on the ascending aorta and/or aortic arch, including pericardiectomy Data: Yes No
63 (64)	NAME: PCTA/OTHER Definition: Was Percutaneous Transluminal Coronary Angioplasty, Coronary Atherectomy, and/or coronary Stent done at any time prior to this surgical procedure (which may include during the current admission). Data: Yes No
64 (65)	NAME: PTCA/OTHER INTERVAL (PTCA - SURGERY) Definition: The time between PTCA/Atherectomy/Stent and surgical repair of coronary occlusion. No. of hours if during same admission Data: No. of hours
65 (66)	NAME: THROMBOLYSIS Definition: Was Thrombolytic treatment given for cardiac indications at any time prior to this surgical procedure, <u>during this admission?</u> Data: Yes No
66 (67)	NAME: THROMBOLYSIS - INTERVAL Definition: The time between thrombolysis treatment and surgical repair of coronary occlusion. No. of hours if during same admission Data: No. of hours
67 (68)	NAME: PREVIOUS NON SURGICAL - BALLOON VALVULOPLASTY Definition: Has the patient had a previous non-surgical Balloon Valvuloplasty Data: Yes No

Section 5: Haemodynamic Data

# (old #)	FUNCTIONAL DEFINITIONS
68 (69)	<p>NAME: HEIGHT</p> <p>Definition: Height in centimetres in bare or stockinged feet</p> <p>Data: cm</p>
69 (70)	<p>NAME: WEIGHT</p> <p>Definition: Weight in kilograms in light clothing and stockinged feet</p> <p>Data: kg</p>
70 (71)	<p>NAME: BSA – MANUAL CALCULATION</p> <p>Definition: Body Surface area as taken from the patient's chart. To be entered only if BSA is available from the chart and height or weight not available.</p> <p>Data: m²</p>
71 (72)	<p>NAME: CARDIAC CATHETERIZATION (ANGIOGRAM OR PRESSURE STUDY)</p> <p>Definition: Has the patient had a cardiac catheter for angiogram or pressure study</p> <p>Data: Yes No</p>
72 (73)	<p>NAME: DATE OF CARDIAC CATHETERIZATION</p> <p>Definition: The date the patient had a cardiac catheter inserted</p> <p>Data:</p>
73 (76)	<p>NAME: LVEF METHOD</p> <p>Definition: Was the Left Ventricular Ejection Fraction measured, and how was this information obtained?</p> <p>Data: No: None of the following were done LV Gram: Left Ventriculogram Radionuclide: MUGA Scan Echo: Echocardiogram</p>
74 (74)	<p>NAME: EF</p> <p>Definition: The percentage of the blood emptied from the left ventricle at the end of the contraction. Use the most recent determination prior to intervention. Enter a percentage in the range of 5 - 90.</p> <p>Data: 5 – 90</p>

FUNCTIONAL DEFINITIONS
(old #)

<p>75 (75)</p>	<p>NAME: EF ESTIMATE</p> <p>Definition: If Nuclear scan, echo or angiogram did not yield a digital EF %, provide an estimate from reviewing the study. Choose one of:</p> <p>Data: Normal: (LV-EF > 60%) Mild: (EF 46-60%) Moderate: (EF 30-45%) Severe: (EF<30%).</p>
<p>76 (77)</p>	<p>NAME: PA MEAN</p> <p>Definition: Mean pulmonary artery pressure in mmHg, recorded from catheterisation data or Swan-Ganz catheter PRIOR to skin incision. (If a Swan-Ganz catheter is not passed at all, or if it is passed after skin incision, or if the patient has not had a right heart catheter, this field will have to be left blank. Indirect measurements of the systolic pulmonary artery pressure (eg. via echocardiography) cannot be recorded here, because they refer to PA systolic pressure.)</p> <p>Data: 0 – 99</p>
<p>77 (78)</p>	<p>NAME: LEFT MAIN DISEASE > 50%</p> <p>Definition: Left Main Coronary Disease is present when there is > 50% compromise of vessel diameter in any angiographic view.</p> <p>Data: Yes No</p>
<p>78 (79)</p>	<p>NAME: NUMBER DISEASED VESSELS</p> <p>Definition: The number of major coronary vessels systems (LAD system, Circumflex system, and/or Right System) with > 50% narrowing in any angiographic view. NOTE: Left main disease (>50%) is counted as TWO vessels (LAD and Circumflex). For example, left main and RCA would count as THREE in total. Dominant circumflex counts as TWO vessels.</p> <p>Data: 0 – 3</p>
<p>79 (80)</p>	<p>NAME: AORTIC STENOSIS</p> <p>Definition: Aortic stenosis that clinically warrants valve replacement</p> <p>Data: Yes No</p>
<p>80 (81)</p>	<p>NAME: MITRAL STENOSIS</p> <p>Definition: Mitral stenosis warranting surgical correction</p> <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

81 (82)	NAME: TRICUSPID STENOSIS Definition: Tricuspid stenosis warranting surgical correction Data: Yes No
82 (83)	NAME: PULMONARY STENOSIS Definition: Pulmonary stenosis warranting surgical correction Data: Yes No
83 (84)	NAME: AORTIC REGURGITATION / INSUFFICIENCY Definition: Is there evidence of Aortic valve regurgitation: Data: 0: None 1: Trivial 2: Mild 3: Moderate 4: Severe
84 (85)	NAME: MITRAL REGURGITATION / INSUFFICIENCY Definition: Is there evidence of Mitral valve regurgitation: Data: 0: None 1: Trivial 2: Mild 3: Moderate 4: Severe
85 (86)	NAME: TRICUSPID REGURGITATION / INSUFFICIENCY Definition: Is there evidence of Tricuspid valve regurgitation: Data: 0: None 1: Trivial 2: Mild 3: Moderate 4: Severe
86 (87)	NAME: PULMONARY REGURGITATION / INSUFFICIENCY Definition: Is there evidence of Tricuspid valve regurgitation: Data: 0: None 1: Trivial 2: Mild 3: Moderate 4: Severe

FUNCTIONAL DEFINITIONS
(old #)

87 (88)	<p>NAME: AORTIC VALVE PATHOLOGY / AETIOLOGY</p> <p>Definition:</p> <p>Data: 1 Rheumatic 11 Previous infection 2 Congenital 12 Marfans 3 Ischaemic 13 Annuloaortic ectasia 4 Idiopathic Calcific 14 Other degen. Disease 5 Myxomatous degen. 15 Dissection 6 Failed prior repair 16 Tumour 7 Prosthetic valve failure 17 Trauma 8 Peri-prosthetic leak 18 Iatrogenic 9 Prosthetic valve thrombosis 99 Other 10 Active infection</p>
88 (88)	<p>NAME: MITRAL VALVE PATHOLOGY / AETIOLOGY</p> <p>Definition:</p> <p>Data: 1 Rheumatic 11 Previous infection 2 Congenital 12 Marfans 3 Ischaemic 13 Annuloaortic ectasia 4 Idiopathic Calcific 14 Other degen. Disease 5 Myxomatous degen. 15 Dissection 6 Failed prior repair 16 Tumour 7 Prosthetic valve failure 17 Trauma 8 Peri-prosthetic leak 18 Iatrogenic 9 Prosthetic valve thrombosis 99 Other 10 Active infection</p>
89 (88)	<p>NAME: TRICUSPID VALVE PATHOLOGY / AETIOLOGY</p> <p>Definition:</p> <p>Data: 1 Rheumatic 11 Previous infection 2 Congenital 12 Marfans 3 Ischaemic 13 Annuloaortic ectasia 4 Idiopathic Calcific 14 Other degen. Disease 5 Myxomatous degen. 15 Dissection 6 Failed prior repair 16 Tumour 7 Prosthetic valve failure 17 Trauma 8 Peri-prosthetic leak 18 Iatrogenic 9 Prosthetic valve thrombosis 99 Other 10 Active infection</p>

FUNCTIONAL DEFINITIONS
(old #)

90 (88)	<p>NAME: PULMONARY VALVE PATHOLOGY / AETIOLOGY</p> <p>Definition:</p> <p>Data:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> 1 Rheumatic 2 Congenital 3 Ischaemic 4 Idiopathic Calcific 5 Myxomatous degen. 6 Failed prior repair 7 Prosthetic valve failure 8 Peri-prosthetic leak 9 Prosthetic valve thrombosis 10 Active infection </td> <td style="width: 50%; vertical-align: top;"> 11 Previous infection 12 Marfans 13 Annuloaortic ectasia 14 Other degen. Disease 15 Dissection 16 Tumour 17 Trauma 18 Iatrogenic 99 Other </td> </tr> </table>	1 Rheumatic 2 Congenital 3 Ischaemic 4 Idiopathic Calcific 5 Myxomatous degen. 6 Failed prior repair 7 Prosthetic valve failure 8 Peri-prosthetic leak 9 Prosthetic valve thrombosis 10 Active infection	11 Previous infection 12 Marfans 13 Annuloaortic ectasia 14 Other degen. Disease 15 Dissection 16 Tumour 17 Trauma 18 Iatrogenic 99 Other
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Section 6: Operative Status/Category

91 (89)	<p>NAME: SURGEON</p> <p>Definition:</p> <p>Data: As code (needs to be coded by ASCTS and software company)</p>
92 (90)	<p>NAME: PROCEDURALIST</p> <p>Definition: Which of the following was the operating surgeon</p> <p>Data:</p> <p>Consultant Senior Registrar: (FRACS) Trainee Registrar Overseas Fellow</p>
93 (91)	<p>NAME: STATUS</p> <p>Definition:</p> <p>Data:</p> <p>Elective: The procedure could be Deferred without increased risk of compromised cardiac outcome.</p> <p>Urgent: Not routine – medical reason for operating this admission – does not include scheduling operation within admission for convenience.</p> <p>Emergency: Unscheduled surgery required in next available theatre on same day due to refractory angina or cardiac compromise</p> <p>Salvage: The patient is undergoing CPR en route to the operating room prior to surgical incision.</p>

FUNCTIONAL DEFINITIONS
(old #)

94 (93)	<p>NAME: DIRECT TRANSFER FROM CATH LAB TO THEATRE</p> <p>Definition: As a result of a cardiac catheter lab complication, in the opinion of the operator or the responsible physician, the patient needed to be moved directly to surgery from the cath lab or hospital ward. Typically due to indications such as ongoing ischaemia, rest angina despite maximal treatment, pulmonary oedema requiring intubation, or shock.</p> <p>Data: Yes No</p>
95 (96)	<p>NAME: CORONARY ARTERY BYPASS</p> <p>Definition: Current Surgical Procedure is Coronary Artery Bypass</p> <p>Data: Yes No</p>
96 (95)	<p>NAME: VALVE SURGERY</p> <p>Definition: Current Surgical Procedure is Valve Surgery</p> <p>Data: Yes No</p>
97 (96)	<p>NAME: OTHER CARDIAC SURGERY</p> <p>Definition: Current Surgical Procedure is Cardiac surgery other than Valve surgery or Coronary Artery Bypass</p> <p>Data: Yes No</p>
98 (97)	<p>NAME: LVA</p> <p>Definition: LVA Surgery</p> <p>Data: Yes No</p>
99 (98)	<p>NAME: VSD (ACQUIRED)</p> <p>Definition: Current Surgical Procedure is for the correction of a Ventricular Septal Defect (acquired)</p> <p>Data: Yes No</p>
100 (99)	<p>NAME: ASD</p> <p>Definition: Current Surgical Procedure is for the correction of an Atrial Septal Defect</p> <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

101 (100)	<p>NAME: OTHER CONGENITAL</p> <p>Definition: Current Surgical Procedure is for a congenital complication not otherwise specified</p> <p>Data: Yes No</p>
102 (101)	<p>NAME: CARDIAC TRANSPLANT</p> <p>Definition: Current Surgical Procedure is Cardiac Transplant</p> <p>Data: Yes No</p>
103 (102)	<p>NAME: TRANSMYOCARDIAL LASER</p> <p>Definition: Current Surgical Procedure is creation of multiple channels in left ventricular myocardium with a laser fibre.</p> <p>Data: Yes No</p>
104 (103)	<p>NAME: PPM</p> <p>Definition: Current Surgical Procedure is insertion of a Permanent Pacemaker</p> <p>Data: Yes No</p>
105 (104)	<p>NAME: ICD</p> <p>Definition: Internal Cardio Defibrillator Surgery</p> <p>Data: Yes No</p>
106 (105)	<p>NAME: CARDIAC TRAUMA</p> <p>Definition: Current Surgical Procedure is for the repair of Cardiac Trauma</p> <p>Data: Yes No</p>
107 (106)	<p>NAME: CARDIAC TUMOURS</p> <p>Definition: Current Surgical Procedure is for removal of Cardiac Tumours</p> <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

108 (107)	<p>NAME: PERICARDIECTOMY</p> <p>Definition: Current Surgical Procedure is a pericardiectomy</p> <p>Data: Yes No</p>
109 (108)	<p>NAME: CARDIAC SURGERY NOT OTHERWISE SPECIFIED</p> <p>Definition: Current Surgical Procedure is a cardiac procedure not otherwise specified</p> <p>Data: Yes No</p>
110 (109)	<p>NAME: OTHER NON CARDIAC SURGERY</p> <p>Definition: Current Surgical Procedure is Non Cardiac</p> <p>Data: Yes No</p>
111 (110)	<p>NAME: AORTIC ANEURYSM</p> <p>Definition: Aortic Aneurysm repair</p> <p>Data: Yes No</p>
112 (110)	<p>NAME: AORTIC DISSECTION</p> <p>Definition: Aortic Dissection repair</p> <p>Data: Yes No</p>
113 (111)	<p>NAME: AORTIC ANEURYSM TYPE</p> <p>Definition: Aortic Aneurysm type. Choose one of the following:</p> <p>Data: Ascending Arch Descending Thor/Abd</p>
114 (111)	<p>NAME: AORTIC DISSECTION TYPE</p> <p>Definition: Aortic dissection type. Choose one of the following:</p> <p>Data: Ascending Descending (only)</p>

FUNCTIONAL DEFINITIONS
(old #)

115 (112)	NAME: AORTIC DISSECTION - ACUTE Definition: Was the dissection acute – occurring within last 2 weeks. Choose one of the following: Data: Acute (<=2 weeks) (>2 weeks)
116	NAME: ACUTE TRAUMATIC AORTIC TRANSECTION Definition: Indication for surgery is traumatic aortic transection – occurring within last 2 weeks. Data: Yes No
117 (113)	NAME: CAROTID ENDARTERECTOMY Definition: Surgical removal of stenotic atheromatous plaque. Data: Yes No
118 (114)	NAME: OTHER VASCULAR SURGERY Definition: Procedures correcting peripheral vascular occlusion. Data: Yes No
119 (115)	NAME: OTHER THORACIC SURGERY Definition: Procedures involving Thorax/pleura. Data: Yes No

Section 7: Minimally Invasive

120 (117)	NAME: MINIMALLY INVASIVE TECHNIQUE ATTEMPT Definition: Was a non-standard incision used to minimise trauma, either as a beating heart off-pump coronary artery procedure or as an on-pump cardiac procedure utilising any form of cardiopulmonary bypass. Data: Yes No
121 (118)	NAME: MINIMALLY INVASIVE TECHNIQUE INDICATION Definition: What was the indication for attempting a minimally invasive technique? Select ONE of the following Data: Surgeon/Patient choice Contraindications for standard incision Combined with Catheter Intervention

FUNCTIONAL DEFINITIONS
(old #)

122 (119)	<p>NAME: OPERATION PERFORMED OFF-PUMP</p> <p>Definition: Was the operation performed off-pump</p> <p>Data: Yes No</p>
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Section 8: CPB and Support

123 (120)	<p>NAME: CARDIOPULMONARY BYPASS USED</p> <p>Definition: Was cardiopulmonary bypass used</p> <p>Data: Yes No</p>
124 (121)	<p>NAME: CARDIOPLEGIA</p> <p>Definition: Was cardioplegia used</p> <p>Data: Yes No</p>
125 (123)	<p>NAME: CROSS CLAMP TIME</p> <p>Definition: Total number of minutes the aorta is completely cross-clamped during bypass. Enter zero if no cross clamp was used.</p> <p>Data: 0 – 600 minutes</p>
126 (124)	<p>NAME: PERFUSION TIME</p> <p>Definition: Total number of minutes on cardiopulmonary bypass. Enter zero if no cardiopulmonary bypass was used.</p> <p>Data: 0 – 999 minutes</p>
127 (125)	<p>NAME: IABP</p> <p>Definition: Was the patient placed on Intra-Aortic Balloon Pump (IABP)?</p> <p>Data: Yes No</p>
128 (126)	<p>NAME: IABP - WHEN INSERTED</p> <p>Definition: What was the time of earliest IABP insertion? Choose one of the following:</p> <p>Data: Pre-Operatively: (before patient enters the operating theatre). Intra-Operatively Post-Operatively</p>

FUNCTIONAL DEFINITIONS
(old #)

129 (127)	NAME: IABP - INDICATION Definition: What was the PRIMARY reason for inserting the IABP? Choose one of the following: Data: Haemodynamic Instability PTCA Support Unstable Angina CBP Wean: Cardiopulmonary bypass (CPB) weaning failure. Prophylactic
130 (128)	NAME: VENTRICULAR ASSIST DEVICE Definition: Was a VAD/ECMO used at the time the patient left the operating room? Data: Yes No

Section 9: Coronary Bypass

131 (129)	NAME: IMA USED Definition: Was an Internal Mammary Artery Used for Coronary Bypass Data: Yes No
132 (130)	NAME: LEFT IMA USED Definition: Was a Left Internal Mammary Artery Used for Coronary Bypass Data: Yes No
133 (131)	NAME: RIGHT IMA USED Definition: Was a Right Internal Mammary Artery Used for Coronary Bypass Data: Yes No
134 (132)	NAME: NUMBER OF DISTAL ANASTOMOSES Definition: The total number of distal anastomoses Data: 0 – 9
135 (133)	NAME: NUMBER OF DISTAL ANASTOMOSES WITH ARTERIAL CONDUITS Definition: The total number of distal anastomoses with arterial conduits, whether IMA, GEPA, radial artery, etc. Data: 0 – 9

FUNCTIONAL DEFINITIONS
(old #)

136 (134)	NAME: NUMBER OF IMA DISTAL ANASTOMOSES Definition: Total number of distal anastomoses done using internal mammary artery grafts. Data: 0 – 6
137 (135)	NAME: NUMBER OF RADIAL ARTERY CONDUITS USED Definition: Total number of radial artery conduits used Data: 0,1,or 2
138 (136)	NAME: NUMBER OF RADIAL DISTAL ANASTOMOSES Definition: Total number of radial distal anastomoses Data: 0 – 6
139 (137)	NAME: NUMBER OF DISTAL ANASTOMOSES - VEIN Definition: The total number of distal anastomoses with venous conduits, eg. saphenous veins Data: 0 – 9
140 (139)	NAME: NUMBER OF GEPA DISTAL ANASTOMOSES Definition: Total number of GEPA distal anastomoses Data: 0 – 6
141 (138)	NAME: ARTERIAL T-GRAFT OR Y-GRAFT Definition: Any form of T or Y graft between segments of arterial conduit Data: Yes No

Section 10: Valve Surgery

142 (140)	NAME: AORTIC VALVE PROCEDURE Definition: Was a surgical procedure done on the Aortic Valve, and if so what? Select one of the following: Data: 1: No. 3: Replacement. 5: Repair/Reconstruction without annuloplasty 6: Root Reconstruction with Valve Conduit; 7: Root Reconstruction with Valve Sparing. 8: Resuspension Aortic Valve; 9: Resection Sub-Aortic Stenosis; 11: Commissurotomy without annuloplasty ring 12: Repair Paravalvular leak
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FUNCTIONAL DEFINITIONS
(old #)

<p>143 (141)</p>	<p>NAME: MITRAL VALVE PROCEDURE</p> <p>Definition: Was a surgical procedure done on the Mitral Valve, and if so what? Select one of the following:</p> <p>Data: 1: No 2: Annuloplasty Only. 3: Replacement. 4: Repair/Reconstruction with Annuloplasty. 5: Repair/Reconstruction without Annuloplasty. 10: Commissurotomy with annuloplasty ring; 11: Commissurotomy without annuloplasty ring. 12: Repair Paravalvular leak</p>
<p>144 (142)</p>	<p>NAME: TRICUSPID VALVE PROCEDURE</p> <p>Definition: Was a surgical procedure done on the Tricuspid Valve, and if so what? Select one of the following:</p> <p>Data: 1: No. 2: Annuloplasty Only. 3: Replacement. 4: Repair/Reconstruction with Annuloplasty. 5: Repair/Reconstruction without Annuloplasty. 10: Commissurotomy with annuloplasty ring; 11: Commissurotomy without annuloplasty ring. 12: Repair Paravalvular leak 13: Valvectomy (no replacement)</p>
<p>145 (143)</p>	<p>NAME: PULMONARY VALVE PROCEDURE</p> <p>Definition: Was a surgical procedure done on the Pulmonic Valve, and if so what? Select one of the following:</p> <p>Data: 1: No. 3: Replacement. 5: Repair/Reconstruction without annuloplasty. 10: Commissurotomy with annuloplasty ring; 11: Commissurotomy without annuloplasty ring. 12: Repair Paravalvular leak</p>
<p>146 (144)</p>	<p>NAME: AORTIC VALVE PROSTHESIS - IMPLANT</p> <p>Definition: Select the code of the prosthesis implanted.</p> <p>Data: See page (26)</p>
<p>147 (149)</p>	<p>NAME: MITRAL VALVE PROSTHESIS - IMPLANT</p> <p>Definition: Select the code of the prosthesis implanted</p> <p>Data: See page (26)</p>
<p>148 (154)</p>	<p>NAME: TRICUSPID VALVE PROSTHESIS - IMPLANT</p> <p>Definition: Select the code of the prosthesis implanted</p> <p>Data: See page (26)</p>

FUNCTIONAL DEFINITIONS
(old #)

149 (159)	NAME: PULMONARY VALVE PROSTHESIS - IMPLANT Definition: Select the code of the prosthesis implanted Data: See below
150 (148)	NAME: AORTIC VALVE PROSTHESIS - EXPLANT Definition: Select the code of the prosthesis explanted. Data: See below
151 (152)	NAME: MITRAL VALVE PROSTHESIS - EXPLANT Definition: Select the code of the prosthesis explanted Data: See below
152 (157)	NAME: TRICUSPID VALVE PROSTHESIS - EXPLANT Definition: Select the code of the prosthesis explanted. Data: See below
153 (162)	NAME: PULMONARY VALVE PROSTHESIS - EXPLANT Definition: Select the code of the prosthesis explanted. Data: See below

Mechanical

101. St. Jude Medical Mechanical
102. Baxter Healthcare – Starr-Edwards Caged-Ball
103. Medtronic-Hall Mechanical
104. Sulzer CarboMedics Mechanical
105. ATS Medical Mechanical
106. Bjork-Shiley Mechanical
107. Edwards Tekna Mechanical (Duramedics)
108. Lillehei-Kaster Mechanical
109. Medical Incorporated – OmniScience and Omnicarbon Mechanical
110. On-X Mechanical
111. Baxter Mira Mechanical
112. Other

Bioprosthetic - Stented

201. Baxter – Carpentier-Edwards Standard Porcine
202. Baxter – Carpentier-Edwards SupraAnnular Porcine
203. Baxter – Carpentier-Edwards Bovine Pericardial
204. Medtronic Mosaic Porcine
205. Medtronic Intact Porcine
206. St. Jude Medical-Bioimplant Porcine
207. Mitroflow Pericardial
208. Biocor Porcine Carbomedics
209. CarboMedics PhotoFix Pericardial
210. Hancock Standard Porcine Bioprosthesis
211. Hancock II Porcine
212. Hancock Modified Orifice Porcine
213. Other

Bioprosthetic – Stentless

301. Baxter Prima Plus Stentless Porcine
302. Medtronic Freestyle Stentless Porcine
303. Medtronic Freestyle “S” Stentless Porcine
304. St. Jude Medical – Toronto SPV Stentless Porcine
305. Cryolife O’Brien Stentless Porcine
306. Cryolife Ross Porcine
307. Other

Allograft and Auto graft

401. Allograft Aortic
402. Allograft Mitral
403. Allograft Pulmonic Root
404. Pulmonary Autograft: root or other method of insertion
405. Other

Rings

501. Baxter – Carpentier-Edwards Classic Ring
502. Baxter – Carpentier-Edwards Physio Ring
503. Baxter – Cosgrove- Edwards Ring
504. Medtronic Duran Ring
505. Medtronic Duran Band Ring
506. Sorin-Puig Messana Ring
507. Medtronic Sculptor Ring
508. St. Jude Medical Seguin Ring
509. Sulzer-Carbomedics AnnuloFlo
510. Pericardial
511. Other

FUNCTIONAL DEFINITIONS
(old #)

154 (145)	NAME: AORTIC VALVE PROSTHESIS – IMPLANT - SIZE Definition: The size of the aortic prosthesis implant Data: 5 – 50 mm
155 (151)	NAME: MITRAL VALVE PROSTHESIS – IMPLANT - SIZE Definition: The size of the mitral prosthesis implant Data: 5 – 50 mm
156 (156)	NAME: TRICUSPID VALVE PROSTHESIS – IMPLANT - SIZE Definition: The size of the tricuspid prosthesis implant Data: 5 – 50 mm
157 (161)	NAME: PULMONARY VALVE PROSTHESIS – IMPLANT - SIZE Definition: The size of the pulmonary prosthesis implant Data: 5 – 50 mm
158	NAME: AORTIC VALVE PROSTHESIS – EXPLANT - SIZE Definition: The size of the aortic prosthesis explant Data: 5 – 50 mm
159	NAME: MITRAL VALVE PROSTHESIS – EXPLANT - SIZE Definition: The size of the mitral prosthesis explant Data: 5 – 50 mm
160	NAME: TRICUSPID VALVE PROSTHESIS – EXPLANT - SIZE Definition: The size of the tricuspid prosthesis explant Data: 5 – 50 mm
161	NAME: PULMONARY VALVE PROSTHESIS – EXPLANT - SIZE Definition: The size of the pulmonary prosthesis explant Data: 5 – 50 mm

FUNCTIONAL DEFINITIONS
(old #)

<p>162 (146)</p>	<p>NAME: AORTIC VALVE PROSTHESIS – IMPLANT - TYPE</p> <p>Definition: Indicate the type of implant; choose one:</p> <p>Data: N: None M: Mechanical B: Bioprosthesis H: Homograft A: Autograft R: Ring/Annuloplasty</p>
<p>163 (150)</p>	<p>NAME: MITRAL VALVE PROSTHESIS – IMPLANT - TYPE</p> <p>Definition: Indicate the type of implant; choose one:</p> <p>Data: N: None M: Mechanical B: Bioprosthesis H: Homograft A: Autograft R: Ring/Annuloplasty</p>
<p>164 (155)</p>	<p>NAME: TRICUSPID VALVE PROSTHESIS – IMPLANT - TYPE</p> <p>Definition: Indicate the type of implant; choose one:</p> <p>Data: N: None M: Mechanical B: Bioprosthesis H: Homograft A: Autograft R: Ring/Annuloplasty</p>
<p>165 (160)</p>	<p>NAME: PULMONARY VALVE PROSTHESIS – IMPLANT - TYPE</p> <p>Definition: Indicate the type of implant; choose one:</p> <p>Data: N: None M: Mechanical B: Bioprosthesis H: Homograft A: Autograft R: Ring/Annuloplasty</p>
<p>166 (147)</p>	<p>NAME: AORTIC VALVE PROSTHESIS – EXPLANT - TYPE</p> <p>Definition: Indicate the type of implant; choose one:</p> <p>Data: N: None M: Mechanical B: Bioprosthesis H: Homograft A: Autograft R: Ring/Annuloplasty</p>

FUNCTIONAL DEFINITIONS
(old #)

167 (153)	<p>NAME: MITRAL VALVE PROSTHESIS – EXPLANT - TYPE</p> <p>Definition: Indicate the type of implant; choose one:</p> <p>Data: N: None M: Mechanical B: Bioprosthesis H: Homograft A: Autograft R: Ring/Annuloplasty</p>
168 (158)	<p>NAME: TRICUSPID VALVE PROSTHESIS – EXPLANT - TYPE</p> <p>Definition: Indicate the type of implant; choose one:</p> <p>Data: N: None M: Mechanical B: Bioprosthesis H: Homograft A: Autograft R: Ring/Annuloplasty</p>
169 (163)	<p>NAME: PULMONARY VALVE PROSTHESIS – EXPLANT - TYPE</p> <p>Definition: Indicate the type of implant; choose one:</p> <p>Data: N: None M: Mechanical B: Bioprosthesis H: Homograft A: Autograft R: Ring/Annuloplasty</p>

Section 11. Post-Operative Data

170 (164)	<p>NAME: BLOOD PRODUCTS - RBC</p> <p>Definition: Were Red Blood Cells transfused post-operatively?</p> <p>Do not include:</p> <ul style="list-style-type: none"> a. Pre-donated Blood b. Cellsaver Blood c. Pump Residual Blood d. Chest Tube Recirculated Blood <p>Data: Yes No</p>
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FUNCTIONAL DEFINITIONS
(old #)

171 (165)	<p>NAME: BLOOD PRODUCTS - NON RBC</p> <p>Definition: Was a transfusion of blood products other than RBC given (eg. FFP, Platelets)</p> <p>Data: Yes No</p>
172 (166)	<p>NAME: POST-OP VENTILATION HOURS</p> <p>Definition: Indicate the number of hours post operation for which the patient was ventilated. Use zero if the patient was extubated on the operating table. Do not count delayed re-intubation time.</p> <p>Data: 0 – 5000</p>
173	<p>NAME: ICU STAY</p> <p>Definition: Number of hours spent by the patient in the ICU prior to transfer to the HDU or General Ward (does not include readmission to ICU)</p> <p>Data: No. of Hours</p>
174	<p>NAME: READMITTED TO ICU</p> <p>Definition: Was patient readmitted to ICU following transfer to the HDU or General Ward</p> <p>Data: Yes No</p>

Complications

175 (167)	<p>NAME: RETURN TO THEATRE</p> <p>Definition: Did patient return to the operating theatre for management of complications. Includes operative procedures done in the ICU that normally would be performed in the operating theatre.</p> <p>Data: Yes No</p>
176 (168)	<p>NAME: RE-OP BLEED</p> <p>Definition: Operative re-intervention was required for bleeding/tamponade.</p> <p>Data: Yes No</p>
177 (169)	<p>NAME: RE-OP VALVE DYSFUNCTION</p> <p>Definition: Operative re-intervention was required for valve dysfunction.</p> <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

178 (170)	<p>NAME: RE-OP GRAFT OCCLUSION</p> <p>Definition: Operative re-intervention was required for coronary graft occlusion.</p> <p>Data: Yes No</p>
179 (171)	<p>NAME: RE-OP DEEP STERNAL INFECTION</p> <p>Definition: Operative re-intervention for infection of sternal bone, muscle and/or mediastinum</p> <p>Data: Yes No</p>
180 (172)	<p>NAME: RE-OP OTHER CARDIAC</p> <p>Definition: Operative re-intervention was required for other cardiac reasons.</p> <p>Data: Yes No</p>
181 (173)	<p>NAME: RE-OP OTHER NON CARDIAC</p> <p>Definition: Operative re-intervention was required for other non-cardiac reasons.</p> <p>Data: Yes No</p>
182 (174)	<p>NAME: PERI-OPERATIVE MI</p> <p>Definition: A peri-operative Myocardial Infarction (MI) is diagnosed by finding at least two of the following three criteria:</p> <p>a. Enzyme level elevation: either (1) CK-MB >30; or (2) troponin >20.0 micrograms /L. Or troponin level equivalent documented at your institution</p> <p>b. New wall motion abnormalities</p> <p>c. Serial EGG (at least two) showing new Q waves</p> <p>Data: Yes No</p>
183 (175)	<p>NAME: NEW CARDIAC ARRHYTHMIA</p> <p>Definition: Did any new form of cardiac arrhythmia occur that required treatment?</p> <p>Data: Yes No</p>
184 (176)	<p>NAME: HEART BLOCK</p> <p>Definition: New heart block requiring the implantation of a permanent pacemaker prior to discharge</p> <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

<p>185</p>	<p>NAME: OTHER BRADY-ARRHYTHMIA</p> <p>Definition: New brady-arrhythmia not otherwise specified requiring the implantation of a permanent pacemaker prior to discharge</p> <p>Data: Yes No</p>
<p>186 (176)</p>	<p>NAME: CARDIAC ARREST</p> <p>Definition: A cardiac arrest documented by one of the following:</p> <p>a. ventricular fibrillation b. rapid ventricular tachycardia with haemodynamic instability c. asystole.</p> <p>Data: Yes No</p>
<p>187 (177)</p>	<p>NAME: ATRIAL FIBRILLATION OR FLUTTER</p> <p>Definition: New onset of atrial fibrillation/flutter (AF) requiring treatment. Does not include recurrence of AF which had been present pre-operatively.</p> <p>Data: Yes No</p>
<p>188</p>	<p>NAME: NEW VENTRICULAR TACHYCARDIA</p> <p>Definition: Did any new form of ventricular tachycardia (greater than 6 beat run) occur that required treatment?</p> <p>Data: Yes No</p>
<p>189 (179)</p>	<p>NAME: NEURO – STROKE PERMANENT</p> <p>Definition: A central neurologic Deficit persisting for > 72 hours.</p> <p>Data: Yes No</p>
<p>190 (180)</p>	<p>NAME: NEURO – STROKE TRANSIENT</p> <p>Definition: A transient neurologic Deficit (TIA, RIND).</p> <p>Data: Yes No</p>
<p>191 (181)</p>	<p>NAME: NEURO – CONT COMA >=24 HOURS</p> <p>Definition: New post-operative coma that persists for at least 24 hours.</p> <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

192 (182)	<p>NAME: PULMONARY - VENTILATION PROLONGED > 24 HOURS</p> <p>Definition: Post Operative Pulmonary Insufficiency requiring ventilatory support - includes (but not limited to) causes such as ARDS and pulmonary oedema- for a total period of longer than 24 hours. Use cumulative period if patient re-intubated.</p> <p>Data: Yes No</p>
193 (183)	<p>NAME: PULMONARY EMBOLISM</p> <p>Definition: Pulmonary Embolism diagnosed by study such as V/Q scan or angiogram.</p> <p>Data: Yes No</p>
194 (184)	<p>NAME: PULMONARY - PNEUMONIA</p> <p>Definition: Pneumonia diagnosed by one of the following: Positive cultures of sputum, blood, pleural fluid, empyema fluid, trans-tracheal fluid or transthoracic fluid; consistent with the diagnosis and clinical findings of pneumonia. May include chest x-ray diagnostic of pulmonary infiltrates.</p> <p>Data: Yes No</p>
195 (185)	<p>NAME: PULMONARY - RE-INTUBATION</p> <p>Definition: Was re-intubation required for any reason during hospitalisation</p> <p>Data: Yes No</p>
196 (186)	<p>NAME: RENAL - NEW RENAL FAILURE</p> <p>Definition: Acute post-operative renal insufficiency resulting in two or more of the following:</p> <ul style="list-style-type: none"> a. Increased serum creatinine to >0.2 mmol/l (>200 µmol/l). b. A doubling or greater increase in creatinine over baseline pre-operative value. c. A new requirement for dialysis/haemofiltration <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

<p>197 (187)</p>	<p>NAME: INFECTION - STERNAL DEEP</p> <p>Definition: A deep sternal infection involves muscle, bone, and/or mediastinum.</p> <p>Must have one of the following conditions: a. Wound opened with excision of tissue b. Positive culture c. Treatment with antibiotics</p> <p>Data: Yes No</p>
<p>198 (188)</p>	<p>NAME: INFECTION - THORACOTOMY</p> <p>Definition: An infection involving a thoracotomy or parasternal site.</p> <p>Must have one of the following conditions: a. Wound opened with excision of tissue b. Positive culture c. Treatment with antibiotics</p> <p>Data: Yes No</p>
<p>199 (189)</p>	<p>NAME: INFECTION - SEPTICAEMIA</p> <p>Definition: Septicaemia (Requires Positive Blood Cultures) post-operatively</p> <p>Data: Yes No</p>
<p>200 (190)</p>	<p>NAME: VASCULAR - AORTIC DISSECTION</p> <p>Definition: Dissection occurring in any part of the aorta.</p> <p>Data: Yes No</p>
<p>201 (191)</p>	<p>NAME: VASCULAR - ACUTE LIMB ISCHAEMIA</p> <p>Definition: Any complication producing limb ischaemia</p> <p>Data: Yes No</p>
<p>202 (192)</p>	<p>NAME: OTHER - ANTICOAGULATION COMPLICATIONS</p> <p>Definition: Bleeding, haemorrhage, and/or embolic events related to anticoagulant therapy.</p> <p>Data: Yes No</p>

FUNCTIONAL DEFINITIONS
(old #)

203 (193)	<p>NAME: GIT COMPLICATIONS</p> <p>Definition: Post-operative occurrence of any GI complication including:</p> <ul style="list-style-type: none"> a. GI bleeding requiring transfusion b. Pancreatitis with abnormal amylase/lipase requiring nasogastric suction therapy c. Cholecystitis requiring cholecystectomy or drainage d. Mesenteric ischaemia requiring exploration e. Other GI complication. <p>Data: Yes No</p>
204 (194)	<p>NAME: MULTI SYSTEM FAILURE</p> <p>Definition: Two or more major organ systems suffer compromised functions</p> <p>Data: Yes No</p>

Section 12: Mortality/Readmission

205 (195)	<p>NAME: HOSPITAL MORTALITY</p> <p>Definition: Specify whether the patient was alive or dead at discharge from the Hospitalisation in which surgery occurred. (Discharge to Hospital in the Home is considered discharge from hospital)</p> <p>Data: Yes No</p>
206 (196)	<p>NAME: MORTALITY WITHIN 30 DAYS POST-PROCEDURE</p> <p>Definition: Specify whether the patient was alive or dead 30 days after the procedure was performed (Date of surgery counts as day 0)</p> <p>Data: Yes No</p>
207 (197)	<p>NAME: MORTALITY - DATE</p> <p>Definition: What was the date of death?</p> <p>Data:</p>
208 (198)	<p>NAME: MORTALITY - LOCATION</p> <p>Definition: Specify the patient location at time of death:</p> <p>Data: Operating Room: (OR). Hospital : (Other than Operating Room). Home: (Including Hospital in the Home). Other Care Facility</p>

FUNCTIONAL DEFINITIONS
(old #)

<p>209 (199)</p>	<p>NAME: MORTALITY - PRIMARY CAUSE</p> <p>Definition: Specify the PRIMARY cause of death, i.e. the first significant abnormal event which ultimately led to death; choose one of the following:</p> <p>Data: Cardiac Neurologic Renal Vascular Infection Pulmonary Valvular Multisystem failure Other Unknown</p>
<p>210 (200)</p>	<p>NAME: READMISSION <=30 DAYS FROM SURGERY</p> <p>Definition: Patient was readmitted as an in-patient within 30 days from the date of surgery for ANY reason. (Not including planned transfer to rehabilitation facility) (Date of surgery counts as day 0)</p> <p>Data: Yes No</p>
<p>211 (201)</p>	<p>NAME: READMIT REASON</p> <p>Definition: Primary reason the patient was readmitted as an in-patient within 30 days from the date of surgery (Select one):</p> <p>Data: Anticoagulant Complication. Arrhythmia. Congestive Heart Failure (CHF). Myocardial Infarction (MI) and/or Recurrent Angina. Pericardial Effusion and/or Cardiac Tamponade. Valve Dysfunction. Other Incisional Complication. Pneumonia or other Respiratory Complication. Deep Sternal infection. Other Complication related to Cardiac Surgery (eg. renal, hepatic, GI, etc.). Other readmission unrelated to Cardiac Surgery</p>

Automatic Data (not entered on the Data Collection Form)

<p>212 (1)</p>	<p>NAME: HOSPITAL ID</p> <p>Definition: Number assigned to participating hospital</p> <p>Data:</p>
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FUNCTIONAL DEFINITIONS
(old #)

213 (2)	<p>NAME: PATIENT ID</p> <p>Definition: This is an arbitrary number, (not a recognisable ID like SSN or Medical Record Number) that uniquely and permanently identifies each patient. Once assigned to a patient, this can never be changed or reused. Determined by software company.</p> <p>Data: (unique arbitrary permanent value for each patient)</p>
214 (3)	<p>NAME: RECORD ID</p> <p>Definition:</p> <p>Data: (Unique permanent value for each record, generated automatically by software)</p>
215 (9)	<p>NAME: PATIENT AGE</p> <p>Definition: Patient age in years, at time of surgery.</p> <p>Data: (calculated)</p>
216 (15)	<p>NAME: INDIGENOUS STATUS</p> <p>Definition: Does racial group include Aboriginal or Torres Strait or both</p> <p>Data: (calculated)</p>
217 (71)	<p>NAME: BSA – AUTOMATIC CALCULATION</p> <p>Definition: Body Surface area calculated by the following equation. (Weight x 0.425) x (Height x 0.725) x 71.84 Calculated automatically where height and weight is available.</p> <p>Data: m²</p>
218 (116)	<p>NAME: PREDICTED RISK OF MORTALITY</p> <p>Definition:</p> <p>Data: (calculated)</p>